

Medicare Physician Fee Schedule Final Rule for Calendar Year 2022 Detailed Summary of the Payment and Quality Payment Program Provisions

The American College of Radiology (ACR) has prepared a detailed summary of final changes to the payment provisions of the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2022. This summary also includes policies for implementation of the sixth year for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Changes will be effective Jan. 1, 2022.

Conversion Factor and CMS Overall Impact Estimates (Page 1816)

The CY 2022 conversion factor will be \$33.5983 compared to the 2021 conversion factor of \$34.8931. CMS estimates an overall impact of the MPFS changes to radiology to be a 1 percent decrease, while interventional radiology would see an aggregate decrease of 5 percent, nuclear medicine a 1 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease. Part of the decrease is due changes in RVUs, redistributive effects of the CMS proposed clinical labor pricing update, and phase-in implementation of the previously finalized updates to supply and equipment pricing.

The Consolidated Appropriations Act, 2021 (P.L.116-260) included a 3.75 percent adjustment to the 2021 conversion factor which rolled back the payment cuts to radiologists. If Congress does not intervene, the percent decreases mentioned above could be greater for CY 2022 for many physicians including radiology.

Appropriate Use Criteria for Advanced Diagnostic Imaging (Page 661)

Background and Overview

The Protecting Access to Medicare Act of 2014 included a provision for the mandatory use of appropriate use criteria (AUC) for advanced diagnostic imaging services. The program was initially slated to begin on January 1, 2017, but faced a series of setbacks as CMS has gone through the rulemaking process to lay out the details of AUC program implementation. An “educational and operations testing period” began on January 1, 2020, and was extended through the end of 2021 due to the COVID-19 public health emergency (PHE).

Through the CY 2016 rulemaking process, CMS addressed the initial component of the AUC program, specifying applicable AUC. CMS established a process for the development of AUC, defined provider-led entities (PLEs), and established the process by which PLEs may become qualified to develop AUC. The first list of [qualified PLEs](#) was posted on the CMS website in late June 2016 and the list is updated annually.

The CY 2017 MPFS final rule identified the requirements clinical decision support mechanisms (CDSMs) must meet for qualification including an opportunity for preliminary qualification for mechanisms still working toward full adherence, and established a process by which CDSMs

may become qualified. The first list of [qualified CDSMs](#) was posted to the CMS website in conjunction with the CY 2017 proposed rule and the list is updated annually.

CMS also defined applicable payment systems under this program (MPFS, Hospital Outpatient Prospective Payment System (HOPPS), and Ambulatory Surgical Center (ASC) payment system), specified the first list of priority clinical areas for the identification of outlier ordering professionals, and identified exceptions to the requirements that ordering professionals consults specified applicable AUC when ordering applicable imaging services. In the CY 2019 MPFS final rule, independent diagnostic testing facilities (IDTFs) were added to the definition of applicable settings.

The CY 2018 MPFS final rule addressed consultation and reporting requirements. In this rule, CMS established a program start date of January 1, 2020, beginning with a one year “educational and operations testing period”. CMS specified that for services ordered on or after this date, ordering professionals must consult specified applicable AUC using a qualified CDSM when ordering applicable imaging services, and furnishing professionals must report AUC consultation information on the Medicare claim. CMS specified that during the testing period, claims would not be denied for failure to include proper AUC consultation information. In addition, CMS established a voluntary reporting program from July 2018 through the end of 2019. Consultation of AUC using a qualified CDSM was designated as a high-weight improvement activity for ordering professionals for MIPS beginning January 1, 2018.

When the AUC program is fully implemented, the following information must be included on all claims for applicable advanced diagnostic imaging services:

1. The qualified CDSM consulted by the ordering professional;
2. Whether the service ordered would or would not adhere to specified AUC, or whether the specified applicable AUC consulted was not applicable to the service ordered; and
3. The NPI of the ordering professional.

Detailed claims processing [instructions](#) are published on the CMS website.

CMS will use future rulemaking to establish the methodology for the identification of outlier ordering professionals who would eventually be subject to a prior authorization process when ordering advanced diagnostic imaging services.

Timing of Payment Penalties

The AUC program was scheduled to enter the payment penalty phase on January 1, 2022. However, CMS recognizes the circumstances of physicians and other practitioners due to the PHE for COVID-19 and that additional time may be needed to prepare for the payment penalty phase. The earliest the CMS claims processing system can begin screening claims using the AUC program claims processing edits for the payment penalty phase is October 2022. CMS notes that an effective date for the claims processing edits in October is not aligned with typical annual updates to the systems used by healthcare providers. Therefore, the earliest practicable

effective date for the AUC program claims processing edits and payment penalty phase is January 1, 2023.

CMS finalized a flexible effective date for the AUC program payment penalty phase to begin the later of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19.

CMS acknowledges that the AUC program has been significantly delayed and that some practitioners and institutions have already invested in qualified CDSMs while others have had to redirect resources due to the PHE.

Proposed Clarification of AUC Program Scope

Modified Orders

CMS acknowledges that updates or modifications to orders for imaging services may be necessary in certain situations once the beneficiary is under the care of the furnishing professional. The AUC program does not allow furnishing professionals to consult AUC on behalf of or in place of the ordering professional. Chapter 15, sections 80.6.1-4 addresses situations where the furnishing professional performs imaging services that are different from ordered services. The rules state that a different or additional imaging service not included on the order generally may not perform the test until a new order from the treating physician/practitioner has been received. If the treating physician/practitioner cannot be reached, the furnishing physician or testing facility may perform the additional services under the following conditions as documented in the patient's medical record:

- The treating physician/practitioner could not be reached,
- The ordered test is performed and an additional diagnostic test is medically necessary because of the abnormal result of that test,
- Delaying performance of the additional test would have an adverse effect on the patient's care,
- The result of the additional test is communicated to and used by the treating physician/practitioner in the patient's treatment, and
- The interpreting physician documents in the report the reasons for the additional testing.

CMS finalized its proposal that when the furnishing professional for an advanced diagnostic imaging service performs one or more additional services under the above circumstances, neither the ordering professional nor the furnishing professional are required to consult AUC for the additional service(s). In these situations, the furnishing professional would report the AUC consultation information from the original order on the claim for the additional service(s). Similarly, if the furnishing professional modifies the order for an advanced diagnostic imaging service without obtaining a new order from the ordering professional, the AUC consultation information provided by the ordering professional with the original order should be reported on the claim.

In response to comments received, CMS may consider in future rulemaking whether an additional modifier should be appended to all modified orders (additional and/or revised) for which new orders are not submitted by the original ordering professional to ensure that furnishing professionals are not furnishing advanced diagnostic imaging services unilaterally and without the acknowledgement of the ordering professional.

Extreme and Uncontrollable Circumstances Hardship Exception

In the CY 2019 final rule, CMS describes the extreme and uncontrollable hardship exception as including natural or man-made disasters that have a significant impact on healthcare operations, area infrastructure or communication systems. CMS acknowledges that stakeholders have endured challenges in continuing to prepare for the payment penalty phase of the AUC program due to the COVID-19 PHE. **CMS finalized the proposal that stakeholders may attest to a significant hardship exception for the AUC program due to COVID-19 throughout the PHE. When the AUC program progresses into the payment penalty phase, this option will continue to be available for ordering professionals beyond the date the PHE expires.**

Other Comments on Exceptions

CMS received comments requesting that CMS align the AUC program hardship exceptions with the Quality Payment Program (QPP) hardship exceptions and allow providers to attest annually to the hardship rather than include a modifier on every claim. CMS responded that as the AUC program requires real time reporting of information as opposed to a retrospective review of data, applying a blanket waiver for a certain period of time would not work.

CMS also received other comments asking for additional exceptions including new providers and providers in value-based care. CMS responded that it does not have the authority to add additional exceptions for the AUC program.

Second Opinions

In response to comments received requesting clarification, CMS stated that they believe the AUC consultation and reporting requirements apply to second opinions in the same way they apply to original patient assessments and resulting orders for advanced diagnostic imaging. The AUC consultation information specific to the original order should be submitted with PC claims for second opinions. If further imaging must be ordered as a result of the second opinion, the new orders would require an additional AUC consultation.

Claims Processing

CMS has encountered a number of operational and administrative issues with reporting and processing claims containing AUC consultation information. The Agency's main concern is ensuring that only appropriate claims are subject to AUC claims processing edits so claims are not inappropriately denied during the penalty phase. CMS acknowledges that inappropriate denials would disproportionately impact radiologists, hospital outpatient departments and freestanding imaging centers. A review of CY 2020 Medicare claims estimates that approximately 9-10 percent of all claims subject to the AUC program reported information sufficient to be considered compliant with the program (noting that the AUC program is in the

educational and operations testing period). An additional 6-7 percent of claims subject to the AUC program included some relevant information, demonstrating an awareness of the AUC program.

Ordering Professional NPI

There are locations on both the practitioner and institutional claim types to report the NPI of the ordering professional. The institutional claim uses the K3 segment and the practitioner claim uses the referring professional field. In order to fully implement the AUC program, CMS must establish a claims processing edit to require these fields to be populated on all advanced diagnostic imaging claims subject to the AUC program.

In addition, there currently are situations in which multiple advanced diagnostic imaging services ordered by more than one ordering professional may be reported on a single claim. This would not be workable for purposes of reporting AUC consultation information because the referring professional field is reported at the claim-level and not at the claim line- or service-level for professional claims. Therefore, the furnishing professional will need to submit separate claims for the services ordered by each referring or ordering professional since only one ordering professional can be reported per claim.

A commenter pointed out to CMS that the 837P form does allow the ordering professional to be identified at the line level. After reviewing the comment, CMS agreed and clarified that 837P claims for multiple imaging exams ordered by multiple ordering professionals will not be required to be submitted separately. CMS will move forward with developing claims processing instructions to allow more than one ordering practitioner to be identified on a single claim form.

Critical Access Hospitals

Imaging services furnished in an outpatient department of a critical access hospital (CAH) are not subject to the AUC program. Generally, all claims for advanced diagnostic imaging services, both the professional component (PC) and technical component (TC), must include the AUC consultation information when they are furnished both in an applicable setting and paid under an applicable payment system. When advanced diagnostic imaging services are performed in the CAH setting, this is not an applicable setting and as such, neither the PC nor TC claim is required to include AUC consultation information.

CMS finalized its proposal that claims submitted by physicians or practitioners for the PC of an advanced diagnostic service when the TC was not furnished in an applicable setting would not be subject to the AUC program. There is currently not a systems-based way for CMS to recognize a PC claim that was performed in a CAH. Place of service codes reported on practitioner claims are not specific enough. Therefore, **CMS finalized its proposal to establish a separate HCPCS modifier that will be used to identify practitioner claims for advanced diagnostic imaging services that are not subject to the AUC program and that are not otherwise identified using the other AUC program modifiers designated to identify specific situations where the claims are not subject to the AUC program.** CMS will continue to

explore ways to automate an edit in the claims processing system to identify CAH claims so that reporting a modifier on these PC claims would no longer be necessary.

In response to a comment received, CMS does not believe ordering professionals that order advanced diagnostic imaging services from a CAH qualify for an exception to the AUC mandate.

