September 1, 2023

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

RE: CMS–1784–P

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 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B to Payment Policies; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Payment for Office/Outpatient Evaluation and Management Services; Proposed Rule.

In this comment letter, we address the following:

- Physician Practice Information Survey (PPIS)-indirect Practice Expense (PE) updates
- Virtual supervision
- MIPS-performance threshold raised to 82 points
- Removal of some topped out measures for radiology
- Data completeness threshold increased to 80%

Physician Practice Information Survey (PPIS)-indirect Practice Expense (PE) updates

CMS has been using the AMA's Physician Practice Information Survey (PPIS) data and the AMA methodology in its MPFS PE since 2010. In the proposed rule, CMS solicited feedback related to the AMA Physician Practice Information (PPI) Survey.

1) If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?

The AMA data collection is not completed, and ASNR recommends evaluating data prior to making a decision regarding data aggregation.

2) Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?

   The ASNR believes that granularity of data to reflect PE inputs is important in ensuring fair, stable and accurate means to account for indirect PEs across various specialties or practice types. Aggregation of services would not yield an accurate means to account for indirect PEs.

3) If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?

   The ASNR believes that geographic location, setting of care, size of practice and specialty type are all important considerations that influence indirect PE. It is our understanding that the AMA is working with Mathmatica to stratify samples to consider these factors which we believe are important in deriving indirect PE inputs.

4) What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?

   The ASNR recommends that any significant changes or recommendations go through the rulemaking process to solicit feedback and allow for input of all stakeholders. Any redistributive changes should be phased-in, and in general PE methodology should attempt to ensure a stable fee schedule for practices.

5) Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

   The ASNR agrees that non-response bias may have an impact on data. The AMA has stated that they will perform a nonresponse bias analysis.

Virtual supervision

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

The ASNR would ask that CMS make permanent the rule allowing virtual direct supervision of level 2 diagnostic tests via real time audio/video communications technology by physicians and non-physician providers (NPPs) whose state law and scope of practice permit them to supervise diagnostic tests. Additionally, the ASNR ask that CMS require secondary non-physician licensed practitioner (RN, LPN, RT, RA, EMT) to be on site throughout the performance of those tests, if no physician is available, to assist with possible patient adverse reactions when contrast agent is used for in regard to patient safety. The ASNR fully supports patient safety and quality and appreciate CMS's prioritization of this.

MIPS-performance threshold raised to 82 points

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

The ASNR strongly opposes CMS's proposal to raise the performance threshold to 82 points. The MIPS scoring program has been disadvantageous for nonpatient facing clinicians. This is because of topped out quality measures for non-patient facing clinicians. Further there have been barriers to introducing new measures into the program that have made the overall process difficult. This issue is also not unique to neuroradiologists but affects other specialties that may be limited in patient facing interactions. In some cases, if just choosing one's own specialty quality metrics in radiology they would not be able to achieve this threshold and would instead have to choose a metric outside of their specialty to not have a negative payment adjustment. Overall, this defeats the purpose of the MIPS program, which is to measure individual clinician performance in areas meaningful to their specialty. CMS needs to consider how these scoring policies negatively affect non-patient facing clinicians. We would urge CMS to adopt new quality measures into the program before increasing the performance threshold further.

The ASNR believes that the pace at which CMS has been increasing the performance threshold outpaces specialties' abilities to propose and develop new, meaningful quality measures into the program. Specialties with limited measure sets are at a disadvantage and penalizes MIPS clinicians for doing well on measure sets which are relevant to them and may contribute meaningfully to patient care.

Data completeness threshold increased to 80%

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

The ASNR opposes CMS's proposal to raise the data completeness threshold beyond 70%. This is due to current technical limitations with electronic health records (EHR) and variability across locations especially for radiologists that may practice at multiple facilities. This is especially true when covering rural areas. The current 70% threshold is already difficult and raising this will only further put physicians at an unobtainable goal.

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,

Yvonne Lui, MD, FACR
President, 2022-2023
American Society of Neuroradiology

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