American College of Radiology

September 6, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure:

The American College of Radiology (ACR), representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) Proposed Rule. In this comment letter, we address the following important issues:

Payment Provisions

- Coverage of Computed Tomography Colonography (CTC) for Colorectal Cancer Screening
- Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025
- Payment for Medicare Telehealth Services under § 1834(m) of the Act
- Adjusting Relative Value Units (RVUs) to Match the Practice Expense (PE) Share of the Medicare Economic Index (MEI)
- Potentially Misvalued Services Under the PFS
- Development of Strategies for Updates to Practice Expense Data Collection and Methodology
- Valuation of Specific Codes for CY 2025
- Professional Component (PC)/Technical Component (TC) Indicator for Medical Physics Dose Evaluation
- Medicare Shared Savings Program

Quality Payment Program

- Updates to the Quality Payment Program (QPP)
- CY 2025 Merit Based Incentive Payment System (MIPS) Value Pathway (MVP) Development and Maintenance
- Quality Measures Proposed for Addition
- Quality Data Completeness Requirements
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PAYMENT PROVISIONS

Coverage of Computed Tomography Colonography (CTC) for Colorectal Cancer Screening

Proposals

CMS is using statutory authority to update and expand coverage for colorectal cancer screening with the following proposals:

- Adding coverage for CTC,
- Removing coverage for the barium enema procedure, and
- Expanding a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare-covered blood-based biomarker colorectal cancer screening test (described and authorized in National Coverage Determination 210.3).

ACR Perspective and Comments

The ACR applauds and strongly supports the proposal to expand coverage of colorectal cancer screening to include CTC. This minimally invasive colorectal cancer screening option will save Medicare beneficiary lives by detecting pre-cancerous polyps and/or identifying cancer at an early stage.

In the United States, colorectal cancer is the third most commonly diagnosed cancer and the third most common cause of cancer-related death in both men women with the majority of diagnoses occurring in individuals over age 65. According to the American Cancer Society (ACS), African Americans are about 20 percent more likely to get colorectal cancer and about 40 percent more likely to die from the disease than most other groups. Even more alarming, an estimated 106,590 new cases of colon cancer (54,210 in men and 52,380 in women) will be diagnosed in 2024.

CTC has been an untapped resource that will be beneficial to broaden screening options and mitigate access issues for Medicare beneficiaries. In addition, with the lowering of the screening age from 50 to 45 years old due to the trends of early age onset of colorectal cancer, there is an even greater demand for screening tests to cover the expanded pool of eligible patients. CTC provides a proven, safe, and minimally invasive exam to both screen for precursor polyps and colorectal cancer and save lives. It has an ideal profile for a safe screening structural examination

of the colon. As emphasized by the ACS, all qualified screening test options are needed to raise screening rates, and offering more choices increases the overall likelihood of screening.

The Biden Administration has shown great interest in healthcare disparities as evidenced by President Biden's Cancer Moonshot initiative that specifically includes a call to action on cancer screening. Providing Medicare beneficiaries access to CTC screening is a necessary step in achieving these goals. While there are other available colorectal cancer screening options for Medicare beneficiaries, a valuable lesson the medical community has come to accept is that we cannot take a "one size fits all" approach to healthcare given the diversity of thought, culture, and historical experiences in patients. What may be an option for the majority is not necessarily a viable or reasonable option for minority populations. As such, ACS has adopted an approach to provide all the options recommended by the United States Preventive Services Task Force (USPSTF) as the solution to increase screening. The ACR agrees with this approach and asks CMS to finalize the proposal to allow CTC to be included among those options provided to the Medicare population. The need for a driver or car transportation, the need to take a day off from work, and the need for anesthesia or sedation for someone with a fear based in cultural background are all important barriers to screening that may be faced by someone outside of the majority. As a result, lack of Medicare coverage for CTC contributed to inequities in access to colorectal cancer screening.

In summary, CTC provides a test with well-documented strength of evidence that overcomes multiple logistical and cultural hurdles in the elderly and underserved population to ensure equity in prevention and the early detection of colon cancer. Medicare patients deserve the same options provided to the commercially insured population. They deserve the right to exercise choice in selecting their appropriate screening test with options that include CTC. **The ACR asks that CMS please finalize the proposal to expand coverage of colorectal cancer screening to include CTC.**

The ACR supports the proposal to remove coverage of double contrast barium enema for colorectal cancer screening given its very limited use.

The ACR also supports the proposal to expand the definition of a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare-covered blood-based biomarker colorectal cancer screening test. We request that this concept also apply to any necessary follow-on colonoscopy after a covered CTC screening exam. In cases where polyps are identified via CTC, the test itself may not constitute a "complete colorectal cancer screening" as the USPSTF Colorectal Cancer Screening Recommendations explicitly state that "abnormal findings identified by flexible sigmoidoscopy or CTC screening require follow-on colonoscopy for screening benefits to be achieved". **Considering this, we urge CMS to expand its approach to a "complete colorectal cancer screening" in § 410.37(k) to include follow-on screening colonoscopies after all Medicare-covered non-invasive colorectal cancer screening tests, including CTC, that require a follow-on screening colonoscopy after an abnormal result.** The removal of cost-sharing for colonoscopies following abnormal results from these tests would

help meaningfully increase access to care across the full continuum of colorectal cancer screening and will save lives.

Proposal

CMS proposes to cap the payment for screening CTC under section 5102(b)(1) of the Deficit Reduction Act (DRA) of 2005. Under the DRA, the technical component of certain imaging services paid under the PFS is capped at the amount paid under the Hospital Outpatient Prospective Payment System (OPPS). The DRA defines imaging services as ''imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including PET), magnetic resonance imaging (MRI), computed tomography (CT), and fluoroscopy, but excluding diagnostic and screening mammography".

ACR Perspective and Comments

CMS is proposing to pay for screening CTC using CPT code 74263 (*Computed tomographic (CT) colonography, screening, including image postprocessing*). While Medicare does not pay for screening CTC in 2024, the PFS shows a 2024 payment for the technical component of CPT code 74263 of $566.22 using the resource-based practice expense methodology. However, CMS is proposing to cap the technical component payment for 2025 at the same rate that is paid under the OPPS at $106.30. This reduction of $459.92 (or 81.2 percent) will make it untenable for many radiologists to provide screening CTC. Therefore, while the ACR is appreciative that CMS is changing its longstanding policy by proposing to pay for screening CTC under the colon cancer screening benefit, the proposed coverage change will have limited benefit unless CMS can provide payment for screening CTC under the PFS at a rate that makes it viable to perform.

The logic behind the DRA provision is that the hospital costs should always be greater than physician costs when performing imaging services. However, the cap assumes that, if a PFS payment is above the hospital payment, the problem must be that PFS payment is too high, rather than the OPPS payment is too low. As explained in more detail below, the ACR does not believe this is the case with CT, MRI and other advanced diagnostic imaging services, including CTC, where the OPPS payment is well below the resources required to perform the test.

Under the OPPS, CMS uses a highly complex methodology to develop the OPPS relative weights. At its basic level, CMS uses hospital charges on claims reduced to costs using cost-to-charge ratios (CCRs) from hospital cost reports. However, the CCR for advanced diagnostic imaging cost centers, specifically CT and MRI, are the lowest being reported by hospitals. In the fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS) proposed rule, the CCRs for CT and MRI respectively are 0.033 and 0.067.[1] This means that CMS is assuming a mark-up for CT of 30 times its cost and for MRI nearly 15 times its cost. The ACR believes these extremely low CCRs are more likely the result of faulty cost reporting rather than the actual level of mark-

[1] Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes, public display copy released on August 1, 2024, page 332

up of hospital charges over cost. The ACR's OPPS proposed rule comment letter provides additional detail on this flawed methodology.

The ACR contrasts the OPPS payment methodology where CMS is using obviously flawed cost reporting data to the PFS payment methodology for practice expenses that uses micro-costing to determine the direct practice expense share of the total payment with an algorithm for allowing indirect costs. Even this methodology applies a scaling adjustment to direct costs (proposed to be 0.4386 in the 2025 PFS proposed rule) before adding indirect costs, and yet it produces a payment for 2024 that is more than $353 and 300 percent higher than CMS is proposing for 2025 for screening CTC. Despite its flaws, the PFS payment for screening CTC, absent the OPPS cap, produces a payment that is tenable for it to be performed by radiologists in 2025.

The best long-term solution to this problem would be to eliminate the DRA cap for imaging services. This approach would at least allow for resource-based payment for screening CTC and other imaging services when paid under the PFS. As a complementary solution, ACR requests in the OPPS comment letter that CMS default all costs and charges under the OPPS to a single diagnostic radiology cost center and not use the CT- and MRI-specific cost centers for valuing services under the OPPS and the IPPS. The ACR recognizes that CMS cannot adopt the first of these two solutions as it would require a statutory change that could only be enacted by Congress. However, the ACR requests that CMS pursue the second of these solutions in the 2025 OPPS final rule.

