

ACR Preliminary Summary of Radiology Provisions in the 2023 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Physician Fee Schedule (MPFS) proposed rule on Thursday, July 7. In this rule, CMS describes changes to payment provisions and to policies for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

CMS did not address the appropriate use criteria (AUC)/clinical decision support (CDS) mandate for all advanced diagnostic imaging services in this rule. However, CMS posted an update on its website indicating that the current educational and operations testing period will continue beyond January 1, 2023, even if the COVID-19 public health emergency (PHE) ends in 2022. The notice states that the agency is unable to forecast when the payment penalty phase of the program will begin. ACR staff will work with CMS to clarify next steps for the imaging AUC program.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2023 conversion factor of \$33.0775 compared to the 2022 conversion factor of \$34.6062. This was calculated by first removing the one-year 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act and then applying a negative 1.55 percent budget neutrality update. The budget neutrality update appears to be largely related to increased values for several evaluation and management code families, including hospital, emergency medicine, nursing facility and home visits.

CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 3 percent decrease, while interventional radiology would see an aggregate decrease of 4 percent, nuclear medicine a 3 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease if the provisions within the proposed rule are finalized. Part of the decrease is due changes in relative value units (RVUs) and the second year of the transition to clinical labor pricing updates. If Congress does not intervene to extend the 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act, the percent decreases mentioned above will be greater for CY 2023.

Valuation of Imaging Services

CMS addressed Relative Value Scale Update Committee (RUC) recommendations for 10 radiology-related CPT® codes. They accepted the values for codes pertaining to contrast x-ray of knee joint, 3D rendering and interpretation, ultrasound guidance, and fluoroscopic guidance. However, CMS proposed to refine the values for codes related to neuromuscular ultrasound and percutaneous arteriovenous fistula creation. The ACR will continue to review the proposed rule, including any practice expense refinements.

Clinical Labor Update

CMS proposed continuing to move forward with year 2 of the 4-year transition to the updated clinical labor input values. CMS updated wages for a few clinical staff types based on

information submitted by stakeholders. The agency will continue to consider public comment related to wage updates for clinical staff during the remainder of the 4-year phase-in.

Practice Expense Data Collection/Methodology

CMS is seeking public comment on strategies for updates to practice expense (PE) data collection and methodology. CMS plans to move forward to a standardized and routine approach to valuation of indirect PE and they welcome feedback from stakeholders on what this might entail. CMS provided some specific topics in the rule on which they are seeking comment. The agency plans to propose the new approach to valuation of indirect PE in future rulemaking.

Colorectal Cancer Screening Coverage

CMS proposed to update coverage of colorectal cancer screening services to align with the updated United States Preventive Services Task Force (USPSTF) recommendation to begin screening at age 45 rather than age 50. In addition, CMS proposed to expand the definition of colorectal cancer screening to include a follow-on screening colonoscopy after a positive result on a Medicare covered non-invasive stool-based screening test. CMS believes this would reduce screening barriers by ensuring patients will not be responsible for cost sharing for the additional test.

The proposed rule does not make any mention of CT colonography for colorectal cancer screening. CMS recently responded to the ACR's formal reconsideration request that there is not sufficient evidence to support changing the current non-coverage determination for CT colonography. The ACR will meet with CMS in the near future to discuss its rationale for the decision.

Medicare Shared Savings Program

CMS proposed changes to the Medicare Shared Savings Program (MSSP) that the agency hopes will advance their overall value-based care strategy of growth, alignment, and health equity. CMS proposed to incorporate advance shared savings payments to certain new MSSP Accountable Care Organizations (ACOs) that could be used to address Medicare beneficiaries' social needs. CMS proposed benchmark adjustments to promote more ACOs to participate and be successful. CMS proposed a health equity adjustment that would upwardly adjust ACOs' quality performance scores to continue encouraging high ACO quality performance, transition ACOs to all-payer eCQMs/MIPS CQMs, and support those ACOs serving a high proportion of underserved beneficiaries while also encouraging all ACOs to treat underserved populations.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

Within this rule, CMS is limiting proposals for traditional MIPS and focusing on further refining implementation of MIPS Value Pathways (MVPs). Five new MVPs are proposed and six previously established MVPs are revised. CMS is providing a means to provide feedback on

MVPs on the QPP website. CMS MVP proposals include changes and clarifications to MVP maintenance and participation options, as well as several additions and revisions to subgroup reporting such as eligibility, registration, and scoring.

MIPS Scoring Overview

The category weights for the 2023 performance year are proposed to remain the same as the 2022 weights: Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%. These percentages are likely to remain fixed for the future of the MIPS program.

The proposed 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.

Beginning with performance year 2022, CMS began calculating the MIPS performance based on prior years' mean and/or median scores. In 2022 this threshold was set to 75 points; CMS proposed to maintain the performance threshold at 75 points for 2023. This is based on the rounded mean final score from the 2019 performance year.

CMS will also no longer offer an exceptional performance adjustment beginning with the 2023 performance year. This was previously finalized in the 2022 MPFS final rule. 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

CMS has not proposed any changes to the low-volume threshold criteria as previously established. To be excluded from MIPS in 2023, 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. CMS proposed no changes to the opt-in policy established which allows 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.

