

ACR Preliminary Summary of Radiology Provisions in the 2021 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2021 Medicare Physician Fee Schedule (MPFS) proposed rule late on Monday, August 3rd. In this rule, CMS describes changes to payment provisions and to policies for implementation of the fifth 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).

The ACR is extremely disappointed that CMS chose to move forward with adoption of the new coding structure for the office/outpatient evaluation and management (E/M) codes as recommended by the AMA, as well as the RUC-recommended values. In order to maintain budget neutrality with these valuation increases, the proposed CY 2021 conversion factor is \$32.2605, a 10.61 percent decrease from the current conversion factor. These changes will result in significant payment reductions to all services including radiology services in 2021 unless Congress acts to suspend the budget neutrality requirement. The ACR will use every avenue available to work with Congress to modify the impact of these changes.

CMS did not address the appropriate use criteria (AUC)/clinical decision support (CDS) mandate for all advanced diagnostic imaging services in this rule. At this time, the current educational and operations testing period is set to expire on December 31, 2020, with full implementation of the program, including payment denials for imaging services that do not include AUC consultation information on the claim beginning on January 1, 2021. ACR staff will contact CMS to clarify next steps for the imaging AUC program.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2021 conversion factor of \$32.2605, which reflects a 10.61 percent budget neutrality adjustment as discussed above.

CMS estimates an overall impact of the MPFS proposed changes to radiology to be an 11 percent decrease, while interventional radiology would see an aggregate decrease of 9 percent, nuclear medicine an 8 percent decrease and radiation oncology and radiation therapy centers a 6 percent decrease if the provisions within the proposed rule are finalized.

Payment for E/M Services

For CY 2021, CMS is moving forward with its proposal finalized in the 2020 MPFS final rule to adopt the new coding structure for the office/outpatient evaluation and management (E/M) codes as recommended by the AMA, as well as the RUC-recommended values. There will be separate payments for each of the five levels of office/outpatient E/M (instead of the blended payments for levels 2-4), along with a new add-on code for prolonged visits and code for complex patients.

In addition, CMS is proposing to revalue a group of code sets that include or rely upon office/outpatient E/M visit valuation, consistent with the increases in values finalized for E/M visits for 2021. These code sets include end-stage renal disease (ESRD) monthly capitation

payment (MCP) services, transitional care management (TCM) services, maternity services, cognitive impairment assessment and care planning, initial preventive physical examination (IPPE) and initial and subsequent annual wellness visits (AWV), emergency department visits, therapy evaluations and psychiatric diagnostic evaluations and psychotherapy services.

Valuation of Services

CMS provided comment on over 40 new/revised codes impacting radiology. The agency is proposing to accept the majority of the RUC-recommended values. To note for 2021, CMS has approved a new code for low dose CT for lung cancer screening, while also proposing to reduce the value for the diagnostic codes for CT of the chest. CMS is also proposing to accept the practice expense inputs for the new medical physics code and the RUC-recommended values for the office/outpatient E/M codes. The ACR will closely review the rationale provided by CMS for proposed code refinements and will submit comments accordingly.

Supervision of Diagnostic Tests by Certain Nonphysician Practitioners (NPPs)

CMS is proposing to permanently allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians. If finalized on a permanent basis, these NPPs will be allowed under Medicare Part B to supervise the performance of diagnostic tests within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.

Direct Supervision by Interactive Telecommunications Technology

CMS is proposing to continue to allow direct supervision to be provided using real-time interactive audio and video technology through December 31, 2021. The agency is seeking comment on whether there should be any “guardrails” in effect or consider extending the policy beyond December 31, 2021. CMS also asks commenters to consider what risks the policy may pose to beneficiaries receiving care with virtual supervision.

Telehealth Services

CMS is proposing the addition of several codes to the list of approved telehealth services, including GPC1X (*Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services*) and 99XXX (*Prolonged office or other outpatient evaluation and management service(s) beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes*) as well as care planning and several home health services codes.

