

## **ACR Preliminary Summary of Radiology Provisions in the 2020 MPFS Final Rule**

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) final rule on Friday, November 1, 2019. In this rule, CMS describes changes to payment provisions and to policies for implementation of the fourth 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 disappointed that CMS chose to finalize its proposals 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 times and values. These changes will result in significant payment reductions to 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.

### Conversion Factor and CMS Overall Impact Estimates

CMS finalized a CY 2020 conversion factor of \$36.0896, which is a slight increase from the current conversion factor of \$36.0391.

CMS estimates an overall impact of the final MPFS changes to radiology, radiation oncology and radiation therapy centers a neutral 0 percent, an overall 1 percent decrease for interventional radiology and a 1 percent increase for nuclear medicine.

The rule includes CMS final values for over 100 new/revised codes impacting Radiology. Following extensive comment from Radiology, CMS did update their proposed values to accept the RUC-recommended values for intravascular ultrasound, computed tomography of the orbit, sella, or fossa, and myocardial imaging with PET. CMS also increased their proposed value for one of the codes related to pericardial drainage procedures. Additional information on these code-specific changes will be provided in the coming weeks.

### Payment for E/M Services

For CY 2021, CMS finalized its proposal 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 times and 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. CMS, however, is not making any changes to the E/M office visits captured in the 10 and 90 day global codes. CMS plans to continue to assess and develop an approach to revaluing global surgery procedure, including the associated post-operative visits. January 1, 2021 implementation will allow time for feedback, provider education, and changes to workflow, updates to EHRs and systems.

### Direct Practice Expense (PE) Inputs for Ultrasound Room

For CY2019, CMS contracted with StrategyGen to review the pricing of CMS medical equipment and supplies, as they had not been reviewed in over a decade. There was a proposal for a four-year phase in for the updated pricing. In the past year, due to continued feedback,

StrategyGen conducted an extensive examination of the pricing for any equipment or supply item that was identified as requiring additional review, and considered any invoices that were submitted. Following this review, the pricing for 70 equipment or supply items were updated, including increases to the prices for the ultrasound room and vascular ultrasound room. CMS finalized the updated pricing for the ultrasound and vascular ultrasound rooms.

#### Appropriate Use Criteria (AUC)/Clinical Decision Support (CDS)

There is no discussion on AUC/CDS pertaining to advanced diagnostic imaging services in the final rule. However, on July 26, CMS did release separate AUC [claims processing guidance](#) with additional information on the applicable HCPCS modifiers and G codes. Last year, CMS reaffirmed that the ordering providers must consult AUC when ordering advanced diagnostic imaging services to include CT, MR, PET scans, and nuclear medicine exams for Medicare patients starting January 1, 2020. Year 2020 is considered to be “Educational and Operations” testing period with no penalties.

#### Potentially Misvalued Services under the MPFS

In the rule, four codes were publicly nominated by CMS as potentially misvalued. Of these four, two of the codes pertain to radiology.

Two codes in the Fine Needle Aspiration code family were publicly nominated as potentially misvalued. CPT codes 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion) was nominated along with 10021 (Fine needle aspiration biopsy, without imaging guidance; first lesion) due to the commenter’s discomfort with the ratio of time to RVU for these specific procedures. CMS indicated in the final rule that they did not receive any additional information to consider in the context of their previous review of these services. Therefore, the Agency did not include the Fine Needle Aspiration codes on the final list of potentially misvalued codes for CY 2020.

CMS nominated CPT code 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; requiring image post-processing on an independent workstation) as potentially valued as it has not been recently reviewed. CPT code 76376 was recently reviewed at the April 2018 RUC meeting. The Rule states that due to these codes’ similarities, CPT code 76377 should be reviewed in order to maintain relativity in the code family. Despite comments from the ACR indicating that CPT code 76377 is different in scope from CPT code 76376, CMS finalized its inclusion as a potentially misvalued code for CY 2020.

#### Comment Solicitation on Opportunities for Bundled Payments under the MPFS

In the proposed rule, CMS sought public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians’ services paid under the MPFS and better align Medicare payment policies. The final rule indicated that many comments were received in response to this request and they will consider them for future rulemaking on this topic.

### Physician Supervision Requirements for Physician Assistants (PAs)

In response to public comment received, CMS finalized its proposal with some revisions to revise the regulation that establishes physician supervision requirements for PAs in order to provide them greater flexibility to practice more broadly in accordance with state law and state scope of practice rules in the state in which services are provided. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would have to be evidenced by documentation at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physicians when furnishing professional services. This is a revision of the proposed rule which required documentation in the medical record of the PA's approach to working with physicians in providing their services.

### Quality Payment Program (QPP) Sections

#### MIPS Value Pathways (MVP)

In the final rule, CMS confirms that it is moving forward with the MIPS Value Pathway (MVP) framework for 2021 and will continue to solicit feedback from stakeholders, especially as it relates to burden reduction across the 4 MIPS categories. CMS has defined MVPs as “a subset of measures and activities established through rulemaking.”

