2020 MPFS Final Rule

November 21st 2019
Kayley Jaquet
Manager of Regulatory Affairs
Agenda

- Fee Schedule
- Direct Practice Expense Inputs for Ultrasound Room
- Physician Supervision Requirements for PAs
- Changes to E/M Codes
- AUC/CDS
- MIPS Program
  - Updates
  - Measures being removed
  - MIPS Value Pathways (MVPs)
Fee Schedule
Fee Schedule

Conversion Factor increased to $36.09

- Increased from $36.04 - +.05

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic radiology</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation oncology and therapy</td>
<td>0%</td>
</tr>
<tr>
<td>Interventional radiology</td>
<td>-1%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>+1%</td>
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</table>
Direct Practice Expense Inputs for Ultrasound Room
Direct Practice Expense Inputs for Ultrasound Rooms

- Pricing for 70 types of equipment or supply items were updated based on pricing review completed by StrategyGen
  - Part of 4 year phase-in from 2019 ruling

- CMS acknowledging an increase in annual cost:

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<tbody>
<tr>
<td>Ultrasound Room</td>
<td>$369,945</td>
<td>$410,303</td>
<td>+ $40,358</td>
<td>$130,252</td>
<td>- $239,693</td>
</tr>
<tr>
<td>Vascular Ultrasound Room</td>
<td>$466,492</td>
<td>$479,753</td>
<td>+ $13,261</td>
<td>$199,449</td>
<td>- $267,043</td>
</tr>
</tbody>
</table>
Physician Supervision Requirements for Physician Assistants
Physician Supervision Requirements for Physician Assistants

• CMS modified requirements to provide more flexibility for the services provided by PAs

• PAs now able to practice more broadly in accordance with state law and state scope of practice

• In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would have to be evidenced by documentation at the practice level the PA’s scope of practice and the working relationships the PA has with the supervising physicians when furnishing professional services.
Changes to E/M Codes
Payment for E/M Codes

CMS accepted the recommended changes in values for office/outpatient evaluation and management visit codes as proposed by the AMA/RUC

- CMS included estimated impact to E/M changes in 2021 due to budget neutrality
  - Specialties that bill a high proportion of E/M codes could see increases up to +16%
  - Specialties that do not bill high proportion of E/M codes could see decreases up to -10%

<table>
<thead>
<tr>
<th>Specialty</th>
<th>RVU Impact</th>
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<tbody>
<tr>
<td>Diagnostic Radiology</td>
<td>-8%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>-5%</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>-6%</td>
</tr>
</tbody>
</table>
Payment for E/M Codes

• CMS decreased the number of levels for new patient (office or out patient) E/M visits to 4.
  • Deletes Level 1 (99201) for new patients

• Established patient E/M visit levels remain at 5
  • CMS will pay at each level of service rather an utilize a blended rate which was proposed/finalized in 2019 rule

• Coding for E/M visits revised to be based on time spent with patient and medical decision making
  • History and exam only required when medically appropriate
Appropriate Use Criteria/Clinical Decision Support
Appropriate Use Criteria/Clinical Decision Support

• AUC/CDS program not mentioned in 2020 rulemaking

• CMS is not delaying the rollout of the program
  • CMS released AUC/CDS – Modifiers and G-Codes in late July 2019

• January 1st, 2020 – Operational Testing period begins
  • AUC/CDS documentation required but no impact on claims if missing or incorrect

• January 1st, 2021 – Payments at risk
  • CMS will not pay claims that are missing AUC/CDS documentation
Merit-Based Incentive Program
MIPS Program Updates

CMS has made updates to several pieces of the MIPS program for 2020 and beyond

**Items staying the same:**

- **Low Volume Threshold**
  - Providers continue to be exempt if they have less than:
    - $90,000 in Medicare charges
    - Sees less than 200 Medicare beneficiaries
    - Provides less than 200 Medicare services

- **Definition of “Small Practice”**
  - Still considered to be any practice with 15 or fewer providers and can submit MIPS via claims based reporting mechanism
MIPS Program Updates

