

Summary of the 2022 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule

On July 13, 2021, the Centers for Medicare & Medicaid Services (CMS) released a [Medicare annual payment rule](#) for calendar year (CY) 2022 that impacts payments for physicians and other health care practitioners. The rule combines *proposed* policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). Below is a summary of key proposals, separated by proposed PFS and QPP policies. Over the next few weeks, ACEP will be working on a comprehensive response. Comments are due to CMS on September 13, 2021.

CMS will issue a final rule, which will include final policies for CY 2022, on or around November 1, 2021.

Physician Fee Schedule (PFS)

A summary of the major proposals is below:

1. **Conversion Factor:** Due to the Centers for Medicare & Medicaid Services (CMS)' decision to increase the office and outpatient evaluation and management (E/M) services in 2021, there is a budget neutrality adjustment, as required by law. This requirement under the Medicare PFS forces CMS to make an overarching negative adjustment to physician payments to counterbalance any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare “conversion factor” which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount.

Congress was able to offset the majority of the budget neutrality cut that was expected go into place in 2021 in the Consolidated Appropriations Act, 2021. Specifically, Congress added back 3.75 percent to the conversion factor. Now, going into 2022, Congress needs to act again or the conversion factor will be cut by that same 3.75 percent.

The proposed CY 2022 PFS conversion factor reflects the looming 3.75 percent cut (and a few other adjustments)—and is \$33.58, a decrease of \$1.31 from the CY 2021 PFS conversion factor of \$34.89. Emergency medicine reimbursement in 2022 is held flat EXCEPT for this across-the-board reduction of 3.75 percent.

ACEP is urging Congress to take action before the end of the year to prevent this cut to Medicare payments.

2. **Evaluation and Management Services:** CMS is proposing a number of refinements to current policies for split or shared E/M visits, critical care services, and services furnished by teaching physicians.

- ***Split or Shared Services:*** CMS is proposing to continue its current policy allowing billing of certain “split” or “shared” E/M visits by a physician when the visit is performed in part by both a physician and a non-physician practitioner (NPP) who are in the same group and the physician performs a substantive portion of the visit. CMS is limiting split or shared visits in the institutional setting to E/M codes only, not procedures. *This is not a change from current policy.*
 - *Emergency Department (ED):* In 2022, the history and physical exam and medical decision making (MDM) components still will apply. Unlike the office setting where in 2021 time can be used to determine the E/M level, time is not a component in the ED setting. Most of the proposed rule discussion involves using time as the deciding factor of code level for a split or shared visit.
 - *Critical Care:* The exception to that rule is when reporting critical care, which is a time-based code. CMS is proposing to allow split (or shared) visit billing in critical care because it believes the practice of medicine has evolved towards a more team-based approach to care, and greater integration in the practice of physicians and NPPs, particularly when care is furnished by clinicians in the same group in the facility setting. Since critical care is a time-based service, CMS is proposing to require practitioners to document in the medical record the total time that critical care services were provided by each reporting practitioner (not necessarily start and stop times).
 - ***Critical Care Policies:*** CMS clarifies in the rule that if more than one E/M visit is provided on the same day to the same patient by the same physician, or by more than one physician in the same specialty in the same group, only one E/M service may be reported unless the E/M services are for unrelated problems. Instead of billing separately, physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. *This is NOT a change from current policy.* CMS is also seeking public comment on whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) ED visits, since those visits also have a unique construct.
 - ***Teaching Physicians:*** CMS clarifies that Medicare will not pay teaching physicians for shared services unless the physician exercises full, personal control over the portion of the case that the physician is seeking payment for. *This is not a change to existing policy.*
3. **Telehealth Services:** In last year’s rule, CMS examined which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 public health emergency (PHE) would remain on the list for an extended period or permanently. CMS broke out the codes that it temporarily added to the list of approved telehealth services into three buckets:
- BUCKET 1: Codes that CMS included on the list of approved telehealth services permanently.
 - BUCKET 2: Codes that CMS included on the list of approved telehealth services for the remainder of the calendar year in which the PHE ends (i.e. until December 31, 2021).

- BUCKET 3: Codes that CMS will remove from the list of approved telehealth services once the PHE ends.

CMS placed all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and some observation codes on the approved telehealth list for the remainder of the year after the PHE expires (i.e., Bucket 2). CMS did note last year that it still needs to see more data and evidence about the benefits of providing ED E/M, critical care, and observation services via telehealth in order to permanently add these codes to the list of approved telehealth services.

