
On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) released the CY 2022 Medicare Physician Fee Schedule (MPFS) [proposed rule](#). This regulation also impacts the Quality Payment Program (QPP). CMS also released accompanying fact sheets on the [MPFS](#) and [QPP](#). Comments on the proposed rule are due by September 13, 2021. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2021, and will take effect on January 1, 2022, except where specified otherwise in the final rule.

2022 Medicare Conversion Factor and Estimated Impact on Family Medicine

The proposed conversion factor for 2022 is \$33.58. This is 3.75 percent lower than the 2021 conversion factor of \$34.89. This reduction can be attributed to the expiration of a 3.75 percent increase in the 2021 conversion factor, which Congress applied via legislation in December 2020. The specialty impact estimates published by CMS do not account for the proposed change in conversion factor from 2021 to 2022 and therefore do not reflect the expected impact on family medicine. The American Medical Association estimates that, if the CY 2022 MPFS goes into effect as proposed without Congressional intervention, there will be a 1.6 percent reduction in allowed charges for family medicine in 2022.

Telehealth Proposals

CMS proposes to retain all services previously added to the Medicare telehealth services list on a Category 3 (temporary) basis until the end of calendar year 2023. Relevant services for family physicians include:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facility discharge day management (CPT 99315-99316)
- Hospital discharge day management (CPT 99238- 99239)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224-99226)

To implement the telehealth provisions in the Consolidated Appropriations Act of 2021 (CAA) CMS proposes the following, effective after the end of the COVID-19 public health emergency (PHE):

- Remove geographic restrictions for telehealth services provided to diagnose, evaluate, or treat a mental health disorder
- Add home of the patient as a permissible originating site for telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder
- Require, as a condition of payment for mental health telehealth services, that the billing practitioner must have furnished an in-person service to the beneficiary within the 6-month period before the date of the telehealth service.

CMS proposes to cover audio-only telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder when the following conditions are met:

- The originating site of the visit is the patient's home,
- The furnishing practitioner has the capacity to furnish the service using interactive two-way, real-time audio/video technology but instead used audio-only in an instance where the

beneficiary is unable to use, does not wish to use, or does not have access to two-way audio/video technology, and

- An in-person service must be furnished within 6 months of the audio-only service.

CMS proposes to permanently adopt coding and payment for HCPCS code G2252 (*Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion*) beginning in CY 2022.

Valuation of Specific Codes

CMS proposes valuation of multiple CPT and HCPCS codes that are new or revised for 2022. Of most interest to family physicians will be CMS's proposals related to the codes for chronic care management (CCM) and principal care management (PCM). CMS proposes to accept the work relative value units (RVUs) and direct practice expense inputs recommended by the Relative Value Scale Update Committee for all these codes. If finalized, this will mean an increase in the work RVUs for each of the existing CCM codes and one of the two PCM codes, which will be converting from HCPCS codes to CPT codes.

Evaluation and Management (E/M) Visits

CMS proposes policy changes in three areas. One relates to split (or shared) visits by a physician and a non-physician provider (NPP) who are in the same group. CMS proposes:

- To define a split (or shared) visit as an E/M visit in the facility setting (i.e., an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited by regulation) that is performed in part by both a physician and an NPP who are in the same group
- That the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting
- To allow split (or shared) visits to be reported for both new and established patients (as well as initial and subsequent visits) and for critical care and certain Skilled Nursing Facility/Nursing Facility E/M visits (i.e., those not required to be performed in their entirety by a physician)
- To allow only the physician or NPP who performs the substantive portion of the split (or shared) visit to bill for the visit. "Substantive portion" would be defined as more than half of the total time spent by the physician and NPP performing the visit
- That the distinct time of service spent by each physician or NPP furnishing a split (or shared) visit would be summed to determine total time and who provided the substantive portion (and therefore bills for the visit), consistent with the CPT E/M Guidelines
- The same listing of activities in the CPT E/M Guidelines will define what can count toward total time for purposes of determining the substantive portion for visits that are not critical care services
- To allow a practitioner to bill for a prolonged E/M visit as a split (or shared) visit.
- That documentation in the medical record must identify the two individual practitioners who performed the visit and that the individual who performed the substantive portion (and therefore bills the visit) would be required to sign and date the medical record
- To create a modifier to describe split (or shared) visits and to require the modifier be appended to claims for split (or shared) visits, whether the physician or NPP bills for the visit

Another area concerns payment for teaching physicians' services. In this section, CMS proposes that:

- When total time is used to determine the office/outpatient E/M visit level, only the time that the teaching physician was present can be included
- Under the primary care exception, only MDM can be used to select office/outpatient E/M visit level

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes 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, provided all requirements for each billing code are met.

CMS proposes to permanently allow FQHCs and RHCs to provide audio-video and audio-only telehealth services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. The proposed conditions for payment are similar to those listed in the Telehealth Proposals section above.

Vaccine Administration Services

Following persistent advocacy from the AAFP, CMS acknowledges that Medicare payments for vaccine administration services have become increasingly insufficient in recent years. The agency seeks detailed comments on the cost of vaccine supplies and administration and indicates it may use this information to create a new, more sustainable payment methodology for vaccine administration services under the MPFS.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

Consistent with the Academy's recommendation, CMS proposes to delay full implementation of the AUC program until the later of January 1, 2023, or January 1 of the year after the year in which the PHE for COVID-19 ends.

Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation

CMS proposes several changes to clarify the role of physicians in pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation, all with the goal of improving access to and utilization of these services.

Medicare Shared Savings Program (MSSP)

CMS is extending the CMS Web Interface reporting option for an additional two years. For the 2022 performance year, CMS is proposing to allow MSSP accountable care organizations (ACOs) to report the 10 CMS Web Interface measures or report the three Alternative Payment Model Performance Pathway (APP) electronic clinical quality measure (eCQM)/Merit-based Incentive Payment System (MIPS) CQMs. For the 2023 performance year, ACOs would be required to report either the 10 CMS Web Interface measures and at least one APP eCQM/MIPS CQM or report the three APP eCQM/MIPS CQMs. Beginning with the 2024 performance period and subsequent years, ACOs will be required to report the three APP eCQM/MIPS CQMs.

CMS is proposing to freeze the quality performance standard at the 30th percentile of MIPS Quality Performance Category scores for an additional year. CMS proposes to raise the quality performance standard in conjunction with the transition to reporting the three eCQM/MIPS CQMs by all ACOs in

performance year 2024. CMS plans to increase the quality performance standard to the 40th percentile beginning with the 2024 performance year.

CMS proposes to add several codes to the list of primary care services, which is used to assign patients to the ACO. CMS also proposes to continue including CPT codes 99441-99445 in the list of primary care services until they are no longer payable under the MPFS.

CMS is proposing to lower the repayment mechanism amounts and to modify the methodology used for the annual repayment amount recalculation to use more recent data.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

CMS is proposing to permanently allow physicians to provide OUD therapy and counseling services using audio-only technology, when/if two-way video is not available to the beneficiary. CMS is also proposing that, during and after the PHE, OTPs will be required to indicate in a patient's medical record when and why a visit for substance use counseling or therapy was audio-only.

Requirement for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

CMS proposes to delay the compliance date for EPCS to January 1, 2023, due to concerns brought forward by prescribers. CMS also proposes to delay the compliance deadline for prescriptions written for beneficiaries in long-term care facilities to January 1, 2025.

Quality Payment Program (QPP)

CMS is proposing several changes to the traditional MIPS track of the QPP.

Quality category:

CMS is proposing to maintain the data completeness criteria threshold of 70 percent for the 2022 performance period and increase the data completeness criteria threshold to 80 percent for the 2023 performance period. CMS is seeking comment on a COVID-19 Vaccination by Clinicians measure.

Cost category:

CMS is proposing to add five new episode-based cost measures, including two chronic condition episodes (melanoma resection, colon and rectal resection, sepsis, asthma/chronic obstructive pulmonary disease, and diabetes).

Promoting Interoperability (PI) Category:

CMS proposes to maintain as optional the Query of Prescription Drug Monitoring Program measure and require reporting the Immunization Registry Reporting and Electronic Case Reporting measures. CMS also proposes to add a new Safety Assurance Factors for EHR Resilience Guides measure that would require an eligible clinician (EC) to attest to conducting an annual self-assessment using the High Priority Practice Guide.

Beginning with the 2022 performance period, CMS is proposing to no longer require a hardship exception application for clinicians and small practices seeking reweighting of the PI category. For small practices (15 or fewer ECs), CMS would automatically assign a weight of zero to the category and redistribute its weight to other performance categories.

Scoring Policies:

CMS is proposing to use performance period benchmarks for the quality category for the 2022 performance period. However, the agency is seeking feedback on an alternative to using historic benchmarks from the 2021 performance period (based on data from the 2019 performance period).

CMS proposes to remove the three-point floor for each measure that can be reliably scored against a benchmark and remove special scoring policies for measures that do not have a benchmark (except for small practices). Instead, they propose a new five-point floor for new measures in their first two years of the program. CMS is also proposing to remove bonus points for reporting high priority measures and for measures submitted using end-to-end electronic reporting.

CMS is proposing to modify the application of the complex patient bonus to better target ECs who treat a higher caseload of more complex and high-risk patients. The complex patient bonus will have a 10-point cap.

CMS is proposing for the 2024, 2025, and 2026 performance years to set the performance threshold at the mean final score of all MIPS ECs from a prior period. For the 2022 performance period, the performance threshold will be 75 points. The exceptional performance threshold will be 89 points.

The performance category weights for the 2022 performance period will be:

- Quality – 30%
- Cost – 30%
- Improvement Activities – 15%
- Promoting Interoperability – 25%.

The maximum payment adjustment will be ± 9 percent.

CMS also makes a variety of proposals to implement MIPS Value Pathways (MVPs). CMS is proposing to begin transitioning to MVPs in the 2023 MIPS performance year. MVP Participants are proposed to include individual clinicians, single specialty groups, multispecialty groups, subgroups, and alternative payment model entities that are assessed on an MVP for all MIPS performance categories. Beginning in the 2025 performance year, CMS proposes that multispecialty groups would be required to form subgroups to report MVPs.

MVPs are designed to allow for a more cohesive participation experience by connecting activities and measures from the four MIPS performance categories that are relevant to a specialty, medical condition, or episode of care. MVPs would include the PI performance category and population health claims-based measures as foundational elements, along with relevant measures and activities for the quality, cost, and improvement activities performance categories.

To report an MVP, CMS proposes that an MVP Participant register for the MVP (and as a subgroup if applicable) between April 1 and November 30 of the performance year.

The seven proposed MVPs for the 2023 performance year align with the following clinical topics: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia.