NAACOS Analysis of the Final 2022 Medicare Physician Fee Schedule

Executive Summary

In November, the Centers for Medicare & Medicaid Services (CMS) released the final 2022 Medicare Physician Fee Schedule (MPFS) rule. This 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. NAACOS submitted comments in response to the proposed 2022 MPFS rule in September. 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.

Medicare Shared Savings Program Policies

- Delay the electronic Clinical Quality Measure (eCQM) requirement for ACOs for three years to 2025
- Postpone the increase in the MSSP quality performance standard threshold for one additional year to 2024
- Finalize a minimum performance threshold of 75 points for Merit-Based Incentive Payment System (MIPS) for 2022 and an exceptional performance threshold of 89 points
- Finalize no changes to the performance category weights for ACOs subject to MIPS
- Finalize updates to the list of primary care services used to assign beneficiaries to ACOs by adding seven codes starting in performance year (PY) 2022
- Decline to make formal changes for now to the regional adjustment of MSSP benchmarks and risk adjustment methodologies
- Reduce MSSP application burden by lowering document submission requirements
- Update beneficiary notification requirements for ACOs that select prospective assignment

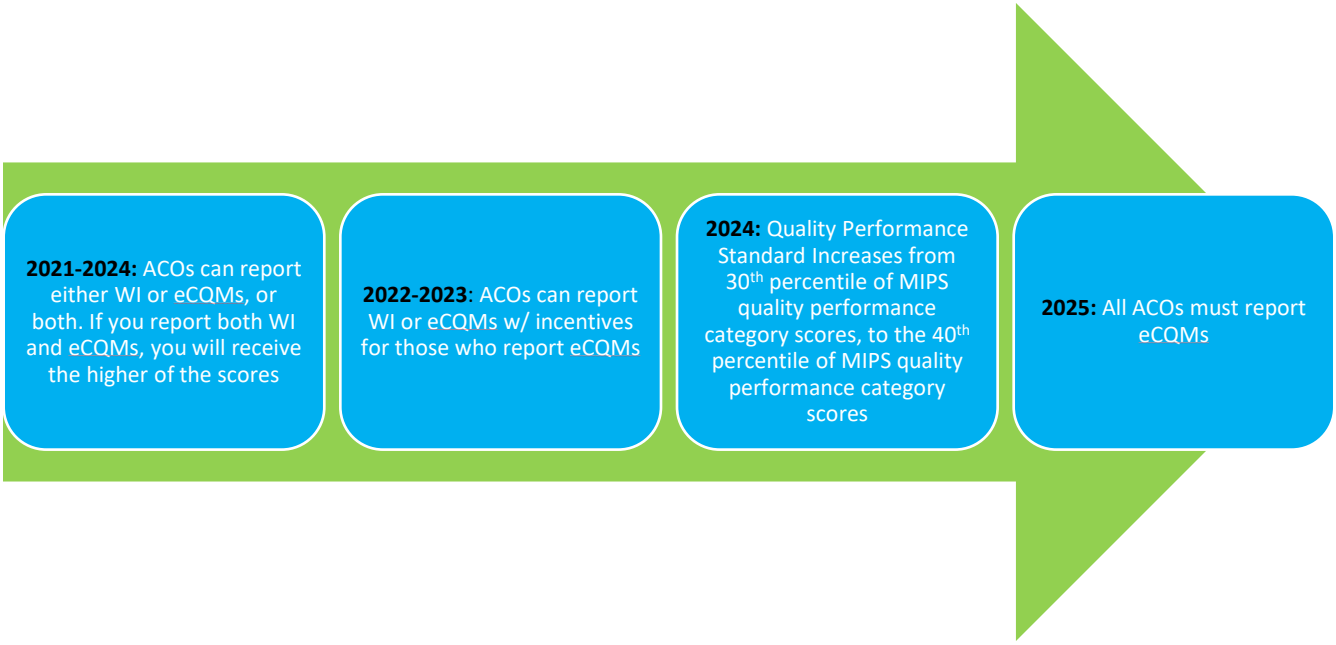
Medicare Physician Payment Policies

- Decrease the Medicare conversion factor to $33.598, from $34.89, which was finalized for 2021, a drop of about 3.8 percent
- Add new chronic care management (CCM) code, 99437, which describes each additional 30 minutes by a physician or other qualified health care professional, per calendar month, along with four additional new principal care management services and increasing payment for certain CCM services including 99490
- Establish a patient's home as a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth, as well as allows tele-mental health to be delivered through audio-only communications
- Finalize the addition of five new "remote therapeutic monitoring" codes in 2022 to cover the collection and interpretation of "non-physiologic" patient data
- Revise evaluation and management (E/M) policies regarding split/shared visits, critical care services, and teaching physician visits