A short-term solution that CMS could potentially adopt would be to not apply the DRA cap to screening services such as CTC. The DRA excludes screening and diagnostic mammography from eligibility for the cap. It is unclear why Congress selected only these procedures for exclusion from the cap, but it seems likely they had a concern specifically about the impact of the cap on screening and diagnostic services to identify breast cancer. Given the prevalence of colon cancer and the relatively new availability of colon cancer screening with CTC, it seems plausible, if not likely, that if the DRA cap were to be enacted today, Congress would have excluded additional screening services from the cap.

Another option that is clearly within CMS's authority would be to assign screening CTC to a higher paying Ambulatory Payment Classification (APC). Screening CTC is assigned to APC 5522 for Level 2 Imaging without Contrast. An alternative APC assignment would be APC 5524 Level 4 Imaging without Contrast that has a proposed 2025 OPPS payment amount of $544.85—which is far more comparable to the resource-based 2024 PFS payment of $566.22. This request was also made in the ACR's OPPS comments.

Again, the ACR requests that CMS consider the public policy implications of assigning screening CTC to a higher paying APC. Given the impact of screening services on public health, public policy encourages their provision on a recommended schedule supported by public health research. The proposed payment of $106.30 would make the provision of screening CTC financially unviable for many imaging practices which could disproportionately affect underserved communities and exacerbate colorectal cancer disparities in diagnosis and early

treatment. A payment of $566.22 will encourage the provision of screening CTC and contribute to early identification and treatment of colon cancer to the better of patients and our health care system.

Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025

Proposal

In the March 31, 2020, COVID-19 interim final rule, CMS changed the definition of "direct supervision" during the public health emergency (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 has previously extended the virtual supervision flexibility through rulemaking. CMS acknowledges the utilization of this flexibility and recognizes that many practitioners have stressed the importance of maintaining it. Nonetheless, CMS continues to seek additional information regarding potential patient safety and quality of care concerns. CMS notes 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, such as incident-to services. CMS also recognizes that physicians and/or other supervising practitioners would need time to reorganize the practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology. CMS is extending this flexibility for all services on a temporary basis only. CMS is proposing to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.

ACR Perspective and Comments

The ACR previously commented[2] in support of CMS's decision to revise regulatory text to allow through December 31, 2024, the presence of the physician (or other practitioner) including virtual presence through audio/video real-time communications technology (excluding audio-only). As previously stated, the ACR supports our previous comments requesting that CMS make permanent the rule that allows virtual direct supervision of level 2 diagnostic tests via real time audio/video communications**. The ACR is supportive of CMS's decision to extend this flexibility through 2025. Additionally, the ACR continues to believe that remote direct supervision for level 2 diagnostic imaging tests is appropriate and will ensure patients have access to timely and safe diagnostic imaging.** The ACR recognizes that flexibility is necessary for those practices that deliver care to rural or underserved populations who may experience access to care issues.

[2] https://www.acr.org/-/media/ACR/Files/Advocacy/AIA/091323-ACR-24-MPFS-PR-Comment-Letter-Final.pdf

Contrast Material Administration
In 2022, the ACR aligned the ACR–SPR Practice Parameter for The Use of Intravascular Contrast Media[3] to comply with the ACR Manual on Contrast Media. The ACR Drugs and Contrast Media Committee has now updated its statement[4] on the supervision of contrast material administration. The committee statement is designed to afford facilities latitude in their operations while upholding safety standards. In instances where a physician offers direct oversight for the study, whether on-site or remotely, the requirement for direct supervision is deemed fulfilled. The ACR's primary concern is to ensure a qualified individual capable of managing contrast reactions is present on-site; these individuals may encompass roles such as Nurse Practitioners (NPs), Registered Nurses (RNs), or other qualified personnel. Deliberately, the Committee abstained from delineating specific professional designations for contrast management, recognizing the substantial variability in local regulations and institutional protocols, including state laws and policies. If individuals possess the competencies outlined in the contrast statement, they may render the service on-site, provided adherence to pertinent local statutes and regulations.

Onsite Personnel to Ensure Patient Safety
The ACR supports CMS's prioritization of patient safety. To ensure patient safety, the ACR believes there should be onsite personnel who would be, in the unlikely event of an adverse contrast reaction, able to appropriately handle contrast reactions. The ACR chooses to focus on qualifications as opposed to specific onsite personnel to account for differences in state and local regulations and in anticipation of possible future changes in scope of practice. In the "Statement from Drugs and Contrast Media Committee on Supervision of Contrast Material Administration," the ACR outlines those qualifications for on-site personnel during virtual direct supervision of level 2 contrast imaging diagnostic tests.

Radiologist-Led Teams
To ensure quality in diagnostic imaging, it is essential that the supervising professional be able to assess the quality of an image relative to the capability of the equipment and diagnostic demands, ensure diagnostic quality, and minimize unnecessary radiation exposure to the patient and personnel. Onsite personnel should continue to be a part of radiologist-led teams. To ensure patient safety is prioritized, CMS should ensure Advanced Practice Registered Nurses (APRNs) and physician assistants (PAs) continue to work alongside physicians as part of physician-led teams.

Maintaining Access
Making the definition of direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications permanent will help ensure afterhours access to radiology services. Additionally, virtual

[3] https://www.acr.org/-/media/ACR/Files/Practice-Parameters/IVCM.pdf
[4] https://www.acr.org/-/media/ACR/Files/Clinical-Resources/FINAL_Statement-from-Drugs-and-Contrast-Media-Committee-on-Supervision-of-Contrast-Administration.pdf

supervision services will allow for better access to services across rural areas where access issues persist. The ACR maintains the importance of patient safety while allowing for access in underserved areas.

Payment for Medicare Telehealth Services under § 1834(m) of the Act

Proposal

CPT code 77427, *Radiation treatment management 5 treatments*, was added to the Telehealth List on a temporary basis during the COVID-19 PHE and, through various regulatory actions, was continued through the end of 2024. In the CY 2021 PFS final rule CMS stated that 77427 would be removed from the Telehealth List at the end of the PHE, but through various Congressional and Agency actions, it remained on the telehealth list through the end of 2024. CMS is now proposing to remove 77427 from the telehealth list in CY 2025.

ACR Perspective and Comments

Face-to-face engagement between radiation oncologists, clinical treatment teams, and patients undergoing treatment is the most appropriate way to manage care. Given that both the patient and the radiation oncologist are present to receive and supervise treatment, respectively, face-to-face visits are logistically feasible. While appropriate to protect patients and radiation oncologists from infection spread during the COVID-19 PHE, the ACR believes that the use of telehealth for the face-to-face portion of radiation treatment management is no longer necessary now that the PHE has concluded. The physical examination is an integral part of patients' cancer treatment management during the course of radiation therapy and ensures quality of care. While occasional exceptions and flexibilities may be needed to address rural and underserved communities, the ACR believes it is essential for the radiation oncologist to conduct the face-to-face portion of the weekly management code in-person.

The ACR supports CMS's proposal to remove CPT code 77427, *Radiation treatment management, 5 treatments* from the Medicare Telehealth List beginning in 2025 and encourages the Agency to finalize this proposal to support patient safety and high quality of care.

Adjusting Relative Value Units (RVUs) to Match the Practice Expense (PE) Share of the Medicare Economic Index (MEI)

Proposal

In the 2023 PFS, CMS finalized the rebasing and revising of the Medicare Economic Index (MEI), which is a measure of the relative weights of work, practice, and malpractice in Medicare payment. The purpose of the rebasing and revising of the MEI is to reflect current market conditions, with the latest adjustment made in 2014.

However, CMS is proposing to delay implementation of the rebased and revised MEI due to stakeholder concerns about the redistributive impacts. CMS is also aware of the American

Medical Association's (AMA) current data collection process through the Physician Practice Information Survey (PPIS).

ACR Perspective and Comments
The ACR supports CMS's decision to delay implementation of the 2017-based MEI in CY 2025. The AMA closed their PPI survey at the end of August and is working to complete their data analysis by early 2025. The data collected by the AMA could be used to derive cost share weights for the MEI and the ACR agrees that CMS should wait until the AMA's PPIS data is available and the Agency has the opportunity to review it.

Potentially Misvalued Services Under the PFS

Proposals
CPT code 27279, *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* is up for nomination for the second year. The nominator is requesting non-facility inputs be established as this code is currently only valued in the facility setting. The nominator offered rationale that the addition of non-facility inputs would allow greater access to patients as this reimbursement would hopefully encourage more providers to perform these procedures in the office. When this code was initially nominated, CMS did not accept it as potentially misvalued, due to mixed feedback from stakeholders and concern about whether the procedure could be safely performed in the office setting.

