January 17, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: The American College of Radiology's comment letter on the Centers for Medicare and Medicaid Services' draft Diagnostic Radiology MIPS Value Pathway

The American College of Radiology (ACR), representing over 40,000 radiologists, radiation oncologists, medical physicists, interventional radiologists, and nuclear medicine physicians, appreciates the Centers for Medicare and Medicaid Services' (CMS) collaboration with the ACR on MIPS participation and the development of the Diagnostic Radiology MVP. Since the introduction of the MVP framework, ACR leaders and staff have evaluated how it can address the unique challenges faced by diagnostic radiologists, particularly given the differences between patient-facing and non-patient-facing specialties and the barriers to traditional MIPS participation. In addition to the comments ACR provided CMS in October 2024, following our meeting with the MVP team, we welcome this opportunity to provide additional feedback on the draft Diagnostic Radiology MVP and offer recommendations to ensure its success.

Quality Performance Category

We greatly appreciate the work CMS has done to be inclusive of non-patient facing specialties like Diagnostic Radiology in MIPS and MVPs. However, ACR emphasizes the need for a broader range of MIPS Clinical Quality Measures (CQMs) and Qualified Clinical Data Registry (QCDR) measures to support diagnostic radiologists in successfully meeting Quality Performance category requirements, including measures scored up to 10 points. Diagnostic radiologists are highly subspecialized physicians. Using various modalities (e.g., CT, MRI, ultrasound, mammography, PET, radiography, and fluoroscopy), radiologists focus their expertise to interpret images in multiple different fields, such as breast and abdominal imaging, neurological, pediatric, musculoskeletal, genitourinary, cardiothoracic radiology, and nuclear medicine among others. In addition, radiology practices vary by type of facility (i.e., large academic institution, community-based practice, private practice, etc.), geographic location (i.e., urban, suburban, exurban, and rural), and setting (inpatient vs. outpatient). As such, no two diagnostic radiology practices are alike. For instance, one breast imaging practice may be integral to a comprehensive cancer center, another may cover a regional hospital system with numerous sites, and a third may serve a broad, widely dispersed rural area. Given this variation, the current draft MVP does not provide enough CQMs applicable or feasible for a substantial number of diagnostic radiology practices.

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While we support CMS' inclusion of QCDR measures in the draft MVP, the limited scope of these measures presents challenges. Many radiology practices rely heavily on QCDRs for successful MIPS participation. As we communicated in our comment letter to CMS' MVP team in October 2024, the restricted list of QCDR measures contained in the draft MVP would disrupt practices' workflows, impose additional burdens on human and cost resources, and exacerbate clinician stress and burnout, especially given the national radiologist shortage and increasing imaging volumes. While ACR previously requested additional QCDR measures to address these issues in the prior comments, we are narrowing our request and focusing our recommendations on the QCDR measures listed below in Table 1 for the draft MVP.

Table 1.

Measure ID	Measure Title	Rationale
ACRad 37	Interpretation of CT Pulmonary Angiography (CTPA) for Pulmonary Embolism	ACR recommends the inclusion of measures supporting radiologist-focused communication and care coordination. This measure ensures treating physicians have the most complete information possible to determine their patients' most appropriate treatment plan.
MSN 13	Screening Coronary Calcium Scoring for Cardiovascular Risk Assessment Including Coronary Artery Calcification Regional Distribution Scoring	ACR recommends the inclusion of this measure, which addresses the risk of clinically significant heart disease, the leading cause of death in the United States.
MSN 15	Use of Thyroid Imaging Reporting & Data System (TI-RADS) in Final Report to Stratify Thyroid Nodule Risk	ACR recommends the inclusion of this measure, which complements MIPS Quality Measure #406. MSN 15 is based on the use of evidence-based criteria to risk stratify thyroid nodules and recommend the appropriate follow-up, when necessary, in contrast to MIPS #406, which focuses on limiting the inappropriate follow-up of likely benign nodules.
QMM 19	DEXA/DXA and Fracture Risk Assessment for Patients with Osteopenia	ACR recommends the inclusion of this measure, which informs the referring clinician of the patient's 10-year Fracture Risk (FRAX) and whether the patient meets the criteria for pharmacological intervention for osteoporosis, per published guidelines.