MEDICARE SHARED SAVINGS PROGRAM

Final MSSP Quality Changes

After a multi-year advocacy campaign, NAACOS was successful in securing MSSP ACOs three additional years to report 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. 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 transitioning to mandatory use of digital measures aggregated at the ACO level. In this final rule, CMS adopts a longer timeframe to allow ACOs to transition gradually to eCQM reporting starting in 2025. Unfortunately, CMS maintains the flawed APM Performance Pathway (APP) scoring structure and all payor requirement for ACOs reporting eCQMs. Changing these policies is a top advocacy priority for NAACOS moving forward. Below is a summary of the key changes to MSSP ACO quality reporting requirements and quality assessment methodologies in the APP for ACOs, beginning in 2022. More information on the policies finalized in the 2021 MPFS Rule is available in our member resource.



ACO APP Reporting Options

CMS finalized a policy to allow reporting of quality measures through the WI for ACOs through 2024. Beginning in 2025, all MSSP ACOs are required to report via eCQMs or MIPS CQMs. CMS also clarified that ACOs may report via both the WI and eCQMs/MIPS CQMs, and those that elect to report in this manner will be provided with the higher of the two scores.

For the first performance year of an ACO's first agreement period under the MSSP if the ACO meets MIPS data completeness and case minimum requirements, the ACO meets the quality performance standard. This continues the previous policy of providing all new ACOs with a pay-for-reporting year at the start of their first contract. ACOs electing to report eCQM/MIPS CQMs will have performance on all three eCQM/MIPS CQM measures used for the purposes of MIPS scoring, should the ACO be subject to MIPS.

CMS also finalized a policy to increase the quality data completeness standard from 70 percent to 80 percent beginning in 2023, which will also apply to ACO quality reporting as well as MIPS quality reporting requirements.

Quality Measure Benchmarks

CMS did not finalize the proposal to use performance period benchmarks or data from the CY 2019 performance period to calculate quality measure benchmarks for the CY 2022 performance period/2024 MIPS payment year. According to CMS, analysis of the CY 2020 performance period data supports its use for benchmarking purposes. This refers to the individual quality measure benchmarks — not the quality performance standard.

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 35: Measures included in the APP Measure Set found on page 65266 in the final rule for the list of measures available in 2022. As a reminder, under APP scoring rules, these measures will be suppressed when calculating the final quality score (removed from the denominator). Finally, CMS is publishing a list of quality measures with substantive changes in the measure specifications in Table Group D found on page 65892.

2022 All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCC) Measure

The APP will rely on the MCC measure as specified for the MIPS program for evaluating ACOs for PY 2022. There are slight differences in the specifications of this measure as compared to the MCC measure as specified for the ACO program. Specifically, CMS notes the MCC for MIPS measure uses an office visit-based attribution algorithm to identify the clinician most responsible for the patient's care for purposes of determining the population to include in the measure denominator. The visit codes used for the attribution algorithm are the same as the visit codes used for the ACO beneficiary assignment. Based on the attribution algorithm, the patient is assigned to a primary care provider or to a relevant specialist based on the number and pattern of visits. The patient then "follows" the clinician to the TIN designated by the clinician (that is, patients are assigned to their clinicians' TINs). ACO-level scores are determined after the TINs of ACO participants are mapped to their respective ACOs. The MCC for MIPS measure attribution considers only certain types of providers who care for patients with MCCs (i.e., primary care providers or specialists including cardiologists, pulmonologists, nephrologists, neurologists, and endocrinologists) and excludes patients who would be attributed to hematologists/oncologists. Further details on the specifications for the MCC for MIPS measure can be found in Table A.5 in Appendix A of this final rule on page 65695.

