CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF PROGRAM OPERATIONS
AND LOCAL ENGAGEMENT

Overview of the CY2022 Final Rules

GKC MGMA Webinar

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Office of Program Operations & Local Engagement

Local Engagement & Administration

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Agenda

- CY2022 Physician Fee Schedule (PFS)/Quality Payment Program (QPP) Final Rule
- CY2022 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule
- CY2022 Home Health and Hospice (HHH) Prospective Payment System Final Rule
- Resources
- Questions

https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/vaccination-regulation-enforcement-rule-imposing-vaccine-requirement-health-care-staff-medicare-and

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-22-04-ALL

DATE: **December 2, 2021**

TO: State Survey Agency Directors

FROM: Directors,
Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Vaccination Regulation: Enforcement of Rule Imposing Vaccine Requirement for Health Care Staff in Medicare- and Medicaid-certified Providers and Suppliers is Suspended so Long as Court Ordered Injunctions Remain in Effect

Memorandum Summary

Survey and Enforcement of the Vaccine Requirement for Health Care Staff in Medicare- and Medicaid-certified Providers and Suppliers Suspended While Court Ordered Injunctions are in Effect: The Centers for Medicare & Medicaid Services (CMS) will not enforce the new rule regarding vaccination of health care workers or requirements for policies and procedures in certified Medicare/Medicaid providers and suppliers (including nursing facilities, hospitals, dialysis facilities and all other provider types covered by the rule) while there are court-ordered injunctions in place prohibiting enforcement of this provision.

CY 2022 Physician Fee Schedule Final Rule

CY 2022 PFS Ratesetting and Conversion Factor

With the budget neutrality adjustment to account for changes in RVUs (required by law), and expiration of the 3.75 percent payment increase provided for CY 2021 by the Consolidated Appropriations Act, 2021 (CAA), the CY 2022 PFS conversion factor is $33.58, a decrease of $1.31 from the CY 2021 PFS conversion factor of $34.89.

Telehealth Services Under the PFS

- Certain services added to the Medicare telehealth services list will remain on the list through December 31, 2023
- Extends inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023
- Permanently adopts coding and payment for HCPCS code G2252 as described in the CY 2021 PFS final rule to describe a “virtual check-in” that involves 11-20 minutes of medical discussion to determine whether an in-person visit is necessary

Telehealth Services Under the PFS

- Implementing Section 123 of the Consolidated Appropriations Act (CAA)
  - Removes geographic restrictions and adds the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a **mental health disorder**
  - Requires an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service
- Finalizes that an in-person, non-telehealth visit must be furnished at least every 12 months for these services

Telehealth Services Under the PFS

- Amends the current definition for interactive telecommunications system for telehealth services
- Limits the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.
- Requires use of a new modifier for services furnished using audio-only communications

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

- Allows RHCs and FQHCs to report and receive payment for mental health visits furnished via telehealth in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of or does not consent to the use of video technology.

- Payment for attending physician services furnished by RHCs and FQHCs to hospice patients

- Concurrent billing for chronic care management services (CCM) and transitional care management (TCM) services

Evaluation and Management (E/M) Visits

- For split (or shared) E/M visits we established:
  - Definition of split (or shared) visits as E/M visits provided in the facility setting by a physician and an NPP in the same group.
  - By 2023, the substantive portion of the visit will be defined as more than half of the total time spent. For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time).
  - Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

Evaluation and Management (E/M) Visits

- Critical Care Services, we established:
  - When medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and critical care services can be furnished as split (or shared) visits.
  - Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if certain conditions are met.
  - 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.

Evaluation and Management (E/M) Visits

Regarding teaching physician services, we finalized the following:

- That the time spent by the teaching physician in qualifying activities, including time that the teaching physician was present with the resident performing those activities, can be included for purposes of visit level selection

- That under the primary care exception, only Medical Decision-Making (MDM) may be used to select the E/M visit level

Electronic Prescribing of Controlled Substances

- Implements the second phase of Section 2003 of the SUPPORT Act requiring electronic prescribing of controlled substances (EPCS) for schedule II, III, IV, and V controlled substances covered under Part D
- Phase 1 implemented in December 2020 – named the standard prescribers must use for EPCS transmissions
- CY22 PFS Final Rule finalized certain exceptions to the EPCS requirement
- Delaying start date for compliance actions to January 1, 2023