By incorporating these measures, CMS would allow more diagnostic radiologists who are eligible clinicians to participate in the MVP, address critical care gaps, minimize reporting burdens, and align with activities outlined in the Improvement Activity section of the draft MVP. CMS' expansion of the QCDR measure list would support a more comprehensive range of clinical scenarios, enabling radiology practices to align MVP participation with their unique community needs and ultimately improve patient care. CMS must recognize the heterogeneity of diagnostic radiology practices, even within subspecialties, and ensure MVPs reflect these diverse needs.

Improvement Activity (IA) Performance Category

Radiologists engage in many of the available IAs during the MIPS performance year. For instance, they play a vital role in care coordination and communication, directly influencing patient outcomes. As such, the ACR commends CMS for including IA_CC_7: *Regular training in care coordination* and IA_CC_19: *Tracking clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes*. We further support aligning MVPs with meaningful measures and activities. However, we question the value of the following IAs in the draft**.**

IA_ AHE_10: Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data, described as using security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8). Since the start of traditional MIPS, radiologists have received automatic reweighting of their Promoting Interoperability scores due to their non-patient-facing or hospital-based status. As such, diagnostic radiologists participating in this MVP would not be capable of performing this activity. **We request clarity on why CMS includes this activity in the MVP and respectfully request its removal, allowing a more suitable activity.**

IA_PCMH: Electronic submission of Patient-Centered Medical Home Accreditation addresses CMS' objective to obtain Patient-Centered Medical Home™ certification, which drives significant and sustainable practice improvements, including population care quality, efficiency, and improved patient satisfaction, all directly linked to better health outcomes. Diagnostic radiology practices do not qualify as Patient-Centered Medical Homes (PCMHs) due to their non-patient-facing status. While they play a significant role in continuous, patient-centered care that matches PCMH domains, their work does not align with the PCMH structure. For instance, diagnostic radiologists engage in *prevention* (e.g., through participating in cancer screening programs or recommending following up on actionable incidental imaging findings), *care management* (e.g., by tracking radiologists' AIF-associated recommendations and monitoring patients' completion of recommended follow-ups), and *care coordination* (e.g., by communicating with patients' and their referring or managing care clinicians). Unlike PCMHs, which provide ongoing general care and serve as central coordinators for a patient's overall health, radiology practices focus on specialized diagnostic imaging. Although diagnostic radiologists contribute to care coordination, they do not deliver the primary care services required by PCMHs, like those of NCQA or CMS.

Further, ACR is unclear whether advanced practitioners (e.g., nurse practitioners, or physician assistants) solely working in diagnostic radiology practices would be eligible to participate in this MVP. If these providers were eligible, they could be part of a PCMH. However, this is very unlikely because these clinicians do not provide primary care; instead, they provide radiologic services under the supervision of a diagnostic radiologist. **As such, we recommend CMS either remove this improvement activity from the MVP and replace it with an IA applicable to diagnostic radiology practices or apply a specialty-level exclusion for radiology practices, like that included in the Total Per Capita Cost measure, so those not routinely providing primary care are automatically removed from the activity's attribution.**

To support diagnostic radiologists' participation in the draft Diagnostic Radiology MVP IA Performance category, Table 2 is comprised of IAs from CMS' inventory that ACR believes are appropriate for demonstrating practices' efforts toward improving quality.

Table 2.

