August 27, 2024

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

RE: CMS-1807-P, Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Ms. Brooke-LaSure,

The American Society of Neuroradiology (ASNR) represents over 5,000 physicians specializing in the field of Neuroradiology. As the preeminent society concerned with diagnostic imaging and image-guided intervention of diseases of the brain, spine, and head and neck, we appreciate the opportunity to comment on the Medicare Program; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments.

In this comment letter, we address the following:

- Payment Provisions
    - Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025
    - Adjusting Relative Value Units (RVUs) to Match the Practice Expense (PE) Share of the Medicare Economic Index (MEI)
    - Potentially Misvalued Services Under the PFS
    - Development of Strategies for Updates to Practice Expense Data Collection and Methodology
    - Valuation of Specific Codes for CY 2025
    - Professional component (PC)/Technical component (TC) Indicator for Medical Physics Dose Evaluation

- Quality Payment Program (QPP)
    - Updates to the QPP

- CY 2025 Merit Based Incentive Payment System (MIPS) Value Pathway (MVP) Development and Maintenance
- Quality Measures Proposed for Addition
- Quality Data Completeness Requirements
- Cost Performance Category
- Improvement Activities Performance Category

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

Proposals

In the March 31, 2020, COVID-19 interim final rule, CMS changed the definition of "direct supervision" during the public health emergency (PHE) for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended the virtual supervision flexibility through rulemaking. CMS acknowledges the utilization of this flexibility and recognizes that many practitioners have stressed the importance of maintaining it, however CMS continues to seek additional information regarding potential patient safety and quality of care concerns. CMS notes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services, such as incident-to services. CMS also recognizes that physicians and/or other supervising practitioners, would need time to reorganize their practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology. CMS is extending this flexibility for all services on a temporary basis only. CMS is proposing to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.

ASNR Perspective and Comments

The ASNR is supportive of CMS's decision to extend this flexibility through 2025. This flexibility helps rural or underserved populations who may experience access to care issues. CMS should further consider making this permanent after the collection of more data regarding the safety of this type of practice.

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

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

However, CMS is proposing to delay implementation of the rebased and revised MEI due to stakeholder concerns about the redistributive impacts. CMS is also aware of the American Medical Association's (AMA) current data collection process through the Physician Practice Information Survey (PPIS).

ASNR Perspective and Comments
The ASNR is in support of CMS's decision to delay implementation of the 2017-based MEI in CY 2025. This is due to the AMA currently surveying practices and CMS should have time to review this data to help make an informed decision regarding possible changes from the MEI adjustments.

Potentially Misvalued Services Under the PFS

Proposals
CPT code 27279, *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* is up for nomination for the second year. The nominator is requesting non-facility inputs be established as this code is currently only valued in the facility setting. The nominator offered rationale that the addition of non-facility inputs would allow greater access to patients as this reimbursement would hopefully encourage more providers to perform these procedures in the office.

ASNR Perspective and Comments
The ASNR agrees that the procedure described by CPT code 27279 may be safely performed in the office or non-facility setting. Therefore direct PE inputs should be obtained to help increase patient access to care for this service.

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

Proposals
In the CY 2023 and CY 2024 MPFS, CMS asked for stakeholder thoughts and feedback on ways to update the PE methodology and inputs that could be repeatable and account for the changes in the health care landscape. The current PE methodology utilizes data from the AMA's 2007/2008 Physician Practice Information Survey (PPIS). The AMA is in the process of collecting updated PPIS data, and many comments have asked CMS to hold off on making any changes to the PE

methodology until the new data is available. The AMA expects their analysis to be complete by the end of CY 2024.

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

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

ASNR Perspective and Comments

The ASNR does not believe there was bias introduced when the AMA sent the PPIS survey out. Simply asking groups that receive the survey to make sure they fill out in order to get enough data is not misleading and necessary to do in order to maximize data collection in order to understand of current practices and their expenses.

Valuation of Specific Codes for CY 2025

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

Proposals

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

ASNR Perspective and Comments

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

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

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

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

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

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

ASNR Perspective and Comments
The ASNR does not agree with all the PE refinements.