Vaccine Administration Services and COVID-19 Monoclonal Antibody Products

- Increases Medicare Part B payment rates for influenza, pneumococcal, and hepatitis B vaccine administration from roughly $17 to $30
- Maintains the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends
- Continues the additional payment of $35.50 for COVID-19 vaccine administration in the home under certain circumstances through the end of the calendar year in which the PHE ends
- Sets the payment rate for COVID-19 vaccine administration at a rate to align with the payment rate for the administration of other Part B preventive vaccines (effective January 1 of the year following the year in which the PHE ends)
- Effective January 1 of the year following the year in which the PHE ends, CMS will pay physicians and other suppliers for COVID-19 monoclonal antibody products as biological products paid under section 1847A of the Act

Medicare Diabetes Prevention Program Expanded Model Policy Changes

- Waives the provider enrollment Medicare application fee for all organizations that submit an application to enroll in Medicare as an MDPP supplier on or after January 1, 2022.
- Shortens the MDPP services period to one year by removing the Ongoing Maintenance sessions phase (months 13-24) of the MDPP set of services for beneficiaries starting MDPP on or after January 1, 2022.
- Redistributes all of the Ongoing Maintenance sessions phase performance payments to certain Core and Core Maintenance Session performance payments.

Other PFS Provisions

- For physician assistant (PA) services, we are implementing section 403 of the CAA which authorizes Medicare to make direct payment to PAs for professional services they furnish under Part B

- Finalized the start date for implementation of the Appropriate Use Criteria (AUC) program to be the late of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19.

- Completes implementation of section 53107 of the Bipartisan Budget Act of 2018, which requires CMS to identify and make payment at 85 percent of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants and occupational therapy assistants – when appropriately supervised by a physical therapist or occupational therapist respectively

CY 2022 Quality Payment Program Final Rule

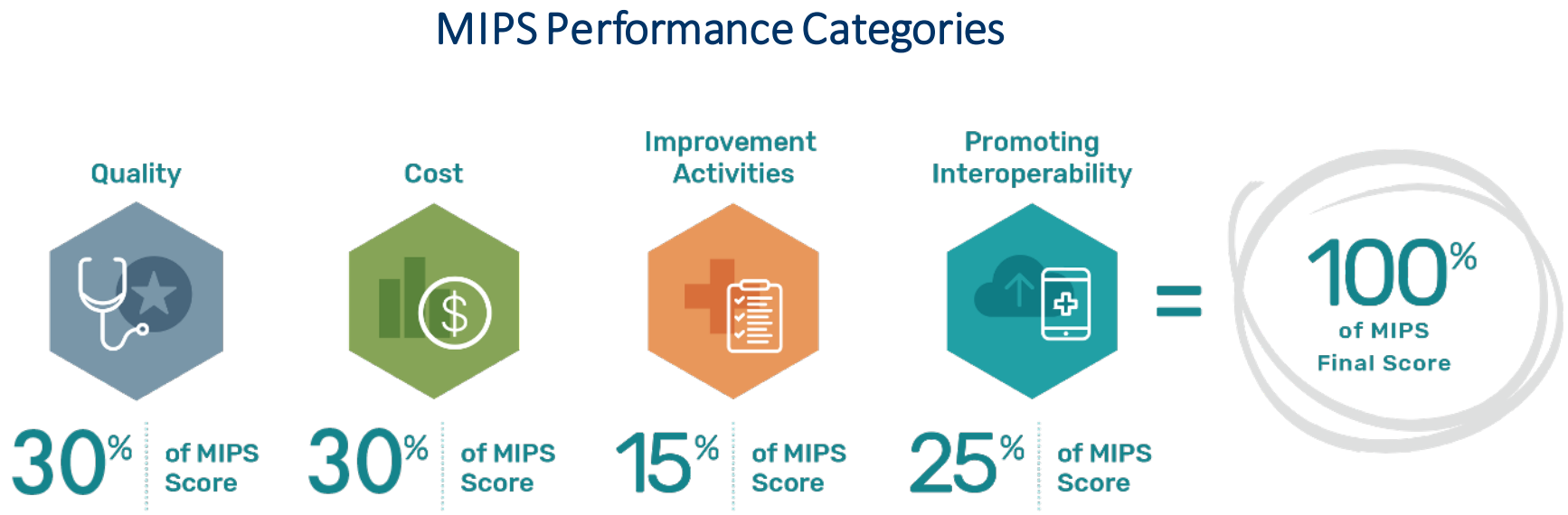
Rule Highlights for the 2022 Performance Year

