American College of Radiology™

January 24, 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 Interventional Radiology MIPS Value Pathway

The American College of Radiology (ACR), representing over 40,000 interventional and diagnostic radiologists, radiation oncologists, medical physicists, and nuclear medicine physicians, appreciates the opportunity to provide feedback on the proposed draft Interventional Radiology MVP. Since the introduction of the MVP framework, ACR leaders and staff have evaluated how it can address the unique challenges faced by radiologists, particularly given the differences between patient-facing and non-patient-facing specialties and the barriers to traditional MIPS participation. We recognize the significance of robust measures and improvement activities in health care as they apply to interventional radiology and value the opportunity to support the successful implementation of this MVP.

Quality Performance Category

ACR emphasizes the need for a broader range of MIPS Clinical Quality Measures (CQMs) and Qualified Clinical Data Registry (QCDR) measures to support interventional radiologists in successfully meeting the Quality Performance category requirements, including measures scored up to 10 points. Interventional radiologists are highly subspecialized physicians. Interventional radiology encompasses many subspecialties including diagnosis and treatment of diseases of the arterial and venous, renal and genitourinary, gynecologic, and musculoskeletal systems; neurointerventional radiology; interventional oncology; and pain management. Utilizing different modalities (e.g., fluoroscopy, ultrasound, CT, MRI, Cone-Beam CT, nuclear medicine and PET, and digital subtraction angiography), interventional radiologists use imaging guidance to diagnose and treat various conditions and to monitor therapeutic interventions (e.g., guiding catheters, needles, or stents to target areas or for tumor ablation or vascular embolization). Interventional radiologists also interpret imaging studies to evaluate patients' conditions and inform on clinical decisions (e.g., evaluating imaging studies to determine feasibility of a procedure, to monitor outcomes, response to treatment, and complications, and to provide diagnostic input throughout the course of treatment).

As drafted, the IR MVP's current selection of quality measures is insufficient for most IRs to meet MVP reporting requirements because many of the measures apply only to specific subsets of IRs. For instance, of the available measures, only Q145: *Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy*, Q374: *Closing the Referral Loop: Receipt of Specialist Report*, and Q487: *Screening for Social Drivers of Health*—are broadly applicable across interventional radiology. The

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remaining measures primarily pertain to subspecialized interventional radiologists who routinely perform procedures like uterine artery embolization (UAE), IVC filter removal, vein treatment, or stroke treatment. As a result, large portions of IR practices are unable to participate in most of the IR MVP.

ACR supports CMS' inclusion of QCDR measures in the draft MVP, given that QCDR measures influence the successful participation of many radiology practices in MIPS. However, like the CQMs proposed in the draft, the available QCDR measures focus solely on dialysis intervention and do not apply to large swaths of interventional radiology practices. With practice resources already stretched thin due to the national radiologist shortage, practices would be unable to successfully pivot to the limited list of MVP measures, further increasing radiologists' already high levels of stress and burnout. ACR is aware of the efforts by the Society of Interventional Radiology (SIR) to develop interventional radiology-specific measures. However, these measures will take time to develop due to the complexity and cost of the process. As such, we want to emphasize the importance of measures broadly applicable across different interventional radiology practice settings and subspecialties to ensure adequate reporting opportunities that meet volume requirements. **ACR recommends CMS include the measures in Table 1 in the draft IR MVP before rulemaking is finalized.**

Table 1.

Measure ID	Measure Title
Q024	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older
Q047	Advance Care Plan
Q130	Documentation of Current Medications in the Medical Record
Q226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Q355	Unplanned Reoperation within the 30-Day Postoperative Period
Q356	Unplanned Hospital Readmission within 30 Days of Principal Procedure
Q357	Surgical Site Infection (SSI)
Q358	Patient-Centered Surgical Risk Assessment and Communication
Q404	Anesthesiology Smoking Abstinence
Q418	Osteoporosis Management in Women Who Had a Fracture

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Cost Performance Category

ACR is concerned with the cost measures included in the draft IR MVP: COST_HAC_1: *Hemodialysis Access Creation,* COST_IHCI_1: *Intracranial Hemorrhage or Cerebral Infarction*, and MSPB_1: *Medicare Spending Per Beneficiary (MSPB).* Interventional radiologists often participate in multi-specialty care teams but indirectly contribute to patients' outcomes and costs associated with episodes in which they participate. For instance, the costs associated with COST_HAC_1 would be attributed to the vascular surgeon responsible for access creation, while interventional radiologists more commonly focus on maintaining or restoring access. While interventional radiologists perform necessary procedures for stroke patients, COST_IHCI_1 is attributed to the clinicians managing stroke patients, a role infrequently assigned to interventional radiologists. The Medicare Spending Per Beneficiary (MSPB) Clinician is a generalized population-based care measure primarily applicable to group practices and would largely be captured in other condition- or specialty-specific-MVPs rather than the IR MVP. If interventional 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. **ACR urges CMS to explore alternative cost measures that are not episode-based and better reflect interventional radiology-specific costs.**

The ACR fully supports the comments submitted by SIR and appreciates the opportunity to comment on the proposed Interventional 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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