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September 9, 2024
Chiquita Brooks-LaSure
Administrator
CENTERS for MEDICARE & MEDICAID SERVICES,
U.S. Department of Health and Human Services,
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Rule: Medicare and Medicaid Programs; Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; etc.

Dear Administrator Brooks-LaSure,

Radiology Partners appreciates the opportunity to submit comments to the CENTERS for MEDICARE & MEDICAID SERVICES (CMS) on the Proposed Rule (CMS 1807-P) regarding updates to the CY 2025 Physician Fee Schedule (PFS) including the Quality Payment Program (QPP).

Radiology Partners through its owned and affiliated practices, is a leading radiology practice in the United States, serving more than 3,400 healthcare facilities across the nation. As a physician-led and physician-owned practice, our mission is to transform radiology by innovating across clinical value, technology, service and economics. Radiology Partners, through its affiliated practices, provides consistent, differentiated care to patients, while delivering enhanced value to the hospitals, clinics, imaging centers and referring physicians we serve.

We address the following sections of the proposed rule:

- Stability of the PFS
- Impact of Cuts on Radiology
- Budget Neutrality
- High-Cost Supplies and Equipment in the PFS
- Virtual Supervision
- Coverage of Computed Tomography Colonography (CTC) for Colorectal Cancer Screening
- Medicare Economic Index (MEI)
- QPP/Merit-based Incentive Payment System (MIPS)
    - Performance Threshold
    - Data Completeness
    - Quality Measures
    - Improvement Activities Performance Category
    - Topped Out Measures
    - Total Per Capita Cost (TPCC) Measure Attribution Process
    - New Reweighting Policy
    - MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

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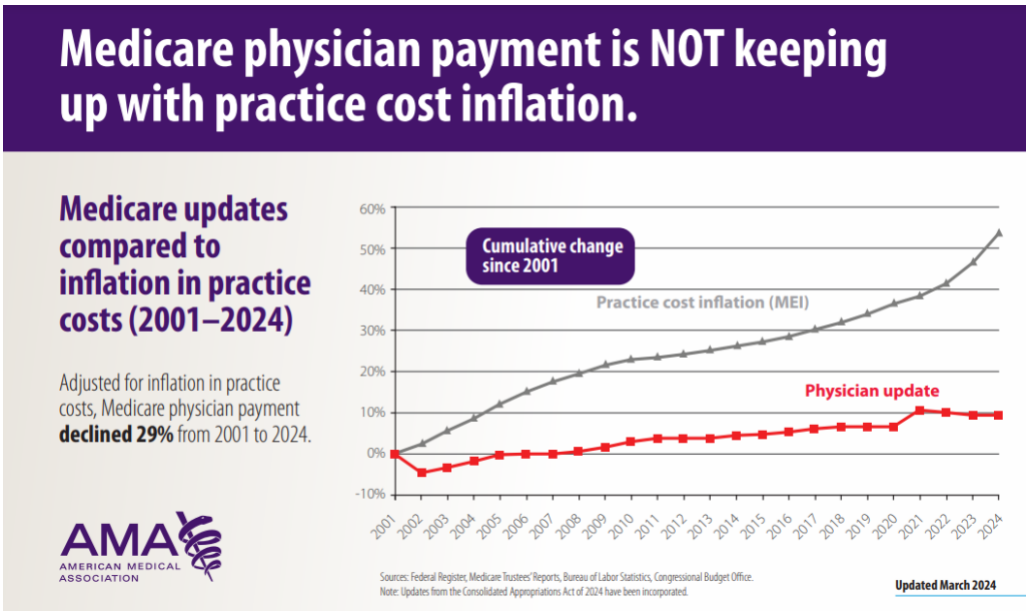
Stability of the PFS

Throughout the CY 2025 proposed rule, payment stability and predictability are mentioned as policy goals for the PFS. As recognized by providers and CMS, unpredictable and often meaningful changes to reimbursement affect a practice's operations, thereby directly impacting its ability to care for Medicare beneficiaries and other patients.

The proposed estimated CY 2025 PFS conversion factor (CF) of $32.3562 is a decrease of $0.93 (or 2.8%) from the CY 2024 CF of $33.2875. This is the lowest CF since 1993.[1] The 2025 CF will be down more than 10% since 2020, while inflation has been rising. According to the American Medical Association (AMA), Medicare physician pay was cut 29% from 2001 to 2024 when adjusted for inflation (see graph below).[2] The gap between inflation and physician pay only continues to widen with time, and without an inflationary adjustment, there is increased instability for many medical practices, resulting in access issues for Medicare beneficiaries and other patients across the country.



