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Summary of 2022 Changes to the Medicare Physician Fee Schedule, Quality Payment Program, and Other Federal Programs Final Rule

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Updates to the Physician Fee Schedule

Introduction

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP) for Calendar Year 2022 (CY22). The final rule updates payment rates and policies for services supplied under the MPFS on or after January 1, 2022. You may access the CMS press release for additional information and links to the relevant fact sheets.

Regulatory Impact Analysis

For CY22, CMS is finalizing the proposed $33.59 conversion factor. This represents a nearly four percent decrease from the $34.89 conversion factor for 2021, and a nearly seven percent decrease from the 2020 conversion factor. To calculate the CY22 PFS conversion factor, CMS took the CY21 conversion factor without the one-year 3.75 percent increase provided by the Consolidated Appropriations Act (CAA) of 2021 and multiplied it by the budget neutrality adjustment required. Table 136 shows the overall estimated impact on total allowed charges for internal medicine. The specialty impacts displayed in Table 136 reflect changes that take place within the pool of total RVUs. Therefore, this table includes any changes in spending which result from finalizing policies within budget neutrality, such as the revaluation of Evaluation and Management (E/M) codes in CY21 or the clinical labor pricing update in CY22 but does not include any changes in spending which result from finalizing policies outside of budget neutrality. The expiration of the 3.75 percent CAA provision for CY22 is a statutory change that takes place outside of budget neutrality, and therefore is not captured in the specialty impacts displayed in Table 136.

In response to ACP and other stakeholder comments requesting that CMS maintain the 3.75 percent increase in PFS payment amounts that was specified under section 101 of the CAA for services furnished during CY21, the Agency reminded commenters that this increase was provided through a time-limited amendment to the statute, which CMS does not have legal authority to alter. This means that the expiration of this 3.75 percent increase in payment amounts will result in the CY22 conversion factor being calculated as though the 3.75 percent increase for the CY21 conversion factor had never been applied.

Clinical Labor Pricing

Since 2019, CMS has been updating the supply and equipment prices used for practice expense (PE) as part of a market-based pricing transition; CY22 will be the final year of this four-year transition. This transition included the phasing in of new supply and equipment pricing over a period of four years; however, CMS has not updated the clinical labor pricing and as such, the clinical labor has remained unchanged during this pricing transition. Clinical labor rates were last updated for CY02. Over the years, stakeholders have raised concerns that the long delay since clinical labor pricing was last updated has created a significant disparity between CMS' clinical wage data and the market average for clinical labor. There was additional concern raised that updating the supply and equipment pricing without updating the clinical labor pricing could create distortions in the allocation of direct PE. Since the pool of aggregated direct PE inputs is budget neutral, if these rates are not routinely updated, clinical labor may become undervalued over time relative to equipment and supplies, especially since the supply and equipment prices are in the process of being updated.

Therefore, CMS is finalizing its proposal to update the clinical labor pricing for CY22, in conjunction with the final year of the supply and equipment pricing update. Similar to those updates for supply and equipment, CMS will utilize a four-year transition to implement the clinical labor pricing update (as shown below). The Agency stated that it believes it is important to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates. The Agency will use the methodology outlined in the CY02 MPFS final rule. Table 12 displays the finalized clinical labor prices. Table 13 shows the anticipated effects of the clinical labor pricing update on specialty payment impacts by comparing the CY22 MPFS rates with and without the clinical labor pricing updates in place, including with both the fully implemented pricing update and the first year of a four-year transition. Specific to internal medicine, payments to services comprising internal medicine would be expected to increase as a result of this clinical labor pricing update, since there is a higher share of direct costs associated with clinical labor.

Current Price	$1.00	
Final Price	$2.00	
Year 1 (CY 2022) Price	$1.25	1/4 difference between $1.00 and $2.00
Year 2 (CY 2023) Price	$1.50	1/3 difference between $1.25 and $2.00
Year 3 (CY 2024) Price	$1.75	1/2 difference between $1.50 and $2.00
Final (CY 2025) Price	$2.00	

Payment and Documentation Proposals for Evaluation and Management (E/M) Services

Refinements to "Split" or "Shared" E/M Visits

CMS is finalizing several policies related to split (or shared) visits, including:

- *Medical Record Documentation:* For purposes of documentation requirements for these services, CMS is finalizing that, by 2023, the "substantive portion" of the visit will be defined as more than half of the total time spent. For 2022, the "substantive portion" can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time). Additionally, documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.
- *Same Group:* CMS is finalizing its policy to define split (or shared) E/M visits as E/M visits provided in the facility setting by a physician and a non-physician practitioner (NPP) in the same group. The visit would be billed by the physician or NPP who provides the substantive portion of the visit.
- *Claim Identification:* CMS also is finalizing that a modifier is required on the claim to identify these services to help inform policy and ensure program integrity.

