



September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Submitted via www.regulations.gov

Dear Administrator Brooks-LaSure:

The American College of Cardiology (ACC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the CY2024 Physician Fee Schedule and Other Changes to Part B Payment Policies proposed rule. The College’s comments focus on multiple code specific values, telehealth policy, the implementation of code G2211, the Medicare Shared Savings Program (MSSP), the Quality Payment Program (QPP) and the continued integration of interoperable health information technology.

The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 56,000 members is to transform cardiovascular care and to improve heart health. The ACC bestows credentials upon cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards, and guidelines. The College also provides professional medical education, disseminates cardiovascular research through its world renowned JACC Journals, operates national registries to measure and improve care, and offers cardiovascular accreditation to hospitals and institutions. For more, visit acc.org.

Conversion Factor

CMS proposes to reduce the conversion factor from \$33.8872 to \$32.7476. This is a 3.36 percent reduction. These cuts coincide with ongoing growth in the cost to practice medicine, as CMS projects the increase in the Medicare Economic Index (MEI) for 2024 will be 4.5 percent. Physician practices cannot continue to absorb increasing costs to run their practices while reimbursements continue to decrease.

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Nearly every other Medicare provider, such as hospitals and nursing homes, receive an annual update. Physicians must compete in the same cities and towns as these employers for clinical and administrative staff, equipment, and supplies. However, physicians are at a significant disadvantage as their payments have failed to keep up with inflation. The ACC has seen this and other trends drive consolidation, which will likely increase future health care costs and reduce access to care, particularly in underserved areas.

The Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase 2024 Medicare physician payments above current law by linking the payment update to the MEI, something the ACC, AMA and organized medicine have long supported. Like others, MedPAC raised concerns about the growing gap between what it costs to run a medical practice and what Medicare pays. **While we understand that CMS does not have the authority to provide an inflation-based update for physicians under current law, we strongly urge the agency to do all it can to reduce the proposed budget neutrality reduction for physician services in 2024. Practice costs are estimated to increase 4.5% in 2024, worsening the gap between the Medicare physician payment update and the real costs to practice. As discussed later in this letter, we believe CMS should delay implementation and/or lower the utilization estimate for the office visit add-on code, which would lower the budget neutrality cut to the conversion factor.**

The ACC, in conjunction with the AMA and essentially all of organized medicine, are also pursuing legislative relief from the unsustainable trajectory of Medicare physician payment. Specifically, we strongly support H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would provide a permanent, annual update equal to the increase in the Medicare Economic Index, allowing physicians to invest in their practices and implement new strategies to provide high-value care. We hope the agency will work with all physician stakeholders and Congress to seek this legislative relief. This would enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Cardiovascular and Pulmonary Rehabilitation

Noting it received multiple requests to permanently add Cardiovascular and Pulmonary Rehabilitation services to the Medicare Telehealth Services List on a Category 1 basis, CMS instead proposes to continue to include these services on the Medicare Telehealth Services List through CY 2024 on a Category 3/provisional basis. CMS would then remove CPT codes 93797 and 94626 from the Medicare Telehealth Services List for CY 2025. CMS states that in the absence of further action by Congress, CPT codes 93797 and 94626 will not be able to be furnished via telehealth to a beneficiary in the home beginning January 1, 2025. CMS explains that because many studies discussing the safety and efficacy of these services when furnished via telehealth focuses on the clinical benefits of patients receiving these services in the home, since the flexibilities for a patient's home to serve as an originating site are slated to end after CY 2024 under current law, it must

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consider that eventuality when adding services on a Category 1 basis.

The ACC thanks CMS for acknowledging the safety and efficacy of Cardiovascular and Pulmonary Rehabilitation services and extending these services on a temporary, Category 3/provisional basis through 2024. The College will continue to work with members of Congress to make necessary changes to ensure beneficiaries continue to have access to Cardiovascular and Pulmonary Rehabilitation services in the comfort of the patient's home.

Proposed Clarifications and Revisions for Considering Changes to the Medicare Telehealth Services List

Outlining a five-step process for consideration of changes to the telehealth services list with a goal of simplifying the process and understanding assessment, CMS explains specific considerations it must make under law. The Agency also proposes to characterize assignments as “permanent” or “provisional,” rather than Category 1, 2, or 3. The College finds helpful the explanations CMS offers regarding what constitutes a telehealth service. Specifically, that a telehealth service is a substitute for an in-person encounter and includes all face-to-face elements, that all elements can be furnished using telehealth, and the need for evidence that the clinical benefit is analogous to that of an in-person visit--not merely a minor or incidental benefit. These parameters will be helpful as we look back on previous submissions and consider future submissions.

Direct Supervision via Two-way Audio/Video Communications Technology

Noting concerns about an abrupt transition to the pre-PHE policy that defines direct supervision to require the physical presence of the supervising practitioner after December 31, 2023 after practitioners established new practice patterns during the PHE, CMS proposes to continue to define direct supervision to permit the presence and “immediate availability” of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.

Since the beginning of the PHE, the ACC has supported this flexibility and appreciates this extension.

