September 8, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

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) 2024 Medicare Physician Fee Schedule (MPFS) Proposed Rule. In this comment letter, we address the following important issues:

Payment Provisions

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services
- Clinical Labor Pricing Update
- Soliciting Public Comment on Strategies for Updates to Practice Expense (PE) Data Collection and Methodology
- Potentially Misvalued Services Under the PFS
- Valuation of Specific Codes for CY 2024
- Adjustments to Payment for Timed Behavioral Health Services
- Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act)
- Direct Supervision via Use of Two-way Audio/Video Communications Technology
- Services Addressing Health-Related Social Needs: Community Health Integration (CHI) services, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) Services

Quality Payment Program (QPP)

- Updates to the QPP

- Merit-Based Incentive Payment System (MIPS) Value Pathway (MVP) Reporting for Specialists in Shared Savings Program Accountable Care Organizations (ACOs) - Request for Information (RFI)
- Transforming the Quality Payment Program RFI
- Sunsetting the MIPS
- MIPS Performance Threshold and Incentive Payments
- MIPS Measures Proposed for Addition
- MIPS Measures Proposed for Removal
- Quality Measure Data Completeness
- Cost

PAYMENT PROVISIONS

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

Proposal

Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) requires ordering physicians to consult appropriate use criteria (AUC) through a qualified clinical decision support system (CDSM) when ordering advanced diagnostic imaging services billed through the MPFS, Hospital Outpatient Prospective Payment System (HOPPS) or the Ambulatory Surgical Center Payment System. When fully implemented, the program penalty for failure to include the required AUC consultation information on applicable imaging claims is claim denial.

The AUC program has been operating in an "educational and operations testing period" without payment penalties in place since January 1, 2020. In the 2024 MPFS proposed rule, CMS proposes to pause the program for reevaluation, including pausing the ongoing educational and operations testing period. In conjunction with this proposal, CMS also proposes to rescind the current AUC program regulations and reserve them for future use. The agency did not propose a timeframe for resumption of implementation. The proposed rule states, "…the real-time claims-based reporting requirement prescribed by section 1834(q)(4)(B) of the Act presents an insurmountable barrier for CMS to fully operationalize the AUC program".

Despite the implementation barriers necessitating the program reevaluation of the program, CMS recognizes the value of the AUC program to improve utilization patterns for Medicare beneficiaries. The Agency indicated that utilizing AUC to ensure that patients receive the right imaging at the right time would "inform more efficient treatment plans and address medical conditions more quickly and without unnecessary tests". The rule states that this could result in potential savings to the Medicare program of $700,000,000 annually. CMS arrived at this estimate by extrapolating savings from a clinical decision support pilot project performed by the Institute for Clinical Systems Improvement in Bloomington, Minnesota.

ACR Perspective and Comments

The PAMA AUC policy for advanced diagnostic imaging services was designed to curb patient exposure to unnecessary radiation, reduce Medicare spending on low-value advanced imaging

procedures, promote the movement towards value-based care, and be a more credible policy alternative to the imposition of burdensome advanced imaging prior authorization programs in Medicare. It is an effective and evidence-based program, founded on physician-developed guidelines that is intended to optimize patient care by guiding providers as to whether an advanced imaging study is appropriate and, if so, which kind of study is most appropriate. The ACR is committed to continuing to work with CMS and Congress to ensure the program's successful implementation.

CMS Coverage and Analysis Group (CAG) staff, while working diligently through the MPFS rulemaking process to develop and implement the PAMA AUC program, have encountered many roadblocks that have made it extremely difficult to get the program fully operational. The ACR has been in regular contact with CAG staff on implementation of the PAMA AUC program and has offered its advice and assistance as needed. Despite the best efforts of everyone involved, significant concerns related to improperly denying claims that may not be subject to the AUC consultation requirement (e.g., imaging performed in critical access hospitals) still exist and preclude full implementation.

The ACR understands the challenges CMS has faced with developing claims processing edits to implement the PAMA AUC program in a way that ensures claims are not inappropriately denied when the penalty phase of the program begins. We applaud CMS for recognizing the value of AUC consultation and the potential savings to the Medicare program should the program be fully implemented.

The College remains firmly committed to the optimization of imaging utilization and therefore believes that the program needs to be statutorily changed in order to be successfully implemented without inappropriately denying claims and to significantly improve and ease its utilization by ordering and rendering providers. The College believes that the claims processing issues could be resolved if the "real time" claims information requirement were eliminated from the statute. The ACR will therefore continue to work with CMS and Congress on changes to the AUC program that will enable its implementation in a manner that is least burdensome for all stakeholders.

Clinical Labor Pricing Update

Proposal

CMS is in the third year of phasing in the updated clinical labor prices. This phase-in will end in 2025. To update the pricing, CMS relied primarily on data from the United States Bureau of Labor Statistics (BLS), but they also considered other data from Salary Expert or data provided by stakeholders. CMS continues to welcome input from commenters on appropriate pricing for all clinical staff. Since no new wage data was submitted for consideration for CY 2024, CMS is proposing to move forward with the pricing finalized in the CY 2023 MPFS.

ACR Perspective and Comments
The ACR appreciates the opportunity to provide input in the clinical labor pricing update process. We believe it is important that CMS continue regular review of the clinical labor pricing to ensure payment accuracy and to avoid potential large redistributive effects to specialties in the future.

Soliciting Public Comment on Strategies for Updates to Practice Expense (PE) Data Collection and Methodology

Proposal
CMS has been using the American Medical Association's (AMA) Physician Practice Information Survey (PPIS) data in its MPFS calculations, including the PE methodology, since 2010. The current PPIS is based on data collected from 2007 and 2008, making it over 15 years old. Even at the time, there were some concerns about gaps in the data and its impact on the allocation of indirect PE for certain specialties.

In CY 2023, CMS sought stakeholder feedback on how to improve and update the PE data collection and methodology. They received several comments asking CMS to wait for the AMA to complete a new PPI survey, which the AMA had started working on.

CMS continues to be open to comments and feedback related to their ongoing PE data collection efforts. They are looking for ways to streamline the process, making it more feasible, easy to update regularly, and to be more transparent and accurate about how the information affects valuations for services paid under the MPFS.