Critical Care Services

In a reversal to its initial proposal, CMS is finalizing that critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same

specialty. The practitioner is required to document that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct. The Agency also stated there cannot be any duplicative elements from the critical care service provided later in the day. CMS is additionally finalizing its proposal that the modifier -25 must be reported on the claim.

Office Visits Included in Codes with a Surgical Global Period

In another reversal to its proposed policy, CMS is finalizing that critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Additionally, preoperative and postoperative critical care may be paid if the patient is critically ill and requires full attention of the physician, and the critical care is above and beyond and unrelated to the specific surgical procedure performed. The Agency is also creating a new modifier for use on these claims to identify that the critical care is unrelated to the procedure.

The Agency stated it found the comments about how the proposed policy would negatively impact the quality and safety of patient care, health system resiliency, health equity, and the surgical workforce especially compelling. Thus, after considering these comments, CMS decided not to finalize the proposal to always bundle critical care visits with procedure codes that have a global surgical period.

Teaching Physician Services and Primary Care Exception Flexibilities

At this time, qualifying activities for selecting the office/outpatient E/M visit level using the reporting practitioner's time are specified by the Current Procedural Terminology (CPT) guidebook. In the 2021 CPT E/M guidelines, the CPT Editorial Panel published a correction addressing teaching physician time by excluding time spent in "teaching that is general and not limited to discussion that is required for the management of a specific patient." CMS is clarifying that only time spent by the teaching physician performing qualifying activities listed by CPT (with or without direct patient contact on the date of encounter), including the time the teaching physician is present when the resident is performing such activities, may be counted for purposes of visit level selection. Regarding extension beyond the COVID-19 pandemic, CMS stated that the issue of making the virtual presence flexibility permanent and extending the flexibility to include residency training centers located inside a metropolitan statistical area was not part of their proposal for general primary care office/outpatient E/M visit level selection.

CMS acknowledged opposition to their proposal to allow medical decision-making (MDM) as the only option for E/M visit level selection under the primary care exception; however, they believe that using MDM to inform office/outpatient E/M visit level selection, rather than time, is appropriate given concerns about accuracy of counting time spent by residents in training. CMS believes that MDM is far more practical and less burdensome because it allows residents in training to take more time to perform services. Therefore, CMS is finalizing their proposal that MDM is used to determine the visit level for office/outpatient E/M visits furnished under the primary care exception.

Telehealth

Temporary Additions to the Medicare Telehealth Services List, and Codes Not Granted Category 3 Status

CMS is finalizing its proposed revised timeframe for inclusion of the services added to the Medicare telehealth services list on a temporary, Category 3 basis. The Agency will retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY23.

New Originating Site

CMS is finalizing its proposals with some modifications. The Agency is adding the home of a beneficiary as an originating site for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders and specifying that the geographic restrictions do not apply to these services; adding the conditions of payment requiring an in-person, non-telehealth visit within six months of the mental health telehealth service in the patient's home; and adding the exception for subsequent mental health telehealth services when the risks and burdens outweigh the benefits of this requirement. More specifically, CMS is modifying the proposed amendments to clarify that payment will not be made for a telehealth service furnished under the rule unless the following conditions are met:

(1) The physician or practitioner has furnished an item or service in-person, without the use of telehealth, for which Medicare payment was made (or would have been made if the patient were entitled to, or enrolled for, Medicare benefits at the time the item or service is furnished) within six months prior to the initial telehealth service;
(2) The physician or practitioner has furnished an item or service in-person, without the use of telehealth, at least once within six months of each subsequent telehealth service described in this paragraph, with exceptions as noted above; and
(3) The requirements of paragraph (2) may be met by another physician or practitioner of the same specialty and subspecialty in the same group as the physician or practitioner who furnishes the telehealth service, if the physician or practitioner who furnishes the telehealth service described under this paragraph is not available.

The Agency is also finalizing that an in-person, non-telehealth visit must be furnished at least every 12 months for these services; exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record); and more frequent visits are allowed under CMS policy, as driven by clinical needs on a case-by-case basis.

