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

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2021 Medicare Physician Fee Schedule (MPFS) final rule Dec. 1. 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 incredibly 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.

CMS chose not to acknowledge the devastating effects this policy change will have on hundreds of thousands of Medicare providers including all of radiology who do not often bill for E/M services. Due to the statutory requirement that the physician fee schedule remains "budget neutral," radiologists, interventional radiology, radiation oncology and nuclear medicine physician payments will all be cut significantly starting Jan. 1, 2021.

To maintain budget neutrality in this massive payment redistribution, the Medicare conversion factor for 2021 will be reduced by 10%, which will disproportionately impact specialty medicine such as radiology, pathology, surgery and subspecialties and nonphysician providers such as physical therapy. In addition, CMS also finalized increased relative value units (RVUs) for 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. In order to maintain budget neutrality with these valuation increases, the final CY 2021 conversion factor is $32.41, a $3.68 decrease from the current conversion factor.

As a result of CMS not addressing the negative impacts these E/M changes will have on thousands of patient services provided by impacted physicians, Congress must enact legislation if these provider cuts are to be averted.

<u>Conversion Factor and CMS Overall Impact</u>
The CY 2021 conversion factor will be $32.4085, which reflects a 10.20 percent budget neutrality adjustment as discussed above.

The overall impact of the MPFS proposed changes to radiology to be a 10 percent decrease, while interventional radiology would see an aggregate decrease of 8 percent, nuclear medicine an 8 percent decrease and radiation oncology and radiation therapy centers a 5 percent decrease.

<u>Payment for E/M Services</u>
For CY 2021, CMS is moving forward with its finalized policy 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 finalizing its proposal 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

In the MPFS 2021 Final Rule, CMS finalized recommendations for over 40 new/revised codes impacting Radiology. Despite our comments and efforts, including a conference call with CMS, the agency will be implementing their values from the proposed rule. This includes a reduction in value for the diagnostic chest CT codes. On a positive note, there is a new code for low dose CT for lung cancer screening, and the practice expense inputs for the new medical physics code have been approved. These values will go into effect January 1, 2021.

Supervision of Diagnostic Tests by Certain Nonphysician Practitioners (NPPs)

CMS is finalizing its proposal 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. 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.

Telehealth

CMS finalized their proposal to add 9 services to the Medicare telehealth services list on a Category 1 basis for 2021. These include: G2211, previously described by placeholder code 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), G2212, previously described by placeholder code 99XXX (Prolonged office or other outpatient evaluation and management services (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), 90853 (Group psychotherapy, other than of a multiple-family group), 96121 (neurobehavioral status exam), 99483 (Cognitive Assessment and Care Planning Services), 99334 and 99335 (Domiciliary, Rest Home, or Custodial Care Services), and 99347 and 99348 (Home visits, established patients).

CMS finalized their proposal to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. Category 3 will include the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Any service in Category 3 will remain on the telehealth services list through the later of the end of the calendar year in which the PHE ends or December 31, 2021. CMS finalized over 60 services to the Medicare telehealth list under Category 3.

In the March 31st COVID-19 IFC, CMS allowed clinical social workers and clinical psychologists, OTs, PTs, and SLPs who bill Medicare directly for their services to bill HCPCS codes G2061 through G2063. CMS finalized their proposal to adopt this PHE policy on a permanent basis. CMS also finalized their proposal to allow billing of other communication technology based services (CTBS) by certain non-physician practitioners, consistent with the scope of these practitioners' benefit categories through the creation of two additional HCPCS G codes (G2250, G2251) that can be billed by practitioners who cannot independently bill for E/M services.

Telehealth and Supervision

During the PHE, CMS adopted an Interim Final Policy to revise the definition of direct supervision to include virtual presence of the supervising physician or practitioner using audio/video real-time communication technology. CMS finalized their proposal to extend this policy through December 31, 2021 or the end of the calendar year in which the PHE ends, whichever is later.

