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September 11, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Attention: CMS–1784-P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

The Society for Cardiovascular Angiography and Interventions (SCAI) has dedicated its work to advancing the profession and is the designated society for guidance, representation, professional recognition, education, and research opportunities for invasive and interventional cardiology professionals. For more than 40 years, SCAI has personified professional excellence and innovation globally, fostering a trusted community of more than 5000 members dedicated to medical advancement and lifesaving care for adults and children with cardiovascular disease.

SCAI appreciates the opportunity to comment on this proposed rule. SCAI offers the following comments on:

1. Conversion factor update
2. Rebasing Medicare Economic Index (MEI) for Practice Expense (PE) and Geographic Practice Cost Indices (GPCI)
3. Clinical labor update
4. Request for information on valuing services
5. Intraoperative ultrasound
6. Venography Services
7. Coronary Lithotripsy

8. Telehealth services
9. Evaluation and Management Visit Complexity Add-on Health Care Procedure Code System (HCPCS) code G2211
10. Dental care and cardiac interventions
11. Transcatheter heart valve procedures
12. Merit-Based Incentive Payment System Value Pathway (MVP) reporting for specialists in Shared Savings Program Accountable Care Organizations (ACOs)
13. Heart failure cost measure
14. MIPS cardiology specialty set changes
15. Advancing care in heart disease MVP changes

Conversion Factor Update

SCAI urges CMS to find a way to avoid another decrease in the conversion factor for CY2024. One option to reduce the impact of the increase would be to not implement G2211 as proposed. This payment reduction compounds the year over year cuts such as the expiration of the moratorium on Medicare sequestration and clinical labor updates that physicians are still attempting to absorb. Physicians' practices are also significantly challenged by other regulatory burdens (e.g., prior authorization, interoperability requirements and participating in Medicare quality programs such as MIPS).

CMS's proposed changes layer on top of many other changes that are rattling the practice of interventional cardiology. Physicians are still dealing with patients that were reluctant to seek care during the public health emergency and have let conditions get worse before they seek care. Providing that care is more time consuming and expensive because the declining health conditions of patients are more complex, and physicians are dealing with market changes that include staff/nursing shortages and inflation, among other things. The impact of these cuts is far reaching because other payers are likely to adopt these RVU changes and make similar revenue neutrality adjustments to their conversion factors. Additionally, Medicare's fees for interventional cardiology have been dramatically reduced over time and payments have not kept up with inflation.

We urge CMS to waive the budget neutrality adjustment and encourage CMS to look at all options for avoiding the proposed fee cuts.

Clinical Labor Updates

As CMS continues its proposal to implement the phase in of clinical labor updates, SCAI continues to have concerns that by increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative value formula. **SCAI requests that CMS update**

pricing data on a more frequent and reasonable basis for all inputs, so adjustments will not be so dramatic and sudden. We believe that there is an underlying unfairness in the current formula in that the real increase in clinical labor costs is not recognized through an update to the conversion factor. We call on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2024 and all future years.

Rebasing and Revising the MEI and GPSCI

CMS indicates that they will not implement the 2017-based MEI in PFS ratesetting for CY 2024 due to the change’s anticipated impact on PFS payments. SCAI appreciates CMS not taking additional action that would cause more cuts based on budget neutrality. **We believe that an underlying unfairness exists here in that the update cost is not recognized through an update to the conversion factor. SCAI calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2024 and all future years.**

CY2024 Proposed Codes – Valuation of Specific Codes

(16) Intraoperative Ultrasound Services (CPT codes 76998, 7X000, 7X001, 7X002, and 7X003)

Code	Long Descriptor	CMS Proposed RVU	RUC Recommended RVU
76998	Ultrasonic guidance, intraoperative	.91	1.20
7X000	Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic	.60	.60
7X001	Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	1.62	1.90
7X002	Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	1.08	1.20
7X003	Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; interpretation and report only	.54	1.55

76998

For CPT code 76998, CMS disagrees with the RUC recommended work RVU of 1.20 and proposes a work RVU of 0.91 based on a total time ratio between the CMS/Other time and the proposed time for 76998. As CMS pointed out, the proposed survey times represent a decrease from the CMS/Other times included in the RUC database and the current CMS time file. SCAI agrees with the RUC in that this service was not surveyed in the Harvard Study and has never been reviewed by the RUC or CMS. Instead, the assigned times were input by CMS 30 years ago at the inception of the RBRVS using an unknown methodology and therefore are not valid for relative comparison to the current survey or to other codes. In addition, CMS/Other services had their service period times and work values assigned without the expert input of the physicians that perform these procedures. SCAI strongly disagrees with CMS calculating total time ratios to account for changes in time especially under the circumstances outlined above.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to the Multi-Specialty Points of Comparison (MPC) code 70490 Computed tomography, soft tissue neck; without contrast material (work RVU= 1.28, intra-service time of 15 minutes, total time of 25 minutes) and CPT code 70544 Magnetic resonance angiography, head; without contrast material(s)(work RVU= 1.20, intra-service time of 12 minutes, total time of 22 minutes). SCAI urges CMS to accept a work RVU of 1.20 for CPT code 76998.

7X000

SCAI thanks CMS for their consideration and acceptance of RUC values for this code.

7X001

For CPT code 7X001, CMS disagrees with the RUC recommended work RVU of 1.90 and proposes a work RVU of 1.62 based on a direct work RVU crosswalk to two separate codes with identical work RVUs and times. SCAI urges CMS to accept a work RVU of 1.90 for code 7X001.

CPT code 73219 was last reviewed by the RUC and CMS over 20 years ago. It is a less intense service that is not intraoperative and only involves the physician performing the interpretation and report. CPT code 78452 describes cardiac imaging performed on a patient before and after the patient exercises. Again, it is not an intraoperative service, and a technologist typically handles the image acquisition which is often more efficient. Neither code CMS proposed to use for direct work value crosswalks are appropriate comparators for 7X001. SCAI urges CMS to accept a work RVU of 1.90 for CPT code 7X001.

7X002

For CPT code 7X002, CMS disagrees with the RUC recommended work RVU of 1.20 and proposes a work RVU of 1.08 based on reducing CMS proposal for 7X001 by 1/3rd. CMS did not agree with the RUC's recommendation to assign work RVUs for CPT codes 7X002 and 7X003 that sum to more than the aggregate work RVU for CPT code 7X001.

CMS initial interpretation that the combination of 7X002 and 7X003 should equal the value for 7X001 is flawed and inconsistent with how the Agency pays for most services that are performed by multiple providers. For a large majority of CPT and other HCPCS codes that are performed by multiple surgeons, CMS provides payment that is greater than 100% to the two surgeons. When there are co-surgeons (modifier 62), CMS's payment of 125% is split between the two surgeons. Similarly, when there is an assistant at surgery (modifier 80), CMS pays the primary surgeon 100% and the assistant at surgery 16%. SCAI urges CMS to accept a work RVU of 1.20 for CPT code 7X002.

7X003

For CPT code 7X003, CMS disagrees with the RUC recommended work RVU of 1.55 and proposes a work RVU of 0.54 based on CMS proposal for 7X001 reduced by 2/3rds. CMS rationale was that, "Because CPT code 7X003 represents one of the three service parts performed by a cardiologist, we allotted 1/3rd of the aggregated work RVU for CPT code 7X001, equaling 0.54 ($1.62 * 1/3 = 0.54$)."

The RUC recommended 7X003 to be valued higher than 7X002; however, CMS is recommending the inverse. The CMS proposed value is only a third of the RUC recommendation. For code 7X003, during the intraoperative image acquisition portion before and after the cardiac repair(s), the cardiologist is in the operating room providing real-time guidance to the cardiothoracic surgeon on probe placement and manipulation (the work of the cardiothoracic surgeon is reported with code 7X002) to ensure adequate image acquisition. The cardiologist is also interpreting the images real-time and discussing the findings with the cardiothoracic surgeon helping the cardiothoracic surgeon determine if the surgical plan needs to be altered before the cardiac repair, and if the repair is adequate or additional procedures are needed after the cardiac repair is completed. With 7X003, the cardiologist completes the echo report.