Stakeholders also nominated CPT codes 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)*, 10004 *(Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure))*, 10005 *(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)*, and 10006 *(Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure))* as potentially misvalued. This family of fine needle aspiration (FNA) codes have been nominated several times in the previous years and addressed by CMS in previous rulemaking. The nominator does not agree with the crosswalk code CMS used to value the code, citing differences in complexity, training, and experience required to perform the procedures. The nominator is urging CMS to accept the AMA Relative Value Scale Update Committee (RUC)-recommended values.

ACR Perspective and Comments
The ACR agrees with the nominator that the procedure described by CPT code 27279 may be safely performed in the office or non-facility setting. As indicated by the studies submitted by the nominator, there is a low complication rate for performing this procedure in the office-based lab setting. Establishing payment for direct PE inputs would increase patient access to care for this service.

Regarding the fine needle aspiration code family, the ACR continues to urge CMS to accept the values previously approved by the RUC. We do not believe this family requires additional RUC

review, as the codes are undervalued as a result of a utilization crosswalk error. The ACR is open to further discussion with CMS to clarify or resolve the issue with the double counting of the utilization.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology

Proposals

In the CY 2023 and CY 2024 PFS, CMS asked for stakeholder thoughts and feedback on ways to update the PE methodology and inputs that could be repeatable and account for the changes in the health care landscape. The current PE methodology utilizes data from the AMA's 2007/2008 PPIS. The AMA is in the process of collecting updated PPIS data, and many comments have asked CMS to hold off on making any changes to the PE methodology until the new data is available. The AMA expects their analysis to be complete by early 2025.

In the CY 2025 proposed rule, CMS shared that they have some concerns about the endorsements the AMA received from many of the national medical specialty societies for their survey and how it may have contributed to bias in the data that is collected. CMS also shared that they have contracted with RAND Corporation to develop other alternative methods for measuring PE. CMS continues to solicit feedback and input from stakeholders on ways to improve the stability and predictability of any future updates, as well as having recurring updates to the PE inputs every four years.

CMS also requested feedback on updates to supply and equipment pricing and ways their methodology could account for inflation or deflation in supply or equipment costs, the impacts of economics of scale, and how to obtain verifiable and independent data.

ACR Perspective and Comments

The current practice cost data being used by CMS is over 15 years old. Over the past year, the AMA has been working on collecting more updated data on practice costs today, as well as physician hours for different specialties. The ACR has been assisting the AMA in their PPIS data collection efforts by encouraging our members to complete the survey if they received it; our encouraging members to complete this survey is consistent with our encouraging members to complete all surveys not just this AMA survey. The ACR does not believe this has introduced bias in the data collected by the AMA. The AMA survey closed on August 31, and they expect to complete their data analysis and share the results with CMS by early 2025.

The ACR believes CMS should wait to implement any changes to the PE methodology until the AMA survey process is complete and sufficient time is allotted for CMS and the specialties to review the data that is collected. We do not agree with CMS's statement that the letter of endorsement signed by the specialties introduced bias into the process.

With respect to updates to clinical staff, medical supply and medical equipment pricing, the ACR agrees that regular updates will improve the stability and predictability of the fee

schedule. However, relative updates alone are insufficient to solve the widening gap of practice expense payments constrained by historic scaling factor adjustments and the real practice expense costs borne by outpatient facilities. We believe the RUC process of building block cost accounting is the most robust method for determining these payments. If budget neutrality adjustments are not addressed, Medicare patients will continue to see reduced access to outpatient services because the non-facility payments are insufficient.

Valuation of Specific Codes for CY 2025

MRI-Monitored Transurethral Ultrasound Ablation of Prostate (CPT codes 5X006, 5X007, and 5X008)

Proposals
The creation of three new CPT codes, 5X006 *(Insertion of transurethral ablation transducers for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed)*, 5X007 *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation),* and 5X008 *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducers for delivery of the thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed)*, were approved for MRI-monitored transurethral ultrasound ablation (TULSA). CMS noted concerns about the experience of the survey respondents and the intra-service times provided in the survey data. CMS stated they would welcome additional data that could be considered in the valuation of the work and direct PE inputs for these CPT codes.

CMS proposed to accept the RUC-recommended values of 4.05 RVU for CPT code 5X006, 9.80 RVUs for CPT code 5XX07, and 11.50 RVUs for CPT code 5XX08. CMS also proposed to accept the RUC-recommended direct PE inputs for all codes without refinement.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the RUC-recommended values for CPT codes 5X006 (4.05 RVUs), 5XX07 (9.80 RVUs), 5XX08 (11.50 RVUs) as well as the PE inputs.

Percutaneous Radiofrequency Ablation of Thyroid (CPT codes 6XX01 and 6XX02)

Proposals
For CPT codes 6XX01 *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)* and 6XX02 *(Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service),* CMS is proposing to accept the RUC-recommended work RVUs (5.75 RVUs and 4.25 RVUs, respectively) and direct PE inputs without refinement.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the RUC-recommended PE inputs and work RVUs for this code family (5.75 RVUs for CPT code 6XX01 and 4.25 RVUs for CPT code 6XX02).

Magnetic Resonance Examination Safety Procedures (CPT codes 7XX00, 7XX01, 7XX02, 7XX03, 7XX04, and 7XX05)

Proposals
Six new codes were created to describe magnetic resonance (MR) examination safety procedures and to capture the physician work involving patients with implanted medical devices that require access to MR diagnostic procedures. CPT codes 7XX00 (*MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes)* and 7XX01 *(MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)* are PE only, while the other four codes (CPT codes 7XX02 *(MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR exam, analysis of risk versus clinical benefit of performing MR exam, and determination of MR equipment, accessory equipment, and expertise required to perform examination with written report)*, 7XX03 *(MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies with written report)*, 7XX04 *(MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room with written report)* and 7XX05 *(MR safety implant positioning and/or immobilization under supervision of physician or qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room with written report)*) capture the associated physician work and PE in performing these services.

CMS proposed to accept the following RUC-recommended work RVUs: 0.60 RVUs for CPT code 7XX02, 0.76 RVUs for CPT code 7XX03, 0.75 RVUs for CPT code 7XX04, and 0.60 RVUs for CPT code 7XX05. CPT codes 7XX00 and 7XX01 are PE-only.

CMS proposed several refinements to the direct PE inputs recommended by the RUC:

- For CPT codes 7XX00, 7XX01, 7XX02, 7XX04, and 7XX05, CMS proposed to refine the clinical labor time for CA034 *(Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.))* from 2 minutes to 1 minute based on 1 minute being allotted to a similar clinical activity for the reference CPT code, 70543 *(Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences)*. CPT code 7XX03 also has 1 minute of time for CA034, and CMS noted that they wanted to maintain consistency in the family.
- For CPT code 7XX01, CMS proposed to refine the clinical labor for the CA021 activity *(Perform procedure/service---NOT directly related to physician work time)* from 27 minutes to 14 minutes. The descriptor for 7XX00 is for the "initial 15 minutes" and the descriptor for 7XX01 is for "each additional 30 minutes." Given that 7XX00 contains 7 minutes for this clinical activity, CMS believes that the associated activity for 7XX01 should be double the time of CPT code 7XX00. This proposed refinement would also result in a reduction to the equipment time for the Technologist PACS workstation (ED050) from 45 minutes to 32 minutes.
- For CPT code 7XX03, the RUC recommended 13 minutes of time for the Professional PACS Workstation (ED053) listed as a Facility PE input. The Agency believes this was an error and proposed to remove this time.
- For CPT codes 7XX04 and 7XX05, CMS proposed to reduce the clinical labor time for CA024 (*Clean room/equipment by clinical staff*) from 2 minutes to 1 minute. Since only the new equipment, EQ412 (*Vitals monitoring system (MR Conditional)*), is being cleaned CMS believes that 1 minute would be typical and appropriate. CMS's refinement also results in a reduction to the equipment time for EL008 (*room, MR*) and EQ412 *(Vitals monitoring system (MR Conditional))* for both codes.
- For CPT code 7XX05, CMS proposed to remove supply item SL082 *(impression material, dental putty (per bite block))*. The Agency believes this was an error since the PE recommendations did not list SL082 as one of the included supplies for CPT code 7XX05 and it does not appear as a supply input for any of the other codes in the family.

ACR Perspective and Comments

The ACR appreciates the Agency's feedback on this complex code family. While we support the proposal to accept the RUC-recommend RVUs for the family (0.60 RVUs for CPT code 7XX02, 0.76 RVUs for CPT code 7XX03, 0.75 RVUs for CPT code 7XX04, and 0.60 RVUs for CPT code 7XX05), the College does not agree with all the PE refinements. Please find our comments below:

- **Refinement of CA034 *(Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.))* from 2 minutes to 1 minute for CPT codes 7XX00, 7XX01, 7XX02, 7XX04, and 7XX05.**
  The ACR disagrees with this refinement.
  - For CPT code 7XX00: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam. The written report will also typically include assessment of eligibility to schedule MR exam including whether exam is declined or requires risk/benefit analysis, with rationale so that these steps will not need to be repeated in the future. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - For CPT code 7XX01: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam. The written report will also typically include assessment of eligibility to schedule MR exam including whether exam is declined or requires risk/benefit analysis, with rationale so that these steps will not need to be repeated in the future. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - For CPT code 7XX02: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam, as determined from the clinical determination of the physician. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - For CPT code 7XX04: 2 minutes is necessary because the technologist must write a detailed report to include clinical staff records with information about the program settings and outputs used during the MR procedure, and status of implant after the exam. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the

procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.