ACR Perspective and Comments
The ACR is aware of the AMA's PE data collection efforts and have encouraged our members to complete the survey if they receive it. We are hopeful that the data collected by the AMA will be accurate and representative of our specialty and other specialties' practice costs, but the data will not be available until late 2024.

The College appreciates the open dialogue that CMS continues to push, as we believe transparency is important in this process. Below, we will address the questions that CMS posed to stakeholders.

(1) If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?
As the AMA's 2023 PE data collection effort is still in the early stages, the ACR recommends waiting for more information or data prior to making any suggestions or decisions regarding data aggregation that could impact specialties' reimbursement. We are aware that the AMA

has worked closely with Mathematica to stratify their sampling methodology in the hopes of collecting representative data for the specialties.

(2) Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
The ACR doesn't believe that aggregation of services will yield a fair, stable, or accurate means to account for indirect PE across specialties or practice types. In order to capture practice costs appropriately—whether within a specialty or across specialties, the need for granularity is necessary.

(3) If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
The ACR agrees that factors such as geographic location, practice ownership, and practice size are important considerations to ensure that all practice types are represented. With their recently-launched PPI survey, the AMA worked with Mathematica to stratify their samples of practices based on specialty, proportion of time in the facility setting, practice size, ownership type, geographic region, and—for practices with complex ownership—whether the practice is part of a vertically integrated health system, and private equity ownership. Adjustments will be made to the sampling based upon response rates during the data collection process. The AMA also plans to weight the data to account for any differences.

(4) What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?
The ACR strongly feels that any changes or recommendations should be clearly laid out in rulemaking, to include the impacts to each specialty for full transparency and consideration. Even the smallest of changes to the PE methodology could result in significant redistributive effects. For this reason, the College highly recommends that any changes be phased-in.

(5) Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?
The ACR agrees that outliers and non-response bias can have a large impact on any data collection process. With the AMA's PPI survey, they have committed to reviewing the incoming data on a regular basis and to make adjustments to the sampling methodology, as necessary, during the process. The AMA will also perform a nonresponse bias analysis.

Potentially Misvalued Services Under the PFS

Proposal

For CY 2024, there were 10 public nominations concerning various codes. One of the nominations involves Current Procedural Terminology (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)*. This code currently contains practice expense inputs and pricing in the facility setting only. However, the nominator believes that this procedure can be safely performed in the office/non-facility setting and that allowing payment in the office will increase access for Medicare patients. CMS is concerned about the safety and effectiveness of this procedure being performed in the

office setting and is seeking comments on whether CPT code 27279 should be considered potentially misvalued.

ACR Perspective and Comments
The ACR believes that the procedure described by CPT code 27279 can be performed safely in an office setting. We urge CMS to allow the AMA Relative Value Scale Update Committee (RUC) to re-review this service for non-facility PE inputs.

CPT code 27279 is already being performed safely in ambulatory surgery centers (ASCs). The available resources with regard to clinical staff, and the approach to how the procedure is performed in an ASC or in an office-based lab (OBL) would be similar. Therefore, there is no change in the safety risk or effectiveness of this procedure when it is being performed in an office setting. The 90-day global period assigned to CPT code 27279 does not imply it should only be performed in the inpatient setting and does not imply a higher risk procedure; it simply refers to the inclusion of post-op visits for monitoring purposes.

Valuation of Specific Codes for CY 2024

Dorsal Sacroiliac Joint Arthrodesis (CPT code 2X000)

Proposal
CPT code 0775T *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg,bone allograft[s], synthetic device[s])* was deleted in September 2022, replaced by new CPT code 2X000 *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*)). Initially, CPT codes 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* and 27280 *(Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed)* were also flagged for RUC review as part of the code family. However, the specialty societies made a case that these codes were clinically different and did not need to be reviewed along with CPT code 2X000. CPT code 27279 had been recently reviewed by the RUC in 2018.

CMS is proposing to accept the RUC's recommended 7.86 work RVUs for CPT code 2X000, as well as the RUC-recommended PE inputs with no refinements.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the RUC recommendation for physician work and PE inputs for CPT code 2X000.

Fractional Flow Reserve with CT (CPT code 7X005)

Proposal

In 2018, four new category III codes, 0501T-0504T, were created to describe Fractional Flow Reserve with CT (FFRCT). Medicare began paying for 0503T *(Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model)* under the Hospital Outpatient Prospective Payment System (HOPPS). Category III codes are typically contractor priced in the MPFS, but an exception was made for FFRCT and CMS has since been trying to understand the resource costs associated with CPT code 0503T in the office setting. CMS, for CY 2022, valued 0503T based on a crosswalk to the technical component of CPT code 93457 *(Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization).*

CPT code 7X005 *(Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional)* will replace 0501T-0504T in CY 2024. CPT code 7X005 was reviewed by the RUC in January 2023, and a software analysis fee listed as a supply item in the practice expense makes up the majority of its valuation. While CMS acknowledges that there is a cost incurred as part of this procedure, these types of software and analysis fees are not well represented in CMS's current PE methodology and not typically accounted for in the direct PE.

CMS is proposing to crosswalk the technical component of CPT code 93457 to the technical component for CPT code 7X005. CMS is proposing the RUC-recommended 0.75 RVU for 7X005 for the professional component. CMS is also proposing to correct the Professional picture archiving and communication system (PACS) Workstation (ED053) time in the practice expense, from 14.5 minutes to 13.5 minutes.

ACR Perspective and Comments

While the specialties submitted an invoice for the software analysis fee required for FFRCT, CMS has repeatedly stated that their current PE methodology is not set up to accurately capture these types of costs. For this reason, CMS proposed a crosswalk methodology for the PE valuation, which is a methodology the Agency has employed previously in similar circumstances.

The ACR also struggles with how to best capture these costs in an alternative methodology. We encourage CMS to work towards a system that will acknowledge software as a service as a direct input so that we can arrive at appropriate and accurate pricing for these procedures.

The ACR supports CMS's proposal to accept the RUC recommendation of 0.75 RVU for CPT code 7X005. We also agree with the correction to 13.5 minutes for the Professional PACS Workstation.

Ultrasound Guidance for Vascular Access (CPT code 76937)

Proposal
CPT code 76937 *(Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)* was flagged for review with the peripherally inserted central venous catheter (PICC) codes in January 2018. Since the new PICC codes now include imaging, utilization for 76937 was expected to decrease, prompting review in October 2022.

