

American College of Radiology Preliminary Summary of Radiology Provisions in the 2023 MPFS Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Physician Fee Schedule (MPFS) final rule on Tuesday, November 1. In this rule, CMS describes changes to payment provisions and to policies 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 announced a CY 2023 conversion factor of \$33.0607 compared to the 2022 conversion factor of \$34.6062. This was calculated by first removing the one-year 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act and then applying a negative 1.60 percent budget neutrality update. The budget neutrality update is due to revaluation of several evaluation and management code families, including hospital, emergency medicine, nursing facility and home visits.

CMS estimates an overall impact of the MPFS finalized changes to radiology to be a 2 percent decrease, while interventional radiology would see an aggregate decrease of 3 percent, nuclear medicine a 2 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease. These reductions are less than the reductions in the proposed rule due to CMS correcting an error in the calculation of the malpractice relative value units (RVUs).

Part of the decrease is due to changes in RVUs and the second year of the transition to clinical labor pricing updates. If Congress does not intervene to extend the 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act, the percent decreases mentioned above will be greater for CY 2023.

Valuation of Imaging Services

CMS accepted the Relative Value Scale Update Committee (RUC) recommended values for 10 Radiology-pertinent codes. This includes increases in values for contrast x-ray of the knee joint and the percutaneous arteriovenous fistula creation code family. Additionally, based on the ACR's comments, CMS also revised its values for the neuromuscular ultrasound code family in the final rule; it had initially proposed a reduction in value. CMS also agreed to maintain the RUC-recommended direct practice expense inputs for the neuromuscular ultrasound codes and the percutaneous arteriovenous fistula creation codes based on stakeholder feedback.

Clinical Labor Update

CMS finalized its proposal to continue to move forward with year 2 of the 4-year transition to the updated clinical labor input values. However, based on stakeholder feedback, CMS is updating the prices for several clinical staff types that pertain to radiology. The Vascular Interventional Technologist (L041A—formerly Angio Technician) is increasing from 0.60 to 0.84, the Mammography Technologist (L043A) is increasing from 0.63 to 0.79, and the CT

Technologist is increasing from 0.76 to 0.78. The Agency will continue to consider public comment related to wage updates for clinical staff during the remainder of the 4-year phase-in.

Practice Expense Data Collection/Methodology

In the proposed rule, CMS solicited public comment on strategies for updates to indirect practice expense (PE) data collection and methodology. CMS will not move forward with any changes to PE in 2023, but will consider proposals for future rulemaking. CMS remains interested in alternatives to using surveys as the sole source of data for indirect PE valuation and emphasizes the need for transparent and repeatable processes. The Agency aims to use verifiable and objective data sets in the future to supplement or augment survey data.

Colorectal Cancer Screening Coverage

CMS finalized its proposal update coverage of colorectal cancer screening services to align with the updated United States Preventive Services Task Force (USPSTF) recommendation to begin screening at age 45 rather than age 50. In addition, CMS finalized its proposal to expand the definition of colorectal cancer screening to include a follow-on screening colonoscopy after a positive result on a Medicare covered non-invasive stool-based screening test. CMS believes this will reduce screening barriers by ensuring patients will not be responsible for cost sharing for the additional test.

The ACR submitted comments requesting that CMS extend coverage of colorectal cancer screening to include CT colonography. CMS responded that this comment was outside the scope of the rule.

CMS responded this summer to the ACR's most recent formal reconsideration request for CT colonography that there is not sufficient evidence to support changing the current non-coverage determination for CT colonography. The ACR is continuing to discuss coverage of CT colonography with appropriate CMS staff.

Payment for Telehealth Services

CMS finalized a number of policies related to Medicare telehealth services including making several services that are temporarily available as telehealth services for the public health emergency (PHE) available through CY 2023 on a Category III basis, which will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list. CMS finalized its policy to implement the telehealth provisions in the Consolidated Appropriations Act of 2022 via program instruction or other subregulatory guidance. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends. This will allow telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services. CMS finalized the proposal to allow physicians and practitioners to

continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person.

Medicare Shared Savings Program

CMS sought to make changes to the Medicare Shared Savings Program that would advance their overall value-based care strategy of growth, alignment, and equity. CMS finalized many proposals with the aim of increasing health equity and aligning with other CMS programs. CMS will allow Accountable Care Organizations (ACOs) applying to the program that are inexperienced with performance-based risk to participate in one 5-year agreement under a one-sided shared savings model, to provide these ACOs more time to invest in infrastructure and redesigned care processes for high quality and efficient health care service delivery before transitioning to performance-based risk. CMS will also revise the benchmarking methodology to reduce the effect of ACR performance on ACO historical benchmarks. CMS finalized an extension of the incentive for reporting Electronic Clinical Quality Measures (*eCQMs*)/MIPS CQMs through performance year 2024 to align with the sunset of the CMS Web Interface reporting option.