Maryland Total Cost of Care Model

Similarly to the CAH issue described above, if both the PC and TC for advanced diagnostic imaging services are not paid under an applicable payment system, neither the PC nor TC claim is required to include AUC consultation information. **Advanced diagnostic imaging services furnished in outpatient departments of Maryland hospitals that participate in the Hospital Payment Program within the Maryland Total Cost of Care Model are not subject to the AUC program because these services are not paid under an applicable payment system.**

CMS believes they can identify all institutional claims from a hospital that is paid under the Hospital Payment Program within the Maryland Total Cost of Care Model based on their CMS Certification Number (CCN) and allow those claims to bypass AUC program claims processing edits. The Agency understands that when the TC and PC of advanced diagnostic imaging services are billed separately, the professional claim must identify in box 32 the location where the TC of the imaging service was furnished to the patient. Therefore, CMS will have the ability to identify situations in which the imaging service was furnished in a hospital that is paid under the Hospital Payment Program within the Maryland Total Cost of Care Model and exclude those claims from being subject to AUC program claims processing edits. This can be accomplished by using the CCN and CMS will continue to work to determine if a list of CCNs can be used as the source of our edits in addition to determining the frequency that the list will be updated.

Note that advanced diagnostic imaging services performed in hospital outpatient departments of hospitals in the state of Maryland that bill under the HOPPS are subject to the AUC program.

CMS received a comment expressing concern that excluding outpatient hospital departments that bill under the Maryland Total Cost of Care Model from the AUC mandate gives such providers a competitive advantage over non-hospital entities such as imaging centers and IDTFs. The commenter requested that all Maryland ordering professionals be excluded from the AUC consultation requirement. CMS responded that it does not have the authority to exempt all Maryland providers.

Inpatients Converted to Outpatients

There are uncommon situations where a beneficiary's hospital inpatient status is changed to outpatient. If the criteria for this to occur are met, condition code 44 (inpatient admission changed to outpatient) is appended to the institutional claim. CMS finalized its proposal to allow institutional claims with condition code 44 to bypass AUC claims processing edits. Professional claims in this situation would include place of service code 21 (inpatient hospital) since the expectation, until just prior to discharge, would be that the patient is an inpatient status.

Deny or Return Claims that Fail AUC Claims Processing Edits

Once the penalty phase of the AUC program begins, claims that do not properly include AUC consultation information will not be paid. CMS considered in the proposed rule whether claims that do not pass the AUC claims processing edits should be initially returned to the health care provider so they can be corrected and resubmitted, or should be denied so they can be appealed. CMS requested comments to help them better understand which path would be most appropriate once the program is fully implemented. The ACR supported returning claims to providers to be corrected and resubmitted.

After consideration of comments received, **CMS decided to at least initially return claims for correction and resubmission when the payment penalty phase begins.** CMS will revisit whether claims denials are appropriate at some point in the future once practitioners become more comfortable with the requirements.

Medicare as a Secondary Payer

CMS heard from stakeholders that in some electronic health records (EHRs), the primary payer information is readily available and known to the ordering professional, but secondary payer information is not typically available. In addition, in many cases where Medicare is the secondary payer, no Medicare payment is made after the primary payer makes payment. Medicare is reported as a secondary payer in approximately 1.5 percent of advanced diagnostic imaging claims that are subject to the AUC program. **CMS finalized its proposal to exclude claims that identify Medicare as the secondary payer from the AUC program.**

Date of Service and Date of Order

Medicare claims include a date of service, but not the date of an imaging order. **CMS finalized its proposal that the AUC program claims processing edits for the payment penalty phase will be applicable for advanced diagnostic imaging services furnished on or after the effective date of the AUC program. For imaging services ordered prior to, but furnished on or after the effective date, the furnishing professional would apply the separate HCPCS modifier described in the CAH section of the rule to indicate that the claim is not subject to the AUC program.**

Some commenters requested that CMS begin the penalty phase with a “grace period” for these circumstances, however, CMS responded that they would not do this as it would essentially extend the educational and operations testing period further.

HCPCS Modifiers

CMS has established two sets of modifiers for the AUC program. The first set is to be included on the same claim line as the G-code identifying the CDSM that was consulted and reports whether or not the imaging service adheres to the AUC.

- Modifier ME – Imaging service adheres to the AUC
- Modifier MF – Imaging service does not adhere to the AUC
- Modifier MG – The qualified CDSM does not contain AUC that applies to the order

The second set of HCPCS modifiers is available for use when the ordering professional does not consult a qualified CDSM. These claims would not include a G-codes for a CDSM since there was no consultation and as such, the modifier would be included on the same line as the procedure code for the imaging service that was performed.

- Modifier MB – Insufficient internet access
- Modifier MC – EHR or CDSM vendor issues
- Modifier MD – Extreme and uncontrollable circumstances
- Modifier MA – Patients with a suspected or confirmed emergency medical condition

Modifier QQ was created for use during the voluntary reporting period before more detailed modifiers and codes were created. This modifier continues to be available for use through the educational and operations testing period, but CMS intends to end the use of that modifier when the penalty phase begins.

Modifier MH was created for use during the educational and operations testing period to identify claims for which AUC consultation information was not provided to the furnishing professional and facility. When the AUC program enters the penalty phase, this modifier will no longer be available since all claims will be required to include AUC consultation or a specific reason the information is not required. Beginning for services furnished on and after the effective date of the penalty phase of the AUC program, CMS proposed to redefine modifier MH to describe situations in which the ordering professional is not required to consult AUC (e.g. CAH claims and Maryland Total Cost of Care Model).

In response to comments received requesting that the MH modifier continue to be available to report situations where the ordering professional did not provide AUC consultation information to the rendering provider, CMS stated that the statute does not allow for use of such a modifier for failure to comply with the mandate. CMS will therefore fully retire modifier MH when the payment penalty phase begins and will create a new modifier to describe situations where the ordering professional is not required to consult AUC.

In response to concerns raised about imaging providers being penalized for the inaction of referring providers, CMS stated that it does not have the authority to modify or mitigate the AUC consultation requirements. CMS will continue to work on education and outreach and explore opportunities to update and expand written outreach materials.

In response to comments received requesting clarification and additional regulatory language on the emergency exception, CMS stated that given the clarifications previously communicated through rulemaking in the CY 2017 and 2019 final rules, they disagree that the regulatory text for the emergency services exception requires additional clarification. CMS also stated that it does not have the authority to completely exempt emergency department services from the AUC mandate.

Additional Claims Processing Information

For institutional claims, CMS finalized its proposal to limit AUC program claims processing edits to apply only to type of bill 13x (hospital outpatient). This claim type code encompasses the hospital outpatient department and the emergency department which represent all applicable settings under the program that would bill Medicare using institutional claims.

For practitioner claims, CMS finalized its proposal to limit the edits to claims with place of service codes 11 (office), 15 (mobile unit), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital), 23 (emergency room) and 24 (ASC). These place of service codes should encompass all applicable settings under the AUC program. Because these type of bill and place of service codes reflect the applicable settings within which advanced diagnostic imaging services must be furnished to be subject to the AUC program requirements, CMS believes setting these parameters will allow them to more accurately pay claims while avoiding the need for other types of professionals and facilities to append modifiers to their claims.

Additional Comments

CMS received many comments requesting that the AUC consultation program for advanced diagnostic imaging services continue to be delayed indefinitely and/or that the program be abandoned altogether. CMS responded that as the program is required by statute, it must implement the program within the bounds of its statutory authority. CMS will continue to explore opportunities for reducing the burden of the AUC program by leveraging other quality programs within the provisions set forth in statute.

Information on the imaging AUC program will continue to be posted on the CMS website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program>).

Billing for Physician Assistant (PA) Services (pg. 476)

Historically, nurse practitioners (NPs) and clinical nurse specialists (CNSs) have been authorized to bill the Medicare program and be paid directly for their professional services, while payment for PA services had to be made to the PA's employer. The payment amount for the services of PAs, NPs, and CNSs is equal to 80 percent of the lesser of the practitioner's actual charge or 85 percent of the amount that would be paid to a physician under the PFS. The regulation also specifies that a group of PAs that incorporate to bill for their services is not a qualified employer. Given the statutory requirement that CMS make payment to the PA's employer, PAs are precluded from directly billing the Medicare program and receiving payment for their services, and do not have the ability to reassign Medicare payment rights for their services to any employer, facility, or billing agent.

The Consolidated Appropriations Act (CAA) of 2021 made amendments to remove the requirement to make payment for PA services only to the employer of a PA effective January 1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that NPs and CNSs do. In the CY 2022 MPFS propose rule, CMS proposed to amend pertinent sections of their regulations to reflect the

amendment made by section 403 of the CAA. CMS finalized policy to amend § 410.74(a)(2)(v) to specify that the current requirement that PA services must be billed by the PA's employer in order to be covered under Medicare Part B is effective only until January 1, 2022. CMS will update their program manual instructions to reflect the statutory change made by section 403 of the CAA and the changes to these regulations.

CMS addressed commenters concerns that this change would result in the diminishing of physician-led teams. CMS stated they do not anticipate that this change will impact the participation of NPPs as vital team members of physician-directed-team care models, or otherwise diminish the quality of health care furnished to Medicare beneficiaries. Medicare law still requires PA services to be furnished under the supervision of a physician and PA services are covered only when furnished in accordance with State law and scope of practice rules. CMS has finalized all their proposed policies and will implement section 403 of the CAA.

Clinical Labor Pricing Update (Page 64)

CMS is finalizing their proposal to update the clinical labor pricing, phasing it in over four years from 2022-2025. The prices for clinical labor had not been updated since 2002. However, CMS has been phasing in updates to the pricing for medical supplies and equipment since 2019, with 2022 being the final transition year for those inputs. With this, CMS feels it is appropriate to begin phasing in the updates to the clinical labor pricing in 2022, as some stakeholders had expressed concern about the last update being 20 years ago and that CMS's clinical wage data does not reflect the current labor rate. There was also concern about distortions within the allocation of direct practice expense (PE), with only two of the components being updated. Practice expense is budget neutral; therefore, changes to one of the components affects the others.

CMS will be using the 2019 Bureau of Labor Statistics (BLS) data to update the clinical labor pricing, stating that it is the most accurate source available. If data is not available for a specific staff type, CMS will crosswalk or extrapolate the wages using other sources, such as Salary Expert, and stakeholder feedback solicited during the proposed rule comment period. All of the clinical staff types will reflect an increased rate over the previous 2002 pricing. As a result of budget neutrality, the increases in clinical labor pricing will decrease reimbursement for specialties, such as Interventional Radiology, Radiation Oncology, and Vascular Surgery, that carry more of their PE costs in supplies and equipment.

CMS received mixed responses from stakeholders, with many supporting the four-year phase-in for the pricing update, while other stakeholders opposed implementation, citing potential negative impacts to patient access to care and the current struggles faced by practices due to continuing impacts of the COVID-19 public health emergency and the 3.75 percent reduction in the conversion factor. It was also suggested that CMS wait until the supplies and equipment pricing update was fully implemented or changes to the PE methodology are fully explored. Additionally, several stakeholders proposed methodological changes for consideration, including adjusting the direct scaling factor, which ensures budget neutrality in the PE, spreading the cost of the clinical labor update across both the direct and indirect PE pools, or even waiving budget

neutrality. CMS disagreed with the proposed changes, stating that they were inappropriate. Budget neutrality is a statutory requirement, and the other suggestions constitute changes to the PE methodology which is not something they are proposing at this time. However, the RAND corporation is currently reviewing the PE methodology for potential improvements.

Other suggestions from stakeholders that CMS was receptive to include: using the median BLS wage data instead of the mean wage data to be consistent with the median statistic used for clinical staff time, and applying the 2019 fringe benefits multiplier instead of the 2002 benefits multiplier. CMS agreed with stakeholders that they should update the pricing of the PE inputs more regularly to ensure accuracy and avoid large adjustments in the future.