Performance Category Weighting

<table>
<thead>
<tr>
<th>Proposed Rule</th>
<th>Final Rule</th>
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</thead>
<tbody>
<tr>
<td>Quality: 40%</td>
<td>Quality: 45%</td>
</tr>
<tr>
<td>Cost: 20%</td>
<td>Cost: 15%</td>
</tr>
<tr>
<td>Improvement Activities: 15%</td>
<td>Improvement Activities: 15%</td>
</tr>
<tr>
<td>Promoting Interoperability: 15%</td>
<td>Promoting Interoperability: 25%</td>
</tr>
</tbody>
</table>

CMS will continue to decrease the weighting of the Quality category while increasing weighting of Cost starting 2021 thru 2022 until they are equal at 30%

Most radiologists remain exempt from cost and promoting interoperability categories so reweighting categories will not change the composite score significantly
### MIPS Program Updates

#### Performance Thresholds

<table>
<thead>
<tr>
<th>Year</th>
<th>Avoid a Penalty</th>
<th>Exceptional Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>30 pts</td>
<td>75 pts</td>
</tr>
<tr>
<td>2020</td>
<td>45 pts</td>
<td>85 pts</td>
</tr>
<tr>
<td>2021</td>
<td>60 pts</td>
<td>85 pts</td>
</tr>
</tbody>
</table>

#### Maximum Incentive/Penalty Amounts

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>+7%</td>
<td>-7%</td>
</tr>
<tr>
<td>2020</td>
<td>+9%</td>
<td>-9%</td>
</tr>
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</table>
MIPS Program Updates

Threshold for “Hospital-Based” special status for Groups

- 75% of clinicians in the group must have status
  - Reduced from 100%

- Definition of “Hospital Based” MIPs eligible clinicians
  - Individuals furnishing 75% or more covered professional services in a hospital setting

Being “Hospital Based” and “Non-Patient Facing” will make the Promoting Interoperability category automatically exempt

- Non-Patient Facing Group
  - More than 75% of the MIPs eligible clinicians in the group are classified as non-patient facing (No change from 2019)
MIPS Program Updates

Quality Performance Category

• Data-Completeness threshold increased to 70%
  • Previously 60%
  • Data completeness is the required percentage of eligible instances reported to the MIPS program necessary to be scored on a measure

• Updated Quality Measure Inventory
  • 4 - Added
  • 42 - Removed
  • 83 – Changed
MIPS Program Updates

Quality Performance Category

Diagnostic Radiology Measure Set Updated

<table>
<thead>
<tr>
<th>Measure</th>
<th>Change for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>361 – Radiation Dose Lowering Index</td>
<td>Removed – deemed as “not meaningful”</td>
</tr>
<tr>
<td>362 – CT Images Available for Follow up</td>
<td>Removed– deemed as “not meaningful”</td>
</tr>
<tr>
<td>195 – Carotid Imaging</td>
<td>Added to measure set</td>
</tr>
<tr>
<td>225 – Mammography: Reminder System</td>
<td>Added to measure set (was proposed to be removed)</td>
</tr>
<tr>
<td>146 – Mammography: Probably Benign</td>
<td>Staying (was proposed to be removed)</td>
</tr>
<tr>
<td>405 – Follow-up: Abdominal Lesions</td>
<td>Changed significantly</td>
</tr>
</tbody>
</table>
MIPS Program Updates

Cost Performance Category

• Adding 10 new cost measures
• Revising attribution methodology for the Total Per Capita Cost of Care (TPCC) and Medicare Spending Per Beneficiary (MSPB)

Improvement Activities

• Adding new activities, removed 15 and modified 7
• Group credit policy updated – now 50% of MIPs eligible clinicians must perform the same activity for 90 continuous days at any point during the performance period to receive credit
  • Previously, only one physician had to report the activity for the group to receive credit
MIPs Value Pathways
MIPS Value Pathways

- CMS finalizing the new MIPS Value Pathways (MVPs) participation framework for 2021

- MVPs – condition or specialty-specific groups of cost, quality and improvement measures with a foundation of the promoting interoperability category.

