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June 9, 2023

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

Re: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Dear Administrator Brooks-LaSure:

The American College of Cardiology (ACC) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the FY 2024 Medicare Hospital Inpatient Prospective Payment System (IPPS) for acute care hospitals and other policies addressed in this proposed rule. The College's comments focus on multiple Medicare-severity diagnosis related groups (MS-DRGs), new technology add-on payment policy (NTAPS), the Medicare Promoting Interoperability Program, the Hospital Value-Based Purchasing Program and Inpatient Quality Reporting (IQR) measures.

The ACC is the global leader in transforming cardiovascular care and improving heart health for all. As the preeminent source of professional medical education for the entire cardiovascular care team since 1949, and now with more than 56,000 members from over 140 countries, the ACC credentials cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards, and guidelines.

Proposed Changes to Medicare Severity Diagnosis-Related Groups (MS-DRGs)

II.C.5.a Surgical Ablation (MS-DRG)

In this proposed rule, CMS addresses a request to review the MS-DRG assignment of cases involving open concomitant surgical ablation procedures. The requestor recommended that CMS reassign open concomitant surgical ablation procedures for atrial fibrillation (AF) from MS-DRGs 219, 220, and 221 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 216, 217

and 218. The requestor further recommended that if CMS does not reassign these cases to MS-DRGs 216, 217 and 218, then CMS should create new MS-DRGs for all open mitral or aortic valve repair or replacement procedures with concomitant surgical ablation for AF to improve clinical coherence when three to four open heart procedures are performed in one setting.

After detailed analysis and review of the request, CMS created the new base MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures) to address cases reporting an open aortic valve repair or replacement (AVR) procedure, a mitral valve repair (MVR) or replacement procedure and another concomitant procedure in MDC 05 including surgical ablation and coronary artery bypass graft (CABG).

The College appreciates CMS recognizing the additional resources required for these concomitant procedures and applauds any effort to address the shortfall in reimbursement versus their cost when these, or any concomitant major cardiovascular procedures, are performed. However, we believe new MS-DRG 212 should represent cases when an open aortic valve repair or replacement procedure **or** a mitral valve repair or replacement procedure are performed with any of the other concomitant procedures from MDC 05 that are included in the proposed MS-DRG 212 GROUPER logic. The combinations of CABG/AVR/MVR plus ablation in identified 6P.3b are generally more expensive and have longer stays than those identified in 6P.3b. While the ACC agrees the presence of AVR and MVR together with another procedure require enhanced resources, it is also the case that a trend exists where AVR plus ablation or MVR plus ablation require enhanced resources.

Concerning this new MS-DRG 212 to address AVR/MVR procedures with concomitant procedures, as well as any concomitant major cardiovascular procedures, the College urges CMS to ensure that the incurred costs are adequately addressed so as to not disincentivize concomitant procedures which can be more efficient, more convenient, provide a better prognosis for the patient and could be more cost effective than the procedures being performed sequentially (i.e., during different hospital stays).

The College recommends that CMS group AVR and MVR single-valve procedures into the newly created MS-DRG 212 when they are performed concomitantly with other services, such as CABG or ablation. Further, the College urges CMS to devise a broader, more inclusive, supplemental payment mechanism to facilitate incremental reimbursement when two major procedures are performed during the same hospital admission.

II.C.5.b External Heart Assist Device

In this rule, CMS proposes to reassign ICD-10-PCS code 02HA0RZ (Insertion of short-term external heart assist system into heart, open approach) from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRG 001 and 002. The agency's review of the data and clinical analysis of the procedure showed that this procedure is generally more resource intensive than the other procedures in MS-DRG 215 despite having shorter average lengths of stays. Further, the procedure appears to be more clinically aligned with the proposed MS-DRGs 001 and 002.

CMS also indicates that if a new ICD-10-PCS code is finalized for the Impella 5.5 with SmartAssist System CMS would use its established process for MS-DRG assignment which examines the MS-DRG assignment for the predecessor codes to determine the most appropriate MS-DRG assignment.