The table below displays the final clinical labor pricing for each of the staff types, with the “Updated Rate Per Minute” column showing the final price at the end of the four-year phase-in. Based on stakeholder feedback, several radiology-pertinent staff types were revised from CMS’s initial proposal. For example, the Angio Technician will now be crosswalked to the Lab Tech/Histotechnologist instead of Other Healthcare Practitioners and Technical Occupations, the Mammography Technologist will now be crosswalked to a Radiologic Technologist instead of a Respiratory Therapist, and the Medical Physicist wage will be based off of data submitted by the American Association of Physicists in Medicine (AAPM) instead of using the 75% BLS data for a general Physicist.

Labor Code	Labor Description	Current Rate Per Minute	Updated Rate Per Minute	Total % Change
L023A	Physical Therapy Aide	0.23	0.28	22%
L026A	Medical/Technical Assistant	0.26	0.36	38%
L030A	Lab Tech/MTA	0.30	0.46	53%
L032B	EEG Technician	0.32	0.44	38%
L033A	Lab Technician	0.33	0.55	67%
L033B	Optician/COMT	0.33	0.39	18%
L035A	Lab Tech/Histotechnologist	0.35	0.55	57%
L037A	Electrodiagnostic Technologist	0.37	0.44	19%
L037B	Histotechnologist	0.37	0.55	49%
L037C	Orthoptist	0.37	0.76	105%
L037D	RN/LPN/MTA	0.37	0.54	46%
L037E	Child Life Specialist	0.37	0.49	32%
L038A	COMT/COT/RN/CST	0.38	0.52	37%
L038B	Cardiovascular Technician	0.38	0.60	58%
L038C	Medical Photographer	0.38	0.38	0%
L039A	Certified Retinal Angiographer	0.39	0.52	33%
L039B	Physical Therapy Assistant	0.39	0.61	56%
L039C	Psychometrist	0.39	0.64	62%
L041A	Angio Technician	0.41	0.58	41%
L041B	Radiologic Technologist	0.41	0.63	54%
L041C	Second Radiologic Technologist for Vertebroplasty	0.41	0.63	54%
L042A	RN/LPN	0.42	0.63	50%
L042B	Respiratory Therapist	0.42	0.64	52%

L043A	Mammography Technologist	0.43	0.63	47%
L045A	Cytotechnologist	0.45	0.76	69%
L045B	Electron Microscopy Technologist	0.45	0.89	98%
L045C	CORF Social worker/Psychologist	0.45	0.70	56%
L046A	CT Technologist	0.46	0.76	65%
L047A	MRI Technologist	0.47	0.76	62%
L047B	REEGT (Electroencephalographic Tech)	0.47	0.76	62%
L047C	RN/Respiratory Therapist	0.47	0.70	49%
L047D	RN/Registered Dietician	0.47	0.70	49%
L049A	Nuclear Medicine Technologist	0.62	0.81	32%
L050A	Cardiac Sonographer	0.50	0.77	54%
L050B	Diagnostic Medical Sonographer	0.50	0.77	54%
L050C	Radiation Therapist	0.50	0.89	78%
L050D	Second Radiation Therapist for IMRT	0.50	0.89	78%
L051A	RN	0.51	0.76	49%
L051B	RN/Diagnostic Medical Sonographer	0.51	0.77	51%
L051C	RN/CORF	0.51	0.76	49%
L052A	Audiologist	0.52	0.81	56%
L053A	RN/Speech Pathologist	0.53	0.79	49%
L054A	Vascular Technologist	0.54	0.91	69%
L055A	Speech Pathologist	0.55	0.82	49%
L056A	RN/OCN	0.79	0.81	3%
L057A	Genetics Counselor	0.57	0.85	50%
L057B	Behavioral Health Care Manager	0.57	0.57	0%
L063A	Medical Dosimetrist	0.63	0.91	44%
L107A	Medical Dosimetrist/Medical Physicist	1.08	1.52	41%
L152A	Medical Physicist	1.52	2.14	41%

The anticipated final impacts as a result of the clinical labor update are zero percent for Nuclear Medicine and Radiology, a negative one percent decrease for Vascular Surgery and Radiation Oncology and Radiation Therapy Centers, and a negative two percent decrease for Interventional Radiology.

Establishment of Values for Remote Retinal Imaging (CPT code 92229), Comment Solicitation for Fractional Flow Reserve Derived from Computed Tomography (CPT code 0503T), and Comment Solicitation for Codes involving Innovative Technology (Page 106)

CMS acknowledges that newer, innovative technologies are emerging that are transforming—substituting and/or augmenting—physician work. However, some of the resource costs associated with these new technologies (software algorithms and artificial intelligence) are not easily captured within the current PE methodology. CMS considers most computer software and licensing fees as part of the indirect practice expense.

CPT code 92229 (*Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral*) is a diagnostic test for diabetic retinopathy that uses a software algorithm, and the RUC provided value recommendations which included a retinal camera and an analysis fee for remote imaging. In the CY 2021 MPFS Final

Rule, CMS assigned contractor-pricing to CPT code 92229 since software algorithms are not well-accounted for within the PE methodology. However, for CY 2022, CMS has approved a crosswalk to CPT code 93925 (*Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study*).

Similar to CPT code 92229, CMS also finalized a crosswalk approach for the PE RVUs of the Trabecular Bone Score (TBS) code family, specifically for CPT codes 77089 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk*) and 77091 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only*).

The Agency noted that the RAND Corporation has found that the data collected by the Physician Practice Information Survey (PPIS) in 2007-2008 may no longer reflect the resource allocation, staffing arrangements, and cost structures that describe practitioners' resource requirements in furnishing services to Medicare beneficiaries, and consequently may not accurately capture the indirect PE resources required to furnish services to Medicare fee-for-service beneficiaries. They cite the challenge of accurately accounting for the resource costs of emerging technologies as a reason to continue their investment in potentially revising the PE methodology.

CMS also clarifies that while they have been hesitant to include software and licensing fees as part of direct PE expenses, exceptions have been made when the software costs have been included directly in the service under review.

CMS addresses comments they received related to resource costs for innovative technologies. Overall, stakeholders were appreciative of the opportunity to engage with CMS on this important topic. Commenters shared that although associated start-up costs may be a one-time fee, there are recurring costs associated with AI-technology or software algorithms, and stakeholders encouraged CMS to consider the costs as direct PE. Other suggestions or ideas included, paying for AI-related work as a separate code, or different cost structures such as subscription models, per-use costs, AI service purchases, or device/supply purchases. Commenters disagreed with the characterization of innovative technologies as a replacement for physician work. Stakeholders pointed out other considerations, such as the potential for these technologies to facilitate more efficient and timely care, but that they may foster or perpetuate bias, and often require specific hardware, software, or broadband capabilities that may disadvantage smaller or rural practices. Commenters highlighted the importance of establishing safeguards against fraud, waste, and abuse, so as not to compromise patient care.

Potentially Misvalued Services Under the PFS (Page 122)

Stakeholders nominated nine codes as potentially misvalued for CY 2022, none of which pertain to Radiology. Upon reviewing the comments, CMS declared that eight of them did not meet the criterion for potentially misvalued.

Valuation of Specific Codes for CY 2022 (Page 187)

Needle Biopsy of Lymph Nodes (CPT code 38505) (Page 249)

CPT code 38505 (*Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)*) was identified on a screen for Harvard Valued codes with utilization over 30,000. The code was reviewed at the January 2020 RUC meeting, at which the RUC approved an increased work RVU of 1.59, due to changes in technology and the dominant specialty. CMS finalized their proposal to accept the increased work RVU of 1.59, as well as the RUC-recommended PE inputs.

Trabecular Bone Score (TBS) (CPT codes 77089, 77090, 77091, and 77092) (Page 303)

Four new codes for Trabecular Bone Score (TBS) were created by the CPT Editorial Panel: 77089 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk*), 77090 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere*), 77091 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only*), and 77092 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional*). Two of the codes, 77090 and 77092, are PE-only codes and do not have a physician work component.

One of the new PE supply inputs recommended by the RUC for CPT codes 77089 and 77091 is the “TBS iNsite Software,” which is priced “per click”. This type of input does not translate into the current PE methodology, as it would typically be considered an indirect input. For this reason, CMS proposed to crosswalk the PE values for the TBS code family, using CPT code 71101 (*Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views*), as a comparator at 0.94 PE RVUs. The sum of 77090, 77091, and 77092 should equal that of 77089.

CMS finalized their proposal to accept the RUC-recommended work RVUs of 0.20 for CPT codes 77089 and 77092. CMS acknowledges that x-ray of the ribs is not a similar service to TBS, but believes their direct resource costs will be analogous. Therefore, CMS finalized their proposal to value the PE for CPT codes 77089 and 77091 based on a crosswalk to CPT code 71101. The PE RVU for CPT codes 77090, 77091, and 77092 will sum to that of 77089. CMS reiterated their position that computer software and licensing fees associated with medical equipment are considered indirect costs.

Removal of Selected National Coverage Determinations (Page 716)

CMS periodically identifies and removes National Coverage Determinations (NCDs) that no longer contain clinically pertinent and current information, in other words those items and services that no longer reflect current medical practice, or that involve items or services that are used infrequently by beneficiaries. When an NCD is removed, coverage decisions are then deferred to local Medicare Administrative Contractors (MACs).

Eliminating an NCD that provides national coverage for items and services means that the item or service will no longer be automatically covered by Medicare and initial coverage determinations for those items and services are made by MACs. On the other hand, removing an NCD that does not allow coverage for an item or service allows MACs to cover the item or service if the MAC determines that such action is appropriate. Removing a national non-coverage NCD may permit more immediate access to technologies that may now be beneficial for some uses.

CMS finalized its proposal to remove the NCD for Positron Emission Tomography (PET) Scans (220.6). CMS believes that allowing local contractor discretion to make a coverage decision for PET scans better serves the needs of the Medicare program and its beneficiaries. This NCD was established in 2000 and indicated broad national non-coverage for non-oncologic indications of PET. This meant that CMS required that every non-oncologic indication for PET must have its own NCD in order to receive coverage.

In 2013, CMS reconsidered the NCD to allow coverage for diagnostic PET imaging for oncologic uses not already determined by an NCD, to be made at the discretion of local MACs, due to “various improvements in the technical, regulatory and professional aspects of PET imaging for diagnosis.” Since the 2013 reconsideration, new non-oncologic PET agents have been approved by the FDA and multiple professional medical societies have published guidelines relevant to appropriate use of these agents.

CMS believes that local contractor discretion provides an immediate avenue to potential coverage in appropriate candidates for non-oncologic indications. Therefore, CMS finalized its proposal to eliminate subsection 220.6 to remove the broad national bar to coverage of PET scans for non-oncologic indications, thus allowing local Medicare contractors to make a coverage determination. CMS did not propose to change any other subsections of 220.6. Thus, the NCDs listed at 220.6.1 through 220.6.20 are not changed.

Regulations Governing Prepayment and Post-Payment Medical Review (Page 1024)

CMS identifies improper payments in the Medicare Fee-for-Service (FFS) program through a variety of program integrity-related activities, and use a network of contractors to carry out program integrity initiatives, including Recovery Audit contractors (RACs), the Supplemental Medical Review Contractor (SMRC), Unified Program Integrity Contractors (UPICs), Medicare Administrative Contractors (MACs), and the Comprehensive Error Rate

Testing (CERT) contractor. Both prepayment and post-payment medical reviews are used by CMS contractors to determine, among other things, whether items or services are reasonable and necessary under section 1862(a)(1) of the Act.

Despite the statutory authority authorizing CMS contractors' activities, there are no regulatory provisions governing certain medical review activities, specifically prepayment and post-payment medical reviews.