- For CPT code 7XX05: 2 minutes is necessary because the technologist must write a detailed report to include clinical staff records with information regarding patient tolerance of head wrap and implant status post procedure to inform future scheduling of MR procedures. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.

- **Refinement of CA021 activity *(Perform procedure/service---NOT directly related to physician work time)* from 27 minutes to 14 minutes for CPT code 7XX01. This would result in a reduction to the equipment time for the Technologist PACS workstation (ED050) from 45 minutes to 32 minutes.**
  The ACR disagrees with CMS's proposed reduction of CA021 time—and the resulting decrease in ED050 time—for CPT 7XX01. The typical work for 7XX01 involves assessment of an implant where there may be no implant information readily available in the medical chart or the patient does not have access to their implant card. We believe there is significantly more work for the technologist in 7XX01 compared to 7XX00 because the technologist typically must call the patient's primary care physician's office to obtain more information about who inserted the implant and then call the relevant physician's office to send information related to the patient's implant to review or asking questions to obtain as much detail as possible as regarding the implant. Information such as date of insertion, location, component model numbers, etc., and if there have been subsequent revision surgeries to the original implant. This is significantly more work than the 7XX00 code, which may be confined to review of the medical chart and/or a call to the patient directly who will have the implant information available.
- **Refinement of ED053 *(Professional PACS Workstation)* from 13 minutes to 0 minutes for CPT code 7XX03 in the Facility.**
  The ACR agrees that there should not be any facility inputs for CPT code 7XX03, including time for ED053. CMS may remove the 13 minutes.
- **Refinement of CA024 *(Clean room/equipment by clinical staff*) from 2 minutes to 1 minute for CPT codes 7XX04 and 7XX05, also resulting in a reduction in time for EL008 *(room, MR)* and EQ412 *(Vitals monitoring systems (MR Conditional)).***
  The ACR agrees with the reduction in CA024 time from 2 minutes to 1 minute, resulting in a 1 minute reduction to EL008 and EQ412 times for both CPT codes.
- **Removal of supply item SL082 *(impression material, dental putty (per bite block))* from CPT code 7XX05.**
  The ACR disagrees with the removal of SL082 from the supplies for CPT code 7XX05. The impression putty is a component of the applied splint and compression bandage. The putty is applied around the protrusion of the cochlear implant to distribute the applied splint pressure on the patient's scalp and improve patient tolerance of the applied compression bandage. A typo in the PE SOR incorrectly listed SL042 instead of the correct supply code of SL082 for impression material.

Ultrasound Elastography (CPT codes 76981, 76982, and 76983)

Proposals
CPT codes 76981 *(Ultrasound, elastography; parenchyma (eg, organ)),* CPT code 76982 *(Ultrasound, elastography; first target lesion),* and CPT code 76983 ***(****Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure))* were flagged for re-review by the new technology/new services screen as a result of the increased utilization of code 76981.

CMS proposed to accept the RUC-recommended work RVUs for the family: 0.59 RVUs each for CPT codes 76981 and CPT code 76982 and 0.47 RVUs for CPT code 76983. CMS also proposed to accept the direct PE inputs as recommended by the RUC.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the PE inputs and work RVUs for the family (0.59 RVUs each for CPT codes 76981 and CPT code 76982 and 0.47 RVUs for CPT code 76983).

CT Guidance Needle Placement (CPT code 77012)

Proposals
CMS proposed to accept the RUC-recommended work RVU for CPT code 77012 (*Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation*) at 1.50 work RVUs.

However, CMS proposed to refine the equipment time for the CT room (EL007), reducing it from the RUC-recommended 26 minutes to maintain the current time of 9 minutes. CMS stated that CPT code 77012 is a radiological supervision and interpretation (RS&I) code, and the Agency has a longstanding convention for assigning 9 minutes of room time for RS&I codes. In previous rulemaking, commenters have made the distinction that while there is precedent for 9 minutes to be assigned to the room time for RS&I codes, it is specific to angiographic rooms. CMS disagrees, citing other RS&I codes with 9 minutes for CT room time.

ACR Perspective and Comments
The ACR appreciates CMS's proposal to accept the RUC-recommended 1.50 work RVUs for CPT code 77012. However, the ACR does not agree with the reduction from 26 minutes to 9 minutes for the CT room. The convention that CMS is applying pertains specifically to RS&I codes in angiographic rooms. This procedure is performed in a CT room. The rationale also states that "the S&I code should receive a base time of 9 minutes for the room, and all other time will be allocated to the procedure code." CMS states in the proposed rule that they agree some portion of the procedure is performed in the CT room but are hesitant to correct the time for this code without first addressing the other 38 RS&I codes due to concerns about relativity. 35 of the 38 codes are performed in the angio room, so the 9 minutes allocated is appropriate. One code, 76080, is performed in the fluoro room but is billed with a code (49424) that includes fluoro

time. However, two codes, 77012 and 75989, are performed in the CT room and should have more than 9 minutes of room time. The codes 77012 are billed with do not include any room time; therefore, it is appropriate to apply the highly technical formula to calculate the minutes for the CT room. The purpose of the RUC and the re-review of services is for the opportunity to update a code's values and inputs to accurately reimburse physicians for the services they perform. To not allocate appropriate time to a code because of an inappropriately applied convention or rationale does not follow long standing precedent.

Transcranial Doppler Studies (CPT codes 93886, 93888, 93892, 93893, 93X94, 93X95, 93X96, and 93890)

Proposals

CMS proposed to accept the RUC-recommended PE inputs and work RVUs for all seven of the new or revised transcranial doppler studies codes: CPT code 93886 *(Transcranial Doppler study of the intracranial arteries; complete study)* at 0.90 RVUs, CPT code 93888 (*Transcranial Doppler study of the intracranial arteries; limited study)* at 0.73 RVUs, CPT code 93892 *(*T*ranscranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection)* at 1.15 RVUs, CPT code 93893 *(Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection)* at 1.15 RVUs, CPT code 93X94 *(Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete)* at 0.81 RVUs, CPT code 93X95 *(Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)* at 0.73 RVUs, and CPT code 93X96 *(Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)* at 0.85 RVUs. CPT code 93890 *(Transcranial Doppler study of the intracranial arteries; vasoreactivity study)* will be deleted.

CMS also stated that it might be beneficial if the AMA CPT Editorial Panel clarified the billing instructions for this code family by explicitly stating that CPT code 93X95 should not be used in conjunction with CPT code 93892 and that CPT code 93X96 should not be used in conjunction with CPT code 93893, as this work would be duplicative and result in overbilling of services.

ACR Perspective and Comments

The ACR supports CMS's proposal to accept the direct PE inputs and RUC-recommended values for the family (0.90 RVUs for CPT code 93886, 0.73 RVUs for CPT code 93888, 1.15 RVUs each for CPT codes 93892 and 93893, 0.81 RVUs for 93X94, 0.73 RVUs for CPT code 93X95, and 0.85 RVUs for 93X96).

We acknowledge the CMS recommendation to the AMA CPT Editorial Panel to more explicitly state that CPT code 93X95 should not be used in conjunction with CPT code 93892 and CPT code 93X96 should not be used in conjunction with 93893. The ACR is committed to providing education to our members on the appropriate use of the revised code set for 2025.

Professional Component (PC)/Technical Component (TC) Indicator for Medical Physics Dose Evaluation

CPT code 76145 *(Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report)* is a PE-only code that was created to describe the work independently done by a medical physicist. Since this code has been implemented in 2021, its utilization has remained at 1 despite the publication of educational material to inform about the creation and usage of this code.

The ACR recently noticed that CPT code 76145 has a PC/TC indicator of "0"in the PFS, which refers to codes that describe physician services, and the concept of PC/TC does not apply since physician services cannot be split into professional and technical components. The College believes this could be an error, as CPT code 76145 is a PE-only code; therefore, we believe that a PC/TC indicator of "3"—technical component only codes—would be more appropriate. This indicator describes stand-alone codes that describe the technical component (like staff and equipment costs) of chosen diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. The ACR requests that CMS review this potential error and make any necessary corrections.

Medicare Shared Savings Program

As of January 1, 2024, the Shared Savings Program has 480 Accountable Care Organizations (ACOs) with over 634,000 health care providers and organizations providing care to over 10.8 million assigned beneficiaries in the Medicare Shared Savings Program (MSSP).