[Diagram showing the relationship between Quality, Improvement Activities, and Cost with a foundation of Promoting Interoperability and Population Health Measures]
CMS aims to reduce clinician burden and streamline reporting requirements

• How are MVPs different than MIPS?
  • Clinicians no longer have to select measures from large pool
  • CMS will assign MVPs to groups or clinicians based on provider specialty or clinical condition
  • All measures within an MVP are required
    • Examples from CMS show reduced number of measures
      • 3 Quality measures
      • 1 to 2 Improvement Activities
      • 2 Cost measures
MIPS Value Pathways

Current Structure of MIPS (In 2020)
- Many Choices
- Not Meaningfully Aligned
- Higher Reporting Burden

New MIPS Value Pathways Framework (In Next 1-2 Years)
- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician’s Practice/Specialty or Public Health Priority

Building Pathways Framework
MIPS Value Pathways
Clinicians report on fewer measures and activities based on specialty and/or outcome within a MIPS Value Pathway.

Moving to Value
Quality
Improvement Activities
Cost
Foundation
Promoting Interoperability
Population Health Measures

Fully Implemented Pathways
Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues. CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

Pathways:
What should be the structure and focus of the Pathways?
What criteria should we use to select measures and activities?

Participation:
What policies are needed for small practices and multi-specialty practices?
Should there be a choice of measures and activities within Pathways?

Public Reporting:
How should information be reported to patients?
Should we move toward reporting at the individual clinician level?

we Need Your Feedback On:

ADVOCATE Radiology Billing Specialists
# MIPS Value Pathways: Diabetes Example

<table>
<thead>
<tr>
<th>Current Structure of MIPS (In 2020)</th>
<th>New MIPS Value Pathways Framework (In Next 1-2 Years)</th>
<th>Future State of MIPS (In Next 3-5 Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track.</strong></td>
<td><strong>Endocrinologist reports some “foundation” of PI and population-health measures on all measures but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment.</strong></td>
<td><strong>Endocrinologist reports on some foundation of measures with portal, reported outcomes also included.</strong></td>
</tr>
<tr>
<td>Four performance categories feel like four different programs</td>
<td><strong>Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice.</strong></td>
<td><strong>Performance category measures in endocrinologist’s Diabetes Pathway are more meaningful to their practice.</strong></td>
</tr>
<tr>
<td>Reporting burden higher and population health not addressed</td>
<td><strong>CMS provides more claim reporting, burden on endocrinologist reduced.</strong></td>
<td><strong>CMS provides more cross-functional (e.g., comparative analytics) using claims data and endocrinologist’s reporting burden even further reduced.</strong></td>
</tr>
</tbody>
</table>

## MIPS Value Pathways for Diabetes Prevention and Treatment

**Quality Measures**
- Hemoglobin A1c (HbA1c) Port Care Control (PI: Quality ID: 009)
- Diabetes Medical Attention for Hypertension (Quality ID: 119)
- Evaluation/Controlling High Blood Pressure (Quality ID: 216)

**Improvement Activities**
- Percent Management Services (PI: Quality ID: 009)
- Chronic Care and Preventive Care Management for Empowered Patients (PI: Quality ID: 119)
- Electronic Submission of Patient Centered Medical Home Accreditation (SMA_PCHMS)

**Cost Measures**
- Total Per Capita Cost (TPCC)
- Medicare Spending Per Beneficiary (MSPB)

*Measures and activities selected for illustrative purposes and are subject to change.*
MIPS Value Pathways

What we know so far:

- Group reporting still an option under MVP
- Multi-specialty groups will have to report multiple MVPs
- Performance categories that don’t apply due to special status will continue to get reweighted
- Quality measures will be reported via Claims
- MVPs are not mandatory
MIPS Value Pathways

CMS is seeking feedback from stakeholders on the creation of MVPs during 2020

MVPs will begin 2021 Performance Year

• MVPs and regular MIPs will run in tandem

More information on MVPs to be released on QPP website and in future rulemaking
Questions?

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Thank you!