In this year's rule, CMS is proposing to extend the amount of time the codes in Bucket 2 would remain on the list of telehealth services **through December 31, 2023**. This will allow CMS more time to collect more information regarding utilization of these services during the pandemic and provide stakeholders the opportunity to continue to develop support for the permanent addition of these services to the list of approved telehealth services. In all, this means that, if the proposal is finalized, emergency physicians could continue to provide emergency telehealth services and bill Medicare using the ED E/M codes, critical care codes, and some observation codes at least through the end of 2023. However, it is important to [remember](#) that other telehealth flexibilities (like the waivers to the "originating site" and geographic restrictions) expire once the COVID-19 PHE ends.

CMS is also implementing a provision of the Consolidated Appropriations Act that removed the geographic restrictions and added the home as originating site for telehealth services when used for the treatment of a mental health disorder. CMS is proposing to require that that patients with mental health disorders receive an in-person service six months prior to the telehealth service and another in-person service six months afterwards as well. In addition, CMS is allowing audio-only telehealth services to be used for the treatment of these patients.

Further, per the Consolidated Appropriations Act, CMS is adding rural emergency hospitals (REHs) as an originating site starting in 2023. More details on REHs should be included in the CY 2022 Outpatient Prospective Payment System (OPPS) proposed rule—which will be released shortly.

4. **Physician Assistant (PA) Services:** CMS is proposing to implement a provision of the Consolidated Appropriations Act that allows Medicare to pay PAs directly for their services. Currently, Medicare only can pay the employer of the PA and PAs cannot bill Medicare directly.
5. **Appropriate Use Criteria Program:** *CMS proposes to delay the Appropriate Use Criteria (AUC) program date to January 1, 2023.* The program has already been delayed several times, most recently to January 1, 2022. As background, it requires clinicians to consult appropriate use criteria using clinical decision support tools prior to ordering advance imaging services for Medicare beneficiaries. As background, the Protecting Access to Medicare Act (PAMA), which created the program, exempts emergency services defined as an "applicable imaging service ordered for an individual with an emergency medical condition" from the requirements. As a result of ACEP's advocacy, in the [CY 2019 Physician Fee Schedule final rule](#) (page 59699), the Centers for Medicare & Medicaid Services (CMS) clarified that exceptions granted for an individual with an emergency medical condition include instances where an emergency

medical condition **is suspected, but not yet confirmed**. This may include, for example, instances of severe pain or severe allergic reactions. In these instances, the exception is applicable even if it is determined later that the patient did not, in fact, have an emergency medical condition. In other words, if physicians think their patients are having a medical emergency (even if they wind up not having one), they are excluded from the AUC requirements.

ACEP has a [webpage](#) dedicated to the action we have taken on this and other electronic health record (EHR)-related issues.

6. **Electronic Prescribing of Controlled Substances:** CMS is continuing to implement a provision of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires electronic prescribing of controlled substances (EPCS) under Medicare Part D. In the rule, CMS:
 - Proposes certain exemptions to the electronic prescribing of controlled substances (EPCS) requirement.
 - When the prescriber and dispensing pharmacy are the same entity;
 - For prescribers who issue 100 or fewer controlled substance prescriptions for Medicare Part D drugs per calendar year; and
 - For prescribers in an area that is undergoing a disaster or who are granted a waiver due to extraordinary circumstances.
 - *Proposes to extend the start date for compliance actions to January 1, 2023, in response to stakeholder feedback.* However, CMS is soliciting comment on whether the original compliance date of January 1, 2022 should remain, in light of the proposed exceptions to the mandate.
 - *Proposes to NOT institute any financial penalties during the first compliance year (January 1- December 31, 2023).* During that first year, CMS' compliance actions will consist of sending letters to prescribers that it believes are violating the EPCS requirement. CMS will consider whether further compliance actions will be necessary and what those compliance actions will be in future rulemaking. CMS seeks comment on this proposal, including what penalties to possibly implement going forward.
7. **Health Equity Data Collection:** CMS is soliciting feedback on how the agency can advance health equity for people with Medicare through potential changes in its quality measures and programs and through improvements in how it collects demographic data.
8. **COVID-19 Vaccination Payment Rates:** CMS notes that Medicare payment rates for vaccines has declined over the last several years. CMS therefore seeks comment on different issues related to the administration and reimbursement of the COVID-19 vaccine.
9. **Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs):** CMS recently implemented a new Medicare benefit for the treatment of opioid use disorder (OUD) furnished by Opioid Treatment Programs (OTPs). In this year's rule, CMS is proposing to allow OTPs to deliver counseling and therapy services via audio-only technology in cases where Medicare beneficiaries do not have access

to devices with audio/visual capabilities. OTPs must specifically document when they perform audio-only services, including their rationale for doing so.

