Summary of CMS' 2022 Physician Fee Schedule Proposed Rule

July 14, 2021

Late yesterday, CMS published the agency's 2022 Physician Fee Schedule proposed rule. The press release is here, the fact sheet is here and the 1,747-page proposed rule PDF is here. Comments on the proposed are due no later than 5 pm EST on September 13th.

Here is a summary of the proposed rule's major provisions.

PFS Conversion Factor

With the expiration Consolidated Appropriation Act's (CAA's) 3.75% payment increase, the proposed 2022 Conversion Factor (CF) is $33.58, or a decrease of $1.31 from the 2021 $34.89 CF.

Health Equity

As in all previous 2022 proposed rules, in the proposed PFS rule CMS is soliciting feedback regarding data collection to better measure and analyze disparities across programs and policies. More specifically, data regarding how the agency can advance health equity for people with Medicare potentially through the creation of confidential reports that allow providers to look at patient impact through a variety of data points. CMS expects hospitals and health care providers will be able to use the results from the disparity analyses to develop strategies that address health equity.

Telehealth Services

CMS proposes to allow audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes. CMS proposes to limit the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology. CMS is also proposing to require an in-person, non-telehealth service be provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service, and at least once every six months thereafter and whether a different interval may be necessary or appropriate for mental health services furnished through audio-only communication technology.

Appropriate Use Criteria (AUC)

CMS is proposing to delay the payment penalty phase of the AUC program to January 1, 2023, or the January 1 that follows the declared end of the PHE.

Evaluation and Management (E/M)

CMS is proposing to refine the agency's longstanding policies for split or shared E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as

members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services. Among other things, CMS is proposing: to require the practitioner who provides the substantive portion of the visit, or more than half of the total time spent, to bill for the visit; and, to allow split or shared visits for both new as well as established patients, for initial and subsequent visits and for prolonged services.

Colorectal Cancer Screenings That Yield Additional Services

CMS is proposing to implement Section 122 of the CAA. It provides a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services. At present, the addition of any procedure beyond the planned colorectal screening results in a beneficiary's having to pay coinsurance. For services furnished on or after January 1, 2022, CMS is proposing that the coinsurance amount paid for planned colorectal cancer screening tests that require additional related procedures shall be equal to a specified percent, i.e., 20% for CY 2022, 15% for CYs 2023 through 2026, 10% for CYs 2027 through 2029, and zero percent beginning CY 2030, of the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to the test.

Diabetes Prevention Program

CMS is proposing to permanently waive the Medicare enrollment fee for new MDPP suppliers on or after January 1, 2022. CMS is also proposing changes to make delivery of MDPP services more sustainable and to improve patient access by making it easier for local suppliers to participate and reach their communities by proposing to shorten the MDPP services period to one year instead of two years. This proposal would reduce the administrative burden and costs to suppliers. CMS is also proposing to restructure payments so MDPP suppliers receive larger payments for participants who reach milestones for attendance and weight loss.

Medical Nutrition Therapy Coverage

CMS is proposing to remove the requirement that the medical nutrition therapy referral be made by the treating physician.

Opioid Treatment Program (OTP) Payment

CMS is proposing to allow OTPs to furnish counseling and therapy services via audio-only interaction, such as telephone calls, after the conclusion of the PHE in cases where audio/video communication is not available to the beneficiary, including circumstances in which the beneficiary is not capable of or does not consent to the use of devices that permit a two-way audio/video interaction, provided all other applicable requirements are met.

Physician Assistant (PA) Services

CMS is proposing to the CAA's Division CC, section 403 that authorizes Medicare to make direct payment to PAs for professional services beginning January 1, 2022. Beginning January 1, 2022, PAs would be able to bill Medicare directly for their services.

Pulmonary Rehabilitation

CMS is proposing to expand coverage of outpatient pulmonary rehabilitation services, paid under Medicare Part B, to beneficiaries who were hospitalized for COVID-19 and experience persistent symptoms, including respiratory dysfunction, for at least four weeks after hospitalization.

Vaccine Administration Services Comment Solicitation

CMS is seeking information on several inter-related vaccine issues including the agency's preliminary policy to pay $35 add-on for certain vulnerable beneficiaries when they receive a COVID-19 vaccine at home. CMS is also interested in stakeholder input on what qualifies as the "home" and how the agency

can balance ensuring program integrity with beneficiary access. Also, as the market for COVID-19 monoclonal antibody products matures, CMS is also seeking comments on whether the agency should treat these products the same way the agency treats other physician-administered drugs and biologicals under Medicare Part B.

