2022: Medicare Physician Fee Schedule Final Rule

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Agenda

- Fee Schedule
- AUC/CDS
- Telehealth
- Evaluation and Management (E/M) Coding
- Scope of Practice
- Quality Payment Program (QPP)
  - Merit-Based Incentive Program (MIPs)
    - Updates
  - MIPs Value Pathways (MVPs)
- Summary

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Fee Schedule

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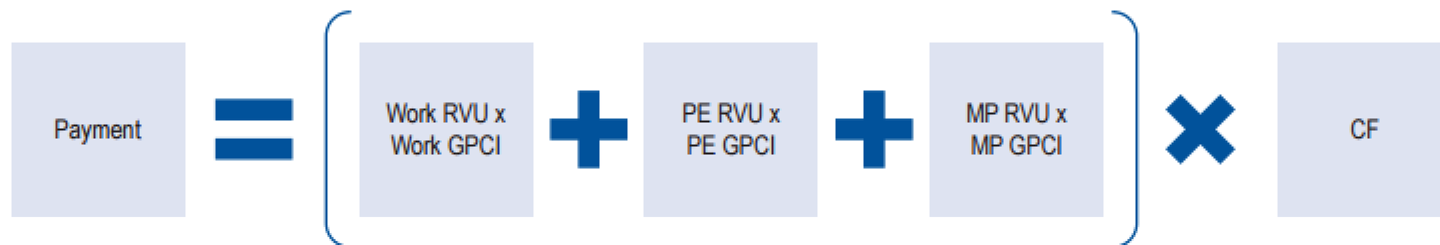
Fee Schedule

2022 Conversion Factor : $33.59

- Decrease of - $1.30 (-3.7%) from 2021 CF of $34.89

- Anesthesia Factor : $20.93
  - Decrease of - $.63 (-2.9%) from 2021 CF of $21.56
  - *Proposed* CF: $21.04



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Fee Schedule

Why is this happening?

- **+3.75% increase from the Consolidated Appropriations Act (CCA) expires**
  - Temporary bump to fee schedule offset E/M cuts going into effect for 2021
  - 2022 Conversion Factor rate accounts for this

- **Practice Expense RVU changes from clinical labor pricing update**
  - Increasing the ‘labor rate’ portion of the PE RVU negatively impacts specialties with higher supply/equipment costs
  - CMS finalized a **4-year phase-in** to the updates, reducing the impact for 2022

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Fee Schedule – Impact by Specialty

Specialty	Impact
Interventional Radiology	-5%
Radiation Oncology	-1%
Radiology	-1%
Physical/Occupational Therapy	-1%
Nuclear Medicine	-1%
General Surgery	0%
Pathology	0%
Gastroenterology	0%
Physician Assistant	0%
Allergy/Immunology	0%
Nurse Anes. / Anes. Assistants	0%
Endocrinology	0%
Family Practice	1%
Anesthesiology	1%
Orthopedic Surgery	1%
Hand Surgery	1%
Dermatology	1%
Podiatry	1%
Diagnostic Testing Facility	6%

- **Final combined impact estimates are *averages* of allowable charges by specialty**
- **Real-world impact depends *heavily* on case-mix, location, and billing arrangements**
- **Facility vs Non-Facility setting has big impact on PE RVU changes**

Full Table - pg 625 of rule

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Fee Schedule – Other Factors

Additional Cuts Possible in 2022

- **- 2% Medicare Sequester**
  - Medicare has been subject to an automatic -2% reduction since 2013 as required by the Budget Control Act of 2011.
  - Temporarily suspended during the COVID-19 PHE
- **- 4% "PAYGO" Sequester**
  - The passage of the American Rescue Plan Act triggered a statutory Pay-As-You-Go (PAYGO) budget control measure that offsets increases to the federal deficit by automatically reducing federal spending.