CMS is proposing to accept the RUC-recommended 0.30 work RVU for CPT code 76937, as well as the RUC-recommended practice expense inputs with no refinements.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the RUC recommendation for physician work and PE inputs for CPT code 76937.

Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76883)

Proposal
CPT codes 76881 *(Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation),* 76882 *(Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation),* and 76883 *(Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity)* were addressed by CMS in the 2023 MPFS. While CPT code 76883 was a new code in 2023, CPT codes 76881 and 76882 have been reviewed by the RUC several times. The practice expense inputs for CPT code 76882, specifically, have been under scrutiny, due to frequent shifts in the dominant specialty over the years. In the 2023 MPFS, CMS recommended that the RUC carefully re-review and confirm the PE inputs for this neuromuscular code family based on the latest Medicare claims data.

The RUC reviewed the specialties' updated PE inputs at the recent January 2023 meeting, with only changes recommended for CPT code 76882. CMS is proposing to accept the RUC-recommended PE inputs for 76881 and 76883. CMS is proposing some refinements to the RUC-recommended PE inputs for CPT code 76882, including correcting the Professional PACS Workstation (ED053) time from 13.5 minutes to 17.5 minutes, and maintaining the ultrasound unit, portable (EQ250) time of 15 minutes to be consistent with how this time was allotted for

CPT codes 76881 and 76883. CMS is not proposing any changes to the work RVUs for these codes.

ACR Perspective and Comments
The ACR supports CMS's proposal to accept the RUC recommendations for the physician work for all three codes and the PE inputs for CPT codes 76881 and 76883. The ACR also agrees with the refinements CMS proposes to the PE inputs for CPT code 76882.

Adjustments to Payment for Timed Behavioral Health Services

Proposal
CMS acknowledges that there is an ongoing behavioral health crisis, especially following the recent COVID-19 pandemic. However, due to workforce shortages, patient access to care has been negatively impacted. CMS discusses how the MPFS rate-setting methodology and budget neutrality impact certain specialties more than others based on how frequently the codes are revalued and the ratio of physician work to PE.

CMS is proposing immediate adjustments to some time-based psychotherapy codes for CY 2024 (19.1% upward RVU increase) to achieve more accurate reimbursement for these codes while other potential systemic solutions are being considered.

ACR Perspective and Comments
While the ACR can sympathize with the need for increased behavioral health access in the U.S., we do not agree or support the methodology in which CMS is proposing to value these codes. We oppose non-resource based systemic increases/decreases to a set of codes, as this has the potential to distort the relativity within the resource-based relative value scale system.

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation

Proposal
The Consolidated Appropriations Act, 2021 (CAA) moratorium on Medicare payment for Healthcare Common Procedure Coding System (HCPCS) code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))* will end December 31, 2023, making it active January 1, 2024.

While there is support for the implementation of HCPCS code G2211 from the practitioners who primarily report office/outpatient (O/O) evaluation and management (E/M) services, many stakeholders have also expressed concern that implementation of G2211 could lead to reductions in the conversion factor or non-resource-based redistributive effects among specialties. In response to the concerns, CMS is proposing several policy refinements.

First, the G2211 would not be payable when the O/O E/M visit is reported with payment modifier-25. Secondly, CMS has revised their initial utilization assumption; the Agency now estimates that HCPCS code G2211 will be billed with 38% of all O/O E/M visits initially, but once fully adopted, the utilization is expected to be 54% after several years. CMS is seeking comment on the utilization assumptions and the application of proposed policy for CY 2024.

ACR Perspective and Comments
The ACR does not support the implementation of G2211 for the following reasons:

G2211 is no longer justified
This code was created because CMS's original policy called for a single payment rate for O/O E/M visit levels 2-5 and that additional non-face-to-face time performed by primary care other specialty services needed to be accounted for. However, the new coding structure for O/O E/M incorporates both non-face-to-face time and face-to-face time and also includes the work and time for three days prior and seven days after the encounter. Physicians can bill the higher-level E/M codes to account for the total time, including non-face-to-face time.

G2211 is duplicative of separately reportable work
CMS insists that there are additional resource costs associated with the ongoing care and management of chronic conditions that the O/O E/M codes do not cover. However, CMS has not specified what the additional resources are. The ACR believes that any additional resources can be reported by other newly developed codes for ongoing care, which can be added to a single office visit. These includes codes for principal care management (PCM), chronic care management (CCM), complex care management (Complex CCM), transitional care management (TCM), the prolonged services code, remote physiologic monitoring, and remote therapeutic monitoring (RTM). The implementation and use of G2211 to report these additional resources will be duplicative of the work described by the existing codes and result in overpayments. In turn, in order to maintain budget neutrality, the conversion factor will need to be decreased, which impacts physician payments.

G2211 is not resource-based
As previously stated, CMS has been vague in defining the additional resources that are meant to be described by HCPCS code G2211. The RVUs assigned to G2211 were based on mitigating any payment instability for physicians and considerations of budget neutrality.

In summary, implementation of HCPCS code G2211 is unnecessary and duplicative of work that can be described by existing codes and reduces the conversion factor, which impacts reimbursement for all physicians.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Proposal
In the March 31, 2020, COVID-19 Interim Final Rule with comment (IFC), 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 states that in the absence of evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services. CMS is proposing to revise the regulatory text to state that, through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

ACR Perspective and Comments

The ACR recognizes the value of telehealth services, and the importance of telehealth services availability in rural areas. The ACR also supports CMS's efforts to protect patient safety. ***The ACR supports CMS's proposal to revise regulatory text that through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).***

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

Proposal

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

ACR Perspective and Comments

The ACR asks that CMS make permanent the rule that allows virtual direct supervision of level 2 diagnostic tests via real time audio/video communications technology by physicians and non-physician providers (NPPs) whose state law and scope of practice permit them to supervise diagnostic tests. Additionally, the ACR ask that CMS require secondary non-physician licensed practitioner (RN, LPN, RT, RA, EMT) to be on site throughout the performance of those tests (not in a supervisory role but be available to assist with possible patient adverse reactions when contrast agent is used). The ACR appreciates and supports CMS's prioritization of patient safety. 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.