The Agency additionally is finalizing its proposal to add a rural emergency hospital as a permissible originating site and clarified that, as proposed, its definition of home can include temporary lodging such as hotels and homeless shelters, as well as locations a short distance from the beneficiary's home.

Payment for Services Using Audio-Only Communication Technology

CMS is finalizing its proposal to create a service-level modifier for use to identify mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology. The Agency is amending the current definition of interactive telecommunications system for telehealth services – which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner – to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients if:

(1) The patient is located in their home at the time of service;
(2) The distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunications system that includes video; and
(3) The patient is not capable of, or does not consent to, the use of video technology for the service.

CMS is also clarifying that substance use disorder (SUD) services are considered mental health services for purposes of the amended definition of "interactive telecommunications system" to include audio-only services. The Agency anticipates that this will have a positive impact on access to care for mental health conditions and contribute to overall health equity.

Outside of the context of mental health services, CMS did not approve any policies related to pay parity for E/M services and did not provide any additional information on such. Currently, pay parity provisions for E/M services are set to expire at the end of the PHE.

Direct Supervision

Prior to the PHE, direct supervision required the "immediate availability" of the supervising physician or other practitioner. CMS interpreted this to mean in-person, physical availability; thus, virtual availability was not permitted. During the PHE, CMS amended the definition of "direct supervision" to allow the supervising physician (or other practitioner) to be immediately available through a virtual presence, using real-time audio/video technology. CMS is finalizing its continuation of this policy through the end of the year in which the PHE ends or December 31, 2021, whichever is later.

Virtual Check-In Code

In 2021, CMS established a new Healthcare Common Procedure Coding System (HCPCS) code, G2252 *(Brief communication technology-based services, e.g., virtual check-in service, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)*, for audio-only virtual check-in services to help clinicians stay connected with Medicare beneficiaries who may not have access to audio-video technology. Establishing payment for this service was initially proposed on an interim basis to support access to care for beneficiaries who may be reluctant to return to in-person visits unless absolutely necessary and allow CMS to consider whether this policy should be adopted on a permanent basis. In the CY21 MPFS final rule, the Agency is finalizing a direct crosswalk to CPT code 99442, the value of which CMS believed most accurately reflected the resources associated with a longer service delivered via synchronous communications technology, which can include audio-only communications.

For CY22, CMS is finalizing its proposal to permanently establish separate coding and payment for the longer virtual check-in service described by HCPCS code G2252 using a crosswalk to the value of CPT code 99442, as proposed. As stated in the CY21 MPFS final rule, the Agency believes that the value of CPT code 99442 most accurately reflects the resources associated with a longer service delivered via synchronous communications technology, which can include audio-only communications. In support of the crosswalk to the CPT code 99442, CMS notes this is consistent with its approach to valuing the virtual check-in service (HCPCS code G2012), which used CPT code 99441 as the basis for the valuation. HCPCS code G2252 and CPT code 99442 both describe 11-20 minutes of medical discussion when the practitioner may not necessarily be able to visualize the patient and is used when the acuity of the patient's problem is not necessarily likely to warrant a visit, but when the needs of the particular patient require more assessment time from the practitioner. In the case of HCPCS code G2252, the additional time would be used to determine the necessity of an in-person visit and result in a work time/intensity that is similar to the crosswalk code.

Vaccine Administration Services

CMS increased the payment rates for administration of the influenza, pneumococcal, and hepatitis B vaccines. Beginning CY22, the vaccine-neutral, site-neutral payment rate will be $30 for each of the three above preventive vaccines. For COVID-19 vaccine administration, the rate will remain at $40 until the end of the year in which the public health emergency (PHE) ends, after which the administration payment will be aligned with other preventive vaccines.

In the CY22 MPFS proposed rule, CMS announced a new add-on payment with a national rate of $35.50 when a COVID-19 vaccine is administered in the home. The Agency is finalizing this policy and will continue making the additional payment when a COVID-19 vaccine is administered in a beneficiary's home under certain circumstances until the end of the year in which the PHE expires. CMS noted that it believes this extension will maximize access to COVID-19 vaccines for vulnerable homebound beneficiaries during the gradual return to normal conditions following the formal termination of the PHE. For purposes of the add-on payment, CMS will maintain the policy that a home can be a private residence, temporary lodging (e.g., a homeless shelter or hostel), an apartment in an apartment complex, a unit in an assisted living facility or group home, or a patient's home that is made "provider-based" to a hospital during the PHE for COVID-19. In response to stakeholder feedback that encouraged CMS to consider maintaining the additional payment for in-home COVID-19 vaccination beyond the PHE and extending it to other preventive vaccines, the Agency stated it will continue to engage with the health care community to evaluate this topic.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) furnished by Opioid Treatment Programs (OTPs) Services

