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Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re:** Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P)

On behalf of the American Society of Nuclear Cardiology, the American Society of Echocardiography, the Society for Cardiovascular Angiography and Interventions, Society for Cardiovascular Magnetic Resonance, and the Society of Cardiovascular Computer Tomography, we are pleased to have this opportunity to submit these joint comments on the MACRA Proposed Rule. This joint statement supplements each organization’s individual comments, and focuses on issues of common concern to the cardiovascular imaging community.

Heart disease is the leading cause of death in the United States for both men and women. About 610,000 people die of heart disease in the United States every year: One in every four deaths is
attributable to heart disease. Cardiovascular imaging has become central in the diagnosis and management of patients with a broad range of cardiac conditions, including heart failure, coronary artery disease, valve disease, arrhythmia and structural heart disease. In addition, physicians in a wide range of disciplines order cardiovascular imaging studies to assist in the management of an ever-widening range of non-cardiac conditions including, for example, stroke, pulmonary embolism, and various forms of trauma.

We share the general concerns that have been expressed by others regarding the extraordinary complexity of the MACRA Proposed Rule, its potential impact on smaller private practices, and the costs that physicians will incur in meeting its detailed requirements.

In addition to these general observations, we wish to offer the following comments, which are specific to cardiovascular imaging.

First, while we appreciate CMS’ expansive approach to the Clinical Practice Improvement Activity component of MIPS, we urge CMS to further expand the list of CPIAs to give physicians credit for a CPIA if they provide services in a cardiovascular imaging laboratory that is accredited by the Intersocietal Accreditation Commission (IAC) or equivalent organization. The accreditation process for cardiovascular imaging laboratories is targeted to ensure labs provide high quality. The IAC process of accreditation includes a comprehensive review of the laboratory’s organization and each lab must reapply for accreditation every 3 years. A random site visit and audit are conducted within the three year period. In addition, a review of the qualifications of a lab’s technical staff, physician staff, and Medical Directors is conducted; the format and content of the reports that it produces are reviewed including a process to ensure that images match reports provided, a thorough analysis of the lab’s quality improvement activities, and a host of other critical organizational and operational requirements. Laboratory accreditation (which is voluntary for all hospital laboratories and all office-based laboratories other than those that provide advanced imaging) is precisely the type of clinical quality improvement that Congress envisioned when it enacted this component of MIPS. We also support providing CPIA credit to a physician whose cardiovascular imaging laboratory institutes a process to review the studies it performs against the AUC. CPIA credit should be made
available for physicians who provide services both in laboratories that provide advanced imaging and for physicians who provide services in laboratories that provide other cardiovascular imaging.

Second, we wish to express our strong reservations about the proposed inclusion of episode-group measures in the cost-resource component of MIPS. Episode-based groups have not been used as a basis for payment under fee-for-service Medicare, and we do not believe that it is prudent to introduce an untested metric at the same time that CMS is rolling out an extraordinarily complex and completely new payment system for physicians’ services. We are particularly concerned about the inclusion of completely new episode groups that have never been included in QRURs, and our concerns are strongest with respect to condition-based episode groups that are triggered by ambulatory care services. These episode groups’ triggers may be based on ICD-10 coding, with which physicians are just becoming familiar. In our view, it is extremely premature to measure physician resources for ischemic heart disease condition-based episodes, in light of the complexity of the condition and multiplicity of treatment options.

Finally, within cardiology we urge CMS to initially focus on discrete procedures for which episode windows and attribution are more easily defined. Given that attribution and episode windows are key elements of a specific bundle, it seems rational that early attempts to scale these methods are focused and well defined. Chronic cardiovascular conditions, including ischemic heart disease, heart failure, and atrial fibrillation are inherently challenging to episodes groups because resource use is a complex function of multiple patient-level demographics (i.e. age, sex, socioeconomic status) and medical co-morbidities (i.e. hypertension, diabetes, chronic kidney disease).

We hope that these joint comments are helpful to CMS, and look forward to working with the agency on issues of concern to the cardiovascular community and our patients as this new program unfolds.

Sincerely yours,
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