CMS is also proposing to create a third temporary category of criteria for adding services to the list of Medicare telehealth services during the public health emergency for (PHE) for the COVID-10 pandemic. These services would remain on the list through the calendar year in

which the PHE ends. Codes proposed for this new category include home health care, emergency department visits, and psychological care.

Removal of Outdated National Coverage Determinations

CMS is seeking comment on a proposal to use the rulemaking process to remove/retire outdated National Coverage Determinations (NCDs). Retirement of an NCD means that coverage decisions for that particular service revert back to the local Medicare Administrative Contractors (MACs). CMS is proposing the removal of nine NCDs, including the NCDs for Magnetic Resonance Spectroscopy and FDG PET for Inflammation and Infection. The agency is seeking comment on its proposed list as well as any additional NCDs that should be considered for removal.

Quality Payment Program

MIPS Value Pathways (MVPs)

While CMS proposes to delay the implementation of MVPs until the 2022 performance year, the rule explains that MVPs would be incrementally added to the QPP, upon availability. To that end, they underscored their intention to continue to support eligible clinicians' participation in "traditional" MIPS. It also consists of more details regarding the implementation of MVPs, including updates to the MVP Guiding Principles included in the 2020 final rule. As proposed, the principles establish CMS' intent to recognize subgroup reporting, which comprehensively reflects the services provided by multispecialty groups and a greater emphasis in the Guiding Principles on including the patient voice. The proposed rule includes a new principle that would designate that MVPs support the transition from electronic clinical quality measures (eQMs) from certified electronic health record technology only to more comprehensive health information technology through digital quality measures (dQMs). CMS identifies dQMs as data sourced from eQMs, health information exchanges, clinical registries, electronic administrative claims, and wearable devices.

The MVP development process and criteria are also proposed and consist of details for each performance category that MVP developers would have to consider before submitting their MVPs into the rulemaking process, similar to that of CMS' Annual Call for Measures. The potential process for including stakeholders in evaluating and recommending MVPs submitted under a call-for-measures-type process is also included.

CMS proposes plans for including qualified clinical data registry (QCDR) measures within MVPs. The rule explains that all QCDR measures approved for use in MVPs must meet the rigorous standard required by MIPS clinical quality measures (CQMs). CMS proposes multiple implementation timelines regarding the incorporation of QCDR measures in MVPs. Additionally, the proposed rule contains potential guidance for MVP submissions with QCDR measures. CMS also anticipates that MVP data will be reportable to CMS through QCDRs.

The proposed rule indicates a new on-ramp to the APM Performance Pathway (APP) in 2021. This new Pathway would be complementary to MVPs. The APP would be available only to

participants in MIPS APMs and may be reported by the individual eligible clinician, group (TIN), or APM Entity. In the APP, performance categories would be scored according to the following.

- The Cost category would be weighted at 0 percent.
- The Improvement Activity (IA) category would automatically receive full credit.
- The Promoting Interoperability (PI) category would be reported and scored at the individual or group level, as is required for the rest of MIPS;
- And the Quality category would be composed of six measures specifically focused on population health and widely available to all MIPS APM participants.

There is a separate proposal that would require ACOs participating in the Shared Savings Program to report their quality measures through the APP. The quality measures reported through the APP would also count for the MIPS Quality performance category for the MIPS eligible clinicians participating in these ACOs.

COVID-19 Flexibility

The 2021 proposed rule includes several provisions related to the ongoing COVID-19 pandemic. First, several services have been added to the Medicare telehealth services list on an interim final basis including radiation treatment management services (CPT code 77427).

The proposed rule acknowledges that the COVID-19 crisis and the subsequent deadline extension for 2019 MIPS reporting have created some delays in finalizing performance numbers, with updates expected later this year.

As noted previously, CMS proposes to delay the implementation of MVPs from 2021 to at least 2022. CMS will continue to develop and evolve MVP policies for future implementation.

CMS also proposes to reduce the neutral payment adjustment threshold for MIPS scoring from 60 points to 50 points as a recognition of the impact of COVID on clinicians. CMS had originally planned to raise the performance threshold based on the mean or median score of previous performance years.

MIPS Category Weighting

The proposed category weights for the 2021 performance year are: Quality – 40%, PI – 25%, Cost – 20%, and IAs – 15%.