- **Refinement of CA034 *(Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.))* from 2 minutes to 1 minutes for CPT codes 7XX00, 7XX01, 7XX02, 7XX04, and 7XX05**
  The ASNR disagrees with this refinement. 2 minutes is necessary given the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam. Proper documentation of this information for a patient will avoid the need to re-do this for future MRI studies if the implant is the same. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance

of the MR procedure and needs less time to complete documentation at completion of the procedure.

- **Refinement of CA021 activity *(Perform procedure/service---NOT directly related to physician work time)* from 27 minutes to 14 minutes for CPT code 7XX01. This would result in a reduction to the equipment time for the Technologist PACS workstation (ED050) from 45 minutes to 32 minutes.**
  The ASNR disagrees with CMS's proposed reduction of CA021 time—and the resulting decrease in ED050 time—for CPT 7XX01. The typical work for 7XX01 will be when an implant has no information readily available. We believe there is significantly more work for the technologist in 7XX01 compared to 7XX00 because the technologist may have to make multiple calls to patients, treating and previously treating physicians to obtain as much detail as possible regarding the implant. Information such as date of insertion, location, component model numbers, etc., and if there have been subsequent revision surgeries to the original implant. Typically for 7XX00 code, the information will likely already be in the medical chart or the patient will have the information readily available.
- **Refinement of ED053 *(Professional PACS Workstation)* from 13 minutes to 0 minutes for CPT code 7XX03 in the Facility**
  The ASNR agrees that there should not be any facility inputs for CPT code 7XX03, including time for ED053.
- **Refinement of CA024 (*Clean room/equipment by clinical staff*) from 2 minutes to 1 minute for CPT codes 7XX04 and 7XX05, also resulting in a reduction in time for EL008 *(room, MR)* and EQ412 *(Vitals monitoring systems (MR Conditional))*.**
  The ASNR agrees with the reduction in CA024 time from 2 minutes to 1 minute, resulting in a reduction to EL008 and EQ412 times for both codes.
- **Removal of supply item SL082 *(impression material, dental putty (per bite block))* from CPT code 7XX05**
  The ASNR disagrees with the removal of SL082 from the supplies for CPT code 7XX05. The impression putty is a component of the applied splint and compression bandage so that patient's can tolerate the exam and positioning. The putty is applied around the cochlear implant so that the splint pressure and compression bandage do not apply too much pressure in one area of the scalp. A typo in the PE SOR incorrectly listed SL042 instead of the correct supply code of SL082 for impression material.

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

Proposals

CMS proposed to accept the RUC-recommended PE inputs and work RVUs for all seven of the new or revised transcranial doppler studies codes: CPT code 93886 *(Transcranial Doppler study of the intracranial arteries; complete study)* at 0.90 RVUs, CPT code 93888 (*Transcranial Doppler study of the intracranial arteries; limited study)* at 0.73 RVUs, CPT code 93892 *(*T*ranscranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection)* at 1.15 RVUs, CPT code 93893 *(Transcranial Doppler study of the*

intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection) at 1.15 RVUs, CPT code 93X94 *(Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete)* at 0.81 RVUs, CPT code 93X95 *(Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)* at 0.73 RVUs, and CPT code 93X96 *(Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)* at 0.85 RVUs. CPT code 93890 *(Transcranial Doppler study of the intracranial arteries; vasoreactivity study)* will be deleted.

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

ASNR Perspective and Comments

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

QUALITY PAYMENT PROGRAM

Updates to the Quality Payment Program (QPP)

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

Building upon the MVPs Framework to Improve Ambulatory Specialty Care RFI

Proposals

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

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

ASNR Perspective and Comments
The ASNR is in favor of CMS exploring MVP-based Ambulatory Specialty Care payment model and trying to further integrate a platform of specialty care with improved coordination and collaboration between primary and specialty care physicians. CMS however proposes that participation in this ambulatory specialty model be mandatory for relevant specialty care providers where and when there are applicable MVPs implemented in the model. The ASNR disagrees with this mandatory participation. CMS should first test this in a smaller cohort to study the financial impact.

Transforming the Quality Payment Program RFI

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

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

ASNR Perspective and Comments

We appreciate that the proposed rule *Transforming the Quality Payment Program RFI* is a step in the right direction. However, given that radiology has become very subspecialized we are uncertain about MIPS-eligible radiologists' future engagement in MVPs. Radiologists who practice 100% of the time within their own subspecialty such as neuroradiology may not be able to report measures outside of the subspeciality such as in the category of breast imaging.