Proposals

CMS is proposing to establish a new "prepaid shared savings" option to assist eligible ACOs with a history of earning shared savings. CMS is also proposing to give eligible ACOs with a history of success in the program access to an advance on their earned shared savings to encourage investment in staffing, health care infrastructure, and additional services, such as nutrition support, transportation, dental, vision, hearing, and Part-B cost-sharing reductions, for people with Medicare. CMS would require that at least 50 percent of prepaid shared savings be reserved for direct beneficiary services not otherwise payable in Traditional Medicare, such as meals, dental, vision, hearing, and Part B cost-sharing support. Additionally, up to 50 percent of the prepaid shared savings could be spent on staffing and infrastructure. CMS is also proposing refinements to advance investment payment policies to allow ACOs receiving advance investment payments to voluntarily terminate participation in the payment option while remaining in the MSSP, and to specify that, if CMS terminates an ACO's participation agreement, the ACO must repay any outstanding advance investment payments it received.

ACR Perspective and Comments

The ACR is supportive of CMS's proposal to establish a new prepaid shared savings option to assist eligible ACOs with a history of earning shared savings. By providing prepaid shared savings, successful ACOs will be able to further invest in quality care to beneficiaries. Giving

ACOs the ability to invest in both direct and indirect beneficiary services will allow ACOs to improve beneficiary care, while also improving the infrastructure and efficiency of the ACO.

QUALITY PAYMENT PROGRAM

Updates to the Quality Payment Program (QPP)

CMS issued new Requests for Information (RFI) focusing on fully implementing Merit Based Incentive Payment System (MIPS) Value Pathways (MVPs) into MIPS and eventually sunsetting traditional MIPS.

Building upon the MVPs Framework to Improve Ambulatory Specialty Care RFI

Proposals

In collaboration with the CMS Innovation Center, CMS is exploring a new payment model design for specialists in ambulatory care that would incorporate elements of both the Innovation Center's comprehensive specialty strategy as well as the MVP framework. CMS sees this as a potential method for increasing the engagement of specialists in value-based payment and Advanced Alternative Payment Models (APMs) and furthering specialty care provider engagement with primary care providers and beneficiaries. As envisioned, specialist participants in an Ambulatory Specialty Care model would not receive a MIPS payment adjustment. Instead, they would receive a payment adjustment based on their performance on a set of clinically relevant performance measures they are required to report. The performance of the specialist participants would be compared to clinicians furnishing similar sets of services. CMS expects this more targeted approach would provide better insight into the clinical decisions and processes (i.e., care coordination) affecting patient outcomes.

Through this RFI, CMS solicits comments on various parameters of a potential model, including mandatory participation (after notice and comment rulemaking) of relevant specialty care providers, definition of participants, performance assessment, and payment methodology. Input is also requested on care delivery and incentives for partnerships with accountable care entities and integration with primary care, health information technology and data sharing, health equity, and multi-payer alignment.

ACR Perspective and Comments

The ACR commends CMS for its goal to improve upon the complexities and unviability of the MIPS program in its current form. As outlined in its proposal for an MVP-based Ambulatory Specialty Care payment model, the desire to construct a program that rewards integration of specialty care across a patient's journey, emphasizing improved coordination and collaboration between primary and specialty care physicians, particularly at the point of referral, is laudable. The ACR's recognition of the value and importance of coordinated care is demonstrated through various concerted efforts, such as contributions and participation in the CMS Innovation Center's Transforming Clinical Practice Initiative (TCPI), through which the radiology community was encouraged and guided to act as champions and partners with referring physicians to be stewards of imaging appropriateness. This work built cross-specialty, continuing relationships through

collaborative efforts to identify tenets of high-value referral management[5], as well as to ensure coordinated emergency department imaging related communication and follow up tracking for actionable and evidence-based incidental findings[6].

The radiology profession prioritizes accurate imaging interpretation combined with concise evidence-based recommendations in radiology reports. Beyond the communication of diagnostic information, radiologist collaboration as part of the care team in the coordination of care, including ensuring the adherence to recommended care, is critical to the effective use of the imaging information to achieve the best patient outcomes. Breast and lung cancer screening programs, as well as appropriate evidence-based follow-up recommendations for actionable incidental findings, in tandem with tracking and management of these preventive care services are examples illustrating radiologists' active engagement in managing population health. Providing supportive guidance documents, care program implementation and management tools for these early cancer detection programs for the radiology community along with associated quality measurement and improvement tools; as well as building clinician, payer and patient communities' awareness and uptake of life-saving benefits of these services to better the patients' experiences, journeys, and outcomes is a priority. These factors point to the critical role radiology plays in integrated primary-specialty care both episodically and longitudinally. As such, the ACR is supportive of the foundation and principles upon which the proposed Ambulatory Specialty Care model using an MVP framework is based.

CMS proposes that participation in this ambulatory specialty model be mandatory for relevant specialty care providers where and when there are applicable MVPs implemented in the model. Previously mandated or proposed mandatory APMs such as the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model, the Comprehensive Care for Joint Replacement (CJR) model and the Radiation Oncology (RO) model have generated concerns regarding inability to ensure fair or predictable payment, excessive payment cuts, lack of proven track record of a net savings, an emphasis on cost savings over treatment quality and substantial administrative burdens for those participating in these models. **The ACR strongly disagrees with making participation mandatory, particularly within the short 3- to 5-year timeframe suggested, and highly recommends that CMS conduct extensive testing. The ACR also believes that a significant on-ramp for the proposed model is warranted for the subset of initially implemented MVPs and for each additional MVP included over time.**

CMS asks if there are certain practice or clinician characteristics that may warrant additional policy flexibilities or exemption from participation in a mandatory ambulatory specialty model and what flexibilities should be considered for such participants. Because the proposed model incorporates use of MVPs, participation for some specialties (most specifically non-patient-

[5] Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration. An American College of Physicians Position Paper 2022 (www.acponline.org)

[6] Moore CL, Baskin A, Chang AM, Cheung D, Davis MA, Fertel BS, Hans K, Kang SK, Larson DM, Lee RK, McCabe-Kline KB, Mills AM, Nicola GN, Nicola LP. White Paper: Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging. J Am Coll Radiol. 2023 Apr;20(4):422-430. doi: 10.1016/j.jacr.2023.01.001. Epub 2023 Mar 13. PMID: 36922265.

facing specialties such as diagnostic radiology and pathology) would be dependent on CMS allowing alternative approaches and flexibilities for specialties who are currently unable or thwarted in participating in MVPs due to CMS's policy requiring inclusion of current types of cost measures. CMS has stated within this rule that "an MVP cannot be developed for a specialty/subspecialty if there is not at least one applicable cost measure, as finalized in the CY 2021 PFS final rule (85 FR 84472)" and that flexibility exists within the Medicare Access and CHIP Reauthorization Act (MACRA) to consider and apply "alternative measures or activities that fulfill the goals of the applicable performance category." If CMS can determine MACRA statute-based flexibilities for this issue, what remains is development and testing of reasonably attributable alternative measures and activities for non-patient-facing MIPS eligible clinicians. **The ACR is willing to explore this pathway with CMS.**

To support the model, CMS questions how it should structure the model and any health IT and data sharing requirements to align with, build upon, and otherwise leverage advances in Federal interoperability policy (e.g., United States Care Data for Interoperability (USCDI) and USCDI+ or Fast Healthcare Interoperability Resources (FHIR)). **The ACR continues its recommendation that the Office of the National Coordinator for Health Information Technology (ONC) elevate USCDI Diagnostic Imaging Level 2 elements Accession Number, Imaging Reference, and Requested Procedure Identifier to USCDI v6.** The electronic health record (EHR) must store references to enable the continuum of care both within a healthcare system and across systems since patients inevitably transition institutions both by choice and in critical care situations. It is especially important during these critical care situations such as mass casualty or emergency transfer to facilities with acute care capabilities, where seconds matter and having imaging prior to arrival can be crucial in a patient's outcome. The Level 2 elements for Diagnostic Imaging provide these references and make immediate access possible both with a facility and outside the enterprise. Standardized, profiled, and tested capabilities enable cross enterprise sharing of imaging which can be further advanced by the elevation of USCDI Diagnostic Imaging Level 2 elements, thus immediately improving patient outcomes.

Transforming the Quality Payment Program RFI

Proposal

CMS wants to learn about clinician readiness for MVP reporting and MIPS policies to sunset traditional MIPS and fully transition to MVPs in the CY 2029 performance period/2031 MIPS payment year. Methods include assessing the remaining MVP gaps that must be filled to confirm participation options for MIPS-eligible clinicians. It also explores options for furthering MVPs developed to facilitate greater reporting rates for clinicians with fewer measures available for their specialty, including collaborating with measure developers and providing transparency on measure gaps and the limitations around quality and cost measure development. CMS acknowledges that all approaches it is considering for expanding MVPs and making them more inclusive of clinicians are hindered by existing gaps in quality and cost measures for specific patient populations, clinical conditions, and specialties. Even with a robust inventory of MVPs, CMS notes that there may be some clinicians who cannot submit an applicable MVP, as currently structured, due to a shortage of measures to build a respective MVP or lack of measure

case counts or specialization that prevents reporting of MVP quality measures and calculation of a cost measure.

