NAACOS Analysis of the Proposed 2022 Medicare Physician Fee Schedule

Executive Summary

In mid-July, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2022 Medicare Physician Fee Schedule (MPFS) rule. This proposed regulation includes a number of policies affecting Medicare physician payment, quality measure and reporting changes for Medicare Shared Savings Program (MSSP) ACOs, and Quality Payment Program (QPP) requirements for 2022. The key proposals affecting ACOs are outlined below and further detailed in this analysis. The rule is summarized in this CMS factsheet along with detailed QPP changes.

NAACOS is seeking member input on the proposals in this rule, which will help shape our comments. Please share your feedback by emailing us at advocacy@naacos.com. CMS will review comments and issue a final rule later this year. Typically, the final MPFS rule is released around November 1.

Medicare Shared Savings Program Proposals

- Provide two additional years to report quality measures using the Web Interface (WI)
- Phase-in the requirement to move ACOs to electronic clinical quality measure (eCQM) reporting by 2024
- Freeze the quality performance standard for one additional year
- Amend the list of primary care services used to assign beneficiaries to ACOs by adding seven more codes starting in performance year (PY) 2022
- Seek feedback on, without formally proposing changes, to the regional adjustment of MSSP benchmarks, specifically how the agency could account for the removal of ACO-assigned beneficiaries from the regional reference population
- Ease burdens and costs of ACO repayment mechanisms by cutting in half the percentages used in the existing repayment mechanism amount calculations
- Reduce MSSP application burden by lowering document submission requirements around prior participation and sample and executed ACO participant agreements
- Change beneficiary notification requirements for ACOs that select prospective assignment by only requiring notices to be sent to beneficiaries prospectively assigned to their ACO

Medicare Physician Payment Proposals

- Decrease the Medicare conversion factor to $33.58, a drop of about 3.75 percent
- Establish a new chronic care management (CCM) code, 99X21, describing CCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner (NPP) who can bill evaluation/management (E/M) services, and CCM services personally furnished by a physician or NPP
- Continue an ongoing review of E/M visit code sets with clarifications on policies finalized for 2021 and proposals to allow split/shared E/M visits by a physician and NPP in the same group, and to clarify that time a teaching physician is present can count toward E/M visit level for teaching services

- Retain all of the services temporarily added to the list of those eligible to be delivered via telehealth during the COVID-19 public health emergency (PHE) through the end of 2023,
- Make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth, as well as allow tele-mental health to be delivered through audio-only communications

MEDICARE SHARED SAVINGS PROGRAM

Proposed MSSP Quality Changes for 2022 and Subsequent Years

After a year-long advocacy campaign, NAACOS was successful in securing MSSP ACOs two additional years of reporting quality measures through the Web Interface (WI). In the 2021 MPFS Rule, CMS finalized a major overhaul of the quality reporting and assessment structure for MSSP ACOs, including a mandatory move to eCQM reporting beginning in 2022. After many NAACOS members raised concerns with this significant and abrupt change, NAACOS advocated for a more phased-in approach to allow the ACO and Electronic Health Record (EHR) industries more time to correct deficiencies and to allow CMS to more thoughtfully approach this transition to the use of mandatory digital measures, aggregated at the ACO level. We are pleased to see CMS propose in this regulation to instead provide a more phased-in approach to the move to eCQM reporting at the ACO level through the revised APM Performance Pathway (APP) requirements for ACOs included in this regulation. Below is a summary of the key changes proposed to MSSP ACO quality reporting requirements and quality assessment methodologies in the APP for ACOs specifically. More information on the policies finalized in the 2021 MPFS Rule is available in our member resource.

Reporting Options

CMS proposes to phase in the eCQM requirement for ACOs by allowing continued use of the WI for two additional years beyond what the agency had finalized in the 2021 MPFS Rule, allowing ACOs the option to report via WI for 2021, 2022 and 2023.

Reporting Options		
2021	Report via Web Interface	Report via APP eCQMs/MIPS CQMs
2022	Report via Web Interface	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard (30th percentile of all MIPS final quality scores) for at least one of the measures. This is a lower standard than those reporting via Web Interface and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2023	Report via WI + one APP eCQM/MIPS CQM	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard (30th percentile of all MIPS final quality scores) for at least one of the measures. This is a lower standard than those reporting via Web Interface and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2024	All ACOs must report the APP eCQMs/MIPS CQMs. The quality performance standard also rises in 2024, as proposed, to the 40th percentile of all MIPS final quality scores	

*Note: if an ACO elects to report eCQMs/MIPS CQMs, data completeness and case minimum requirements must be met

For the first performance year of an ACO's first agreement period under the Shared Savings Program, if the ACO meets Merit-Based Incentive Payment System (MIPS) data completeness and case minimum requirements CMS proposes that the ACO would meet the quality performance standard. This continues the current policy of providing all new ACOs with a pay-for-reporting year at the start of their contract. CMS is also seeking feedback on whether this proposal allows sufficient lead time to provide ACOs in preparing for the full transition to mandatory eCQM/MIPS CQM reporting. Finally, note that CMS states if an ACO decides to report both the ten CMS Web Interface measures and the three eCQM/MIPS CQM measures, it will receive the higher of the two quality scores for purposes of the MIPS Quality performance category. NAACOS has reached out to CMS to clarify whether this policy also applies for PY 2021, as this is not expressly stated in the rule. While not yet confirmed in writing, during CMS webinars the agency has indicated this will be the policy in 2021 as well as in future years. Finally, for ACOs electing to report eCQM/MIPS CQMs, CMS notes they will use performance on all three eCQM/MIPS CQM measures for the purposes of MIPS scoring, should the ACO be subject to MIPS.