The purpose of the MVP framework will be to transform MIPS into a more streamlined and cohesive program, with the hope of offering measures and activities which are meaningful to all clinicians, including specialists and those who have found MIPS participation to be burdensome. ACR continues to digest the MVP information offered in the final rule and expects more detailed information to become available next year.

#### MIPS Category Weighting

For 2020 MIPS, CMS is maintaining the same category weights as 2019, meaning that the quality category will remain at 45%, promoting interoperability at 25%, cost at 15% and improvement activities also at 15%. If a MIPS eligible clinician is scored on fewer than two performance categories, a final score equal to the performance threshold will be assigned and the MIPS eligible clinician will receive a payment adjustment of 0%.

#### 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. For the 2020 MIPS performance year, CMS will increase the performance threshold to 45 points, with the intention of increasing it to 60 points for the 2021 MIPS performance year. Additionally, CMS will increase the exceptional performance bonus threshold to 85 points for the 2020 and 2021 MIPS performance years. Finally, CMS will move forward with increasing the minimum MIPS penalties and maximum MIPS base incentives from -7%/+7% in 2019 to +9%/-9% for 2020.

### Low Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations

CMS will maintain the low-volume threshold criteria as established in 2019. To be excluded from MIPS in 2020, clinicians or groups will need to meet one of the following three criteria: have  $\leq$  \$90K in Part B allowed charges for covered professional services, provide care to  $\leq$  200 beneficiaries, or provide  $\leq$  200 covered professional services under the Physician Fee Schedule. CMS has made no changes to the opt-in policy established in 2019, 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 added to the quality performance category score.

CMS will also continue to award small practices 3 points for submitted quality measures that do not meet the data completeness requirements of 70%.

Small practices may still submit quality data through the Medicare Part B claims submission type for the Quality performance category; however CMS will only allow this option to clinicians or groups who submitted data via claims submission in 2018.

CMS states it will maintain technical assistance to small and rural practices.

### Quality Category

Although CMS intends to maintain the Quality category's weight at 45% for the 2020 performance year, CMS has outlined its plan to lower the weight to 35% in 2021 and finally 30% in 2022. CMS has also established a guideline for removing Quality measures which do not meet the case minimum and reporting volume required for benchmarking after two consecutive years in the MIPS program.

For 2020, CMS will continue allowing eligible clinicians and groups to submit a single measure via multiple collection types (e.g. MIPS CQM, eCQM, QCDR measures and Medicare Part B claims measures).

CMS has also decided to keep MIPS quality measures #146 and #225, "Inappropriate Use of Probably Benign" and "Reminder System for Screening Mammograms," in the program for performance year 2020. These measures had originally been proposed for removal.

### Data Completeness Requirements

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 is raising the data completeness standard to 70% for quality measure data submission. This number defines the minimum subset of patients within a measure denominator that must be reported.

### Cost Category – New Episode-based Cost Measures

CMS is moving forward with the inclusion of ten new episode-based cost measures for implementation in 2020:

- Non-Emergent Coronary Artery Bypass Graft (CABG),
- Femoral or Inguinal Hernia Repair,

- Lower Gastrointestinal Hemorrhage,
- Elective Primary Hip Arthroplasty,
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels,
- Hemodialysis Access Creation,
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation,
- Acute Kidney Injury Requiring New Inpatient Dialysis,
- Renal or Ureteral Stone Surgical Treatment
- Lumpectomy, Partial Mastectomy, and Simple Mastectomy.

These cost measures are attributed to clinicians who provide a trigger service for procedural episodes or bill inpatient Evaluation and Management claims for chronic inpatient episodes. The Lower Gastrointestinal Hemorrhage measure is only available for group reporting.

CMS is changing both the Medicare Spending Per Beneficiary measure and the Total Per Capita Cost measure. The Medicare Spending Per Beneficiary (MSPB) measure's name will be changed from MSPB to MSPB Clinician (MSPB-C) to distinguish it from measures with similar names currently in use. CMS has also created a service exclusion list that is considered clinically unrelated to the index admission of the revised MSPB clinician measure, and a change in the attribution methodology to distinguish between medical episodes and surgical episodes.

CMS has finalized numerous changes to the Total Per Capita Cost (TPCC) measure, which include a revised primary care attribution methodology, a revised risk adjustment methodology, service and specialty category exclusions for clinicians that perform non-primary care services, and evaluating beneficiary cost on a monthly basis rather than an annual basis.

### Improvement Activities

In the 2020 Final Rule, non-patient-facing physicians are still required to earn two medium-weighted improvement activities (IAs) or one high-weighted IA to receive full credit in this category. Although CMS hasn't changed the basic requirements of the IA category, CMS has made significant changes to improvement activity (IA) reporting requirements for group reporters. Previously, groups could report an IA as long as one member of the practice had completed that IA. For 2020, CMS has raised that requirement to at least 50% of the group over a continuous 90-day period, although this doesn't have to be the same 90-day period for all physicians.

