2022 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule Summary

Physician Payment Schedule

On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2022 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies proposed rule (published in the Federal Register on July 23, 2021 – Docket number CMS-1751-P). In addition, CMS published a fact sheet on the PFS proposed rule highlighting the key provisions. If finalized, the proposed policies in the rule will take effect on January 1, 2022. CMS is requesting that **comments be submitted no later than September 13, 2021.** The American Medical Association (AMA) will share a draft comment letter in response to the proposed rule with the Federation prior to this submission deadline. The AMA is continuing to review the rule and will work with our colleagues in the Federation to further analyze these policies in the coming weeks.

The proposed rule covers diverse topics, including the CY 2022 Rate Setting and Medicare Conversion Factor, Evaluation/Management (E/M) office visit services, telehealth and other services involving communications technology, and updates to the Quality Payment Program through Merit-based Incentive Payment System (MIPS) activities, methodology, payment adjustments, and the Promoting Interoperability performance category, amongst other provisions. Below is a summary of select provisions proposed in the rule.

CY 2022 PFS Rate Setting and Medicare Conversion Factor

The proposed CY 2022 PFS conversion factor is $33.58, a decrease of $1.31 from the CY 2021 PFS conversion factor of $34.89. This represents a 3.75 percent decrease in the conversion factor compared to last year. The proposed CY 2022 anesthesia conversion factor is $21.04, a decrease of $0.52 from the CY 2021 anesthesia conversion factor of $21.56. These CMS proposed conversion factors include the budget neutrality adjustment from the 2021 implementation of improved payments to Evaluation and Management (E/M) Office Visits.

Under the Medicare Access and CHIP Reauthorization Act (MACRA), the statutory physician payment update for CY 2022 is zero percent. Further, the budget neutrality adjustment will be required in 2022 to offset the payment increases for office visits.

The consensus of the AMA and the Federation is that the budget neutrality adjustment must continue to be waived in light of the continued COVID-19 public health emergency (PHE) and the **AMA strongly urges Congress to waive the budget neutrality payment reduction of 3.75 percent.** For more information, please see the AMA prepared specialty level **Combined Impact of Proposed Rule and Conversion Factor Reduction for 2022** sent along with this summary which combines the proposed specialty level impacts and the decreased CF.

Physician Work and Practice Expense Relative Value Changes

CMS proposes to implement 76 percent of the AMA/Specialty Society RVS Update Committee (RUC) recommendations related to the physician work of performing services articulated by new and revised Current Procedure Terminology® (CPT®) 2022 codes. Nearly all of the direct practice cost recommendations for these services were accepted and will be implemented.

CY 2022 will be the final year of transition to the new CMS prices for medical supplies and equipment. For 2022, CMS proposes to also implement new wage data from the United States Bureau of Labor Statistics to update clinical labor costs. These wage rates were last updated in 2002 and the updated data significantly increase the overall pool of direct costs. The direct practice expense data within the Medicare Physician Payment Schedule is a fixed pool of resources, and therefore implementation of these

increased costs result in a redistribution. The total direct practice expense pool increases by 30 percent under this proposal, resulting in a significant budget neutrality adjustment. The specialty level impacts illustrate that specialties that perform high supply and equipment cost procedures in the office (e.g., radiation oncology, vascular surgery and interventional radiology) are particularly harmed by the budget neutrality provision of this proposal. Office-based specialties with high labor costs (e.g., family medicine, internal medicine subspecialties) benefit from the proposal. CMS has requested comment as to whether this proposal should be fully implemented in CY 2022 or whether a four-year transition should occur.