2022 CAHPS Measure

The APP will rely on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS measure for evaluating ACOs on patient satisfaction. In this regulation, CMS clarifies that the agency will inform any ACO that is at risk of falling below the minimum sampling threshold when it may not have enough beneficiaries to field a CAHPS for MIPS Survey prior to the deadline for contracting with a CAHPS for MIPS Survey vendor. An ACO that does not meet the minimum sampling threshold to administer the survey will not receive a score for the CAHPS for MIPS Survey under the APP. When an ACO fails to meet the sampling threshold and is unable to administer the survey, the ACO's measure set will be scored accordingly, and the number of measures included in the calculation of the ACO's quality performance

score will be reduced from 10 to nine measures (if reporting Web Interface) or from six to five measures (if reporting eCQMs/MIPS CQMs) in the APP.

MSSP Quality Performance Threshold

The MSSP quality performance threshold is the minimum performance threshold required to meet reporting obligations and earn shared savings in the MSSP. As a result of NAACOS advocacy, in this rule, CMS finalized a policy to maintain a quality performance standard threshold of the 30th percentile of all MIPS quality performance category scores through 2023. Beginning in 2024, the threshold rises to the 40th percentile of MIPS quality performance category scores. In 2022 and 2023, CMS finalized incentives for ACOs who elect to report eCQMs/MIPS CQMs by establishing a lower performance threshold for these ACOs. In particular in 2022 and 2023, an ACO will meet the quality performance standard used to determine shared savings and losses if the ACO:

- Achieves a quality performance score equivalent to or higher than the 30th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; or
- Reports the three eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements) and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and achieves a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set. Consequently, the ACO would be required to meet the performance benchmark on either two outcome measures (one measure at the 10th percentile and the other at the 30th percentile) or one outcome measure at the 10th percentile and any other measure in the APP measure set at the 30th percentile.

CMS also reiterated that the agency is not able to provide estimates of what the quality performance standard threshold scores would look like prior to the start of the performance year because CMS calculates the 30th percentile based on the distribution of all MIPS quality performance category scores for the applicable performance year, and therefore CMS must wait until the close of the reporting period to calculate such scores. CMS committed to providing information on historic MIPS data to serve as a guide for ACOs. As a reminder, CMS states that based on historic MIPS data:

- For PY 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 PY 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.
- Of notable concern to NAACOS is CMS data shows that roughly one in five ACOs or approximately 20 percent of ACOs, could fall below the 40th percentile MIPS Quality performance category score by PY 2023 and would not be eligible to share in savings or would owe maximum shared losses, if applicable.

These policies are summarized in Table 34 in the final rule found on page 65263 and included on the following page.

TABLE 34: Comparison of APP Reporting Requirements for Performance Year 2021 and Subsequent Performance Years

	Performance Year 2021	Performance Years 2022 and 2023	Performance Year 2024	Performance year 2025 and Subsequent Performance Years
Shared Savings Program ACO Quality Reporting requirements	ACOs are required to report the 10 measures under the CMS Web Interface **or** the 3 eCQMs/MIPS CQMs and administer the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures will be included in calculating the ACO's quality performance score.	Same as performance year 2021	Same as performance year 2021	ACOs are required to report on the 3 eCQMs/MIPS CQMs 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 performance year 2021. However, in order to encourage all-payer measure reporting if the ACO reports all 3 eCQMs/MIPS CQMs under the APP, the ACO will satisfy the quality performance standard if it achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a performance score that is equivalent to or higher than the 30th percentile on at least one of the remaining five measures in the APP measure set	A quality performance score that is equivalent to or higher than the **40th** percentile across all MIPS Quality performance category scores.	Same as performance year 2024.

Data Aggregation Issues for ACOs Reporting eCQMs/MIPS CQMs

CMS provided instructions for de-duplication for ACOs in the final rule. This raises additional questions/challenges but is the current instruction from the agency on how ACOs are to aggregate data, de-duplicate data, and submit to CMS as a Quality Reporting Document Architecture (QRDA) III file:

We note that the ACO would utilize the QRDA I format, which specifies patient level collection of data from each of the ACO's participant TINs. The ACO would then aggregate these data across the ACO and

submit them to CMS in the QRDA III format. Collecting and aggregating these data in the QRDA I format allows for de-duplication given the granularity of the data. (p. 65260)

While the QRDA I format provides additional patient level detail such as name, sex, date of birth and other details to assist in de-duplication, ACOs will still need to match patients and data across NPIs and TINs on a measure-by-measure basis. NAACOS will be developing resources to assist ACOs as they continue to work with EHR vendors to work through patient matching and de-duplication challenges that aggregation at the ACO level brings.