CMS will exclude the new supplemental payment under the Medicare Hospital Inpatient Prospective Payment System (IPPS) for Indian Health Service (IHS)/Tribal hospitals and hospitals located in Puerto Rico from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program and include this new supplemental payment in calculations of ACO participant revenue for the performance year beginning January 1, 2023, and subsequent performance years.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

In this rule, CMS limits updates to traditional MIPS and focuses on further refining the implementation of MIPS Value Pathways (MVPs). CMS finalized five new MVPs in addition to revisions to the seven previously established MVPs. Modifications to the MVP development process now include means for providing feedback on new and established MVPs on the QPP website. CMS updates rules regarding MVP maintenance and participation options, as well as several additions and revisions to subgroup reporting such as eligibility, registration and scoring.

MIPS Scoring Overview

The category weights for the 2023 performance year will remain the same as the 2022 weights: Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%. These percentages are likely to remain fixed for the future of the MIPS program.

The MIPS program will continue 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.

Beginning with performance year 2022, CMS is statutorily mandated to calculate the MIPS performance threshold based on prior years' mean and/or median scores. In 2022 this threshold was set to 75 points; CMS will maintain the performance threshold at 75 points for 2023. This is based on the rounded mean final score from the 2019 performance year.

CMS will no longer offer an exceptional performance adjustment beginning with the 2023 performance year. This was previously finalized in the 2022 MPFS final rule. In earlier rules, CMS finalized the maximum payment adjustment of +/- 9% for performance years 2020 and beyond.

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

CMS has not made any changes to the low-volume threshold criteria as previously established. To be excluded from MIPS in 2023, 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 has likewise made 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.

Quality Category

As established in previous rules, this category will be weighted at 30% for 2023 and likely for the remainder of the MIPS program.

As established in the 2022 MPFS final rule, beginning with performance year 2023, CMS will 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. New measures will continue to be scored at a minimum of 7 points for their first year and a minimum of 5 points in their second year. 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 finalized the removal of the following measures:

- #76: Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections
- #110: Preventive Care and Screening: Influenza Immunization
- #111: Pneumococcal Vaccination Status for Older Adults

Measures #110 and #111 have been combined into a new measure, #493: Adult Immunization Status, which includes immunization for influenza, tetanus and diphtheria, zoster and pneumococcal in its numerator.

CMS has also finalized the addition of the following new measure to the Diagnostic Radiology and Radiation Oncology measure sets:

- #487: Screening for Social Drivers of Health

Data completeness for quality measure submission will not change in 2023 and 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. However, CMS has finalized the proposal to increase this threshold to 75% beginning with the 2024 and 2025 performance years.

Cost Category

CMS will continue to weigh the Cost performance category at 30% for MIPS performance year 2023 and likely for all subsequent years. CMS finalized its proposal to add the Medicare Spending Per Beneficiary (MSPB) Clinician cost measure as a care episode group alongside the episode-based measures already established as part of the Cost category.

Improvement Activities

CMS will maintain the 15% weight for the Improvement Activities category. The 2023 Final Rule also adds 4 new activities and removes 6 previously adopted activities.

The IAs finalized for addition are:

- Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
- Create and Implement a Plan to Improve Care for LGBTQ Patients
- Create and Implement a Language Access Plan
- COVID-19 Vaccine Achievement for Practice Staff

The IAs finalized for removal are:

- IA_BE_7: Participation in a QCDR that promotes use of patient engagement tools
- IA_BE_8: Participation in a QCDR that promotes collaborate learning network opportunities that are interactive
- IA_PM_7: Use of QCDR for feedback reports that incorporate population health
- IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program
- IA_PSPA_20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
- IA_PSPA_30: PCI Bleeding Campaign

The QCDR-related improvement activities have been consolidated into the already-existing IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements.

Promoting Interoperability Category

CMS finalized several modifications to Promoting Interoperability objectives and measures, including scoring updates, mandating and expanding the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program measure, adding a new alternative "yes/no" attestation measure for "Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)" under the Health Information Exchange Objective, and consolidating compliance options for the Public Health and Clinical Data Exchange Objective.

Advanced Alternative Payment Models (APMs)

An Advanced APM is an APM that: 1) requires participants to use certified electronic health record (HER) 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). After performance year 2022, which correlates with payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year. Beginning in payment year 2025, the statutory incentive structure under the QPP for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians.

CMS finalized its policy to apply the 50 eligible clinician limits to the APM Entity participating in the Medical Home Model based on the TIN/NPIs on the APM Entity's participation list. Similarly, CMS is also proposing to apply the 50 eligible clinician limit directly to the APM Entity participating in Aligned Other Payer Medical Home Model and Medicaid Medical Home Model, and to no longer look to the parent organization for the APM Entity.

CMS finalized its policy to introduce a voluntary reporting option for APM Entities to report the promoting interoperability performance category at the APM Entity level beginning with the CY 2023 performance period.

CMS published Fact Sheets on the overall [MPFS final rule](#) and the [Medicare Shared Saving Program](#).

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.