Services Addressing Health-Related Social Needs: Community Health Integration (CHI) services, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) Services

Proposal

CMS is proposing coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. The proposal helps implement the Biden-Harris Cancer Moonshot goal of every American with cancer having access to covered patient navigation services. CMS is proposing new coding to describe and separately value three types of services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services, and under the billing practitioner's supervision, when reasonable and necessary to diagnose and treat the patient: community health integration services (CHI), social determinants of health (SDOH) risk assessment, and principal illness navigation (PIN). CMS expects the proposed new codes to support the CMS pillars for equity, inclusion, and access to care for the Medicare population and improve patient outcomes, including for underserved and low-income populations where there is a disparity in access to quality care.

ACR Perspective and Comments

The ACR is supportive of CMS's recognition of the resources involved in providing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel and recommends CMS finalize its proposals for CHI and PIN services to provide for coverage and payment of these essential services that are critical to coordinating all the aspects of a beneficiary's care. We also support CMS's recognition of SDOH's impacts on the effective treatment of beneficiary's illness and recommend CMS finalize its policies related to SDOH risk assessment.

The ACR members are a critical component of the medical team; our members also function as the health care physician providing oversight to auxiliary staff personnel responsible for assisting Medicare beneficiaries with serious high risks (e.g., cancer) to identify and connect with appropriate clinical and support services. Radiology and radiation oncology staff is not only coordinating different aspects of the diagnosis or treatment of a condition, including navigation of the increasingly complex health care system, but actively engages with the beneficiary to provide many vital services including health education, emotional support, and assistance in accessing related social services (e.g., community-based social services). In these situations, our members are providing PIN services.

The ACR supports the proposals for PIN services; our comments are directed at enhancing access to PIN services. In general, we agree with CMS's requirement that a beneficiary has one serious, high-risk condition expected to last at least 3 months, but we are concerned that the examples provided do not include the wide expanse of possibilities. Specifically, we recommend CMS include chronic kidney disease, chronic liver disease, diabetes mellitus, and stroke in the list of examples of serious, high-risk conditions. We recommend that dual-eligible individuals with a serious high-risk condition be eligible for PIN services even when the condition might be

less than 3 months duration. From our members' experiences, this vulnerable population needs patient navigation services for high-risk illnesses, including some cancer diagnoses, that might be diagnosed and treated in less than 3 months.

Given the important role of auxiliary personnel in providing PIN services, we recommend CMS establish additional guidance about the training requirements. We recommend CMS base guidance on the best practices currently used by states that require licensure for individuals performing PIN services.

We do not agree with CMS's requirement to limit PIN and CHI services to only one billing practitioner per calendar month. For both PIN and CHI services, within the same billing month, a beneficiary with complex medical needs in combination with multiple comorbidities may be seen by different health systems or physician practices that provide these services. There are also situations where the beneficiary might be receiving treatment in different states and require distinct PIN services with different community resources available in different states. We recommend that CMS acknowledge that in certain situations, as documented in the medical record, a patient might benefit from two billing practitioners providing PIN and CHI services during the same calendar month.

The ACR also recommends that CMS require consent at initiating PIN and CHI services to ensure that the beneficiary understands that these services are being provided as a Medicare benefit with applicable cost sharing. This will reduce confusion between services that are PIN services but are not provided by the health care provider.

QUALITY PAYMENT PROGRAM

Updates to the Quality Payment Program (QPP)

CMS issues requests for information (RFI) on areas that would affect traditional Merit-Based Incentive Payment System (MIPS) and future MIPS Value Pathways (MVPs) participation and seeks input on the following proposals. CMS also proposes changes to the MIPS performance threshold, quality measure data completeness requirements, and the Diagnostic Radiology measure set.

MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs - Request for Information (RFI)

Proposal

The CMS RFI *MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs* aims to identify quality measure implementation by ACOs with participating specialists so such specialists may appropriately demonstrate quality performance immediately associated with the care they provide. CMS requests feedback on proposed regulations that would incentivize specialists participating in ACOs to report their quality through MVPs.

ACR Perspective and Comments

The ACR appreciates CMS's efforts to reduce the measurement burden imposed on those participating in its many quality programs and to consider alternatives for specialists to participate and demonstrate their care quality. The Advanced Payment Model Participation Pathway (APP) measure set for Shared Savings Plan (SSP) ACOs successfully reduced the measurement burden for the ACO-primary care provider population. However, since the APP measures are irrelevant to specialties like radiology, it reduces the likelihood of radiologists joining an ACO.

The ACR acknowledges determining care value from (cost and quality) measures immediately linked to the specialty or subspecialty care provided by ACO participants is logical when employing MVPs strictly through the lens of CMS's MVP framework. However, the ACR is concerned with the real-world obstacles that radiology practices face regarding their participation in traditional MIPS and future MVPs—specifically, the absence of cost measures appropriately attributed to radiologic care. Most MIPS-participating diagnostic radiology practices are exempt from the Cost category; with their Cost scores reweighted to the Quality and Improvement Activity categories, ACO-participating radiology practices could not show their significance on patient care under CMS's definition of value.

The ACR recognizes that resources like payment incentives and scoring flexibilities for ACO MVP participation may encourage specialists to join ACOs. **We suggest that CMS first invest resources into identifying quality programming with flexibilities so that all medical specialties can successfully convey their CMS-defined value before rewarding specialists that have already begun using MVPs, given these MVP participants can earn scores by participating in all MIPS categories. We further recommend that ACO MVP participation incentives and scoring flexibilities only be applied once all specialties have access to an MVP**; otherwise, CMS would reward those ACO-participating specialists who can most readily participate in MVPs, while those currently without MVPs may not ever see these incentives or benefit from scoring flexibilities.

Transforming the Quality Payment Program RFI

Proposal

CMS plans to modify the QPP policies to "foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries." As such, feedback regarding QPP participation policies is sought.

ACR Perspective and Comments

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

these initiatives demonstrates continuous dedication to improving the quality of care they provide.