CMS also proposes to increase the quality data completeness standard from 70 percent to 80 percent beginning in 2023, which if finalized would apply to would apply to ACO quality reporting as well as the MIPS more broadly.

MSSP Performance Threshold

CMS proposes to maintain the 30th percentile quality performance standard in 2021, 2022 and 2023 and proposes to increase the threshold to the 40th percentile beginning in 2024. If finalized, this would extend the 30th percentile quality performance standard for one additional year beyond what was finalized in the 2021 MPFS Rule. The performance thresholds for each year are:

- **2021:** ACOs' final quality score must be equal to or higher than the 30th percentile across all MIPS Quality performance category scores. If this performance standard is met, ACOs are eligible to share in savings earned at the maximum sharing rate available in their particular track.
- **2022:** Same as 2021, however if an ACO elects to report all three eCQM/MIPS CQMs in the APP, the ACO will satisfy the quality performance standard if the final quality score is equal to or greater than the 30th percentile on at least one measure in the APP measure set. This is designed as an incentive to encourage eCQM reporting.
- **2023**: Same as 2022, however ACOs must also report at least one eCQM/MIPS CQM measure in the APP in order to meet the quality performance standard.
- **2024:** Beginning in 2024 CMS proposes to require mandatory eCQM reporting for all ACOs. In addition, ACOs' final quality score must be equal to or greater than the 40th percentile across all MIPS Quality performance category scores.

Unfortunately, CMS does not provide further details or examples of how this threshold is calculated. Instead, CMS provides information regarding the agency's estimates for what the quality standard would be if using prior year performance data. Specifically, CMS states the following on page 39274 of the proposed rule:

- For performance year 2018 the MIPS Quality performance category score at the 30th percentile was equivalent to 83.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 93.3. For performance year 2019 the MIPS Quality performance category score at 30th percentile was equivalent to 87.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 95.7.
- Roughly 1-in-5 ACOs, or approximately 20 percent of ACOs, could fall below the 40th percentile MIPS Quality performance category score by performance year 2023, and would not be eligible to share in savings or would owe maximum shared losses, if applicable.

- The estimated percent of Shared Savings Program ACOs falling below the 40th percentile MIPS Quality performance category score was 6.5 percent based on a simulation using 2018 data and 22.9 percent based on a simulation using 2019 data.

CMS seeks comment on publishing prior year performance scores for the 30th and 40th percentile MIPS Quality performance category score, as well as other ways the agency could provide additional information prior to the start of the performance year regarding the performance standard to assist ACOs in planning for improvement strategies, etc.

These policies are summarized in Table 24 in the proposed rule found on page 39269 and included below.

TABLE 24: Comparison of APP Reporting Requirements for Performance Year 2021 through 2024

	PY 2021	PY 2022	PY 2023	PY 2024
Shared Savings Program ACO Quality Reporting requirements	ACOs are required to report the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures and administer the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data. Based on the ACO's chose reporting option, either 6 or 10 measures will be included in calculating the ACO's quality performance score	Same as PY 2021	ACOs will be required to report either the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures. ACOs reporting the 10 CMS Web Interface measures must also report at least one of the 3 eCQM/MIPS CQM measures under the APP. ACOs will be required to field the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data.	ACOs will be required to report on the 3 eCQM/MIPS CQM measures and field the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data. All 6 measures will be included in calculating the ACO's quality performance score.
Shared Savings Program ACO Quality Performance Standard	A quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores. Quality performance standard met: ACOs are eligible to share in savings at the maximum sharing rate; ACOs in two-sided models share in losses based on their quality score or at a fixed percentage based on Track. Quality performance standard not met: ACOs are ineligible to share savings and owe the maximum amount of shared losses, if applicable.	Same as PY 2021. However, in order to encourage all payer measure reporting if the ACO reports all 3 eCQM/MIPS CQM measures under the APP, the ACO will satisfy the quality performance standard if it achieves a performance score that is equivalent to or higher than the 30th percentile on at least one measure in the APP set.	Same as PY 2022. However, if an ACO does not report at least one eCQM/MIPS CQM measure, the ACO will not meet the quality performance standard.	A quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores

Extreme and Uncontrollable Circumstances Policy for Quality

Finally, CMS also proposes to make changes to the MSSP Extreme and Uncontrollable Circumstances Policy to reflect these proposals. Specifically, CMS proposes for PY 2021 and 2022 if the ACO is able to report quality data and meets the MIPS data completeness and case minimum requirements, CMS would use the higher of the ACO's MIPS Quality performance category score or the 30th percentile MIPS Quality performance category score. If the ACO is unable to report quality data and meet the MIPS Quality data completeness and case minimum requirements due to an extreme and uncontrollable circumstance, CMS would apply the 30th percentile MIPS Quality performance category score. For PY 2023, if the ACO is able to report quality data, including at least one eCQM/MIPS CQM measure, and meets data completeness and case minimum requirements, CMS will use the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score.