Quality Category

As established in previous rules, this category will be weighted at 30% for 2023 and likely for the remainder of the MIPS program. As established in the 2022 MPFS final rule, beginning with performance year 2023, CMS will change the scoring range for benchmarked measures to 1 to 10 points, eliminating the 3-point floor; second, they intend to score non-benchmarked measures at 0 points even if data completeness is met. New measures will continue to be scored at a minimum of 7 points for their first year and a minimum of 5 points in their second year. These new measures will still be able to achieve higher points if a same-year benchmark is established,

but if a benchmark isn't established after 2 years in the program, that measure will not achieve any points. The exception to this rule is small and rural practices, who will be awarded 3 points for measures which either do not have a benchmark or do not meet case minimum.

CMS has proposed the removal of the following measures:

- #76: Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections
- #110: Preventive Care and Screening: Influenza Immunization
- #111: Pneumococcal Vaccination Status for Older Adults

CMS has also proposed the addition of the following new measure to the Diagnostic Radiology and Radiation Oncology measure sets:

- #TBD: Screening for Social Drivers of Health

No changes to Quality measure data completeness requirements were proposed for 2023, 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. However, CMS proposed to increase this threshold to 75% beginning with the 2024 and 2025 performance years.

Cost Category

CMS will continue to weigh the Cost performance category at 30% for MIPS performance year 2023 and likely for all subsequent years. CMS proposed to add the Medicare Spending Per Beneficiary (MSPB) Clinician cost measure as a care episode group alongside the episode-based measures already established as part of the Cost category.

Improvement Activities

CMS will maintain the 15% weight for the Improvement Activities (IAs) category. The 2023 Proposed Rule also adds 4 new activities and removes 5 previously adopted activities.

The IAs proposed for addition are:

- Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
- Create and Implement a Plan to Improve Care for LGBTQ Patients
- Create and Implement a Language Access Plan
- COVID-19 Vaccine Achievement for Practice Staff

The IAs proposed for removal are:

- IA_BE_7: Participation in a QCDR that promotes use of patient engagement tools
- IA_BE_8: Participation in a QCDR that promotes collaborate learning network opportunities that are interactive
- IA_PM_7: Use of QCDR for feedback reports that incorporate population health
- IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program
- IA_PSPA_20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes

Promoting Interoperability Category

The Promoting Interoperability category will continue to be weighted at 25% of the overall MIPS score, with reweighting options for non-patient facing clinicians and small and rural practices.

CMS proposed several modifications to Promoting Interoperability objectives and measures for participants reporting this performance category, including expansion of the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program measure, addition of a new alternative "yes/no" attestation measure for "Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)" under the Health Information Exchange Objective, and consolidation of prior compliance options for the Public Health and Clinical Data Exchange Objective.

Additionally, CMS has requested stakeholder comments on policy levers to advance information exchange through TEFCA-participating health information networks.

Advanced Alternative Payment Models (APMs)

An Advanced APM is an APM that: 1) requires participants to use certified electronic health 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%. The Consolidated Appropriations Act, 2021, froze the APM payment incentive thresholds for performance years 2021 and 2022 (payment years 2023 and 2024). After performance year 2022, which correlates with payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year. Beginning in payment year 2025, the statutory incentive structure under the QPP for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians.

CMS is concerned that the statutory incentive structure under the QPP beginning in the 2023 performance year and corresponding 2025 payment year could potentially lead to a drop in Advanced APM participation, and a corresponding increase in MIPS participation as eligible clinicians may believe their payments would be higher if they receive the MIPS payment adjustment. CMS concluded that it would be more prudent to forego administrative action for the 2023 performance period and 2025 payment year, and instead to seek robust public input that CMS will consider in identifying potential options for the 2024 performance period and 2026 payment year of the QPP.

APM Entity Reporting

CMS proposed to introduce a voluntary reporting option for APM Entities to report the promoting interoperability performance category at the APM Entity level beginning with the 2023 performance period. CMS has also asked for comments regarding sunsetting the use of

APM Entity level QP determinations and instead making QP determinations at the individual eligible clinician level only.

CMS proposed to apply the 50 eligible clinician limits to the APM Entity participating in the Medical Home Model based on the TIN/NPIs on the APM Entity's participation list. Similarly, CMS also proposed to apply the 50 eligible clinician limit directly to the APM Entity participating in Aligned Other Payer Medical Home Model and Medicaid Medical Home Model, and to no longer look to the parent organization for the APM Entity.

APM Incentive Payment Recipient

Under the QPP, an eligible clinician who is a Qualifying APM Participant (QP) for a performance year earns an APM Incentive Payment, which is made in the corresponding payment year for payment years 2019 through 2024. CMS seeks comment on the proposal to amend to change the cutoff date for response to the public notice from November 1 to September 1 of each payment year, or 60 days from the date on which CMS make the initial round of APM Incentive Payments, whichever is later.

Request for Information Regarding the Transition from APM Incentive Payments to the Enhanced PFS Conversion Factor Update for QPs

CMS has requested regarding the gap in statutory financial incentives for QPs in the 2025 payment year, and the difference in potential financial incentives between QPs and MIPS eligible clinicians in payment years beginning in 2026.

CMS published Fact Sheets on the overall [MPFS proposed rule](#), the [Medicare Shared Saving Program](#), and the [Quality Payment Program](#).

ACR staff will review the entire MPFS proposed rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline.