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CMS Releases 2022 Proposed Physician Fee Schedule and Quality Payment Program Rule

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The Centers for Medicare and Medicaid Services (CMS) released the 2022 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule on July 13. This rule includes updates to payment rates for physicians and other health care professionals, expands the use of telehealth, clarifies evaluation and management (E/M) policies, proposes policies for the 2022 performance year of the quality payment program, and includes many other provisions.

The AAMC will provide comments on the proposed rule, which are due to CMS by Sept. 13.

Below are of some of the key proposals in the rule:

Physician Fee Schedule Highlights:

- **Conversion Factor:** Lowers the conversion factor from $34.89 in calendar year (CY) 2021 to $33.58 for CY 2022, a decrease of $1.31. This is due in part to the expiration of the 3.75% payment increase provided for in CY 2021 by the Consolidated Appropriations Act.
- **Refines E/M polices:** Clarifies and refines policies related to split (or shared) E/M visits, critical care services, and services furnished by teaching physicians involving residents.
- **Split/Shared Visits**: Defines split (or shared) E/M visits as visits provided in a facility setting by a physician and a non-physician provider in the same group, and states that the practitioner who provides the substantive portion of the visit would bill for the visit.
- **Teaching Physician Time:** Clarifies that the time when the teaching physician was present can be included when determining the E/M visit level. Under the primary care exception specifically, only medical decision-making would be used to select the visit level.
- **Electronic Prescribing of Controlled Substances**: Establishes exceptions to the requirement for electronic prescribing of controlled substances and proposes to extend the start date for compliance actions to Jan. 1, 2023.
- **Appropriate Use Criteria Program (AUC)**: Would initiate payment penalty of the AUC program on Jan. 1, 2023 or the Jan. 1 that follows the declared end of the public health emergency (PHE), whichever is later, instead of Jan. 1, 2022. The timeframe was delayed to take into account the impact that the PHE has had on providers and beneficiaries.
- **Medicare Shared Savings Program**: Proposes a longer transition for the Accountable Care Organizations (ACOs) reporting electronic clinical quality measure/Merit Based Incentive Payment System (MIPS) all payer quality measures under the Alternative Payment Model Performance Pathway. Would allow collection of data through the CMS Web Interface for an additional two years, through performance year 2023.
- **Telehealth**: Permitting certain services added to the Medicare telehealth list to remain on the list to the end of Dec. 31, 2023 to collect data to determine whether services should be permanently added to the telehealth list following the COVID-19 PHE.
- **Telehealth Services for Mental Health:**

- Removes geographic location requirements and allows patients in their homes access to telehealth services for diagnosis, evaluation, and treatment of mental health disorders.
- Requires an in-person, non-telehealth service for mental health services within six months prior to the initial telehealth service, and at least once every six months.
- Permits Medicare to pay for mental health visits furnished via telehealth by Rural Health Clinics and Federally Qualified Health Centers.
- Allows payment for behavioral health services to patients via audio-only telephone calls from their homes, including counseling and therapy services provided through Opioid Treatment Programs.
- Limits the use of an audio-only interactive telecommunications system to circumstances where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.
- Solicits comments on whether:
  - Additional documentation should be required in the patient's medical record to support the clinical appropriateness of audio-only telehealth.
  - Audio-only telehealth should be precluded for some high-level services, such as level 4 or 5 E/M visit codes or psychotherapy with crisis.
  - An interval other than six months should be required for audio-only behavioral health services.
  - There are any additional necessary guardrails.

Quality Payment Program Highlights:

- **MIPS Value Pathways (MVPs):** In 2023, MVPs will go into effect, beginning with seven options.
- **MIPS Sunsets:** After the end of the 2027 performance and data submission periods, CMS solicits feedback on its goal to sunset the traditional MIPS program.
- **Subgroups:** Proposes to establish voluntary subgroup reporting to enable reporting of information about performance at a more granular level. Subgroup reporting would initially be limited only to clinicians reporting through MVPs or APM Performance Pathway.
- **CMS Web Interface:** In the 2022 and 2023 performance years, Shared Savings ACOs may continue to report quality measures using the CMS Web Interface. Other ACOs and group practices may continue to use the Web Interface in 2022.
- **Performance Category Weights:** For 2022 performance year/2024 payment year, the performance category weights are: 30% for quality; 30% for cost; 15% for improvement activities; and 25% for promoting interoperability.
- **Promoting Interoperability:** Makes revisions to reporting requirements for promoting interoperability.
- **Cost Performance Category:** Five new episode cost-measures would be added to the cost category.
- **Performance Threshold:** Proposes a performance threshold of 75 points.