Fee Schedule – Other Factors

Additional Cuts Possible in 2022

- **No healthcare provisions included in stop-gap spending bill signed 12/3/21**
  - Congress has until **2/18/22** to pass budget

But…

- **Supporting Medicare Providers Act of 2021 (HR 6020)**
- **Medicare Sequester Relief Act (S. 748)**
- ***NEW* The Supporting Health Care Providers During the Covid-19 Pandemic Act**

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Fee Schedule – Other Factors

Additional Cuts Possible in 2022

- The Supporting Health Care Providers During the Covid-19 Pandemic Act
  - Introduced to the House of Representatives - 12/7/2021
    - Extends moratorium on -2% Medicare Sequester until March 31st, 2022
    - -4% PAYGO cut delayed until 2023
    - 2022 Conversion Factor increased by +3%
    - 1 year delay of the phase-in for clinical labor pricing updates
    - 1 year delay to start of mandatory CMS Radiation Oncology payment model

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Appropriate Use Criteria/Clinical Decision Support (AUC/CDS)

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AUC/CDS

2014 PAMA Mandate requires CMS to create regulations requiring ordering providers to consult appropriate use criteria when ordering *advanced imaging studies* for Medicare beneficiaries.

- MRIs/MRAs, CTs, PET, Nuclear Medicine
- Ordering providers must pass along AUC data (modifiers and g-codes) to furnishing providers to append to claims

- **Program *currently* in an extended operations and testing phase**
  - No consequence to reimbursement if claims are missing AUC data

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AUC/CDS

2022 Final Rule finalizes delay to the *payment penalty phase* of program to now begin on the latter of the following:

- **January 1st, 2023**

OR

- **January 1 following the declared end of the COVID-19 public health emergency**
  - PHE currently active until mid-January 2022

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AUC/CDS

Critical Access Hospitals

- **CMS will create a new modifier to identify scenarios where the AUC mandate is not applicable due to the *applicable payment setting* provisions of the rule**
  - AUC mandate applies to Medicare beneficiaries who are seen in an outpatient setting (including the ER) and paid for under the MPFS, HOPPS, or ASC payment systems
    - This is **different** than the approved hardships of the program
- **MH modifier currently used to report 'unknown if ordering provider consulted AUC' was originally proposed to be repurposed for CAH**

Medicare as Secondary Payor

- **CMS is clarifying that AUC mandate will not apply to beneficiaries with Medicare as secondary insurance**
  - This is a reversal of earlier guidance

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AUC/CDS

Payment Penalty Phase

- CMS is still establishing claims processing operations for AUC
  - Claims will first be returned for edits instead of being denied
  - More information on process will be released on CMS Website HERE

- COVID PHE qualifies for MD ‘extreme and uncontrollable circumstances’ hardship modifier
  - CMS encourages use of this for impacted ordering providers in 2022 Final Rule

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AUC/CDS

Modifier	Description
MA	Ordering professional **not required to consult** a CDSM due to patient having a suspected or confirmed medical emergency
MB	Ordering professional is **not required to consult** a CDSM due to the significant hardship exception of insufficient internet access
MC	Ordering professional is **not required to consult** a CDSM due to the significant hardship exception of EHR or CDSM vendor issues
MD	Ordering professional is **not required to consult** a CDSM due to the significant hardship exception of extreme and uncontrollable circumstances – including COVID PHE
ME	The order **adheres** to the appropriate use criteria in the CDSM consulted by the ordering professional
MF	The order **does not adhere** to the appropriate use criteria in the CDSM consulted by the ordering professional
MG	The order for this service **does not have** appropriate use criteria in the CDSM consulted by the ordering professional
MH	****WILL EVENTUALLY BE REMOVED**** **Unknown** if ordering professional consulted a CDSM for this service, **related information was not provided** to the furnishing professional or provider

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AUC/CDS

Implementation Considerations

- **Plan around the delay, make the most of extension**
  - **Keep going!**
  - **More time to analyze data, looks for trends, make adjustments**

- **Keep in mind, PAMA is law – it would take congressional action to toss out AUC altogether**
  - **Industry groups calling for rework or repeal**
  - ***Some* attention being paid by House Ways and Means Committee**
  - **Wait and see…**

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Telehealth

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Telehealth

The COVID-19 PHE rapidly expanded telehealth utilization and access for Medicare beneficiaries, supported by temporary waivers available during the PHE.