- Revising definition of MIPS eligible clinician to include **social workers and certified nurse-midwives**
- Setting MIPS performance threshold at **75** points and exceptional performance threshold at 89 points
- Weighting cost and quality performance categories equally (as statutorily required) at **30%**
- Revising quality scoring policies, including introduction of a floor for new measures (7 points for first year, 5 points for second year) and removal of outcome/high priority measure bonus points and end-to-end electronic reporting bonus points
- Extending CMS Web Interface in traditional MIPS for 2022 performance year only
- Added 5 new episode-based cost measures to the cost performance category
- Added 7 new and modified 15 current improvement activities
- Redistribution of final scoring for small practices

Rule Highlights for the 2022 Performance Year

- Finalizing **7** MIPS Value Pathways (MVPs) that will be available, beginning with 2023 performance year (PY)
- Providing description of registration process and timeline for MVP and subgroup registration, beginning with PY 2023
    - Multispecialty groups required to form subgroups in order to report MVPs starting with PY 2026
- Starting with PY 2023, the 3-point floor for quality measures that 1) can be scored against a benchmark, 2) don't have a benchmark, and 3) don't meet case minimum will be removed
- Will continue to double the complex patient bonus available for the performance year 2021

Performance Category Weights – Traditional MIPS



MIPS scoring is comprised of **4** performance categories

The points from each performance category are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

2022 Traditional MIPS – Performance Threshold and Payment Adjustments

2021 Final

Final Score 2021	Payment Adjustment 2023
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
60.01-84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
60 points	• Neutral payment adjustment
15.01-59.99 points	• Negative payment adjustment greater than -9% and less than 0%
0-15 points	• Negative payment adjustment of -9%

2022 Final

Final Score 2022	Payment Adjustment 2024
≥89 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
75.01-88.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment greater than -9% and less than 0%
0-18.75 points	• Negative payment adjustment of -9%

The 2022 performance year/2024 payment year is the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

Medicare Shared Savings Program

2022 - 2024 Performance Years	2025 and Subsequent Performance Years
An ACO must report on either the 10 CMS Web Interface measures (Diabetes: Hemoglobin A1c (HbA1c) Poor Control, Preventive Care and Screening: Screening for Depression and Follow-up Plan, Controlling High Blood Pressure, Falls: Screening for Future Fall Risk, Preventive Care and Screening: Influenza Immunization, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, Colorectal Cancer Screening, Breast Cancer Screening, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease and Depression Remission at Twelve Months) or the 3 eCQM/MIPS CQMs (Diabetes: Hemoglobin A1c (HbA1c) Poor Control, Preventive Care and Screening: Screening for Depression and Follow-up Plan and Controlling High Blood Pressure). An ACO must administer a CAHPS for MIPS survey. CMS will calculate 2 measures using administrative claims data (Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups and Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCC) for MIPS). Based on the ACO's chosen reporting option, either 6 (3 eCQM/MIPS CQMs, 1 CAHPS for MIPS Survey measure, and 2 administrative claims-based measures) or 10 (7 CMS Web Interface measures, 1 CAHPS for MIPS Survey measure, and 2 administrative claims-based measures) measures will be included in calculating the ACO's quality performance score.	An ACO must report the 3 eCQM/MIPS CQMs and administer a CAHPS for MIPS survey. CMS will calculate 2 measures using administrative claims data. All 6 measures will be included in calculating the ACO's quality performance score.

Medicare Shared Savings Program

2022 and 2023 Performance Years	2024 and subsequent Performance Years
An ACO **will** meet the quality performance standard if it: • Achieves a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, or • If the ACO reports the 3 eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements for all 3 measures) and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least 1 of the 5 remaining measures in the APP measure set An ACO won't meet the quality performance standard if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey.	An ACO **will** meet the quality performance standard if it: • Achieves a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring An ACO won't meet the quality performance standard if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey.

