

High-level Summary of the Combined 2022 Medicare Physician Fee Schedule (PFS) and MACRA Quality Payment Program (QPP) Final Rule

On November 2, 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 policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the quality performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). CMS had issued a [proposed rule](#) in July, which ACEP [responded to](#) with a robust set of comments. Below is a high-level summary of key final policies.

Physician Fee Schedule

- **Conversion Factor:** Due to the 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. 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 final CY 2022 PFS conversion factor reflects the looming 3.75 percent cut (and a few other adjustments)—and is \$33.60, a decrease of \$1.29 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.

- **Evaluation and Management (E/M) Visits:** CMS is refining a number of its current policies for split or shared E/M visits, critical care services, and services furnished by teaching physicians.
 - **Split or Shared Services:** CMS will continue its current policy of 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.
 - **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. CMS confirmed in the final rule that only for 2022, the history, physical exam, MDM, or more than half of the total time (inclusive of activities on the finalized listing) can comprise the substantive portion of any E/M visit (including ED visits) except critical care. Starting in 2023, a list of “qualifying” activities will apply to all split (or

shared) E/M visits except critical care for the purposes of determining the substantive portion. CMS also recommended the CPT Editorial Panel review the list of qualifying activities to provide additional levels of detail and specificity. The final policy for ED visits will be to use the CPT listing of qualifying activities for time, as CMS proposed.

- **Critical Care:** CMS is finalizing its proposal 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, with 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 finalizing its proposal to require practitioners to document the total time that critical care services were provided by each reporting practitioner (not necessarily start and stop times) in the medical record.
 - **Critical Care Policies:** CMS recognizes that physicians, including emergency physicians, may at times deliver distinct E/M services prior to a critical care service taking place. Therefore, CMS is allowing a physician to bill separately for the E/M service delivered prior to the critical care service, as long as “the physician documents that the E/M service was provided prior to the critical care service at a time when the patient did not require critical care, that the service is medically necessary, and that the service is separate and distinct, with no duplicative elements from the critical care service provided later in the day...” Physicians must use modifier -25 on the claim when reporting these critical care services. In addition, critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure.
 - **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 for which the physician is seeking payment.
- **Telehealth:** *CMS is finalizing its proposal to extend the amount of time certain codes will remain on the approved list of telehealth services through the end of CY 2023.*

As background, 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 divided the temporarily 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.
- 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 list of approved telehealth services for the remainder of the year after the PHE expires (i.e., Bucket 2). CMS did note last year that it still needed 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 extending the amount of time the codes in Bucket 2 will 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 emergency physicians can 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 the originating site for telehealth services when used for the treatment of a mental health disorder. CMS is also allowing audio-only telehealth services to be used for the treatment of these patients.

- **Appropriate Use Criteria Program:** *CMS is finalizing its proposal 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, the AUC program 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), 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.

We have a webpage on our website dedicated to the action we have taken on this and other EHR-related issues:

<https://www.acep.org/federal-advocacy/federal-advocacy-overview/acep4u/acep4u-electronic-health-records-ehr/>.

- **Physician Assistant (PA) Services:** CMS is finalizing its proposal 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.
- **Electronic Prescribing of Controlled Substances:** CMS is continuing to implement a provision of the SUPPORT Act, which requires that the prescribing of controlled substances under Medicare Part D be done electronically. In the rule, CMS is:
 - *Delaying the start date for compliance actions to January 1, 2023, in response to stakeholder feedback.*
 - Instituting certain exemptions to the electronic prescribing of controlled substances (EPCS) requirement.
 - Allowing prescribers to request a waiver where circumstances beyond the prescriber’s control prevent the prescriber from the ability to electronically prescribe controlled substances covered by Part D.
- **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 allowing 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 and include their rationale for doing so.
- **Medicare Shared Savings Program:** The Medicare Shared Savings Program (MSSP) is the national accountable care organization (ACO) program. In the final rule, CMS is allowing ACOs to continue reporting quality measures via the CMS Web Interface collection type for an additional three years, thereby delaying the transition to electronic reporting through the Alternative Payment Model (APM) Performance Pathway (APP). CMS is also freezing the quality performance standard that ACOs need to meet to share in savings for an additional year through 2023. Further, CMS is finalizing 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 finalizing revisions to the methodology it uses to assign beneficiaries to ACOs.
- **Open Payments:** Open Payments is a national transparency program that requires group purchasing organizations and drug and device manufacturers to report payments or other “transfers of value” to physicians, teaching hospitals, and other providers to CMS. In this rule, CMS institutes a number of changes aimed at improving the usability of the data collected through this program.
- **Medicare Provider Enrollment:** CMS is implementing several changes to Medicare provider enrollment processes including giving the agency 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.