ACOs have also raised concerns with the sharing of protected health information (PHI) beyond Medicare patients and beyond Medicare ACO assigned patients, particularly in the context of their current Business Associate Agreements (BAAs) as well as the HIPAA Privacy Rules for BAAs. In this rule, CMS noted the disclosure of all-payer data to CMS as required by § 414.1340(a) would be permitted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule under the provision that permits disclosures of PHI as "required by law." Under this provision, a HIPAA covered entity, or its business associate when authorized by its BAA, may use or disclose PHI to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. CMS also noted the HIPAA Privacy Rule minimum necessary standard does not apply to uses or disclosures that are required by law. More information is provided in the preamble of the rule, see page 65258. Regarding disclosures of PHI between an ACO participant TIN and the ACO, CMS provided the following guidance:
Regarding disclosures of PHI between an ACO participant TIN and the ACO, we encourage ACOs and their ACO participants to consult with their legal counsels as necessary to ensure that their Business Associate Agreements (BAAs) address the need to share data for patients covered by all payers with the ACO to permit the ACO to comply with its legal obligation to completely and accurately report data to CMS on eCQMs/MIPS CQMs. (p. 65261)

Extreme and Uncontrollable Circumstances Policy for Quality
Finally, CMS made changes to the MSSP Extreme and Uncontrollable Circumstances Policy to reflect the final policy changes included in this regulation regarding the MSSP quality performance standard. Specifically, for PY 2023, if an ACO is able to report quality data via the APP and meets the MIPS data completeness and case minimum requirements, CMS will use the higher of the ACO's Quality performance category score or the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring for the relevant performance year. 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 will apply the 30th percentile across all MIPS Quality performance category scores.

For PY 2024 and subsequent performance years, the minimum quality performance score for an ACO affected by an extreme and uncontrollable circumstance during the performance year, including the applicable quality data reporting period for the performance year, will be set equal to the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year. If the ACO is able to report quality data via the APP and meets the MIPS data completeness and case minimum requirements, CMS will use the higher of the ACO's MIPS Quality performance category score or the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year. 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 will apply the 40th percentile MIPS Quality performance category score.

MSSP Beneficiary Assignment

Following NAACOS advocacy, CMS finalized updates to the list of primary care services used to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. The additional codes include:

- 99437 (chronic care management [CCM])
- 99424, 99425, 99426, and 99427 (principal care management [PCM])
- G2212 (prolonged office or other outpatient E/M service)
- G2252 (communication technology-based service)

CMS already lists a number of CCM and PCM codes on the MSSP assignment list. Therefore, CMS stated it seems logical to add those five services to that list. The CCM and PCM services are new to the MPFS starting in 2022. However, some of the PCM codes being added to MSSP assignment list will replace temporary Healthcare Common Procedure Coding System (HCPCS) codes G2064 and G2065. G2212 is also a new billing code finalized in this rule, and because it is an add-on code for office/outpatient E/M services 99205 and 99215, CMS stated it would be appropriate to include G2212 for use in MSSP assignment.

Also elsewhere in this rule, CMS finalized paying for G2252, a "virtual check-in" code, on a permanent basis starting in 2022. CMS is adding 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 finalizing policy 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 public health emergency (PHE). CMS is also finalizing its decision to keep using 99441, 99442, and 99443 in MSSP assignment until those codes are no longer payable under Medicare FFS policies.

Finally, CMS finalized policy to use Current Procedural Terminology (CPT) codes that are directly replacing 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

In the proposed rule, CMS sought feedback on the regional adjustment component of MSSP benchmarks. Specifically, CMS wanted feedback on how to account for the removal of ACO-assigned beneficiaries from the regional reference population, which is used to determine the regional adjustment in benchmarks. Unfortunately and despite NAACOS advocacy, CMS didn't finalize any changes in this regulation but said it will take comments into consideration as it contemplates additional refinements to MSSP benchmarking methodologies. If CMS decides to make any changes, they will come in future rulemaking.

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. As ACOs lower the cost of care on their assigned populations, they inevitably lower the spending of their region and their benchmarks as a result. 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. NAACOS analysis shows an overwhelming majority of MSSP ACOs would benefit from removing ACO-assigned beneficiaries' costs from the regional reference population, and we will continue to urge CMS and Congress to correct this unintended flaw.