10. **Medicare Shared Savings Program:** The Medicare Shared Savings Program (MSSP) is the national accountable care organization (ACO) program. CMS is proposing to continue allowing ACOs to report quality measures via the CMS Web Interface collection type for an additional two years, thereby delaying the transition to electronic reporting through the Alternative Payment Model (APM) Performance Pathway (APP). CMS is also proposing to freeze the quality performance standard that ACOs need to meet to share in savings for an additional year through 2023. Further, CMS is proposing some other refinements to how the repayment mechanism is calculated for ACOs that bear financial risk. The repayment mechanism helps assure CMS that ACOs can repay losses they may owe. CMS is also proposing revisions to the methodology it uses to assign beneficiaries to ACOs and is seeking comment on various aspects of ACO benchmarking policies.
11. **Open Payments:** Open Payments is a national transparency program that requires drug and device manufacturers and group purchasing organizations to report payments or other “transfers of value” to physicians, teaching hospitals, and other providers to CMS. In this rule, CMS proposes a number of changes aimed at improving the usability of the data collected through this program.
12. **Medicare Provider Enrollment:** CMS is proposing several changes to Medicare provider enrollment processes including giving CMS broader authority to deny or revoke a provider’s enrollment in cases of potential fraud or abuse and establishing “rebuttal” procedures for providers whose Medicare billing privileges have been deactivated.
13. **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):** CMS is proposing to allow RHCs and FQHCs to act as a distant site for the purposes of providing telehealth services to mental health patients (including audio-only visits when the beneficiary does not have access to video technology). CMS is also implementing a provision of the Consolidated Appropriations Act that requires that independent RHCs and provider-based RHCs in a hospital with 50 or more beds receive an increase in their payment limit per visit starting April 1, 2021. This increase would be phased-in over an 8-year period (2021-2028), with a specific amount for each year.

[The Quality Payment Program](#)

CMS introduces policies that impact the sixth performance year (2022) of the Quality Payment Program (QPP). The QPP includes two tracks: [the Merit-based Incentive Payment System \(MIPS\)](#) and Advanced Alternative Payment Models (APMs).

[MIPS Policies](#)

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formally Meaningful Use). Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or

neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2022 will impact Medicare payments in 2024).

1. **2021 Reporting Exemptions Due to COVID-19:** As described [here](#), CMS is granting hardship exemptions on a case-by-case basis due to COVID-19. It is therefore possible for a clinician or group to request to be exempted from all four performance categories in 2021. If clinicians submit a hardship exception application for all four MIPS performance categories, and their application is approved, they will be held harmless from a payment adjustment in 2023—meaning that they will not be eligible for a bonus or potentially face a penalty based on their MIPS performance in 2021.

Like last year, due to concerns around treating patients during the COVID-19 PHE, CMS is proposing to double the complex patient bonus for the 2021 MIPS performance year. These bonus points, which will be capped at 10-points, would be added to the final score.

2. **MIPS Value Pathways (MVP):** CMS has heard feedback, including from ACEP, that MIPS reporting should be streamlined and more meaningful to clinicians. Therefore, CMS created the MIPS Value Pathways (MVPs), an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit.

ACEP developed and proposed an emergency medicine-focused MVP and CMS is proposing to adopt it. The first batch of seven MVPs, which includes ACEP’s MVP, will start in 2023. The delayed start date of 2023 will provide practices the time they need to review requirements, update workflows, and prepare their systems as needed to report MVPs.

CMS is also proposing to sunset the traditional MIPS program after the 2027 performance year and fully transition to reporting through MVPs. CMS is seeking comment on this proposal.

MVP Details

CMS is proposing additional MVP requirements, a process for registering for an MVP, and an MVP scoring methodology. Participation in an MVP will initially be voluntary.

- ***MVP Participation Registration:*** CMS is proposing that if an individual or group would like to report through an MVP, the “MVP Participant” would need to register for the MVP between April 1 and November 30 of the performance year (i.e., for the first year, between April 1 and November 30, 2023). An MVP Participant would not be able to submit or make changes to the MVP it selects after the close of the registration period and would not be allowed to report on an MVP it did not register for.
- ***Qualified Clinical Data Registries (QCDRs):*** QCDRs, such as ACEP’s [Clinical Emergency Data Registry](#) (CEDR), will be required to support MVPs starting in 2023. Some of the measures included in the emergency medicine-focused MVP are CEDR measures. More QCDR policies are found below.