If the ACO is unable to report quality data and meet the MIPS Quality data completeness and case minimum requirements due to an extreme and uncontrollable circumstance, CMS would apply the 30th percentile MIPS Quality performance category score. Similarly, for PY 2024 and subsequent years, CMS proposes if the ACO is able to report quality data and meets MIPS data completeness and case minimum requirements, CMS would use the higher of the ACO's MIPS Quality performance category score or the 40th percentile MIPS Quality performance category score. If the ACO is unable to report quality data and meet data completeness requirements due to an extreme and uncontrollable circumstance, CMS would apply the 40th percentile MIPS Quality performance category score.

CMS Solicitation of Comments on Quality

CMS also solicits comments on a number of ACO issues related to the move to eCQMs and digital quality measurement, highlighted below. NAACOS encourages members to share your feedback on these issues by emailing us at advocacy@naacos.com. Comments to CMS in response to the proposed rule are due on September 13 and may be submitted on the reulgations.gov website.

Data Aggregation

CMS seeks comment on policy changes that may alleviate concerns with ACO data aggregation issues related to the move to eCQM/MIPS CQM reporting:

- CMS seeks comment on allowing ACO providers/suppliers to submit eCQMs/MIPS CQM measures to CMS at the ACO participant TIN level, instead of requiring ACOs to aggregate this data and submit one numerator/denominator to CMS.
- Alternatively, CMS could calculate an ACO-level numerator for each measure (sum of performance met across TINs within the ACO) and an ACO-level denominator (sum of the met and performance not met across TINs within the ACO), then divide the two — numerator/denominator x 100 — to obtain the ACO-level performance rate.

Please note that in this proposed rule, CMS clarifies that ACOs do need to de-duplicate patient level measure data across ACO providers/suppliers when submitting aggregate numerator/denominator to CMS. Specifically, CMS states that an ACO that submits eCQM quality data to CMS must de-duplicate the patient level measures data across its ACO providers/suppliers to ensure that the aggregated QRDA III file that is submitted to CMS incorporates only quality data that meets the intent of the measure.

All-payor Data and Denominator Size

CMS notes that ACOs have raised concerns with the move to eCQM/MIPS CQM reporting and the issues that arise with requiring reporting on all-payor data. As such, CMS seeks comment on alternatives to this all-payor requirement in eCQM reporting applied to ACOs. Specifically, CMS seeks feedback on the following questions:

- Should ACOs report on a small sample size similar to the sample size for the CMS WI?

- Should CMS revise the beneficiary sample to include all ACO assigned beneficiaries that meet the denominator for a given measure?
- Should CMS provide ACOs with a bigger sample size which is larger than the size that has historically been used for CMS WI but smaller than all of the assigned beneficiaries that meet the denominator for a given measure, regardless of payor?
- Should CMS develop other ACO-level eCQM/MIPS CQM measure sampling specifications?

Specialists and Quality Measurement in ACOs

CMS seeks comments related to how specialists should be evaluated on quality in the context of ACOs using digital quality measurement. CMS seeks feedback on the following questions:

- Should CMS allow ACO participant TINs to report either the eCQM/MIPS CQM measures in the APP measure set at the TIN level or the applicable MIPS Value Pathways? How could APP and MIPS Value Pathway data reported at the ACO participant TIN level be aggregated in order to assess ACO quality performance?
- What specialty measures in the current eCQM or MIPS CQM measure set should be considered for inclusion in the MSSP quality measure set in future performance years? Alternatively, how could the existing APP measure set be used or modified to reinforce the role of specialists in ACO population health strategies?

Health Equity and the eCQM Requirement for ACOs

CMS notes the agency believes the move to eCQMs and measuring quality for all payors will assist in improving health equity, and it seeks comment on other ways to improve health equity in the MSSP, including the following questions:

- How can ACOs utilize their resources to ensure that patients, regardless of racial/ethnic group, geographic location and/or income status, have access to equal care and how ACOs can improve the quality of care provided to certain communities, while addressing the disparities that currently exist in healthcare?
- How can CMS encourage health care providers serving vulnerable populations to participate in ACOs and other value-based care initiatives? Should adjustments be made to quality measure benchmarks to take into account ACOs serving vulnerable populations?