CMS further seeks comment specifically on whether virtual direct supervision is safe or whether it would be a more appropriate option to designate only a subset of services to receive virtual direct supervision beyond 2024. The Agency considers an approach of extending or permanently establishing this flexibility for services valued in the fee schedule based on the presumption they are nearly always performed in entirety by auxiliary personnel. That approach may prove a conservative place to start or could be attempted through pilots to collect more data to inform future decision-making. An example of a service with no direct physician work that CMS and the RUC reviewed in recent years is G0166 for a session of external counterpulsation treatment. This service would fit the limited approach CMS describes and still benefit patients.

Moving beyond services performed by entirely auxiliary staff, the ACC has previously offered that in certain circumstances, when the technician, nurse, or other health care provider on staff is appropriately trained, the College believes direct supervision by virtual presence enhances the ability of the cardiovascular care team to provide appropriate care to their patients. For example, the

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interrogation of cardiac implantable electronic devices (CIEDs) including pacemakers, implantable cardioverter defibrillators (ICDs), and loop recorders has increased over the past several years. While patients are supported by remote home monitoring, they often need device interrogations in the clinic setting to assess device settings, evaluate stored events, or determine the cause of syncope or defibrillator discharge. In this case, pacemaker/ICD technicians, pacemaker nurses, or other clinical personnel are highly trained and capable of performing the in-office interrogation. At times, the supervising physician is on hospital grounds, not directly present with the clinician, but in a separate hospital building overseeing the procedure virtually. The College believes this clinical scenario is a good example where virtual supervision is both appropriate for the patient and also an efficient use of hospital resources. The College encourages CMS to allow this virtual presence of the supervising physician as long as other members of the cardiovascular care team are appropriately trained and licensed.

Valuation of Specific Codes

Phrenic Nerve Stimulation System

The College appreciates and supports CMS recommending the RUC recommended values for all 12 codes (3X008-3X015, 9X045-9X048) describing the implantation, removal and programming of the Phrenic Nerve Stimulation System.

Fractional Flow Reserve with CT

For CPT 2024, the AMA CPT Editorial Panel created new Category I code 7X005 *Fractional Flow Reserve with Computed Tomography (FFRCT) Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional*, to replace the series of four Category III codes. **The ACC supports the CMS proposal to utilize the RUC-recommended work RVU of 0.75 for the professional component of 7X005.**

For practice expense, CMS proposes to continue using the same crosswalk to the technical component of code 93457 it previously used for 0503T because it approximates the costs reflected in payment under the OPPS, which are thought to be similar to those in the physician office. The ACC agrees with CMS that the analysis portion of the service would not likely be adequately reflected under the current PE methodology, yet also find this crosswalk solution to be problematic for its ad hoc approach and possible lack of stability if it is changed in future years. The \$1,100 fee for FFRCT Software Analysis is a cost paid by the practice for each patient who receives 7X005. The software is not owned by the practice, essentially making it a high-cost supply. The ACC has previously recommended that CMS separately define and pay for high-cost disposable supplies and believes that approach would alleviate concerns about stability for this service, consistency across the fee schedule, and transparency as discrete items could be reviewed and updated on a regular basis.

The ACC agrees that an error CMS identified in the equipment time should be corrected from 14.5 minutes for ED053 to 13.5 minutes.

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Intraoperative Ultrasound Services

Code	Long Descriptor	CMS Proposed RVU	RUC Recommended RVU
76998	Ultrasonic guidance, intraoperative	0.91	1.20
7X000	Ultrasound, intraoperative thoracic aorta (eg, epi-aortic), diagnostic	0.60	0.60
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	0.54	1.55

76998 Ultrasonic guidance, intraoperative

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 in their proposal to reject the RUC recommended value, the proposed survey times represent a decrease from the CMS/Other times included in the RUC database and the current CMS time file. However, 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, code 76998 is newly described because the specific services that were previously reported in this code during the CMS/Other valuation are now reported with new CPT codes. It is not appropriate to compare the CMS/Other time for 76998 with the new survey time.

CMS/Other services had their service period times and work values assigned without the input of the physicians that perform these procedures. **The ACC strongly disagrees with CMS calculating total time ratios to account for changes in time. This is particularly inappropriate for a CPT code with a CMS/Other valuation and physician time which was performed with completely different major surgical procedures 30 years ago.** Prior to about 20 years ago, CMS commonly would change the work RVUs of many services without also updating the physician times, which was also the case for 76998 for CY 1993 and CY 1995 when its value was reduced without its time being adjusted. Therefore, the relationship between the originally assigned time and originally assigned work value became untethered. In addition, this former practice demonstrates the reduced rigor/importance placed on physician time relative to the modern

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processes currently used by CMS and the RUC.

During the RUC presentation, the specialty societies and RUC discussed the median intraoperative time of 12 minutes from the survey and observed that the survey respondents may have underestimated their typical time to perform the ultrasound service. Intraoperatively, ultrasound is used first to outline the margins of the mass. Then, periodically, the surgeon uses ultrasound to: (1) identify the mass and the margins as well as the surrounding normal tissue; and (2) guide additional incisions, dissection and excisions until clear margins are obtained. Intraoperative permanent images are interpreted and captured throughout the procedure. This is a dynamic procedure because the surgical field and lesion of interest is changing between images. That amount of typical physician work performed during the intra-service period would be challenging to complete in only 12 minutes.

