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## SPECIAL ISSUE

*Coverage of the final 2022 Medicare physician fee schedule and Quality Payment Program*

(continued from p. 4)

practitioners identified in section 1842(b)(18)(C) of the Act [who can dispense telehealth]."

Lawmakers have introduced numerous bills aimed at expanding telehealth flexibilities in recent months. One such bill, the Expanded Telehealth Access Act, was introduced in the U.S. House of Representatives in March. That bill would "permanently allow audiologists, physical therapists, occupational therapists, speech-language pathologists and other providers designated by [CMS] to provide telehealth services under Medicare." But the bill, like other similar ones, appears stuck.

### Supervision stalls

CMS also declined to rule on making its direct supervision telehealth allowance permanent (*PBN 7/26/21*). The agency cited MedPAC, which had sent a cautionary letter to CMS on Sept. 9, 2021, warning that "allowing clinicians to supervise 'incident to' services virtually could pose a safety risk to beneficiaries because the clinician would not be physically available to help the individual being supervised, if necessary, which is important if the service is a complex procedure." CMS also cited spending issues.

Rebecca E. Gwilt, Esq., co-founder and partner at Nixon Gwilt Law in Richmond, Va., hopes that CMS will find a way to interpret its authority more broadly when the PHE ends. With regard to supervision, for example, "CMS could choose to exercise its interpretive powers using subregulatory guidance to enable a provider to meet 'direct supervision' requirements through 'virtual presence' — that is, live, interactive audio/video or even audio-only telehealth. This change in policy could mean a great deal to [therapy] practitioners whose only option for Medicare reimbursement is to bill 'incident to' once the PHE ends." — *Roy Edroso* (redroso@decisionhealth.com) ■

*Quality Payment Program*

## Tough year, big change: MIPS players challenged on scores, then by MVP

The delay on a full switchover to the MIPS Value Pathways (MVP) program may relieve anxious participants, but experts say it's merely a reprieve in a Quality Payment Program (QPP) that is slated to undergo fundamental change in coming years. In 2022, in what may be the final year of traditional MIPS reporting, providers will face thresholds that are higher than ever, and participants who've been breezing through may find rougher going.

Originally scheduled to begin in 2021, then in 2022, MVP — a major rethinking of reporting requirements for the program — will start for MIPS participants with the 2023 performance/2025 reporting year, according to the final 2022 Medicare physician fee schedule (*PBN 7/26/21*).

Under MVP, MIPS performance will be reported in new categories that will be relevant to specific specialties, medical conditions or episodes of care. An MVP subgroup is defined as "a subset of a group which contains at least one MIPS-eligible clinician and is identified by a combination of the group TIN, the subgroup identifier and each eligible clinician's NPI," according to CMS.

At first glance, MVP looks like a reduction in provider effort: As described in new CMS materials, MVP reporters who currently report at least six Quality measures will report four Quality measures, one of which must be an outcome measure. They will report two medium-weighted or one high-weighted Improvement Activity (or, for some reporters, membership in a patient-centered medical home), rather than four medium- or two high-weighted activities currently, and the same seven required Promoting Interoperability measures (e.g., security risk analysis, e-prescribing) as now. Cost will still be calculated by CMS.

But you'll find significant changes to the standards for reporting: Participants will be slotted into condition-specific pathways that will dictate the measures they report. They also will be assigned population health measures.

CMS promises to phase in some requirements over time: For example, multispecialty groups, which will be required to form subgroups for the MVP reporting process and would have started that in 2025 under the proposed rule, will now start in the 2026 performance/2028 reporting year. More details will be forthcoming in the 2023 rules.

### Last leg's the hardest

But in 2022, simply breaking even in MIPS will be tough. Category weights are finalized for 2022 at 30% for the Quality performance category (down 10% from 2021); 30% for the Cost performance category (up 10% from 2021); 15% for the Improvement Activities performance category; and 25% for the Promoting Interoperability performance category. The performance threshold leaps from 60% to 75%, and the data completeness criteria threshold will be 70% (the proposed rule had the latter amount at 80%).