2022 WI Quality Measures

For 2022, three of the CMS WI measures (Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Tobacco Cessation: Screening and Cessation Intervention (Quality ID# 236)) do not have benchmarks for PY 2022, and, therefore, will not be scored. However, these measures are required to be reported in order to complete the CMS WI dataset. See Table 25: Measures included in the Proposed APM Performance Pathway Measure Set found on page 39271 in the proposed rule for the list of measures available in 2022.

TABLE 25: Measures included in the Proposed APM Performance Pathway Measure Set**

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MISP Survey	Third Party Intermediary	Patient's Experience
Measure# 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions

Measure # TBD	Risk Standardization, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventative Care and Screening: Screening for Depression and Follow-Up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventable Healthcare Harm
Quality ID#: ll0	Preventative Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 226	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Prevention and Treatment of Opioid and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Readmission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

**We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 236) do not have benchmarks and are therefore not scored for PY 2022; they are, however, required to be reported in order to complete the Web Interface dataset.
* ACOs will have the option to report via Web Interface for the 2022 & 2023 MIPS Performance years only.

Finally, CMS is publishing a list of quality measures with substantive changes in the measure specifications in Table Group D found on page 39791.

MSSP Beneficiary Assignment

CMS proposes to amend the list of primary care services it uses to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. The additional proposed codes include:

- 99X21 (chronic care management [CCM])*
- 99X22, 99X23, 99X24, and 99X25 (principal care management [PCM])*
- G2212 (prolonged office or other outpatient E/M service)*
- G2252 (communication technology-based service)

*not yet finalized

CMS already lists a number of CCM and PCM codes on the MSSP assignment list, therefore it seems logical to add these proposed services to that list. Some of the new PCM codes being proposed to be used in MSSP assignment will replace temporary Healthcare Common Procedure Coding System (HCPCS) codes G2064 and G2065 in the fee schedule. G2212 is a new billing code being proposed in this rule, but

because it is an add-on code for office/outpatient E/M services 99205 and 99215, CMS states it would be appropriate to include G2212 for use in MSSP assignment. Also elsewhere in this rule, CMS is proposing to pay for G2252 on a permanent basis starting in 2022. CMS is proposing to add it to the list of codes used in MSSP assignment because it is similar to other codes currently on that list.

As described elsewhere in this resource, CMS is proposing to keep temporarily added services on the list of those eligible to be delivered via telehealth through the end of 2023. Three of those codes, 99441, 99442, and 99443 (which pay for audio-only telephone E/M services), are used in MSSP assignment during the COVID-19 PHE. CMS is also proposing to keep using 99441, 99442, and 99443 in MSSP assignment until they are no longer payable under Medicare FFS policies.

Finally, CMS proposes to use Current Procedural Terminology (CPT) codes that are directly replaced by another code in the fee schedule for purposes of MSSP assignment. Because ACO assignment windows may include temporary G codes that have been replaced with permanent CPT codes used in performance years, CMS wants to make clear both codes will be used in assignment, even if they are different as they are essentially the same service.

MSSP Benchmarking

CMS seeks feedback on, but doesn't propose any changes as of yet, to the regional adjustment of MSSP benchmarks. Specifically, CMS wants feedback on how to account for the removal of ACO-assigned beneficiaries from the regional reference population, which is used to determine the regional portion of benchmarks. NAACOS has consistently called for ACO-assigned beneficiaries to be removed from the regional population since ACOs that make up a large market share and lower the cost of their populations lose the benefit of the regional adjustment, thereby penalizing themselves. This benchmarking flaw is often referred to as the "rural glitch" because it disproportionately harms rural ACOs, although the issue affects urban and suburban ACOs as well.

CMS suggests a formula to account for the removal of ACO-assigned beneficiaries. The agency ran an analysis of MSSP ACOs who participated in the six-month performance year starting on July 1, 2019. Updated benchmarks using CMS's suggested formula would range from increases of 0.1 percent to 1.4 percent. However, some ACOs would see their benchmarks decrease from -0.02 percent to -1.5 percent. ACOs with higher market share tended to see slightly higher increases in benchmarks. NAACOS has conducted its own analysis of how fixing this rural glitch would impact ACOs and found about 80 percent would benefit with higher benchmarks. That finding was consistent over a few years of data.

To account for ACOs who might be harmed by the fixing of the rural glitch, CMS seeks comment on what would constitute a heavy market penetration and how to strike a balance between helping ACOs with high market share without harming ACOs with relatively low market share. CMS asks other specific questions in the rule, including:

- If removing ACO-assigned beneficiaries from regional reference populations would create incentives for ACOs to have beneficiaries who are healthier than the remaining comparison group;
- How ACOs that serve larger proportions of medically complex patients and cared for in home-based or long term-care facilities would be affected;
- How removing ACO-assigned beneficiaries from regional reference populations would affect very small populations; and
- If there are alternative ways to determine regional spending that would reduce the influence of an ACO's assigned beneficiaries on regional expenditure calculations.

Notably, CMS doesn't propose any changes to ACO benchmarking polices to account for the COVID-19 pandemic. However, the agency says it is continuing to monitor for any anomalies in Medicare spending and utilization resulting from the PHE. Such monitoring could result in future changes to MSSP benchmarking policies.

