

ACR Preliminary Summary of Radiology Provisions in the 2020 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) proposed rule on Monday, July 29, 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).

Conversion Factor and CMS Overall Impact Estimates

CMS estimates 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 MPFS proposed changes to radiology of 1 percent decrease, 2 percent decrease for interventional radiology, 1 percent increase for nuclear medicine, and neutral 0 percent change for radiation oncology and radiation therapy centers if the provisions within the proposed rule are finalized.

The rule includes CMS comment on over 100 new/revised codes impacting Radiology. Of those codes, CMS is proposing to accept the RUC-recommended values for over 60 codes; however, CMS is also proposing to decrease values for 41 radiology-related codes pertaining to procedures such as intravascular ultrasound, computed tomography of the orbit, sella, or fossa, abdominal aortography, pericardial drainage procedures, bone biopsy, lumbar spinal puncture, x-ray of sinuses, x-ray of neck, and myocardial imaging with PET. Additional information on these code-specific changes will be provided in the coming weeks.

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

There is no discussion on AUC/CDS pertaining to advanced diagnostic imaging services in the proposed rule. However, on July 26, CMS did release a separate AUC claims processing guidance transmittal 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.

Payment for E/M Services

For CY 2021, CMS proposes 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. 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.

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 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.

Comment Solicitation on Opportunities for Bundled Payments under the MPFS

CMS states that identifying and developing appropriate payment policies that aim to achieve better care and improved health for Medicare beneficiaries is a priority for the agency. CMS is interested in exploring new options for establishing MPFS payment rates or adjustments for services that are provided together. CMS is seeking 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.

Physician Supervision Requirements for Physician Assistants (PAs)

CMS proposes 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 be evidenced by 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)

CMS acknowledged concerns from clinicians and stakeholders about the complexity, burden, lack of performance comparability, questionable meaningfulness and lack of patient focused measurement within the MIPS program. CMS states that although they have made efforts to streamline the program, they are now focusing on more substantial changes to improve MIPS.

With that in mind, CMS is proposing the MIPS Value Pathways (MVPs), a conceptual participation framework for future proposals beginning with the 2021 performance year. CMS' goal with the MVP is to align measures across the "siloes" MIPS categories to make for a more meaningful and relevant assessment of a clinician's practice. The MVP framework would also incorporate a combination of administrative claims-based measures and specialty/condition specific measures while leveraging Promoting Interoperability measures. Within this rule, CMS is requesting information from stakeholders to help shape the MVP framework.

MIPS Category Weighting

CMS has proposed to increase the weight of the cost category under MIPS for 2020 to 20%, lower the quality category weight to 40% and maintain the weights for promoting interoperability and improvement activities categories at 25% and 15% respectively. 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) in order 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 2019 MIPS performance year, CMS set the MIPS performance threshold at 30 points, and is proposing to increase it to 45 points for 2020 MIPS performance year and 60 points for 2021 MIPS performance year. Additionally, CMS proposes to increase the exceptional performance bonus threshold to 80 points for the 2020 MIPS performance year and 85 points for the 2021 MIPS performance year. CMS is proposing to 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 proposes to maintain the low-volume threshold criteria as established in 2019. To be excluded from MIPS in 2020, clinicians or groups would 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 proposes 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 included in the quality performance category score.

CMS proposes to 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 is proposing to only allow this option to clinicians or groups who submitted data via claims submission in 2017.

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

Quality Category

In addition to lowering the Quality category's weight to 40% for the 2020 performance year, CMS outlines its plan to lower the weight to 35% in 2021 and finally 30% in 2022. CMS also proposes to establish 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 proposes to 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).

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 proposing to raise 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 proposing to move 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 proposed for group reporting.

CMS is proposing changes to both the Medicare Spending Per Beneficiary measure and the Total Per Capita Cost measure. The Medicare Spending Per Beneficiary (MSPB) measure has a proposed name change from MSPB to MSPB Clinician to distinguish it from measure with similar names currently in use. CMS has also proposed 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 proposed 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 Proposed 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 proposed to change the basic requirements of the IA category, CMS has proposed to make 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 is proposing to raise that requirement to at least 50% of the group within the same continuous 90-day period.

Recognizing the importance of appropriate use criteria (AUC) for diagnostic imaging, CMS proposes to 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 proposed 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 proposing the addition of 2 new improvement activities, the modification of 7 existing improvement activities and the removal of 15. CMS has also proposed 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 proposes to modify 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 proposes to update the PCMH guideline so that it is no longer exclusive to those specific accrediting organizations.

Promoting Interoperability Category

CMS proposes to implement ACR's long-advocated recommendation 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 the "hospital-based" special status as a group/virtual group. This change would begin with the 2022 MIPS payment year and provide another means for radiology and multispecialty groups/virtual groups to be reweighted from the Promoting Interoperability performance category.

CMS proposes to re-establish automatic reweighting of the Promoting Interoperability category for "non-patient facing" groups. CMS unintentionally altered the application of auto-reweighting to such groups in last year's final rule, and this proposal would correct that administrative issue.

CMS proposes modifications and clarifications to several of the Promoting Interoperability measure scores and exclusions. CMS also requests information on secondary topics, EHR efficiency, patient-generated health data integration, provider-to-patient exchange, and so on.

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.

Virtual Group – Sub-group

No proposed changes to the virtual group election process.

Physician Compare

CMS is seeking comments on 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 discusses the applicability of its proposed MIPS Value Pathways (MVP) to MIPS APMs as a means to pave the way more readily to qualify for MIPS APMs or APMs.

Because quality measures based on an APM's measures are not always available for MIPS scoring, CMS proposes 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.

Additionally, CMS proposes 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, CMS proposes a credit equal to 50 percent of the MIPS Quality performance category weight.

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. One of CMS' goals in

proposing the use of MVPs is to standardize the use of measures and activities reported by APMs as well.

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 proposes 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 would mean the episode target price.

For your reference, read [CMS' extensive fact sheet](#) on the major changes in this rule for the fourth year of Medicare's Quality Payment Program for physicians who are required to participate in either APMs or MIPS.

ACR's staff and MACRA Committee continue to digest and analyze changes in this rule and will provide a comprehensive summary of the rule in the coming weeks. The ACR will also submit comments to CMS by the comment period deadline on September 27. CMS has posted a [MPFS press release](#) and [MPFS fact sheet](#) on their website.