- **CMS will retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of 2023.**
  - **CMS identifying which codes would leave list at end of current PHE**
- **Certain permanent expansions provided for Behavioral Health telehealth services**

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Telehealth

Virtual Check Ins – had proposed to permanently adopt coding and payment for HCPCS code G2252

- **Brief communication technology-bases service, 11-20 minutes of medical discussion**
- **CMS did NOT move forward with this proposal in the Final Rule**

Reminder - Congressional intervention necessary for major/permanent expansion of Telehealth

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Evaluation and Management (E/M) Coding

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E/M Coding

CMS revised rules around split or shared billing under new E/M guidelines

Effective January 1st, 2022:

- Split/shared visits may be performed in any facility setting and for critical care services

- Split/shared visits, except for critical care visits, should be reported by the treating practitioner
  - Healthcare professional performing the "substantive portion" of the visit as determined by history, physical exam, medical decision-making, or more than half of the total time of the encounter.

- Critical care should be billed by the treating practitioner based on time

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E/M Coding

Effective January 1st, 2022:

- **Split/shared visits can be reported for new and established patients**
  - Initial and subsequent encounters included

- **CMS will require a modifier to be reported with split/shared services**
  - CMS did not define the specific modifier for split/shared visits
  - Critical Care services require modifier -25

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Scope of Practice

Physician Assistants

CMS will allow Physician Assistants to bill Medicare directly effective January 1st, 2022

Congress removed the requirement for Medicare to reimburse the PA's employer with the passage of the Consolidated Appropriations Act of 2021.

CMS is using this authority to authorize PAs to be paid directly for their services in the same way that NPs and CNSs are under Medicare

Quality Payment Program(QPP/MIPs)

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MIPS Program Updates

General Program Eligibility

- **CMS did NOT make updates impacting program eligibility besides adding Clinical social workers and Certified nurse-midwives as eligible clinician types**
- **Clinicians enrolled in Medicare for at least 1 year who meet all elements of the LVT *as an individual* must participate in MIPS.**
- **Low Volume Threshold (LVT):**
  - **$90,000 in Medicare Part B**
  - **200+ Medicare Part B Services**
  - **200+ Medicare Part B Beneficiaries**

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MIPS Program Updates

<u>2021</u> Program Flexibilities

- **Complex Patient Bonus**
  - **Max of 10 pts towards total score**
    - 2020 Complex PT Bonus should be indicator of points
    - **CMS permanently expanded this bonus, altered methodology starting 2022**
- **COVID-19 hardship application**
  - **Open until December 31, 2021**
  - Apply through QPP.cms.gov portal
  - ****NEW** AUTOMATIC policy will be applied to *<u>individuals</u>***

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MIPS Program Updates

Performance Thresholds and Category Weights

Performance	2021	2022	Change
Penalty	**60**	**75**	+15 pts
Exceptional Performer*	**85**	**89**	+4 pts
Maximum Payment Adjustment	**+/- 9%**	**+/- 9%**	None
Category Weights			
Quality	40%	30%	- 10%
Cost	20%	30%	+10%
Promoting Interoperability	25%	25%	None
Improvement Activities	15%	15%	None

****2022** is the **LAST** year to earn the ***exceptional performer*** bonus

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MIPS Program Updates

Historical Performance Year Thresholds

Performance Year	Payment Year	Max Payment Adjustments	Performance Threshold	Exceptional Performance Threshold	Payment Adjustments
2017	2019	(+/ -) 4%	3 pts	70 pts	1.88%
2018	2020	(+/ -) 5%	15 pts	70 pts	1.68%
2019	2021	(+/ -) 7%	30 pts	75 pts	1.79% 4.67% **
2020	2022	(+/ -) 9%	45 pts	85 pts	*2.20%* 6.25% **
2021	2023	(+/ -) 9%	60 pts	85 pts	6 – 8 % **
2022	**2024**	**(+/ -) 9%**	**75 pts**	**89 pts**	**8+%** **
2023	2025	(+/ -) 9%	TBD	N/A	8+%**

****COVID PHE significantly reduced availability of positive adjustments**

MIPS Program Updates

Special Statuses:

Small Practices (15 or fewer clinicians) to be added to list of clinician types exempt from the Promoting Interoperability category

- **New Final Score Weighting**

Category Weights	With Cost	Without Cost
Quality	40%	**50%**
Improvement Activities	30%	**50%**
Cost	30%	0%