In the proposed rule, CMS proposed key terms and definitions. associated with these two review types: language codifying a contractors' authority to request additional documentation within established timeframes; and provisions detailing a provider's or supplier's responsibility to comply with requests for additional documentation, including the impact should a provider or supplier fail to comply with a request. These provisions are based on existing operational practices used by the contractors. CMS believes that adding these provisions in regulation will enhance provider and supplier understanding of CMS' review processes, as well as improve consistency among the contractors.

Key Terms and Definitions

To ensure consistency across prepayment and post-payment reviews and establish clear requirements, CMS proposed adding the following key terms and their definitions to § 405.902:

- *Additional documentation* - the information requested by a contractor when conducting a prepayment review or post-payment review.
- *Additional Documentation Request (ADR)* - a contractor's initial documentation request in reviewing claims selected for prepayment review or post-payment review.
- *Post-payment medical review* (or post-payment review) - a review that occurs after payment is made on the selected claim to determine whether the initial determination for payment was appropriate.
- *Prepayment medical review* (or prepayment review) - a review that occurs before an initial determination for payment is made on the selected claim to determine whether payment should be made.

CMS did not receive any public comments on this specific section and decided to finalize as proposed.

Prepayment and Post-Payment Medical Review

CMS proposed adding a new regulation § 405.903 to outline the prepayment medical review provisions. CMS proposed to codify its contractors' authority to conduct prepayment medical review on selected claims to determine whether and how much payment should be made. They proposed language detailing the contractors' authority to request additional documentation while conducting a prepayment review. CMS proposed that a provider or supplier will be provided 45 calendar days to submit additional documentation in response to a contractor's request. The contractor may accept documentation received after 45 calendar days for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other

extenuating circumstances that the contractor deems good cause in accepting the documentation. Lastly, CMS proposed to specify that a contractor's prepayment review will result in an initial determination under § 405.920. These provisions reflect longstanding requirements MACs have used in conducting prepayment reviews.

Post-Payment Medical Review

CMS proposed adding a new regulation § 405.929 to outline the post-payment medical review provisions. Similar to pre-payment provisions, CMS proposed language outlining its contractors' authority to select claims and conduct post-payment medical reviews and that specifies the contractors' authority to request additional documentation. Additionally, the contractor will give a provider or supplier 45 calendar days to submit additional documentation in response to a request. A contractor may accept documentation received after 45 calendar days for good cause. Good cause is defined the same for pre-post payment reviews. CMS proposed that when conducting a post-payment review, a contractor's review will result in either no change or a revised determination under § 405.984.

CMS also proposed to add new § 405.930 to clearly outline its contractors' authority to deny a claim should a provider or supplier fail to convey the additional documentation in response to a request. The proposed language clarifies that the contractor must give the provider or supplier notice and time to respond to the additional documentation request.

Lastly, CMS proposed to revise the section heading of § 405.986(a) to read, "Establishing good cause for reopening." This revision clarifies the distinction made between the process for establishing good cause to reopen an initial determination made on a claim, and the good cause factors that may be applied in accepting documentation submitted after the applicable timeframes. In establishing criteria to determine whether to accept late documentation in response to an ADR, CMS is adopting the criteria set forth in §§ 405.903 (pre-payment provisions) and 405.929 (post payment provisions), and CMS is not utilizing the good cause criteria for reopening an initial determination on a claim in § 405.986. CMS believes this change will add further clarification to the substantive text to reflect that the section only applies to reopening of initial determinations on a claim.

As with prepayment reviews, these provisions reflect longstanding requirements contractors have used in conducting post-payment reviews.

Last year, the Centers for Medicare and Medicaid Services (CMS) issued MLN Matters Number: [MM11659 Special Provisions for Radiology Additional Documentation Requests](#) with an implementation date of December 1, 2020. This change request discusses a pilot process enabling Medicare Administrative Contractors (MACs) to request pertinent documentation from the treating/ordering provider during medical review, to support the necessity and payment for radiology service(s) or item(s) billed to Medicare. The ACR encourages Medicare Administrative Contractors to provide the physician community with updates on the outcomes and future directions of this valuable program integrity initiative.

CMS received public comments on these proposals. All commenters supported their proposal acknowledging the need to conduct oversight activities to protect the Medicare program. One commenter suggested that CMS provide additional flexibility to providers who cannot meet ADR deadlines due to the challenges of collecting the necessary information from other providers. **CMS did not make modifications to its proposal and believes there is adequate time for providers and suppliers to respond.** CMS provided exceptions where there is good cause to accept documentation after applicable timeframes.

Lastly, several commenters suggested that CMS attempt to minimize the burden of these reviews, including contractors coordinating with referring and treating clinicians to gather orders, images, and other documentation. **CMS considers these comments outside the scope of this rule but may consider these suggestions in future rulemaking. After consideration of the public comments, CMS finalized their proposals without modification.**

Evaluation and Management Visits (Page 421)

CMS clarifies and refines policies related to split (or shared) E/M visits.

A split (or shared) visit refers to an E/M visit that is performed (“split” or “shared”) by both a physician and a NPP who are in the same group. For visits in the non-facility (for example, office) setting for which the physician and NPP each perform portions of the visit, the physician can bill for the visit rather than the NPP as long as the visit meets the conditions of payment for services furnished “incident to” a physician’s professional services.

For visits furnished under similar circumstances in facility settings (for example, in a hospital), CMS current regulations provide for payment only to the physician or NPP who personally performs all elements of the service, and no payment is made for services furnished “incident to” the billing professional’s services.

Medicare Part B pays for services and supplies furnished “incident to” a physician’s (or other practitioner’s) professional services if those services and supplies are provided in a noninstitutional setting to noninstitutional patients. In certain institutional (or “facility”) settings, CMS longstanding split (or shared) billing policy allows a physician to bill for an E/M visit when both the billing physician and an NPP in their group each perform portions of the visit, but only if the physician performs a substantive portion of the visit. The manual also limited billing for split (or shared) visits to services furnished to established patients.

When the physician bills for such a split (or shared) visit, the Medicare Part B payment is equal to 80 percent of the payment basis under the PFS, which is the lesser of the actual charge or the fee schedule amount for the service. In contrast, if the physician does not perform a substantive portion of such a split (or shared) visit and the NPP bills for it, the Medicare Part B payment is equal to 80 percent of the lesser of the actual charge or 85 percent of the fee schedule rate.

The CPT E/M Guidelines state, “A split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).”

CMS made a number of proposals to improve transparency and clarity regarding CMS policies on billing for split (or shared) visits, to update them to account for recent revisions to E/M visit coding and payment, and to revise their regulations to reflect these policies.

Definition of Split (or Shared) Visits

CMS defined a split (or shared) visit as an E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations. CMS defined split (or shared) visits as services that are 1) Furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner’s professional services is prohibited under CMS’ regulation and 2) Furnished in accordance with applicable law and regulations, including conditions of coverage and payment, such 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 (rather than as a split (or shared) visit). CMS also revised their regulations to codify this definition. CMS modified their policy to allow physicians and NPPs to bill for split (or shared) visits for both new and established patients, and for critical care and certain skilled nursing facility/ nursing facility E/M visits. Also, to account for changes that have occurred in medical practices, including the evolving role of NPPs as part of the medical team.

Definition of Substantive Portion

CMS defined “substantive portion” as more than half of the total time spent by the physician and NPP performing the split (or shared) visit. Given recent changes in the CPT E/M Guidelines, HPI and physical exam are no longer necessarily included in all E/M visits. For office/outpatient E/M visits, the visit level can now be selected based on either MDM or time, and history and exam are performed only as medically appropriate. CMS believes that time is a more precise factor than MDM to use as a basis for deciding which practitioner performs the substantive portion of the visit. CMS does not believe that MDM is necessarily the most critical or central component of E/M visits, and it is not the only service component included in the PFS payment for the service.

CMS understands that an adjustment period may be needed to establish systems to track and attribute time for split (or shared) visits, especially since the coding for E/M visits in many facility settings will not use MDM or time to distinguish visit levels until 2023. CMS is modifying its proposed policy for one transitional year. For CY 2022, the practitioner who

spends more than half of the total time, or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit.

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).

*Office visits will not be billable as split (or shared) services.

Distinct Time

CMS is finalizing as proposed 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). This would be consistent with the CPT E/M Guidelines stating that, for split (or shared) visits, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

Qualifying Time

Below is the listing of activities that could count toward total time for purposes of determining the substantive portion. For visits that are not critical care services, CMS proposes the same listing of activities that can count when time is used to select E/M visit level, when performed and regardless of whether or not they involve direct patient contact:

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver.
- Care coordination (not separately reported).

Practitioners would not count time spent on the following:

- The performance of other services that are reported separately.

- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

For 2022, CMS will allow history, or exam, or MDM, or more than half of the total time (inclusive of activities on the finalized listing), to comprise the substantive portion of any E/M visit (including ED visits) except critical care. Starting in 2023, the finalized listing of qualifying activities will apply to all split (or shared) E/M visits except critical care, for purposes of determining the substantive portion.

For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion could be entirely with or without direct patient contact, and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact.

Application to Prolonged Services

Starting in 2023, CMS will allow a practitioner to bill for a prolonged E/M visit as a split (or shared) visit. The physician or practitioner who spent more than half the total time (that is, who performed the substantive portion) would bill for the primary E/M visit and the prolonged service code(s) when the service is furnished as a split (or shared) visit, if all other requirements to bill for the services were met. The physician and NPP would sum their time together, and whomever furnished more than half of the total time, including prolonged time, (that is, the substantive portion) would report both the primary service code and the prolonged services add-on code(s), assuming the time threshold for reporting prolonged services is met.

For services furnished in the 2022 transition year, the same policy will apply. When practitioners use a majority of total time as the substantive portion; but when practitioners use a key component as the substantive portion, there will need to be different approaches for office/outpatient E/M visits than other kinds of E/M visits. For shared office/outpatient visits where practitioners use a key component as the substantive portion, prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged office/outpatient services (HCPCS code G2212). For all other types of E/M visits (except ED and critical care visits), prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged E/M services other than office/outpatient E/M visits (60 or more minutes beyond the typical time in the CPT code descriptor of the primary service). CMS summarized these policies in Table 27.

TABLE 27: Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	2022		2023
	If Substantive Portion is a Key Component...	If Substantive Portion is Time...	Substantive Portion Must Be Time
Other Outpatient*	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212
Inpatient/Observation/Hospital/Nursing Facility	Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)	Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

Acronyms: E/M (Evaluation and Management).

*Office visits will not be billable as split (or shared) services.

New and Established Patients, and Initial and Subsequent Visits

CMS permits the physician or NPP to bill for split (or shared) visits for both new and established patients, as well as for initial and subsequent visits.

Settings of Care

CMS regulations define the non-institutional setting as all settings other than a hospital or SNF. CMS allows billing of split (or shared) visits, including critical care visits, when they are performed in any institutional setting. This would not apply to the SNF/NF visits that are required to be performed in their entirety by a physician; any SNF/NF visit that is required to be performed in its entirety by a physician cannot and would not be able to be billed as a split (or shared) visit.

Same Group

Without further defining “group” at this time, CMS states that a physician and NPP must be in the same group in order for the physician and NPP to bill for a split (or shared) visit. If a physician and NPP are in different groups, CMS would expect the physician and NPP to bill independently, and only for the services they specifically and fully furnish.

Medical Record Documentation

CMS states that documentation in the medical record must identify the two individual practitioners who performed the visit. The individual who performed the substantive portion (and therefore bills the visit) would be required to sign and date the medical record.

