

September 2, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

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) 2023 Medicare Physician Fee Schedule (MPFS) Proposed Rule. In this comment letter, we address the following important issues:

Payment Provisions

- Updates to Prices for Existing Direct Practice Expense (PE) Inputs
- Clinical Labor Pricing Update
- Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology
- Determination of Malpractice Relative Value Units (RVUs)
- Valuation of Specific Codes
- Rebasing and Revising the Medicare Economic Index (MEI)
- Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers
- Payment for Medicare Telehealth Services
- Medicare Shared Savings Program (MSSP)

Quality Payment Program

- Updates to the Quality Payment Program
- Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information
- Transforming the Merit-Based Incentive Payment System (MIPS): MIPS Value Pathway (MVP) Strategy
- MIPS Performance Threshold and Incentive Payments
- MIPS Measures Proposed for Addition
- Quality Measure Data Completeness
- Cost Performance Category
- Qualified Clinical Data Registry (QCDR) Measure Testing Requirements

PAYMENT PROVISIONS

Updates to Prices for Existing Direct Practice Expense (PE) Inputs

Proposal

Over a four-year period, CMS updated the prices for over 1,300 medical supplies and 750 equipment inputs. The phase-in period ended in 2022.

For 2023, CMS received invoices for several supply and equipment items from stakeholders. Based on the invoice submissions, CMS is proposing to update the prices for eight supplies and two equipment items. CMS continues to welcome stakeholder feedback on the updated pricing of supplies and equipment and will consider any new invoices submitted.

ACR Perspective and Comments

The ACR recognizes CMS's continued efforts to ensure that practice expense inputs are updated.

Clinical Labor Pricing Update

Proposal

In CY 2022, CMS began the first year of transitioning in the clinical labor pricing update, which had not been updated since 2002. 2023 will mark the second year of the phase-in, which is expected to finish in 2025. Data from the Bureau of Labor Statistics (BLS) was the primary source of clinical labor pricing information, but CMS also cross-walked or extrapolated wages from other sources such as Salary Expert.

For CY 2023, CMS is proposing to update the pricing of the Histotechnologist (L037B), for which it received data supporting a pricing increase. The pricing for the Histotechnologist is utilized in calculating the price for a Lab Tech/Histotechnologist (L035A), so this staff type also received a slight pricing increase from \$0.55 to \$0.60. As a result, the Angio Technician (L041A), which is included in many radiology codes, also received a pricing increase from \$0.55

to \$0.60, as CMS previously established that L041A and L035A should be valued the same. No other changes were made to previously proposed clinical labor pricing.

CMS continues to welcome stakeholder feedback on the clinical labor rates.

ACR Perspective and Comments

Even though the four-year phase-in of the clinical labor pricing update is underway, the ACR would like to reiterate our continued concern about the timing of the update, following the recent COVID-19 pandemic. While we understand that the pricing for clinical staff had not been updated for 20 years, it is unfair that specialties with higher supplies and equipment costs will be experiencing additional cuts as a result of the budget neutral adjustments to compensate for the increases in clinical labor pricing. Moving forward, **the ACR would support regular updates to the practice expense components (supplies, equipment, clinical labor staff) to avoid large redistributive effects to specialties in the future.**

The ACR does not agree with the crosswalk of the Angio Technician (L041A) staff type to Lab Tech/Histotechnologist (L035A). While we appreciate that CMS is proposing a slight increase in pricing for L041A to \$0.60 as a result of increased pricing to L035A, this crosswalk still undervalues the work of the Angio Technician.

In our CY 2022 comment letter, we stated that the Angio Technician (L041A) should be valued closer to that of the magnetic resonance imaging (MRI) Technologist (L047A, BLS 29-2035) due to their similar educational requirements and radiologic similarities. However, CMS did not agree based on hourly wage data that it received from Salary Expert.

Reliable data demonstrates that the crosswalk of the Angio Technician to Lab Tech/Histotechnologist is not appropriate. The American Society of Radiologic Technologists (ASRT) 2022 Radiologic Technologist Wage and Salary Survey includes updated wage data for several Radiology clinical staff. Based on the collected data, the Angio Technician staff type is most similar to the Vascular Interventional Technologist staff type in the ASRT survey, which has a per minute rate of \$0.84. **The ACR urges CMS to reconsider the pricing for the Angio Technician (L041A) and crosswalk it to the pricing for the Vascular Interventional Technologist at \$0.84 as provided by the ASRT data.**

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

Proposal

In the proposed rule, CMS solicited for comments from stakeholders on how it might improve the collection of practice expense (PE) data inputs and refine the PE methodology. They acknowledge that while they have made some strides toward updating the supplies, equipment, and clinical labor pricing, some of the indirect PE inputs are over a decade old and would benefit from routine updates in order to avoid unpredictable shifts in payment.

CMS has worked with contractors to identify possible strategies to update the PE and believe that the indirect PE data inputs (rent, IT costs, and non-clinical expense) provide the opportunity to build transparency, consistency, and predictability into the PE methodology. The most recent data was last collected via the 2007 and 2008 Physician Practice Information Survey (PPIS) performed by the AMA.

CMS contracted with RAND Corporation to assess potential improvements to the current PE methodology and that they (CMS) intend to move toward a standardized and routine approach to indirect PE valuation. CMS requests stakeholder feedback on topics related to the identification of the appropriate instrument, methods, and timing for updating specialty-specific PE data. This would include comments related to representative sampling methods, survey design that would lend itself to transparency, and frequency and phase-in of adjustments to direct PE pricing.

CMS also expressed interest in receiving comments about potential unintended impacts (positive or negative) that may result from changes to the PE methodology—such as concerns about beneficiaries’ access to care, the burden to small group or solo practitioners, or possible consolidation of group practices. It is requesting that feedback also includes discussion on health equity impacts.