- **Reporting Requirements:**
 - MVP Participants will need to select one population health measure to be calculated on. Initially in 2023, there will be two options: the Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate and the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.
 - MVP Participants would select four quality measures.
 - MVP Participants would select two medium-weighted improvement activities OR one high-weighted improvement activity.
 - CMS would calculate performance exclusively on the cost measures that are included in the MVP using administrative claims data.
 - **Subgroup Reporting:** CMS is allowing subgroup reporting (i.e., a subset of individual clinicians within a group) of MVPs and is establishing requirements for subgroup registration and reporting.
 - **MVP Scoring:** CMS is proposing that the scoring methodology for MVPs will align with that used for traditional MIPS (the MIPS scoring methodology changes are described below).
3. **APM Performance Pathway:** Last year, CMS implemented a complementary pathway to MVPs that will be available for clinicians who participate in APMs and who must still report in MIPS. As described in the Medicare Shared Savings Program section above, CMS is lengthening the transition period to the APP by allowing ACOs to continue using the CMS web interface as a method for reporting through 2023.
4. **Performance Category Weighting in Final Score:** As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. **CMS is proposing to reduce the quality category weight from 40 to 30 percent and increase the Cost category from 20 to 30 percent. These new weights are required by law.**
- General Performance Category Weights Proposed for 2022:
 - **Quality: 30% (down from 40% in 2021)**
 - **Cost: 30% (up from 20% in 2021)**
 - Promoting Interoperability (EHR): 25%
 - Improvement Activities: 15%
5. **The Performance Threshold:** The performance threshold is the score that clinicians need to achieve to avoid a penalty and receive a bonus. For the first five years of the program (2017-2021), CMS had the discretion to set the performance threshold at any level it chose. CMS used this flexibility to set artificially low thresholds, making it easier for clinicians to avoid a penalty. However, starting in 2022, CMS is required by law to set the threshold at the mean or median of prior performance. CMS therefore is proposing to set the threshold at **75 points in 2022** (the mean score during the 2017 performance period), a significant increase from the 2021 threshold of 60 points. There is also an additional bonus for exceptional performance. CMS is proposing to set that **exceptional bonus threshold at 89 points.**

The maximum negative payment adjustment in 2024 (based on performance in 2022) is -9 percent, and the positive payment adjustment can be up to +9 percent (before any exceptional performance bonus). Since MIPS is a budget neutral program, the size of the positive payment adjustments is ultimately controlled by the amount of money available through the pool of negative payment adjustments. In other words, the 9 percent positive payment adjustment can be scaled up or down (capped at a factor of + 3 percent). Likewise, the exceptional performance bonus is capped at \$500 million across all eligible Medicare providers, so the more providers who qualify for the bonus, the smaller it is.

In the first few years of the program, most clinicians qualified for a positive payment adjustment, so the size of the adjustment was relatively small. For example, if a clinician received a perfect score of 100 in 2019, the clinician is only receiving a positive adjustment of 1.79 percent in 2021 (much less than the 7 percent permissible under law). However, since the performance threshold is increasing so much in 2022, CMS expects that many more clinicians will receive a downward payment adjustment. ***Therefore, the maximum bonus for achieving a perfect score is projected to be +14 percent.***

6. **Quality Performance Category:** CMS is proposing a total of 195 quality measures for the 2022 performance period. This includes substantive changes to 84 existing MIPS quality measures, changes to specialty sets (including removing one measure from the emergency medicine specialty set), the removal of 18 quality measures, and the addition of five new measures, including two new administrative claims quality measures.

Due to the COVID-19 pandemic, CMS is proposing to change how it establishes quality benchmarks. Since CMS held clinicians harmless if they were unable to report data from 2020, CMS believes that 2020 data may be unreliable. Therefore, CMS intends to develop performance period benchmarks for the CY 2022 MIPS performance period using the data submitted during the CY 2022 performance period or a different baseline period.

CMS is also making the following important changes to the Quality Category:

- ***Data Completeness:*** CMS is proposing to maintain the current data completeness threshold (the percentage of applicable patients on which providers must report on for a particular measure) at 70 percent for the 2022 performance period but is proposing to increase the data completeness threshold to ***80 percent for the 2023 performance period.***
- ***Scoring Rules for Measures Without a Benchmark or That Do Not Meet Case Minimum:*** ***CMS is proposing to change its existing policy to award three points to measures without a benchmark or that do not meet the case minimum. CMS is eliminating this policy and instead proposing to establish a five-point floor for the first two performance periods for new measures. Thus, except for new measures in the first two performance periods, measures without a benchmark or that do not meet the case minimum will receive 0 points (except when reported by small practices—small practices will still receive 3 points for reporting these measures).***