Claim Identification

For services furnished beginning in CY 2022, CMS will require a modifier to be reported on the claim to identify split (or shared) visits as such. Note that Medicare does not pay for partial E/M visits for which all elements of the service are not furnished. Therefore, modifier -52 (reduced services) could not be used to report partial E/M visits, including any partial services furnished as split (or shared) visits.

Physician Self-Referral Updates (pg. 1045)

The physician self-referral law, popularly known as the Stark law, prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which she or he, or an immediate family member, has a financial relationship, unless an exception applies. This prohibits the entity from filing claims with Medicare (and many Medicaid programs) or billing another individual, entity, or third-party payer for those referred services. The statute establishes several specific exceptions and grants the Secretary of HHS the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

In the CY 2022 MPFS CMS proposed rule, CMS proposed to revise its Stark regulations relating to indirect compensation arrangements. Under the Stark statute, these arrangements involve an “unbroken chain” between the referring physician and the entity providing DHS of at least one individual or entity that has a financial relationship between them. Thus, each link in the chain must have an ownership or investment interest or compensation arrangement with the prior link. In these arrangements, the referring physician or immediate family member receives aggregate compensation from the individual or entity in the chain with which the physician or family member has a direct financial relationship that varies with the volume or value or referrals or other business that referrer generates for the entity furnishing the DHS. Additional factors regarding compensation must apply as well. Any ACR member who engages in an indirect compensation arrangement must satisfy the requirements of an applicable exception in order to avoid the referral and billing prohibitions of the law.

In 2020, CMS modified its test to determine whether an indirect compensation arrangement exists. It attempted to balance safeguarding against the risk of patient or program abuse or compromised program integrity, with granting more flexibility to industry participants. However, CMS apparently forgot to include in the definition of “indirect compensation arrangements” a component of “unbroken chains” of compensation arrangements that it has targeted for years: certain arrangements with unit of service-based payment to rent office space or equipment.

Therefore, CMS would revise its regulations to include as a potential indirect compensation arrangement any unbroken chain of financial relationships in which the compensation arrangement closest to the physician, or immediate family member of the physician, involves compensation for anything other than services that she or he personally performs. Historically, CMS allocated a reduced level of risk of program or patient abuse where compensation to a physician, or his or her immediate family member, is solely for services that she or he personally performs.

ACR submitted comments urging CMS to finalize its proposals regarding indirect compensation arrangements.

In the Final Rule, CMS finalized its proposed changes to the Stark regulations to require a two-step analysis of any unbroken chain of financial relationships in which the compensation paid under the arrangement closest to the physician is for anything other than services personally

performed by the physician, including arrangements for the rental of office space or equipment. Thus, CMS is reinforcing that its prohibition on certain unit-of-service based compensation formulas for leasing or using such space or equipment applies to all compensation arrangements that include them.

CMS revised the regulation to consider an unbroken chain of financial relationships between a physician and an entity that meets certain regulatory conditions to be an indirect compensation arrangement for purposes of the Stark law - if the unit of compensation received by the physician, or immediate family member, is payment for anything besides services the physician (or immediate family member) personally performs. CMS clarified that these conditions relate to the formula for calculating the amount of compensation per unit.

CMS reaffirmed it would consider services that any person other than the physician (or immediate family member) performs, including, but not limited to, the referring physician's (or immediate family member's) employees, independent contractors, group practice members, or persons supervised by the physician (or the immediate family member) not to be personally performed by the physician. However, CMS opted to not finalize its proposal regarding payment for anything other than services personally performed by the physician (or immediate family member) or its proposal to codify its interpretation of services that are personally performed by a physician (or immediate family member).

These policy updates underscore CMS' longstanding views that certain economic and clinical arrangements remain problematic. Per-unit or per-service space or equipment rental might compromise physicians' decisions and lead to overutilization or patient steering. ACR successfully advocated in 2008 for CMS to restrict such arrangements in imaging and radiation therapy. CMS did so then and has supported ACR's advocacy now.

Telehealth (pg. 139)

Category 1 and Category 2 Telehealth Services

Category 1 telehealth services include services that are similar to professional consultations, office visits, and office psychiatry visits that are currently on the Medicare telehealth services list. Category 2 telehealth services include services that are not similar to those on the current Medicare telehealth services list, and the criterion for adding services under category 2 is that there is evidence of clinical benefit if provided as telehealth. CMS received several requests to permanently add various services to the Medicare telehealth services list effective for CY 2022. However, CMS found that none of these services (received by the February 10 deadline) met the criteria for Category 1 or Category 2 services for permanent addition to the Medicare telehealth services list. Table 15 in the final rule lists all the requests for permanent addition to the telehealth list.

Category 3 Telehealth Services

In the CY 2021 MPFS final rule, CMS created a third category of criteria for adding services to the telehealth services list on a temporary basis in response to the COVID-19 public health emergency (PHE). Category 3 telehealth services include services which CMS believes there is

likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence to be Category 1 or 2. Services on the Category 3 telehealth list will be temporary and remain on the telehealth services list through the end of the calendar year in which the COVID-19 PHE ends. There have been stakeholder concerns surrounding uncertainty of when the PHE will end and concerns that services added to the telehealth services list on a temporary basis could be removed from the list before there is enough time to compile and submit evidence to support permanent addition of the service as a Category 1 or 2 service. In response, in the CY 2022 MPFS proposed rule, CMS proposed to retain all Medicare services added on a Category 3 basis until the end of CY 2023, to allow more time to collect information on utilization of these services. CMS is finalizing as proposed the revised timeframe for inclusion of the services added to the Medicare telehealth services list on a temporary, Category 3 basis.

CMS received comments to add several CPT codes to the category 2 telehealth list; CPT codes 93797 (Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)) and 93798 (Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)); and HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session).

CMS will also be adding CPT codes 93797 and 93798 and HCPCS codes G0422 and G0423 to the Category 3 Medicare telehealth services list. CMS will facilitate the submission of requests to add services permanently to the Medicare telehealth services list for consideration in the CY 2023 PFS rulemaking process and for consideration in the CY 2024 PFS rule.

Consolidated Appropriations Act, 2021 (pg 157)

The Consolidated Appropriations Act, 2021 (CAA) made numerous provisions to the Medicare telehealth services list. In order to implement the new statutory requirement to specify when an in-person service is required, CMS will require, as a condition of payment for a mental health telehealth service the billing physician or practitioner must have furnished an in-person, non-telehealth service to the beneficiary within the 12-month period before the date of the telehealth service. CMS updated its original proposal from 6-month period based on comments received concerned about access to mental health providers.

Audio-Only Telehealth Services

In the CY 2021 MPFS final rule, CMS explained its belief that the regulatory definition of “telecommunications system” included two-way real-time, audio/video communication technology and did not include audio-only services. CMS has defined interactive telecommunications system to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient’s home. CMS has found that audio-only E/M visits have been one of the most performed telehealth services during the PHE, with most beneficiaries receiving mental health services. Given the mental health professional

shortage and areas in which beneficiaries have limited broadband access due to geographic area or socioeconomic challenges, CMS believes beneficiaries may have come to rely on these audio-only mental health care services and that a sudden discontinuation could have a negative impact on access to care.

CMS finalized policy to limit payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology 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.

Expiration of Virtual Direct Supervision, PHE Flexibilities

Outside the PHE, direct supervision requires the immediate availability of a supervising physician or other practitioner, but they do not need to be in the same room. Through the end of the year in which the COVID-19 PHE ends, CMS is allowing direct supervision to include immediate availability via a virtual presence using real-time, audio/video technology. CMS sought comments on the extent to which the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology is being used during the PHE, and whether physicians and practitioners anticipate relying on this flexibility after the end of the PHE. Additionally, CMS sought comments on whether this flexibility should potentially be made permanent. CMS stated they will address comment in future rules or guidance as appropriate.

Medicare Shared Savings Program (MSSP) (page 756)

The Affordable Care Act (ACA) established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among healthcare providers to improve quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce Medicare expenditures. Eligible groups of providers and suppliers may participate in the MSSP by forming or participating in an Accountable Care Organization (ACO). Under the MSSP, participants in an ACO continue to receive traditional FFS payments under Parts A and B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements. In the CY 2021 MPFS final rule, CMS finalized that for performance year (PY) 2021 and subsequent years, MSSP participants are required to report quality data via the alternative payment model performance pathway (APP) and finalized a phased-in approach to the new MSSP quality performance standard.

Reporting Requirements under the APP for PY 2022 and 2023

ACOs only need to report one set of quality metrics via the APP to satisfy the quality reporting requirements under MIPS and the MSSP. Stakeholders have expressed concern about CMS requiring ACOs to report eCQMs/MIPS CQMs via the APP, due to the cost of purchasing and implementing the infrastructure/EHR. In the CY 2022 MPFS proposed rule, CMS proposed to extend the CMS Web Interface as a collection type for the MSSP ACOs reporting under the APP for PY 2022 and PY 2023. CMS is finalizing a longer transition for MSSP ACOs by extending the CMS Web Interface as a reporting option for 3 years through PY 2021. After reviewing

public comments, CMS will allow CMS Web Interface as a collection type for the MSSP ACOs reporting under the APP for PY 2022, PY 2023, PY 2024. The CMS Web Interface will be unavailable beginning in PY 2025. CMS is not finalizing the proposed requirement that an ACO must report at least on eCQM/MIPS CQM in PY 2023 in order to meet the quality performance standard.

CMS modified their proposal and will now require for PY 2023 and PY 2024, an ACO would report on either:

- The ten CMS Web Interface measures, at least one eCQM/MIPS CQM measure, and administer a CAHPS for MIPS Survey, or
- The three eCQM/MIPS CQM measures and administer a CAHPS for MIPS survey.

For PY 2025 and subsequent performance years an ACO must report the three eCQMs/MIPS CQMs and administer a CAHPS for MIPS survey and CMS will calculate the two claims-based measure included under the APP. CMS believes providing ACOs a total of 4 years (from PY 2021 to PY 2024) to transition to eCQM/MIPS CQM reporting is responsive to the commenters' concerns that it could take ACOs 3 to 5 years to transition to all-payer reporting.

Addressing Health Disparities and Promoting Health Equity

CMS believes that the move to eCQM/MIPS CQM measures is the appropriate next step for ACO quality measurement, and that assessing MSSP ACO quality performance on a broader population can have a positive impact on the quality of care for all groups. The Agency expects that the transition to eCQM/MIPS CQM measures will help to address health disparities and promote health equity by promoting a single standard of care across all patients receiving care from a practice participant in an MSSP ACO and regardless of location or racial/ethnic group. CMS sought comments and recommendations on how ACOs can utilize their resources to ensure that patients, regardless of racial/ethnic group, geographic location, or income status, have access to equal care and how ACOs can improve the quality of care provided to certain communities, while addressing the disparities that exist in healthcare. CMS sought comments on how they can encourage health care providers serving vulnerable populations to participate in MSSP ACOs. CMS stated they may consider comments to inform future rulemaking.

Reporting Options for Specialist Providers within an ACO

CMS heard from stakeholders that the population health/primary care focused measures in the APP are not applicable to specialty providers in ACOs. CMS sought comments on allowing ACO participant TINs to report either the eCQM/MIPS CQM measures in the APP measure set at the TIN level or the applicable MIPS Value Pathway (MVP). CMS sought comment on the role specialists play in ACOs and what specialty measures in the current eCQM or MIPS CQM measures set should be considered for inclusion in the MSSP quality measure set in future performance years. CMS stated they may consider comments to inform future rulemaking.