These cuts are happening despite increases to operational costs for medical practices. In a summer 2024 poll, the overwhelming majority (90%+) of respondents indicated that operating expenses in 2024 increased compared to 2023.[3] In a previous poll, over 90% of respondents indicated that Medicare reimbursement does not adequately cover the cost of delivering care.[4]

Radiology Partners believes that the patient-physician relationship is central to high-quality care, which is being threatened due to the financial instability for Medicare providers and is contributing to the physician shortage and burnout of the remaining physicians.[5] According to the Association of American

[1] https://www.ama-assn.org/system/files/cf-history.pdf
[2] Association of American Medical Colleges, "Medicare physician payment is NOT keeping up with inflation." Published March 2024.www.ama-assn.org/system/files/medicare-updates-inflation-chart.pdf
[3] https://www.mgma.com/mgma-stat/nearly-all-medical-groups-still-feeling-the-squeeze-of-rising-operating-expenses
[4] https://www.mgma.com/getkaiasset/744dc4c6-69ac-4ce3-841e-51560153e6a8/09.21.2022_Impact-of-Payment-Reductions-to-Medicare-Rates-in-2023-Full-Report.pdf
[5] https://fortune.com/well/2024/05/23/doctors-overworked-underpaid-doximity-survey-we-are-often-stretched-quite-thin/

Medical Colleges, by 2034, there will be an estimated shortage of up to 124,000 physicians across all specialties.[6]

Physician burnout has become widespread, due in part to continued declines in government and private payor reimbursement and increased administrative burden, including those related to the implementation of the federal No Surprises Act (NSA) and the Merit-based Incentive Payment System (MIPS). These additional stressors, coupled with the burden of running a business and practicing medicine, can quickly lead to burnout.

In addition to inflation-adjusted reductions in overall physician reimbursement, research[7] has shown that reimbursement cuts to radiologists have been especially severe. Reimbursement per beneficiary between 2005 and 2021 declined approximately 25%, despite a double-digit increase in relative value unit (RVU) productivity. This implies that radiologists are working harder to meet increasing clinical demand but are being paid less. This is undoubtedly contributing to burnout, which is widely reported among radiologists and contributes to early retirement from the practice of medicine.

Radiology Partners recognizes that CMS is bound by budget neutrality requirements and thus has limited control over the CF, and that the reduction in the 2025 CF from 2024 is due predominately to expiration of Congressional support. Nonetheless, due to a lack of inflationary adjustments, the proposed CF threatens access to care and quality of care for Medicare beneficiaries.

Radiology Partners appreciates and strongly supports CMS' commitment to "payment stability and predictability" in the PFS. We also recognize that CMS is limited in what it can do, given budget neutrality restraints. In light of budget neutrality requirements, we urge CMS to consider the downstream impact on Medicare providers and beneficiaries from decisions within its control.

Impact of Cuts on Radiology

In addition to cuts to Medicare providers generally, radiology specialists have taken further reductions in reimbursement. From 2010 to 2025, diagnostic radiology has not had a positive adjustment noted in the impact tables. Interventional radiology (IR) again received the most negative score in the impact table in the CY 2025 proposed rule, just as it did in CY 2024, 2023 and 2022. As seen in Figure 1, since 2007, diagnostic and IR have taken the largest cuts due to RVU related changes, approaching -40%.[8]

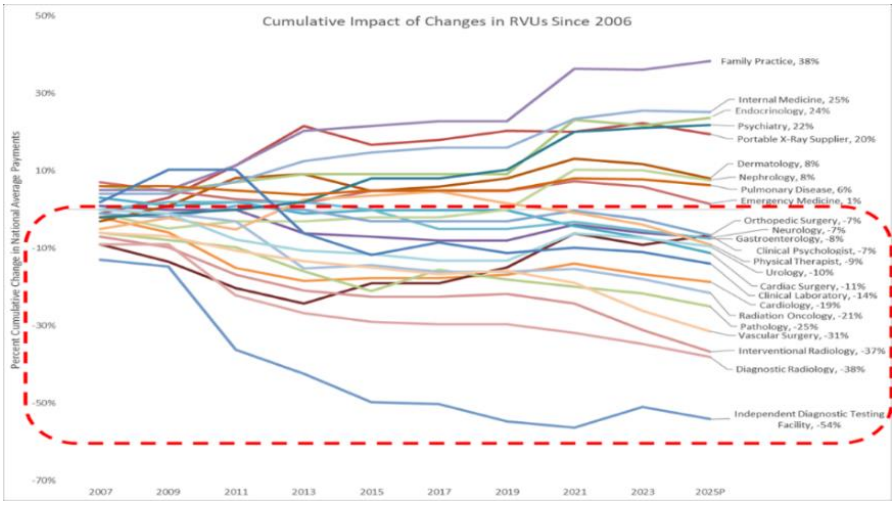
These cuts are occurring despite outsized contributions of radiologists to patient care. Although professional radiology services are a small percentage of the overall PFS spending, representing less than 3% of such payments in 2019, research[9] has shown that on average, radiologists provide care for more unique Medicare fee-for-service beneficiaries than any other specialty.