Comment Solicitation for Impact of Infectious Disease on Codes and Ratesetting

During the COVID-19 PHE, CMS heard stakeholders' concerns regarding additional costs borne by physicians due to the pandemic that may impact the professional services furnished to Medicare beneficiaries. CMS seeks comments on whether Medicare should make changes to payments for services or develop separate payments to account for PHE-related costs, such as disease control measures, research-related activities and services, or PHE-related preventive or therapeutic counseling services. The AMA and 127 state medical and national specialty societies have urged CMS to implement and pay for CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* to compensate physician practices for the additional supplies and new staff activities required in order to provide safe patient care during the COVID-19 PHE without patient cost-sharing. **The AMA continues to urge CMS to adopt CPT code 99072, which describes the extra supplies and clinical staff time required to perform safety protocols for the provision of evaluation, treatment, or procedural services during a PHE in a setting where extra precautions are taken.**

Evaluation and Management (E/M) Services

Effective January 1, 2021, CMS implemented sweeping revisions to office and outpatient E/M visits as recommended by the CPT Editorial Panel and the RUC, which allow physicians to select the E/M visit level to bill based on either total time spent on the date of patient encounter or the medical decision making utilized in the provision of the visit. Due to these changes and recent withdrawal of guidance in the Medicare Claims Policy Manual, CMS is reviewing other E/M visit code sets and proposes clarifications regarding split (or shared) visits, critical care services, and teaching physician visits.

CMS proposes to define a split (or shared) visit as an E/M visit in the facility setting, for which "incident to" payment is not available, and that is performed in part by both a physician and a non-physician practitioner (NPP). Only the physician or NPP who performs the substantive portion of the split (or shared) visit would bill for the visit. CMS proposes to define substantive portion as more than half of the total time spent by the physician and NPP. CMS also proposes to modify its existing policy to allow either physicians or NPPs to bill for split (or shared) visits for both new and established patients, and for critical care and certain Skilled Nursing Facility/Nursing Facility (SNF/NF) E/M visits. CMS also notes that Medicare does not pay for partial E/M visits. CMS proposes that a modifier be utilized to designate these split (or shared) visits in claims data.

CMS proposes to adopt the CPT prefatory language for critical care services as currently described in the CPT Guidelines. CMS further proposes to prohibit a practitioner that reports critical care services furnished to a patient from also reporting any other E/M visit for the same patient on the same calendar day that the critical care services are furnished to that patient and vice versa. Additionally, CMS would prohibit billing critical care visits during the same time as a procedure with a global surgical period.

Finally, CMS proposes that when total time is used to determine the office or outpatient E/M visit level for teaching physician services, only the time that the teaching physician was present can be included.

Telehealth / Audio Only

Retention of Category 3 Services Through the End of 2023

CMS is proposing to continue paying for services placed temporarily on the telehealth list through the end of 2023. This proposal is consistent with AMA's advocacy that the CMS maintain Medicare coverage and payment for the many services that were temporarily added to the Medicare telehealth list during the PHE for two years after the PHE ends in order to provide more time to evaluate whether these services should be permanently added to the telehealth list following the COVID-19 PHE.

Telehealth and Audio Only for Mental Health Services

CMS is proposing changes to implement a recent change to Section 1834(m), which removes geographic restrictions and permits the home as an originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, so long as the practitioner has provided these services to the patient in person within the last 6 months. CMS is seeking comment on whether the required in-person, non-telehealth service could also be furnished by another physician or practitioner of the same specialty and same subspecialty within the same practice group as the physician or practitioner who furnishes the telehealth service. It is also proposing to require that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within 6 months before each telehealth service furnished for the diagnosis, evaluation, or treatment of mental health disorders.

CMS is also proposing to revise its regulatory definition of "interactive telecommunications system" to permit use of audio-only communications technology for mental health telehealth services under certain conditions when provided to beneficiaries located in their home. Coverage will be limited to physicians who have capability to furnish two-way audio-visual services, but the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.

Expiration of PHE Flexibilities for Direct Supervision Requirements

During the PHE, CMS has allowed for the requirement for direct supervision to be met for diagnostic tests, physicians' services, and some hospital outpatient services through the use of virtual presence using real-time audio/video technology, instead of requiring a physician's physical presence. CMS is seeking comment on whether this policy should be extended beyond the end of the PHE, and, if so, whether it should only be extended for a subset of services and whether these services would require a service level modifier.