Activity ID	Activity Title	Rationale
IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements	As mentioned in the Quality Performance section of this letter, QCDRs are an essential tool for many diagnostic radiology practices participating in MIPS due to their expanding quality measure inventory intended to meet radiologists where they are. As such, clinical data registries serve as an incubator for high quality measures implemented by practices to support their participation in various practice improvement programs (e.g., Lung Cancer Screening, Breast Cancer Screening, etc.) and for testing measures before submitting them to CMS as CQMs or QCDR measures. Further, participation in clinical data registries allows practices to receive real-time feedback on their performance and immediately identify areas for improvement that directly link to the MVP quality measures during the current performance year. This improvement activity would be an incentive for practices to use meaningful measures.
IA_PSPA_2	Participation in MOC Part IV	CMS emphasizes that MVP participation supports clinician burden reduction and that strong linkages between MVP activities and measures must exist. By incorporating this IA into the Diagnostic Radiology Draft MVP, radiologists can engage in at least one Practice Quality Improvement (PQI) Project or PQI Activity. Such participation demonstrates radiologists' efforts to improve and maintain high-quality, patient-centered care through ongoing evaluation and enhancement of their practices. Decreasing report turnaround time, improving patient access, optimizing radiation dose/exam, and reducing unnecessary repeat exams are all examples of activities implemented by radiology practices to address CMS' high-priority improvement topics. ACR also wants to highlight that incorporating this IA would provide a low-burden activity with a robust return on investment for quality improvement for radiology practices and their patients. It would also encourage practices to implement new programs and processes for continuous improvement when reporting quality measures.
IA_BE_6	Regularly Assess Patient Experience of Care and Follow Up on Findings	Assessments of the impact of patient experience improvement programs in radiology practices have demonstrated measurable improvements in patient experience.[i] IA_BE_6 fosters a culture of continuous improvement, teamwork, and accountability in clinical practices for improving patient care and outcomes. Integrating this IA into the diagnostic radiology MVP would encourage radiologists to use feedback from patient experience surveys to identify meaningful improvement projects (like providing all staff with name badges displaying name and role, improving comfort and appeal of the physical space, preserving patient dignity and respect, reducing check-in times, and improving interactions with staff).[ii]

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Activity ID	Activity Title	Rationale
IA_EPA_3	Collection and use of patient experience and satisfaction data on access	Patient access issues are common in radiology; scheduling delays, long waiting times, and difficulty obtaining desired appointments can significantly impact overall patient experience and quality of care. Including IA_EPA_3 into the Diagnostic Radiology MVP would encourage radiology practices to obtain survey data to devise meaningful improvement interventions, such as: 1. **Improving Scheduling Systems**: Implementing efficient scheduling systems may reduce delays. For example, Steele et al. demonstrated that structural changes in staffing, workflow, and room use can substantially reduce scheduling delays for critical imaging procedures, decreasing the mean time to the next available appointment from 25 days to 1 day.[iii] 2. **Enhancing Communication and Staff Training**: Ensuring staff are trained in patient-centered communication can improve patient satisfaction. Ajam et al. found that patient-centered empathic communication was highly predictive of favorable overall ratings in radiology. Training staff to be sensitive to patient needs and concerns can enhance the patient experience.[iv] 3. **Streamlining Registration and Intake Processes**: Simplifying the registration and intake processes can reduce waiting times and improve patient flow. Dibble et al. identified front office experience, intake experience, and examination experience as key constructs affecting patient satisfaction, with waiting times being a significant area for improvement.[v] 4. **Facility and Environment Improvements**: Enhancing the physical environment, such as waiting area comfort, can positively impact patient perceptions. Rosenkrantz and Pysarenko emphasized the role of the practice's physical facility, including aesthetics and amenities, in shaping the patient experience.[vi] 5. **Utilizing Technology**: Implementing electronic kiosks for patient satisfaction surveys can help gather real-time feedback and identify areas for improvement. Boos et al. found that electronic kiosks placed next to elevators had higher completion rates and provided valuable insights into patient satisfaction.[vii]
IA_PSPA_19	Implementation of formal quality improvement methods and practice improvement processes for tracking clinician-patient relationships using MACRA codes	We strongly recommend including this IA, which encourages radiology practices to adopt new or enhance existing improvement methods and processes appropriate to their relationship with patients.

Cost Performance Category

MVPs must include at least one applicable, feasible cost measure as outlined in CMS' MVP Candidate Development and Submission process; otherwise, the candidate MVP will not enter the rulemaking process. The ACR recognizes this statutory requirement yet questions the relevance of the Medicare

Spending Per Beneficiary (MSPB) cost measure in the Diagnostic Radiology draft MVP. Because their work focuses on interpreting imaging studies rather than direct patient evaluation, diagnostic radiologists rarely use E&M codes. While there are some exceptions, multispecialty groups reporting under MIPS typically receive the Cost performance category score based on their patient-facing colleagues who bill E&M codes. ACR acknowledges that the MSPB cost measure is not directly applicable to most diagnostic radiologists and lacks alignment with CMS-included quality measures and IAs, but is the most viable option given current circumstances.