In CMS's summary of the comments received, the agency noted that several commenters did not support removing ACO-assigned beneficiaries from the regional reference population. They noted that correcting the rural glitch would reward already low-spending ACOs without creating further care efficiencies and reduce incentives for high-spending ACOs to reduce costs. There were also fears that if ACO patients are removed and the remaining population is healthier and using fewer services, then the ACO will be left with a higher, more unattainable benchmark. Others suggested setting a threshold for high penetration, such as 30 or 50 percent, and making a change for just those ACOs, which would be smaller in number. There were also suggestions to use a larger region to diminish the effect of the ACO or use a regional-only trend since a national trend can be overemphasized for ACOs with a high market share.

Notably, CMS makes no changes to ACO benchmarking polices to account for the COVID-19 pandemic. However, the agency recognized NAACOS' suggestion that ACOs starting new agreements in 2022 be allowed to choose between their baseline years being 2019–2021 or 2017–2019 to avoid the use of pandemic years.

MSSP Risk Adjustment

CMS sought feedback on different aspects of risk adjustment in MSSP, which takes into account changes in severity and case mix of the ACO's assigned population when establishing the benchmark and adjusting the benchmark each performance year. Specifically, the agency sought input on approaches to improving risk adjustment, including for ACOs with medically complex, high-cost beneficiaries, along with how to balance the need for accurate and complete coding while protecting against incentivizing ACO coding intensity initiatives.

Unfortunately, and despite NAACOS advocacy, CMS didn't finalize any changes in this regulation, but as with benchmarking, said it will take comments into consideration as it contemplates additional refinements to MSSP risk adjustment methodologies. If CMS decides to make any changes, those updates will come in future rulemaking. NAACOS will continue to advocate for a risk adjustment cap of no less than 5 percent and a downward cap no greater than -5 percent. Additionally, we believe CMS should align any risk adjustment cap for the ACO and its region, applying a consistent capping policy to both. Currently, the region is not capped and can grow, while an ACO's region is limited to 3 percent growth over the duration of the five-year agreement period, effectively penalizing ACOs. Current policy, we believe, is unfair to ACOs and harmful to the work to grow the program and improve care coordination.

In CMS's summary of the comments it received, some commenters expressed support for the current CMS-HCC risk adjustment model. Some suggested CMS address incentives for coding intensity and suggested that rising risk scores could provide more incentive to over code patients. Others pointed to CMS's own comments in 2018 that a 3 percent cap could incentivize ACOs to avoid high-risk beneficiaries or seek low-cost beneficiaries. However, there was also concern expressed that current policy could exacerbate health inequalities since ACOs serving high-risk populations would be harmed if risk scores are capped. Some also suggested shorter windows than the current five-year period for risk scores to increase.

Repayment Mechanisms

Citing ACO administrative and financial burdens of securing repayment mechanisms, CMS is modifying policies to ease these requirements. Specifically, the agency finalized its proposal to cut in half the repayment mechanism amounts, which result in ACOs paying the lesser of either: (1) 0.5 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 will 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. For CY 2022, the agency will rely on data from CY 2020.

NAACOS commented in support of this burden reduction and is pleased to see the agency finalize this and other changes to the MSSP repayment mechanism policies. Additional final policies in this regulation include adjusting the data on assigned beneficiaries used for calculating repayment mechanism amounts and dropping a requirement that ACOs increase their repayment mechanism amounts when they increase by 50 percent. Under the revised policy CMS finalized, ACOs will only have to update their repayment mechanism amount if it increases by at least $1,000,000. These policies are effective beginning with PY 2022. CMS notes it will communicate revised repayment mechanism amounts to ACOs before the end of 2021. ACOs with repayment mechanisms already in place will be eligible to reduce the amount of their repayment mechanisms if they decrease due to the revised policies finalized in this regulation.

Beneficiary Notification

In order to eliminate potential confusion among beneficiaries receiving notices from ACOs to which they are not and will not be assigned, CMS finalized an update to the beneficiary notification requirements such that ACOs that have selected prospective assignment are no longer required to furnish written notices to beneficiaries who have not been prospectively assigned to the ACO for the relevant performance year. Rather, they will only be required to send notices to beneficiaries that have been prospectively assigned to their ACO. ACOs that have selected preliminary prospective assignment with retrospective reconciliation are still required to submit written notices to all FFS beneficiaries receiving primary care services from ACO providers. All ACOs, regardless of assignment methodology, are still required to furnish notices prior to or at the first primary are visit of the performance year. Despite NAACOS and others advocating that CMS remove the beneficiary notification requirement, CMS declined to act further. The agency did however indicate that it would consider reducing the frequency with which the beneficiary notification must be furnished, such as once per agreement period, in future rulemaking.