CMS noted that their proposal represents a valuation for 76998 that is still more intense than 76641 *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete* (work RVU= 0.73, total time = 22 minutes). However, this proposed value is inappropriately only one third more intense than reference code 76641. Reference code 76641 describes a diagnostic ultrasound study that is typically performed by a technician, where the saved images are then reviewed and an interpretation report is generated by a radiologist at a later time. In comparison, for surveyed code 76998, a surgeon uses an ultrasound probe periodically during the operation and interprets the images in real time to help direct the limits of surgical excision of a mass. Images are saved and a report is generated by the surgeon. The intensity and complexity of code 76998 (dynamic real-time ultrasound at operation) is significantly greater than code 76641. In addition, reference code 76641 represents a single ultrasound session typically performed by a technician, whereas code 76998 includes multiple separate ultrasound maneuvers throughout an operative procedure by the surgeon, which require a more intense immediate interpretation in order to direct resection of the breast tissue to ensure a thorough and complete surgical excision of the abnormal breast tissue.

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). **The ACC urges CMS to accept a work RVU of 1.20 for CPT code 76998.**

7X001 Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report

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 that have identical work RVUs and times, CPT code 73219 *Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)* (work RVU of 1.62, intra-service time of 20 minutes, total time

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of 40 minutes) and CPT code 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU of 1.62, intra-service time of 20 minutes, total time of 40 minutes).

CPT code 73219 was last reviewed by the RUC and CMS over 20 years ago and 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. It is not an intraoperative service, and a technologist typically handles the image acquisition. Neither code CMS proposed to use for direct work value crosswalks are appropriate comparators for 7X001. CPT code 7X001 describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart, hence, a very intense and complex service to perform. CMS proposal inappropriately puts this service's intensity on par with the proposed value of 76998, even though it is a more intense service to perform. CMS proposed value assigns an inappropriately low intensity to a service that is so intense and complex. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to reference code 78431 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan* (work RVU= 1.90, intra-service time of 21 minutes, total time of 39 minutes). **The ACC urges CMS to accept a work RVU of 1.90 for CPT code 7X001.**

7X002 Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only

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. However, the RUC would like to provide some additional context.

CMS proposed value assigns an inappropriately low intensity to a service that is very intense and complex. CPT code 7X002 describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart. For the congenital cardiac epicardial echocardiography codes (7X001, 7X002, 7X003), it is not uncommon for a cardiologist to perform a portion of the procedure. For this reason, the congenital cardiac codes were developed to allow for one provider (typically the cardiothoracic surgeon) to perform all aspects of the intraoperative ultrasound (7X001) and two codes (7X002 and 7X003) for

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when the work is split out between two providers including a cardiothoracic surgeon and a cardiologist.

CMS's proposed 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' 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 18%.

For 7X002, there would be two separate physicians performing the cumulative work with both physicians in the operating room performing different aspects of the work prior to the cardiac repair and again after the cardiac repair has been completed. During the intraoperative image acquisition portion before and after the cardiac repair, the cardiologist is in the surgical suite with the cardiothoracic surgeon directing the surgeon on manipulating the probe to capture images of multiple structures of the heart. Additionally, the cardiothoracic surgeon is discussing the findings real-time in the surgical suite during the operation with the cardiologist making decisions on whether the surgical plan needs to be altered or additional repairs are required based on the findings. The cumulative time of the cardiologist and the cardiothoracic surgeon is therefore higher than the overall procedure time. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 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 MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU= 1.30, total time of 30 minutes). **The ACC urges CMS to accept a work RVU of 1.20 for CPT code 7X002.**

7X003 Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; interpretation and report only

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 two thirds. CMS rationale was that, "Because CPT code 7X003 represents one of the three service parts performed by a cardiologist, we allotted one third of the aggregated work RVU for CPT code 7X001, equaling 0.54 (1.62 * 0.33 = 0.54)."

CMS also proposed to reject the RUC-recommended intra-service time of 20 minutes, and instead proposed an intra-service time of 15 minutes. The IWP/UT that CMS proposed value and times would assign 7X003 is only 0.014, which is only slightly more than half the assigned intensity of a

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99211 nurses visit, a value that is already inappropriately low for physician work for a major surgery.

The RUC recommended 7X003 to be valued higher than 7X002. CMS is recommending the inverse and CMS proposed value is only a third of the RUC recommendation. During the intraoperative image acquisition portion before and after the cardiac repair, the cardiologist is in the operating room helping to direct the cardiothoracic surgeon on image acquisition, interpreting the images real-time and discussing the findings with the cardiothoracic surgeon for images acquired before and after the cardiac repair.

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), 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 18%.

CPT code 7X003 describes real-time ultrasound image acquisition direction, interpretation and report performed in the operating room, where the probe is placed through an open chest directly on the patient's beating heart. The procedure requires two separate physicians performing the cumulative work with both physicians in the operating room performing different aspects of the work prior to the cardiac repair and again after the cardiac repair has been completed. During the intraoperative image acquisition portion before and after the cardiac repair, the cardiologist is in the operating room with the cardiothoracic surgeon directing the surgeon on manipulating the probe to capture images of multiple structures of the heart. Additionally, the cardiologist is making decisions whether the surgical plan needs to be altered or additional repairs are required based on the findings and discussion of the findings in real-time during the operation with the cardiothoracic surgeon. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for regarding physician work.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes CPT code 78491 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/ or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.56, intra-service of 15 minutes, total 30 minutes) and CPT code 78492 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/ or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)* (work RVU= 1.80, intra-service time of 20 minutes, total time of 38 minutes). **The ACC urges CMS to accept a work RVU of 1.55 for CPT code 7X003.**

Percutaneous Coronary Intravascular Lithotripsy (IVL)

The College appreciates and supports CMS recommending the RUC recommended work RVU value of 2.97 for the newly created IVL code.