ACR Perspective and Comments

The ACR has been closely following CMS’s work with RAND in reviewing the PE methodology and accepts the invitation to provide additional input. We are also aware of recent efforts by the American Medical Association (AMA) towards a new physician practice cost survey. It has been working with WebMD professional/Medscape Market Research and Mathematica and is anticipating a survey to be released in 2023.

Transparency leading up to and throughout the survey and data analysis process is key in getting buy-in from stakeholders. Allowing specialties the opportunity to provide insight on their specific practice patterns and by ensuring that the survey will reach the appropriate individual(s) within the practice such as business managers and financial officers is important in order to collect complete and accurate data. Likewise, the survey questions should appropriately reflect the diverse geography and practice patterns of multiple specialties is imperative in gathering representative data. Unquestionably, practices’ structures and business practices have changed in the 15 years since the last practice cost survey was performed; therefore, we believe that the survey questions should be reviewed to reflect this.

The ACR believes that if our comments regarding transparency, appropriate sampling, consideration of different specialties’ practice patterns, and reevaluation of the survey questions are taken into account, then the AMA process may have the potential to collect representative data that CMS could use in its indirect PE calculations. **The ACR urges CMS to not make any changes to the indirect PE methodology or calculations until after the AMA collects and shares the data from their practice cost survey. Given the AMA’s proposed 2023 survey launch timeline, we do not believe any changes should occur before 2025.**

While the direct practice expense data is reviewed regularly at the AMA's Relative Value Scale Update Committee, indirect PE has not been. **The ACR agrees that practice expense data (direct and indirect) for repricing of clinical staff, supplies and equipment should be routinely updated at least every five years to avoid potentially large swings in reimbursement due to redistributive effects in a budget neutral system that could impact smaller practices or patient access to care.**

Determination of Malpractice Relative Value Units (RVUs)

Proposal

Malpractice (MP) relative value units (RVUs) are comprised of three factors (1) specialty-level risk factors derived from data on specialty-specific malpractice premiums incurred by practitioners; (2) service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and (3) an intensity/complexity service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor portion of the direct PE RVU. MP RVUs are updated annually to reflect changes in the mix of practitioners for the services, and to adjust MP RVUs for risk for intensity and complexity. The specialty mix assignments are also now based on three years of data instead of only one year of data. In 2020, CMS finalized a policy to review and update the MP RVUs every three years, consistent with its review of the Geographic Practice Cost Indices (GPCIs).

CMS is proposing to use updated MP premium data from State insurance rate filings to calculate CY 2023 MP RVUs. It is also proposing two methodological refinements to the calculation process. First, for specialties with incomplete premium data, CMS is proposing to use mapped data from a more commonly reported specialty within the same risk class instead of excluding the underrepresented data. Secondly, CMS is proposing to utilize a true MP risk index (ratio of a specialty's national average premium to the volume-weighted national average premium across all specialties) instead of derived risk factors (ratio of a specialty's national average premium to a single referent specialty's national average premium) in the calculation of MP RVUs.

Based on updated calculations, CMS noted that the data yielded significantly lower premiums and risk index values for several specialties. Therefore, CMS proposes to phase in the MP RVUs over three years for specialties that have a 30% or more threshold reduction.

ACR Perspective and Comments

The ACR appreciates CMS's continued efforts to collect and utilize specialty-specific data in calculating MP RVUs. For 2023, the risk index for diagnostic radiology has increased from 0.94 to 1.01. However, we have some concerns about the application or calculation of the new premium data and its impact on imaging codes, particularly those with a professional component (PC)/technical component (TC) split.

The majority of PLI RVUs has historically been allocated to the PC. However, there are patterns in CMS's proposed values for the TC and PC that fail to make logical sense and lead the College to believe that there is an error affecting both the professional and technical component

calculations. For many of the codes, CMS’s proposed values reflect a decrease in the PC and an increase in the TC MP RVUs.

For example, in looking at CPT® code 70450 (*CT head or brain without contrast*), there is a 75% decrease in the professional component MP RVU, while the technical component MP RVU doubled, resulting in an overall 40% decrease in the overall MP RVU.

Code	2022 PFS MP RVUs	2023 PFS PR MP RVUs	% Change in MP RVUs
70450	0.05	0.03	-40%
70450 TC	0.01	0.02	100%
70450 PC	0.04	0.01	-75%

Given that the Radiology risk index has gone up, seeing a negative return in the MP RVU calculations seems incorrect, especially the large decrease in the PC. For 70450, the PC MP RVU is expected to be higher than that of its TC since the specialty-weighted risk index factor is being multiplied by the higher work RVU. The ACR has modeled the MP RVU calculations for about 2,000 radiology codes that have a technical and professional component, the results of which support our concern that there appears to be a systemic technical error in the calculations. **The ACR urges CMS to identify the cause of this technical error and to correct it for CY 2023. If CMS is unable to identify and resolve the error, the ACR recommends that CMS delay implementation and apply the previous methodology until the technical error is corrected. We also recommend that the corrected values be made interim final to allow for specialty review and comment.**

Valuation of Specific Codes

Percutaneous Arteriovenous Fistula Creation (CPT codes 368X1 and 368X2)

Proposal

Two new codes for Percutaneous Arteriovenous Fistula Creation were created by the CPT Editorial Panel: 368X1 (*Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*) and 368X2 (*Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*). CPT codes 368X1 and 368X2 represent two percutaneous approaches to creating arteriovenous access for End-Stage Renal Disease (ERSD) patients during hemodialysis.