The College supports the CMS proposal to reassign ICD-10-PCS code 02HA0RZ (Insertion of short-term external heart assist system into heart, open approach) from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRG 001 and 002 to align the clinical cohesiveness and resource utilization more appropriately. The College concurs that CMS should continue to monitor the clinical cohesiveness of the procedures assigned to MS-DRGs 001 and 002 to ensure continued alignment and determine if any refinements would be needed in the future. If a new ICD-10-PCS code is finalized for the Impella 5.5 with SmartAssist System, ACC encourages CMS to assign the new code(s) to Pre-MDC MS-DRG 001 and 002.

II.C.5.d. Coronary Intravascular Lithotripsy (MS-DRG)

The College appreciates CMS's detailed analysis of the costs and resources required to perform coronary intravascular lithotripsy (IVL) relative to the MS-DRGs the procedure is currently grouped to. Upon review of the agency's analysis of IVL costs and lengths of stay the College understands the proposal to create new MS-DRGs to house the procedure. The College supports this adjustment which should provide for greater access to this new technology that should contribute to better outcomes for patients.

Given the findings of the analysis of IVL relative to its current MS-DRG placements and feedback from member experts who perform the spectrum of percutaneous coronary intervention (PCI) procedures, it seems possible that other services that prepare vessels for PCI could demonstrate similar increased costs and acuity. For future rulemaking, the College encourages CMS to perform the same analysis with regard to all ICD-10-PCS codes for atherectomy, which would all also be considered "vessel preparation techniques" as the agency referred to IVL, to determine if these should also be segregated out of their current MS-DRGs to account for their costs and length of stays. Depending on the results of the analysis the atherectomy codes could be kept as is, put in their own MS-DRG (as IVL was) or perhaps be added to the newly created IVL MS-DRGs with a change in name.

The College recommends CMS proceed with the creation of the new MS-DRG 323 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC), MS-DRG 324 (Coronary Intravascular Lithotripsy with Intraluminal Device without MCC), and MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device) as supported by cost data. The College further recommends that CMS analyze the atherectomy procedures within proposed FY2024 MS-DRGs 250, 251, 321 and 322 to determine if similar action is needed regarding these procedures in the future as is being done for IVL.

In reviewing this issue, CMS noted that they received a separate but related request in FY2022 rulemaking. The requestor suggested that CMS eliminate the distinction between drug-eluting and bare-metal coronary stents in the MS-DRG classification. According to the requestor, coated stents have a clinical performance comparable to drug-eluting stents. However, they are grouped with bare-metal stents because they do not contain a drug. The requestor asserted that this comingling muddies the clinical coherence of the MS-DRG structure, as one cannot infer distinctions in clinical performance or benefits among the groups, and potentially creates a barrier (based on hospital decision-making) to patient access to modern coated stents. In response, CMS stated that based on a review of the procedure codes that are currently assigned to MS-DRGs 246, 247, 248, and 249, the CMS clinical advisors agreed that further refinement of these MS-DRGs may be warranted.

The CMS analysis of these concerns bore out that it was no longer necessary to subdivide the MS-DRGs for percutaneous cardiovascular procedures based on the type of coronary intraluminal device inserted. As such, CMS is proposing to delete MS-DRGs 246, 247, 248, and 249 and create a new base MS-DRG with a two-way severity level split for cases describing percutaneous cardiovascular procedures with intraluminal device in MDC 05.

The College finds it reasonable, based on the explanation CMS gave, to condense two groups of two MS-DRGs with apparent redundancy into two new MS-DRGs. We do urge monitoring of any unintended consequences due to these changes.

II.C.5.e. Shock DRG Modifications

In this proposed rule CMS responds to a request to add cardiogenic shock (R57.0) as a secondary diagnosis that groups to MS-DRGs 222 and 223. After detailed review of these as well as other related MS-DRGs CMS concluded that they would not grant this request, but also that the cost analysis shows it is no longer necessary to subdivide the MS-DRGs for cases reporting cardiac defibrillator implant based on diagnosis code reported (notably AMI, HF or Shock). CMS believes their analysis shows that while cases involving cardiac defibrillator implant with cardiac catheterization continue to demonstrate higher average costs and lengths of stays this is due to the procedures performed rather than the diagnoses reported on the claim. For this reason, CMS is proposing to delete MS-DRGs 222, 223, 224, 225, 226, and 227. CMS will also create three new MS-DRGs. These proposed MS-DRGs will be MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC), MS-DRG 276 (Cardiac Defibrillator Implant with MCC), and MS-DRG 277 (Cardiac Defibrillator Implant without MCC).