Remote Therapeutic Monitoring (RTM)

CMS is proposing to adopt and cover the family of 5 RTM codes at their recommended RUC valuation. CMS is proposing to characterize these services as falling under the Medicare "incident to" policy and, therefore, would preclude certain non-MD/DOs from reporting the services. It is seeking comment on the typical types of devices and the costs associated with those devices that might be used to collect the data associated with RTM code descriptors.

Medicare Diabetes Prevention Program Expanded Model (MDPP)

CMS is proposing several significant changes to the Medicare Diabetes Prevention Program (MDPP) and requests comment on three key aspects of the expanded model program.[1]

1. Elimination of ongoing maintenance sessions (year 2) from Medicare DPP for beneficiaries who start their MDPP on or after January 1, 2022. (§ 410.79) Consistent with the emergency MDPP policy precipitated by the COVID-19 PHE, Medicare DPP beneficiaries who began the program in 2021 or who were in ongoing maintenance classes in 2021 will have the option of accessing year 2 or not;
2. In tandem with the elimination of year 2, CMS proposes to redistribute a portion of the payment from the ongoing maintenance sessions to the core and core maintenance session performance payments. (§ 414.84); and
3. The Medicare provider enrollment application fee ($599) is waived for all organizations applying to be a MDPP supplier, effective January 1, 2022. (§ 424.205).

Requiring Certain Manufacturers to Report Drug Pricing Information

CMS is implementing legislation that requires Medicare Part B drugs without a rebate agreement to report the average sales price (ASP) of their drugs to CMS. The amended regulation will now require the ASP of any item, service, supply, or product that is payable under Part B as a drug or biological to be reported to CMS. This requirement will apply to drug repackages as well.

Appropriate Use Criteria

As urged by the AMA, CMS proposes to delay enforcement of the Appropriate Use Criteria (AUC) program by at least one year until the later of January 1, 2023, or the January 1 that follows the end of the public health emergency. The AUC program requires ordering physicians to consult appropriate use criteria using a clinical decision support mechanism prior to ordering advanced imaging services for Medicare beneficiaries and furnishing physicians to report this information on the claim. Currently, CMS is scheduled to begin denying claims that do not report AUC information on January 1, 2022. The proposed delay recognizes the significant disruptions caused by the COVID-19 pandemic and will allow more time for the education and operations testing period, which is critical given CMS' finding that only 9-10 percent of 2020 diagnostic imaging claims would have met the AUC reporting requirements to be paid if enforcement had been in effect. CMS also seeks comment on several claims processing proposals meant to address scenarios that have been identified as challenging or impractical for AUC compliance and areas that need more education and outreach. This AMA webpage provides additional information about the AUC program and reporting requirements.

Electronic Prescribing of Controlled Substances (EPCS)

The SUPPORT Act required that Medicare Part D prescriptions for controlled substances be prescribed electronically starting on January 1, 2021, and also required the Drug Enforcement Administration (DEA) to modify the biometric component of the multifactor authentication requirements within its EPCS standards. The DEA has not yet revised these standards. CMS is also required to specify circumstances when the EPCS requirement may be waived, establish exceptions to the requirement, and determine

[1] As a reminder, the Medicare Diabetes Prevention Program (MDPP) is an expanded model test under the CMS Centers for Medicare and Medicaid Innovation (CMMI). The MDPP's goal is to prevent or delay the onset of type 2 diabetes by offering the preventive services patterned off of the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program (National DPP), which is structured with hourly sessions offered weekly for 6 months where participants learn how to eat healthy, manage stress, increase physical activity. Ultimately, the goal is for participants to lose at least 5 percent of theirs starting body weight.