Medicare Payments to OTPs

CMS is finalizing the proposal to codify the application of the annual updates and locality adjustments to the non-drug component of the codes describing add-on payments for opioid antagonist medications (i.e., naloxone) that were new for CY21. In addition, CMS is finalizing the proposal to clarify that the prohibition on duplicative payments applies to drugs provided as part of an add-on payment, as well as the bundled payment.

OTP Coding and Payment for New Nasal Naloxone Product

CMS is finalizing the proposal to establish a new code for a higher dose of naloxone hydrochloride nasal spray; the new code is G1028. The agency is also updating the code descriptor for HCPCS code G2215 to be "*Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program".*

Counseling and Therapy furnished via Audio-Only Telephone

CMS is finalizing its proposal to allow OTPs to furnish individual and group therapy and substance use counseling using audio-only telephone calls rather than two-way interactive audio/video communication technology after the conclusion of the PHE for COVID-19 when audio/video communication is not available to the beneficiary, provided all other applicable requirements are met. "Not available to the beneficiary" includes situations where the beneficiary is not capable or has not consented to use of two-way communication technology because audio/video communication technology is not able to be used in furnishing services to the beneficiary. The Agency will defer to the judgment of treating clinicians to determine when audio-only or audio/video counseling or therapy are appropriate and whether there

are certain circumstances, such as when patients are considered to be high risk, when in-person services are needed.

CMS is finalizing the proposal that service-level modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) be appended to claims submitted for the counseling and therapy add-on code (HCPCS code G2080) when services are furnished via an audio-only interaction. Following the COVID-19 PHE, if two-way interactive audio/video communication technology is used and billed under G2080, OTPs will be required to use modifier 95 in claims. For purposes of the bundled payment for additional counseling or therapy services furnished using audio-only technology, the Agency is amending its proposal to require that after the COVID-19 PHE, the practitioner must certify that they had the capacity to furnish the services using two-way, audio/video communication technology, but used audio-only technology because audio/video communication technology was not available to the beneficiary.

Updates to Physician Self-Referral Regulations under Stark Law

CMS is finalizing its proposal to amend the provisions of 42 CFR § 411.354(c)(2) identifying unbroken chains of financial relationships that constitute "indirect compensation arrangements" to ensure that a longstanding prohibition on certain per unit of service-based compensation formulas for determining charges for the rental of office space and equipment remains within the scope of the law. The Agency believes this amendment is necessary to protect against potential abuses such as overutilization and anti-competitive behavior. Additionally, CMS is adding provisions to assist stakeholders in identifying the individual unit to be analyzed under the provisions of § 411.354(c)(2)(ii)(A)(2)(*i*) through (*iv*), stating it believes this clarity will help facilitate compliance without adding burden.

The Agency is also finalizing its proposal to permit the use of the exception for preventive screening tests and vaccines at § 411.355(h) for COVID-19 vaccines during such period as the vaccines are not subject to CMS-mandated frequency limits, provided that all other requirements of the exception are satisfied. CMS believes this policy will ensure that the physician self-referral law will not impede the availability of critically important COVID-19 vaccines for Medicare and other patients.

Lastly, CMS is finalizing its proposal to publish the Code List for Certain Designated Health Services solely on the CMS website. The Code will be updated annually and published at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes. This includes a 30-day public comment period for each update using www.regulations.gov.

Requiring Certain Manufacturers to Report Drug Pricing Information for Part B, and Other Items

CMS is finalizing their proposal to implement the reporting requirements of Section 401 of the CAA (2021). Section 401 established a requirement that manufacturers without Medicaid drug rebate agreements report quarterly average sales price (ASP) information beginning in January 2022 for drugs and biologics paid for by Part B. A civil monetary penalty of $10,000 per price misrepresentation per day will be issued for the failure to report.