CMS initial interpretation that the combination of 7X002 and 7X003 should equal the value for 7X001 is flawed and inconsistent with how the Agency pays for most services that are performed by multiple providers. Just as there are often time-savings when a single physician

performs multiple procedures in the same session, there are also numerous circumstances where CMS recognizes that there is additional work involved when two physicians are involved in a procedure or perform multiple procedures during the same session. For a large majority of CPT and other HCPCS codes that are performed by multiple surgeons, CMS provides payment that is greater than 100% to the two surgeons. When there are cosurgeons (modifier 62), CMSs payment of 125% is split between the two surgeons. Similarly, when there is an assistant at surgery (modifier 80), CMS pays the primary surgeon 100% and the assistant at surgery 16%. SCAI urges CMS to accept a work RVU of 1.55 for CPT code 7X003.

(17) Percutaneous Coronary Interventions (CPT code 9X070)

Code	Long Descriptor	CMS Proposed RVU	RUC Recommended RVU
9X070	Percutaneous transluminal coronary lithotripsy	2.97	2.97

SCAI thanks CMS for their consideration and acceptance of RUC values for this code.

(19) Venography Services (CPT codes 9X000, 9X002, 9X003, 9X004, and 9X005)

Code	Long Descriptor	CMS Proposed RVU	RUC Recommended RVU
9X000	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)	1.20	1.20
9X002	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemi-azygos venous system (List separately in addition to code for primary procedure)	1.13	1.13

9X003	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)	1.43	1.43
9X004	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)	1.92	2.11
9X005	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)	2.04	2.13

The new venography service codes represent add-on services that are performed during cardiac catheterization for congenital heart defects in the superior vena cava, the inferior vena cava, and in other congenital veins to be reported in conjunction with the main cardiac catheterization injection procedure codes (CPT codes 93593 – 93597). CMS is proposing the RUC-recommended work RVUs for CPT codes 9X000, 9X002, and 9X003. SCAI thanks CMS for their consideration of these three codes. However, SCAI urges CMS to accept the RUC recommendations for the two veno-venous collateral codes (9X004, 9X005).

9X004

For CPT code 9X004, CMS disagrees with the approved RUC-recommended work RVU of 2.11 and believes that a work RVU of 1.92 is more accurate to account for the increased intra-service time compared with CPT code 9X000. CMS notes that 9X004 “has six additional minutes more than CPT code 9X000 (10 minutes), which is 60 percent more physician time.” The proposed value of 1.92 appears to be obtained using an equation to calculate 60% of the 9X000 code value ($1.20 \times .60 = .72$) and adding this amount to the value of 9X000 ($1.20 + .72 = 1.92$). There is no further justification provided for the proposed value. Using such mathematical or computational methodology to value physician work is inappropriate as it ignores magnitude estimation, is inconsistent with RBRVS principles and not supported by policy.

Moreover, SCAI believes that using a percentage of 9X000 to reach its proposed values for 9X004 and 9X005 also ignores procedure intensity. All five new venography service codes including 9X000 are add-on codes and as such vary in intensity from the other add-on codes in the family. Such a comparison is therefore inappropriate as both time and intensity should be considered in the valuation. The RUC-recommended work RVU is more accurate than the CMS proposed work RVU as it takes into account the change in intensity of intra-service time.

The work of 9X004 is extremely complex as it requires significantly different and more extensive catheter manipulation as the congenital anomaly can be in a different place in every patient. The physician work involves the use of assorted catheters and wire combinations to navigate surgically-altered or congenital-altered anatomy. The physician work for this procedure is typically performed on two vessels that are often tortuous and difficult to both locate and navigate. These VV collaterals occur in unpredictable locations due to chronically high systemic venous pressures. SCAI believes that the intensity of the physician work supports the RUC recommended value.