CMS compared the RUC-recommended intra-service time for 368X1 to that of its second key reference code, 36905 (*Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision*

and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty), and applied their intra-service time ratio calculation in order to reach their 7.20 RVU recommendation. For 368X2, CMS applied the RUC-recommended interval of 2.10 RVU between 368X1 and 368X2 to reach its proposal of 9.30 RVU.

In line with RUC recommendations, CMS is also proposing to delete HCPCS codes G2170 (*Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed*) and G2171 (*Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, wen performed) and fistulogram(s), angiography, enography, and/or ultrasound, with radiologic supervision and interpretation, when performed*) and to replace them with 368X1 and 368X2.

The Agency also requested information about specific practice expense supply items. They would like feedback on whether SD149 (catheter, balloon inflation device) and SD152 (catheter, balloon, PTA) are typically utilized with CPT codes 368X1 and 368X2, as well as how often they are used. CMS is also interested in whether SF056 (detachable coil) and SF057 (non-detachable embolization coil) are typical and how often they are used with CPT code 368X2.

ACR Perspective and Comments

The ACR disagrees with CMS's proposal to refine the RUC-recommended RVUs for this family simply because they are on the higher end of the RVU spectrum compared to other codes with similar times.

The ACR does not support CMS's alternative methodology for valuation of CPT code 368X1, as an intra-service time calculation does not appropriately depict the level of complexity involved with this service from a clinical standpoint. CPT code 368X1 is the first and only FDA approved Category I code for a percutaneous approach to create an arteriovenous anastomosis. When there is a complication, it will require emergent embolization or surgical exploration, which reflects the increased intensity of physician work.

The physician will percutaneously access a single vessel under continuous ultrasound guidance for CPT code 368X1 and then, using ultrasound, find and select the nearby artery and directly puncture this artery using the same needle. This requires diligent interpretation of real time imaging. The needle is then removed over a wire and a device passed through each vessel. Once the position is carefully confirmed using ultrasound guidance, the device is used to deliver energy to the two adjacent vessels to create a permanent connection, or fistula, to arterialize the

vein. The potential for complication is very high, as mentioned, and the management becomes an emergent situation for the patient if a complication does occur.

As with CPT code 368X1, CPT code 368X2 also uses the percutaneous approach to create an arteriovenous anastomosis but includes additional complexity and intensity while still presenting the potential for complications, which also may require emergent embolization and/or surgical exploration.

For CPT code 368X2 the physician will place two catheters from two different percutaneous access sites, one in the vein and one in the artery, under continuous ultrasound guidance. This requires the physician to handle and maneuver two points of access into the patient with just one set of hands. Most percutaneous endovascular procedures are performed through a single access; the use of two accesses now increases the number and types of complications which can arise. As with the single access, the physician will find and select a vein and adjacent artery, requiring fluoroscopic guidance to select the correct vein, sometimes in a retrograde fashion against the flow of blood. Catheters are then inserted into each vessel using fluoroscopic guidance and energy is activated to pull the vessels together and create a permanent connection, or fistula, to arterialize the vein. A second access into the artery increases the risk and physician intensity of this procedure relative to 368X1.

The ACR disagrees with CMS's refinement of these codes and urge CMS to finalize the RUC-recommended values of 7.50 RVU for 368X1 and 9.60 for 368X2. The ACR supports CMS's proposal to replace HCPCS codes G2170 and G2171 with CPT codes 368X1 and 368X2.

With regard to the supply inputs, SD149 (catheter, balloon inflation device) and SD152 (catheter, balloon, PTA) are typical and necessary supplies for both CPT codes 368X1 and 368X2, as both are part of the fistula creation process for every procedure immediately after energy is delivered to the anastomosis. Therefore, these procedures cannot be performed without these supply inputs.

Moreover, SF056 (detachable coil) and SF057 (non-detachable embolization coil) are typical and necessary for CPT code 368X2. For SF056, dialysis embolization typically is high flow, which requires a single detachable coil first to secure the location; for SF057, two additional non-detachable coils are utilized once a secure coil has been placed. The two non-detachable embolization coils (SF057) are utilized once a secure coil is placed and typically are necessary to effectively perform the percutaneous arteriovenous fistula creation for hemodialysis patients. Coil embolization is a typical part of a fistula creation procedure when performed with the WavelinQ device (used for CPT code 368X2) and is performed at least 75% of the time, if not more. The supply inputs are typical for the manner in which coil embolization is performed in high flow vascular structures and is reflected in codes which represent similar clinical scenarios (36909 and 37241).

The ACR believes that all four supply items, SD149, SD152, SF056, and SF057 are typically employed in the procedures described by CPT codes 368X1 and 368X2.

Somatic Nerve Injections (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 76942, 77002, and 77003)

Proposal

At the October 2018 RUC, it came to light that the somatic nerve injection codes, 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed*), 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*), 64417 (*Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed*), 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed*), 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*), 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed*), and 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*) were reported over 50 percent of the time with imaging code 76942 (*Ultrasonic guidance for needle placement, imaging supervision and interpretation*). These codes were presented at the October 2021 RUC meeting, along with CPT code 77002 (*Fluoroscopic guidance for needle placement*) and CPT code 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)*).

CMS proposed refinements to several codes in the somatic nerve injection family but recommended maintaining the RUC-recommended values for CPT codes 76942 (0.67 RVU), 77002 (0.54 RVU), and 77003 (0.60 RVU). CMS also proposed to implement the PE inputs as recommended by the RUC.

ACR Perspective and Comments

Speaking only to the valuation of the imaging codes, the ACR supports CMS's proposal to accept the physician work valuation 76942, 77002, and 77003. We defer to the appropriate specialties to comment on the refined valuations for the somatic nerve injection codes. The ACR also supports CMS's decision to approve the RUC's recommendation regarding the PE inputs for this code family.