Relative to many other specialties, IR physicians undergo years of additional training to perform minimally invasive, image-guided procedures. These procedures are frequently used as a substitute to traditional surgery and are often more cost effective, since they may reduce the patient's length of stay

[6] Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034." Published June 2021. www.aamc.org/media/54681/download?attachment. (page viii)
[7] JACR. Budget Neutrality and Medicare Physician Fee Schedule Reimbursement Trends for Radiologists, 2005 to 2021. https://www.jacr.org/article/S1546-1440(23)00521-5/abstract
[8] Slide courtesy Office-Based Facility Association; HMA analysis 2007-2025P Medicare Physician Fee Schedule Impact Tables. The values presented for 2021-2025P are adjusted to reflect the effects of the CAA, 2021, 2022, 2023, 2024.
[9] Pub Med. Unique Medicare Beneficiaries Served: A Radiologist-Focused Specialty-Level Analysis.

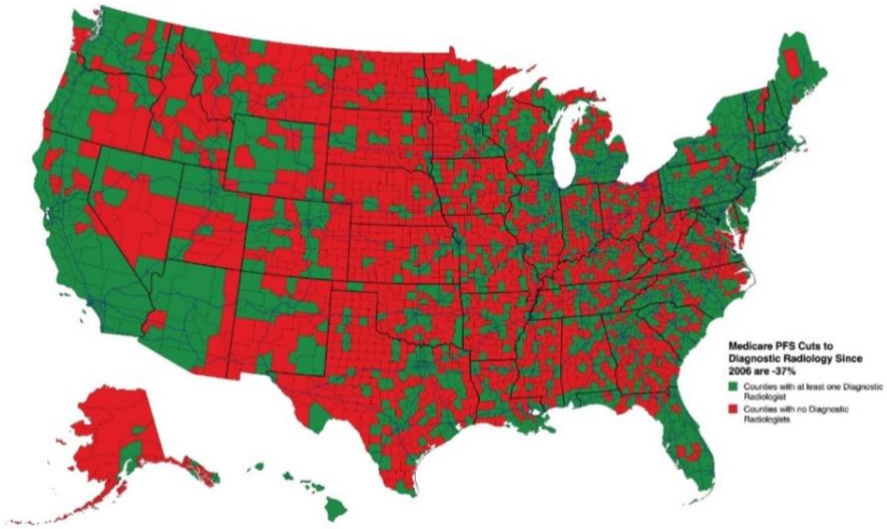
and overall costs of therapy.[10,11] Additionally, IR services expand access to care, since many IR patients may not be ideal candidates for traditional surgery due to patient complexity and disease severity.[12] These less invasive treatments result in lower complication rates, improved health outcomes, reduced in-patient hospital stays, and better morbidity and mortality rates.[13, 14]

Figure 1



It was only a few months after Professor Roentgen's discovery of the X-ray in 1895 that the first clinical radiograph in the United States was obtained in January 1896. Since that time, medical imaging has been a central component of modern healthcare delivery. Despite this, there are large sections of the country which have limited access to their services. Figure 2 highlights in red diagnostic radiology deserts.[15]

Figure 2



[10] Charalel RA, McGinty G, Brant-Zawadzki M, et al. Interventional radiology delivers high-value health care and is an Imaging 3.0 vanguard. J Am Coll Radiol 2015;12:501-6.

[11] Wright TN, Gilligan L, Zhurbich O, Davenport DL, Draus JM Jr. Minimally invasive drainage of subcutaneous abscesses reduces hospital cost and length of stay. South Med J 2013;106:689-92.

[12] Mabotuwana T, Hall CS, Flacke S, Thomas S, Wald C. Inpatient complexity in radiology—a practical application of the case mix index metric. J Digit Imaging 2017;30:301-8.

[13] La LRoy JR, White SB, Jayakrishnan T, Dybul S, Ungerer D, Turaga K, Patel PJ. Cost and Morbidity Analysis of Chest Port Insertion: Interventional Radiology Suite Versus Operating Room. J Am Coll Radiol. 2015 Jun;12(6):563-71. https://doi.org/10.1016/j.jacr.2015.01.012.

[14] Zafar AM, Dhangana R, Murphy TP, Goodwin SC, Duszak R Jr, Ray CE Jr, Manolov NE. Lower-extremity endovascular interventions for Medicare beneficiaries: comparative effectiveness as a function of provider specialty. J Vasc Interv Radiol. 2012 Jan;23(1):3-9.e1-14. https://doi.org/10.1016/j.jvir.2011.09.005.

[15] Figure 2 courtesy Office-Based Facility Association

For diagnostic radiology, telehealth can help address this problem. Patients imaged in a rural community may have their images interpreted by a radiologist in a different region. However, not all imaging exams can be handled remotely, forcing many patients to travel for their care. For example, fluoroscopic exams are generally handled by an onsite radiologist. The way many facilities handle this is periodic onsite coverage by a radiologist, with telehealth support the remaining time. With the radiologist shortage and continued reimbursement cuts, such unique services become increasingly less feasible. The result is reduced access to care and longer travel times for patients in need of imaging.