The RUC offers a solid comparison between 9X004 and MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time). Both codes include catheter placement and have similar time and intensity and should therefore be valued similarly. 9X004 has one more minute of intra-service time and was ranked higher than the comparator code in all intensity/complexity measures, including 84% of survey respondents rating 9X004 as requiring more technical skill relative to 36227, justifying the slightly higher value. Additionally, the carotid artery is a known artery in the same position every time and much easier to locate and catheterize.

SCAI urges CMS to accept a work RVU of 2.11 for CPT code 9X004.

9X005

For CPT code 9X005, CMS disagrees with the approved RUC-recommended work RVU of 2.13 and believes that it would be more accurate to propose a work RVU of 2.04 to account for the increased intra-service time compared with CPT code 9X000. CMS notes that 9X005 “has seven additional minutes more than CPT code 9X000 (10 minutes), which is 70 percent more physician time.” The proposed value of 2.04 appears to be obtained using an equation to calculate 70% of the 9X000 code value ($1.20 \times .70 = .84$) and adding this amount to the value of 9X000 ($1.20 + .84 = 2.04$). There is no further justification provided for the proposed value. Using such mathematical or computational methodology to value physician work is inappropriate as it ignores magnitude estimation and is inconsistent with RBRVS principles.

Moreover, SCAI believes that using a percentage of 9X000 to reach its proposed values for 9X004 and 9X005 also ignores procedure intensity. All five new venography service codes including 9X000 are add-on codes and as such vary in intensity from the other add-on codes in the family. Such a comparison is therefore inappropriate as both time and intensity should be considered in the valuation. The RUC-recommended work RVU is more accurate than the CMS proposed work RVU as it takes into account the change in intensity of intra-service time.

The work of 9X005 is extremely complex as it requires significantly different and more extensive catheter manipulation as the congenital anomaly can be in a different place in every patient. Systemic venous anomalies may create an increase in technical and procedural complexity by making it more challenging to obtain essential information during cardiac catheterization or by necessitating alternative vascular access sites to perform catheterization procedures. The physician work for this procedure is typically performed on two vessels that are often tortuous and difficult to both locate and navigate. The VV collaterals occur in unpredictable locations due to chronically high systemic venous pressures. SCAI believes that the intensity of the physician work supports the RUC recommended value.

Recognizing the scarcity of ZZZ codes with similar time and intensity as the venography service codes, the RUC offers a solid comparison between 9X005 and CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50, 20 minutes intra-service and total time). 9X005 has three minutes less intra-service time yet the same intensity as the comparator code, justifying the RUC-recommended value.

SCAI urges CMS to accept a work RVU of 2.13 for CPT code 9X005.

Proposal for Outpatient/Office (O/O) E/M Visit Complexity Add-on HCPCS code G2211

With the CAA, 2021 moratorium ending, CMS is proposing to assign an active status indicator to the O/O E/M Visit Complexity add-on code G2211, making the code payable. CMS has adjusted the code descriptor, clarifying that the code should only be applied to medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. CMS has also adjusted utilization assumptions down to 38 percent initially. SCAI appreciates that CMS has revised utilization assumptions for G2211 based on stakeholder feedback, lessening the impact of the code on budget neutrality. However, we are still very unclear on the requirements for the service and whether interventional cardiologists would be able to use the code. Clarification of documentation requirements is necessary to fully understand the code's intended use and properly estimate its utilization. Even though the

utilization assumption was decreased, it is estimated that allowing payment for the G code may be responsible for roughly 90% (-2%) of the budget neutrality reduction in the CY 2024 MPFS proposed rule. As interventional cardiologists bill a large number of procedures, we have concerns about the negative impact of the budget neutrality reductions on the specialty, especially given the ambiguous description of G2211 and our inability to determine if interventional cardiologists will receive any benefit from being able to bill the code.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

CMS has requested comment on how CMS can potentially move forward with reforms to the way values are established for E/M and other services. SCAI has been concerned that recent decisions have been made solely on time, without adequate consideration to the intensity involved. Time should not be the deciding factor in code valuation.