Contrast X-Ray of Knee Joint (CPT Code 73580)

Proposal

CPT code 73580 (*Radiologic examination, knee, arthrography, radiological supervision and interpretation*) was first identified via the high-volume growth screen in 2008. In 2021, the Relativity Assessment Workgroup (RAW) noted that code 73580 was never surveyed and

remains CMS/Other sourced and recommended that it be surveyed for the October 2021 RUC meeting.

CMS is proposing to accept the RUC-recommended 0.59 work RVU, as well as the PE inputs.

ACR Perspective and Comments

The ACR supports CMS’s proposal to accept the RUC-recommended work RVU and PE inputs.

3D Rendering with Interpretation and Report (CPT Code 76377)

Proposal

CMS nominated CPT code 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation*) in the CY 2020 PFS final rule as potentially misvalued. The Agency believes it is in the same family as CPT code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*), which was recently reviewed at the April 2018 RUC, and requested that CPT code 76377 be reviewed to maintain relativity.

Citing changes in technique and patient population, the RUC recommended maintaining the current 0.79 RVU despite a slight reduction in physician time. CMS is proposing to accept the RUC’s recommendation of 0.79 RVU, as well as the PE inputs without refinement. The Agency does state, however, that they believe the codes belong to the same family and should be surveyed together.

ACR Perspective and Comments

The ACR supports CMS’s proposal to accept the PE inputs and physician work valuation of 0.79 for CPT code 76377.

Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76XX0)

Proposal

CPT code 76XX0 (*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*) was created to report real-time complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. CPT codes 76881 (*Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation*) and 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*) were editorially revised to clarify the distinction between complete

and limited studies. All three codes were surveyed and presented at the January 2022 RUC meeting. CMS does not agree with RUC's value recommendations for this code family.

CPT code 76881 describes a complete evaluation of a specific joint in an extremity. The RUC recommended physician times of 5 minutes pre-service, 20 minutes intra-service—an increase of 5 minutes over existing—and 5 minutes post-service. This code is typically reported with an office Evaluation and Management (E/M) visit but there is no physician overlap with the work performed. However, CMS disagrees, citing language from the pre- and post-work descriptions. As a result, CMS removed the 5 minutes of pre-time and 5 minutes of post-time and utilized a reverse building block methodology to calculate its proposed RVU of 0.54 for CPT code 76881. It stated that this value also maintains the current IWPUT, as there was no discussion to support a change in intensity.

CPT code 76881 describes a limited evaluation of a joint or a focal evaluation of a structure(s) in an extremity other than a joint. The RUC recommended physician times of 5 minutes pre-service, 15 minutes intra-service—an increase of 4 minutes over existing—and 5 minutes of post-service. While CMS agrees that the additional 4 minutes of intra-service time is appropriate, it stated that there was no information to support (or explain) a change in intensity. Therefore, CMS applied a reverse building-block methodology to account for the 4 minutes of increased intra-service time while maintaining the current IWPUT. This resulted in a proposal of 0.59 RVU for CPT code 76882.

CPT code 76XX0 describes real-time, complete neuromuscular ultrasound of nerves and accompanying structures through their anatomic course, per extremity. The RUC recommended physician times of 7 minutes pre-service, 25 minutes intra-service—and 7 minutes of post-service and indicated that this service is not performed with an office E/M visit. The RUC valued 76XX0 based on comparisons to CPT code 76881, for which CMS is proposing to remove pre- and post-time. Therefore, CMS is proposing a value of 0.99 RVU for CPT code 76XX0 based on a reverse building block methodology using it proposed 0 pre-service, 20 intra-service, and 0 post-service minutes for 76881 as a comparison.

For practice expense, CMS is proposing to remove 2 minutes of clinical labor time from CA006 (*Confirm availability of prior images*), 1 minute from CA007 (*Review patient clinical extant information and questionnaire*), and 2 minutes from CA011 (*Provide education/obtain consent*) for CPT code 76881 due to the overlap with the E/M visit. No changes were proposed to the PE inputs for CPT codes 76882 and 76XX0.

ACR Perspective and Comments

The ACR strongly disagrees with CMS's refinement of this code family and the reverse building block methodology employed to do so. We believe that the newly proposed values create a rank order issue between the 76881 (US, complete joint), at 0.54 RVU and 76882 (US, limited joint), at 0.59 RVU, where the complete procedure is valued less than the limited procedure.

For CPT code 76881, the RUC discussed the change in intra-service time and intensity related partially to the change to rheumatologists performing the scanning of the current patient population. Ultrasound technology has evolved immensely since the code was valued in 2010, including proliferation of high-frequency ultrasound probes dedicated to musculoskeletal imaging, with the ability to produce images with higher fidelity and more detail. The complete ultrasound code is increasingly used to evaluate for a greater range of complex musculoskeletal injuries and has replaced MRIs as the first line investigation for many pathologies. Further, ultrasound can be used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work intensity. For the typical patient with gradual onset, activity limiting ankle pain requires a detailed examination in order to provide optimal patient care.

Similar to the complete ultrasound code, ultrasound technology has evolved immensely since the limited joint code, 76882, was last valued in 2010, including proliferation of high-frequency ultrasound probes dedicated to musculoskeletal imaging, with the ability to produce images with higher fidelity and more detail. For the typical patient, the limited joint ultrasound code is used to evaluate patients with acute injury and triage for urgent surgical intervention or conservative physical therapy. The improved level of detail by current ultrasound technology allows for physicians to perform this work with ultrasound rather than advanced imaging to optimize patient outcomes, but results in an overall increased intensity based on the number and quality of images to obtain and review for medical decision making. The ACR believes that CMS's flawed intensity argument relies on anchoring to incorrect IWP/UT values established based on previous assumptions and ignores the rigorous values obtained from physician survey data and approved by accepted RUC methodology.

