

ACR Preliminary Summary of Radiology Provisions in the 2024 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule on Thursday, July 13. 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 estimates a CY 2024 conversion factor of \$32.7476 compared to the 2023 conversion factor of \$33.8872. This was calculated by applying 1.25 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act and then applying a negative 2.17 percent budget neutrality update.

CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 3 percent decrease, while interventional radiology would see an aggregate decrease of 4 percent, nuclear medicine a 3 percent decrease and radiation oncology and radiation therapy centers a 2 percent decrease if the provisions within the proposed rule are finalized. Part of the decrease is due to changes in relative value units (RVUs) and the third year of the transition to clinical labor pricing updates.

Protecting Access to Medicare Act (PAMA) Appropriate Use Criteria (AUC) Program

In light of continual implementation issues, CMS proposed to pause the PAMA AUC program for advanced diagnostic imaging services for “reevaluation”, including ending the current educational and operations testing period. CMS did not propose a time frame that implementation efforts may resume. The Agency stated that the real time claims processing aspect of the statute “presents an insurmountable barrier for CMS to fully operationalize the AUC program”.

The ACR recognizes the significant issues CMS faces with the real time claims processing aspect of the AUC program and the potential impact on our members should claims be denied inappropriately. The College is working with Congress to streamline and modernize the PAMA AUC program, including the removal of this requirement, to allow the program to move forward and ensure Medicare patients receive the right imaging tests at the right time. CMS also acknowledges the value of clinical decision support in the proposed rule to “improve the quality, safety and efficiency and effectiveness of health care” and encourages the continued voluntary use of clinical decision support tools.

Valuation of Imaging Services

In the MPFS 2024 Proposed Rule, CMS accepted the RUC-recommended values for the radiology codes pertaining to ultrasound guidance for vascular access, dorsal sacroiliac joint, and

fractional flow reserve. The ACR will continue to review the proposed rule, including the practice expense refinements to the neuromuscular ultrasound codes.

G2211 (Office/Outpatient (O/O) E/M visit complexity code)

CMS proposes to change the status indicator to make it separately payable by assigning the “active” status indicator, effective January 1, 2024. CMS proposes that code G2211 would not be payable when the O/O E/M visit is reported with payment modifier -25. CMS estimates that code G2211 will be billed with 38 percent of all O/O E/M visits initially and 54 percent when fully adopted. CMS seeks comments on the utilization assumptions and the application of their proposed policy for CY 2024.

Clinical Labor Update

CMS is proceeding with the third year of phasing in the updated clinical labor prices based on the CY 2023 prices they approved. No new pricing information was submitted for CY 2024.

Practice Expense Data Collection/Methodology

CMS continues to solicit feedback from and engage with stakeholders on how to best review or update their current PE methodology. They are looking for long-term policies or methods that will consider the feasibility of frequent or regular updates. CMS acknowledges the AMA PPIS data collection effort, but is asking for comment on whether contingencies or alternatives may need to be considered if there was data lacking during the collection effort. Specifically, CMS is requesting feedback on:

- Whether they should consider aggregating data for certain specialties, and if so what thresholds or methodologies should be employed to establish such aggregations?
- Whether aggregations of services, for the purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
- If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
- What possible unintended consequences may result if CMS were to act upon the respondents’ recommendations for any highlighted considerations above?
- Whether specific types of outliers or non-respond bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

Medicare Economic Index (MEI)

In CY 2023, CMS finalized the rebasing and revising the Medicare Economic Index (MEI). However, due to the AMA’s practice expense data collection efforts and some stakeholder concern about the redistributive impacts of the rebased and revised MEI, CMS decided to delay the implementation in 2023. For those same reasons, CMS is proposing to not incorporate the

updated 2017-based MEI for CY 2024 at this time. The 2017 data relies primarily on the U.S. Census Bureau's Services Annual Survey (SAS), while the current 2006-based MEI relies on the AMA's 2006 PPIS data. The AMA is currently working on collecting updated PPIS data. CMS is also waiting for the 2022 SAS data to be released later this year.

Medicare Shared Savings Program

As of January 1, 2023, 10.9 million people with Medicare receive care from one of the 573,126 health care providers in the 456 ACOs participating in the Medicare Shared Savings Program (MSSP). CMS is proposing changes to the MSSP that CMS hope will advance their overall value-based care strategy of growth, alignment, and equity. CMS is proposing updates to the definition of primary care services used for purposes of beneficiary assignment to remain consistent with billing and coding guidelines. Further, CMS is proposing an update that would add a third step to the step-wise beneficiary assignment methodology under which CMS would use an expanded period of time to identify whether a beneficiary has met the requirement for having received a primary care service from a physician who is an ACO professional in the ACO to allow additional beneficiaries to be eligible for assignment, as well as changes to how CMS identify assignable beneficiaries used in certain MSSP calculations.

Lastly, CMS is seeking comment on potential future developments to MSSP policies, including with respect to incorporating a new track that would offer a higher level of risk and potential reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting ACO and community-based organization (CBO) collaboration.

Telehealth

CMS believes that simplification toward a binary classification approach could address the confusion that CMS has noticed from interested parties submitting requests during the PHE. CMS's proposal would restore the binary that existed with Category 1 and 2, without displacing or disregarding the flexibility of Category 3. CMS is proposing to simply classify and consider additions to the Medicare Telehealth Services List as either permanent, or provisional. Under this new system, CY 2025 submissions would be due by February 10, 2024.