When a CPT code is established for an underrepresented specialty, an expert panel from the specialty should be consulted. The panel would be able to provide clinical advice about the procedures' details and complexity that could assist both the RUC and CMS with appropriate valuation of the procedures. This insight would include more detailed descriptions of pre, intra, and post service work to increase understanding of the complexity of the procedures being valued. Reinstatement of the Refinement Panel would serve to meet this need by allowing an appeals process that is heard by both physicians and medical contractors. It would also allow for an additional level of appeal so that all interested parties may be certain that their points are heard.

While the RUC process may be imperfect, it's strength is that it is built on the critically valuable experience of physician experts. Bias is removed from the process by incorporating the latest scientific evidence and clinical expertise in an adjudicated process. Improvements could be made to the physician survey process. For example, we believe that the number of completed physician surveys could be increased and the results improved by modernizing the educational materials provided. Shorter, more clearly written clinical descriptors utilized in a more user-friendly format could expedite the collection of data. We maintain that physician input into this process is essential to ensuring that procedures are valued appropriately.

CMS should defer to the process especially when CMS does not have the appropriate specialty representation to make informed decisions about the RUC recommendations. When it doesn't, CMS should publish the reasons for not following the recommended values. If CMS believes that other factors beyond time and intensity should impact code valuation, CMS should

communicate with the RUC and work to alter the process requirements so all interested parties can work together on the desired outcome.

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

SCAI appreciates CMS' proposal to pay for necessary dental services performed as part of a comprehensive workup prior to organ transplant, cardiac valve replacement, or valvuloplasty procedures. Infection from dental issues can undermine recovery. In these circumstances SCAI agrees with CMS that dental services may be integral to the clinical success of the procedure and as such should be covered by the Medicare program. In addition to organ transplant, cardiac valve replacement, and valvuloplasty, SCAI maintains that dental services should also be allowed for device closure of intracardiac defects and stent implants.

Supervision by Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Services

As an aging health care workforce remains a significant concern (nearly 50% of registered nurses are over 50 years old, and 44% of physicians in 2019 were at least 55 years old), SCAI agrees with CMS' decision to expand the practitioners who may supervise cardiac rehabilitation. Allowing virtual presence for direct supervision is also appropriate in this setting.

Changes Related to Telehealth Services

CMS is proposing to change the telehealth taxonomy from categories 1-3 to permanent and provisional services in order to reduce confusion regarding the status of telehealth codes. SCAI agrees with this simplification of language, which will be much easier to understand. SCAI appreciates that CMS will continue with a process to allow provisional telehealth coverage as more evidence becomes available to support the use of telehealth for varying services. We would urge CMS to allow continued access to the provisional telehealth services currently on the Category 3 list after 2024.

CMS is proposing that claims billed with POS 10 (Telehealth Provided in Patient's Home) be paid at the non-facility PFS rate. SCAI applauds CMS' recognition that providers performing telehealth services are also maintaining an office practice and therefore their practice expense is not reduced by performing some telehealth services. SCAI strongly supports this proposal.

CMS is also proposing to continue to allow direct supervision via virtual presence through 2024. SCAI appreciates this policy extension and believes that CMS should continue in perpetuity to allow the direct physician supervision of cardiac rehabilitation programs to be met by the

virtual presence of the physician via real-time, two-way audio/visual telecommunications technology.

Physicians are clearly in the best position to determine whether virtual direct supervision can be provided safely and effectively to their patients based on their medical needs, and they should be given the flexibility to make those decisions on a case-by-case basis. Therefore, CMS should continue to allow physicians the ability to make decisions based clinical judgment as to whether a service is appropriate for virtual direct supervision.