While the RUC discussed that this code is reported with an office E/M visit 58.9% and a non-facility office E/M visit 66.3% of the time, the code is imaging-specific so the physician work described would not overlap with the E/M service. In the typical rheumatology office, the physician performing the imaging will typically not be the same physician providing the E/M service. We have demonstrated that the ultrasound service is a separate and identifiable visit from the E/M visit, thus the rendering physician still require time to review for prior imaging for comparison, review patient clinical information and provide consent and patient education. The technical skill required to review, interpret, and provide conclusive findings for ultrasound images are beyond the technical skill related to management decisions related to the E/M visit. Therefore, the history and pertinent clinical information must be reviewed, in addition to any prior applicable imaging studies, in order to optimize the examination. Similarly, because it is an imaging code, the post-service time is required because the physician must still perform the following: dictate, discuss, and explain findings of the examination to the patient as needed, separate from the E/M encounter, review and sign an imaging specific final report for the medical record, and communicate findings to referring clinician, as needed. An accurate comparison is important in assessing disease severity activity and changes to therapeutic interventions made since the previous ultrasound. Then the report must be dictated (or typed) and made available in the patient's chart.

We respectfully request that CMS reconsider the RUC-recommended values of 0.90 RVU for 76881, 0.69 RVU for 76882, and 1.21 RVU for 76XX0.

The ACR also disagrees with the removal of minutes from clinical labor activities, CA006 (*Confirm availability of prior images*), CA007 (*Review patient clinical extant information and questionnaire*), CA011 (*Provide education/obtain consent*) for CPT code 76881. Reviewing the clinical history is done specifically for things that pertain to the exam (does the patient have contraindications, any reason to do a different study instead) which is different work than reviewing the history for an office visit in general. The same logic applies with regard to pulling prior images and getting consent. **The ACR believes that the minutes approved by the RUC for CA006, CA007, and CA011 are appropriate and should not be removed, as they are not duplicative of work performed during the general E/M visit.**

Rebasing and Revising the Medicare Economic Index (MEI)

Proposal

CMS proposes to rebase and revise the Medicare Economic Index (MEI) to reflect more current market conditions and the prices of resources used in medical practices through the use of publicly available data for input costs. The MEI is a fixed-weight input price index that measures changes in the prices of inputs used in provide medical services including, for example, labor (physician and non-physician), office space, utilities, supplies, and professional liability insurance.

The current MEI weights are based on 2006 costs using data obtained from the AMA’s PPIS that was conducted in 2007/2008. CMS proposes to update the MEI cost weights using annual expense data collected from the 2017 U.S. Census Bureau’s Services Annual Survey (SAS). It proposes, however, to delay the implementation of the proposed rebased and revised MEI cost weights for both PFS rate setting and the proposed GPCIs given its potential significant redistributive impacts.¹ The proposed 2017-based MEI cost weights would significantly shift payment allocation away from physician work and malpractice to practice expense. For example, the practice expense weight increased by 6.5 percentage points from 44.8% to 51.3%.

	2006 Based Weights (Current)	2017-Based Weights (Proposed)
Physician Work	50.9%	47.3%
Practice Expense	44.8%	51.3%
Professional Liability Insurance	4.3%	1.4%

In the proposed rule, CMS illustrates specialty-specific impacts if CMS were to use the proposed rebased and revised MEI cost share weights to adjust the RVUs for 2023. Overall, the reduction in the physician work weight would result in a dramatic decrease of the PFS conversion factor

¹ The PE GPCI relies on updated data for four categories of practice expense: employee wages; purchased services; office rent; and equipment, supplies, and other miscellaneous expenses.

(CF) of 6.5% in order to keep the work RVUs at the same level. The PE RVUs, however, would increase and the MP RVUs would decrease, commensurate with the changes in the proposed 2017-based cost weights.

ACR Perspective and Comments

At the specialty level, the shift in payment weights from physician work to practice expense would also be dramatic and favor specialties with higher PE costs such as Diagnostic Testing Facility (+13%), Portable X-Ray Supplier (+13%), Independent Laboratory (+10%) and Radiation Therapy Centers (+6%) whereas specialties with higher physician costs such as Cardiothoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%) and Anesthesiology (-5%) would experience negative shifts. Radiology would experience a decrease of -2% based on its mix of services as any increases from PE RVUs was offset by the decrease in the MPFS CF. Given other policy changes impacting the MPFS CF and the calculation of RVUs, the ACR is very concerned, when the MEI cost weights are updated, about the potential impact and ability of radiology practices to absorb such reductions in the CF and shifts in RVUs for its codes. We would urge CMS that any such changes, when implemented, be transitioned over multiple years consistent with other major policy changes, such as the update of clinical labor inputs, to maintain stability and predictability in its payments.

The ACR also agrees with CMS that the data currently utilized for the MEI is outdated and needs to be updated. We have significant overall concerns, however, with CMS's proposal to use the 2017 SAS data to update the MEI. First, there is limited information on the number and type of practices that were sampled from the SAS survey based on what CMS provided in the proposed rule and our review of the U.S Census documentation on the SAS survey available on its website. Thus, we were unable to assess whether the physician practices that the SAS surveyed for its purposes is appropriate for use in determining the MEI cost share weights for the MPFS. Second, the SAS source of data was not designed for this purpose and is not precise enough to capture the types of costs specific to the MPFS. CMS's approach relies on the use of supplemental data sources for key aspects of the cost share weights. This could introduce measurement error based on the use of proxy measures instead of specific data from the SAS survey; this potential error is amplified each time such an approach is used to develop an estimate for a MEI cost category and when this result is subsequently used in other calculations to determine the aggregate MEI cost-based weights. In addition, we are concerned that the SAS data is not sufficiently detailed and lacks specificity related to how physicians are compensated and lacks sufficient detail to exclude separately billable supplies and drugs. Third, CMS does not provide any analyses that show how robust its estimates are to changes in key assumptions and its potential impact on the estimated 2017 based MEI cost weights. As a result of these concerns, we believe it is difficult to discern whether changes in the MEI cost-share weights reflect "true" changes in the price of inputs used in providing medical services or whether they are simply changes based on a different source of data and methodological approach than was previously used.

The ACR recognizes the urgent need to update the MEI cost share weights to better reflect the current cost structures of medical practices. We believe, however, that CMS's proposed

approach to use the SAS survey data and the use of supplemental data to calculate cost weights will not provide sufficiently reliable results to update the MEI weights given its design and intended purpose. Overall, the ACR favors an approach that uses survey data collected for the specific purpose of collecting practice expense data by specialty and can be aggregated into physician work, practice expense, and professional liability components for purposes of updating the cost share weights needed for the MEI. These same data can then also be used to update the PE component of the GPCI, as appropriate.

The ACR recommends that CMS collaborate with national medical societies and other health care professional organizations to ensure that data collection efforts are successful and represent the cost structures that are unique to each specialty. **For these reasons, the ACR urges CMS to not finalize its proposal and postpone any updates to the MEI weights using other practice cost data until new survey data is available for consideration and review, particularly given the significant redistributive impacts of rebasing and revising the MEI.**

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

Proposal

CMS acknowledges that existing statute and regulations for colorectal cancer (CRC) screening expressly give the Secretary authority to add other tests and procedures for colorectal cancer screening “based on consultation with appropriate organizations”. CMS proposes to expand coverage of colorectal cancer screening in accordance with the 2021 United States Preventive Services Task Force (USPSTF) recommendations. These recommendations lowered the screening starting age from 50 to 45 years. CMS also proposes to expand the definition of screening to include a follow-on screening colonoscopy after a positive result on a non-invasive stool-based CRC screening test. If finalized, this means that the colonoscopy is paid at 100% without patient cost sharing. CMS states these proposals reflect its desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services.

ACR Perspective and Comments

The ACR supports CMS’s proposal to lower the screening age from 50 to 45 years. The ACR also supports the proposal to expand the definition of screening to include a follow-on screening colonoscopy after a positive result on a non-invasive stool-based CRC screening test.

The ACR is concerned with the continued lack of coverage of USPSTF-approved Computed Tomography Colonography (CTC) for screening Medicare patients for colorectal cancer and requests that the Secretary use his authority to expand colorectal cancer screening coverage to include CTC. Despite ample evidence presented to CMS in several coverage requests over the past 14 years, including peer reviewed literature specific to the Medicare-age group population, CTC remains the only USPSTF and American Cancer Society (ACS) recommended test to not be covered by Medicare for primary screening. As the Affordable Care Act requires private insurers to cover all USPSTF-approved screening services without patient cost-sharing, patients lose access to this screening option once they become

Medicare age. Inconsistent with CMS’s desire to expand access to early detection services for CRC, the Agency continues to not provide coverage for this important screening examination.

CTC is a minimally invasive, direct visualization test, which, as indicated by both the prior and recent USPSTF review, has a high sensitivity for precursor polyp detection. Polyp identification and subsequent removal provide an opportunity for the “prevention” of cancers as compared to the stool-based test options which have a lower sensitivity for detection of precursor polyps and are primarily effective in cancer detection. The March 2022 report from the Medicare Payment Advisory Commission report to Congress identified colorectal cancer as one of the most expensive conditions to treat per Medicare beneficiary. Offering another screening option that can prevent the development of colorectal cancer should lower these treatment costs. This is a significant cost savings that is not realized with the stool-based tests.

The ACR strongly urges CMS to extend national coverage of CTC for colorectal cancer screening to Medicare beneficiaries. CTC is an untapped resource that will be beneficial to broadening screening options and mitigating access issues of Medicare beneficiaries. There is a continued and significant increase in the size of the Medicare population and only a limited number of specialists performing optical colonoscopy who also now need to cover the procedure in an expanded pool of patients starting at age 45. CTC provides a proven safe and minimally invasive exam to both screen for precursor polyps and CRC and save lives. It has an ideal profile for a safe screening structural examination of the colon. The College urges CMS to provide coverage for CTC for all Medicare candidates and to help bridge the gap in reaching the ACS’ “80% In Every Community!” campaign. As emphasized by the ACS, all qualified screening test options are needed to raise screening rates, and offering more choices increases the overall likelihood of screening, which continues to be at a plateau and has been negatively affected due to COVID-19 as identified by the President’s Cancer Panel².

The Administration has shown great interest in healthcare discrimination as evidenced by the recent proposed rule on Nondiscrimination in Health Programs and Activities as well as President Biden’s Cancer Moonshot initiative that specifically includes a call to action on cancer screening. As a Mobilization Team member of the Radiology Health Equity Coalition (RHEC), the ACR is also committed to addressing health disparities. Expanding access to CTC screening is a necessary step in achieving these goals. CTC provides a test with well-documented strength of evidence that overcomes multiple logistical and cultural hurdles in the elderly and underserved population to ensure equity in prevention or the early detection of colon cancer. Medicare patients deserve the same options afforded to the commercially insured population. They deserve the right to exercise choice in selecting their appropriate screening test with options that include CTC.

² <https://prescancerpanel.cancer.gov/report/cancerscreening/>

Payment for Medicare Telehealth Services

Proposal

For CY 2023, CMS is proposing a number of policies related to Medicare telehealth services including making several services that are temporarily available as telehealth services for the public health emergency (PHE) available through CY 2023 on a Category III basis. This will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list. CMS is proposing to implement the telehealth provisions in the Consolidated Appropriations Act (CAA), 2022 via program instruction or other subregulatory guidance. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends. This will allow telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services.