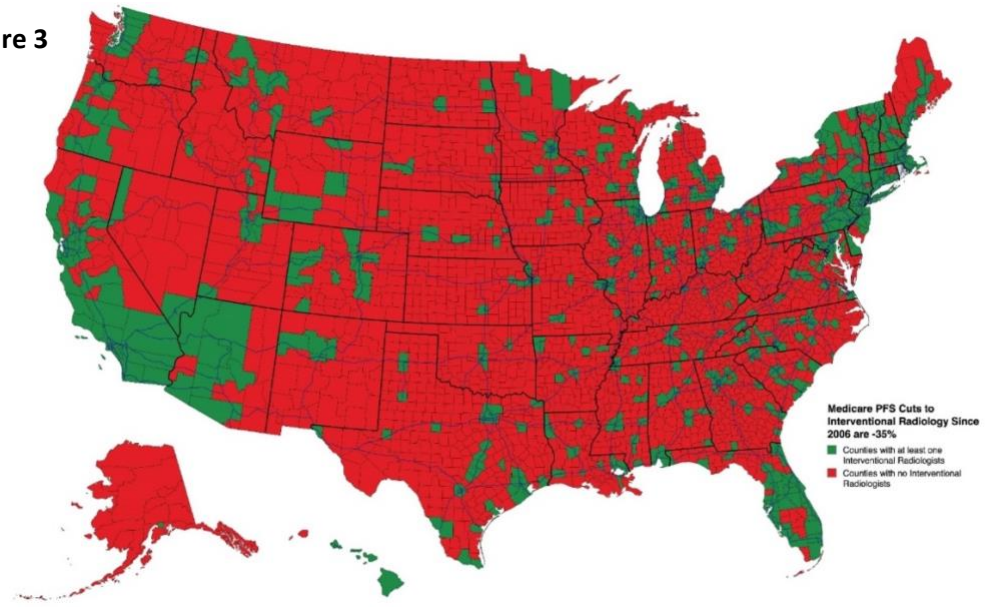
Budget Neutrality

Due to a law Congress passed over 30 years ago, the Omnibus Budget Reconciliation Act of 1989, if the projected cost of the changes that CMS makes to the PFS raise spending by more than $20 million in a year, a budget neutrality adjustment must be applied to reduce the payment rate (the CF). For CY 2025, the proposed budget neutrality adjustment is 0.05%, but in 2021 it was -10%.

Although the idea behind budget neutrality is understandable, in practice, it forces illogical action. For example, in 2025, the field of IR again has the largest negative impact. This cut is the unintended consequence of support for other areas of the fee schedule and the requirement of budget neutrality.

While it is not the intent of CMS to limit access of patients to IR services, ongoing reimbursement cuts disincentivize clinicians from becoming or staying IR providers and limit investments in equipment. Figure 3 highlights in red large portions of the country that do not have ready access to IR.[16]

Figure 3



Since IR physicians specialize in minimally invasive procedures, which frequently are more cost effective than alternative approaches, the effect of reimbursement cuts to IR are counter to the goals of improving the value of care to Medicare beneficiaries. Additionally, since many IR services frequently serve the Black and Latino communities, cuts to IR could exacerbate healthcare inequities.[17]

[16] Figure 3 courtesy Office-Based Facility Association

[17] Zarkowsky DS, Arhuidese IJ, Hicks CW, et al. Racial/Ethnic Disparities Associated With Initial Hemodialysis Access. *JAMA Surg.* 2015;150(6):529–536. doi:10.1001/jamasurg.2015.0287. Example: code 36902, Dialysis Vascular Access

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Radiology Partners urges CMS to consider ways to halt the cuts to radiology and IR and work to preserve and invest in access to safe, timely and high-quality medical imaging-based patient care.

High-Cost Supplies and Equipment in the PFS

Since the PFS was implemented in the early 1990s, there has been a migration from hospital-based care to the office setting. The effect of this transition has been the inclusion of expensive supplies and equipment in the PFS. As previously noted, due to budget neutrality requirements, the PFS is limited in its growth. With limited capital available to the PFS, the inclusion of high-priced supplies and equipment has meant that relatively less resources are available to support Medicare providers.

We note that the AMA/Specialty Society RVS Update Committee (RUC) has previously commented on this issue and made a policy suggestion: "…during the April 2020 RUC meeting, the RUC recommended that CMS separately identify and pay for high cost disposable supplies priced in excess of $500 using appropriate HCPCS codes."[18]

Radiology Partners encourages CMS to work with Congress to address high-priced supplies and equipment within the PFS, including support for efforts by CMS to separately identify and pay for high-cost disposable supplies priced in excess of $500 outside of PFS budget neutrality.

Virtual Supervision

Radiology Partners wishes to comment on CMS' request on whether it should consider extending the definition of direct supervision to permit virtual supervision. Specifically, CMS requested feedback on potential changes to supervision, including permanently extending the definition of direct supervision to include the use of two-way audio/video communications technology.