- **Non-small practices will have *higher* Quality weighting when exempt from other categories**

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MIPS Program Updates

Quality Category

- **Removal of 3-point floor delayed until 2023**
  - ***Except* for Small Practices**
  - **Measures with a benchmark (and DC and case minimum) to earn between 1-10 points**
  - **Measures with NO benchmark or under DC or under case minimum to earn 0 points**

- **Increased point floors for NEW measures**
  - Measures **NEW** to MIPs would earn a minimum of 7 points during first performance period available, 5 points during second
  - **If benchmarked, measures would return between up to 10 points once DC and case minimum is met**

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MIPS Program Updates

Quality Category

- **Removal of measure related bonus points**
  - **Outcome Bonus -** 2 bonus points will be given for each additional outcome or patient experience measure reported
  - **High Priority Bonus -** 1 bonus points will be given for each additional high priority measure reported
  - **End-to-end Bonus -** 1 point given for each measure that's collected in 2015 Edition CEHRT and submitted to CMS without manual manipulation

- **Participants should expect loss up to 6 points towards Quality**

- **Small Practice bonus, Quality Improvement Bonus still available**

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MIPS Program Updates

Quality Category

- **4 new quality measures**
  - **1 Administration Claims Based**
    - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
      - **For groups of 16 + clinicians**
  - **3 Reportable Measures**
    - Intravesical Bacillus Calmette-Guerin (BCG) for non-muscle Invasive Bladder Cancer – **eCQM reporting**
    - Hemodialysis Vascular Access: Long term care rate – **MIPS CQM (registry) reporting**
    - Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure **– MIPS CQM (registry) reporting**

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MIPS Program Updates

Quality Measures Removed
#19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
#21 Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
#23 Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
#44 Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
#50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
#67 Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemia
#70 Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
#137 Melanoma: Continuity of Care – Recall System
#154 Falls: Risk Assessment
#195 Radiology: Stenosis Measurement in Carotid Imaging Reports
#225 Radiology: Reminder System for Screening Mammograms
#317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
#337 Psoriasis: Tuberculosis (TB) Prevention
#342 Pain Brought Under Control Within 48 Hours
#429 Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy
#434 Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair
#444 Medication Management for People with Asthma

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MIPS Program Updates

Quality Category

Topped-out/Point-capped Measures

- **Topped-out measures -**the national median performance rate is so high that there is no meaningful difference in performance between clinicians.
  - **Even 1 encounter failing to meet a measure's criteria will lower the amount of points returned significantly**

- **Point-capped measures –**after a measure is considered 'topped-out', CMS may apply a point cap to lower the **maximum points from 10 to 7**
  - All measures with a point-cap are also topped-out

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MIPS Program Updates

Cost Category

- **5 new episode-based cost measures**
  - Melanoma Resection
  - Colon and Rectal Resection
  - Sepsis
  - Diabetes
  - Asthma/Chronic Obstructive Pulmonary Disease [COPD]

- **CMS will now allow externally developed Cost measures into the program**
  - **Call for measures to be added in the 2024 performance year**

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MIPS Program Updates

Improvement Activity

- Added new criteria for nominating new activities
- CMS now has the ability to suspend Improvement Activities during a performance period
  - In the case that patient care is at risk due to the activity
- 7 new activities proposed, 6 current activities removed:
  - IA_BE_13
  - IA_PSPA_11
  - IA_BE_17
  - IA_BE_18
  - IA_BE_20
  - IA_BE_21

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MIPS Program Updates

Promoting Interoperability Category

- **Public Health and Clinical Data Exchange Objective**
  - Participants now required to report the Immunization Registry Reporting and Electronic Case Reporting measures unless an exclusion can be claimed
    - The three other measures within this section are **optional** to report in addition to the two required and will return 5 bonus points

- **Attestations**
  - Modified Information Blocking to distinguish between the OIG Information Blocking Rules
  - Participants required to attest to conducting risk assessments under Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

- **Provide Patients Electronic Access measure**
  - **Modified to add January 1st, 2016 as the required date for patient access**

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MIPS Program Updates

Magic Quality Numbers for 2022:

Goal	Small Practices	Non-Small Practices
Avoid Penalty 75 points	**30/60 points for Quality** • Average of 4 pts per measure **OR** • Two capped measures at 100% performance met	**42/60 points for Quality** • Average of 7 pts per measure **OR** • 6 capped measures at 100% met • Complex Patient Bonus still needed to reach threshold
Exceptional Performer 89 points	**45/60 points for Quality** • Average of 6.5 pts per measure **OR** • Five capped measures at 100% performance met • Complex Patient Bonus still needed to reach threshold	**48+/60 points for Quality** • Average of 8.75 pts per measure • Need at least two 10 pt measures and 100% performance met • Complex Patient Bonus still needed to reach threshold

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MIPs Value Pathways (MVPs)

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MIPS Value Pathways

- **CMS is finalized 7 MVPS to be available for reporting beginning 2023**
  - Rheumatology
  - Stroke Care and Prevention
  - Heart Disease
  - Chronic Disease Management
  - Emergency Medicine
  - Lower Extremity Joint Repair
  - Anesthesia

- **MVPs – condition or specialty-specific groups of cost, quality and improvement measures with a foundation of the promoting interoperability category.**

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MIPS Value Pathways

CMS intends MVPs to be the future of MIPS reporting, *solicited comments* on the sunset of traditional MIPS with the end of the 2027 performance period

- **How are MVPs different than MIPS?**
  - **Clinicians select from a smaller list of measures or activities**
  - **Clinicians will register to report an MVP during the performance year**
    - **Between April 1st – November 30th**
  - **MVPs require less data submission than traditional MIPS**
    - **CMS calculates administrative claims and Cost measures**
    - **MVPs require fewer quality measures**

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MIPS Value Pathways

Appendix A: MVP Reporting Requirements

The table below provides an overview of the MVP reporting requirements.

QUALITY PERFORMANCE CATEGORY*	IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY*	COST PERFORMANCE CATEGORY
An MVP Participant selects 4 quality measures, 1 must be an outcome measure (or a high priority measure if an outcome is not available or applicable). Note: As applicable, an administrative claims measure, that is outcome-based, may be selected at the time of MVP registration to meet the outcome measure requirement.	MVP Participant selects: • Two medium weighted improvement activities **OR** one high weighted improvement activity. **OR** • Participates in a certified or recognized patient-centered medical home (PCMH) or comparable specialty practice, as described at (82 FR 53652) and at §414.1380(b)(3)(ii)	An MVP Participant is scored on the cost measures included in the MVP they select and report.

FOUNDATIONAL LAYER (MVP AGNOSTIC)

Population Health Measures*
An MVP Participant selects 1 population health measure, at the time of MVP registration, to be scored on. The results are added to the quality performance category score.

Promoting Interoperability (PI) Performance Category
An MVP Participant is required to meet the Promoting Interoperability performance category requirements at § 414.1375(b).

*Indicates MVP Participant may select measures and/or improvement activities.

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MIPS Value Pathways

MVP Participation Options

2023 - 2024 performance years	2025 performance year and beyond
• Individual clinicians • Single specialty groups • Multispecialty groups* • Subgroups • APM Entities	• Individual clinicians • Single specialty groups • Subgroups • APM Entities
• Opt-in or Voluntary eligible providers would not be able to report MVPs at first	• Multispecialty groups MUST report via subgroups

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MIPS Value Pathways

Transitioning to MVPs

- **MVP scoring will follow 'traditional MIPs' policies**
  - MVPs available in tandem and participants can report both ways
- **More MVPs to become available**
  - Keep an eye out for 2023 proposed rule
- **Important to consider if MVPs will be beneficial and what changes needed in order to report**
  - Sub-group reporting
  - QCDR measures

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2022 Summary

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2022 Summary

Reimbursement Uncertainty

- ***Exact* impact of fee schedule hard to determine**
  - Case-mix and setting will be major influences on the final result
- **Other factors outside the fee schedule have further impact**
  - - 2% Medicare Sequester
  - - 4% PAYGO
- **Congressional action possible**
  - Stand alone bill delays many factors until 2023
  - Appropriations Budget for 2022 still needs passed
- **MIPs Program Penalties real possibility**
  - Impact to 2024 Medicare claims

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Thank you!