CY 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule

OPPS/ASC Payment System Final Rule

- Updated OPPS payment rates by 2 percent
  - Based on the projected hospital market basket increase of 2.7 percent reduced by 0.7 percentage point for the productivity adjustment
  - Using CY 2019 claims data to set payment system rates
- Adopted 3 new measures for the Hospital Outpatient Quality Reporting (OQR) Program

Radiation Oncology Model

- The Radiation Oncology (RO) Model aims to improve the quality of care for cancer patients receiving radiotherapy (RT) and move toward a simplified and predictable payment system.

- Tests whether prospective, site neutral, modality agnostic, episode-based payments to physician group practices (PGPs), hospital outpatient departments (HOPD), and freestanding radiation therapy centers for RT episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

- The Consolidated Appropriations Act, 2021 (H.R. 133) enacted on December 27, 2020 included a provision that prohibited implementation of the RO Model prior to January 1, 2022.

- Several modifications in the CY22 OPPS/ASC Final Rule including:
  - The baseline period is 2017-2019 rather than 2016-2018
  - The five-year model performance period now ends on December 31, 2026
  - There is a 3.5% professional component discount and a 4.5% technical component discount

CY 2022 Home Health Prospective Payment System Final Rule

Provider Enrollment

- Largely regulatory codification of long-standing subregulatory guidance.
- Added § 424.522 that specifies that a reassignment of benefits under § 424.80 is effective beginning 30 days before the Form CMS-855R is submitted, if all applicable requirements during that period were otherwise met.
- § 424.522(b) specifies that the effective date of a Form CMS-855O enrollment is the date on which the Medicare contractor received the Form CMS-855O application, if all other requirements are met.
- Clarified that § 424.525 applies to all CMS provider enrollment application submissions, including initial applications, CHOWs, revalidations, reactivations, & EFT agreements. – i.e. rejections apply to currently enrolled providers, not just new applicants.
- Established § 424.526 which codifies Program Integrity Manual guidance on when provider enrollment applications will be returned and the return process.
- Added ten (10) additional reasons for provider enrollment application rejection under § 424.525(a).

Provider Enrollment - Deactivation

- Modified § 424.540(a) to add five (5) additional grounds for provider deactivation. Currently there are (3) reasons for provider deactivation.

- Revised § 424.540(b)(1) to state that for a deactivated provider or supplier to reactivate its Medicare billing privileges, the provider or supplier must recertify that its enrollment information currently on file with Medicare is correct, furnish any missing information as appropriate, and be in compliance with all applicable enrollment requirements in title 42.

- In new § 424.540(e), a provider or supplier may not receive payment for services or items furnished while deactivated under § 424.540(a). CMS previously allowed some payment retroactively for deactivated period.

- Modified the regulations such that effective date of a deactivation is the date on which the deactivation is imposed. CMS may apply a retroactive deactivation effective date--based on the date that the provider's or supplier's action or non-compliance occurred or commenced (as applicable).

Other Home Heath Final Rule Provisions

- Pursuant to the CARES Act, allowed licensed practitioners may establish and review home health plan of care. Previously, this function was limited to physicians

Resources

PFS Final Rule Resources

CMS Press Release – Medicare Physician Fee Schedule Final Rule
https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs

CMS Fact Sheet – Medicare Physician Fee Schedule Final Rule
https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

CMS Fact Sheet – Final Policies for the MDPP Expanded Model
https://www.cms.gov/newsroom/fact-sheets/final-policies-medicare-diabetes-prevention-program-mdpp-expanded-model-calendar-year-2022-medicare

Final Rule
https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

Quality Payment Program Resources

QPP 2022 Final Rule Resources Zip File
(Click on link above)

Overview Fact Sheet: Offers an overview of the QPP Final Rule policies for the 2022 performance year.
Policies Comparison Table: Compares the final 2022 performance year policies to the requirements for the 2021 performance year.
MVP Policies Table: Provides an overview of the policies for implementation of MVPs beginning in the 2023 performance year.
Frequently Asked Questions (FAQs): Addresses the FAQs for the 2022 QPP Final Rule policies.

Electronic Code of Federal Regulations, Subpart O
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-O

OPPS/ASC Final Rule Resources

CMS CY 2022 OPPS/ASC Final Rule:
https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

CMS Newsroom Fact Sheet:

CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC) | CMS

Home Health PPS Rule Resources

Fact Sheet:

https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-calendar-year-2022-home-health-prospective-payment-system-rate-update-home-health

Final Rule:

https://www.federalregister.gov/documents/2021/11/09/2021-23993/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home

Questions?

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