Recognizing the importance of appropriate use criteria (AUC) for diagnostic imaging, CMS will continue offering high-weighted improvement activity (IA) credit for those referring physicians who are early adopters by participating in clinical decision support for 2020. Under the final rule, the seven medium-weighted IAs related to ACR's R-SCAN program will continue to be available.

For 2020 MIPS performance year CMS is adding 2 new improvement activities, modifying 7 existing improvement activities and removing 15. CMS has also finalized a set of criteria to be used in determining whether an IA should be removed for future program years.

Practices designated as a certified patient-centered medical home (PCMH) will continue to receive automatic credit for the Improvement Activities category, but CMS has modified the definition of a PCMH to be more inclusive. In previous years, CMS listed four accrediting organizations and required that practices receive accreditation from one of those four to be considered a PCMH. CMS has updated the PCMH guideline so that it is no longer exclusive to those specific accrediting organizations.

#### Promoting Interoperability Category

CMS finalized its proposal that the required percentage of *hospital-based MIPS eligible clinicians* billing under groups or virtual groups be reduced from 100 percent to 75 percent to qualify for that special status as a group or virtual group. This change would begin with the 2022 MIPS payment year.

CMS finalized its proposal to re-establish automatic reweighting of the Promoting Interoperability category for *non-patient facing MIPS eligible clinician* groups or virtual groups. CMS unintentionally altered the application of auto-reweighting to such groups in last year's final rule, and this revision corrects the regulatory language.

Finally, CMS modified and clarified several of the Promoting Interoperability measure scores and exclusions.

#### 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 changes for facility-based scoring eligibility in the 2020 final rule.

#### Virtual Group – Sub-group

No changes to the virtual group eligibility and election process.

#### Physician Compare

CMS intends to publish aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores on Physician Compare, as feasible.

CMS is still considering whether to establish a “value indicator” for MIPS-eligible physicians whose information is published on the Physician Compare website. This would potentially be a composite of their cost, quality, and patient experience and satisfaction scores. CMS will take comments into consideration during future rulemaking cycles.

### MIPS APMs

CMS has maintained the same APM scoring standards for MIPS APMs: the quality performance category at 50 percent, the cost performance category at 0 percent, the improvement activities performance category at 20 percent; and the Promoting Interoperability category at 30 percent. Because quality measures based on an APM's measures are not always available for MIPS scoring, CMS is moving forward with their proposal to allow APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS Quality performance category. MIPS eligible clinicians in MIPS APMS will receive a quality performance score through either individual or TIN level reporting.

Additionally, CMS finalized a MIPS APM Quality Reporting Credit for APM participants in other MIPS APMs where quality scoring through the APM is not technically feasible. For these APM participants, a credit equal to 50 percent of the MIPS Quality performance category weight will be given. This credit is subject to a cap of 100 as a total score for the Quality performance category.

### Advanced Alternative Payment Models

For payment years 2019 and 2020, eligible clinicians may become qualifying physicians (QPs) only through participation in Medicare Advanced APMs. For payment years 2021 and later, eligible clinicians may become QPs through a combination of participation in Medicare Advanced APMs and Other Payer Advanced APMs (which is also referred to as the All-Payer Combination Option). The requirements for these APMs include the use of CEHRT, base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category, and a requirement that participants bear a certain amount of financial risk. The process for determining whether a payment arrangement meets these criteria is initiated either by the payer or the eligible clinician.

In payment years 2019 through 2024, QPs receive a lump sum incentive payment annually equal to 5 percent of their prior year's estimated aggregate payments for Part B covered professional services. Beginning in 2026, QPs receive a higher annual fee schedule update (.75) than non-QPs (.25).

The generally applicable revenue-based nominal amount standard is set at 8 percent or greater for QP Performance Periods extended out to 2024. This standard applies to models that express risk in terms of revenue. The total expenditure-based nominal amount standard is 3 percent or greater beginning with no specified date for expiration or increase. CMS finalized the proposal to redefine expected expenditures to be the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures now mean the episode target price. The expected expenditures under the terms of the APM should not exceed the expected Medicare Parts A and B expenditures for a participant in the absence of the APM. If expected expenditures under the APM exceed the Medicare Parts A and B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for Advanced APM determinations.

CMS will not finalize their proposed change to only apply Partial QP status to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status. CMS finalized the proposal to revise regulations to state that, beginning in the 2020 QP Performance Period, an eligible clinician is not a QP or Partial QP for the year if: (1) the APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or (2) the APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs. CMS finalized their proposal to use the average marginal risk rate for comparison when the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, with exceptions for large losses and small losses. CMS amended this in an effort to continue to require significant and meaningful financial risk among Other Payer Advanced APMs.

ACR's staff and MACRA Committee continue to digest and analyze the final rule and will provide a comprehensive summary of the rule in the coming weeks. CMS has posted a [MPFS press release](#) and [MPFS fact sheet](#) on their website.