The ACR understands that CMS's regulation of the QPP must follow the Medicare Access and CHIP Reauthorization Act (MACRA) statute and is therefore limited in the policies it implements for regulating the QPP. However, due to several regulations, processes, and procedures imposed by CMS, MIPS participation has become tenuous for radiologists to earn incentive or neutral payment adjustments even when scoring perfectly in traditional MIPS. As such, we recognize that investing resources to foster our members' participation in and advocating for the fair implementation of MIPS is paramount. Therefore, **we strongly urge CMS to reconsider its current policies regarding MIPS scoring and medical specialty-deemed meaningful measures.** As currently regulated, CMS views practices providing high-quality care as those readily participating in the one-size-fits-all program structure of traditional MIPS and, eventually, MVPs.

MIPS-eligible clinicians with access to a comprehensive set of quality measures with assigned benchmarks can achieve full scores when reporting their measures. In contrast, others with dwindling measure sets comprising mostly topped-out measures or those not yet benchmarked have limited scoring capability. Unfortunately, this biases MIPS-eligible clinicians' scores. For example, Eligible Clinician A and B participate in MIPS from different medical specialties. Eligible Clinician A submits measures from his applicable measure set. Even with some topped-out, other measures are available, with benchmarks allowing the full-ten-point earning potential so that he may earn up to a 60-point measure score. In comparison, Eligible Clinician B submits measures from her applicable measure set, comprising fewer measures, including many topped-out or those without benchmarks (limiting scoring capacity), which prevents the possibility of earning ten points per measure or 60 points for all measures submitted with perfect scores. Eligible Clinician A may not perform as well on their measures as Eligible Clinician B, but Eligible Clinician A will earn a higher measure score, prompting them to earn a higher payment incentive than Eligible Clinician B due to the scoring limitations on Eligible Clinician B's measures. This is more than theoretical. Practices shared data with us demonstrating that despite scoring perfectly (100th percentile) on the freely available quality, improvement activity and cost measures on which their score is based, it is possible (and probable) that they would score below the performance threshold and receive a penalty. Scores below the 100th percentile, including 99.99th percentile, result in more damaging penalties.

Measure ID	Measure has a Benchmark	Seven-Point Cap	99.99% Quality Performance	100% Quality Performance
145	N	N	0	0
360	Y	Y	4.9	7
364	Y	Y	4.9	7
405	Y	Y	6.9	7
406	Y	Y	4.9	7
487	N	N	0	0
TBD 1	N	N	0	0
TBD 2	N	N	0	0
	Quality Points Earned out of 60		21.60	28.00
Cost Reweighted		Quality	30.6	39.67
		IA (100% score)	15	15
		PENALTY	45.60	54.67
Cost Scored		Quality	19.80	25.67
		IA (100% score)	15	15
		Cost (100% score)	30	30
		PENALTY	64.80	70.67

In light of this example, we propose CMS consider MIPS performance to be compared among eligible clinicians practicing in the same medical specialty or subspecialty.

Radiologists view their 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. Again, Diagnostic Radiologists do not fit in the CMS one-size-fits-all model because they do not control the patients' imaging orders or clinical management. However, they do control how well they communicate in their reports. Therefore, care gaps for radiologists occur in adopting evidence-based processes, like using structured reporting or confirming that evidence-based follow-up recommendations are in the report. A lack of evidence-based recommendations leads to inappropriate variability and lower value care. Due to CMS not recognizing this issue for radiologists and other specialties experiencing the same program limitations, their ability to access measures meaningful to their practices is diminishing.

During a recent meeting between CMS staff and ACR's leadership and staff, we discussed CMS's efforts for quality measures to access electronic health record (EHR) systems and electronic clinical quality measure (eCQM) data sources. The ACR agreed with CMS that by using these data sources, the ACR could develop more robust quality measures that would more likely be approved in rulemaking and remain in the MIPS program longer. However, this becomes difficult because these other data sources are disconnected from radiology PACS and the essential information contained in the radiology report.

The ACR cautions CMS with increasing reporting requirements and requiring reporting on specific measures once MVPs are mandatory. Given the issues previously mentioned regarding participation inflexibility, lack of recognition of the differences between medical specialties, and limitations to radiologists fully participating in MVPs, we are concerned with CMS deciding which specific measures would be appropriate for reporting. Given CMS's approach to reducing the reporting burden, we request that CMS work with medical specialty societies to understand the intricacies of their members' participation, such that the MIPS program has policies supporting the wide range of medical specialties and subspecialties, removing biased procedures and rules.

As mentioned previously, the ACR strongly champions radiologists participating in diverse quality improvement opportunities within the College (e.g., NRDR, Diagnostic Imaging Center of Excellence, ACR Learning Network, etc.), as well as their efforts in external quality improvement programs, like the American Board of Radiology's Continuing Certification (MOC). Considering the high level of engagement in these comprehensive quality improvement opportunities, the ACR strongly encourages CMS to consider new QPP policies that incorporate MIPS-eligible clinicians' participation in such programs as their participation in continuous performance improvement.

Sunsetting the MIPS

Proposal
Although CMS has not set a specific timeframe for sunsetting the MIPS program in favor of alternatives, CMS notes that this is still their intention at some point in the future.

ACR Perspective and Comments
The ACR acknowledges that the MIPS program is burdensome and imperfect at effectively measuring clinician performance, however we encourage CMS to commit to not sunsetting MIPS until there is an option available which is viable to all specialties. While CMS is putting greater emphasis on MVP development and radiologists are eager for an alternative to MIPS, there has not been a viable option proposed in which radiologist participation is feasible. We urge CMS to consider the implications of sunsetting MIPS as it relates to non-patient facing medical specialties which have thus far been unable to participate in any MIPS alternatives.

MIPS Performance Threshold and Incentive Payments

Proposal
CMS proposes to raise the 2024 performance threshold from 75 points to 82 points. CMS also proposes changing the methodology for calculating the performance threshold by using the average from three consecutive years of MIPS performance scores beginning with 2017-2019 participation.

ACR Perspective and Comments

The ACR strongly opposes CMS's proposal to raise the performance threshold to 82 points until the effects of topped out quality measures on non-patient facing clinicians and the barrier for introducing new measures is addressed.

We understand the requirement to "compute the performance threshold such that it is the mean or median (as selected by the Secretary) of the final scores for all MIPS eligible clinicians with respect to a "prior period" specified by the Secretary." It is important to acknowledge that due to declining measure availability and an increased fraction of topped out measures for some specialties, such as radiology, as well as the removal of bonus points, there is not equivalency between past and present years. As a result, past performance is not reflective of the current challenges. **We thus strongly urge CMS to use the flexibility provided in the statute to maintain the threshold until these issues are successfully addressed.**

Although our concerns arise from observing how MIPS scoring policies affect radiologists, many medical specialties are in a similar position. They have a dwindling set of measures available, many of which are topped out and capped at 7 points. CMS has rejected multiple new measures proposed for addition to the program. As noted above, it is likely that some practices will score perfectly on the freely available measures and still be penalized for "under performance".

Because non-patient facing clinicians' MIPS scores are so heavily determined by their quality category score, many clinicians are now forced to adopt measures outside their own measure sets in order to avoid a negative payment adjustment. It is the ACR's opinion that this defeats the purpose of the MIPS program, which is to measure individual clinician performance in areas meaningful to their specialty. We believe that this disproportionately penalizes certain medical specialties for attempting to do their best on the measures which are available to them, and likewise detracts from meaningful quality improvement by incentivizing the adoption of less relevant quality measures. Similarly, the need to purchase measures to avoid a negative adjustment serves as a tax or penalty of its own on these practices and raises the administrative costs of health care.

Generally speaking, the ACR believes that CMS's process for increasing the performance threshold outpaces the ability of specialty societies to propose new quality measures into the program. This places all specialties with limited measure sets at a disadvantage and penalizes MIPS clinicians for doing well on the measures which are relevant to them.

We urge CMS to consider how these scoring policies may negatively affect non-patient facing clinicians who are typically exempt from the Cost and Promoting Interoperability performance categories and whose MIPS score is primarily determined by their quality score. One option would be to revise the reweighting policies for clinicians who are exempt from promoting interoperability and cost. Distributing more of those category weights into the improvement activities category would greatly ameliorate this issue (e.g., 70% for quality and 30% for improvement activities). **Alternatively, we urge CMS to show increased**

willingness to adopt new quality measures into the program before increasing the performance threshold further.

Again, we strongly urge CMS to use the flexibility provided in the statute to maintain the performance threshold until these issues are successfully addressed.

MIPS Measures Proposed for Addition

Proposal
First introduced in the 2023 Proposed Rule, CMS proposes to continue including measure #487: *Screening for Social Drivers of Health* in the Diagnostic Radiology and Radiation Oncology measure sets.

ACR Perspective and Comments
The ACR urges CMS to remove this measure from the Diagnostic Radiology measure set, as we do not feel it measures a quality action that is attributable to radiologists, who are overwhelmingly non-patient facing. The ACR, a cofounder of the Radiology Health Equity Coalition (RHEC), is committed to working with CMS and other stakeholders to promote health equity to achieve a more equitable healthcare system. As such, the ACR applauds CMS's efforts in prioritizing health equity across its quality programs, including measures intended to examine social risk factors in MIPS. However, because a radiologist typically does not have any interaction with the patient prior to imaging, it is not within a diagnostic radiologist's purview to screen patients for the elements associated with this measure. **The ACR requests that CMS revise the Diagnostic Radiology measure set to only include measures whose quality actions are within the radiologist's purview to influence—namely, measures which examine the radiology report and its related processes and outcomes.**

Proposal
CMS proposes to add the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults* measure to the Diagnostic Radiology measure set.

CMS proposes to adopt the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)* eCQM into the MIPS program beginning with the calendar year (CY) 2024 reporting period/fiscal year (FY) 2026 payment determination.

ACR Perspective and Comments
The ACR has concerns about the proposed *Excessive Radiation Dose or Inadequate Image Quality* measure as we provide below, many of which were also outlined in our comments on the FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and FY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems proposed rules. However, we first would like to emphasize that the ACR is a strong advocate and proponent for patient radiation safety as demonstrated by the multiple and various ongoing efforts and activities in which the organization and the radiology community are involved (i.e.,

guidelines and technical standards, imaging appropriateness criteria, the Image Gently and Image Wisely alliances and campaigns, radiation safety manuals, accreditation, dose index monitoring and management, educational products, publications, and performance measures). The ACR fully supports entities or individuals that put forward valid and feasible tools to optimize patient exposure to radiation through dose monitoring and imaging appropriateness.

The ACR also supports CMS's efforts to prioritize radiology-focused patient safety eCQMs that address patient outcomes. However, we caution CMS with finalizing this measure in the MIPS program, particularly as immediately as the CY 2024 reporting period.

Implementation challenges, burden, and timing

This measure necessitates considerable organizational efforts to access and process the data elements required to calculate the measure score. Reporting this measure at the clinician level will be difficult for radiology groups without collaboration, coordination or implementation support at hospitals, hospital systems and imaging facilities for whom groups provide services, particularly for non-academic, community and private practices when CT equipment and systems are primarily owned by the hospital or imaging facility. The hospital or facility owns the data and must agree to support radiology groups wishing to implement the measure. Furthermore, most radiology groups provide services for multiple locations that may or may not be part of a singular hospital system. As such, this will require contact and coordination by clinician groups with individual facilities as well as with organizations or corporate healthcare systems.

Granted, through FY 2024 rulemaking, CMS has proposed or finalized inclusion of this measure within the Hospital Inpatient Quality Reporting (IQR) and the Hospital Outpatient Quality Reporting (HOQR) programs, proposals that may encourage radiology groups' facility partners to begin implementing the measure, albeit appropriate to each setting. However, the timeframe proposed by CMS for adoption of the measure, as well as the requirements for reporting, within each of the three quality programs (IQR, HOQR and MIPS), are somewhat discordant. Particularly, the proposal for the MIPS program introduces it for CY 2024 reporting, while it is being introduced as voluntary in the IQR program in CY 2025 and in the HOQR in CY 2025 voluntary reporting and CY 2026 mandatory reporting. While the ACR believes that mandatory HOQR reporting in CY 2026 is premature (as stated in our comments for the HOPPS FY 2024 rule), having cross setting uptake of the measure is key to successful collection of data and reporting to CMS by radiology groups.

Even so, given the already limited resources and competing priorities for information technology support in many hospitals and radiology practices, implementing this measure in various settings may prove challenging for many. While some large, integrated hospital systems with well-run internal management and coordination across multiple locations and information systems may have few problems in adopting the measure, other hospitals, imaging centers and groups supporting rural or underserved communities may not. The complexity of the measure, particularly concerning methods for calculated data elements, requires the creation of measure software and logic by technical staff or the use of a commercial product. Currently, the only software for implementing this eCQM was created and maintained by a single commercial

vendor, Alara Imaging Inc., in conjunction with the measure steward. The measure steward has affirmed that organizations may obtain access to a version of the software without charge. There may not be a cost to obtaining the Alara software but there is a resource cost to integrating it into existing technology such as the EHR, RIS or PACS. Healthcare information technology (IT) staff are always cognizant of security concerns implementing software products as well as ongoing management.

Regardless of in-house or commercial solutions, healthcare IT staff who are likely already juggling multiple technological priorities, software upgrades, transitions, or installations will be tasked with implementing the proposed measure. Additionally, hospitals may need to provide the ability for radiology groups to access detailed clinician/group level performance data (with the idea of using it to improve) which will be necessary for radiologists to report the measure if this is implemented in MIPS. Operational staff will need to oversee installation, configuration, and ongoing management of any measure software, commercial or proprietary. Software configuration requires mapping or extracting data element components from the relevant systems necessitating connections across systems, determining the source for CPT/International Classification of Diseases (ICD) codes used to classify an exam for the CT Category field values (extracted from an EHR, billing/practice management system, or a radiology information system (RIS)), as well as radiation dose and global noise values (size-adjusted dose and image quality) to determine measure performance. Thus, total costs to organizations to implement the software could be high—regardless of the price of the software.

Additionally, Logical Observation Identifier Names and Codes (LOINC) codes created for the measure calculated fields exist but may not necessarily be used by every facility or group; capturing data for the new codes will need to be configured. The LOINC codes do not rely solely on standardized fields from a system; any system that implements the fields must embed some calculations. For instance, there is a Digital Imaging and Communications in Medicine (DICOM) field for patient size for calculating size-adjusted doses, however, it is frequently null. Most radiation dose monitoring tools calculate patient size from CT images.

Although the proposed "Excessive Dose" measure was tested at multiple pilot sites of varying facility types specified, the ACR has much more experience extracting similar data from more than 2,500+ facilities utilizing the ACR Dose Index Registry or that have undergone ACR CT Accreditation. Through such experience with these facilities, we have found that the ability to extract these data elements and transform them into the calculated fields with any degree of accuracy or consistency even with an available software solution is far from trivial. We have serious concerns about the feasibility of this approach.

Measure methodology

The ACR is concerned with the lack of demonstrated validity or reliability supporting the measure, particularly with using the calculated fields. The data elements needed for the measure are calculated using multiple structured fields within the EHR and the radiology electronic clinical data systems, including the RIS and the PACS.

CT Dose and Image Quality Category (CT Category)
The accuracy and specificity of CPT/ICD codes to determine the true indication for an exam at the time of order is a cause for concern. Indications for exams at the time of order do not typically have standardized language that could be used to categorize the CT exam purpose (CT Category) nor fully characterize the patient's condition. As a result, the clinical reason for performing an imaging exam is often extremely limited within the exam order, even if using an ICD-10 code. For example, an order for CT abdomen with an indication of "pain" may use a low dose kidney stone or a routine CT protocol. Most health and IT systems capture CPT and ICD-10 coding for reimbursement, but codes are typically assigned after the imaging exam's completion. Since the imaging exam is a diagnostic tool to support the final diagnosis by the treating physician, which likely includes other factors, ICD and CPT codes assigned at that point would serve only as a proxy for the understood indication at the time of the imaging exam. This is a particular problem if the exam is normal/negative for the suspected condition. Additionally, EHR systems are notoriously incomplete, lacking this type of information, and interoperability issues may exist with other software systems containing such information, like billing/coding systems.

CT Size-Adjusted Dose and CT Global Noise
The two primary components of the proposed measure, "CT size-adjusted dose" and "CT global noise" are not widely accepted image quality measurements, nor have they been widely tested and validated. CT noise measurements are especially problematic, as finding a reliable measure of image noise that can be taken directly from the image has proven elusive over the decades, despite a number of the world's foremost labs pursuing this in earnest for many years. The fact that Alara Imaging Inc. has proposed a proprietary version that has not been released for public review makes it difficult to verify the validity and reliability of the global noise methodology.

Actionability/Usability
The imaging protocol selection appropriate for a clinical indication is a crucial factor in radiation dose management and optimization. It requires that each component be addressed as a separate quality action. The most accurate way to address the appropriate and safe use of multi-phase CT studies is to measure the clinical indication of an exam and the radiation output (dose indices) per exam and assess the two separately or distinctly together. However, this measure conflates the appropriateness of the protocol for the clinical indication and radiation dose optimization, disregarding applicability, from which a facility may be unable to determine if adjusting protocols or focusing on the appropriateness of the exam ordered could improve performance. Therefore, improvement may be limited[1]. Consider the following practical examples:

- Should the protocol always be adjusted because of patient size if the dose index value is high on a specific exam?
- The exam may have been inadequate for image quality, as shown by measure results, but the physician was comfortable making a diagnosis using the images. How does that relate to the image quality benchmark? Again, in cases with broad indications such as "pain", the protocol selection may vary (i.e., low dose kidney stone or a routine CT protocol).

[1] Mahesh M. Benchmarking CT Radiation Doses Based on Clinical Indications: Is Subjective Image Quality Enough? Radiology. 2021 Nov 9:212624.

- What is an appropriate radiation dose index benchmark for routine abdomen CT for a patient weighing 300 lbs.?

These are just a few of the many unanswered (and potentially unanswerable) questions that have not been addressed. The ACR strongly believes that it is premature to require providers across the country to measure performance on excessive radiation dose based on clinical indication thresholds, particularly at the clinician level when this measure is better suited for healthcare system level performance, until more advanced national benchmarks are standardized and available.