## CY2022 Final Clinical Labor Pricing Update

| Labor code | Labor description | Current rate per minute | Updated rate per minute | 2022 rate per minute (Year one) | Total % change |
|---|---|---|---|---|---|
| L023A | Physical therapy aide | 0.23 | 0.28 | 0.24 | 22% |
| L026A | Medical/technical assistant | 0.26 | 0.36 | 0.29 | 38% |
| L030A | Lab tech/MTA | 0.30 | 0.46 | 0.34 | 53% |
| L032B | EEG technician | 0.32 | 0.44 | 0.35 | 38% |
| L033A | Lab technician | 0.33 | 0.55 | 0.39 | 67% |
| L033B | Optician/COMT | 0.33 | 0.39 | 0.35 | 18% |
| L035A | Lab tech/Histotechnologist | 0.35 | 0.55 | 0.40 | 57% |
| L037A | Electrodiagnostic technologist | 0.37 | 0.44 | 0.39 | 19% |
| L037B | Histotechnologist | 0.37 | 0.55 | 0.42 | 49% |
| L037C | Orthoptist | 0.37 | 0.76 | 0.47 | 105% |
| L037D | RN/LPN/MTA | 0.37 | 0.54 | 0.41 | 46% |
| L037E | Child life specialist | 0.37 | 0.49 | 0.40 | 32% |
| L038A | COMT/COT/RN/CST | 0.38 | 0.52 | 0.42 | 37% |
| L038B | Cardiovascular technician | 0.38 | 0.60 | 0.44 | 58% |
| L038C | Medical photographer | 0.38 | 0.38 | 0.38 | 0% |
| L039A | Certified retinal angiographer | 0.39 | 0.52 | 0.42 | 33% |
| L039B | Physical therapy assistant | 0.39 | 0.61 | 0.45 | 56% |
| L039C | Psychometrist | 0.39 | 0.64 | 0.46 | 62% |
| L041A | Angio technician | 0.41 | 0.58 | 0.45 | 41% |
| L041B | Radiologic technologist | 0.41 | 0.63 | 0.47 | 54% |
| L041C | Second radiologic technologist for vertebroplasty | 0.41 | 0.63 | 0.47 | 54% |
| L042A | RN/LPN | 0.42 | 0.63 | 0.47 | 50% |
| L042B | Respiratory therapist | 0.42 | 0.64 | 0.48 | 52% |
| L043A | Mammography technologist | 0.43 | 0.63 | 0.48 | 47% |
| L045A | Cytotechnologist | 0.45 | 0.76 | 0.53 | 69% |
| L045B | Electron microscopy technologist | 0.45 | 0.89 | 0.56 | 98% |
| L045C | CORF social worker/psychologist | 0.45 | 0.70 | 0.51 | 56% |
| L046A | CT technologist | 0.46 | 0.76 | 0.54 | 65% |
| L047A | MRI technologist | 0.47 | 0.76 | 0.54 | 62% |
| L047B | REEGT (Electroencephalographic tech) | 0.47 | 0.76 | 0.54 | 62% |
| L047C | RN/Respiratory therapist | 0.47 | 0.70 | 0.53 | 49% |
| L047D | RN/Registered dietician | 0.47 | 0.70 | 0.53 | 49% |
| L049A | Nuclear medicine technologist | 0.62 | 0.81 | 0.66 | 32% |
| L050A | Cardiac sonographer | 0.50 | 0.77 | 0.57 | 54% |
| L050B | Diagnostic medical sonographer | 0.50 | 0.77 | 0.57 | 54% |
| L050C | Radiation therapist | 0.50 | 0.89 | 0.60 | 78% |
| L050D | Second radiation therapist of IMRT | 0.50 | 0.89 | 0.60 | 78% |
| L051A | RN | 0.51 | 0.76 | 0.57 | 49% |
| L051B | RN/Diagnostic medical sonographer | 0.51 | 0.77 | 0.58 | 51% |
| L051C | RN/CORF | 0.51 | 0.76 | 0.57 | 49% |
| L052A | Audiologist | 0.52 | 0.81 | 0.59 | 56% |
| L053A | RN/Speech pathologist | 0.53 | 0.79 | 0.60 | 49% |
| L054A | Vascular technologist | 0.54 | 0.91 | 0.63 | 69% |
| L055A | Speech pathologist | 0.55 | 0.82 | 0.62 | 49% |
| L056A | RN/OCN | 0.79 | 0.81 | 0.80 | 3% |
| L057A | Genetics counselor | 0.57 | 0.85 | 0.64 | 50% |
| L057B | Behavioral health care manager | 0.57 | 0.57 | 0.57 | 0% |
| L063A | Medical dosimetrist | 0.63 | 0.91 | 0.70 | 44% |
| L107A | Medical dosimetrist/Medical physicist | 1.08 | 1.52 | 1.19 | 41% |
| L152A | Medical physicist | 1.52 | 2.14 | 1.68 | 41% |