Electronic Prescribing of Controlled Substances (EPCS)

The Agency is finalizing its proposal to extend the date of compliance actions to no earlier than January 1, 2023. CMS is also finalizing its proposal that the earliest date of compliance actions against prescribers writing Part D controlled substance prescriptions for beneficiaries in long-term care (LTC)

facilities be no earlier than January 1, 2025 to allow adequate time for EPCS to be adopted across the industry. In order to implement this provision, CMS will be excluding LTC prescriptions from its counting of compliance actions to help ensure that prescribers writing prescriptions for beneficiaries in these facilities do not have these prescriptions counted against them for purposes of the compliance threshold and the number of prescriptions written per prescriber for purposes of determining who is classified as a small prescriber under the rule.

The Agency is finalizing this provision as proposed, which would require prescribers to prescribe at least 70 percent of their Schedule II, III, IV, and V controlled substances that are Part D drugs electronically, except in cases where an exception or waiver applies. CMS notes that prescriptions for beneficiaries in LTC facilities would be excluded from the calculation of the compliance threshold until the January 1, 2025 compliance threshold calculation is made, which would be using data beginning on January 1, 2024. CMS will determine compliance with the EPCS requirement by examining prescription drug events (PDE) data at the end of the calendar year (86 FR 39330), which is why the Agency will begin considering data for Part D prescriptions written for beneficiaries in LTC facilities on January 1, 2024 and continuing through December 31, 2024 for compliance actions that CMS takes on or after January 1, 2025.

Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging

CMS is finalizing its proposal to delay the penalty effective date of the AUC program until January 1, 2023, or the January 1 that follows the declared end of the COVID-19 PHE, whichever is later. The payment penalty phase had been previously set to begin January 1, 2022.

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

CMS thanked commenters and said the information submitted would be taken under advisement in potential future rulemaking.

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR®) in Physician Quality Programs – Request for Information

CMS is finalizing its plan to move fully to digital quality measures (dQMs) by 2025, with the acknowledgement that the timeline may vary across CMS' quality programs. CMS believes that their efforts to move to dQMs align with efforts described in the Office of the National Coordinator for Health Information Technology's (ONC) 21st Century Cures Act final rule and will coordinate with HL7's ongoing work to advance FHIR®. CMS plans to use policy levers and work with stakeholders, (e.g., programs, agencies, and private payers) to solve the issue of interoperable data exchange and to transition to full digital quality measurement.

While CMS will not be responding to specific comments submitted in response to this Request for Information in the CY22 MPFS final rule, the Agency will actively consider all input as it develops future regulatory proposals or future sub-regulatory policy guidance. Any updates to specific program requirements related to quality measurement and reporting provisions may be addressed through separate and future notice and comment rulemaking, as necessary.

Health Equity Initiative

CMS thanked commenters and said the information submitted would be taken under advisement in potential future rulemaking.

Quality Payment Program (QPP)

MIPS Value Pathway (MVP)

Quality Measures

The final rule maintains the data completeness criteria threshold of 70 percent for the 2022 and 2023 performance periods. For performance period 2022, the quality performance category weight is set at 30 percent.

CMS is finalizing the Optimizing Chronic Disease Management MVP which includes nine quality measures and 12 improvement activities, the Advancing Rheumatology Patient Care MVP which includes nine quality measures and 11 improvement activities, and the Advancing Care for Heart Disease MVP which includes eight quality measures and 11 improvement activities.

In the final rule, CMS also suggests that "to the extent feasible" MVPs should include a maximum of 10 quality measures and 10 improvement activities.

Improvement Activities

As with the Merit-based Incentive Payment System (MIPS), groups and sub-groups will select two medium-weighted or one high-weighted activity, or participation in a patient-centered medical home (PCMH), if available in the MVP.

For the CY22 performance period/2024 MIPS payment year and future years, CMS is finalizing adding seven new improvement activities, modifying 15 previously adopted improvement activities, and removing six previously adopted improvement activities. For performance period 2022, the improvement activities category weight is set at 15 percent.

Promoting Interoperability

In order to give MIPS-eligible clinicians time to familiarize themselves with MVPs and subgroup reporting, CMS is finalizing its proposal to delay public reporting of new improvement activities and Promoting Interoperability measures and attestations reported via MVPs by one year and begin publicly reporting subgroup-level performance information in performance year (PY) 2024, on the compare tool hosted by the U.S. Department of Health and Human Services (HHS). CMS is finalizing its proposal to create a separate subgroup workflow that would allow subgroup performance information to be publicly reported in an online location that can be navigated to and from an individual clinician or group profile page. This also aligns with the historical approach to report performance information at the level that it is submitted.

