Summary of CMS' Final Physician Fee Schedule Rule – November 2, 2021

On November 2, CMS released the agency's 2022 final Physician Fee Schedule, Medicare Shared Savings Program and Quality Payment Program rule (here). The related fact sheet is here.

Here is a summary of the major provisions.

Payment update: By law, the PFS conversion factor for CY 2022 is 0.00 percent before applying other adjustments. After accounting for this the budget neutrality adjustment, the final conversion factor for CY 2022 is $1.30 less than 2021, or $33.59 compared to $34.89.

Evaluation and Management (E/M): CMS will implement the agency's 2021 E/M policy, that was substantially offset by late December 2020 Congressional action, for 2022. CMS is making several related "refinements" regarding split or shared E/M visits, critical care services and services furnished by teaching physicians involving residents.

Telehealth Services: CMS finalized several telehealth policies, including: allowing certain services added to Medicare telehealth during the pandemic to remain on the list to the end of CY 2023; adopting coding and payment for longer virtual check-in service on a permanent basis; removing geographic restrictions and adding a patient's home as an originating site for telehealth services used for diagnosing, evaluating, or treating mental health disorders - as required under the Consolidated Appropriations Act of 2021 (CAA); and, allowing use of audio-only technology for telehealth services for diagnosing, evaluating, or treating mental health disorders when the patient is not capable of using or does not consent to audio/video technology. CMS also clarifies that mental health services can include services for treatment of substance use disorders.

Merit-based Incentive System (MIPS): For 2024 payment, i.e., the 2022 performance year, CMS is finalizing the following proposals regarding MIPS participation requirements: CMS is adding clinical social workers and certified nurse midwives as MIPS eligible clinicians (ECs); CMS is maintain the data completeness threshold at 70 percent for 2022 and 2023 (CMS had proposed an increase to 80 percent for 2023); CMS is removing bonus points for reporting additional outcome and high priority measures beyond the one required; removing bonus points for measures that meet end-to-end electronic reporting criteria; will continue to double the complex patient bonus for the 2021 performance year and limit the bonus to clinicians who have a median or higher HCC or duals 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; and, CMS will create historical benchmarks for the 2022 performance period using data submitted for the 2020 performance period.

Concerning MIPS Value Pathways, CMS plans to move forward with the MVP, beginning with the 2023 MIPS performance year. CMS is finalizing 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.

Medicare Shared Savings Program (MSSP): The final rule provides: a revision to the agency's methodology for calculating repayment mechanism amounts that will result in lower required initial repayment mechanism amounts and less frequent increases during the agreement period; streamlines the MSSP application process by modifying participation disclosure requirements and reducing the frequency and circumstances under which ACOs must submit participation agreements to CMS; amends beneficiary notification requirements based on assignment methodology; and, revised the definition of primary care services for purposes of beneficiary assignment, beginning with PY2022.

CMS will also: delay sunsetting the CMS Web Interface by three years, allowing ACOs the option to continue using it as a collection type through PY 2024 (CMS had originally proposed to sunset the CMS Web Interface in PY 2024); freeze the quality performance standard at the 30th percentile MIPS quality performance category score for PY 2023 (the threshold will increase to the 40th percentile in PY 2024); and, provide an incentive for ACOs to report eCQM/MIPS CQM measures earlier than PY 2025.

This rule making cycle CMS sought comment on several topics related to the ACO benchmarking and risk adjustment methodologies. CMS summarizes these comments in the final rule noting the agency will take stakeholder input into consideration for refining these methodologies in future rulemaking.

Appropriate Use Criteria (AUC) Program: CMS will delay the payment penalty phase for the AUC program to the later of January 1, 2023 or the January following the end of the COVID-19 PHE. Previously, penalties were set to begin January 1, 2022.

Payment for Vaccine Administration: CMS finalized continuation of several payment policies related to COVID-19 through the calendar year in which the PHE ends: CMS will maintain current payment rate of $40 per dose for administration of COVID-19 vaccine (in the year following the end of the PHE, CMS will set at the same rate as other Part B preventive vaccines); continue an additional payment of $35.50 for COVID-19 vaccine administration in the home under certain circumstances; pay for COVID-19 monoclonal antibodies under the Medicare Part B vaccine (through the year in which the PHE ends, CMS will pay $450 for when the therapy is administered in a healthcare setting and $750 for when it is administered in the home); and, iIn the year following the end of the PHE, CMS will begin paying for the therapy as a biological product or under applicable payment systems.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS finalized several policies for RHCs and FQHCs, including: will allow RHCs and FQHCs

to provide mental health services via telehealth, including audio-only services; increase the per-visit payment limits for independent RHCs and provider-based RHCs in hospitals with 50+ beds, as required under the CAA (the policy also establishes payment limits per-visit for smaller provider-based RHCs and newly enrolled on or after January 1, 2021; allow FQHCs and RHCs to receive payment for hospice attending physician services when provided by an employed physician, nurse practitioner or physician assistant who is not separately employed by a hospice program, as required under the CAA; and, allow for concurrent billing of chronic care management (CCM) and transitional care management (TCM) services for FQHCs and RHCs.