MSSP Quality Performance Standard

The quality performance standard is the minimum performance level ACOs must achieve to be eligible to share in any savings earned, avoid maximum losses, and avoid quality-related compliance actions. In the CY 2021 MPFS final rule, CMS finalized a gradual phase in of the revised performance standard: for PY 2021 and 2022 the 30th percentile across all MIPS quality performance category scores; and for PY 2023 the 40th percentile.

CMS finalized policy to freeze the quality performance at the 30th percentile MIPS quality performance category score for an additional year (PY 2023), and to raise the quality performance standard in conjunction with the transition into eCQM/MIPS CQM measures by all ACOs in 2024. CMS received comments raising concerns regarding the current quality performance standard, such that CMS is considering a broader set of policy options for PY 2023 and beyond that would provide incentive for ACOs to transition to full eCQM/MIPS CQM reporting.

CMS sought comment on whether publicly displaying prior year performance scores that equate to the 30th or 40th MIPS Quality performance category scores would help to address ACOs' concerns regarding the lack of advance information regarding the quality performance score they must meet in order to satisfy the quality performance standard under the MSSP. CMS responded to commenters stating they will work toward providing additional historical on performance scores as it becomes available.

Revisions to the Extreme and Uncontrollable Circumstances Policy

CMS made modifications to their proposals for PY 2023 and 2024. For PY 2023 if the ACO is able to report quality data via the APP and meets the MIPS data completeness and case minimum requirements, CMS will use the higher of the ACO's MIPS Quality performance category score or the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year. If the ACO is unable to report quality data and meet the MIPS Quality data completeness and case minimum requirements due to an extreme and uncontrollable circumstance, CMS will apply the 30th percentile across all MIPS Quality performance category score.

CMS updated their policy for the extreme and uncontrollable circumstances policy to align with the finalized policies outlined above. For PY 2024 and subsequent years, the minimum quality performance score for an ACO affected by an extreme and uncontrollable circumstance during the performance year, including the applicable quality data reporting period for the performance year, will be set equal to the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year. If the ACO can report quality data via the APP and meets the MIPS data completeness and case minimum requirements, CMS will use the higher of the ACO's MIPS Quality performance category score or the 40th percentile across all MIPS Quality performance category scores, excluding entities eligible for facility-based scoring, for the relevant performance year.

Medicare Provider and Supplier Enrollment Changes (Page 997)

The overarching purpose of the enrollment process is to help confirm that providers and suppliers seeking to bill Medicare for services and items provided to Medicare patients meet all federal and state requirements to do so. CMS finalized its proposal to several changes to their existing provider enrollment regulations.

Expansion of Authority to Deny or Revoke Based on Office of Inspector General (OIG)

Exclusion

If excluded by the OIG, CMS denies or revokes a provider's or supplier's enrollment if the provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier. CMS finalized its proposal to expand the categories of parties within the purview of these denial and revocation provisions to include excluded administrative or management services personnel who provide services payable by a federal health care program, such as a billing specialist, accountant, or human resources specialist. This would align with existing OIG guidance stating that providers and suppliers may not employ excluded persons to provide management or administrative services that are payable by a federal health care program.

Deny or Revoke Enrollment for Surrender of Drug Enforcement Administration (DEA)

Certificate of Registration in Response to Show Cause Order

If DEA certificate of registration to dispense a controlled substance is currently suspended or revoked, CMS has existing authority to deny a physician's or other eligible professional's enrollment. CMS finalized its proposal to expand these authorities to include situations where the physician or other eligible professional surrenders his or her DEA certificate in response to an order to show cause.

Creation of Specific Rebuttal Rights for Deactivation

Deactivation means that the provider's or supplier's billing privileges are stopped, but not revoked or terminated. This is intended to protect the provider or supplier from the misuse of its billing number and to safeguard the Trust Funds from unnecessary overpayments. Under existing regulations, a provider's or supplier's billing privileges may be deactivated if the provider or supplier: (1) does not submit any Medicare claims for 12 consecutive calendar months; (2) fails to report certain changes in its enrollment information within required timeframes; or (3) fails to fully and accurately comply with a CMS revalidation request within 90 days. To reactivate one's billing privileges, current regulations state that the deactivated provider or supplier must recertify that their enrollment information on file with Medicare is correct and must furnish any missing information as appropriate. CMS has outlined deactivation rebuttal procedures in subregulatory guidance, these procedures are not reflected in regulations. CMS finalized its proposal to revise 42CFR part 424, subpart P to describe the deactivation rebuttal process in detail, a process that would generally mirror our existing subregulatory procedures on the topic.

Modernizing Enrollment Policies for Emerging Technologies in Independent Diagnostic Testing Facilities (IDTFs)

There are provisions with which IDTFs must comply in order to enroll in (and maintain enrollment in) Medicare. This includes requirements for supervising physicians, nonphysician personnel, and the ordering of tests. And various certification standards that IDTFs must meet. CMS established these standards to help ensure the quality and safety of IDTF diagnostic testing and to strengthen their ability to verify the IDTF's compliance with enrollment requirements. IDTF standards were designed for traditional IDTF suppliers that engage in direct or in-person beneficiary interaction, treatment, and/or testing. However, some health care entities have developed or utilize diagnostic tests that do not require this form of interaction. Certain IDTFs perform diagnostic services via computer modeling and analytics, or other forms of testing not involving direct beneficiary interaction. The service is often conducted by a technician who undertakes a computer analysis offsite or at another location at which the patient is not present. The physician then reviews the image to determine the appropriate course of action.

The issue is that these entities often cannot meet certain IDTF requirements (and thus cannot enroll in Medicare) strictly because of the test's indirect nature. CMS finalize its proposal that IDTFs that have no patient interaction, treatment, or testing at their practice location and would be exempt from specific IDTF requirements.

CMS finalized its proposal that nonphysician personnel performing test in an exempted IDTF must meet all applicable state licensure requirements and the IDTF must maintain documentation available for review that these requirements have been met.

CMS finalized its proposal that the following IDTF certification standards would not apply to exempted IDTFs.

- The IDTF must have a comprehensive liability insurance policy of at least \$300,000 per location that covers both the place of business and all customers and employees of the IDTF.
- The IDTF must answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. For mobile IDTFs, this documentation would be stored at their home office.
- The IDTF must openly post the standards outlined for review by patients and the public.

Proposed Revisions Related to Revocation

CMS may revoke a provider's or supplier's enrollment if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. The purpose of this provision is to place providers and suppliers on notice that they are legally obligated to always submit correct and accurate claims and that failing to do so could lead to the revocation of their enrollment.

CMS has encountered situations where providers and suppliers have engaged in periods of non-compliant billing that, though comparatively brief, have or could have harmed the Medicare program. While CMS has attempted revocation action per against such providers and suppliers,

the current wording in their regulations, have hampered their ability to do so. To increase their flexibility to address periods of abusive billing irrespective of their duration, CMS finalized its proposal to revise their revocation provisions.

Quality Payment Program

Following is a summary of CMS' final changes to policies for the sixth year of the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Updates to the Quality Payment Program

In the Physician Fee Schedule proposed rule for 2022, CMS introduced multiple requests for information (RFI) on areas that would impact traditional MIPS and future MVP participation.

MIPS Value Pathways and APM Performance Pathway (P. 1147)

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs – RFI (p. 1151)

CMS sought comments on transitioning CMS quality reporting and value-based purchasing programs to digital quality measurement by 2025. The shift to digital quality measurement (dQM), an overarching initiative by CMS to modernize their “quality measurement enterprise,” maintains alignment with the Department of Health and Human Services (HHS), encompassing strategy to promote data interoperability and access in conjunction with other federal agencies. For instance, the Office of the National Coordinator for HIT's (ONC) finalized policies in the Cures Act regarding “complete access, exchange, and use of all electronically accessible health information.” CMS notes that the comments received will be used to continue formulating potential plans for making this technological shift.

Closing the Health Equity Gap in CMS Clinician Quality Programs— (RFI) (p. 1168) is consistent with the executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government. In response to the large volume of comments in this RFI, CMS continues to draft potential future policies to achieve health equity for all patients.

Transforming MIPS: MIPS Value Pathways (p. 1195)

As part of CMS' transition from traditional MIPS to MIPS Value Pathways (MVPs), CMS finalizes a comprehensive set of policies and procedures that inform the eligibility, implementation, and scoring of MVPs for eligible clinicians participating in MIPS (as individuals and group). CMS maintains that MVPs will be incrementally added to the QPP upon availability as part of rulemaking.

CMS will collect more granular level data on measures and activities for a specific medical specialty, condition, episode of care, or procedure using MVPs. Therefore, clinicians will receive performance feedback reports that immediately inform practices' strengths and weaknesses,

thereby designating distinct areas for care improvement by practice. Although finalizing seven new MVPs for utilization beginning in the performance year 2023 (Rheumatology, Stroke Care, Ischemic Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia), CMS acknowledges the gaps in quality and cost measurement that impede the development of MVPs for some medical specialties and continues to work with stakeholders to identify MVPs that meet participants' unique needs.

Considering CMS' understanding of the problems with immediately developing MVPs for all specialties due to the lack of currently available measures, they finalize expanding the MVP Guiding Principles to address external-stakeholder cost measure development (a function only available to CMS until now).

MVP Participant

CMS finalizes that **MVP Participants are:**

- **Individual MIPS eligible clinicians.**
- **Single or multispecialty groups.**
- **Subgroups.**
- **APM Entities assessed on an MVP.**

However, multispecialty groups will transition to subgroups to report MVPs by the performance year 2026. CMS explains that the formation of subgroup reporting is important. Currently, multispecialty groups report the same set of measures, which are likely irrelevant or lack meaning for portion of specialists who participate within the multispecialty group—preventing these specialists from improving the care they provide to patients.

MVP and Subgroup Implementation Timeline (p. 1207)

As mentioned previously, the seven MVPs finalized in this rule will be available for reporting *voluntarily* beginning with performance year 2023. CMS anticipates that *mandatory* reporting of MVPs would not begin before MIPS performance year 2028. They also expect to sunset the traditional MIPS program at the end of calendar year 2027 to coincide with the mandatory MVP participation at the start of performance year 2028.

CY 2021 QPP final rule modified the MVP guiding principles to reference subspecialty group reporting. In this final rule, CMS determines the implementation timeline and other considerations for subgroup reporting. Beginning in MIPS performance year 2023 through 2025, CMS finalizes that recognized groups start voluntarily forming subgroups and participating in MVPs. Subgroups comprise a subset of MIPS eligible clinicians who share the same medical specialty-type within their groups' practice. Participation in MVPs through subgroup reporting allows each MIPS eligible clinician to receive feedback from CMS on the care they are directly attributed, providing the opportunity for all clinicians in the multispecialty practice to make data-driven improvements on the quality of care provided. **Although mandatory subgroup**

reporting for multispecialty groups was proposed to begin with MIPS performance year 2025, CMS is delaying this requirement until performance year 2026.

Catalyst for Reporting MVPs (p. 1216)

In the Physician Fee Schedule for proposed rule for 2022, CMS recognized potential hesitancy by MIPS eligible clinicians to transition to MVPs. Lacking the financial resources to reward early MVP adopters for incentivizing MVP participation, CMS states that MVP policies incentivize MVP adoption. For example, MVP participation policies reduce the volume of measures and activities required to achieve MIPS performance scores. Further burden reduction is achieved when participating in MVPs because measures and activities are more relevant to the clinical topic, condition, procedure, or care episode beginning reported on through a particular MVP. Further, CMS asserts that MVP and subgroup reporting will collect granular-level data, thereby enhancing feedback reports providing more meaningful comparisons to similar clinicians, making the data more helpful in making care improvements. Notably, CMS also refers to the alignment of MVP participation with CME and MOC requirements, recommending that accrediting organizations work with MVP submitters for consideration of awarding CME and/or MOC credit for those reporting MVPs.