In accordance with the 2020 MPFS Final Rule, CMS has proposed to lower the weight of the Quality category to 40% in 2021 and finally 30% in 2022 and beyond. Cost has increased to 20% for the 2021 performance year and will increase to 30% beginning in 2022.

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.

MIPS Performance Threshold and Incentive Payments

The Bipartisan Budget Act of 2018 gave CMS the flexibility to set a performance threshold for three additional years (program years 2019-2021) so as to continue an incremental transition to the statutorily required performance threshold based on the mean or median of final scores from a prior period. In the 2020 Final Rule, CMS finalized the performance threshold for 2021 at 60 points. CMS would like to re-examine the performance threshold for 2021 due to the Novel Coronavirus (COVID-19) pandemic, and is proposing to lower the performance threshold to 50 points for the 2021 performance year. The exceptional performance threshold remains at 85 points, as established in the 2019 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 proposes to maintain the low-volume threshold criteria as previously established. To be excluded from MIPS in 2021, 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 proposes 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 continues to award small practices 3 points for submitted quality measures that do not meet the data completeness requirements.

Quality Category

As established in previous rules, CMS proposes to continue lowering the weight of the Quality performance category. This category will be weighted at 40% for 2021 (down from 45% in 2020) and starting in the 2022 performance year will be weighted at 30%.

CMS also proposes to sunset the CMS Web Interface measures collection type, which had previously been available for groups with 25 or more eligible clinicians, beginning with the 2021 performance year. This is a result of decreased utilization of the CMS Web Interface in favor of other collection types such as Qualified Registries and Qualified Clinical Data Registries.

CMS has proposed the addition of some new quality measures as well as the removal of other measures. MIPS measures 146, "Inappropriate Use of 'Probably Benign' Assessment Category in Screening Mammograms," and 437, "Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure," have been proposed for removal because they are considered extremely topped out due to high performance rates.

Regarding their methodology for scoring topped out measures, CMS proposes to 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.

CMS has also proposed to use performance period benchmarks rather than historical benchmarks for the 2021 performance year out of concern that the COVID-19 public health emergency could skew benchmarking results.

Quality Data Completeness Requirements

No changes to data completeness requirements were proposed for 2021, remains at 70%. According to analysis of program year 2017 submission data, individuals, groups, and small practices have submitted quality data with an average completeness of roughly 76%, 85%, and 74% respectively. Based on this data, CMS raised the data completeness standard to 70% for quality measure data submission in 2020. This number defines the minimum subset of patients within a measure denominator that must be reported;

Cost Category

CMS is proposing to weight the cost performance category at 20% for the 2021 MIPS performance year and 30% for 2022 and all subsequent years per the statute.

CMS is proposing to include telehealth services that are directly applicable to existing episode-based cost measures and the Total Per Capita Cost measure.

Improvement Activities

CMS proposes to maintain the 15% weight for the Improvement Activities category. There are no major changes to this performance category proposed for 2021, and no activities proposed for addition or removal.

CMS is proposing to allow flexibility when submitting new improvement activities to the Annual Call for Activities, which is currently open from February 1st through June 30th, in the event of public health emergencies (PHE) such as the COVID-19 crisis. This proposal would allow stakeholders to submit new improvement activities outside of the established 4-month timeframe in the event of a PHE.

Similarly, CMS proposes a process to allow activities nominated by the Department of Health and Human Services (HHS) to be considered year-round for addition to the improvement activities inventory.

Promoting Interoperability

CMS proposes to allow satisfaction of the Health Information Exchange (HIE) objective via participation in bi-directional exchange through an HIE network using certified EHR technology functionality. Additionally, CMS proposes minor modifications to the “Query of Prescription

Drug Monitoring Program (PDMP)” and “Support Electronic Referral Loops by Receiving and Incorporating Health Information” measures.

CMS does not propose specific provider disincentives for violations of “information blocking” per the 21st Century Cures Act in this NPRM; however, the agency is considering changes for future years of the Promoting Interoperability category.