MSSP Application Burden

In order to alleviate burden on ACOs applying to participate in the MSSP, CMS finalized changes to the document submission requirements. First, CMS amended the requirement to submit prior participation information such that it is only required upon request by CMS. Additionally, ACO applicants will no longer be required to submit sample ACO participant agreements unless requested by CMS. Lastly, CMS modified the requirement that an ACO must submit an executed ACO participant agreement for each ACO participant at the time of initial application and during the renewal process. Under updated policy, ACOs are only required to submit executed ACO participant agreements during initial application and when requesting additions to their ACO participant list. These changes go into effect for the 2023 application cycle.

PHYSICIAN PAYMENT AND POLICY CHANGES

Overview

As is typical in the MPFS Rule, CMS finalized 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 changes the practice expense for many services associated with an update to clinical labor pricing. 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 make notable GPCI updates for 2022.

The CY 2022 conversion factor is lower than in CY 2021. This is a result of a budget neutrality adjustment to account for changes in RVUs, as required by law, the expiration of a temporary MPFS increase of 3.75 percent from the Consolidated Appropriations Act (CAA) of 2021 and a 0 percent automatic conversion factor update from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Therefore, the 2022 MPFS conversion factor specified in the final MPFS is $33.598, a decrease from the 2021 conversion factor of $34.89. More detail on payment changes and shifts among specialties can be found on page 1817 of the rule, Table 136: CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty. It's important to note that the figures in this table do not reflect the expiration of the 3.75 percent increase, which should be taken into consideration. A table showing the estimated impact of all of the changes on total payments for selected high volume procedures is available under "downloads" on the CY 2022 MPFS final rule website. Unfortunately, in addition to the payment decreases explained above, Medicare Part B providers will also see additional cuts due to sequestration. The moratorium of the 2 percent sequestration cut ends December 31, 2021, and on top of that cut going back into effect providers will see an additional, new 4 percent sequestration cut stemming from passage of the American Rescue Plan Act. The combined effect of all these cuts is nearly 10 percent in 2022.

Chronic Care Management (CCM) Services

As part of evaluating payment for Medicare services, 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 Principal Care Management (PCM), and added five new CPT codes, as shown in the table below. CMS is finalizing Medicare payment for these codes effective January 1, 2022. Also for 2022, the agency is increasing payment for certain CCM services, such as 99490, and is adopting higher work RVUs for many codes based on recommendations from the AMA RUC.

New Care Management Services for 2022

Code	Brief Descriptor
99437	CCM services each additional 30 minutes by a physician or other qualified health care professional, per calendar month
99424 ***Replaces 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
99425	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
99426 ***Replaces G2065***	PCM, 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
99427	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

As noted in the table above, CMS finalized its proposals to replace two G-codes with CPT codes. This follows a pattern in recent years where the agency has shifted more towards using CPT codes as opposed to G-codes. The overall 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 (that is, CCM, CCCM, or PCM), who furnishes the care (that is, clinical staff or the physician or non-physician practitioner [NPP]), and the time allocated for the services.

Evaluation and Management (E/M) Visits

As part of the ongoing process to update coding and payment for office/outpatient E/M visits, CMS finalized several policy refinements regarding split (or shared) visits, critical care services, and teaching physician visits. First, the agency revised the definition of split visits to include only E/M visits in institutional settings for which "incident to" payment is not permitted under Medicare rules. CMS also finalized the proposal to allow physicians and NPPs in the same group to bill for split visits for both new and established patients, for critical care services, and for certain skilled nursing facility (SNF) visits, though only the physician or NPP who performs the substantive portion of the visit may bill for the visit. In response to comments, the agency defined "substantive portion" as either one of the three key components of an E/M visit (history, exam, and/or medical decision making) or more than half the total time spent on the visit for CY 2022. Beginning January 1, 2023, it will be defined as more than half of the total time spent by the physician and the NPP performing the visit. CMS will use the CPT E/M Guidelines listing of qualifying activities for time.

For critical care services, CMS finalized the proposal to adopt CPT definitions and the CPT listing of bundled services, which are not separately billable by a practitioner during the time period when that practitioner is providing critical care for a given patient. In light of an increase in alternative payment models that employ a more team-based approach to care, CMS finalized the proposal to allow split visit billing for critical care services. Noting concerns from commenters on the proposal to prohibit practitioners (or practitioners in the same specialty in the same group) who report critical care services from reporting any other E/M visit for the same patient on the same calendar day, CMS modified the policy such that practitioners may bill for both services under the conditions that the E/M service was provided prior to the critical care service, the service is medically necessary, and the service is separate and distinct, with no duplicative elements from the critical care services provided later. Finally, CMS finalized 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, only medical decision making may 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

Following NAACOS advocacy, CMS finalized its proposal to keep all services temporarily added to the list of those eligible to be delivered via telehealth through the end of 2023, regardless of when the PHE ends. This move will allow more time to collect additional information regarding utilization of these services and possibly keep them on the telehealth-eligible list on a permanent basis. Roughly 135 services were added to the list of those eligible to be delivered via telehealth near the start of the COVID-19 PHE. The agency continued to add other services as needed.

CMS finalized its proposal 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 moved to make it permanent starting next year given concerns about avoiding unnecessary in-person visits. Payment would be cross walked with 99442.

Telehealth for Mental Health

As required in the CAA, CMS finalized its proposal to make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth. This move greatly expands the reach of tele-mental health. Congress requires, and CMS is implementing, a requirement that beneficiaries have an in-person visit within six months before the date of their first at-home telehealth service. CMS is also requiring an in-person visit occur at least every 12 months after the patient's first telehealth service. These in-person requirements 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. However, CMS states that if the patient and practitioner agree the benefits of an in-person visit within 12 months of the first tele-mental health service outweigh the risks and burdens associated with an in-person service, then no in-person visit is required. The basis for that decision must be documented in the patient's medical record. CMS is allowing a clinician's colleague in the same subspecialty in the same group to furnish the in-person visit if the original practitioner is unavailable. This is consistent with other CMS policy around billing for E/M services.

In a move to expand the reach of telehealth, CMS finalized policy to allow audio-only tele-mental health services delivered at patients' homes. However, an in-person visit within six months before the date of the at-home telehealth service would still be required when the home is the originating site. CMS finalized its proposal to limit payment for audio-only services for clinicians who have the capacity to furnish two-way, audio/video telehealth but the beneficiary is not capable of or does not consent to use video technology. CMS is creating a modifier to identify tele-mental health services furnished to beneficiaries in their homes using audio-only communications. The agency is requiring documentation in the patient's record the reason for using audio-only technology.

Remote Therapeutic Monitoring

CMS finalized the addition of five new "remote therapeutic monitoring" (RTM) codes (98980, 98981, 98975, 98976, and 98977) in 2022. 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 covering 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 physiatrists, nurses, and physical therapists, although this would be conducted with "incident to" physician supervision.

Following NAACOS advocacy, CMS is requiring the use of a medical device approved by the Food and Drug Administration (FDA) for RTM services, as it does with RPM. However despite NAACOS advocacy, the agency states in the final rule 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. NAACOS believes that self-reported data could be unreliable and may open the door to fraud and misuse. Because CMS believes RTM codes will require similar staff and clinician work, the agency sets similar payment rates for RPM services.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
CMS finalized its proposal 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 parts of this rule, CMS will 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 will require an in-person visit at least every 12 months of the telehealth service, as the agency finalized elsewhere in this rule. However, exceptions to the in-person visit may be made if the visit is inadvisable or impracticable, and those reasons are documented in the medical record. CMS, however, notes that these finalized changes do 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 finalized changes made by Congress in the CAA that increase 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 finalized its decision 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 delivered by a physician, NP, or PA working for the RHC or FQHC. The RHC or FQHC would bill for these services as it would for any other qualified service.

Billing for Physician Assistant (PA) Services
Section 403 of the CAA removed the requirement in Medicare to make payment for PA services only to the employer of a PA effective January 1, 2022. In order to implement this change, CMS finalized the proposal 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.

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 gathered feedback from various stakeholders on payment rates for vaccines covered under the Medicare Part B vaccine benefit. Commenters provided feedback on the higher cost of administering the COVID-19 vaccines, misinformation that impeded the national immunization effort, and the expenses associated with mass immunization sites. In response to comments on cost data for vaccine administration, CMS updated the payment rate for preventive vaccines under the Medicare Part B vaccine benefit (influenza, pneumococcal, or HBV) to $30, effective January 1, 2022. The agency notes that it will maintain the current $40 per dose payment rate for the administration of COVID-19 vaccines through the end of the calendar year in which the COVID-19 PHE ends and subsequently set the rate in alignment with the rate for other preventive vaccines.