penalties for non-compliance. CMS is continuing to encourage EPCS adoption and notes that EPCS increased from 38 percent of prescriptions in 2019 to 70 percent in 2021. Previous CMS rules pushed back the deadline for EPCS compliance until January 1, 2022, and CMS is now proposing to push it back further to January 1, 2023. For patients in long-term care facilities, the compliance deadline would be 2025. CMS also proposes that the threshold prescribers would need to meet for compliance is 70 percent of their controlled substances being e-prescribed. CMS also outlines exceptions and waivers from the requirement, for example, for those who issue 100 or fewer Part D controlled substance prescriptions annually, those in disaster areas, as well as those who request and receive from CMS a waiver due to circumstances that prevent EPCS such as lack of broadband access.

Chronic Pain Management

CMS is soliciting comments on whether it should create separate coding and payment for chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate, or whether these services are already appropriately recognized in the payment system. CMS cites multiple federal reports that urge better support for person-centered pain management, including the 2016 National Pain Strategy and the 2019 HHS Pain Management Best Practices Inter-Agency Task Force Report. It also notes the intersection between the problems with pain care and the worsening epidemic of drug overdose deaths, primarily due to illicitly manufactured fentanyl, other synthetic opioids, and methamphetamine. CMS also notes that untreated and inappropriately treated pain may translate to increased Medicare costs as more patients experience functional decline, incapacitation, and frailty.

Billing for Physician Assistant Services

Section 403 of the CAA, 2021 amends section 1842(b)(6)(C)(i) of the Act to remove the requirement to make payment for physician assistant (PA) services only to the employer of a PA effective January 1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that nurse practitioners (NPs) and clinical nurse specialists (CNSs) do. PAs also may reassign their rights to payment for their services and may choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs may do. CMS notes that this amendment only changes the statutory billing construct; it does not change the statutory benefit category or the requirement that PA services are performed under physician supervision.

Therapy Services

In the CY 2019 PFS final rule, CMS finalized modifiers -CQ *PT services furnished in whole or in part by PTAs* and -CO *OT services furnished in whole or in part by OTAs* to specify therapy services provided in whole or in by Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants OTAs as of January 1, 2020. These modifiers are required to be appended on claims for therapy services, in addition to the already established -GP and -GO modifiers that indicate the services are furnished under a PT or OT plan of care.

In the CY 2022 proposed rule, CMS proposes to revise the *de minimis* policy previously finalized in the CY 2020 PFS final rule which delineate when the -CQ and -CO modifiers apply. CMS now proposes to allow a timed therapy service to be billed without the -CQ and -CO modifiers in cases when a PTA or an OTA participates in providing care to a patient with a PT or OT, but the PT or OT meets the Medicare requirements for a timed service without the minutes furnished by the PTA or OTA by providing more than the 15-minute midpoint (also known as the 8-minute rule). Under this proposal, any minutes that the PTA or OTA furnish in the preceding scenario would not matter for purposes of billing Medicare.

Innovative Technology and Artificial Intelligence (AI) Request for Information (RFI)

In the proposed rule, CMS is soliciting feedback on a variety of questions regarding coverage of AI and other innovative technologies. Among other questions, CMS is looking for feedback on:

- To what extent are innovative technologies like software or AI are replacing physician work?
- How innovative technology such as software algorithms and/or AI is affecting physician work time and intensity of furnishing services involving the use of such technology?
- How is innovative technology such as software algorithms and/or AI changing cost structures in the physician office setting?
- How is innovative technology affecting beneficiary access to Medicare-covered services?
- Compared to other services paid under the PFS, are services that are driven by or supported by innovative technology such as software algorithms and/or AI at greater risk of overutilization or more subject to fraud, waste, and abuse?

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs) and Subgroups

In response to concerns raised by the AMA and the Federation that MIPS is overly burdensome and not clinically relevant, MVPs are intended to hold physicians accountable for cost, quality and use of technology around a condition or episode of care. CMS proposes an initial set of MVPs and detailed scoring and registration policies for individual clinicians, groups, and subgroups interested in participating in this voluntary option beginning in 2023. The proposed MVPs include Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia.