The College finds this reasonable based on the cost data and rationale CMS gave of condensing three groups of two DRGs with apparent redundancy into three new DRGs. We do urge monitoring of any unintended consequences. (As a point of information, it appears Version 41 Definitions Manual HTML version does not show MCC as part of the table for 275 and 276. That appears to be a typographical error.)

Other MS-DRG Assignments

Endovascular Cardiac Valve Replacement and Supplement Procedures

The ACC has followed the creation of new ICD-10-PCS codes to report the percutaneous placement of bioprosthetic valves into the inferior vena cava (X2H03R9) and superior vena cava (X2H13R9). While not discussed in the proposed rule, draft Version 41.0 Definitions Manual places these codes in MS-DRGs 252-254 for Other Vascular Procedures with MCC, CC, and without MCC/CC.

With the exception of some cranial nerve stimulator lead placement procedures, the services under these MS-DRGs are all on veins or arteries to treat disease in the veins and arteries. That includes some services in the inferior vena cava and superior vena cava, so it is understandable why these two new procedure codes would be placed in MS-DRGs 252-254. However, these services are different from other percutaneous vascular procedures performed in the inferior and superior vena cava. The procedures described by the new ICD-10-PCS codes are the placement of bioprosthetic valves to treat tricuspid valve disease. In this sense it seems more appropriate to place these procedures in MS-DRGs 266-267 with other Endovascular Cardiac Valve Procedures. The bioprostheses replace the function of the diseased tricuspid valve while leaving the native valve in place. While the ICD-10-PCS codes are new and do not yet have cost data associated with them, they will require resources and work similar to other endovascular cardiac valve replacement procedures, such as placement within the major vessels and heart to treat valve disease. **The ACC urges CMS to consider moving X2H03R9 and X2H13R9 to MS-DRGs 266-267 and monitor the costs of these procedures going forward to ensure appropriate assignment**

II.E.8 New Technology Add-on Payment (NTAP) Eligibility Requirement Modifications

The College appreciates the CMS proposal to require NTAP applicants to have either received FDA marketing authorization or have a complete, actively filed FDA marketing authorization application prior to submitting their NTAP application. More available information equates to greater transparency which enhances the process of stakeholder commentary in this process.

The College also understands the rationale the agency presents for moving the required deadline for having received FDA approval from the current date of July 1 to May 1 beginning in FY2025. However, this does raise some concerns for the College. CMS notes, the number and complexity of applications have greatly increased in recent years which the agency advises now requires more time to review and assess whether the new technologies meet the criteria for NTAP. CMS states that they are proposing this date change, "to allow adequate time to fully evaluate the new technology add-on payment criteria for FDA-authorized technologies in advance of the final rule, and to further facilitate and inform public comment." While this change would allow CMS more time to evaluate the new technology with the added information from the full FDA authorization, we do not see how this would "further facilitate and inform public comment," as the IPPS rule generally is released to the public in April. Therefore, any information gleaned from full FDA approval would not be

available in the proposed rule the public would be commenting on.

Another concern regarding this change is the effect it will have on the availability of the NTAP for these devices. There is already a small window in which new technologies can receive NTAP for three fiscal years. Only technologies receiving FDA approval in the second half of the fiscal year and before the current July 1 deadline, i.e., April, May, or June, can obtain three years of NTAP support. This proposed rule would reduce this window to just one month, April, in order to obtain three years of NTAP support. Reimbursement of new devices that is pivotal to encouraging innovation should not be penalized as a consequence of allowing the agency to have more time to evaluate applications.

The College proposes that, if it is necessary for CMS to move the required date of FDA approval for NTAP applicants from July 1 to May 1 to address the increased volume and complexity of the applications, then the consequences of this policy change that limit the availability of NTAP to the applicants should be mitigated so as to not damage the intent of the program – encouraging innovation and improving health outcomes. **If this proposed policy change is enacted, regulations addressing the duration of NTAP should also be adjusted so that all devices that receive NTAP approval are granted three fiscal years of reimbursement regardless of when in the process cycle FDA approval is received.** For example, should FDA approval be granted after May 1, 2024 making that technology ineligible for the NTAP payments beginning October 1, 2024, the technology would still be allowed three fiscal years of NTAP beginning October 1, 2025 of the following calendar year, presuming CMS did subsequently approve the NTAP application.

Even this revision to award three-year support to all approved applications still leaves some problems unsolved. For example, a technology that receives FDA approval on May 15, 2024, would not be able to obtain an NTAP enhanced payment until October 1, 2025. That is not a responsive and efficient way to support exciting new technologies. **The ACC urges CMS to think carefully about the limits to patient access that could be created under its current proposals.**

Training in new Rural Emergency Hospital (REH) Facility Type

The FY2023 IPPS Final Rule created the new category of REH's that were to be created out of converted Critical Access Hospitals (CAH) or rural hospitals. The questions was raised to CMS of whether these new REHs were able to participate in the graduate medical education (GME) programs as there was some ambiguity around the CAHs in this regard. Through clarification and revision CMS proposes that if statutory requirements are met, an REH can include full-time equivalent (FTE) residents training at the REH in its direct GME and indirect medical education FTE counts for Medicare payment purposes, or, the REH may decide to incur direct GME costs and be paid based on reasonable costs for those training costs. **The College supports this proposal which should encourage greater physician participation in rural healthcare and improve patient access in underserved areas.**

Proposed Changes to the Medicare Promoting Interoperability Program

Proposed EHR Reporting Period in CY 2025 for Eligible Hospitals and CAHs

CMS proposes to maintain a minimum of any continuous 180-day period for the Electronic Health Record (EHR) reporting period in CY 2024 and CY 2025 for any new or returning participants in the Medicare Promoting Interoperability (PI) Program. **The College thanks CMS for continuing to provide PI participants with stability and consistency in reporting.** Program consistency has led to nearly universal EHR adoption among non-federal acute care hospitals and use by most office-based physicians. CMS also states it is considering increasing the length of the EHR reporting period in CY 2026 for eligible hospitals and critical access hospitals (CAHs) to report under the PI program given that beginning in CY 2023, entities are required to submit four calendar quarters of data for each of the required electronic clinical quality measures (eCQMs). **The ACC thanks CMS for signaling the intention to consider changes to EHR reporting periods in future years and for the measured consideration of certified electronic health record technology (CEHRT) utilization by eligible hospitals and CAHs to determine the feasibility of a longer reporting period.** The College encourages CMS to work closely with the Office of the National Coordinator for Health IT (ONC) and talk with a diverse array of stakeholders to understand the implications of implementing a longer reporting period and provide sufficient notice through rulemaking to ensure eligible hospitals and CAHs can comply with updated rules.

Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

In CY 2022, CMS added new Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure to the Protect Patient Health Information objective. Eligible hospitals and CAHs were required to attest whether they had conducted an annual self-assessment using all nine SAFER guides, but they were not scored and an attestation of yes or no was acceptable without penalty. For CY 2024, CMS proposes to require eligible hospitals and CAHs to conduct the annual SAFER Guides self-assessments and attest a "yes" response accounting for a completion of the self-assessment for all nine guides. Failure to attest "yes" would result in not meeting the measure and not satisfying the definition of a meaningful user of EHR technology. For CY 2022, the College supported CMS' efforts to promote cyber security and EHR safety and appreciated CMS making the measure required but not scored for the first year to allow for eligible hospitals and CAHs to prepare for compliance with the measure. **The ACC thanks CMS for allowing eligible hospitals and CAHs two years to grow accustomed to reporting this new measure before making it a required measure and commends CMS for the continued emphasis on the promotion of safe use of EHRs.**

Scoring Methodology for the EHR Reporting Period in CY 2024

CMS does not propose any changes to scoring methodology for EHR reporting in CY 2024. **The ACC thanks CMS for continued program stability with minimal changes to reporting requirements for the PI program.** Stability in the PI program, coupled with progress enhancing

electronic health information availability and technical interoperability, has been a main contributor to steady growth of EHR use and serves as the foundation for future gains in semantic interoperability and data liquidity.