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Venography Services

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 College appreciates and supports CMS recommending the RUC recommended work RVU values of 1.20 for 9X000; 1.13 for 9X001; and 1.43 for 9X003.

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)

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 an intra-service time (16 minutes) that is 60% greater than that of 9X000 (10 minutes). The proposed value of 1.92 appears to be obtained by assigning a work RVU that is 60% greater than the work RVU of 9X000. There is no further justification provided for the proposed value. CMS states, “Although we do not imply that increases in time as reflected in survey values must equate to a one-to-one or linear increase in the valuation of work RVUs . . .” yet that is exactly how the 9X004 valuation is formulated. The College believes using such mathematical or computational methodology to value physician work is

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inappropriate as it ignores magnitude estimation and is inconsistent with RBRVS principles.

Furthermore, even if such a method of valuation were appropriate, using a percentage of 9X000 to reach proposed value for 9X004 is inherently flawed as 9X000 is not a base code to 9X004. All five new venography service codes, including 9X000, are add-on codes. As such, they all 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 of each of these add-on codes independently. The RUC-recommended work RVU is more accurate than the CMS proposed work RVU as it takes into account the change in intensity and 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 congenitally-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 are not present at birth, instead, they develop as complications of chronically high systemic venous pressures. The College 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. **The ACC urges CMS to finalize a work RVU of 2.11 for CPT code 9X004.**

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)

For CPT code 9X005, CMS disagrees with the approved RUC-recommended work RVU of 2.13 and believes that a work RVU of 2.04 is more accurate to account for the increased intra-service time compared with CPT code 9X000. CMS notes that 9X005 has an intra-service time (17 minutes) that is 70% greater than that of 9X000 (10 minutes). The proposed value of 2.04 appears to be obtained by assigning a work RVU that is 70% greater than the work RVU of 9X000. There is no further justification provided for the proposed value. CMS states, “Although we do not imply that increases in time as reflected in survey values must equate to a one-to-one or linear increase in the valuation of work RVUs . . .” yet that is exactly how the 9X005 valuation is formulated. The College believes using such mathematical or computational methodology to value physician work is

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inappropriate as it ignores magnitude estimation and is inconsistent with RBRVS principles.

Furthermore, even if such a method of valuation were appropriate, using a percentage of 9X000 to reach proposed value for 9X005 is inherently flawed as 9X000 is not a base code to 9X005. All five new venography service codes, including 9X000, are add-on codes. As such, they all 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 of each of these add-on codes independently. The RUC-recommended work RVU is more accurate than the CMS proposed work RVU as it takes into account the change in intensity and 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 are not present at birth, instead, they develop as complications of chronically high systemic venous pressures. The ACC 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. **The ACC urges CMS to accept a work RVU of 2.13 for CPT code 9X005.**

Remote Interrogation Device Evaluation – Cardiovascular (HCPCS code G2066, and CPT codes 93297, and 93298)

The ACC appreciates and supports CMS's proposal to create direct practice inputs and national pricing for CPT codes 93297 and 93298, and to delete code G2066 that had been contractor priced since CY 2020. This change will stabilize payment—based on the proposed inputs—for these services that had seen significant fluctuation throughout the country depending on variable MAC pricing.

In reviewing the specific inputs CMS proposes from the RUC-recommended direct PE inputs, one flaw in the formula and RUC recommendation for equipment time was discovered. As noted in the RUC recommendations submission, the RUC recommended two changes to the initially proposed inputs.

-EQ198 Default formula adjusted to remove 11 minutes from CA021 because equipment would not be used while tech is educating/ re-educating the patient; noted in table on page 4

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-CA021 reduced by 7 minutes to 4 minutes for shorter education/re-education staff time

However, the recommendation spreadsheet formula for equipment captured BOTH the removal of the 11 minutes from the equipment formula AND the removal of the additional 7 minutes when that clinical staff time was shortened, even though those 7 minutes were part of the previously removed 11 minutes. That approach reduces the equipment time for 93297 and 93298 by 18 minutes rather than 11 minutes. For 93297 the equipment time for EQ 198 should be 40 minus the 7-minute reduction to clinical staff time minus the remaining 4 minutes when staff is not using the equipment, $40-7-4=29$ rather than $40-11-7=22$. For 93298 it should be 76 minutes minus the 7-minute reduction to clinical staff time minus the remaining 4 minutes when staff is not using the equipment, $76-7-4=65$ rather than $76-11-7=58$. **We recommend CMS update the minutes for EQ198 by adding 7 minutes to both services to correct this inadvertent double reduction of minutes.**

The ACC supports CMS finalizing the proposal to create direct PE inputs for CPT codes 93297 and 93298 in place of HCPCS code G2066 with the noted corrections.

Office/Outpatient E/M Visit Complexity Add-on HCPCS code G2211

CMS proposes to move forward with previously finalized implementation of add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient's single, serious or complex condition.