The proposed MVP scoring methodology responds to some of the recommendations made to CMS by the AMA after significant consultation with specialty and state medical societies, such as fewer check-the-box reporting requirements. Specifically, CMS proposes to require MVP participants select four, rather than six, quality measures; two medium-weighted or one high-weighted improvement activity; and be scored on only the cost measures included in the MVP. Unfortunately, however, CMS maintains many of the same traditional MIPS reporting and scoring requirements, including requiring reporting on the same Promoting Interoperability measures required under traditional MIPS. Additionally, CMS proposes to require MVP participants to select one population health measure to be scored on.

CMS proposes to establish a subgroup reporting option for MVP participation by a subset of clinicians in a multispecialty group. To form a subgroup, interested clinicians must identify the MVP the subgroup will report on, identify the clinicians in the subgroup by TIN/NPI, and provide a plain language name for the subgroup for purposes of public reporting. Registration for both MVPs and subgroups would take place between April 1 and Nov. 30 of the performance period. Subgroups would be scored at the subgroup level on Quality, Cost, and Improvement Activities and would receive the group's Promoting Interoperability score. CMS proposes to use performance period benchmarks, or a different baseline period, such as calendar year 2019, for scoring quality measures in the 2022 performance period.

CMS also requests comment on moving to mandatory subgroup reporting beginning in 2025 for multispecialty groups interested in MVP participation and potentially phasing out traditional MIPS after the 2027 performance year, and mandating MVP participation for all MIPS clinicians beginning in 2028.

Quality Performance Category

As required by statue, CMS proposes to reduce the weight of Quality Performance Category from 40 percent to 30 percent of the final MIPS score in 2022 and beyond. CMS proposes to update quality measure scoring to remove end-to-end electronic reporting and high-priority measure bonus points as well as the 3-point floor for scoring measures (with some exceptions for small practices). In addition, extend the CMS Web Interface as a quality reporting option for registered groups, virtual groups, or other APM Entities for the 2022 performance period, as well as update the quality measure inventory (a total of 195 proposed for the 2022 performance period). Lastly, increase the data completeness requirement to 80 percent beginning with the 2023 performance period.

Cost Performance Category

As required by statute, CMS proposes to increase the weight of the Cost Performance Category from 20 to 30 percent of the final MIPS score in 2022 and beyond. CMS proposes to add five new episode-based cost measures, including the first chronic condition cost measures. The proposed measures include Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease, and Diabetes. Measure specifications can be downloaded here. CMS also proposes a new process for stakeholders to develop cost measures for MIPS beginning in 2022 for earliest adoption in MIPS in 2024. Finally, CMS proposes criteria for determining whether a cost measure change is

considered substantive and thus must be proposed through notice-and-comment rulemaking before it is implemented in MIPS.

Improvement Activities Category

CMS included several new proposals for the Improvement Activities (IA) Performance Category for the 2022 performance year and beyond. Most substantively, it included a proposal around group reporting requirements to address subgroup participation. Essentially, each IA for which groups and virtual groups attest to performing must be performed by at least 50 percent of the NPIs that are billing under the group's TIN or virtual group's TINs or that are part of the subgroup, as applicable. The NPIs must perform the same activity during any continuous 90-day period within the same performance year. If, for example, out of a group of 100 Eligible Clinicians, 30 of them choose to form a subgroup, 15 Eligible Clinicians in the subgroup must perform the IA, and 35 (50 percent of the group's remaining 70 Eligible Clinicians) must perform an IA on behalf of the larger group to receive credit. Additionally, CMS revised the timeframe for IAs nominated during a public health emergency; revised the required criteria for IA nominations received through the Annual Call for Activities; and added seven new IAs, modified 15 existing IAs, and removed six existing IAs. It also proposed a process to suspend IAs that raise possible safety concerns or become obsolete from the program when this occurrence happens outside of the rulemaking process.