Proposed Updates to the Medicare Spending per Beneficiary (MSPB) Measure

CMS is proposing to adopt measure updates to the MSPB Hospital measure (CBE #2158) in the Hospital VBP Program beginning with the FY 2028 program year. These changes include new trigger episodes to expand conditions that may be included in the measure, a new variable to indicate if there was a 30-day stay prior to the episode window, and a revision of the calculation from the sum to the mean of observed over expected costs. The measure changes were reviewed by a consensus-based entity (CBE) and received endorsement during the 2020 endorsement cycle and were implemented in the 2023 IQR. In addition, CMS proposes to remove the MSPB Hospital Measure from the IQR Program and retain the measure solely within the VBP program, also beginning in 2028.

The College recognizes that the MSPB measure may provide hospitals with a less burdensome way to measure resource use. However, one caveat is that the MSPB measure does not inform performance by condition, whereby hospitals may be interested in seeing certain care patterns. In addition, while the MSPB measure is potentially actionable, there is the concern of a potential inverse relationship with outcomes and under-adjustment for social risk factors and medical complexity. Vulnerable groups such as dual-eligible and minority patient populations may drive performance differences in MSPB among hospitals. CMS must ensure that the MSPB measure alone can stand as a reliable and valid measure of efficiency and cost reduction for all hospitals under the VBP.

We agree with the proposal to remove the MSPB measure from the IQR program, as we recognize that it would reduce the burden, confusion, and complexity of reviewing feedback and reports on the measure from different programs. We also agree this would serve patients better when reviewing public reporting performance data, as multiple sources of information for the same measure may cause further confusion and be a hindrance in patient engagement. Since the VBP is designed to incentivize healthcare providers to deliver high-quality, cost-efficient care, and the MSPB measure is one of the tools used to achieve this goal, we agree that the measure should reside within this program.

Proposal to Add Health Equity Scoring Adjustment in the Hospital VBP Program

CMS proposes changes to its scoring methodology for the Total Performance Score by adding Health Equity Adjustment points. The scoring change rewards quality care in underserved populations by adding the adjustment through a hospital's performance on existing Hospital VBP Program measures and the proportion of individuals with dual eligibility status (DES) that a hospital treats. We applaud CMS' proposal to revise the VBP scoring methodology to reward hospitals based on their performance of the proportion of patients that are dual eligible for Medicare and Medicaid. We also believe that this modification will provide incentives for hospitals to improve outcomes for

all patients while also allowing for hospitals that care for more vulnerable patients to be fairly assessed.

CMS states that the proposed calculation methodology utilizing DES is the first step in addressing disparities in the VBP program. While we do agree this is in an important step in achieving health equity and accounting for vulnerable patients, we do believe that the measure should initially be utilized as a pilot before full implementation in the VBP program. By piloting this measure on a smaller scale, its effectiveness may be evaluated, and any potential issues or challenges may be identified before releasing this for all users in the VBP program. This will help ensure that the measure is reliable, valid, and feasible, and that it will produce the intended results. We agree with CMS' future consideration to utilize the Area Deprivation Index (ADI) in score calculations.

CMS should also consider the impact of states' decisions for Medicaid expansion versus non-expansion on the proposed calculation methodology. When a state does not expand Medicaid, it is axiomatic that fewer patients will qualify for both Medicare and Medicaid than would be the case had that state chosen to expand in Medicaid. Also, states that have not expanded Medicaid have higher rates of uninsured individuals; anticipated delays in seeking and then gaining access to care are expected to lead to more serious health problems and thus higher healthcare costs over time.