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 weighted categories roll 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).

- **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 doubling the complex patient bonus for the 2021 MIPS performance year. These bonus points, which will be capped at 10-points, will be added to the final score.

NOTE FOR 2022: CMS is extending the COVID-19 hardship exemption policy into 2022 as well.

- **MVPs:** 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 that CMS is including in the first batch of MVPs, which 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.

MVP Details

CMS is finalizing 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:* 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 for which it did not register.
- *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.
- *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 or 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. QCDRs also must support subgroup reporting.
- *MVP Scoring:* The scoring methodology for MVPs will align with that used for traditional MIPS (the MIPS scoring methodology changes are described below).
- **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. 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 2024.
- **Performance Category Weighting in Final Score:** CMS is reducing 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 Finalized for 2022:

- **Quality: 30% (down from 40% in 2021)**
- **Cost: 30% (up from 20% in 2021)**
- Promoting Interoperability (EHR): 25%
- Improvement Activities: 15%
- **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 setting 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 setting 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; as more providers qualify for the bonus, the size of the bonus for each provider decreases.

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 will only receive 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 +14.4 percent.

- **Quality Performance Category:** CMS is finalizing a total of 200 quality measures for the 2022 performance period. This includes substantive changes to 87 existing MIPS quality measures, changes to specialty sets, the removal of 13 quality measures, and the addition of four new measures, including one new administrative claims quality measure.

CMS also includes the following policies related to the Quality Category:

- *Data Completeness:* CMS is finalizing its proposal 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. However, CMS is NOT finalizing its proposal to increase the data completeness threshold to **80 percent for the 2023 performance period**. Instead, the data completeness threshold will remain at 70 points in 2023.
- *Scoring Rules for Measures Without a Benchmark:* CMS is changing its existing policy to award three points to measures without a benchmark.

Beginning in 2022, CMS is establishing a new policy for scoring new measures without a benchmark in their first year in MIPS to receive a 7-point scoring floor (receive 7 to 10 points) and in their second year to receive a 5-point scoring floor (receive 5 to 10 points).

Beginning in 2023, CMS is removing the 3-point floor for quality measure scoring from traditional MIPS. Therefore, measures without a benchmark will receive 0

points starting in 2023 (except if they are new measures or when reported by small practices—small practices will still receive 3 points for reporting these measures).

- *Bonus Points:* CMS is eliminating 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 expanding the list of reasons that a quality measure may be impacted during a performance period. Errors included in the final measure specifications can result in the suppression or truncation of a measure.
- **Cost Category:** CMS is adding 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, including the chair of the workgroup, are now participating.

In addition to the current Acumen process, CMS is adding a new process of cost measure development by stakeholders, including a call for cost measures.

- **Improvement Activities:** CMS is creating a process for removing an improvement activity in cases where performing the activity raises possible patient safety concerns. CMS is adding new criteria for nominating a new improvement activity. Finally, CMS is adding seven new improvement activities, three of which are related to promoting health equity; modifying 15 current improvement activities; and removing six improvement activities.
- **Promoting Interoperability:** CMS is making modifications to the Public Health and Clinical Data Exchange Objective. CMS is creating 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 modifying the Prevention of Information Blocking attestation statements that are required.
- **Complex Patient Bonus:** CMS is refining 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.
- **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 creating a new policy to determine the MIPS final score for clinicians and groups who are eligible for facility-based measurement. 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.

- **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.

Specific QCDR policies in the rule include:

- As stated above, QCDRs must support MVPs starting in 2023, as well as subgroup reporting.
- Based on public comment, CMS is considering proposing in next year's rule to delay its requirement that QCDR measures be fully tested in order to be approved until 2024.

Alternative Payment Model (APM) Policies

- **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).