Repayment Mechanisms

Citing ACO administrative and financial burdens of securing repayment mechanisms, CMS proposes to ease requirements. Specifically, the agency proposes to cut in half the current repayment mechanism amounts, which if finalized would result in ACOs paying the lesser of either: (1) one-half percent of the total per capita Medicare Parts A and B fee-for-service (FFS) expenditures for the ACO's assigned beneficiaries; or (2) 1 percent of the total Medicare Parts A and B FFS revenue of its ACO participants. Both options would use data on expenditures, revenue, and the number of assigned beneficiaries for the most recent calendar year for which 12 months of data are available. CMS is seeking comments on this proposal along with an alternative approach for calculating repayment mechanism amounts by using a per beneficiary dollar amount, based on a percentage of actual historical median per capita shared losses for ACOs, multiplied by an estimate of the size of the ACO's assigned population as identified during the annual application or annual change request cycle. For this alternative, CMS is seeking comment on applying different per beneficiary dollar amounts for low revenue and high revenue ACOs, such as $10 and $20, respectively.

CMS proposes to adjust the data on assigned beneficiaries used for calculating repayment mechanism amounts. The agency also proposes to drop a requirement that ACOs increase their repayment mechanism amounts should they increase by 50 percent. If finalized, ACOs would only have to revise their repayment mechanism amount if it increases by at least $1,000,000. If these policies are finalized, they would be effective beginning with PY 2022, and CMS would communicate revised amounts to ACOs in late 2021. The agency proposes to allow certain ACOs with repayment mechanisms already in place to reduce the amount of their repayment mechanisms should the required amounts decrease under the revised policies, if finalized.

Beneficiary Notification

CMS currently requires that ACO participants post signs and provide written notice that its providers are participating in the MSSP, that beneficiaries may decline claims data sharing, and that beneficiaries may identify or change their primary clinician. CMS proposes to alter the current beneficiary notification requirements such that ACOs that have selected prospective assignment would not be required to send written notice to beneficiaries who are not assigned to the ACO for the relevant performance year. Under the proposed policy, ACOs that have selected prospective assignment must provide standardized written notice to each prospectively assigned beneficiary prior to or at the first primary care visit of the performance year. The proposed changes are intended to reduce burden on ACOs and eliminate potential confusion among beneficiaries who, under current policy, are required to receive notice that describes details that will not apply to them.

MSSP Application Process

CMS has reviewed the MSSP application process and found that document submission requirements substantially increase burden without adding significant value to the application review process. To alleviate burden, CMS proposes several changes to the application process, including eliminating requirements that ACOs tell CMS about past participation. Instead, it would only be required if CMS requests it. CMS also proposes to remove requirements that ACOs submit sample participant agreements during the application process. These too would only be required at CMS's request. Lastly, CMS proposes to modify the requirement that an ACO must submit an executed ACO participant agreement for each ACO participant at the time of its initial application and during the renewal process. Instead, ACOs would

only be required to submit agreements during initial application and when requesting additions to their ACO participant list.

PHYSICIAN PAYMENT AND POLICY CHANGES

Overview

As is typical in the MPFS rule, CMS outlines proposed 2022 relative value units (RVUs), which include work, malpractice, and practice expense (PE) RVU updates. These building blocks of the MPFS are adjusted over time to reflect new developments and services as well as shifts in payments within the fee schedule. For 2022, CMS proposes to update clinical labor pricing, which would result payment shifts across specialties as shown in Table 6 on page 39122. The agency also identifies payment changes through its process to update what it determines are misvalued services. Geographic Practice Cost Indices (GPCIs) are another essential component of MPFS payments and, following a scheduled three-year update in 2020, CMS does not propose notable GPCI updates for 2022.

With the budget neutrality adjustment to account for changes in RVUs, as required by law, the Calendar Year (CY) 2022 MPFS conversion factor is estimated to be $33.58, a decrease from the 2021 conversion factor of $34.89. This decrease is largely a result of a 0 percent automatic conversion factor update from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the expiration of a 3.75 percent conversion factor increase for 2021 stemming from the Consolidated Appropriations Act, 2021. More detail on payment changes and shifts among specialties can be found on page 39531 of the rule, Table 123: CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty.

Chronic Care Management (CCM) Services

As part of evaluating payment for Medicare services, the CMS considers updates to care management services which many ACOs use as part of their overall care coordination strategy. For CY 2022, the American Medical Association (AMA) Resource-Based Relative Value Scale (RVS) Update Committee (RUC) resurveyed the CCM code family, including Complex Chronic Care Management (CCCM) and PCM, and added five new CPT codes, as shown in the table below. CMS proposes to pay for these codes in Medicare effective beginning in 2022.