*Source:* Table 12, Finalized Clinical Labor Pricing Update, final 2022 Medicare physician fee schedule

The exceptional performance threshold that makes high performers eligible for a special bonus, in its last year of existence, will be 89 points. That may benefit the few who can attain it; in years past the available bonus came to very little when it was split among everyone who qualified (*PBN 2/4/19*).

## New Cost measures

CMS is adding five episode-based MIPS measures to the Cost category metrics by which they calculate the MIPS participant's score:

- Melanoma Resection.
- Colon and Rectal Resection.
- Sepsis.
- Diabetes.
- Asthma/Chronic Obstructive Pulmonary Disease (COPD).

The current Cost measures are Total Per-Capita Costs (TPCC), Medicare Spending per Beneficiary Clinician (MSPB Clinician) and 18 other episode-based measures. CMS also is working on a process whereby all Cost measures would be "developed by CMS' measure development contractor."

For APM entities — that is, APMs that either choose not to be scored in the Advanced APMs QPP track or do not qualify for lack of qualified participants (QPs) or other reasons — the metrics in 2022 are the same as 2021: Quality is 55%; Cost is 0%; Promoting Interoperability is 30%; and Improvement Activities is 15%.

For APMs that are on the Advanced APM track, the APM Incentive Payment remains 5% of Part B covered professional services and will be paid to the qualifying participant's (QP) TIN or divided proportionally between or among the TINs with which the QP is associated, based on the relative paid amount for Part B covered professional services that are billed through each of the TINs.

Clinical social workers and certified nurse midwives are added to MIPS-eligible providers.

## Doubling down on MVP

Dave Halpert, chief, client team of Roji Health Intelligence in Chicago, says that in the final rule "CMS doubles down on its commitment to move providers out of 'traditional MIPS' and into APMs [alternative payment models] or MVPs."

With ACOs in the Shared Savings plan, for example, Halpert sees CMS attempting to lure MIPS participants by "delaying the requirement to report on all patients" via the all-payer eCQM system (*see related story, p. 9*). At the same time, the difficult 2022 MIPS targets will get participants looking harder — and maybe with relief — at alternatives.

"With penalties remaining high — up to a 9% penalty — those who have 'gotten by' in prior years are making a risky bet that the same strategy will clear the newly-raised bar," Halpert says.

Lauren Patrick, CEO of Healthmonix, says that MIPS participants "will be doubly surprised in 2022" because "many took the extreme and uncontrollable circumstances [MIPS exception] in 2020 and 2021," which insulated them from performance threshold changes. "During that time, the performance threshold went from 30 to 60 and it's going to 75 for 2022," she says.

In addition, "the opportunity to achieve the same scores as in prior years is waning. First, bonus points for high-priority and eCQM/end-to-end collection are removed," Patrick says. "Secondly, there are fewer measures, and the benchmarks for many measures are higher — hence it's more difficult to get the same decile score for individual measures. Thirdly, the Cost category will be worth 30% of the score and providers do not understand this category. If providers don't start early, they will have a very difficult time avoiding a penalty."

## Plan ahead

Halpert suggests that you prepare for MVP insofar as possible now. For example, there will be a new registration process that will force some groups to report as smaller, specialty-specific groups to ensure that the measures are meaningful. For example, Halpert says, in a multispecialty group "the orthopedists will report one set of measures, while the anesthesiologists will report another." This will require a rethink in reporting because while under traditional MIPS "the group can pick and choose the most optimal — but not necessarily most meaningful — set of measures," MVP may force them to report measures in which they are not strong.

"In order to succeed then, providers and groups must establish a strategy now that gives them insights into their care and costs, with the ability to see the big picture and the flexibility to trace the effects of their overall strategy down to the individual patient level," Halpert says. — *Roy Edroso* (redroso@decisionhealth.com) ■