Reporting Part B Drug Pricing Information

Drug manufacturers with Medicaid Drug Rebate Agreements are required to submit Average Sales Price (ASP) data for their Part B products for their covered outpatient drugs to be payable under Part B. Manufacturers without such agreements have the option to voluntarily submit ASP data. For calendar quarters beginning January 1, 2022, the CAA requires manufacturers of drugs or biologicals payable under Part B without a Medicaid Drug Rebate Agreement to report ASP data. CMS is proposing to make regulatory changes to implement the new reporting requirements.

MIPS

Among other proposed changes:

- CMS proposes to add clinical social workers and certified nurse midwives as MIPS eligible clinician types.
- CMS proposes to use performance period benchmarks for 2022 or a different baseline (e.g., CY2019) pending analysis of 2020 performance period data.
- CMS is proposing to maintain current data completeness threshold at 70% for 2022 and to increase to 80% for 2023 performance period.
- CMS is proposing to remove High-Priority Bonus Points for reporting additional outcome and high priority measures beyond the one required.
- Is proposing to end Electronic Reporting Bonus Points or remove bonus points for measures that meet end-to-end electronic reporting criteria.
- CMS is proposing to continue Complex Patient Bonus for the 2021 performance year and limit the bonus to clinicians who have a median or higher HCC or dual proportion beginning in the 2022 performance year,
- MIPS quality and cost performance scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher MIPS final score through another MIPS submission.

MIPS Value Pathways (MVPs)

CMS delayed last year introduction of the MIPS Value Pathways (MVP) because of the PHE. CMS plans to move forward with the MVP beginning in CY2023. As part of this year's rulemaking, CMS proposes the first seven MVP clinical areas: rheumatology; stroke care and prevention; heart disease; chronic disease management; lower extremity joint repair (e.g., knee replacement); emergency medicine; and, anesthesia.

APM Pathway

The APM Performance Pathway (APP), which was finalized last year, is complementary to the MVPs. It is only available to participants in MIPS APMs and may be reported by individual eligible clinicians, groups, or APM entities. CMS is proposing to allow MIPS eligible clinicians to report the APP as a subgroup. The definition of subgroup and eligibility to participate is the same as for MVP.

The Medicare Shared Savings Program (MSSP)

Among other proposed changes:

- CMS is proposing a longer transition for ACO's reporting electronic clinical quality measure/Merit-based Incentive Payment System clinical quality measure (eCQM/MIPS CQM) all-payer quality measures under the Alternative Payment Model (APM) Performance Pathway

(APP) by extending the availability of the CMS Web Interface collection type for two years, or through 2023.

- CMS is proposing to freeze the quality performance standard for PY 2023 by providing an additional one-year before increasing the quality performance standard ACOs must meet to be eligible for shared savings. CMS is proposing additional revisions to the quality performance standard to encourage ACOs to report all-payer measures.
- CMS is proposing to revise the methodology for calculating repayment mechanism amounts for risk-based ACOs. CMS is also proposing to modify the threshold for determining whether an ACO is required to increase its repayment mechanism amount during its agreement period.
- CMS is proposing to streamline the SSP application process by modifying the prior participation disclosure requirement, so that the disclosure is required only at the request of CMS during the application process, and by reducing the frequency and circumstances under which ACOs submit sample ACO participant agreements and executed ACO participant agreements to CMS. CMS is proposing to amend the beneficiary notification requirement to set forth different notification obligations for ACOs depending on the assignment methodology selected by the ACO to help avoid unnecessary confusion for beneficiaries.
- CMS is proposing revisions to the definition of primary care services used for purposes of beneficiary assignment. CMS is proposing that the changes would be applicable for determining beneficiary assignment beginning with PY 2022. CMS is also seeking comment on whether stakeholders believe there are other codes that should be included in this definition to inform future rulemaking.
- CMS also seeks comments SSP's calculation of the regional adjustment, and blended national-regional growth rates for trending and updating the benchmark, as well as comments on the risk adjustment methodology. We are exploring how these policies interact with the Shared Savings Program's other benchmarking policies.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS is proposing several related policy reforms.

- CMS is proposing to revise the current regulatory language for RHC or FQHC mental health visits to include visits furnished using interactive, real-time telecommunications technology. CMS is proposing to allow RHCs and FQHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology.
- CMS proposing to implement Section 132 of the CAA which makes FQHCs and RHCs eligible to receive payment for hospice attending physician services when provided by a FQHC/RHC physician, nurse practitioner, or physician assistant who is employed or working under contract for an FQHC or RHC, but is not employed by a hospice program, starting January 1, 2022.
- CMS is proposing to allow RHCs and FQHCs to bill for Transitional Care Management (TCM) and other care management services furnished for the same beneficiary during the same service period.

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