The ACC appreciates CMS's intent to ensure that physicians are adequately paid for those patients that are outliers to the typical patient described in the valuation of office visits. However, we believe this code or similar future version, would be more effective if it were more clearly defined. The additional guidance in this proposed rule, which clarifies that the code will not be billable with the 25 modifier nor in situations where ongoing care by the physician is not expected, is helpful but insufficient. A definition of a "single, serious or complex condition" must be more clearly defined. Further, the vignettes utilized in the recent RUC survey of E/M services already often describe a patient that would have ongoing primary care services and/or have a single, serious or complex condition. For example, the vignette for 99215 is an office visit for an established patient with a chronic illness in a severe exacerbation that poses a threat to life or bodily function or an acute illness/injury that poses a threat to life or bodily function. The College believes that this lack of clarity in definition of the code could have multiple negative impacts. The lack of specificity could lead to inappropriately indiscriminate usage of the code. Such a vague description also leaves physicians extraordinarily susceptible to audit, post-payment review, and recoupment efforts; adding potential administrative and financial burdens.

The ACC remains uncertain of the description of this service, its applicability to cardiovascular care, and whether it is redundant to updated valuations for E/M codes. From a certain perspective it could conceivably be applicable to virtually all E/M visits.

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In the CY 2021 proposed utilization projections for add-on code G2211, CMS assumed the code would be applied to 58% of all office visit claims. The ACC appreciates that CMS heard concerns from stakeholders and adjusted its proposed utilization projection for G2211 in 2024 to 38% of all office/outpatient E/M visits but believes this is still too high. The ACC recommends that if the code is implemented, the agency begin with a conservative initial utilization estimate for the service. The College's experience is that even with established services that undergo redesign, utilization rarely hits the same threshold as the prior coding system for several years. In the instance of a brand-new code with definitional problems that will limit use by those leery of future compliance issues, the ACC suggests it would be appropriate for CMS to estimate G2211 utilization at 5% of relevant E/M services, or roughly 11 million units. This would more closely parallel the experience of transitional care management services in 2013, which seems a very reasonable analog for estimating initial use.

The ACC suggests that CMS delay implementation of G2211, more clearly define its purpose and usage parameters, and reduce its estimated utilization more than proposed to mirror the experience of transitional care management services more closely.

Request for Comment on Improving Evaluation and Management (E/M) Coding and Valuation

- a. Do the existing E/M HCPCS codes accurately define the full range of E/M services with appropriate gradations for intensity of services?*

The ACC generally believes the existing E/M codes accurately define the full range of E/M services as we understand them today. Existing processes may identify gaps that still need to be addressed, and cardiologists have raised some candidates for future action. Members commonly express that the complexity of managing heart failure patients' multiple comorbidities and medications or the amount of time needed to patiently counsel parents of a pediatric congenital patients are not fully captured anywhere in available codes, whether for E/M or therapeutic procedures. In those instances, prolonged service codes or modifiers for enhanced/increased work could correctly be billed, yet those solutions generally do not produce increased payment for those efforts. The codes and modifiers exist; CMS and other payers simply need to recognize them effectively.

- b. Are the methods used by the RUC and CMS appropriate to accurately value E/M and other HCPCS codes?*

The processes established by the RUC to provide recommendations to CMS is appropriate to accurately value E/M and other HCPCS codes. However, ACC has also commonly seen those recommendations disregarded by CMS when the agency proposes and implements values/inputs lower than the RUC recommendations. The Agency has stated, including in this proposed rule, that, "Although we do not imply that increases in time as reflected in survey values must equate to a one-to-one or linear increase in the valuation of work RVUs, we believe that since the two components of work are time and intensity, significant increases in time within the same code

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family should typically be reflected in increases to work RVUs.” In the next sentence, the Agency proposes a value it “believe[s] would be more accurate” for one code with 60% more time than a related code at 60% more value. This over-reliance on time rather than intensity, magnitude estimation, and physician expertise artificially lowers the values of individual services and distorts the relativity of the fee schedule. The RUC is also aware of these actions by CMS and in some instances may also be too sensitive to time.

c. Are the current Non-E/M HCPCS codes accurately defined?

Yes, the CPT Editorial Panel accurately defines current Non-E/M HCPCS codes.

d. Are the methods used by the RUC and CMS appropriate to accurately value the non-E/M codes?

While the CPT Editorial Process is equipped to accurately define Non-E/M HCPCS codes, the applicability of those codes to capture all the resources for a service in different settings of care is limited in some instances. In instances where high-cost supplies are utilized in the office setting, the inability to describe variability in a “typical” service means that additional codes must be created to capture variable practice expense costs, or that services that require additional or different high-cost supplies are significantly underpaid.

e. What are the consequences if services described by HCPCS codes are not accurately defined?

If a service is vaguely or incorrectly defined, it would create problems for billing and compliance staff. Should it be determined that a specific code does not describe a service in the way it was intended, the best mechanism to report a service may be through a general unlisted code. It is often challenging to obtain payment for unlisted codes, and some clinicians may choose or be unable to offer certain services without the certainty that comes from a dedicated code.

f. What are the consequences if services described by HCPCS codes are not accurately valued?

Incorrectly valued services distort relativity within the fee schedule and can inaccurately shift resources. Incorrectly valued services may also create incentives to avoid performing an undervalued service or embrace an overvalued one. Most commonly, throughout the broader healthcare ecosystem, clinicians find Medicare and Medicaid valuations to be inadequate and therefore they are required to limit patient access from those payers or cover costs by negotiating higher rates with non-governmental payers.

g. Should CMS consider valuation changes to other codes similar to the approach in section II.J.5. of this rule?