Subgroup Composition (p. 1218)

CMS will continue to define groups as a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN. However, some groups' characteristics will impact subgroup eligibility and special status within subgroups. CMS finalizes the following designations required to form subgroups:

1. A subset of a group with at least one MIPS eligible clinician identified by a combination of the group TIN, subgroup identifier, and each eligible clinician's NPI.
2. Groups will identify their affiliated subgroups, and those subgroups will submit data on the MVPs which are clinically meaningful to MIPS eligible clinicians within a subgroup or their patients.
3. Each MIPS eligible clinician in the subgroup will receive a final score based on the subgroup's combined performance assessment, allowing for an exception for subgroups to receive a final score based on the subgroup's combined performance.

Stakeholders have impressed upon CMS the importance of accurately assessing team-based care as part of MVPs and mitigating the potential for subgroup competition. CMS' special status determination (finalized in CY 2018 QPP final rule) applies to non-patient-facing MIPS eligible clinicians, rural area, or small practices. **Given aligning clinical relevance, care scope, and patient population, CMS finalizes that special status designation may inform the composition of subgroups.**

Subgroup Eligibility (p. 1226)

Each MIPS eligible clinician in the subgroup will receive a final score based on the subgroup’s combined performance assessment, allowing for an exception for subgroups to receive a final score based on the subgroup’s combined performance. Further, a TIN must exceed the MIPS annual low-volume threshold at the group level to participate in a subgroup, and subgroups will not be evaluated for the low-volume threshold at the subgroup level. The subgroup will also inherit the special statuses assigned to their affiliated group, even if the subgroup composition does not meet the criteria.

MVP Development and Maintenance (p. 1239)

Several elements that support the formation of MVPs (i.e., factors MVP submitters need to consider before submitting to rulemaking) were finalized in the CY 2021 QPP final rule. This final rule augments the previously finalized guidance, policy, and procedures and establishes a detailed compendium of MVP candidate submission, participation, and scoring. CMS, again, stresses the importance of team-based care when approaching MVP development (when appropriate). With respect to MVP maintenance, CMS describes their plan for MVPs to be available for public comment regularly, ensuring that the measures and activities within MVPs are agile and significant.

Selection of Measures and Improvement Activities within an MVP (p 1241)

Since its introduction in the CY 2018 QPP final rule, CMS highlighted the role of MVPs in reducing MIPS participation burden by lowering the MIPS reporting requirements. Comparisons between MVP composition and participation requirements against traditional MIPS requirements are in the table below.

Performance Category	Traditional MIPS Reporting Requirements <i>To Earn Full MIPS Score</i>	MVP Reporting Requirements
Quality **Population Health Measurement	Report 6 quality measures, including an outcome measure or high-priority measure (in the absence of an outcome measure). **Not Applicable.	If applicable, 4 quality measures, including an outcome measure or high-priority measure (in the absence of an outcome measure). ** Administrative claims based. No data submission requirement for the clinician.
Improvement Activities	Attest to: 1 high-weighted activity <u>AND</u> 2 medium-weighted activities, <u>OR</u>	Attest to: 1 high-weighted activity <u>OR</u> 2 medium-weighted activities

	4 medium-weighted activities	
Promoting Interoperability	Unless designated otherwise, report all 6 Promoting Interoperability measures.	Report all Promoting Interoperability measures (unknown how many measures there will be). <i>Not all applicable to radiologists. CMS considering flexibilities.</i>
Cost	Administrative claims based. No data submission requirement for the clinician.	Administrative claims based. No data submission requirement for the clinician.

Scoring and Re-weighting in MVPs

CMS proposes MVP scoring policies as follows:

Final scoring policies will generally align with traditional MIPS scoring. Performance category weights would be consistent with traditional MIPS performance category weights. Reweighting policies for the redistribution of category weights will also align with traditional MIPS, except that the quality performance category will not be reweighted if a score cannot be calculated for a MIPS eligible clinician due to lack of an applicable MVP quality measure.

Population health measures will be included in the Quality performance category score. As in traditional MIPS, these measures will be excluded from scoring if the measure does not have a benchmark or case minimum is not met. Subgroups will receive the population health measure score of their affiliated group, if applicable if the measure selected by the subgroup does not have a benchmark or meet the case minimum.

Quality category scoring policies will align with those in traditional MIPS, as finalized in this rule and described in the Quality Performance Category section below. Note that MVPs will be scored with a three-point floor, unlike traditional MIPS scoring in performance year 2022. Small practices will earn three points for measures lacking a benchmark or are below the case minimum. Measures scored against a benchmark can earn points on a scale of one through 10.

Medium-weight improvement activities equal 20 points, and high-weight activities are 40 points. Cost category scoring policies align with traditional MIPS category weights, with cost measures included in the MVP only being scored.

The scoring hierarchy will include subgroups where a MIPS eligible clinician will receive the highest final score attributed to their TIN/NPI combination from any reporting option (traditional MIPS, APM Performance Pathway (APP) reporting, or MVP reporting) and participation option (as an individual, group, subgroup, or APM Entity), except for virtual groups. CMS asserts that including subgroups in the scoring hierarchy allows for meaningful data collection and assessment under MVPs while applying the existing policy of allowing clinicians to receive the highest final score and payment adjustment that can be attributed to them.

Public Reporting of MVP Data (p. 1217)

CMS finalizes that individuals, groups, and subgroups participating in MVPs will experience a one-year delay when publicly reporting new Improvement Activities and Promoting Interoperability measure performance. CMS believes that this encourages clinician participation in MVPs while also transitioning into the new framework. As previously finalized, CMS will continue not to publicly report Quality measures in their first two years of existence. CMS further emphasized that subgroup performance will maintain a separate workflow from traditional MIPS and MVP group public reporting. In other words, MVP subgroup reporting data will be linked to the practices' Care Compare profile page, where it will describe who is attributed to the subgroups' performance.

Public reporting information for MVP participants and standard MIPS participants will continue to be available via the Department of Health and Human Services' [Compare Tools website](#).

MIPS Category Weighting (p. 1577)

The final category weights for the 2022 performance year will be: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%**.

In accordance with the 2020 MPFS Final Rule, CMS is lowering the weight of the Quality category to 30% in 2022 and beyond. Cost has increased to 30% for the 2022 performance year. These percentages are likely to stay fixed for the future of the MIPS program.

The final rule continues to offer category reweighting for physicians who are unable to submit data for one or more performance categories. In most cases, the weight of these categories will continue to be redistributed to the Quality category.

Regarding small practices, however, CMS has finalized a proposed change which will redistribute the weight for promoting interoperability and/or cost to both quality and improvement activities rather than to quality only. In a scenario where only promoting interoperability is reweighted, quality would be weighted at 40%, cost at 30% and improvement activities at 30%. If both promoting interoperability and cost are reweighted, quality and improvement activities would both be weighted at 50%. **CMS believes this will benefit small practices by placing greater weight on a lower-burden performance category** (p. 1588).

MIPS Performance Threshold and Incentive Payments (p. 1595)

The MIPS performance threshold is the value which determines whether a MIPS participant will receive a positive, negative or neutral payment adjustment during the associated MIPS payment year. During the first two MIPS performance years, this value was set at 3 points and then 15 points (out of 100) to allow clinicians to transfer into the new payment program more easily. The Bipartisan Budget Act of 2018 gave CMS the flexibility to set a performance threshold for three additional years (program years 2019-2021) to continue this process of incremental transition.

During the following three years, the performance threshold was set at 30 points, 45 points, and finally 60 points for the 2021 performance year.

From 2022 onward, CMS is required to set the MIPS performance threshold at either a mean or median value based on previous years' scoring data. CMS has analyzed mean and median performance data from 2017 through 2019 and found a range of scores between 74.65 (the 2017 performance year mean) and 99.63 (the 2018 performance year median).

Beginning with performance year 2022, CMS has raised the performance threshold to 75 points, which represents the mean of 2017 performance year data. This means that clinicians scoring 75 points or higher will receive a neutral or positive payment adjustment, while clinicians falling below 75 points will receive a negative adjustment.

The exceptional performance threshold has been set at 89 points, representing the 25th percentile of actual final scores above the performance threshold from the 2017 performance year. Clinicians scoring above the exceptional performance threshold will receive an additional bonus to their payment adjustment. This is the last year that the additional MIPS adjustment factors for exceptional performance will be available. (p. 1610)

CMS finalized the payment adjustment of +/- 9% for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment.

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (p. 1874)

CMS did not make any changes to the low-volume threshold criteria as previously established. To be excluded from MIPS in 2022, clinicians or groups would need to meet one of the following three criteria: have \leq \$90K in allowed charges for covered professional services, provide covered care to \leq 200 beneficiaries, or provide \leq 200 covered professional services under the Physician Fee Schedule. The opt-in policy remains the same, allowing physicians who meet some, but not all, of the low-volume threshold criteria to opt-in to participate in MIPS.

CMS is maintaining the small practice bonus of 6 points that is included in the Quality performance category score. CMS also continues to award small practices 3 points for submitted quality measures that do not meet case minimum requirements or do not have a benchmark.

In previous MIPS performance years, small practices had been allowed to submit Quality measure data via claims reporting rather than registry-based reporting. The 2022 Final Rule continues to allow claims submission for small practices, but they acknowledge that this has caused some unintended consequences, such as physicians who may be exempt from MIPS due to the low-volume threshold receiving MIPS scores because their group has submitted claims data. Beginning in 2022, **CMS will require that claims-reporting small practices who wish to submit MIPS data as a group must signal their intention to participate as a group by submitting either Improvement Activities, Promoting Interoperability measures, or MIPS**

CQMs as a group. If they do not report another performance category as a group, they would be considered individual submitters.

Quality Performance Category (p. 1308)

CMS has signaled their intention to lower the Quality category weight to 30% in previous rules, therefore CMS is confirming in this final rule that the weight of the Quality performance category will be set at 30% for 2022 and beyond (down from 40% in 2021).

CMS has finalized one major change to measure scoring beginning in 2022. Measures in their first year of use in the MIPS program will receive a minimum of 7 achievement points, and measures in their second year will receive a minimum of 5 points. This is an increase from the 3-point floor which was previously established for non-benchmarked measures. Once the measure is in its third year and beyond, it will be subject to the standard measure scoring framework.

CMS has also finalized extensive changes to the measure scoring system beginning in 2023. In previous years, non-benchmarked measures which met data completeness were eligible to receive 3 points, with the possibility of a higher score if enough data was received to establish a same-year benchmark. Benchmarked measures were scored between 3 and 10 points if they met data completeness. **Beginning with performance year 2023, two major changes will go into effect.**

First, CMS will change the scoring range for benchmarked measures to 1 to 10 points, doing away with the 3-point floor. Small practices will be excepted from this change and will continue to receive at least 3 points for all measures.

Second, CMS will score non-benchmarked measures at 0 points even if data completeness is met if these measures are not in their first two years of use in the MIPS program. Again, small practices will be excepted from this change.

Quality Measures Proposed for Removal (p. 2098)

CMS has finalized the removal of several measures which have historically been reported by radiologists:

- #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
- #23: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- #154: Falls: Risk Assessment
- **#195: Radiology: Stenosis Measurement in Carotid Imaging Reports**
- **#225: Radiology: Reminder System for Screening Mammograms**

In the proposed rule, CMS had also considered removing measures #144 (Oncology: Medical and Radiation – Plan of Care for Pain) and #317 (Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented). Upon review of comments, these two measures will not be removed in 2022.