In the RFI, CMS explicitly asks what "meaningful MIPS participation would look like for clinicians who in the future, with the sunset of traditional MIPS, may not have an applicable MVP, e.g., clinician types without an MVP due to having less than four applicable quality performance measures and less than one cost measure identified in the 2025 MVP Needs and Priorities." It also asks if ″flexibilities or alternative policies such as non-patient-facing clinician policy changes should be considered for clinicians with limited performance measures that allow them to participate in MIPS."

ACR Perspective and Comments

As a leader in quality improvement, the ACR is heartened by CMS's interest in transforming the QPP and is pleased to highlight our long, proud history of prioritizing radiologic quality improvement, including developing and implementing quality measures, collecting clinical quality data through the National Radiology Data Registry (NRDR), engaging practices in a learning health systems approach to process improvement through the ACR Learning Network, and awarding the Diagnostic Imaging Centers of Excellence (DICOE) status. The participation of radiology practices or facilities in any of these initiatives demonstrates dedication to continually improve the quality of care they provide.

We are encouraged by the proposed rule *Transforming the Quality Payment Program RFI.* However, we are uncertain about MIPS-eligible radiologists' future engagement in MVPs. While ACR's National Radiology Data Registry (NRDR) Qualified Clinical Data Registry successfully reports on quality measures and improvement activities for its users, we cannot gauge MIPS-eligible clinicians' adoption capacity without knowing the components of future radiology-focused MVPs (which would include the foundational layer requirements of MVPs). Under the current MVP framework, radiologists may have some quality measures and improvement activities available for reporting but not cost measures or promoting interoperability (PI) measures. As such, future MVP participation and scoring would function like traditional MIPS, for which the Cost and PI categories are reweighted to Quality and Improvement Activity (IA) categories, given their non-patient-facing status. The ACR understands CMS's goal of supporting a limited number of MVPs by specialty and subspecialty, which may allow some radiologists to participate in an MVP. However, because radiology is highly sub-specialized, it is more likely to leave portions of radiology-eligible clinicians unqualified to use these future MVPs due to their subspecialty.

Proposal

Expand Previously Finalized MVPs to Include Different Specialties Included in Care Delivery for Patient Populations: CMS may expand the Advancing Cancer Care MVP to include measures related to non-patient-facing MIPS-eligible clinicians supporting cancer patient care, increasing the specialties that could report a given MVP without increasing the number of standalone MVPs. However, CMS is concerned that too many measures and activities could undermine the goal of having a smaller, cohesive set of measures and activities in MVPs.

ACR Perspective and Comments

Given the barriers preventing non-patient-facing clinicians from reporting MVPs under the current framework (i.e., nonmeaningful cost measures, limited quality measures, and minimal control over EHR systems, preventing reporting Promoting Interoperability measures), the **ACR requests an outline detailing how the Advancing Cancer Care MVP could integrate measures and activities for non-patient-facing specialties, like radiology.** Given radiologists' integral role in diagnosing and ensuring proper follow-up for patients with cancer or at risk for potential cancers, an outline could provide information on measure development and other details that could promote their success in MVPs. Additionally, the ACR believes that a multi-specialty condition-based MVP such as Advancing Cancer Care could be easily segmented into cohesive specialty-specific buckets.

Proposal

Develop MVPs based on Multiple Specialty Measure Sets: CMS proposes developing MVPs using existing specialty measure sets for those specialties without MVP coverage. CMS explains that this effort would serve as a bridge until new applicable measures are developed. This would allow for the creation of individual MVPs for clinicians without an MVP specific to their specialty, patient populations served, or the primary conditions treated. For example, CMS could broadly develop an MVP geared towards non-patient-facing clinicians until more meaningful options may be finalized.

CMS suggests that specialty measure sets transitioned to MVPs may provide clinicians with early experience with MVPs. However, this method could also replicate traditional MIPS and fall short of MVP's goals of a cohesive set of measures and activities. Clinicians may choose unlinked measures with high-performance levels rather than addressing performance areas needing improvement. It may also lessen the comparability of performance measures reported by clinicians providing similar services.

ACR Perspective and Comments

The ACR questions the utility of using existing specialty measure sets to bridge MVPs because CMS aims for MVPs to contain aligned quality measures, improvement activities, and cost measures to demonstrate value to consumers. While the measure specialty sets benefit MIPS-eligible clinicians' particular specialties in traditional MIPS, specialty set measures do not automatically align as mandated under MVP regulation. CMS would conflict with its stated MVP purpose of cost and quality measurement-driven value by shifting the specialty sets to MVPs, assigning IAs, and other measures. Further, the ACR strongly supports retaining measure specialty sets for traditional MIPS until non-MVP-covered specialties can access meaningful MVPs. However, should the decision be made to transition MIPS specialty measure sets to MVPs and promote unlinked measures, we urge that performance in such MVPs be compared among eligible clinicians practicing in the same medical specialty or subspecialty, not just the same MVP users.

Proposal
Develop MVPs based on Cross-Cutting and Broadly Applicable Measures: CMS could develop an MVP that applies to multiple specialty types by leveraging frequently reported cross-cutting or broadly applicable measures that can be reported by clinicians who currently do not have MVPs specific to their scope of care, also serving as a temporary bridge for clinicians without other MVP reporting options. However, CMS is concerned that this could duplicate the value of the primary care MVP. Also, a broader, cross-cutting MVP does not solve the concerns of all specialties identified in CMS's 2024 MVPs Needs and Priorities interested in submitting measures and activities related to their specialties. CMS may also need policies to discourage clinicians from choosing this broad MVP when a more specifically applicable MVP is available. CMS discusses using claims-based data to ascertain whether a clinical condition or specialty-specific MVP better matches the type of care delivered or if a bridge MVP submission fits, potentially within an auditing activity or tying payment to MVP selection.

In the RFI, CMS, knowing the measures may not be as highly relevant to the clinicians' scope of care, asks if it should consider developing a more global MVP with broadly applicable measures as an interim bridge for those clinicians with too few specialty-specific quality measures.

ACR Perspective and Comments
The ACR would strongly encourage the development of a policy that protects non-patient-facing clinicians from participating in MVPs based on cross-cutting and broadly applicable measures. Given our understanding that these MVPs would be appropriate for patient-facing clinicians who lack MVP coverage, CMS must recognize the barriers to MVP participation previously mentioned for non-patient-facing eligible clinicians.

The ACR does not support CMS developing a more global MVP with broadly applicable measures as an interim MVP because the measures must be relevant to the clinicians' scope of care. Mandating that non-MVP-covered clinicians report in a broad MVP that lacks meaning to their practice creates an unnecessary burden and threatens the quality of care provided because these practices would become focused on measures less relevant to their practice. In many cases, such cross-cutting measures are reported by radiology practices that have nurse practitioners, advanced practice providers or interventional radiologists who may bill evaluation and management codes on which the measures are based.

Proposal
Develop MVPs for Non-Patient-Facing MIPS Eligible Clinicians: CMS notes that measurement gaps for some non-patient-facing MIPS-eligible clinicians, like diagnostic radiologists and pathologists, present challenges in developing a respective MVP. CMS is interested in exploring alternative measures and activities that would allow it to measure the performance of non-patient-facing MIPS-eligible clinicians. CMS also requests input on addressing measure gaps and making MVPs more widely available. CMS is researching the flexibilities included in the Act to develop new MVPs for non-patient-facing MIPS-eligible clinicians. However, the proposed rule emphasizes that flexibilities explored must support CMS's overall MIPS goals; reweighting a

performance category would not support performance measurement to drive value or provide comparable information for patients selecting clinicians or care teams.

In the RFI, CMS asks if flexibilities or alternative policies, such as non-patient-facing clinician policy changes, should be considered for clinicians with limited performance measures that allow them to participate in MIPS.

ACR Perspective and Comments

The ACR applauds CMS's efforts to understand the practice of radiology, its limitations in participating in the current MVP framework, and its efforts to examine the MACRA legislation for flexibilities that would enable the development of meaningful and applicable MVPs for non-patient-facing eligible clinicians. As stated earlier, the ACR and its members are dedicated and highly engaged in developing and participating in meaningful and actionable quality improvement programs. Radiologists view their recommendations and communication with referring or managing care clinicians and patients as their most important responsibility for contributing to positive health outcomes, making the radiology report integral to assessing their care quality.