CMS is finalizing that a subgroup may receive reweighting independent of the affiliated group in certain circumstances, but non-patient facing status is not one of those circumstances. The Agency also is finalizing that special status (such as non-patient facing status) is determined for a subgroup at the group level, not at the subgroup level.

CMS is finalizing calculation of the Promoting Interoperability performance category score for an MVP Participant using specific methodology detailed in the rule, with some exceptions.

CMS is finalizing a requirement for subgroups to submit their affiliated group's data for the Promoting Interoperability performance category and also is finalizing that if a subgroup does not submit its

affiliated group's data for the Promoting Interoperability performance category, the subgroup will receive a score of zero for the Promoting Interoperability performance category.

MVP Review: Quality Measure, Patient Reported Outcome Measure, Population Health Measure, and Cost Measure

CMS is finalizing that it will begin to transition to MVPs from the 2023 performance year. They delayed the requirement of multispecialty groups needing to form subgroups in order to report MVPs to 2026, in response to the comments received. Subgroup reporting will be voluntary in 2023, 2024, and 2025. CMS highlighted that they would be requiring QCDRs, Qualified Registries, and Health IT vendors to support MVPs, starting from 2023.

CMS is finalizing the seven MVPs that will be available to report in 2023:

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

The MVP participants will be required to report on four Quality measures, out of the quality measures included in that MVP, where one must be an outcome measure. Participants can report on a high-priority measure to meet this requirement if an outcome measure is not included in the MVP. Other than Quality, MVPs will also have to report on Improvement Activities Performance Category, Cost Performance Category, and an MVP agnostic Foundational Layer.

CMS has included two new quality measures in the MVPs. One is a population health measure, Clinician and Clinician Group Risk standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Q484), which is included in all seven MVPs' Foundational Layer. The other new measure is the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM), which is included in the Optimizing Chronic Disease Management MVP.

The MVP agnostic Foundational Layer has two parts:

(1) Population Health Measure: MVPs will have to report on one of these two available measures, and:
   - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups
   - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.

(2) Promoting Interoperability Measures.

The Scoring of the Quality category for MVPs differs slightly from that of the traditional MIPS. There is no three-point floor available for MVPs. Existing measures with no benchmark will score zero but new measures without a benchmark will score a seven-point floor in the first year and five-point floor in the second year. Similar to traditional MIPS, CMS is finalizing the removal of end-to-end electronic reporting

and high priority/outcome measure bonus points from the 2022 performance period. The score of the Population Health Measure will be added to the Quality Score for MVPs.

Though CMS acknowledged that their existing portfolio of patient reported outcome measures are limited and may not be applicable to all specialties and subspecialties, CMS is not taking any further action at this time. The Agency thanked commenters and stated the information submitted would be taken under advisement in potential future rulemaking.

CMS also is finalizing the inclusion of the TPCC (Total Per Capita Cost) cost measure for three MVPs (Advancing Rheumatology Patient Care, Advancing Care for Heart Disease, and Optimizing Chronic Disease Management) as proposed (displayed in Table 54 and Tables A, C, and D).

PY 2022 MIPS Changes

PY22 Reporting Exemptions Due to COVID-19
CMS is finalizing continuing its MIPS extreme and uncontrollable circumstances exceptions for the 2022 performance year on a case-by-case basis.

PY 2022 Scoring and PY 2021 Performance Feedback

CMS delayed MVPs until 2023. It will begin as optional, but eventually CMS intends to sunset traditional MIPS and require reporting via MVPs. MIPS ECs will generally be able to participate in MVPs, with limited exceptions. CMS will start with seven MVPs and plans to add more in the future. CMS also still aims to sunset traditional MIPS and replace it with MVPs starting with PY 2028.

Quality Category/Quality Category: Data Completeness
CMS has not made significant changes to the Quality Category for PY22. Quality will be 30 percent of the total score, compared to 40 percent in 2021. CMS had initially proposed to increase the data completeness threshold to 80 percent, from 70 percent in 2021. In the final rule, CMS said that it was maintaining it at 70 percent for the 2022 and 2023 performance periods in response to the comments received. CMS is finalizing that it would use the CMS Web Interface as a quality reporting option for the 2022 performance period.