The ACC lacks expertise in the specifics of valuing timed behavioral health services. However, the proposed valuation changes CMS makes in II.J.5 do not appear to comport with the underlying principles of a resource-based relative value system.

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Split (or Shared) Evaluation and Management (E/M) Visits

The ACC appreciates CMS’s proposal to delay the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit; continuing to allow history, exam or medical decision making (MDM) to be included in the definition of “substantial portion” of the service, until at least January 1, 2025. While the proposed delay is appreciated, the ACC has concerns about the merits of the proposal and the confusion created by leaving this flawed policy intact but inapplicable for another year.

Cardiologists have a history of close collaboration with other advanced practice providers (APPs) to provide physician-led, team-based patient care. Patients benefit from the collaboration of physicians and QHPs who care for patients in hospitals, skilled nursing facilities, and other facilities. However, billing based on the physician or QHP who performs more than 50 percent of the total time of the visit will disincentivize and jeopardize the continuation of these care relationships and eliminate the value and clinical advantage of Team Based Care. This also undermines the need for clinicians to work at the top of their license and training. There is significant variability in how much time it takes to perform elements of the visit based on factors such as the level of training and expertise of the physician and QHP. Using medical decision making to direct the management of the patient’s care determines the course of treatment for the patient, but it typically does not require the most time. Just as is the case now, the physician or QHP who performs these critical elements of the visit should be able to bill for it.

While CMS believes time-based billing is auditable, CMS has a long history of auditing E/M services based on documentation in the medical record substantiating appropriate billing based on history, exam, and medical decision-making. CMS would still be able to use these same program integrity levers to audit split or shared visits billed on the basis of time or medical decision-making.

The proposed changes and the uncertainty regarding the timing of implementation of the new split (or shared) billing regulations has created a burden for hospital systems and physician groups. The work that is required to ensure compliance with the new CMS split (or shared) billing regulations while maintaining a healthy working relationship between physicians and APPs is extensive. These burdens include:

- Educating on the CMS split (or shared) billing changes
- Communicating the repeated changes to the timing of implementation
- Reviewing the volume of split (or shared) visits within a system
- Reviewing of medical staff bylaws to ensure compliance if care models are changed
- Changing medical staff bylaws if needed to meet the needs of workflow changes, a lengthy and complicated process
- Creating focus groups to review models of care to adapt workflows
- Sharing best practices between care teams
- Developing new compensation models
- Addressing threats to the system

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- Physician frustration with compensation impact in productivity models
- APP dissatisfaction if limited to practice in only the outpatient arena or low acuity services
- Providers leaving the organization, decreasing patient access to care
- Removal of APPs from hospital-based environments, risking impact to throughput, quality, and patient engagement, particularly in an academic setting in which learners rotate frequently and APPs serve as the constant to address these facets of care
- Strain in the collaborative relationship between physicians and APPs
- Enhanced compliance risks with CMS
- Duplicated workloads
- Increased cost to organizations

The ACC strongly urges CMS to fully abandon this policy in the CY 2024 final rule. Delay with the looming possibility of eventual implementation of the policy will be immensely disruptive to team-based care in the facility setting. Delay without full withdrawal of the policy would continue to place undue burdens of time and administrative capacity on practices and facilities as they continuously prepare for the change, then cease preparations, then begin again.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Medical Services

CMS has long been precluded from paying for dental services, though an exception exists for payment to be made under Medicare Part A when hospitalization is required because of a beneficiary’s underlying medical condition or the severity of the dental procedure. Additionally, payment is made for dental services that are an integral part of a covered primary procedure for dental services such as wiring of teeth for reduction of a jaw fracture, tooth extraction for radiation treatment, or oral exam on inpatient basis as part of comprehensive workup prior to renal transplant surgery.

After reconsideration of existing policies some view as unnecessarily restrictive, CMS in CY 2023 rulemaking worked to clarify and amend its existing interpretation of statute to pay for dental services under Parts A and B when “the dental service is inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services...” Specific examples include dental or oral exam as part of a workup prior to organ transplant, cardiac valve replacement, or valvuloplasty, and the diagnostics and treatments necessary to eliminate oral/dental infections before those procedures.

The ACC appreciates CMS’s thoughtfulness in implementing these updates to its payment rules for dental care. It is well established that chronic diseases disproportionately impact Medicare beneficiaries and impose a substantial cost on the federal government. It is also well established that untreated oral microbial infections are closely linked to a wide range of costly chronic conditions, including diabetes, heart disease, dementia, and stroke. In addition, oral diseases have been documented by researchers and medical specialty societies as precluding, delaying, and even jeopardizing medical treatments such as organ and stem cell transplantation, heart valve repair or

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replacement, cancer chemotherapies, placement of orthopedic prostheses, and management of autoimmune diseases.

The ACC supported CMS’s previous expansion of dental care, finding it consistent with relevant guidelines to assess and remediate oral health issues before valve procedures. Dental infections and poor oral health increase the risk of infection in a newly implanted heart valve. Patients can have primary bacterial endocarditis or, worse, prosthetic valve endocarditis secondary to neglected dental health and chronic dental abscesses. These are life-threatening situations that may be prevented with payment for medically necessary oral/dental health therapies.