Regarding their methodology for scoring topped out measures, CMS will continue capping measures at 7 points (out of a possible 10) if they have been topped out for two or more performance years but will adjust the score if the measure ceases to be topped out upon completion of data submission for the current performance year.

Quality Category Bonus Points (p. 1488)

CMS has finalized the proposal to end the practice of awarding bonus points for additional high priority or outcome measures beyond the required one measure. CMS notes that their previous policy of awarding bonus points for additional high priority or outcome measures was a transitional policy designed to encourage the reporting of such measures. They believe it may no longer be necessary to incentivize high priority measures in this way.

Similarly, CMS also finalized the proposal to discontinue the end-to-end reporting bonus which incentivized users to report measures using Certified Electronic Health Record Technology (CEHRT).

CMS notes that they believe that the creation of MVPs will allow new methods of incentivizing high priority measures, outcome measures and end-to-end reporting. They invite stakeholders to comment on these proposals.

CMS also notes that their decision to grant a higher score to new quality measures during their first two years is intended to provide an incentive for reporting new measures in lieu of bonus points.

Quality Data Completeness Requirements (p. 1883)

No changes to data completeness requirements were finalized for 2022, so quality measure submission must continue to account for at least 70% of total exam volume. This number defines the minimum subset of patients within a measure denominator that must be reported. Although CMS had proposed raising the data completeness threshold to 80% beginning in 2023, **CMS has confirmed that they will maintain the 70% data completeness threshold for the 2023 performance year as well.**

Quality Measure Benchmarking (p. 1500)

Because of the complications related to the COVID-19 emergency—specifically the allowances made to exempt non-submissions from receiving negative payment adjustments during the 2020 MIPS performance year—CMS sought comments during the proposed rule about potentially tying 2022 quality measure benchmarks to a performance period benchmark rather than a

historical benchmark. CMS also considered using 2019 data rather than 2020 data to set 2022 benchmarks.

CMS notes that many commenters both supported and opposed these proposals, but ultimately determined that 2020 performance year data was sufficient for establishing benchmarks. Quality measure benchmarks in 2022 will therefore be based on historical data from the 2020 performance year and will not use a performance period benchmark.

Cost Performance Category (p. 1540)

CMS acknowledges that there is a need for flexibility in calculating scores for cost measures when there are external factors that may negatively impact clinician performance, such as changes during a performance period that impede the effective measurement of resource use. Due to the impact of the COVID-19 public health emergency (PHE) on service utilization and the underlying data used to calculate cost measures, CMS could not reliably calculate scores for the cost measures in the 2020 performance year. CMS has decided to assign a weight of zero percent to the cost performance category for that program year.

CMS is adding five new episode-based cost measures in the 2022 performance year and beyond: Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease (COPD) and Diabetes. The first three cost measures (Melanoma Resection, Colon and Rectal Resection and Sepsis) follow the same framework as the previously established cost measures currently in use in MIPS. The last two measures (Asthma/COPD and Diabetes) are chronic conditions and are calculated using claims data from Medicare Parts A, B and D. The patient population is stratified into smaller, clinically similar cohorts, to ensure an accurate comparison of costs across clinicians. All these measures have a 20-episode case minimum except for the Melanoma Resection episode-based cost measure, which has a ten-episode case minimum.

A more in-depth summary of the chronic condition cost measure framework can be found on [CMS.gov](https://www.cms.gov).

Beginning in 2022, stakeholders can develop cost measures to expand the current inventory of episode-based cost measures. Similar to the Call for Quality Measures, CMS will conduct a Call for Cost Measures and review all candidate measures through the MUC list for earliest adoption into the MIPS program by 2024. To ensure new cost measures align with program needs, CMS will conduct an environmental scan to outline priority areas and clinical performance gaps. Candidate measures must be fully specified, feasible, and scientifically acceptable.

Improvement Activities Performance Category (p. 1410)

CMS is proposing to revise group reporting requirements to prepare for MVP subgroup reporting. The 50 percent threshold requirement for group reporting will also apply to subgroup reporting an improvement activity.

In 2020, CMS finalized an exception to the Call for Improvement Activities timeline, allowing stakeholders to submit an improvement activity nomination at any time during a public health emergency (PHE). **CMS has revised that exception; all nominations during a PHE must be submitted by January 5 of the activity implementation year. CMS also added two new criteria for candidate improvement activities: they should not duplicate other improvement activities and should drive improvements that go beyond standard clinical practice.** To increase the chances of an improvement activity’s acceptance to the program, **six previously required factors for submissions will be optional factors beginning in 2022:** alignment with patient-centered medical homes, support for the patient’s family or personal caregiver, responds to a public health emergency as determined by the Secretary, addresses improvements in practice to reduce health care disparities, focus on meaningful actions from the person and family’s point of view, and representative of activities that multiple individual MIPS eligible clinicians or groups could perform. **Beginning with 2022, CMS will suspend improvement activities that might raise patient safety concerns or are obsolete.** These activities would then be proposed for removal in the next rulemaking cycle.

There are seven improvement activities finalized for adoption, 15 improvement activities with modifications, and six improvement activities for removal.

Table 1. Improvement Activities Finalized for Adoption.

Activity ID	Improvement Activity Title	Description	Category Weight
IA_AHE_8	Create and Implement an Anti-Racism Plan	Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.	High
IA_AHE_9	Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols	Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.)	Medium
IA_BMH_11	Implementation of a Trauma-	Create and implement a plan for trauma-informed care (TIC) that recognizes the	Medium

	Informed Care (TIC) Approach to Clinical Practice	potential impact of trauma experiences on patients and takes steps to mitigate the effects of adverse events in order to avoid re-traumatizing or triggering past trauma.	
IA_BMH_12	Promoting Clinician Well-Being	<p>Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches:</p> <ul style="list-style-type: none"> • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement. 	High
IA_ERP_4	Implementation of a Personal Protective Equipment (PPE) Plan	Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients.	Medium
IA_ERP_5	Implementation of a Laboratory Preparedness Plan	Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities.	Medium
IA_PSPA_33	Application of CDC's Training for Healthcare Providers on Lyme Disease	Apply the Centers for Disease Control and Prevention's (CDC) Training for Healthcare Providers on Lyme Disease using clinical decision support (CDS). CDS for Lyme disease should be built directly into the clinician workflow and support decision making for a specific patient at the point of care. Specific examples of how the guideline could	Medium

		be incorporated into a CDS workflow include but are not limited to: electronic health record (EHR) based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	
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Table 2. Improvement Activities Finalized for Removal.

Activity ID	Improvement Activity Title	CMS' Rationale
IA_BE_13	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms	There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.
IA_PSPA_11	Participation in CAHPS or other supplemental questionnaire	This improvement activity is duplicative of another activity.
IA_BE_17	Use of tools to assist patient self-management	This improvement activity is duplicative of another activity.
IA_BE_18	Provide peer-led support for self-management	This improvement activity is duplicative of another activity and there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.
IA_BE_20	Implementation of condition-specific chronic disease self-management support programs	This improvement activity is duplicative of another activity and there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.
IA_BE_21	Improved practices that disseminate appropriate self-management materials	This improvement activity is duplicative of another activity and there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.

Promoting Interoperability Performance Category (p. 1545)

The minimum performance period for the Promoting Interoperability category will continue to be any continuous 90-day period within the calendar year. Small practices will obtain a hardship exception and receive automatic reweighting if they do not report data for this category. There were no changes to the category exception for non-patient facing eligible clinicians.

CMS finalized most of its proposed modifications to Promoting Interoperability category objectives and measures for CY 2022. The Electronic Prescribing Objective's "Query of Prescription Drug Monitoring Program (PDMP)" measure will continue to be optional and worth 10 bonus points. CMS will only require "Immunization Registry Reporting" and "Electronic Case Reporting" measures under the Public Health and Clinical Data Exchange objective—the measures for "Public Health Registry Reporting," "Clinical Data Registry Reporting," and "Syndromic Surveillance Reporting" will be optional and worth bonus points. CMS finalized a new, unscored objective and measure that requires a "yes/no" attestation to having conducted an annual self-assessment using the High Priority Practices Guide published by the HHS Office of the National Coordinator for Health IT (ONC).

CMS eliminated two of the three "yes/no" attestation statements previously required for information blocking prevention. This change was made to better differentiate the MIPS-Promoting Interoperability attestation requirement from the broader definition of "information blocking" in the ONC's regulations to implement the 21st Century Cures Act "Information Blocking Provision."

Facility-based Measurement (p. 1591)

Facility-based scoring was implemented in 2019. Clinicians and groups would not need to elect or opt-in to facility-based measurement if they were eligible and benefitted from having a higher combined quality and cost performance score.

Beginning with the 2022 performance year, the MIPS quality and cost performance category scores will be based on facility-based measurement unless their MIPS final score is higher through another MIPS submission. This new scoring method will calculate two final scores for clinicians and groups who are facility-based: one for the clinician or group's performance and the weights of the performance categories if facility-based measurement did not apply, and another based on the application of facility-based measurement. CMS will accept the higher of the two scores.

In the proposed rule, CMS included several requests for information (RFI) on areas that would impact traditional MIPS and future MVP participation.

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs – RFI (p. 1153) and transitioning CMS quality reporting and value-based purchasing programs to digital quality measurement by 2025. The shift to digital quality measurement (dQM) is an overarching initiative by CMS to modernize their "quality measurement enterprise" and maintain alignment with the Department of Health and Human Services (HHS) encompassing strategy to promote data interoperability and access in conjunction with other federal agencies. For instance, the Office of the National Coordinator for

HIT's (ONC) finalized policies in the Cures Act regarding "complete access, exchange, and use of all electronically accessible health information." CMS did not respond to commenters in the final rule, but will actively consider all input as they develop future regulatory proposals or future subregulatory policy.

Closing the Health Equity Gap in CMS Clinician Quality Programs— (RFI) (p. 1168) This RIF was consistent with the executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS issued an RFI from stakeholders to achieve health equity for all patients by implementing new policies. CMS sought comments on approaches to ensure the delivery of health equity. CMS thanked the commenters and will consider the information to inform future rulemaking.

Advanced Alternative Payment Models (page 1142)

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

For payment years 2019 through 2024, Qualifying APM Participants (QPs) receive a 5 percent APM Incentive Payment. Starting in payment year 2026, the update to the PFS CF for QPs will be 0.75%. Those that are qualifying APM participants (QPs) for the year receive a 5 percent lump sum incentive payment during the corresponding payment year through CY 2024, or a differential payment update under the PFS for payment years beginning in 2026.

The Consolidated Appropriations Act, 2021, froze the APM payment incentive thresholds for performance years 2021 and 2022 (payment years 2023 and 2024). Therefore, in CY 2022, the QP payment amount threshold will remain at 50 percent of Medicare payments and the QP patient count threshold will remain at 35 percent of Medicare patients.

APM Incentive Payment Recipient

In the CY 2021 MPFS final rule, CMS finalized a hierarchy to identify potential payee Taxpayer Identification Numbers (TINs) in the event that the QP's original TIN is no longer active. This process has improved CMS' ability to make more payments to TINs with up-to-date and valid affiliations. CMS is finalizing a policy to extend the hierarchy to include billing TINs that are active only during the payment year. CMS states that because such TINs are active within the same year payments are to be made, adding this step to the processing hierarchy will make it easier for CMS to complete payments to more QPs in their first round of QP Incentive Payments.

The Radiation Oncology Model is expected to be an Advanced APM in the 2022 QP performance period.