The overall scoring and the scoring for the Quality Section has been altered. CMS is finalizing that it would be increasing the performance threshold for the total score to 75, from 60. There is an additional threshold of 89 points for exceptional performance. The Agency also mentioned it would be using 2020's performance data as the historical benchmark for 2022 reporting because their research showed that CMS would be able to create reliable benchmarks with 2020 data. For the Quality section scoring, CMS is finalizing the removal of end-to-end electronic reporting and high priority/outcome measure bonus points from the 2022 performance period. However, in response to comments concerning the removal of three-point floor during this PHE, CMS is finalizing that it would be delaying the removal of three-point floor for measures until the CY23 performance period. CMS is finalizing the addition of one new measure, Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM), to the Internal Medicine Set. The Agency also is finalizing the removal of the following four measures from the IM set:

1. Falls: Risk Assessment

2. Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier
3. Pain Brought Under Control Within 48 Hours
4. Medication Management for People with Asthma

Quality Category: Quality Measure Scoring Changes
MIPS scoring, as statutorily required, will be as follows for PY22:

- Traditional MIPS (individuals, groups, virtual groups): Quality 30 percent, Cost 30 percent, Promoting Interoperability 25 percent (no change), and Improvement activities 15 percent (no change).
- Traditional MIPS (APM entities) did not change: Quality 55 percent, Cost zero percent, Promoting Interoperability 30 percent, Improvement Activities 15 percent.
- APM Performance Pathway did not change: Quality 50 percent, Cost zero percent, Promoting Interoperability 30 percent, Improvement Activities 20 percent.

CMS will continue to double the complex patient bonus (five points multiplied by two) for the 2021 MIPS performance year. For PY 2022, the Agency will limit the bonus to clinicians who have a median or higher value for at least one of the two risk indicators (HCC score and dual eligible patients). The maximum bonus will increase to 10 points.

Promoting Interoperability Changes
CMS is finalizing their proposal to make the Immunization Registry Reporting a required measure under the Public Health and Clinical Data Exchange objective of the Promoting Interoperability performance category beginning with the CY22 performance period/CY24 MIPS payment year. The Agency believes that making the Immunization Registry Reporting measure required will increase the reporting of immunization data by health care clinicians and other providers to public health agencies and that it is critical for the COVID-19 vaccination response because it will provide a better view of the vaccines administered and distributed at national, state, and local levels. The Agency believes requiring the measure will reduce the regulatory and administrative burden health care practitioners experience when exchanging information with immunization registries.

CMS additionally is finalizing these proposals:

- Beginning with the CY22 performance period/CY24 MIPS payment year, a MIPS-eligible clinician will receive 10 points for the Public Health and Clinical Data Exchange objective if they report a "yes" response for each of the following required measures: Immunization Registry Reporting; and Electronic Case Reporting. In the event that a MIPS-eligible clinician is able to claim an exclusion for one or more of these required measures, they will receive 10 points for the objective if they report a "yes" response for one measure and claim an applicable exclusion for which they qualify for the remaining measure. If the MIPS-eligible clinician fails to report on any one of the two measures required for this objective or reports a "no" response for one or more of these measures, the MIPS-eligible clinician will receive a score of zero for the Public Health and Clinical Data Exchange objective, and a total score of zero for the Promoting Interoperability performance category. If a MIPS-eligible clinician claims applicable exclusions for which they qualify for both required measures, the Agency will redistribute the points associated with the objective to the Provider to Patient Exchange objective.

- The Public Health Registry Reporting, Clinical Data Registry Reporting, and Syndromic Surveillance Reporting measures will be optional and available for bonus points beginning with the CY22 performance period/CY24 MIPS payment year. A MIPS-eligible clinician may earn five bonus points if they report a "yes" response for either the Public Health Registry Reporting measure or the Clinical Data Registry Reporting measure or the Syndromic Surveillance Reporting measure.
- CMS is removing the three exclusions established in the CY 2019 PFS final rule at 83 FR 59815 through 59817 for the Public Health Registry Reporting measure, Clinical Data Registry Reporting measure, and the Syndromic Surveillance Reporting measure.

Improvement Activities (IA) Category

This final rule adds seven new activities, modifies 15, and removes six. There are two new activities, "Create and implement an anti-racism plan" (IA_AHE_8) and "Implement food insecurity and nutrition risk identification and treatment protocols" (IA_AHE_9), as well as several modifications to other IAs that are intended to address health equity and social drivers of health. Others are intended to address clinician well-being, emergency preparedness, and PPE management.

Groups that report IAs must be performed by at least 50 percent of the National Provider Identifier's (NPIs) billing under the group's or virtual group's tax identification number (TIN), and the NPIs must perform the same activity during any continuous 90-day period during the same performance period.

The final rule also made some changes to the process of nominating new IAs during the PHE. CMS also is finalizing two additional criteria for new IAs, requiring that they are not duplicative of other IAs, and that they "drive improvements that go beyond purely common clinical practices".

Cost Performance Category

CMS is adding five new episode-based measures, including two chronic condition episodes (asthma/chronic obstructive pulmonary disease, diabetes), two procedural episodes (colon and rectal resection (COPD), melanoma resection), and one acute inpatient medical condition episode (sepsis). This adds to the two global or population-based measures and 18 episode-based measures. For performance period 2022, the cost performance category weight is set at 30 percent.

Advanced Alternative Payment Model (APM) Performance Pathway (APP)

CMS is finalizing that individual MIPS-eligible clinicians who are participants in MIPS APMs may report through the APP at the individual level. Additionally, CMS is finalizing that groups and APM entities may report through the APP on behalf of constituent MIPS-eligible clinicians.

Regarding CMS' proposal to allow MIPS-eligible clinicians to report the APP as a subgroup beginning with PY 2023, CMS is finalizing this with the modification that multispecialty groups will be required to form subgroups in order to report MVPs beginning in the CY26 performance period/2028 MIPS payment year, instead of the CY25 performance period/2027 MIPS payment year as proposed.

Complex Patient Bonus

CMS is finalizing its proposal on formulas for the complex patient bonus with two separate components (medical complexity and social complexity) and an overall cap of 10 bonus points beginning with the 2022 MIPS performance year.

Medicare Shared Savings Program (MSSP)

In the final rule, CMS is finalizing extending the availability of the CMS Web Interface collection type for an additional three years (through PY 2024) for Accountable Care Organizations (ACOs) to prepare for reporting electronic clinical quality measures (eCQM)/MIPS clinical quality measures (MIPS CQM) under the Alternative Payment Model (APM) Performance Pathway (APP). For PYs 2022-2024, CMS will allow ACOs to report either the 10 CMS Web Interface measures and administer Consumer Assessment of Healthcare Providers and Systems (CAHPS) or report the three Alternative Payment Model Performance Pathway (APP) eCQMs/MIPS CQMs and administer CAHPS. Beginning with the 2025 performance period and subsequent years, ACOs must report the three APP eCQM/MIPS CQMs.

For PY 2022 and 2023, CMS has established an incentive for the quality performance standard for ACOs that report the eCQMs/MIPS CQMs. CMS will add several codes (include CPT codes 99441-99445, until they are no longer payable under the MPFS) to the list of primary care services used to assign patients to the ACO.

CMS is finalizing lowering the repayment mechanism amounts and modification of the methodology used for the annual repayment amount recalculation to use more recent data.

CMS is finalizing freezing the quality performance standard at the 30th percentile for MIPS Quality Performance Category scores for an additional year (PY 2023). CMS will increase the quality performance standard to the 40th percentile beginning with PY 2024.

CMS is finalizing policies impacting the Shared Savings Program application process by modifying the prior participation disclosure requirement. The disclosure is required only at the request of CMS during the application process.

Regional adjustment includes an ACO's own beneficiaries in the regional calculation. While this has minimal impact for ACOs in urban areas with a lot of provider competition, the impact can be significant in rural areas where an ACO covers a large number of the region's fee-for service beneficiaries. No ACO should be placed in a less favorable financial position due to their geography alone, and design flaws that discourage ACOs from operating in rural areas should be eliminated. CMS did not address the issue in this final rule.

Medicare Diabetes Prevention Program (MDPP) PHE Permanent Exceptions

The final rule increases payments for the core and first year maintenance sessions, waived the enrollment fee for suppliers, and eliminated Year 2 maintenance session payments. While the maximum payment did not increase, the front-loaded payments into Year 1 makes a one-year beneficiary commitment more realistic. The increase in payment is intended to improve access to the beneficiaries for whom transportation or distance creates a barrier toward completing nine sessions during their one-year commitment. The elimination of the second year is also intended to increase the number of locations. CMS will study claims data to determine if the changes were effective.

Advanced Alternative Payment Models (APMs)

CMS is finalizing that qualifying APM participants (QPs) for the year receive a five percent lump sum incentive payment through CY24, or a differential payment update under the MPFS beginning with PY26.

Determination of the Advanced APM five percent bonus takes place at the facility/APM entity level (TIN) or at the individual eligible clinical level.

CMS did not finalize any rules impacting the timeline of incentive payments for APM participation beyond the MACRA 2024 deadline.