If diagnostic radiologists are eventually required to participate in this MVP, their Cost performance category scores would be reweighted to the Quality and IA categories. ACR seeks clarification on how reweighting aligns with the MVP framework's intent to create connected, meaningful measures and promote subgroup reporting for specialties within multispecialty groups. With CMS' plans to explore flexibilities in MACRA to apply feasible cost measures for non-patient-facing clinicians like radiologists, **we would be pleased to help CMS operationalize flexibilities in the Cost Performance category defined in MACRA by CMS.**

MVP Foundational Layer

Regardless of medical specialty and practice applicability, all MVPs must contain the same foundational layer to support CMS-prioritized measurement topics and ensure all MVP participants meet CMS-defined baseline requirements. The foundational layer comprises Population Health measures and Promoting Interoperability Performance category measures.

Promoting Interoperability (PI) Performance Category

Diagnostic radiology practices institute various health information technology (HIT) platforms into their workflow; in fact, radiologists have often been early adopters of various types of technology. However, like the Cost Performance category scoring, diagnostic radiologists have historically had their PI Performance category scores automatically reweighted to the Quality and IA performance categories under the special status of non-patient-facing and/or hospital-based providers. As described previously, diagnostic radiologists infrequently engage directly with their patients in a medical billing sense; therefore, radiologists' use of certified electronic health record technology (CEHRT) is largely limited to viewing data, which prevents them from aligning with the PI Performance category participation requirements. Diagnostic radiologists do not have control over the CEHRT and cannot report PI measures.

Given HIT's integral role in radiology practices, the ACR supports the nationwide implementation of electronic radiologic image exchange, recognizing that its widespread adoption depends on regulation from CMS or other HHS agencies. A December 2024 EpicResearch.org published article demonstrated that referring clinicians using the Epic EHR system can receive alerts notifying them of duplicate or unnecessary imaging orders from their own health systems and external systems. These alerts advise clinicians of recent imaging results real-time when place new orders. The study found these alerts potentially prevented up to 500,000 duplicative orders monthly, with annual savings estimated at $310

million to $2.6 billion, depending on the imaging modality costs. In addition to reducing healthcare payments and practice savings, such technology would help reduce issues associated with the radiology workforce shortage.

Population Health Measures

ACR understands that CMS prioritizes quality improvements for patient populations and therefore requires Q479: *Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups* and Q484: *Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* in the MVP foundational layer. We understand there is flexibility to remove these measures from scoring if practices lack sufficient cases to meet the measures' data completeness criteria, which will likely be the case for diagnostic radiology practices.

ACR is pleased to share that we are working on a spectrum of appropriate population health measures to include in future iterations of the Diagnostic Radiology MVP. A subset of these measures introduce diagnostic radiology practices to processes and procedures necessary for integrating tracking and monitoring systems for patients with AIFs, while the other measures assess the quality of radiologists' follow-up recommendations and patients' completion of these recommendations. The measures, which are undergoing testing, address high-priority AIFs affecting distinct patient populations who would strongly benefit from early detection of findings like lung nodules and abdominal aortic aneurysms, and demonstrate radiologists' effect on patient outcomes. Given the radiologists' responsibility for communicating imaging study findings with patients and their referring clinicians, these measures would be appropriate for assessing individual clinicians' or groups' performance. **ACR also welcomes collaboration with CMS on future population health measures applicable to diagnostic radiology (e.g., cancer screening measures).**

The ACR appreciates the opportunity to comment on the proposed Diagnostic Radiology draft MVP. We encourage CMS to continue working with radiologists and the ACR throughout this pre-rulemaking and eventual rulemaking process to support the successful adoption of this MVP. We look forward to continued dialogue with CMS officials about this important transition from traditional MIPS to MVPs that ensure patient-centered care through appropriate and applicable measures and activities.

Respectfully Submitted,

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