

# CMS Finalizes Regulatory Changes and Updates Physician Payment System

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact the reimbursement of physicians. On November 2, 2021, CMS [finalized a rule](#) updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2022. The final rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients. CMS expects payments across the specialty of neurology to stay at current levels in 2022, with variations depending on the individual provider's practice. However, all specialties are also potentially facing a 3.7 percent reduction in the conversion factor used to formulate payments under the Medicare Physician Fee Schedule. The AAN is working with physician associations from across the house of medicine to fight against these potential cuts, which recently resulted in having [247 members of the US House of Representatives sign a letter](#) urging congressional leaders to act on this issue before the end of the year.

## Evaluation and Management (E/M) Visits

Like in previous years, CMS continues its ongoing review of E/M code sets. The AAN remains highly supportive of the new coding and payment structure implemented on January 1, 2021, and lauds the agency for moving forward with implementation. For 2022, the agency is refining several policies to align with the revised E/M visit codes guidelines which took effect January 1, 2021. Four new principal care management codes will be available for neurologists to use in 2022, recognizing the comprehensive services provided for a single high-risk disease.

CMS is refining its policies for split or shared E/M visits to reflect the evolving role of advanced practice providers (APP) and changes to the practice of medicine. For 2022, CMS defines split or shared E/M visits as those provided in the facility setting by a physician and an APP in the same group and expands to include new patient encounters. CMS has decided on a new, time-based definition of the "substantive portion" of a visit that must be furnished by the physician to bill split (shared), but this change will not be implemented until 2023, as the AAN requested.

## Telehealth Regulations

As expected, the final rule codified that the telehealth services added to the Medicare telehealth services list under the temporary "category 3" during the COVID-19 public health emergency (PHE) be removed from the list after the PHE ends. These services will have to be submitted to be made permanent under either category 1 or 2. However, CMS acknowledges that there has not been sufficient time to collect the utilization data needed on these telehealth services for submission and approval. Therefore, CMS will retain all telehealth services added due to the PHE through calendar year 2023 so that they can be analyzed and submitted for the 2023 and 2024 fee schedules for permanent inclusion. This is a welcome decision by CMS as it gives providers a clear timeframe

during which they can continue to use these temporarily approved telehealth services and allows for the much-needed study of these services for their potential permanent inclusion.

The AAN was glad to see that CMS accepted our recommendation that the requirement for an in-person visit every six months to be reimbursed for telehealth services be raised to a 12-month period. This will relieve an undue obstacle to the continuation of care provided via telehealth. CMS also finalized its proposal to allow another physician in the same specialty and practice to fulfill this requirement should the original physician be unavailable, as the AAN requested.

CMS has finalized the change to the requirements of telehealth provision to permanently allow audio-only telehealth services for the diagnosis, evaluation, or treatment of mental health disorders when the patient's home is the originating site. Only providers who are set up to provide full audio/visual telehealth services can make use of audio-only services; this is to ensure that it is the patient's aversion or inability to use audio/visual services that leads to an audio-only visit. The AAN was supportive of this change as it represents a logical adjustment of regulation to match the incorporation of technology in the provision of care.

### **Appropriate Use Criteria**

CMS will delay the beginning of the payment penalty phase of the Appropriate Use Criteria (AUC) program to no sooner than January 1, 2023, or the January 1 that follows the declared end of the COVID-19 Public Health Emergency. The flexibilities offered by CMS are intended to consider the impact of COVID-19 on providers and their beneficiaries. The current payment penalty phase of the AUC program was to begin at the start of 2022. This is a welcomed change. We continue to advocate for modifications to the AUC program recognizing its potential burden on neurologists.

### **Quality Payment Program**

The rule includes finalized policies related to the Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS), Advanced Alternative Payment Model (APM), and MIPS Value Pathways (MVPs).

For the MIPS track, CMS finalized increasing the 2022 performance threshold to 75 points from 60 points, as well as the exceptional performance bonus to 89 points from 85 points. For the Quality and Cost components, CMS finalized decreasing the weight of the MIPS Quality component to 30 percent from 40 percent and increasing the weight of the MIPS Cost component to 30 percent from 20 percent. For Improvement Activities, CMS finalized seven new activities, including three that are dedicated to promoting health equity. For Promoting Interoperability, small practices are now automatically exempt from the component, and it will be reweighted to Quality and Improvement Activities.

CMS finalized its policy awarding doubled bonus point opportunities to clinicians caring for complex patients during the COVID-19 public health emergency, while also finalizing the removal of bonus point opportunities for reporting additional outcome and high priority measures.

For the APM track, CMS finalized extending the CMS Web Interface reporting option through 2024, thus delaying the plan to sunset this reporting mechanism by two years.

### **MIPS Value Pathway**

The rule finalized seven MIPS Value Pathways (MVPs) or sets of defined measures and activities related to a specialty or condition, beginning in 2023. Included in the set is an MVP titled "Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes" which features measures and activities related to caring for stroke patients and may be relevant to some neurologists. The AAN actively engaged with CMS during the development process at CMS's invitation and provided extensive comments on the proposed stroke MVP. In addition to foundational population health measures and Promoting Interoperability measures, the stroke MVP features nine quality measures and nine improvement activities to choose from and one cost measure relevant to stroke care. In the rule, CMS also finalized policies on reporting and scoring expectations, which closely align with current MIPS policies. The AAN will develop resources for neurologists interested in transitioning to MVPs for the 2023 performance year.