CMS is proposing to allow the teaching physician to have a virtual presence in all teaching settings, only in clinical instances when the service is furnished virtually (for example, a 3-way telehealth visit, with all parties in separate locations) through 2024 and seeking comment on how telehealth services can be furnished in residency programs after 2024. In this setting as well, physicians are clearly in the best position to determine whether virtual direct supervision can be provided safely and effectively to their patients based on their medical needs, and they should be given the flexibility to make those decisions on a case-by-case basis. Therefore, CMS should allow physicians the ability to make decisions based clinical judgment as to whether a service is appropriate for virtual direct supervision.

Changes to the Payment Policy Indicators for Transcatheter Cardiac Valve Procedures

SCAI is requesting that CMS consider the following changes to the payment policy indicators for transcatheter mitral valve and tricuspid valve Category III CPT procedure codes to allow for the use of assistant surgeons, co-surgeons and team surgeons:

1. Change the assistant surgeon payment policy indicator to “2” for the following transcatheter valve procedure codes; 0483T, 0544T, 0545T, 0569T, 0570T and 0646T.
2. Change the co-surgeon payment policy indicator to “1” for transcatheter valve procedure codes 0544T, 0545T, 0569T and 0570T, and to “2” for CPT code 0646T.
3. Change the team surgeon payment policy indicator to “1” for CPT code 0646T.

Transcatheter valve procedures are extremely technical in nature and require a highly functional multi-disciplinary (MDT) surgical and operating room team. Both transcatheter mitral valve and tricuspid valve interventions require skillful maneuvering in a complex environment under image guidance. The anatomy is complex and often unpredictable, necessitating the skills of two operators to perform distinct parts of the navigation and implant procedure.

Changes to these payment policy indicators will ensure patient procedural safety and bring policy alignment to all complex transcatheter valve procedures.

MVP Reporting for Specialists in Shared Savings Program ACOs

CMS is seeking feedback on MVP reporting for specialists in Shared Savings Program ACOs. We appreciate CMS' commitment to enhancing specialist participation in ACOs and for exploring participation in MVPs. However, we see challenges in this approach.

MVPs tend to limit available quality measures, potentially not meeting specialists' reporting requirements. Given the diverse subfields within cardiology, this constraint could pose difficulties in incentivizing the entire specialty to participate. For example, even with the changes made to the Advancing Care for Heart Disease MVP to be more inclusive of subspecialties, the existing measures make it difficult for interventional cardiologists to successfully participate. Quality measures that are relevant and meaningful to specialists' practice areas may need to be tailored. This ensures that specialists' contributions are accurately reflected in the ACO's performance assessment.

Heart Failure Cost Measure

SCAI has concerns due to the complexity and heterogeneity of this patient population, any cost measure for heart failure has the potential to create unintended consequences impacting the ability to provide guideline-directed care.

SCAI proposes that the categorization of heart failure should be limited to a specific subset of ICD-10 codes from the I50 family. While this restriction may result in lower patient volumes being attributed, it ensures that only genuine cases of heart failure are captured, excluding patients with conditions like end-stage renal disease that may present with similar symptoms but have a different underlying condition.

SCAI believes that attribution of care for a complex longitudinal condition such as heart failure to a single clinician under MIPS is problematic. Patients see a variety of clinicians in multiple settings, possibly by clinicians under multiple Tax Identification Numbers (TINs) within the same setting or care team. In addition, some health outcomes are influenced by several factors and not directly attributable only to the care provided by a clinician.

SCAI encourages CMS to explore the utilization of other data sources, such as clinical registry data, and analytic techniques to support more accurate attribution and ensure that evidence supports the assignment of responsibility. CMS must also provide clinicians with the claims data behind their cost episodes so they can fully understand and act on manageable costs. This would require greater transparency and access to data from CMS. This would ultimately provide the much-needed information for providers to make meaningful differences in the

costs of care. With the increase in team-based care, it becomes important to determine the appropriate proportions of care and outcomes across all members of the care team.

MIPS Cardiology Quality Measure Specialty Set Changes

CMS is proposing to add two new measures to the cardiology specialty set and delete three other measures. The first addition is known as, Connection to Community Service Provider: Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening. SCAI promotes measures that advance health equity and believes it is reasonable to rate cardiologists on this aspect of care, but only if all other specialties are also rated by this metric. It is true that cardiovascular disease is profoundly affected by social health needs, but it is also true that virtually every other disease is similarly influenced. By this logic, every specialty should be rated on this metric.