Code	Descriptor
99X21	CCM services each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99X22 ***Currently G2064***	PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99X23	PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99X24 ***Currently G2065***	PCM services, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month)
99X25	PCM services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

CMS proposes to replace codes G2064 and G2065 with CPT codes 99X22 and 99X24, respectively. The agency also proposed to accept the RUC-recommended values for the codes in the table above as well as

for the following existing codes that would all have RVU increases, should CMS finalize its proposed revaluations.

- 99490, CCM clinical staff first 20 minutes
- 99439, CCM clinical staff each additional 20 minutes
- 99491, CCM physician or non-physician practitioner (NPP) work, first 30 minutes
- 99487, CCCM clinical staff time, first 60 minutes
- 99489, CCCM clinical staff time, each additional 30 minutes

The CCM/CCCM/PCM code family now includes five sets of codes, each set with a base code and an add-on code. The sets vary by the degree of complexity of care, who furnishes the care (that is, clinical staff, physician or NPP), and the time allocated for the services. CMS seeks comments on obtaining beneficiary consent for care management services. NAACOS previously has expressed concerns about the burdens associated with obtaining this consent. Specifically, the agency requests feedback on what level of supervision, general versus direct, should be required.

Evaluation and Management (E/M)Visits

Following an overhaul of office/outpatient E/M visits with major changes that went into effect in 2021, CMS is engaged in an ongoing review of coding and payment for office/outpatient E/M visits to further refine and clarify current policies. The agency proposes certain updates in response to evolving care delivery, such as a shift to team-based care and APMs, such as ACOs. Proposed policies focus on split or shared visits, critical care services, and teaching physician visits. The proposed rule clarifies that physicians in a facility setting may bill for a split/shared visit only if they perform a substantive portion of the visit, for both new and established patients, when the visit is performed in part by both a physician and a NPP and both practitioners are in the same group. CMS also proposes to limit the definition of a split/shared visit to include only E/M visits in institutional settings for which "incident to" payment is not permitted under Medicare rules. CMS notes that the agency does not perceive a need for split visit billing in the office setting because the "incident to" billing is permitted and governed under existing regulations.

For critical care services, CMS clarifies new billing policies, proposing to prohibit practitioners who report critical care services from reporting any other E/M visit for the same patient on the same calendar day or during the same time period as a procedure with a global surgical code. The agency proposes to allow split billing for critical care services as well as to adopt the CPT prefatory language for these services. Finally, CMS proposes to clarify that only the time a teaching physician is present can count toward E/M visit level for teaching services, with a "primary care exception" that allows for payment for certain low and mid-level complexity services furnished by a resident without the physical presence of a teaching physician in certain teaching hospital primary care centers. Under this exception, CMS proposes that only medical decision making be used for office/outpatient E/M visit level selection.

Telehealth and Other Services Involving Communications Technology

Revised Timeframe for Services Temporarily Added to the Telehealth List

Near the start of the COVID-19 PHE, CMS temporarily added 135 services to the list of those eligible to be delivered via telehealth. The agency continued to add additional services as needed and stated it intended to keep those services on the list through the PHE. In this rule, CMS proposes to keep all of those services on the list of those eligible to be delivered via telehealth through the end of 2023, regardless of when the PHE ends. CMS states this move, if finalized, will allow it more time to collect additional information regarding utilization of these services and possibly keep them on the telehealth-eligible list on a permanent basis.

However, CMS proposes to permanently cover G2252 (a "virtual check-in" between 11 and 20 minutes) beyond the PHE. Virtual check-ins are short, audio-only, patient-initiated communications with a healthcare practitioner. CMS temporarily added G2252 last year but is moving to make it permanent in 2022 given concerns about avoiding unnecessary in-person visits. Payment would be cross-walked with 99442.

Telehealth for Mental Health

As required in the Consolidated Appropriations Act of 2021 (CAA), CMS proposes to make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth. This move would greatly expand the reach of tele-mental health. However, CMS proposes that beneficiaries must have an in-person visit within six months before the date of their at-home telehealth service. Congress requires such an in-person visit, and CMS explains that the agency chose six months because any time shorter would impose potentially burdensome travel requirements and any time longer could result in the beneficiary not receiving clinically necessary in-person care. This in-person requirement wouldn't apply to telehealth services for treatment of a diagnosed substance use disorder with a co-occurring mental health disorder, since Congress didn't specify the need for an in-person visit for substance use disorder treatment via telehealth.

CMS seeks comments on whether the required in-person visits could be delivered by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service. CMS is also seeking feedback on if the agency should use a claims-based mechanism to distinguish between services that require an in-person visit and those that don't require an in-person visit, such as for substance use disorder treatment.

In a move that would expand the reach of telehealth, CMS proposes to allow audio-only tele-mental health services delivered at patients' homes. However, an in-person visit would still be required when the home is the originating site, and CMS seeks comment on if that should also be within six months before the date of their at-home telehealth service. CMS proposes to limit payment for audio-only services for clinicians who have the capacity to furnish two-way, audio/video telehealth but the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology. If finalized, CMS says it would create a modifier that would identify tele-mental health services furnished to a beneficiary in their home using audio-only communications. CMS is seeking feedback on if additional documentation should be required to support the clinical appropriateness of providing audio-only tele-mental health and whether CMS should exclude higher-level services, such as level 4 or 5 E/M visit codes, when furnished with add-on codes for psychotherapy.