Proposed Adoption of *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults* eCQM

The ACC is generally supportive of any measure that provides a standardized method for oversight of the performance of diagnostic CT by monitoring the use of high radiation doses (a risk factor for cancer) while preserving image quality. However, the ACC does have concerns regarding this particular metric for consideration by CMS. Measure stewardship is in collaboration with the University of California San Francisco (UCSF). UCSF created Alara Imaging to develop the eCQM software and support measure stewardship. While there is presently no cost to use the software, CMS should consider the implications of adopting a measure that relies upon use of a proprietary system. Hospitals and health systems will face an additional burden in implementing the proprietary program and ensuring compatibility within their system IT networks. As the software requires access to hospital or health system electronic health records to calculate the variables necessary for completing the measure, the potential for information system vulnerability (i.e., cybercrime) warrants consideration.

Further, concern has been expressed through the consensus process regarding the current level of consensus as to what constitutes "excess radiation dose". Endorsed national benchmarks are lacking. Patient-centered care should encompass appropriate imaging – the right test for the right patient. This means that at times a higher radiation dose will provide greater test accuracy, and that trade-off may be entirely appropriate for a particular patient. Test substitution may result (e.g., stress echocardiography for stress nuclear perfusion imaging) solely for the purpose of metric performance rather than proceeding forward with what might be the better test for a particular patient. Additional potential unintended consequences should be monitored over time, such as the inappropriate shifting of care or coding/billing practices, or increased patient morbidity and mortality.

Proposed Modifications to the *Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measure* and the *Hybrid Hospital-Wide All-Cause Readmission (HWR) Measure*

In this proposed rule, CMS is proposing to modify both measures to expand the cohort of the Hybrid HW Mortality and Hybrid HW All-Cause Readmissions measures from only Medicare fee-for-service (FFS) patients to a cohort which includes both FFS and Medicare Advantage (MA), beginning in 2027. Overall, the ACC is supportive of the inclusion of the MA population, as the ACC notes that the MA population is anticipated to surpass the FFS population by the time this modification is implemented. Given the growth of the MA cohort, inclusion of this population should better ensure that these measures of hospital-wide outcomes more completely convey the experience of all Medicare beneficiaries.

While the ACC believes that inclusion of MA patients will provide a more comprehensive assessment of the Medicare population, we are concerned about reports regarding the practice of some MA plans in selectively enrolling healthier patients, down-coding diagnoses, and engaging in other behaviors to manipulate risk scoring. While this type of risk-adjustment "gaming" remains a concern for applying traditional FFS Medicare quality measures to MA patients, we applaud CMS for having implemented a number of programs and initiatives to address these practices, including risk adjustment data validation, medical record audits, and continued refinement of the Hierarchical Condition Categories (HCC) model.

Specifically regarding the hospital-wide mortality measure, the ACC is uncertain as to what extent improving performance on this measure is truly actionable. Its ability to truly reflect the patient complexities and differences in care environment is uncertain. Risk adjustment for this measure is crucial — and should include incorporation of the impact of SES — as meaningful differences in patient outcomes are anticipated for those residing in underserved areas and for those who are economically disadvantaged.

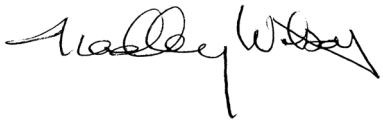
With respect to the hospital-wide readmissions measure, ACC has a concern with respect to clinician attribution for hospital readmission. How a specific clinician is assigned responsibility for a hospital readmission is difficult to understand, as multiple clinicians typically serve in a care team in the contemporary hospital environment. The ACC also raises the fundamental question as to whether hospital-wide readmission is indeed a true measure of the quality of care delivered or whether instead it simply serves as a measure of care utilization. Last, the recognition that larger, integrated hospital systems typically achieve higher levels of performance on readmission metrics must be underscored; smaller hospitals or health systems may be disadvantaged by this measure unless it is somehow adjusted to reflect the environment of care delivery.

Conclusion

Thank you for your consideration of these comments from the ACC. The College appreciates the thought and effort that go into rulemaking and looks forward to future engagement on topics

included in this and other rules and policy discussions. Please contact Matthew Minnella, Associate Director, Medicare Payment Policy at mminnella@acc.org if additional information would be helpful.

Sincerely,



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