Some of our most significant concerns with MVP participation apply to the absence of meaningful cost measures available due to diagnostic radiology's lack of care episodes as characterized by current cost measures; fewer health outcomes are directly linked to diagnostic radiologists' care because they do not control their patients' imaging orders or management of clinical treatment, resulting in the reliance on process measures for which radiologists may use to ensure the delivery of high-quality care for the role they play in patients' care paths. Considering the absence of meaningful cost measures due to the focus on episode-based cost measures, the ACR considers appropriateness and efficiency measures valuable to demonstrating radiologists' efforts to reduce costs while improving quality. We understand that such measures could not serve in the Cost category, as mandated by the Act. **However, given their proximity to cost, they could be used in MVPs in addition to the required quality measures.** For instance, service efficiency and recommendation appropriateness measures could inform CMS of efforts to avoid waste in radiology practices.

CY 2025 Merit Based Incentive Payment System (MIPS) Value Pathway (MVP) Development and Maintenance

Proposal

CMS states that its intended goal is to offer MVPs for all specialties and subspecialties during the full MVP transition. However, this proposed rule acknowledges that CMS's portfolio of quality and cost measures is not applicable for all specialties and subspecialties due to gaps in both measure types, including those for interventional and diagnostic radiology, noting that most radiologists are not captured under existing cost measures. Further, despite existing policies to reweight the cost performance category for individuals, groups, and subgroups of MIPS-eligible clinicians that cannot be scored on cost measures, CMS acknowledges that MVPs may not be developed for a specialty/subspecialty without at least one applicable cost measure (per the CY

2021 PFS final rule). As such, CMS invites the submission of cost measures into the Annual Call for Measures for candidate quality and cost measures relevant to their specialty.

ACR Perspective and Comments
The ACR appreciates CMS recognizing that developing robust MVPs includes cost measures relevant to its specialty or subspecialty. We also agree that MVPs that reweight scores for radiologists not captured under most cost measures, including the two population-based cost measures, negate the purpose of MVPs. We are concerned, however, with CMS's invitation for developers to submit cost measures to the Annual Call for Measures relevant to their specialty to fill the gap.

Under CMS regulation, cost measures must apply to care episodes. As described in this letter, care episodes in radiology have not been identified, preventing the development and submission of candidate cost measures to the Annual Call. The ACR is committed to supporting the development of MVPs that appropriately assess costs. However, until CMS recognizes alternative cost measures not founded on an episode, there will remain a scarcity of measures capturing radiologists' care costs for which a radiology MVP may be formed and implemented.

MVP Requirements and Scoring

Proposal
CMS proposes several updates to MVP scoring, specifically on aligning MVP scoring with traditional MIPS policies by cross-referencing the MVP Cost performance category scoring policies to traditional MIPS for scoring cost measures and by removing references to high and medium-weighted IAs in MVPs for consistency with the proposed removal of such weighting under traditional MIPS. Other proposals for MVP scoring comprise the provision of full credit (i.e., 40 points) for the Improvement Activities (IA) performance category for MVP participants who report one IA and an extension to the 2025 performance period and beyond the requirement that subgroups submit their affiliated group's data for the PI performance category.

ACR Perspective and Comments
The ACR supports the MVP scoring updates to align with the proposed changes to the traditional MIPS IA performance category.

MIPS Category Weighting

Proposal
CMS proposes a new reweighting policy for clinicians using third-party intermediaries to submit MIPS data to CMS on their behalf. In this new proposal, which would go into effect for the 2024 MIPS performance year, a group or individual clinician could request that CMS reweight a performance category if their third-party intermediary failed to report MIPS data to CMS within the mutually agreed-upon timeframe due to circumstances beyond the control of the clinician.

ACR Perspective and Comments
The ACR supports this new reweighting policy. We appreciate that this new proposal may help clinicians avoid penalties for errors that were made through no fault of their own.

MIPS Performance Threshold

Proposal
For the 2025 performance period, CMS proposes to maintain the 75-point performance threshold.

ACR Perspective and Comments
The ACR supports this proposal, and we are glad to see that CMS has elected not to raise the performance threshold in 2025. The 75-point threshold is difficult for some practices to reach, but it is still an attainable figure for practices who are scoring well on quality measures.

Proposal
CMS has proposed to identify, annually, a selection of topped-out measures from certain specialty sets for which the seven-point cap will be removed and replaced with an adjusted benchmark that allows for up to 10 achievement points.

ACR Perspective and Comments
The ACR strongly supports this proposal, but asks that CMS provides additional clarification on how broadly this will be applied. The College has long advocated for the MIPS program to allow some sort of reweighting for specialties such as radiology who are disproportionately affected by topped-out, point-capped measures, as well as a dwindling number of available measures in general. Many radiology practices see their Quality category weighted at 85 percent of their overall score, and with a limited supply of 10-point measures, even scoring perfectly on all six quality measures may not be sufficient to reach the neutral threshold. Therefore, we believe that this proposal, and the proposed adjusted benchmarks for topped out measures, will be greatly beneficial to practices who are exempt from Promoting Interoperability and Cost, and who, therefore, have a greater weight placed on their Quality category score.

While we appreciate and support this new approach, we encourage CMS to allow for 9-9.9 measure achievement points. We understand that CMS considered this but, "ultimately excluded them to necessitate exceptional clinical quality performance to achieve maximum scores." As a compromise approach, we hope that CMS will allow for 9-9.9 points for a performance rate of 99-99.9 percent. This slight adjustment in the scoring deciles aligns with the goal of CMS to require exceptional performance for high scores, but also provides a more appropriate score for a performance that falls just short of perfect.

The ACR would appreciate clarification from CMS on whether this scoring change will be applicable regardless of collection type: Qualified Registry, Qualified Clinical Data Registry (QCDR), Claims, etc. Specifically, we are seeking confirmation that this scoring adjustment will

be applied to clinicians reporting QCDR measures as well as those who are only reporting MIPS measures. We have observed that among radiology groups reporting QCDR measures, the 7-point cap often discourages them from reporting MIPS measures. Extending this new scoring proposal to all MIPS participants is likely to increase reporting on MIPS measures while also supporting the continued use of QCDR measures. The ACR believes this is a worthwhile goal, especially considering that many QCDR measures have the potential to eventually be adopted as MIPS measures.

Quality Measures Proposed for Addition

Proposal

In this rule, the quality measure, #494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults was noted as being previously finalized for inclusion in CY 2025 Performance Period/2027 MIPS Payment Year and Future Years.

ACR Perspective and Comments

Measure Specifications

Although this measure is finalized for inclusion in 2025 MIPS, the ACR would like to provide ongoing comments related to measure challenges that we have gathered, as practices, hospitals, radiation dose monitoring system and other technology vendors and supporting entities have gained experience with measure implementation as they work towards making it available for reporting to CMS by their clients, radiologists, or constituents.

Our primary concerns are regarding the lack of specificity in the published Electronic Clinical Quality Measure (eCQM) specifications and logic as provided on the Electronic Clinical Quality Improvement (eCQI) Resource Center. There are limited or lack of details on the exact steps, algorithms or computations required to convert the primary data elements (CT exam administrative coding data: CPT/ICD-10 code combinations, patient age; CT exam Digital Imaging and Communications in Medicine (DICOM) data: image pixel values, patient size/diameter, and radiation dose (dose length product-DLP)) to the measure intermediate data elements' (CT Dose and Image Quality Category, Calculated CT Size-Adjusted Dose, and Calculated CT Global Noise) LOINC codes for measure computations. The specifications even state that the "eCQM requires the use of additional software (translation software) to access the primary data elements that are required for measure computation and translate them into data elements that can be ingested by this eCQM."

The capability for technology vendors and other entities to develop products and tools that will support measure calculation, scoring and reporting should be expected and acceptable, and numerous vendors and entities have or are developing such products. Without clear, detailed insight or availability of primary data conversion algorithms or logic used in the sole, proprietary provider's translation software, it seems highly likely that there will be variability in the measure outputs from other vendors or providers.

For example, the CT Exam Category exam assignments require use of tables for binning by radiation dose levels (low, routine, high) and the associated category assignment logic. This was initially available from the National Quality Forum (NQF) during the required consensus-based entity review and evaluation for the measure endorsement, as provided by the measure steward. It is no longer available on the NQF website and is not known to be documented or published in its entirety elsewhere, although a recent publication provides a framework of the methods (Smith-Bindman R, et. al**,** Radiology 2022; 302:380–389**;** https://doi.org/10.1148/radiol.2021210591). Additionally, the methods and logic used to determine CT Global Noise (image quality) are unclear. NQF measure steward endorsement documentation cited two publications related to derivation of global noise, but the measure materials did not describe or detail calculations. Similarly, detailed methods of algorithms, computation methods or validation for determining Calculated CT Size-Adjusted Radiation Dose are not known to be published except for limited information in the NQF endorsement materials. Additionally, for the measure exclusions, how to determine what primary data is missing when any of these three intermediate variables cannot be calculated is unclear**.**

Along with the eCQI Resource Center specifications, the reference materials are available to the extent mentioned above and can be used by technology vendors and entities for developing products and tools that translate the primary data, compute the intermediate variables, and calculate measure scores. It can only be assumed that, at some points in the process, conclusions and inferences need to be made, absent clarity in the specifications.