CMS is seeking comments regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services. CMS recognizes that it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety.

ACR Perspective and Comments

The ACR recognizes the value of telehealth services, particularly in rural areas, and the extent to which they have been utilized during the PHE. The ACR supports CMS's efforts to protect patient safety. **The ACR proposes that CMS make permanent the rule that permits the virtual direct supervision of Level 2 tests via real-time audio/video communications technology (set to expire on December 31 of the year when the PHE ends) by physicians and those non-physician practitioners (NPPs) whose state law and scope of practice permit them to supervise diagnostic tests.** Additionally, the ACR asks that CMS require secondary non-physician licensed practitioners (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).

Medicare Shared Savings Program (MSSP)

Proposal

Through the proposed changes in this rule, CMS seeks to reverse certain recent trends in the MSSP. In recent years, growth in the number of beneficiaries assigned to accountable care organizations (ACOs) has plateaued; higher spending populations are increasingly underrepresented in the program since the change to regionally-adjusted benchmarks; and access to ACOs appears inequitable as shown by data indicating that Black (or African American), Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native beneficiaries are less likely to be assigned to a Shared Savings Program ACO than their Non-Hispanic White counterparts.

CMS aims to increase participation in accountable care arrangements. Within the proposed rule, CMS has various proposals and request for comments related to these proposals.

ACR Perspective and Comments

The ACR supports CMS’s focus on health equity within the MSSP. **The ACR continues to have concerns for the ability of radiologists to meaningfully participate in ACOs and other CMS quality programs.** Radiologists are not well represented in the MSSP, except for in large multispecialty practices. The ACR looks forward to continuing to work with CMS on the future of radiologists’ participation in MSSP.

The ACR is committed to working with CMS and other stakeholders to promote health equity. The ACR is a member of the Radiology Health Equity Coalition³ whose mission is to positively impact health care equity in the radiology field and beyond. The Coalition aims to address the systemic challenges in the practice of radiological care to reduce existing inequities for historically medically underserved communities. The Coalition will collect, assess, and disseminate resources and best practices, advocate for and connect with patients and community members, and collaborate on programs and services to improve access and utilization of preventative and diagnostic imaging. Well-known disparities in access to screening and high-value imaging care for uninsured and marginalized populations must be improved. The Coalition is taking on this challenge by developing the gaps analysis and data at the community level while empowering radiologists in those communities to partner locally to make transformational change.

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.

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information

Proposal

The CMS RFI *Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs* builds off the RFI included in the CY 2023 proposed rule, which introduced the transition of CMS quality reporting and value-based purchasing programs to digital quality measurement (dQM). CMS requests feedback on suggested implementation guides, approaches to optimize data flows for quality

³ <https://www.radhealthequity.org/>

measurement to retrieve data from electronic health records via FHIR Application Programming Interfaces (APIs), and data aggregation methods.

ACR Perspective and Comments

The ACR remains attentive to CMS's adoption of FHIR for reducing the collection and analysis burden imposed by current electronic clinical quality measures (eCQMs). We appreciate CMS's plan to learn through doing, relating to the transition of eCQM to dQM specifications and how alternate measure specification formats (e.g., claims, registry) might follow the process. The ACR recognizes the superior data functionality available once transitioned to dQM. **However, we urge CMS to consider the frequency with which quality measures in MIPS are removed and added and how this affects standardized elements in FHIR.** Standardizing data elements is a slow process because it provides a consistent specification for all users; this runs counter to the speed with which measures are added and removed in MIPS since research takes time and is required to standardize new data elements. At its core, FHIR aims to provide a consistent specification while measures generate continuously changing targets.

Transforming MIPS: MVP Strategy

Proposal

CMS proposes a plan to monitor MVP participation beginning in the 2023 performance year and emphasizes MVPs' influence on practices transitioning to alternative payment models (APMs), in addition to proposing to collect public input on candidate and established MVPs during a 30-day comment period separate from the MVP-rulemaking process. For candidate MVPs, CMS would collect public feedback and potentially revise MVPs before subjecting them to rulemaking. CMS would also solicit public comments on established MVPs during the MVP maintenance period. Should input from the 30-day comment period be appropriate to revise an MVP, CMS would host public listening sessions so that it may learn the public's opinion on the potential changes before proposing an updated MVP during rulemaking.

ACR Perspective and Comments

The ACR appreciates that a deadline is not proposed for sunseting traditional MIPS and is encouraged that CMS intends to ascertain reporting characteristics beginning with 2023 MVP participation. Given the absence of applicable radiologic episode-based cost and population health measures and radiologists' difficulty meeting the full set of Promoting Interoperability (PI) measures, MVP developers face barriers in drafting radiology-specific MVPs. Further, radiologists would also experience difficulty participating in MVPs that include appropriate quality measures and improvement activities but lack cost, population health, and PI measures. **The ACR urges that traditional MIPS not be sunset until a time when all clinicians who qualify as MIPS eligible clinicians are capable of participating in at least one MVP.**

Since the start of MIPS and even more so with the introduction of MVPs, CMS has conveyed the intention of MIPS to serve as an onramp for APM participation. **The ACR requests clarity on**

CMS’s plan to enable the shift from MIPS to APMs because APMs are most relevant to primary care physicians, and options for radiologists to participate in APMs are limited.