At the same time, while the ACC believes that targeted coverage of these specific dental services will improve outcomes, CMS should proceed cautiously and be guided by strong evidence of when to conserve scarce resources as it considers additional services in the future under the newly proposed process, which seems appropriate at this juncture. In this CY 2024 proposed rule, CMS summarizes additional requests for dental coverage it has received and seeks additional information on whether dental services are inextricably linked to clinical success for implantation of electronic devices in the heart, such as pacemakers, cardioverter defibrillators, and monitors.

The CMS-commissioned AHRQ Rapid Response report, “Efficacy of Dental Services for Reducing Adverse Events in Those Undergoing Insertion of Implantable Cardiovascular Devices” correctly characterizes guidelines in which ACC participated that address valvular disease, congenital heart disease, heart failure, and rhythm disorders. Most guidelines do not make any recommendations for prophylactic dental procedures before undergoing subsequent cardiovascular procedures or device implantations. In contrast, other guidelines counsel the value of optimal oral health hygiene and the use of antibiotic prophylaxis to avoid infective endocarditis in patients with congenital heart disease and/or prior prosthetic valve implant. Current evidence may not support a role for pre-treatment dental care for preventing downstream infections related to implantation of ventricular assist devices, artificial pacemakers, implantable cardioverter defibrillators, synthetic grafts and patches, or coronary and vascular stents. However, as evidence and guidelines continue to evolve—especially as increasing emphasis is placed on both health equity and high-quality outcomes that conserve scarce health care resources—it may prove appropriate for CMS to determine dental services are inextricably linked to certain cardiovascular therapies in the future.

Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners

CMS proposes additions and revisions to implement statutory changes required by the Bipartisan Budget Act of 2018, which expanded the types of clinicians who may supervise pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation. To facilitate patient access to these underutilized services, the ACC vigorously supported that Improving Access to Cardiac and Pulmonary Rehabilitation Act—which passed as part of the Bipartisan Budget Act of 2018—to allow physician assistants, nurse practitioners, and clinical nurse specialists to supervise these services beginning January 1, 2024. **The proposed changes to the Code of Federal Regulations**

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appear to implement these changes, and ACC supports CMS's proposed definitions and standards.

Proposal for Shared Savings Program ACOs To Report Medicare CQMs

In the CY 2021 PFS final rule, CMS finalized modifications to the Shared Savings Program quality reporting requirements and quality performance standard for performance year 2021 and subsequent performance years. For performance year 2021 and subsequent years, ACOs are required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP). Through performance year 2024, ACOs must report the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs, and the CAHPS for MIPS survey. In performance year 2025 and subsequent performance years, ACOs must report the three eCQMs/MIPS CQMs and the CAHPS for MIPS survey. **Due to these modifications, the ACC has expressed concerns with requiring ACOs to submit eCQMs/MIPS CQMs through the APP due to the high costs of purchasing and implementing new data systems.** Additionally, the ACC notes that the financial burden of aggregating, deduplicating, and exporting eCQM data across multiple TINs and EHRs is very difficult for member practices. **ACC members participating in ACOs have faced challenges with the requirements to report all payer measures, including for patients not directly seen by specialists, which can in turn impact the ACO's performance.** Although CMS has extended this reporting incentive through PY 2024, the ACC would like to see CMS address the concerns related to data aggregation and the all-payer requirement.

Reporting Medicare CQMs

CMS is proposing to support ACOs in the transition to digital quality measure reporting by establishing the Medicare CQMs for ACOs participating in MSSP as a new collection type within the APP measure set. These Medicare CQMs would serve as a transitional collection type to help ACOs build the infrastructure and skills to report all payer/all patient MIPS CQMs and eCQMs through defining a population of beneficiaries. **The ACC thanks CMS for creating Medicare CQMs in an effort to allow ACOs with a higher proportion of specialty practices or multiple EHR systems to capture beneficiaries with no primary care relationships to the ACOs. This effort would allow for Medicare Parts A and B claims data to help identify ACOs' eligible populations and validate ACO patient matching and deduplication efforts.** However, the creation of Medicare CQMs may also not be the best data collection type for ACOs with single-EHR platforms or a high number of primary care practices. Under this proposal, CMS is also allowing ACOs to report quality data using the CMS Web Interface measures, eCQMs, and MIPS CQMs collection types. Ideally, CMS hopes that the Medicare CQM collection type would aid ACOs in the transition to all payer/all patient focused measures.

Benchmarking Policy for Medicare CQMs

CMS is proposing that new benchmarks for scoring ACOs on the Medicare CQMs under MIPS would be developed in alignment with MIPS benchmarking policies. For PY 2024 and PY 2025, CMS is proposing to score Medicare CQMs using performance period benchmarks. For PY 2026

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and subsequent years, CMS is proposing to allow ACOs to transition to using historical benchmarks for Medicare CQMs when the baseline period data is available to establish historical benchmarks.