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

ASNR Perspective and Comments
Non-patient-facing clinicians such as neuroradiologists do not have significant input on MVPs under the current framework (i.e., nonmeaningful cost measures, limited quality measures, and minimal control over EHR systems, preventing reporting Promoting Interoperability measures). Therefore, it would be best if CMS could provide more details on how radiologists would fit into the MVP equation.

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

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

ASNR Perspective and Comments
ASNR believes that there should be thorough consideration for non-patient facing specialties and how they will appropriately integrate into this proposal.

Proposals

Develop MVPs for Non-Patient-Facing MIPS Eligible Clinicians: CMS notes that measurement gaps for some non-patient-facing MIPS-eligible clinicians, like diagnostic radiologists and pathologists, present challenges in developing a respective MVP. CMS is interested in exploring alternative measures and activities that would allow it to measure the performance of non-patient-facing MIPS-eligible clinicians. CMS also requests input on addressing measure gaps and making MVPs more widely available. CMS is researching the flexibilities included in the Act to develop new MVPs for non-patient-facing MIPS-eligible clinicians. However, the proposed rule emphasizes that flexibilities explored must support CMS's overall MIPS goals; reweighting a performance category would not support performance measurement to drive value or provide comparable information for patients selecting clinicians or care teams.

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

ASNR Perspective and Comments

The ASNR is fully in favor of CMS's efforts to understand the practice of radiology, its limitations in participating in the current MVP framework, and its efforts to examine the MACRA legislation for flexibilities that would enable the development of meaningful and applicable MVPs for non-patient-facing eligible clinicians.

CY 2025 MVP Development and Maintenance

Proposals

CMS states that its intended goal is to offer MVPs for all specialties and subspecialties during the full MVP transition. However, this proposed rule acknowledges that CMS's portfolio of quality and cost measures is not applicable for all specialties and subspecialties due to gaps in both measure types, including those for interventional and diagnostic radiology, noting that most radiologists are not captured under existing cost measures. Further, despite existing policies to reweight the cost performance category for individuals, groups, and subgroups of MIPS-eligible clinicians that cannot be scored on cost measures, CMS acknowledges that MVPs may not be developed for a specialty/subspecialty without at least one applicable cost measure (per the CY 2021 MPFS final rule). As such, CMS invites the submission of cost measures into the Annual Call for Measures for candidate quality and cost measures relevant to their specialty.

ASNR Perspective and Comments

While CMS has invited to submit cost measures to the Annual Call for Measures relevant to their specialty to fill the gap, this is currently not possible for neuroradiologists as it must apply to care episodes which is not practical, hindering submissions.

MVP Requirements and Scoring

Proposals

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

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

MIPS Category Weighting

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

ASNR Perspective and Comments
The ASNR supports this new reweighting policy.

MIPS Performance Threshold

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

ASNR Perspective and Comments
The ASNR supports this proposal.

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

ASNR Perspective and Comments
The ASNR supports this proposal to allow reweighting for specialties such as radiology because topped out, point-capped measures, can disproportionately affect overall scoring. In radiology

we also suffer from limited MIPS measures. While groups could achieve perfect points in a particular measure, they may still not reach neutral scoring.

Quality Data Completeness Requirements

Proposals

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

ASNR Perspective and Comments

The ASNR supports this proposal. This allows for accurate capture of measure performance without undue burden on practices that may struggle with capturing a higher percentage of accurate data.

Conclusion

The ASNR appreciates the opportunity to comment on this CMS Proposed Rule for the Physician Fee Schedule for CY 2024. Please feel free to contact us with any questions or comments. Rahul Bhala, MBA, MPH can be reached at rbhala@asnr.org.

Respectfully Submitted,

Max Wintermark, MD
President, 2024-2025
American Society of Neuroradiology

cc:
Melissa Chen MD, Chair, Health Policy and Economics Chair, RUC Alternate Advisor
Jacob Ormsby, MD, MBA,Vice Chair, Health Policy, RUC Advisor
Rahul Bhala, MBA, MPH, Public Affairs and Health Policy Strategy Officer
Mary Beth Hepp, MBA, Executive Director