Use of the term "excessive radiation dose"
The term "excessive radiation dose" is subjective, imprecise, inaccurate, and alarmist. The effort to inform patients regarding risks of ionizing radiation while reassuring them that the risks are low is a delicate balance. Terminology matters a great deal, as has been highlighted by many prominent experts, especially those leading the Image Gently campaign. The ACR has developed numerous educational and guidance materials on radiation dose safety. Of note, our communications and guidance balance providing patients with awareness of the risk associated with radiation exposure and the incredible benefits medical imaging provides to patient care. We carefully craft statements so as not to raise undue alarm or fear of potential life-saving clinical care. Terms such as "optimization" or "dose lowering" are preferable to those such as "excessive dose" and using the term "excessive dose" may be inaccurate and unnecessarily alarmist.

Healthcare community understanding
The ACR recognizes that the Excessive Radiation Dose measure has received substantial support across the medical and healthcare community, including from numerous radiology groups and leadership within the specialty. Based on input received from multiple contacts, we believe that a majority or large percentage of commenters support the general concept of addressing radiation dose optimization by indication for exam, which the ACR also supports, while not understanding the details of the measure approach or methods for implementation. We strongly encourage that CMS reach out to various stakeholders supporting the measure to gauge comprehension of the measure details and implementation logistics.

The ACR fully supports valid and feasible tools to optimize patient exposure to radiation dose. However, we strongly recommend that CMS take a considered approach to implementing the Excessive Radiation Dose measure into the MIPS program, allowing a period for larger-scale testing, implementation, and experience with the measure before including it for the CY 2024 reporting period, merely months away.

The ACR appreciates the opportunity to provide comments on the CMS proposal to include the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)* eCQM into the MIPS program. As stated in our introduction, the ACR is a strong advocate and proponent for patient radiation safety, as demonstrated by our many efforts, alliances, and collaborations. As evidenced by numerous commenters during the measure review process, many in the healthcare community strongly support programs and

efforts for optimization and management of radiation dose associated with medical imaging. Although the ACR has outlined various concerns with the proposed measure, we are aligned with its goal. We seek to work in partnership with this stakeholder community and CMS to identify and implement measures addressing radiation dose and safety that are methodologically and scientifically sound, provide meaningful feedback and improvement opportunities, have transparent data collection and calculation methods, and are as least burdensome as possible. We hope these comments provide valuable input for your consideration.

MIPS Measures Proposed for Removal

Proposal

CMS proposes to remove MIPS measure #436, *Radiation Consideration for Adult CT: Utilization of Dose-Lowering Techniques* measure from the program due to being duplicative of the newly proposed *Excessive Radiation Dose or Inadequate Image Quality* measure.

ACR Perspective and Comments

The ACR opposes the CMS proposal to remove measure #436 from MIPS. We do not believe the existing measure is duplicative of the new measure, and additionally, as the new *Excessive Radiation Dose* measure is proposed as an eCQM, we believe that there will be significant burden in implementing this new measure due to lack of available data in EHR systems. As stated in a previous comment, the new *Excessive Radiation Dose* measure does not measure a quality action which can be attributed to a diagnostic radiologist. While we believe the goal of reducing excessive dose is important, the radiologist has little control over the radiation dose used during a CT exam; this is more within the purview of the radiologic technologist and the medical physicist. On the other hand, measure #436 directly examines whether the radiology report is adequately communicating to referring clinicians and patients whether dose-lowering techniques were used during the CT. While these measures both encourage the use of dose-lowering techniques in CT, only measure #436 includes a quality action which can be directly attributable to the radiologist.

The ACR also believes the removal of measure #436 will negatively affect radiologists who may have difficulty adopting the new *Excessive Radiation Dose* measure. As stated in the proposed rule, this new measure "requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM." Because this measure will require structural changes to a facility's EHR, the groups or individuals who may want to report this new measure will be faced with additional burden and limitations based on their EHR vendor—elements which may be entirely beyond their control. **Rather than remove one measure to replace it with a dissimilar measure that may also be infeasible to quickly implement, ACR encourages CMS to keep measure #436 in the program.**

Quality Measure Data Completeness

Proposal
CMS proposes to raise the data completeness threshold for quality measures to 75% during the 2024-2025 MIPS performance years and to 80% beginning in 2026.

ACR Perspective and Comments
The ACR opposes CMS's proposal to raise the data completeness threshold beyond 70%, because it specifically disadvantages clinicians who practice at a large number of locations, especially facilities which are small or rural. The current data completeness threshold, although high, allows some leeway for clinicians who practice at facilities whose EHR data may be less complete and more burdensome to capture. In the ACR's experience, clinicians always strive for 100% data completeness, but find themselves at the mercy of technical limitations which prevent them from capturing 100% of relevant data. Until EHR data availability is sufficiently standardized across all health IT vendors, MIPS clinicians will continue to be limited by facilities which are unable to provide adequate measure data. **We believe the current data completeness threshold of 70% is difficult but fair and should be maintained until EHR data availability is improved on a larger scale.**

Cost

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 this measure if any non-exempt clinicians are practicing under their Taxpayer Identification Number (TIN).

ACR Perspective and Comments
CMS has stated that the TPCC measure focuses on effective primary care management to support Medicare savings. As such, the attribution of this 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 based on their Provider Enrollment, Chain, and Ownership System (PECOS) code. The ACR believes that the intent of that exclusion is at the radiology group, TIN, or service level. However, based on instances where radiology groups have reported attribution of the TPCC for the performance year 2022, 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 services under a radiology group TIN are attributed the TPCC measure, resulting in their costs attributed under the radiology TIN.

The ACR believes there are at least two mechanisms to address this problem. First, using "Exclude Clinicians Based on Service Category Exclusions", non-physician providers could be excluded if their TIN billed radiology or interventional radiology services during 5% or more of their candidate events. This is consistent with the exclusions for other specialties. Alternatively,

using "Exclude Clinicians Based on Specialty Exclusions", CMS could exclude non-physician providers based on their affiliation with an excluded specialty, such as Radiology or Interventional Radiology. This is consistent with the exclusion of "non-physicians without chronic management of significant medical condition."

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 comprising of mostly exempt National Provider Identifiers (NPIs) from having the non-exempt NPIs contributing to their Cost category scores.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2024 MPFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process in order to create a stable and equitable payment system and promote an equitable delivery system. The ACR looks forward to continued dialogues 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 Angela Kim at akim@acr.org.

Respectfully Submitted,

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