Promoting Interoperability Category

CMS included several new proposals for the Promoting Interoperability (PI) Category for the 2022 performance year. Most notably, CMS is proposing that physicians meet the requirements of two new measures. For the first new measure, CMS is proposing that physicians must report "yes" to being in active engagement with a public health agency to a) electronically submit case reporting of reportable conditions, and b) submit and receive immunization data. Unless an exclusion can be used, physicians who fail to report "yes" on either (a) or (b) would score zero for the PI category. For the second new measure, CMS is proposing to require that physicians attest "yes" to having conducted an annual self-assessment of the high priority practices listed in ONC's SAFER Guides. CMS is also proposing to require that physicians make patient health information available indefinitely starting with encounters on or after January 1, 2016. CMS is proposing to reduce the required attestation statements physicians must make related to actions taken that limit or restrict the compatibility or interoperability of EHRs. CMS is proposing to temporarily not require an application from physicians and small practices seeking to qualify for the small practice hardship exception and reweighting. Instead, the exception would be applied automatically. Lastly, CMS includes three requests for information regarding technical standards and additional PI considerations.

Advanced Alternative Payment Models (Advanced APMs)

CMS notes that during the 2019 Qualifying APM Participant (QP) performance period, 195,564 eligible clinicians earned QP status and 27,995 earned partial QP status. These QPs received a five percent lump sum incentive payment in 2021. For the 2022 QP performance period, CMS estimates that between 225,000 and 290,000 eligible clinicians will become QPs, be excluded from MIPS, and qualify for the lump sum APM incentive payment in 2024. Each year that the QP incentive payments have been made, there have been thousands of physicians who CMS has had difficulty locating to make their payments, although the number declined from more than 20,000 in 2019 to fewer than 10,000 in 2021. CMS now proposes some changes in how it accesses the TIN information for QPs to increase the likelihood of paying incentive payments in a timely manner. Advanced APMs for 2022 are: Bundled Payments for Care Improvement Advanced; Comprehensive Care for Joint Replacement; Global and Professional Direct Contracting; Kidney Care Choices; Maryland Total Cost of Care; Medicare Shared Savings

Program; Oncology Care Model; Primary Care First; Radiation Oncology model; and Vermont All-Payer ACO Model.

Other MIPS Policies

CMS proposes to increase the 2022 MIPS threshold to 75 points and the exceptional performance threshold to 89 points.

MIPS Threshold Score

As required by statute, beginning with the 2022 performance year/2024 payment year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. CMS proposes to increase the MIPS performance threshold, which must be achieved to avoid a penalty, from 60 to 75 points based on the mean final score from the 2017 performance period/2019 MIPS payment year.

Exceptional Performance Threshold

For the 2024 MIPS payment year, the additional performance threshold must be set at either 1) the 25th percentile of the range of possible final scores above the performance threshold, or 2) the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold with respect to a prior period. CMS proposes to increase the additional performance threshold from 85 to 89 points.

Projected 2022 MIPS Participation and 2024 Payment Adjustments

CMS estimates approximately 809,625 clinicians will be MIPS eligible in 2022. Due to the expiration of the MIPS transition policies and CMS proposals to fully implement the program as required by statute, CMS estimates the overall proportion of clinicians who will avoid a MIPS penalty and/or earn an incentive payment decreases from 91.7 percent to 67.5 percent. The mean final score would be 75.86 and the median would be 80.30. The maximum positive payment adjustment, including the exceptional bonus, is estimated to be 14 percent, while the maximum penalty is 9 percent. Under statute, the 2022 performance period is the last year that an exceptional performance bonus from a $500 million pool that is not tied to budget neutrality is available. Payment adjustments stemming from the 2022 performance period will be applied to 2024 Medicare payments.