AHPA
ADVENTIST HEALTH POLICY ASSOCIATION

Summary: Physician Fee Schedule (PFS) Payments Proposed Rule CY 2022

The Centers for Medicare and Medicaid Services (CMS) has released a proposed rule that updates payments for physician services for CY 2022. The rule contains several proposals including a decrease of the Physician Fee Schedule (PFS) conversion factor, changes to the Quality Payment Program (QPP), expanded coverage of telehealth services and a delay of the Appropriate Use Criteria (AUC) program. **Comments are due September 13th.** To review the proposed rule, click here.

Key Proposals

General Payment Policies

- Adopt a CY 2022 Conversion Factor (CF) of $33.5848. The impact of this policy by specialty can be found here.
- Eliminate the CY 2021 one-year 3.75% CF increase.
    - The Consolidated Appropriations Act of 2021 (CAA) provided a 3.75% increase in the CF for CY 2021 *only.* Congress would need to pass legislation again to increase the CF for CY 2022 and evert future physician payment reductions.
- As established by the CAA, allow physician assistants to bill Medicare directly beginning in CY 2022.
- **CMS seeks comments on the pricing of innovative technologies, such as artificial intelligence.**

Medicare Telehealth and Mental Health Services

- Retain all services added to the Medicare telehealth services list on a Category 3 basis (temporary basis) until the end of CY 2023.
- Remove Medicare's originating site requirements for mental health services provided via telehealth.
    - Coverage only provided if a face-to-face visit is done within six months prior to providing the initial telehealth service and at least once every six months thereafter.

- Allow rural health clinics and federally qualified health centers to receive payment for mental health visits furnished via telehealth, including via audio-only connection, in certain circumstances.
    - Beginning in CY 2023, add rural emergency hospitals as a telehealth originating site.
- Allow the use of audio-only communication for the diagnosis, evaluation or treatment of mental health disorders furnished to established patients in their homes but only if the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.
- **CMS seeks comments on whether it should establish any additional guardrails for the provision of audio-only telehealth services for mental health care.**

Split/Shared Evaluation and Management Visits (E/M)

- Define split (or shared) E/M visits as visits provided in a facility setting by a physician and a non-physician provider in the same group.
- Allow physicians and non-physician practitioners to bill for split (or shared) visits for both new and established patients.
- Require the practitioner providing more than half of the time on the E/M visit to bill for the visit.
    - Documentation in the medical record would need to identify both professionals who performed the visit and the individual who performed the substantive portion.
- Allow health care professionals to bill for split or shared visits in a Skilled Nursing Facility.
- Create a claim modifier that would be mandatory for split (or shared) visits.

Quality Payment Program (QPP)

A CMS fact-sheet detailing all the changes impacting the QPP program can be found here.

Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs)

- Adopt seven optional MIPS Value Pathways beginning in 2023.
    - Optional MVPs are: Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair and Anesthesia.

    - To report an MVP, an MVP participant would need to register for their desired MVP between April 1st and November 30th of the performance year, or a later date as specified by CMS. No changes would be allowed after.
- Phase-in the requirement to report the MIPS APM Performance Pathway (APP) measure set over the course of 2022 and 2023.
- As required by MACRA, proposes to increase the performance threshold from 60 to 75 points for the CY 2022 performance year/ 2024 Payment Year (PY) and adopt an exceptional performance threshold of 89 points.[1]
- Freeze the PY 2023 quality performance standard at 30th percentile of the MIPS Quality performance category score. This would increase to 40th percentile in PY 2040.
    - Beginning in the PY 2024, CMS is required to set performance threshold as the mean or median of final scores for all MIPS eligible clinicians in prior period.
- Expand the definition of MIPS eligible clinician to include clinical social workers and certified nurse midwives.
- **CMS invites comment on when it should mandate MVP participation for all MIPS participants, suggesting that it aims to sunset the current MIPS approach after the CY 2027 performance period.**

Alternative Payment Model (APM) Performance Pathway (APP)

- Allow MIPS eligible clinicians to report the APP as a subgroup beginning with the 2023 performance year.
- Announced that the Radiation Oncology model and the Kidney Choices model will be an Advanced APM in 2022.

Medicare Shared Savings Program (MSSP)

- Freeze the quality performance standard at the 30th percentile MIPS quality performance category score and provide an incentive for ACOs to report eCQMs in PY 2022 and 2023. In PY 2024, the threshold would increase to the 40th percentile.
- Establish new requirements around repayment mechanisms, the MSSP application process, beneficiary notification requirements, and the definition of primary care services that is used for beneficiary assignment.