Facility-based Scoring

Facility-based scoring was implemented in 2019. The measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period would be used for facility-based clinicians. A facility-based group would be defined as one in which 75 percent or more of the MIPS eligible clinicians NPIs billing under the group’s TIN are eligible for facility-based measurement as individuals. There are no submission requirements for individual clinicians in facility-based measurement but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a group under facility-based measurement. CMS will automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score. There are no proposed changes for facility-based scoring eligibility.

Physician Compare

CMS is proposing to define “Physician Compare” to mean Physician Compare Internet Website of the Centers for Medicare and Medicaid Services to more accurately reference the site where CMS posts information available for public reporting.

MIPS APMs

In 2017, CMS finalized the APM scoring standard to reduce reporting burden for participants in MIPS APMs by eliminating the need for such MIPS eligible clinicians to submit data for both MIPS and their respective APMs. Due to significant public comment about the complexity of the APM scoring standard, CMS is proposing to terminate the APM scoring standard beginning on January 1, 2021. In addition, with the removal of the APM scoring standard, CMS is proposing to end the full-TIN APM policy, as well as the term “full TIN APM”. CMS is proposing that the MIPS final score calculated for the APM entity would be applied to each MIPS eligible clinician in the APM entity group.

CMS is proposing to remove the use of low-volume threshold determinations and the term “APM Entity group” beginning January 1, 2021.

CMS is also proposing to establish a MIPS APP for MIPS eligible clinicians in MIPS APMs beginning January 1, 2021.

Advanced Alternative Payment Models (APMs)

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 5 percent APM Incentive Payment. Beginning in the CY 2021 QP Performance Period, the QP payment amount threshold increases from 50 percent to 75 percent of Medicare payments, while the QP patient count threshold increases from 35 percent to 50 percent of Medicare patients.

CMS is proposing to clarify that the APM Incentive Payment amount is calculated based on the paid amount of the applicable claims for covered professional services that are subsequently aggregated to calculate the estimated aggregate payments.

CMS also proposes to establish a revised approach to identifying the TIN(s) to which they make the APM Incentive Payment. This approach would involve looking at a QP's relationship with their TIN(s) over time, as well as considering the relationship the TIN(s) have with the APM Entity or Entities through which the eligible clinician earned QP status, or other APM Entities the QP may have joined in the interim.

CMS is proposing to introduce a cutoff date of November 1st of each payment year (or 60 days from the day on which CMS makes the initial round of APM Incentive Payments, whichever is later), as a point in time after which CMS will no longer accept new helpdesk requests from QPs or their representatives who have not received their payments.

CMS is proposing to apply a hierarchy system to identify the TIN(s) to which CMS makes APM incentive payment for a QP. In addition, the agency proposes to establish a Targeted Review process for limited circumstances surrounding QP Determinations.

CMS is proposing to specify in regulations that beneficiaries who have been prospectively attributed to an APM entity for a QP performance period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list.

Due to the impacts of COVID-19, CMS will not reconsider advanced APM determinations of APMs that have already met the criteria for CY2020, even if they have undergone changes due to the Public Health Emergency. Additionally, CMS will evaluate all APMs in future years with the understanding that any provisions of the Participation Agreement or governing regulation designed in response to the COVID-19 PHE will not be considered to the extent they would prevent the APM from meeting the Advanced APM criteria for a year.

Due to the impacts of the COVID-19 PHE, certain APMs may adopt earlier end dates. CMS will not consider this to be termination from an agreement, and would not revoke QP status of eligible clinician participants.

CMS clarified that they will continue to perform QP determinations at the established times for the 2020 QP performance period without modification for the PHE.

CMS seeks comment on whether to allow Partial QP elections to be made by APM Entities on behalf of all eligible clinicians within the APM Entity, and how to handle potentially conflicting elections.

ACR's MACRA Committee and staff continue to digest and analyze changes in this rule. A more detailed summary will be published in coming weeks. In the meantime, read CMS' extensive fact sheet on the major changes in this rule for the fifth year of Medicare's Quality Payment Program for physicians who are required to participate in either APMs or MIPS.

CMS has posted a press release and fact sheet on their website. 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.