- *Bonus Points:* CMS is proposing to eliminate bonus points for reporting high-priority and outcome measures as well measures that meet end-to-end electronic reporting criteria.
 - *Quality Scoring Flexibilities:* CMS is proposing to expand the list of reasons that a quality measures may be impacted during a performance period. Errors included in the final measure specifications can result in the suppression or truncation of a measure.
7. **Cost Category:** CMS is proposing to add five newly developed episode-based cost measures into the MIPS Cost Category beginning in 2022. It is important to note that CMS’ contractor, Acumen, has convened a workgroup to develop an emergency medicine episode-based cost measure. ACEP nominated a few individuals to serve on that workgroup and we are pleased that three ACEP members are now participating in it—including the chair of the workgroup.
 8. **Improvement Activities:** CMS is proposing a process for removing an improvement activity in cases where performing the activity raises possible patient safety concerns. CMS is also proposing new criteria for nominating a new improvement activity. Finally, CMS is proposing: the addition of seven new improvement activities, three of which are related to promoting health equity; the modification of 15 current improvement activities; and the removal of six improvement activities.
 9. **Promoting Interoperability:** CMS is proposing to make modifications to the Public Health and Clinical Data Exchange Objective. CMS is also proposing to modify the Provide Patients Electronic Access to Their Health Information measure to require patient health information to remain available to the patient to access indefinitely. Further, CMS is proposing a new measure where clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides. Finally, CMS is proposing to modify the Prevention of Information Blocking attestation statements that are required.
 10. **Complex Patient Bonus:** Starting in 2022, CMS is proposing to refine its methodology for defining higher-risk patients for the purposes of allotting the complex patient bonus. CMS will increase the bonus to a maximum of 10 points.
 11. **Facility-based Scoring Option:** Under the facility-based scoring option, clinicians who deliver 75 percent or more of their Medicare Part B services in an inpatient hospital, on-campus outpatient hospital, or ED setting will automatically receive the quality and cost performance score for their hospital through the Hospital Value-based Purchasing (HVBP) Program. Most emergency physicians qualify for this option. Clinicians who qualify for the option can still report quality measures through another submission mechanism (such as a QCDR) and receive a “traditional” MIPS score for quality. If they do so, CMS will automatically take the highest of the HVBP score and the traditional MIPS score. Some emergency physicians, especially those who work in small groups or practice in rural areas, rely on this option since they do not have the resources or technology necessary to meet all the MIPS quality and cost requirements.

CMS has heard from clinicians that in some cases, individuals and groups are receiving a lower score than they would otherwise receive outside of facility-based measurement. CMS is

therefore proposing a new policy to determine the MIPS final score for clinicians and groups who are eligible for facility-based measurement. CMS is proposing that, starting in 2022, the MIPS Quality and Cost Category scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher MIPS final score through another MIPS submission. Under this proposed policy, CMS would calculate two final scores for clinicians and groups who are facility-based. One score would be based on the clinician or group's performance and the weights of the performance categories if facility-based measurement did not apply, and the other would be based on the application of facility-based measurement.

- 12. Qualified Clinical Data Registries (QCDRs):** QCDRs are third-party intermediaries that help clinicians report under MIPS. As stated above, ACEP has its own QCDR called the Clinical Emergency Data Registry (CEDR). Over the last few years, CMS has consistently increased QCDR requirements.

In this year's rule, CMS proposes:

- That QCDRs must have a minimum of 25 participants signed up by the prior performance period.
- Two new criteria for rejecting QCDR measures: (1) QCDR does not have permission to use a QCDR measure; and (2) QCDR not approved or not in good standing.
- More flexibility for CMS to take remedial action, including termination of, QCDRs if the data they submit on behalf of clinicians include inaccuracies.
- Starting in 2023, that QCDRs must support MVPs, including through subgroup reporting.

- 13. Public Reporting:** CMS is seeking public comment through a Request for Information (RFI) on the types of utilization data that could be added to Care Compare (the public website that compares performance of clinicians and facilities in Medicare) to inform patients' health care decisions. CMS is also proposing that subgroup scores be publicly reported separately from group scores starting in 2024.

Alternative Payment Model (APM) Policies

- 1. Qualifying APM Participant (QP) Thresholds:** Clinicians who have a certain proportion of their revenue or patient population tied to an Advanced APM (known as the revenue or patient threshold) is classified as a Qualifying APM Participant (QP) and is eligible for a five percent bonus. In the rule, CMS is implementing a provision of the Consolidated Appropriations Act which froze the current thresholds through 2022. This provision will make it easier for clinicians participating in Advanced APMs to surpass the QP threshold and be eligible for a five percent bonus and be exempt from MIPS.