We strongly urge CMS to extend the definition of direct supervision to permit virtual presence beyond December 31, 2025. We further recommend CMS make permanent the flexibility allowing the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology for level 2 diagnostic tests. We recognize that CMS may have ongoing safety concerns about certain level 2 diagnostic tests and may wish to extend the flexibility by only a year, as it collects more data. However, for those level 2 diagnostic tests, such as diagnostic imaging examinations, where there is not this concern, we encourage CMS to make the flexibility permanent.

Radiology Partners believes that patient safety comes first. Across our practice, we have standardized policies to ensure this principle is upheld. If intravenous contrast is administered, there must be onsite personnel who can, in the unlikely event of an adverse reaction, assess and manage the patient. These onsite personnel, who may be non-physician providers (NPPs) (e.g., nurse practitioners (NPs), registered nurses (RNs), radiologist assistants (RAs) or physician assistants (PAs)) must meet local regulations and institutional protocols, including state laws and policies.

Virtual supervision has given our radiologists the flexibility to supervise through two-way audio/video communications, rather than being physically onsite. As a result, access to care has increased for patients, especially those in rural and underserved areas. In some rural communities, it may not be feasible to have a radiologist onsite. The option then is to limit days or hours of operation, limit the

[18] American Medical Association/Specialty Society RVS Update Process. RUC Recommendation for CPT 2022. Published October 2020 Meeting. Page 2. https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf

services offered or close the imaging facility, requiring patients to travel further for their care. Virtual supervision also allows for extended after-hours imaging, permitting the center to remain open while guaranteeing the same level of care and without suspending certain services.

A contrast reaction can rarely be a severe allergic reaction, which is preferably handled by a provider who is frequently involved in managing acutely ill patients. While radiologists are expected to be proficient in managing contract reactions, given their rarity, many diagnostic radiologists infrequently manage such acutely ill patients. Thus, working with qualified NPPs is appropriate from a safety perspective.

Importantly, this flexibility also means radiologists will spend less time commuting to imaging centers, and more time focused on patient care and interpreting imaging examinations. This benefits both radiologists and patients.

Radiology Partners strongly urges CMS to make the virtual supervision flexibility permanent.

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

In the proposed rule, CMS proposes:

1) Adding coverage for CTC; if finalized, CMS will revise the current non-coverage policy for CTC in NCD 210.3,
2) Removing coverage for the barium enema as a colorectal screening test, and
3) Expanding the definition of "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare-covered, blood-based biomarker CRC screening test.

For reasons detailed in the proposed rule, **Radiology Partners strongly encourages CMS to finalize its proposal to expand coverage of CRC screening to include CTC.** We also understand and accept the proposal to remove coverage for barium enema.

However, we are concerned that the proposed approach to payment will limit the impact of CTC on colorectal health. Specifically, CMS proposes to cap the payment for screening CTC under section 5102(b)(1) of the Deficit Reduction Act (DRA) of 2005. With the DRA, the technical component of certain imaging services paid under the PFS is capped at the amount paid under the Outpatient Prospective Payment System (OPPS).

CMS is proposing to pay for screening CTC with CPT 74263 (computed tomographic (CT) colonography (i.e., virtual colonoscopy), screening, including image postprocessing is never covered). The 2024 PFS has a rate for the technical component of CPT 74263 of $566.22, using the resource-based practice expense methodology. However, CMS is proposing to cap the technical component payment for CY 2025 at the same rate that is paid under the OPPS at $106.30. **We are concerned that a payment reduction of 81% would negatively impact the ability of many radiologists to provide screening CTC services, significantly limiting the benefit of CMS' approval of screening CTC.** We also direct CMS to the OPPS proposed rule comment letter from the American College of Radiology (ACR) which addresses this issue.

To address this, **perhaps CMS could opt not to apply the DRA cap to screening services, such as screening CTC. This is logically consistent with the DRA, which excludes screening and diagnostic mammography from eligibility for the cap. Alternatively, CMS could assign screening CTC to a higher paying Ambulatory Payment Classification (APC) level.** Screening CTC is currently assigned to APC 5522 for Level 2 Imaging without contrast. CMS could use APC 5524 Level 4 Imaging without contrast, which

has a proposed 2025 OPPS payment amount of $544.85. This is below but at least closer to the resource-based 2024 PFS payment of $566.22.

Finally, Radiology Partners 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 CRC screening test. Additionally, we request that this policy be extended to follow-on colonoscopy after a covered screening CTC exam. For example, in cases where polyps are identified via CTC, the test itself may not constitute a "complete colorectal cancer screening." The U.S. Preventive Services Task Force (USPSTF) Colorectal Cancer Screening Recommendations explicitly state that "abnormal findings identified by flexible sigmoidoscopy or CT colonography screening require follow-up colonoscopy for screening benefits to be achieved."[19] Thus, **we urge CMS expand its approach to a "complete CRC Screening" in § 410.37(k) to include follow-up colonoscopies after all abnormal Medicare-covered, non-invasive colorectal cancer screening tests, including CTC.**

Medicare Economic Index (MEI)

In the proposed rule, CMS states: "Because we finalized significant methodological and data source changes to the MEI in the CY 2023 PFS final rule and significant time has elapsed since the last rebasing and revision of the MEI in CY 2014, we believed that delaying the implementation of the finalized CY 2023 rebased and revised MEI was consistent with our efforts to balance payment stability and predictability with incorporating new data through more routine updates…we are not proposing to incorporate the 2017-based MEI in PFS rate setting for CY 2025."

Radiology Partners supports CMS' goal to balance PFS stability and predictability by pausing the incorporation of the 2017-based MEI until the updated AMA Physician Practice Information Survey is made available.

QPP/Merit-based Incentive Payment System (MIPS)

As we have noted in past comment letters, radiology suffers from a lack of freely available performance measures in the Quality category. In the 2025 performance year, there are six Quality category performance measures in the diagnostic radiology measure set and eight in the IR set, many of which are topped out or lack a benchmark. One of the six in the diagnostic radiology set (measure 494) may not be accessible for many practices due to factors outside of their control (i.e., the hospital does not grant third-party software access to their network).

In specialties like radiology, with limited availability of MIPS performance measures, providers must turn to reporting on Qualified Clinical Data Registries (QCDR) measures. While this flexibility is useful, it comes at a meaningful expense. As a result, MIPS eligible clinicians and their practices must consider if the financial benefit from QCDR measures outweighs the cost and burden of compliance. In essence, specialties without a sufficient number of measures from CMS must pay an extra tax in the form of QCDR fees to participate in MIPS. For our organization, this added expense can be in the millions of dollars.

As CMS is aware, radiologists also are limited in their access to advanced alterative payment models and there are no MVPs for radiology. While Radiology Partners appreciates that CMS is working to address these problems, they remain an ongoing and meaningful concern.

[19] The U.S. Preventive Services Task Force. Final Recommendation Statement on Colorectal Cancer: Screening. Published May 18, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening

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Performance Threshold

Due to changes in MIPS, including a paucity of freely available Quality measures, loss of bonus points and topped out and capped Quality measures, many radiology practices are struggling to avoid a penalty at the 75-point performance threshold. Further elevation of the threshold could negatively impact those same radiology practices, even though they provide high quality, high-value care to Medicare patients. We urge CMS not to elevate the threshold until further adjustments are made to level the playing field across the specialties.

Radiology Partners appreciates CMS' recognition that the performance threshold should be held at 75 points and strongly supports this decision.

Data Completeness

Radiology Partners appreciates CMS' extension of the 75% data completeness criteria threshold. **Radiology Partners supports the extension of the 75% data completeness criteria threshold through the CY 2028 performance year.**

Quality Measures

CMS is requesting comments on the previously finalized measures for CY 2025 in the proposed diagnostic radiology specialty set, including the new measure #494.

#494 Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Clinician Level)
Radiation dose optimization is an important issue. While this measure is well-intended, as we and other organizations, including the American Association of Physicists in Medicine (AAPM), noted last year, there are meaningful concerns about this specific measure outlined below. But first, we must acknowledge that radiation dose measurement and management is a highly complex area, and medical physicists are best positioned to comment on specific technical details. We defer to the AAPM on these aspects of the measure.

We have several concerns about the implementation of measure #494.

1. Feasibility: There is a large and rapidly growing concern among healthcare executives regarding cybersecurity. The ability to coordinate with hospitals and imaging centers to allow an unknown third-party to access their internal network will be difficult and time consuming, and sometimes may not be feasible.
2. Terminology: We believe that the goal of radiation dose management should be dose *optimization*, not simply dose *minimization*. A low-dose exam that is insufficient to answer the clinical question is detrimental to patient care.
3. Accountability: For many radiologists, remote-read CT exams are from equipment that is owned and managed by another organization, such as a hospital. In terms of accountability, performance measures should focus on those organizations that own and manage the equipment, not the individual radiologist.

Radiology Partners strongly supports radiation dose safety, understands the idea behind this measure and appreciates the measure has been previously finalized for implementation in 2025. **We urge CMS to track usage of the measure and be open to future feedback on its feasibility and merits. We also encourage CMS to work with societal organizations like the AAPM and the ACR on future measures of radiation dose optimization.**

Additional measures Radiology Partners would like to comment on, include:

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- ***#145 Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy.*** Radiology practices that use older fluoroscopy machines will be disproportionately impacted by this quality measure, as older fluoroscopy machines do not document or produce radiation exposure indices. Further, the years of Medicare cuts to medical imaging may make investments in new equipment difficult for many organizations, who rely on existing equipment. This measure can be especially difficult for those providers and groups who use older machines that do not automatically report the radiation dose indices. As a result, those practices least able to afford new equipment will likely be the ones most negatively impacted.
- ***#360 Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies.*** CMS is proposing to substantially change this measure by expanding the denominator of eligible cases by including coding for cardiology infarct imaging. This change will create a meaningful burden on radiologists to report all prior CT and cardiac nuclear medicine studies that a patient has received in the 12-month period prior to the current study.
- ***#364 Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines, #405 Appropriate Follow-up Imaging for Incidental Abdominal Lesions, and #406 Appropriate Follow-Up Imaging for Incidental Thyroid Nodules in Patients.*** Radiology Partners encourages CMS to adopt additional measures based on use of evidence-based criteria to ensure appropriate follow-up recommendations are made.
- ***[Removal] #436: Radiation Consideration for Adult CT – Utilization of Dose Lowering Techniques.*** While Radiology Partners understands the removal of measure #436, we remain concerned about the lack of freely available MIPS Quality measures.

CMS is also requesting comments on the seven previously finalized measures for CY 2025 in the proposed IR specialty set. Overall, these IR measures are burdensome for reporting due to availability of data points, and to date, all seven of these IR measures have failed to establish a benchmark. **Radiology Partners recommends CMS consider how burdensome a measure will be and its ability to achieve a benchmark as it considers new IR Quality measures.**

We disagree with continuing with two of the seven IR measures previously finalized for CY 2024, specifically:

- ***#487 Screening for Social Drivers of Health and #498 Connection to Community Service Provider.*** These two measures are not well suited for a provider who has limited encounters with a patient and is not managing their care. While well-intentioned, these measures are impractical for many providers, such as interventional radiologists, who typically have focused and relatively brief encounters with patients, on behalf of another provider, who is managing their overall care. An example of a patient interaction with an interventional radiologists would be when a patient is sent to an interventional radiologist to drain an abscess. This is a one-time encounter for the patient and the interventional radiologists and would not be an appropriate time to screen a patient for food insecurity or ask about contact with a Community Service Provider, like an interaction with a primary care physician would be. These measures were not intended for such specialties and should be removed from the IR specialty set.

Radiology Partners also asks that CMS consider the lack of digitally reported measures for radiology. Without digital measures, complying with performance metrics for diagnostic and IR measures requires manual input and review of radiology reports, which is time-intensive, limits already strained provider ability, and has a high margin of error.

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Improvement Activities Performance Category

Radiology Partners acknowledges CMS' proposals on scoring and reporting policy changes to simplify the Improvement Activities performance category effective for the CY 2025 performance period. CMS proposes to eliminate the weights associated with Improvement Activities to simplify the scoring of this category. Previously, Improvement Activities were identified as either high-weight or medium-weight, and with its new proposal, all activities would be weighted equally. Further, CMS proposes to reduce the number of activities to which clinicians are required to attest to achieve a full score. Standard MIPS participants will be required to report two activities, while small, rural, and non-patient facing clinicians and MVP participants will be required to report one activity.

Radiology Partners agrees with CMS' approach in removing Improvement Activity weights and reducing the number of activities to which clinicians are required to report.

Radiology Partners also wishes to comment on the new Improvement Activity in the Population Management subcategory: "Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake." As stated in the proposed rule, this activity "would allow MIPS eligible clinicians to receive credit for establishing a process or procedure to increase rates of lung cancer screening." **Radiology Partners agrees with this new addition.**

Topped Out Measures

In the proposed rule, CMS acknowledges that "certain clinician specialists have limited measure choice and that their opportunities to maximize their MIPS performance score may be particularly affected by the current topped out measure scoring policy." This holds true for the specialty of radiology, which suffers from a lack of relevant Quality category measures resulting in limited scoring opportunities and unfair penalties under the current policy.

To address the disproportionate impact of topped out measures on specialties, CMS is proposing to develop "defined topped out measure benchmarks," eliminate the seven-point cap on measures deemed to come from specialty sets with a limited number of measures available, and consider if the specialty set has enough measures to allow for a clinician "to reasonably achieve 75 percent of the available quality achievement points based upon measures available to them and program requirements."

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, we hope that CMS will allow for 9-9.9 points for a performance rate of 99-99.9%. 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.

Radiology Partners appreciates CMS' recognition that the MIPS playing field is far from even. We further appreciate CMS' attempt to create a pathway for a high-performing practice that is limited by measure inventory and topped out and capped measures to achieve an incentive payment or at least avoid a penalty. **We support the newly proposed scoring approach, but hope that CMS will refine the scoring methodology to allow for 9-9.9 measure achievement points for "exceptional clinical quality performance" with a performance rate of 99-99.9%.**

However, this is only a short-term, partial solution that does not address the underlying problem. Certain specialties, especially non-patient facing specialties, have difficulties developing meaningful outcome measures that are within their control. Until this is addressed, CMS will have to continue to find workarounds to address the inequities.

Total Per Capita Cost (TPCC) Measure Attribution Process

As part of the MIPS scoring process, the TPCC measure is taken into consideration as part of the Cost category. Although the proposed rule does not address any change to the current TPCC measure attribution process, Radiology Partners continues to voice its concerns about the current TPCC measure attribution process as part of the MIPS program.