Expiration of PHE Flexibilities for Direct Supervision Requirements

CMS continues to seek feedback on flexibility around allowing direct supervision and immediate availability requirements to be provided via telehealth. Direct supervision and immediate availability are mandated for some in-person services, but CMS has allowed to be furnished via telehealth during the COVID-19 PHE. This flexibility is set to expire at the end of the year in which the PHE ends. The agency also wants to know if stakeholders feel this flexibility should be temporarily extended beyond the PHE to allow more information to be gathered about its use.

Remote Therapeutic Monitoring

CMS proposes to add five new "remote therapeutic monitoring" (RTM) codes (989X1, 989X2, 989X3, 989X4, and 989X5) in 2022. If finalized, RTM will cover the collection and interpretation of "non-physiologic" patient data, such as that for musculoskeletal system status, respiratory system status, medication adherence, and medication response. In contrast to the remote physiological monitoring (RPM) codes, of which the agency has approved seven codes in recent years and covers physiologic data,

RTM could be used to cover pain and medication adherence. One notable difference is that RTM codes are expected to be primarily billed by nurses and physical therapists, although this would be conducted "incident to" physician supervision.

If finalized, CMS would require the use of a medical device approved by the Food and Drug Administration (FDA) for RTM services as it does with RPM, but the agency proposes that non-physiologic data may include self-reported data, which is an important departure from RPM requirements, which currently require data to be automatically transmitted by a connected device. Because CMS believes RTM codes will require similar staff and clinician work, the agency proposes similar payment rates for RPM services.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
CMS proposes to allow RHCs and FQHCs to report and be paid for telehealth services used to diagnose, evaluate, or treat a mental health disorder. Consistent with other proposals in this rule, CMS proposes to allow tele-mental health to be delivered through audio-only interactions when beneficiaries are not capable of or do not consent to a two-way, audio/video interaction. CMS seeks comment on whether RHCs and FQHCs should require an in-person visit within six months before the date of the telehealth service, as the agency proposes elsewhere in this rule. CMS, however, notes that these proposed changes would not allow RHCs and FQHCs to report or be paid as distant site providers for Medicare telehealth services once the COVID-19 PHE ends.

CMS implements changes made by Congress in the CAA that increases the per-visit payment limit for independent RHCs and RHCs in a hospital with 50 or more beds. This is the first of an eight-year phase in of the congressionally required payment increases, and each year gives a prescribed increase. Smaller provider-based RHCs enrolled before January 2021 will have a per-visit payment limit established, starting at $100 in 2021.

CMS also proposes to allow RHCs and FQHCs to bill for transitional care management and other care management services furnished for the same beneficiary during the same service period. Currently, RHCs and FQHCs may not bill for such services if another practitioner or facility has already billed for CCM services for the same beneficiary during the same time-period. Also mandated by Congress in the CAA, CMS will allow RHCs and FQHCs to bill for hospice services starting next year when a delivered by a physician, NP, or PA working for the RHC or FQHC. The RHC or FQHC would bill for these services as they would for any other qualified service.

Billing for Physician Assistant (PA) Services
Under current policy, PAs are not authorized to bill the Medicare program and be paid directly for their professional services. CMS proposes to allow direct payments to PAs for professional services furnished under Part B, allowing PAs to bill Medicare directly for their services and reassign payment for their services the same way that NPs and CNSs may do. This policy change, if finalized, would fix issues related to PAs receiving Advanced APM incentive payments under the QPP.

Vaccine Administration Services
In light of the COVID-19 pandemic and the importance of access to preventive vaccines and in response to stakeholder concerns about the reduction in Medicare payment rates for administering preventive vaccines, CMS solicits comments on the costs involved in furnishing preventive vaccines. The agency notes that the national payment rate for administering preventive vaccines has declined more than 30 percent since 2015, though payment for administering COVID-19 vaccines is considerably higher than that of administering other common vaccines. CMS requests detailed feedback from stakeholders to support the development of an accurate and stable payment rate for the administration of preventive

vaccines that could be appropriate for use on a long-term basis. They also seek feedback on issues regarding vaccine administration in the home and monoclonal antibodies used to treat COVID-19.

Medicare Diabetes Prevention Program (MDPP)
CMS proposes several changes to the MDPP, including to preclude the provision of ongoing maintenance sessions and to update the amount of performance payments for core sessions, core maintenance sessions, and ongoing maintenance sessions, increasing payments for core sessions and core maintenance sessions and eliminating payment for ongoing maintenance sessions. This elimination causes a decrease in the total maximum payment amount, despite other increases. CMS also proposes to waive the provider enrollment application fee for all organizations enrolling as MDPP suppliers. These policy changes are intended to make the implementation and operation of MDPP less burdensome and promote participation in the program. Additional details can be found on the CMS MDPP webpage.