CMS is soliciting comments on their proposed analysis procedures for additions to, removals from, or changes in status for services on the Medicare Telehealth Services List.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

In the March 31, 2020 COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS states that in the absence of evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate

reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services. CMS is proposing to revise the regulatory text to state that, through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

CMS is soliciting comments on whether CMS should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, CMS is interested in input on potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns, or if this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

In addition to proposing scoring incentives to those ACOs participating in MIPS through MVPs, within the proposed rule, CMS included a request for information (RFI) regarding multiple aspects of MPV reporting for specialists in Shared Savings Program ACOs. CMS also proposes to include five new MVPs beginning in the 2024 MIPS performance year. Topics include women's health; infectious disease; quality care for ear, nose, and throat; rehabilitative services for musculoskeletal care; and mental health and substance use disorders. Additionally, subgroup reporting updates are also proposed.

MIPS Scoring Overview

The category weights for the 2023 performance year are proposed to remain the same as the 2023 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 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.

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 2024, 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.

Quality Category

As established in previous rules, this category will remain weighted at 30% of the overall MIPS score.

There are no proposed quality scoring changes for 2024. As in 2023, benchmarked measures will continue to be scored from 1 to 10 points, doing away with the 3-point floor. CMS will continue 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.

CMS has proposed the removal of the following measures (p. 1517):

- MIPS 147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
- MIPS 324: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
- MIPS 436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

CMS has also proposed the addition of the following new measure to the Diagnostic Radiology measure set (p. 1437):

- #TBD: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults

This measure is proposed for use in the Inpatient Quality Reporting program under the FY 2024 IPPS/LTCH PPS and may also be proposed for the Hospital Outpatient Quality Reporting program.

Data Completeness Requirement

As stated in the 2023 MPFS Final Rule, CMS proposes to raise the quality measure data completeness requirement from 70% to 75% of total exam volume. This number defines the minimum subset of patients within a measure denominator that must be reported. They propose to maintain data completeness at 75% through 2026 and raise it to 80% in the 2027 program year (p. 875).

Cost Category

CMS will continue to weigh the Cost performance category at 30% for MIPS performance year 2024 and likely for all subsequent years.

CMS proposes to reintroduce the episode-based Low Back Pain cost measure that was previously used in the MIPS Cost category. The measure underwent comprehensive reevaluation and field testing from 2020-2022. Stakeholder input and workgroup review was used to obtain detailed input on specifications for the measure. The ACR participated in the review. CMS is also proposing to add Depression, Emergency Medicine, Heart Failure and Psychoses and Related Conditions as new episode-based Cost measures for 2024 (p. 875).

Improvement Activities

CMS will maintain the 15% weight for the Improvement Activities category. The 2024 Proposed Rule also adds 5 new activities and removes 3 previously adopted activities.

The IAs proposed for addition are:

- IA_PM_XX: Improving practice capacity for Human Immunodeficiency Virus (HIV) prevention services
- IA_MVP: Practice-wide quality improvement in MIPS Value Pathways
- IA_PM_XX: Use of computable guidelines and clinical decision support to improve adherence for cervical cancer screening and management guidelines
- IA_BMH_XX: Behavioral/mental health and substance use screening and referral for pregnant and postpartum women
- IA_BMH_XX: Behavioral/mental health and substance use screening and referral for older adults

The IAs proposed for removal are:

- IA_BMH_6: Implementation of co-location PCP and MH services
- IA_BMH_13: Obtain or renew an approved waiver for provision of buprenorphine as medication-assisted treatment for opioid use disorder
- IA_PSPA_29: Consulting appropriate use criteria (AUC) using clinical decision support when ordering advanced diagnostic imaging

Promoting Interoperability Category

CMS proposes to modify Certified EHR Technology (CEHRT)-related requirements to remove “Edition” titles to reflect proposed regulatory changes within the HHS Office of the National Coordinator for Health IT (ONC) to that agency’s health IT certification criteria naming conventions. ONC updates to any criteria incorporated by reference into CMS’ CEHRT definition would be automatically accounted for without needing additional rulemaking. CMS proposes to align Shared Savings Program CEHRT requirements with MIPS CEHRT requirements. CMS also proposes to lengthen the Promoting Interoperability performance period from 90 days to 180 days and make various minor modifications to existing Promoting Interoperability measures and exclusions.

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.

If an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment). Eligible clinicians who are QPs for the 2023 performance year receive a 3.5 percent APM Incentive Payment in the 2025 payment year, and, beginning with the 2024 performance year (payment year 2026), a higher PFS payment rate (calculated using the differentially higher “qualifying APM conversion factor”) than non-QPs. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

CMS is proposing to modify the CEHRT use criterion for Advanced APMs to provide greater flexibility for APMs to tailor CEHRT use requirements to the APM and its participants.

APM Performance Pathway

CMS is proposing to include the Medicare Clinical Quality Measure (Medicare CQM) for Accountable Care Organizations Participating in MSSP collection type in the APM Performance Pathway (APP) measure set.

APM Entity Reporting

CMS is proposing to end the use of APM Entity-level QP determinations and instead make all QP determinations at the individual eligible clinician level. CMS is proposing to include any beneficiary who has received a covered professional service furnished by the NPI for the purpose of making QP determinations. Also, CMS is proposing to amend § 414.1430 to reflect the statutory QP and Partial QP threshold percentages for both the payment amount and patient count

methods under the Medicare Option and the All-Payer Option with respect to payment year 2025 (performance year 2023) in accordance with amendments made by the CAA, 2023.

CMS published Fact Sheet on the overall [MPFS proposed rule](#) and [Press Release](#).

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.