The current TPCC attribution methodology explicitly excludes diagnostic and interventional radiologists, but this exclusion only applies to radiologists, not advanced care practitioners (ACPs), such as PAs and NPs, who work in radiology. The inclusion of radiology ACPs results in candidate events being attributed to a practice that would otherwise be exempt from this measure. If a radiologist in the same practice performed the same pre- and post-imaging consults currently furnished by ACPs, the TPCC measure would *not* apply. This is not only logically inconsistent, but also counter to the goal of the QPP, since it disincentivizes the use of ACPs and may worsen the value of care delivery by adding cost and reducing efficiency.

Within the context of subgroup reporting, CMS acknowledges the difficulty in determining if a practice should be considered single or multispecialty especially when there are ACPs involved in the scope of care provided. It would not be accurate to assume ACPs are only providing primary care services. CMS stated, “the primary specialty designation of physician assistants and nurse practitioners would only be representative of their education credentials, and not the scope of care provided.” CMS is recommending an approach to solve for this issue when stating, “one approach we could consider is providing flexibility for a group practice to determine and inform CMS of their specialty composition.” We urge CMS to recognize the parallel issue between subgroup reporting and TPCC attribution as it pertains to specialty assignment of PAs and NPs.

Radiology Partners recommends that the TPCC attribution methodology exclude providers based on billing entity taxonomy code instead of the individual provider Health Care Financing Administration (HCFA) code(s). Radiology Partners supports CMS’ approach of allowing a group Taxpayer Identification Number to identify the group’s specialty composition. In addition, CMS should consider making it a goal to exclude providers (both physicians and ACPs) who practice in excluded specialties, including radiology, both diagnostic and IR.

New Reweighting Policy

Radiology Partners acknowledges and agrees with CMS’ new reweighting policy that could potentially go into effect for the CY 2024 performance year. This policy allows for more scoring flexibility for groups or individuals who delegated the responsibility of submitting their MIPS data to a third-party intermediary who did not meet the required submission timeframe.

MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS requests information on the development of MVPs, including the design of a future ambulatory specialty model and MVPs for non-patient facing specialties.

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Like CMS, we also believe that coordination between primary and specialty care is critical to overall patient care, both in terms of quality and cost. We agree that a novel MVP could serve as a bridge until new measures are available to support the creation of individual MVPs for clinicians without a MVP specific to their specialty or patient populations served. Further, we hope that this could open the door for developing a value-based care model that focuses on how specialists, like radiologists, can work with primary care/referring physicians for specific medical conditions to improve patient outcomes and reduce fragmentation of care.

We also appreciate CMS specifically considering how non-patient facing specialties, like radiology, fit into MVPs ("Develop MVPs for Non-Patient Facing MIPS Eligible Clinicians"). However, we have concerns about the MVP framework which limits radiologists, especially diagnostic radiologists, from participating in a meaningful way. Specifically, the MVP framework still requires Cost measures which are typically based on patient attribution. As CMS knows, it is it difficult to attribute patients to radiology, particularly diagnostic radiologists. Medicare Spending Per Beneficiary (MSPB) occasionally applies to radiology groups, but since radiologists are generally not the primary providers managing the patients' care, attributing Cost to radiologists may not meet the intent of the measure. And as noted previously, TPCC is a primary care focused measure that is not appropriate for radiology, neither diagnostic nor IR. In addition to Cost category attribution, non-patient facing specialties like radiology also struggle with the Foundational Layer: Population Health, which requires evaluation on one of two measures: *Hospital-Wide, 30-Day, All-Cause Unplanned Readmission* or *Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*, neither of which are generally applicable to Radiology specialties.

We encourage CMS to consider proxy measures for Cost, such as adherence to evidence-based recommendation criteria that limit unnecessary downstream utilization. Additionally, we hope that CMS will consider measures of performance on imaging-based screening as a way to meet the ideals underlying the Foundational Layer: Population Health.

With respect to sunsetting traditional MIPS by the 2029 performance year, **we strongly urge CMS conduct extensive testing before mandating use of an MVP for a specialty.**

We urge CMS to continue its work with radiology in the development of appropriate and applicable MVPs that align with the ideals of the QPP, meet statutory requirements and are tailored to the realities of the practice of radiology. Just as Quality category measures are specific to radiology, Cost and Population Health measures should reflect the unique nature of non-patient facing specialties, including radiology.

Conclusion

Radiologists are the "doctor's doctor," and physicians in nearly every clinical specialty rely on their radiologist colleagues to interpret medical imaging, diagnose disease, and help determine the proper treatment for patients. Interventional radiologists provide high-quality, high-value care for the benefit of both patients and the healthcare system. Instead of further payment reductions, we believe that investments in radiology specialties and its evidence-based practice elevate value by improving quality and limiting cost.

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malea.reising@radpartners.com, with questions or comments on this letter or any other issues with respect to radiology.

Respectfully Submitted,

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