Medicare Diabetes Prevention Program (MDPP)
In order to incentivize supplier participation in the MDPP and increase beneficiary access to MDPP services, CMS finalized several policy changes to make the program more attractive and less burdensome for suppliers. For beneficiaries who start receiving MDPP services on or after January 1,

2022, ongoing maintenance sessions will no longer be offered, aligning the MDPP with other evidence-based diabetes prevention programs that have a 12-month duration. In response to comments on MDPP payment inadequacy, CMS modified the proposed policy such that all previous payments for ongoing maintenance sessions will be reallocated to increase payment for core session and core maintenance session performance payments such that the total maximum payment for the program is not decreased. To address financial burden on MDPP suppliers that may limit uptake of the program, CMS is waiving the provider enrollment Medicare application fee for all organizations that apply to enroll in Medicare as an MDPP supplier. 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 is not making notable changes to the Advanced APM side of QPP. Overall, the agency estimates that for PY 2022, which corresponds to the 2024 payment adjustment year, between 225,000 and 290,000 eligible clinicians will 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. Thankfully, following extensive advocacy by NAACOS and others, the Qualifying APM Participant (QP) thresholds will remain steady in PY 2022. Therefore, PY 2022 QP thresholds will be 50 percent for the payment amount method and 35 percent for patient count method. It's important to note that PY 2022 is the last performance year to qualify for the 5 percent Advanced APM bonus. Starting with PY 2024 and payment year 2026, 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 final rule, CMS modified its process for identifying QPs who earn the bonus but are no longer affiliated with the TIN associated with their Advanced APM participation when the bonus is paid. The agency needs updated TIN information to distribute the bonuses. While the agency is maintaining the overall hierarchy for attempting to find and pay these clinicians, described in regulations at § 414.1450(c), the agency finalized its proposal to add sub-steps to the hierarchy. Under the revised approach, CMS will look at the Medicare enrollment records in the Provider Enrollment, Chain, and Ownership System (PECOS) for the QP, focusing on the "base year" which is the year between the performance and payment year, then looking at the enrollment in the payment year. CMS hopes this approach will allow the agency to more easily find and pay clinicians who have earned the bonus.

Final MIPS Policies for 2022

CMS did not make significant changes to MIPS for ACOs for 2022. Importantly, CMS does not make 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. In this final rule, CMS discusses the potential for sunsetting the traditional MIPS program and transitioning to mandatory use of MIPS Value Pathways (MVPs) for all MIPS clinicians as early as 2027 and allowing for reporting of a limited number of MVPs beginning in 2023. An overview of the MVP requirements and implementation timeline is available in Table 49 found on page 65419. Note that this does not apply to ACOs, which are scored separately using the APP as described earlier in this document.

CMS also made a small 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 established 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 establishes 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) of MACRA.

MIPS Final Scoring and Projected MIPS Scores for 2022

CMS estimated 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 anticipates high performance in the program overall and, therefore, fewer clinicians receiving penalties, which would lower the actual positive payment adjustment amounts available significantly. The maximum negative adjustment in PY 2022 is -9 percent, as required by statute. Please refer to Figure A on p. 65535 for an illustrative example of MIPS payment adjustment factors based on established performance thresholds for PY 2022 (corresponding to the 2024 payment year).

MIPS Quality Benchmarks for 2022

CMS did not finalize the proposal to use performance period benchmarks or data from the CY 2019 performance period to calculate quality measure benchmarks for the CY 2022 performance period/2024 MIPS payment year. According to CMS, analysis of the CY 2020 performance period data supports its use for benchmarking purposes. This refers to the individual quality measure benchmarks used in MIPS — not the MSSP quality performance standard. 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 finalized a policy to modify the hierarchy used when multiple final MIPS scores exist for a clinician. Table 73 (p. 65537) summarizes these changes for 2022. Specifically, CMS updated 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 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. In this regulation, CMS acknowledged the complexity this introduces to ACO scoring but did not outline any additional detail.

Promoting Interoperability Policies for 2022

CMS finalized modest updates to the PI performance category requirements for PY 2022. These policies are outlined in Table 56: Objectives and Measures for the Promoting Interoperability Performance Category in 2022, found on page 65478. Table 57 lists the 2015 Edition certification criteria required to meet the outlined objectives and measures, found on page 65483.