During the PHE, CMS adopted a policy on an interim basis to allow Medicare to make payment under the PFS for teaching physician services when a resident furnishes Medicare telehealth services to beneficiaries while a teaching physician is present using audio/video real-time communication technology. CMS is permanently extending this policy but only for services furnished in residency training sites that are located outside of the OMB-defined metropolitan statistical area (MSA).

Removal of Outdated National Coverage Determinations

CMS is finalizing its 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 finalizing the removal of several NCDs, including the NCDs for Magnetic Resonance Spectroscopy and FDG PET for Inflammation and Infection. In response to comments from the ACR, CMS will modify the NCD manual to ensure that contractors have the authority to make a coverage determination when claims are submitted for Pet for Inflammation and Infection.

In addition, the ACR requested in our comments that CMS retire the NCD for CT Colonography for Colorectal Cancer Screening. CMS responded that they will consider the comments for future review and will be in touch with interested stakeholders.

MIPS Value Pathways (MVPs)

CMS states that while they are moving forward with MIPS Value Pathways (MVPs) policy development, proposals for initial MVPs is delayed until at least the 2022 performance year. The delay is primarily due to the PHE for COVID-19 with the need for front line clinician burden relief in the form of extreme and uncontrollable circumstances policy exceptions through 2021. CMS continues to believe that MVPs will allow for a more "cohesive participation experience" through overarching activities and measures across categories that are relevant to specific conditions or specialties, and that MVP policies will reduce MIPS reporting burden and inefficiencies.

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.

In this rule, CMS finalized certain updates to the MVP Guiding Principles including recognition of subgroup reporting, which comprehensively reflects the services provided by multispecialty groups; using connected complementary sets of measures and activities; use of the "Meaningful Measures" approach and a greater emphasis on including the patient voice. CMS also finalized inclusion of a new principle that MVPs should support the transition to more comprehensive health information technology through digital quality measures (dQMs). CMS identifies dQMs as data sourced from eCQMs, health information exchanges, clinical registries, electronic administrative claims, and wearable devices.

In preface to finalization of MVP development process and criteria proposed policies, CMS emphasized the importance of a gradual transition to MVPs, without immediate elimination of the current MIPS program, in order to work collaboratively with stakeholders in MVP development.

MVP Development Criteria
CMS finalized proposals so that at beginning with the 2022 MIPS performance period, MVPs will be developed using criteria considering certain aspects of the following framework:

- Use of measures and activities from the Quality, Cost and Improvement Activities categories; inclusion of the entire Promoting Interoperability measure set.
- Intent of the MVP measurement is clear
- Measure and Activities have clear linkages within the MVP
- Appropriateness of reporting
- Comprehensibility
- Incorporation of patient voice

CMS also discussed finalized policies for the MVP solicitation and evaluation, as well as stating the importance of consideration of Qualified Clinical Data Registry (QCDR) measures within MVPs.

COVID-19 Flexibility

MIPS Category Weighting
CMS has finalized the category weights which they proposed for the 2021 performance year: Quality – 40 percent, Promoting Interoperability – 25 percent, Cost – 20 percent, and Improvement Activities – 15 percent.

CMS will lower the weight of the Quality category to 30 percent for the 2022 performance year and beyond. Cost has increased to 20 percent for the 2021 performance year and will increase to 30 percent beginning in 2022.

The 2021 final 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 will maintain this 60-point performance threshold for 2021. The exceptional performance threshold remains at 85 points, as established in the 2019 final rule.

In previous rules, CMS finalized the payment adjustment of +/- 9 percent for performance years 2020 and beyond. This adjustment factor will not change for 2021.

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations
CMS will 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 ≤ $90K in allowed charges for covered professional services, provide covered care to ≤ 200 beneficiaries, or provide ≤ 200 covered professional services under the Physician Fee Schedule. CMS has not made any changes to the previously established opt-in policy 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 will also continue 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 will continue to lower the weight of the Quality performance category. This category will be weighted at 40 percent for 2021 (down from 45 percent in 2020) and starting in the 2022 performance year will be weighted at 30 percent.

CMS has also finalized their earlier proposal 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 finalized 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," will be removed beginning with the 2021 performance year because they are considered extremely topped out due to high and unvarying performance rates.

Regarding their methodology for scoring topped out measures, CMS will 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.

Lastly, CMS had 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. They ultimately decided against this proposal due to pushback received during the comment period. The 2021 performance year will be scored against historical benchmarks as usual.

Quality Data Completeness Requirements

The data completeness requirement for quality measures remains at 70 percent. 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 percent, 85 percent, and 74 percent respectively. Based on this data, CMS raised the data completeness standard to 70 percent 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 has finalized the cost performance category weight at 20 percent for the 2021 MIPS performance year and 30 percent for 2022 and all subsequent years per the statute.

CMS has finalized adding costs associated with telehealth services that are directly applicable to existing episode-based cost measures and the Total Per Capita Cost measure. The addition of

telehealth service codes ensures that the current cost measures adapt to the changes in care provision and service utilization caused by the public health emergency (PHE).

Improvement Activities

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

CMS has finalized their proposal 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 PHE, such as the COVID-19 crisis. This allows stakeholders to submit new improvement activities outside of the established 4-month timeframe in the event of a PHE. This flexibility permits CMS to respond to the present needs of clinicians.

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

Finally, CMS is adopting an additional criterion for new improvement activities submitted in 2021 and subsequent years. The criterion is entitled "Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible" and will be added to the current list of Improvement Activity criteria.

Promoting Interoperability Category

CMS finalized the 90-day reporting period for this MIPS performance category as well as the proposal 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. CMS also finalized its relatively minor proposed modifications to the "Query of Prescription Drug Monitoring Program (PDMP)" and "Support Electronic Referral Loops by Receiving and Incorporating Health Information" measures.

Physician Compare

CMS has finalized a new definition for Physician Compare. "Physician Compare" is now recognized as 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 finalizing their proposal to terminate the APM scoring standard beginning on January 1, 2021. In addition, with the removal of the APM scoring standard, CMS is ending the full-TIN APM policy, as well as the term "full TIN APM". The MIPS final score calculated for the APM entity would be applied to each MIPS eligible clinician in the APM entity group.

CMS is finalizing their proposal to remove the use of low-volume threshold determinations and the term "APM Entity group" beginning January 1, 2021.

Advanced Alternative Payment Models

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 a 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. For 2021, Partial QP status also increases to 50 percent of Medicare payments and 35 percent of Medicare patients.

QP Threshold Scores
CMS finalized their proposal for calculating the Threshold Scores used in making QP determinations, and beginning in the 2021 QP Performance Period, Medicare patients who have been prospectively attributed to an APM entity during a QP Performance period will not be included as attribution-eligible Medicare patients for any APM entity that is participating in an Advanced APM that does not allow such prospectively attributed patients to be attributed again. This policy removes prospectively attributed Medicare patients from the denominators when calculating QP Threshold Scores for APM Entities or individual eligible clinicians in Advanced APMs that do not allow for attribution of Medicare patients that have already been prospectively attributed elsewhere. This prevents dilution of the QP Threshold Score for the APM Entity or individual eligible clinician in an Advanced APM that uses retrospective alignment.

Targeted Review
CMS finalized their proposal to establish a Targeted Review process for limited circumstances surrounding QP Determinations. Starting in the 2021 QP Performance Period, CMS will accept Targeted Review requests when an eligible clinician or APM Entity believes in good faith CMS has made a clerical error such that an eligible clinician(s) was not included on a Participation List of an APM Entity participating in an Advanced APM for purposes of QP or Partial QP determinations. CMS also finalized that after the conclusion date of the targeted review, there would be no further review of QP determination with respect to an eligible clinician during the relevant performance period.

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.