QUALITY PAYMENT PROGRAM

Advanced Alternative Payment Models (APMs)
As the QPP enters its sixth performance year in 2022, CMS does not propose notable changes to the Advanced APM side of program. Overall, the agency estimates that for PY 2022, which corresponds to the 2024 payment adjustment year, there will be between 225,000 and 290,000 eligible clinicians who qualify for 5 percent Advanced APM incentive payments, based on their Part B paid amounts for covered professional services in 2023. CMS estimates aggregate bonuses will total between $600 million and $750 million. The agency notes that more clinicians will qualify for the Advanced APM incentives due to changes for PY 2021 and 2022 that prevented the Qualifying APM Participant (QP) thresholds from dramatically jumping. Therefore, PY 2022 QP thresholds will remain at the PY 2021 levels, 50 percent for payments and 35 percent for patient counts. This is a result of congressional action and extensive advocacy by NAACOS and others.

It's important to note that PY 2022 is the last year for the 5 percent Advanced APM bonus. Starting with PY 2024, QPs will earn a higher annual update of 0.75 percent compared to the 0.25 percent automatic update for those in MIPS. NAACOS continues to advocate for Advanced APM changes, including extending the 5 percent incentive for six additional years. This requires congressional action and is a provision included in the NAACOS-backed *Value in Health Care Act of 2021*, summarized here.

In the proposed rule, CMS puts forward a modified process for identifying QPs who change organizations following the performance year. Specifically, CMS's proposed change would maintain the current hierarchy for attempting to find and pay these clinicians, described in regulations at § 414.1450(c) available here, while adding a sub-step at each level in which the agency would conduct the search based on more current Medicare enrollment information, as identified in the Provider Enrollment, Chain, and Ownership System (PECOS). The proposed change would focus identification of an appropriate TIN or TINs at each step by first checking the base year, which is the year between performance and payment years, and then checking the payment year before moving on to the next step in the process.

MIPS Proposals
CMS proposes very minimal changes to MIPS for 2022. Importantly, CMS does not propose any changes to the way ACOs subject to MIPS are scored via the APP, maintaining the 2021 performance category weights for all four performance categories. CMS does propose one change in the definition of a MIPS eligible clinician, to include clinical social workers and certified nurse midwives. Note that clinical social workers will not receive a score for the Promoting Interoperability (PI) performance category when calculating average ACO PI scores, however certified nurse midwives will be scored.

MIPS Performance Thresholds for 2022

CMS proposes to establish a MIPS performance threshold of 75 points in 2022; this is the mean final MIPS score from PY 2017 and represents a 15-point increase in the threshold from 2021. CMS also proposes an 89-point exceptional performance threshold in 2022; this is the 25th percentile of 2017 final MIPS scores above 75 points. This is a four-point increase proposed in the exceptional performance threshold from 2021. Note that PY 2022, corresponding to 2024 payment adjustments, is the final year that additional funding is provided to those meeting or exceeding the exceptional performance threshold under section 1848(q)(6)(C).

MIPS Final Scoring and Projected MIPS Scores for 2021

CMS estimates a score of 100 in PY 2022 could earn an approximately 14 percent positive adjustment in the 2024 payment year based on these proposed performance thresholds. However, CMS also notes it anticipates there could be higher performance and therefore fewer clinicians receiving penalties which would lower the maximum positive adjustment to potentially lower than 9 percent. The maximum negative adjustment in PY 2022 is -9 percent, as required by statute. Please refer to Figure A on p. 39456 for an illustrative example of MIPS payment adjustment factors based on proposed performance thresholds for PY 2022 (corresponding to the 2024 payment year).

MIPS Quality Benchmarks for 2022

CMS proposes to establish MIPS quality benchmarks using performance year data (2022) or 2019 data, due to anomalies in the 2020 data set due to COVID-19. Please note that these quality benchmarks are now used in the MSSP. For more information regarding how ACOs subject to MIPS are scored, please refer to our ACO Guide to MACRA.

Hierarchy When Multiple Final MIPS Scores Exist

CMS proposes to again modify the hierarchy used when multiple final MIPS scores exist for a clinician. Table 61 (p. 39458) summarizes these proposed changes for 2022 by providing a scenario example for when multiple final MIPS scores exist. Specifically, CMS proposes to update the scoring hierarchy to include subgroups and to specify that the scoring hierarchy would apply with respect to any available final score that is associated with a TIN/NPI from MIPS Value Pathways (MVPs), traditional MIPS and/or the APP. This adds an incredible amount of complexity and NAACOS has reached out to CMS to clarify how this will work in conjunction with ACO scoring, particularly if an individual EC or TIN chooses to report outside the ACO.

Promoting Interoperability Proposals

CMS proposes modest updates to the PI performance category requirements for PY 2022. These proposals are outlined in Table 44: Objectives and Measures for the Promoting Interoperability Performance Category in 2022, found on page 39417. Table 45 lists the 2015 Edition certification criteria required to meet the outlined objectives and measures, found on page 39422.