[1] The performance threshold is the total MIPS score at which neutral MIPS payment adjustments apply; scores above or below the threshold result in positive or negative adjustments respectively.

- Permit ACOs to report either the current MSSP measure set via the web interface or the MIPS APP measure set in performance years 2022 and 2023.
    - Require ACOs that choose to report through the web interface measure set to also report at least one measure from the APP measure set in CY 2023.
- **CMS seeks comment on considerations related to the use of regional fee-for-service expenditures in establishing, adjusting, updating and resetting the ACOs' historical benchmarks.**

Appropriate Use Criteria (AUC)

- Delay implementation of the penalty phase of the AUC program to the later of January 1, 2023, or the CY that follows the end of the COVID-19 Public Health Emergency (PHE).
- Provides clarification and proposals related to the scope of the AUC program and in response to claims processing issues that have arisen.
- **CMS seeks comment on:**
    - *Proposed start date for the payment penalty phase of the program and whether it sufficiently accounts for the COVID-19 pandemic.*
    - *Denying or returning claims that fail AUC claims processing edits.*
    - *Hospital inpatient status changing to outpatient CMS proposes bypassing AUC claims processing edits.*

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services

- Require Opioid Treatment Programs (OTPs), when providing additional counseling and therapy billed under the add-on code after the end of the PHE, to use the modifier 95.
- Require OTPs providing services using audio-only telephone calls to document in the beneficiary's medical record that the counseling or therapy was provided via telephone call and the rationale for doing so.
- **CMS seeks comment on whether there should be additional conditions to ensure program integrity and patient safety.**

Electronic Prescribing of Controlled Substance (ECPS) For Part D Drugs

- Extend the compliance date for ECPS requirements until January 1, 2023, and the compliance date for Part D controlled substance prescriptions written for beneficiaries in long-term care facilities until January 1, 2025.

- For prescribers to be considered compliant, they must prescribe at least 70% of their Part D controlled substance prescriptions electronically every calendar year.
    - Exceptions to this requirement would be for prescriptions issued where the prescriber and dispensing pharmacy are the same entity, prescribers who prescribe 100 or fewer Part D controlled substance prescriptions per year, prescribers who are prescribing during a recognized emergency (e.g., a natural disaster or pandemic) and prescribers who request and receive a waiver from CMS due to extraordinary circumstances.

Indirect Compensation Arrangements (ICAs)

- Revise the ICA definition to include financial relationships where compensation is exchanged for equipment rentals, office space, or the services of anyone other than the referring physician.[2]
    - Would require a two-step analysis of any unbroken chain of financial relationships in which the compensation paid under the arrangement closest to the physician (or immediate family member) is for anything other than services personally performed by the physician.

Medicare Provider Enrollment

- Expand CMS' authority to deny or revoke a provider's or supplier's Medicare enrollment.
- Establish specific rebuttal procedures in regulation for providers and suppliers whose Medicare billing privileges have been deactivated.

Health Equity

- **In this Request for Information (RFI), CMS solicits comments on:**
    - *How to improve the collection and utility of data around health disparities that arise from social risk factors, including race and ethnicity.*
    - *Efforts to collect additional data to identify and respond to health disparities in its programs and policies.*
    - *Future stratification of quality results by race and ethnicity and demographic data collection.*

[2] ICA regulatory definition proposed changes.

- *Information about the ways that hospitals currently collect demographic data, including but not limited to race, ethnicity, sex, sexual orientation and gender identity, language preference, tribal membership, and disability status.*
- *Challenges associated with the use of such a data set and additional improvements to the MIPS program that can be made to address health equity.*

Vaccine Administration Services

- **CMS seeks comments on the costs involved in furnishing preventive vaccines. Specifically:**
  - *The different types of health care providers who administer vaccines and how that has changed since the beginning of the pandemic.*
  - *How the costs of furnishing flu, pneumococcal and hepatitis B vaccines compare to the cost of furnishing COVID-19 vaccines.*
  - *How the PHE may have impacted costs, including whether those costs will continue beyond the PHE.*
  - *Whether COVID-19 monoclonal antibody treatments should be treated in the same way other physician-administered drugs and biological products are under Part B.*
- **CMS also seeks comments on the current $35 add-on payment for certain vulnerable beneficiaries who receive the COVID-19 vaccine at home. CMS is interested in stakeholder input on what qualifies as the "home."**