A measure specification should be easily or reasonably translatable by measure users to produce comparable calculations and scores. If that can only be accomplished by a single resource, there are concerns about reliability and replicability of the measure. **The ACR strongly recommends that CMS obtain and publish on the eCQI Resource Center detailed methods and specifications to translate primary data elements and further clarify computations.** In doing so, broader implementation of the measure may be accomplished.

Ongoing Concerns
The ACR wishes to maintain on record our ongoing concerns with the *Excessive Radiation Dose or Inadequate Image Quality* measure as previously provided in our and the American Association of Physicists in Medicine (AAPM) comments on the Fiscal Year (FY) 2024 Hospital Inpatient Prospective Payment System (IPPS), FY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and FY 2024 Physician Fee Schedule proposed and final rules, from comments during the National Quality Forum 2021-2022 endorsement review of the measure. We summarize these below.

Implementation challenges: In addition to the concerns described above regarding the lack of availability of detailed specifications for conversion or translation of the primary data elements to the intermediate variables to support comparability, this measure is complex and requires multiple layers of implementation. These include new software installation, integration across multiple IT systems (EHR, RIS, PACS), new performance feedback dashboard development, and testing of these implementations to address security and privacy concerns potentially across

multiple locations. There will be variability in how easily or quickly this can be accomplished across the spectrum of hospitals, imaging centers and radiology groups.

Measure methodology: The potential lack of reliability of the primary data used to calculate intermediate data elements is of concern. CT Category: the accuracy or specificity of CPT and ICD-10 codes assigned after completion of the study may vary from the indicated clinical reason for the exam at the time it is performed, which serves as the basis for setting CT protocols. CT Size-Adjusted Dose and CT Global Noise*:* the primary data elements and methodology to calculate these intermediate variables are not widely accepted radiation dose and image quality measurements nor have they been broadly tested and validated across the various settings in which this measure will be implemented.

Scientific: Significant concerns have been raised by the AAPM about the scientific validity of the measure; please refer to comments from AAPM.

Usability: Concerns remain about the usefulness of the measure for improving processes supporting dose optimization. The imaging protocol selection appropriate for a clinical indication is a crucial factor in radiation dose management and optimization. It requires assessing the clinical indication of an exam and the radiation output (dose indices) per exam separately or distinctly together. However, this measure conflates the appropriateness of the protocol for the clinical indication and radiation dose optimization. A facility will be unable to determine if adjusting dose output through protocol management or focusing on the appropriateness of the exam ordered could improve performance.

Terminology: The term “excessive radiation dose” is inflammatory and implies that the caring institution harmed the patient, when in fact the opposite is almost certainly true. Further, this measure incentivizes dose minimization rather than optimization. We believe that the goal of radiation dose management should be *optimization*, not *minimization*. A low dose exam that is insufficient to answer the clinical question is detrimental to patient care.

Future costs: While the Alara, Inc. translation software is currently free, there are concerns about ongoing and future support costs. It is also unclear whether this software provides performance feedback tools at no cost. If not, it is then incumbent upon hospitals, facilities, and other vendors to make such information available to radiologists.

In closing, we reiterate our position as a strong advocate and proponent for patient radiation safety as demonstrated by the multiple and various ongoing efforts and activities in which our organization and the radiology community are involved. The ACR fully supports entities or individuals that put forward valid, feasible and reliable tools to optimize patient exposure to radiation through dose monitoring and imaging appropriateness.

Quality Data Completeness Requirements

Proposal
In the 2024 PFS final rule, CMS signaled that it intended to raise the quality measure data completeness requirement to 75 percent for the 2024 and 2025 performance periods. This number defines the minimum subset of patients within a measure denominator that must be reported. CMS now proposes to maintain this threshold through the 2027 and 2028 MIPS performance periods.

ACR Perspective and Comments
The ACR supports CMS's proposal to maintain the quality measure data completeness threshold at 75 percent through the 2028 MIPS performance period. We believe this is an attainable threshold that leads to an accurate picture of measure performance without placing undue burden on practices who may face difficulties in accurately capturing and reporting a higher percentage of relevant measure data.

Cost Performance Category

Proposal
Diagnostic radiologists and other types of non-patient-facing clinicians continue to be exempt from the Total Per Capita Cost (TPCC) measure at the individual level; however, reporters at the group level can sometimes be attributed to this measure if any non-exempt clinicians are practicing under their tax identification number (TIN).

ACR Perspective and Comments
CMS has stated the TPCC measure focuses on effective primary care management to support Medicare savings. As such, the attribution of the MIPS cost measure should capture the overall care costs after establishing a primary care relationship. Therefore, the TPCC measure methodology provides a specialty-level exclusion for radiologists (and similarly designated specialties) based on their Medicare Provider Enrollment, Chain, and Ownership System (PECOS) code. The ACR believes that exclusion is intended to take place at the radiology group, TIN, or service level. However, based on instances where radiology groups have reported attributions of the TPCC for the performance years 2022 and 2023, there appears to be an inadvertent gap in that exclusion methodology whereby advanced practice providers such as nurse practitioners or physician assistants who are providing advanced primary care services under a radiology group TIN are attributed to the TPCC measure, resulting in their costs being attributed under the radiology TIN. The ACR strongly encourages CMS to modify the TPCC attribution methodology to allow a service or group-level exclusion and proposes CMS draft policies that would prevent TINs comprised of mostly exempt National Provider Identifiers (NPIs) from having the non-exempt NPIs negate their exclusion from TPCC attribution.

Improvement Activities Performance Category

Proposal
CMS has proposed changes to simplify the Improvement Activities performance category scoring by removing the weight previously assigned to all activities. With the new proposal, all activities would be assigned the same weight. Regular MIPS clinicians would be required to submit two activities for full category credit, while small, rural, and non-patient-facing clinicians would only be required to submit one activity.

ACR Perspective and Comments
The ACR supports the proposal to simplify the scoring of Improvement Activities by removing the designation of medium or high weight. Although we have not observed that radiology practices faced difficulty in adequately reporting IAs, we acknowledge the previous scoring system may have been unnecessarily convoluted and could be difficult to communicate to MIPS participants. As CMS continues to refine the list of available IAs, we agree that it is fair to weigh all IAs equally, and we support any proposal that streamlines the reporting process for MIPS performance categories.

Proposal
CMS proposed removing several improvement activities, including CC_1: Implementation of the use of specialist reports back to the referring clinician or group to close the referral loop and CC_2: *Implementation of improvements that contribute to more timely communication of test results*. Within the rule, CMS explains that CC_1 is being removed for being duplicative of another activity and not aligning with the Quality, Cost, or Promoting Interoperability categories, while CC_2 has been designated by CMS as obsolete.

ACR Perspective and Comments
The ACR understands the importance of adopting up-to-date activities that align with the other MIPS performance categories. However, we question CMS's proposal that CC_1 be removed for duplicating another activity (for which CMS did not specify the other activity) and misaligning the performance categories. Diagnostic radiologists have begun to build aspects of care coordination into their practices' budgets and workflows, supporting their practices' ability to adopt such systems and processes successfully.

ACR also strongly advocates for the retention of CC_2, which supports timely communication of test results. Radiologists communicate critical imaging results to referring clinicians and other approved recipients without question. However, they must also communicate non-critical findings promptly. As noted, radiologists are building systems and workflows into their practices to support timely communication of non-critical findings.

As radiology and other specialties without MVPs attempt to draft MVPs, the measures must align with the improvement activities. Removing CC_1 and CC_2 would prevent MVP developers from organizing MVPs that concisely link these activities to potential MVP quality

measures. Considering the significance that CC_1 and CC_2 provide radiology practices for implementing this aspect of high-quality care, ACR emphatically encourages CMS to retain these activities to promote high-quality patient care that influences the adoption and measurement of timely, well-communicated care so that patients may receive treatment appropriately and as timely as possible and provide the opportunity for MVP development for specialties that do not currently exist. We also request more information on CC_1's duplicative nature and the obsoleteness of CC_2.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2025 PFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process to create a stable and equitable payment system and promote an equitable delivery system. The ACR looks forward to continued dialogue with CMS officials about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kathryn Keysor at kkeysor@acr.org.

Respectfully Submitted,

Dana Smetherman, MD, MPH, MBA, FACR, FSBI
Chief Executive Officer

cc: Ryan Howe, CMS
Tamara Syrek Jensen, CMS
Joseph Hutter, MD, CMS
Gift Tee, CMS
Michael Solace, CMS
Renee O'Neill, CMS
Sophia Sugumar, CMS
Michelle Schreiber, MD, CMS
Gregory N. Nicola, MD, FACR, Chair, ACR Commission on Economics
David Larson, MD, MBA, Chair, ACR Commission on Quality and Safety
Cynthia Moran, ACR
Mythreyi Chatfield, PhD, ACR
Angela Kim, ACR
Judy Burleson, ACR
Kathryn Keysor, ACR
Samantha Shugarman, ACR