The second measure CMS is proposing to add is Gains in Patient Activation Measure (PAM®) Scores at 12 Months: The Patient Activation Measure® (PAM®) is a 10 - or 13 -item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM® performance measure (PAM® PM) is the change in score on the PAM® from baseline to follow-up measurement. While this measure can provide a good assessment of patients who actively participate in their healthcare, it fails to account for socioeconomic status, healthcare access, and comorbidities. Given the challenges in this population, it is highly unlikely that anyone with health related social needs will be an active participant in their healthcare. Challenges exist with a survey-based tool, such as the possibility of response bias, and time and resource constraints on administration. While the PAM® Scores at 12 Months quality measure can offer valuable insights into self-management in cardiology patients, it should be used in conjunction with other clinical assessments and considerations to provide a more comprehensive evaluation of a patient's cardiac health and overall well-being.

CMS is proposing to remove the measure Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters. CMS is proposing this deletion because of the development of a new more comprehensive quality measure under Table A.6. However, this new measure is not proposed for addition to this

specialty set. SCAI believes that the number of quality measures available to interventional cardiologists is already limited, and has concerns about removing any measures that can currently be appropriately reported by the specialty.

CMS is proposing to remove the measure Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients: Percentage of all stress single photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection. SCAI agrees with this decision and thanks CMS for removing this measure.

CMS is also proposing to remove Tobacco Use and Help with Quitting Among Adolescents: “The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.” SCAI has been very active with groups such as Tobacco-Free Kids and other anti-smoking efforts. We maintain, however, that this measure is duplicative of measure Q226 when the denominator is adjusted, support the removal of this measure from the specialty set.

Changes to Advancing Care for Heart Disease MVP

CMS is proposing to add four quality measures to the Advancing Heart Disease MVP that are relevant to the care of heart disease. The four measures are Q006: Coronary Artery Disease (CAD): Antiplatelet Therapy, Q118: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker–(ARB)–Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF \leq 40%), Q487: Screening for Social Drivers of Health, which addresses health equity, and Gains in Patient Activation Measure (PAM[®]) Scores at 12 Months. While SCAI appreciates the addition of quality measures to the MVP, we remain concerned that the measures selected are not the best fit for interventional cardiologists attempting to report this MVP. SCAI recommends that additional measures from the cardiology specialty set be added to the MVP to facilitate wider inclusion.

CMS is proposing to add two improvement activities: IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols and IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings.

CMS is also proposing to add two cost measures: Medicare Spending Per Beneficiary (MSPB) Clinician and Heart Failure. For the MSPB measure, attribution to multiple clinicians/clinician groups, especially on a retrospective basis, provides clinicians with little information as to how to better coordinate care to improve efficient use of resources or costs. This must be done at the hospital or facility-level and trickle down to the clinicians, as many clinicians are not involved in performance measure activity, which may typically fall to administrative staff. This lack of specificity is an impediment to helping clinicians/TINs quickly identify where the key areas are that drive overall differences in spending. As such, the burden is then on the provider to investigate and analyze the information received. We believe that reports should be provided which contain actionable data aimed at improving patient care and related costs. Please see our comments on the heart failure measure above.

Conclusion

SCAI appreciates the opportunity to provide comments on this Proposed Rule for CY 2024 and we look forward to continuing working with CMS to address these important issues. If SCAI can be of any assistance as CMS continues to consider and review these issues, please do not hesitate to contact SCAI's director, regulatory affairs Monica Wright at 202-327-5451 or at mlwright@scai.org if there are any questions or further requests.

Sincerely,

A handwritten signature in black ink, appearing to read "George Dangas". The signature is fluid and cursive, with the first name "George" being more prominent than the last name "Dangas".

George Dangas, MD, PhD, MSCAI
President