

ACR Preliminary Summary of Radiology Provisions in the 2022 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) proposed rule on Tuesday, July 13th. In this rule, CMS describes changes to payment provisions and to policies for implementation of the sixth 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).

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

On initial review, the ACR is pleased with CMS's proposal to move forward with the appropriate use criteria (AUC) program for advanced diagnostic imaging services mandated by the Patient Access to Medicare Act of 2014 with the penalty phase scheduled to begin on January 1, 2023, or the first of the year following the end of the COVID-19 public health emergency (PHE). CMS recognizes the significant hardships faced by hospitals and medical practices during the pandemic as well as the investment that many practices have already made in AUC systems. When fully implemented, the AUC program will be a valuable tool to ensure that Medicare patients receive the right imaging at the right time. The proposed rule also includes several potential solutions to claims processing issues that have delayed the program's implementation. These solutions appear to be a step in the right direction, however, the ACR will review the proposals in detail in the coming weeks and will provide feedback to CMS during the comment period.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2022 conversion factor of \$33.5848 compared to the 2021 conversion factor of \$34.8931. CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 2 percent decrease, while interventional radiology would see an aggregate decrease of 9 percent, nuclear medicine a 2 percent decrease and radiation oncology and radiation therapy centers a 5 percent decrease if the provisions within the proposed rule are finalized. Part of the decrease is due changes in RVUs, redistributive effects of the CMS proposed clinical labor pricing update, and phase-in implementation of the previously finalized updates to supply and equipment pricing. The Consolidated Appropriations Act, 2021 (P.L.116-260) included a 3.75 percent adjustment to the 2021 conversion factor which rolled back the payment cuts to radiologists from 10 percent to approximately 4 percent. If Congress does not intervene, the percent decreases mentioned above could be greater for CY 2022 for many physicians including Interventional Radiology and Radiation Oncology.

Payment for E/M Services

CMS continues to move 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.

Billing for Physician Assistant (PA) Services

Historically, NPs and CNSs have been authorized to bill the Medicare program and be paid directly for their professional services, while payment for PAs services must be made to the PA's employer. The Consolidated Appropriations Act (CAA) of 2021 made amendments to remove the requirement to make payment for PA services only to the employer of a PA effective January

1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that NPs and CNSs do. CMS is proposing to amend pertinent sections of their regulations to reflect the amendment made by section 403 of the CAA. CMS is proposing to amend § 410.74(a)(2)(v) to specify that the current requirement that PA services must be billed by the PA's employer in order to be covered under Medicare Part B is effective only until January 1, 2022. Additionally, CMS is proposing to add a new paragraph that will be effective for services furnished on or after January 1, 2022, that payments will be made to a PA for their professional services, including services and supplies furnished incident to their services.

Valuation of Services

In the MPFS 2022 Proposed Rule, CMS proposed to accept all of the RUC-recommended values for 5 new/revised codes impacting Radiology. CMS accepted an increased value for needle biopsy of lymph nodes and approved the values for the new, trabecular bone score code family. No radiology codes were identified as potentially misvalued. The ACR will continue to review the proposed rule, including any practice expense refinements, and work with our RUC advisors to provide timely comments to CMS.

Removal of Select National Coverage Determinations

CMS is proposing to remove the national coverage determination (NCD) for position emission tomography (PET) scans (NCD 220.6). Removing the NCD would defer coverage decisions to local Medicare Administrative Contractors. The existing NCD for PET was last updated in 2013 and requires separate NCDs for every non-oncologic indication for PET scans. Since 2013, new non-oncologic PET agents have been approved by the FDA and multiple professional medical societies, including the ACR, have published guidelines relevant to appropriate use of these agents. CMS believes that allowing local contractors the discretion to consider coverage would allow Medicare beneficiaries greater access to PET scans for non-oncologic indications.

Telehealth

Category 1 and Category 2 Telehealth Services

CMS received several requests to permanently add various services to the Medicare telehealth services list effective for CY 2022. However, CMS found that none of these services (received by the February 10 deadline) met the criteria for Category 1 or Category 2 services for permanent addition to the Medicare telehealth services list.

Category 3 Telehealth Services

In the CY 2021 MPFS final rule, CMS created a third category of criteria for adding services to the telehealth services list on a temporary basis in response to the COVID-19 public health emergency (PHE). Category 3 telehealth services include services which CMS believes there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence to be Category 1 or 2. Services on the Category 3 telehealth list will be temporary and remain on the telehealth services list through the end of the calendar year in which the COVID-19 PHE ends. There have been stakeholder concerns surrounding uncertainty of when the PHE will end and concerns that services added to the telehealth services list on a temporary basis could be removed from the list before there is enough time to compile and submit evidence to support permanent addition of the service as a Category 1 or 2 service. In response, CMS is proposing to

retain all Medicare services added on a Category 3 basis until the end of CY 2023, to allow more time to collect information on utilization of these services. CMS is also soliciting comment on whether any of services that were added to the Medicare telehealth list for the duration of the PHE for COVID-19 should now be added to the Medicare telehealth list on a Category 3 basis.

Audio-Only Telehealth Services

CMS is proposing to define interactive telecommunications system to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home. CMS has found that audio-only E/M visits have been one of the most commonly performed telehealth services during the PHE, with most beneficiaries receiving mental health services. Given the mental health professional shortage and areas in which beneficiaries have limited broadband access due to geographic area or socioeconomic challenges, CMS believes beneficiaries may have come to rely on these audio-only mental health care services and that a sudden discontinuation could have a negative impact on access to care.

Expiration of Virtual Direct Supervision, PHE Flexibilities

CMS is seeking comment on the extent to which the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology is being used during the PHE, and whether physicians and practitioners anticipate relying on this flexibility after the end of the PHE. CMS is seeking comment on whether this flexibility should potentially be made permanent.

Quality Payment Program

MIPS Value Pathways (MVPs)

CMS continues to refine plans for the transition of MVPs into MIPS. In this rule, they propose further delaying the implementation of MVPs until the 2023 performance year, maintaining that MVPs would be incrementally added to the QPP upon availability. CMS is seeking comments on the proposed timeline for removing "traditional" MIPS after the end of the 2027 performance and data submission periods.

Further, CMS proposes that an initial set of seven MVPs that, if finalized, would become available beginning with the 2023 performance period. The initial set of proposed MVP clinical areas include: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia. As such, during the 2023 and 2024 performance periods, voluntary subgroup reporting within MIPS is encouraged for those reporting through MVPs or the APP. With plans to require multispecialty groups to form subgroups to report MVPs, beginning in the 2025 performance year.

To support future MVP reporting, in this rule, CMS proposes MVP scoring policies, which closely align with those used in traditional MIPS, with some exception.

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs – Request for Information

This RFI collects information on planning and transitioning CMS programs to complete digital measurement by 2025. Maintaining alignment with the Department of Health and Human Services (HHS) Health Quality Roadmap, CMS approaches priorities and initiatives with other entities, like the Office of the National Coordinator on Health Information Technology (i.e., 21st Century Cures Act), to promote data interoperability and access. The RFI seeks comments on the following:

- CMS adoption of FHIR to reduce the collection and analysis burden imposed by current electronic quality measures. Under the HL7 framework, quality data reporting programs would utilize a standardized data collection structure and single terminology to collect electronic measure data.
- Enhancement of the definition of dQM so that it contains language regarding proposed software that processes digital data to determine measure scores.
- Redesign quality measures as "self-contained tools" that dQM software incorporates end-to-end measure calculation solutions.
- Alignment of quality measure reporting programs across federal and state agencies and other sectors via the adoption of a dQM Portfolio.

Closing the Health Equity Gap in CMS Clinician Quality Programs—Request for Information (RFI)

Consistent with the executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS issued an RFI from stakeholders to achieve health equity for all patients by implementing new policies. The following are the topics for which CMS requests comments on ways to ensure the delivery of health equity:

- Augmentation of hospital-specific reports that stratify measure results by Medicare/Medicaid dual eligibility, race and ethnicity, and other social risk factors.
- Standardization of demographic data collection across quality programs and quality measures for the potential creation of developing a method to publicly report a hospital equity score for consolidating results across multiple measures and social risk factors.

COVID-19 Flexibility

CMS anticipates that the national public health emergency (PHE) COVID-19 will continue to affect clinicians throughout the rest of PY 2021. CMS is allowing individual clinicians, clinician groups, and virtual groups to apply for [Extreme and Uncontrollable Circumstances](#) (EUC) to reweight one or more performance categories for PY 2021. If a clinician, clinician group or a virtual group submits an EUC application and also submits performance data for a category, the data will override the EUC application.

MIPS Category Weighting

The proposed category weights for the 2022 performance year are: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%.**

In accordance with the 2020 MPFS Final Rule, CMS has proposed to lower the weight of the Quality category to 30% in 2022 and beyond. Cost has increased to 30% for the 2022 performance year. These percentages are likely to stay 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.

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. **Beginning with performance year 2022, CMS is proposing to raise the performance threshold to 75 points, which represents the mean of 2017 performance year data.**

CMS is also proposing to set the exceptional performance threshold at 89 points, representing the 25th percentile of final scores above the performance threshold from the 2017 performance year.

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 2022, 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 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.

In previous MIPS performance years, small practices had been allowed to submit Quality measure data via claims reporting rather than registry-based reporting. The 2022 Proposed Rule continues to allow claims submission for small practices, but they acknowledge that this has caused some unintended consequences, such as physicians who may be exempt from MIPS due to the low-volume threshold receiving MIPS scores because their group has submitted claims

data. **CMS proposes to require that claims-reporting small practices who wish to submit MIPS data as a group must signal their intention to participate as a group by submitting either Improvement Activities, Promoting Interoperability measures, or MIPS CQMs as a group.** If they do not report another performance category as a group, they would be considered individual submitters.

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 30% for 2022 (down from 40% in 2021).

CMS has proposed extensive changes to the measure scoring system. In previous years, non-benchmarked measures which met data completeness were eligible to receive 3 points, with the possibility of a higher score if enough data was received to establish a same-year benchmark. Benchmarking measures were scored between 3 and 10 points if they met data completeness. **Beginning with performance year 2022, CMS proposes three major changes: first, they intend to change the scoring range for benchmarked measures to 1 to 10 points, doing away with the 3-point floor; second, they intend to score non-benchmarked measures at 0 points even if data completeness is met; third, for new measures which do not yet have a benchmark, the scoring floor will be raised to 5 points for their first two years in the MIPS program.** 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 also proposed to end the practice of awarding bonus points for additional high-priority measures submitted beyond the required 6.

CMS has proposed the removal of several measures which have historically been used by radiologists reporting through ACR's NRDR QCDR:

- #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
- #23: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- #144: Oncology: Medical and Radiation - Plan of Care for Pain
- #154: Falls: Risk Assessment
- **#195: Radiology: Stenosis Measurement in Carotid Imaging Reports**
- **#225: Radiology: Reminder System for Screening Mammograms**
- #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

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.

Quality Data Completeness Requirements

No changes to data completeness requirements were proposed for 2022, 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. **CMS is proposing to increase this threshold to 80% beginning with the 2023 performance year.**

Cost Category

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

CMS is proposing that, beginning with performance year 2022, stakeholders will have the opportunity to develop and submit Cost measures for addition to the MIPS program.

Five new episode-based Cost measures have been proposed for implementation into MIPS: **Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease, and Diabetes.**

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 2022.

CMS will continue to require GPRO (group) reporters to attest to the participation of at least 50% of NPIs within the group TIN when attesting to completion of improvement activities. This policy was established in the 2021 final rule.

The 2022 Proposed Rule also adds 7 new activities, modifies 15 existing activities, and removes 6 previously adopted activities.

Promoting Interoperability Category

CMS proposes to maintain the hardship exception with auto-reweighting for small practices that do not report data on Promoting Interoperability. CMS proposes several changes to measures under the e-Prescribing, Public Health and Clinical Data Exchange, and Provider to Patient Exchange objectives. CMS proposes a new objective and measure—mandatory, but not scored—requiring an annual self-assessment using the [High Priority Practices Guide](#) at any point during the calendar year. Also, CMS proposes to eliminate two of three previously required yes/no attestation statements for information blocking prevention.

In addition to the above proposals, CMS requests information on furthering health information exchange-related Promoting Interoperability objectives using application programming interfaces (APIs), assessing patient access outcomes, and clinical notes availability.

Facility-based Scoring

Facility-based scoring was implemented in 2019. Clinicians and groups would not need to elect or opt-in to facility-based measurement if they were eligible and benefitted from having a higher combined quality and cost performance score.

CMS is proposing a new policy to determine the MIPS final score for eligible clinicians and groups. **Beginning with PY 2022, the MIPS quality and cost performance category scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher MIPS final score through another MIPS submission.** This proposal would calculate two final scores for clinicians and groups who are facility-based: one for the clinician or group's performance and the weights of the performance categories if facility-based measurement did not apply, and another based on the application of facility-based measurement. CMS will accept the higher of the two scores.

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. 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). Therefore, in CY 2022, the QP payment amount threshold will remain at 50 percent of Medicare payments and the QP patient count threshold will remain at 35 percent of Medicare patients.

APM Incentive Payment Recipient

CMS proposes to revise their decision hierarchy for making APM payments so that the Agency would first seek to identify a TIN associated with the QP during the base year, and if no such TIN is identified in the base year, CMS would then seek to identify a TIN associated with the QP during the payment year.

The Radiation Oncology Model is expected to be an Advanced APM in the 2022 QP performance period.

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

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.