The ACR appreciates CMS's proposal to provide greater stakeholder engagement in MVP development and maintenance through the proposed comment periods separate from the rulemaking process. **However, we strongly urge that CMS extend the proposed comment periods to 60 days paralleling the notice-and-comment rulemaking process. This timeframe presents the opportunity for considering revisions as early in the year as possible. Further, when CMS considers comments appropriate for it to update MVPs (candidate or established), CMS should consult with the MVP developers before making revisions and submitting the updated versions into rulemaking.** There may be reasons why comments from the public that CMS considers relevant for improving an MVP may have been determined inappropriate by the developers. This collaboration between CMS and MVP developers could prevent future problems with revised MVPs.

MIPS Performance Threshold and Incentive Payments

Proposal

CMS proposes to maintain the 2023 MIPS performance threshold at 75 points, which is the same as the current 2022 performance threshold.

ACR Perspective and Comments

The ACR supports CMS’s proposal to retain the 2023 performance threshold. However, we are concerned that the 2019, 2020 and 2021 performance year extreme and uncontrollable circumstances (EUC) exemptions affect CMS’s ability to calculate a performance threshold accurately. We request that CMS take action to lessen the impact of this high-performance threshold. Over the past two years, many clinicians who found themselves at risk of falling below the neutral threshold opted for non-participation, meaning that MIPS performance data from these periods are likely unreliable for calculating future thresholds. In tandem with rising performance thresholds, the removal of quality measure bonus points, and the increasing number of quality measures capped at 7 points or removed from the program, it will become more difficult for many clinicians to achieve a neutral adjustment even when performing well on quality measures. In 2023, clinicians will be held to a standard based on 2017 performance data, even though in 2017, a high MIPS score was significantly more attainable.

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. Right now, a “non-patient facing” clinician who isn’t attributed cost measures will have their quality score weighted at 85%, with improvement activities remaining at 15%. With many measures being capped at seven points, it may be impossible to meet the neutral threshold even with perfect performance on six topped out quality

measures. Distributing some of those quality points into the improvement activities category would greatly ameliorate this issue (e.g., 70% for quality and 30% for improvement activities).

We are also curious whether CMS can subtract certain transitional policies such as high priority measure bonus points and the three-point scoring floor when calculating a performance period mean or median. If the current benchmark is based on performance from a year when many of these policies were implemented to boost clinicians' scores, it is unrealistic for clinicians to meet that same standard after removing those policies.

MIPS Measures Proposed for Addition

Proposal

CMS proposes to add the new measure, *Screening for Social Drivers of Health*, to the Diagnostic Radiology and Radiation Oncology measure sets.

ACR Perspective and Comments

As previously noted, the ACR, a convener and founding member of the RHEC, is committed to working with CMS and other stakeholders to promote health equity and 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, we caution CMS against finalizing the proposed Screening for Social Drivers of Health quality measure for the 2023 MIPS performance year. While we appreciate the urgency of including a measure addressing health equity, we are concerned that prematurely adding measures to MIPS on this topic could interfere with progress on improving disparities. We are concerned that clinicians might become hyper-focused on asking patients about their social needs/social determinants of health (SDOH) without addressing them, leaving patients to "navigate to nowhere," worsening this problem. The ACR suggests coordinated efforts across the health care ecosystem for addressing SDOH interventions as an important factor.

The ACR is also concerned with the measure's design, given the limited specification and missing testing information cited in the proposed rule. We lack the means to confirm whether this measure produces reliable and valid results. We are troubled by the lack of alignment of the measure for MIPS compared to those proposed for the Hospital Inpatient Quality Reporting Program. For example, in the Inpatient Prospective Payment System's proposed rule, the Screening for Social Drivers of Health measure numerator allows hospitals to screen patients on "one or all" of the measure's five factors. There is a risk when comparing hospitals that screen one health-related social need to those that focus on all five. Further, this proposed measure does not provide this level of detail. It is inconsistent with previous statements regarding the need to ensure consistency in specifications of related measures across CMS quality programs.

Quality Measure Data Completeness

Proposal

CMS proposes to maintain the quality measure data completeness requirement at 70% for 2023 but has signaled their intention to raise this to 75% beginning with the 2024 performance year.

ACR Perspective and Comments

The ACR appreciates CMS's proposal to retain the 2023 data completeness threshold. We also consider 75% to be a reasonable increase beginning in 2024. However, we request that CMS commit to maintaining this threshold for 2025. While most radiologists meet 100% data completeness for most measures, we perceive that increasing this threshold too quickly will create an undue burden, especially regarding new measure adoption. The ACR has observed that many groups and individuals experience difficulty meeting 100% data completeness when beginning to report new measures. This difficulty is due to issues with capturing the correct data elements. Maintaining data completeness requirements at a high but attainable level (such as 70% or 75%) will encourage the continued adoption of new measures without penalizing those unable to report 100% of relevant cases.

Cost Performance Category

Proposal

CMS proposes to add the Medicare Spending Per Beneficiary (MSPB) clinician measure as a care episode group.

ACR Perspective and Comments

The ACR requests clarification as to whether the case minimum for MSPB would change if it were transitioned to a care episode group. If the case minimum for MSPB attribution is lowered from 35 to 20, we perceive an imposed burden for clinicians to whom this measure is not typically attributed. Should the case minimum remain at 35, in line with the current methodology for attributing the MSPB measure, then the ACR would not oppose including this measure as a care episode group.

Qualified Clinical Data Registry (QCDR) Measure Testing Requirements

Proposal

CMS proposes to delay the QCDR measure testing requirement for traditional MIPS until the 2024 performance period.

ACR Perspective and Comments

The ACR supports this proposal, and also requests that CMS similarly delay the requirement that QCDR measures be fully tested prior to their inclusion in an MVP. This would simplify the program's rules by maintaining consistency between traditional MIPS and MVPs. It would also provide an opportunity for more specialty-specific measures to be included in MVPs, which is critical for moving towards subgroup reporting.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2023 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 Kathryn Keysor at kkeysor@acr.org.

Respectfully Submitted,



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