Expanding the Health Equity Adjustment to Medicare CQMs

To support ACOs in the transition to all payer/all patient eCQMs/MIPS CQMs, CMS is proposing that ACOs that report Medicare CQMs would be eligible for a health equity adjustment to their quality performance category score when calculating shared savings payments. Specifically, for PY 2024 and subsequent years, an adjusted health equity quality performance score would be applied for an ACO that reports the three Medicare CQMs in the APP measure set and administers the CAHPS for MIPS survey. **The ACC supports CMS for proposing this change to advance equity within MSSP by supporting ACOs delivering high quality care and delivering care to underserved patient populations.**

Proposals to Modify the Health Equity Adjustment Underserved Multiplier

CMS is proposing to revise the underserved multiplier calculation to specify the calculations in further detail and allow consistency between the calculation of an ACO's assigned beneficiaries residing in a census block group with an ADI national percentile rank of at least 85 and the proportion of an ACO's assigned beneficiaries who are enrolled in Medicare Part D LIS or are dually eligible for Medicare and Medicaid. More specifically, CMS is proposing to remove beneficiaries who do not have a numeric national percentile rank available for ADI from the health equity adjustment calculation for PY 2023 and subsequent years. **The ACC supports this proposal to further health equity efforts as it will help to not penalize ACOs with beneficiaries that do not have a national percentile ADI rank beginning in 2024.**

Proposal to Use Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score

For PY 2024 and subsequent performance years, CMS is proposing to use historical submission-level MIPS Quality performance category scores to calculate the 40th percentile MIPS Quality performance category score. Specifically, CMS proposes to use a rolling 3-performance year average with a lag of 1 performance year. This proposal to use a 3-year historical average allows for ACOs to be provided a performance score that can be used as the quality performance standard for a given performance year prior to the start of that year. **The ACC supports the use of 3 historical base years to alleviate issues with scoring, and performance anomalies as was seen during the COVID-19 pandemic. The use of longer-term historical data will allow for limiting the impact of the MIPS targeted review and MIPS scoring corrections. However, using historical benchmarks will not reflect the most recent scores and measure specifications.**

Proposal to Apply a Shared Savings Program Scoring Policy for Excluded APP Measures

Currently, the Shared Savings Program does not determine excluded quality measures and does not allow ACOs to have a choice of measures that they can report under the APP. To avoid negatively

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impacting shared savings determinations for events outside of an ACO's control, CMS is proposing for PY 2024 and subsequent years that if an ACO reports all required measures under the APP and meets all data completeness requirements while receiving a MIPS Quality performance score under the ACO's total available measure achievement points, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS Quality performance category score to determine if an ACO meets the quality performance standard required to share in savings at the maximum rate under its track. **The ACC supports this proposal due to the potential of reducing the negative impacts of shared savings determinations that may arise if one or more of the quality measures under the APP is excluded.**

CMS also proposes to change the MIPS policy so the 10% threshold for coding changes, clinical guidelines and measure specifications is removed. **The ACC agrees with the removal of this threshold to allow for more flexibility for ACOs.**

Proposal to Align CEHRT Requirements for Shared Savings Programs with MIPS

CMS is proposing to remove the Shared Savings Program Certified Electronic Health Record Technology (CEHRT) threshold requirements. Additionally, beginning in PY 2024, require that all MIPS eligible clinicians, qualifying APM participants and partial qualifying APM participants regardless of track meet the following criteria:

- Report the MIPS Promoting Interoperability (PI) performance quality measures and requirements
- Earn a MIPS performance category score for the MIPS PI performance category at the individual, group or APM entity level
 - Applies to all MIPS eligible clinicians, QPs and Partial QPs participating in an ACO

CMS is also proposing to require ACOs to publicly report the number of MIPS eligible clinicians, QPs and partial QPs that participate in an ACO that earns a MIPS performance category score for the MIPS PI performance category. Additionally, CMS has proposed an additional requirement that ACOs report all measures under a MIPS PI performance category which removes the option for MIPS eligible clinicians, QPs and Partial QPs participating in an ACO to report MIPS PI performance categories at the individual or group level.

The ACC strongly believes that there should be a transitional delay for this requirement as January 1, 2024 is too early to require ACOs to begin reporting the MIPS PI quality measures and other requirements. The ACC recommends that CMS give ACOs a transition year and delay the implementation of this requirement until PY 2025 given that the deadline to submit a list of all MSSP participants for PY 2024 occurred on August 1, 2023.

With a goal to streamline requirements and alleviate the requirement burdens for ACOs, **the ACC believes that this proposal will have the opposite effect as it will increase compliance requirements and reporting.** This proposal will decrease participation incentives in APMs for specialists, thereby not meeting the CMS goal of moving more Medicare clinicians to APMs. To

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increase participation, CMS must consider efforts that would allow for flexibility with clinicians in healthcare systems.

Proposal to Revise the Requirement to Meet the Case Minimum Requirement for Quality Performance Standard Determinations

For PY 2024 and subsequent years, CMS is proposing to replace the references to meeting the case minimum requirement with a requirement that the ACO must receive a MIPS Quality performance category score to meet the quality performance standard. **The ACC believes that this proposal will better incorporate all case minimums in the MIPS Quality performance category scoring policy to determine an ACO's quality performance standard under MSSP.**

Proposal to Change QP Determinations within Alternative Payment Models (APMs)

Currently, CMS assesses most eligible clinicians at the APM entity level as a group for QP determination. However, CMS is now proposing to make QP determinations at the individual eligible clinician level only, instead of the APM Entity level. Additionally, CMS is increasing the QP thresholds beginning in PY 2024 for Medicare payments from 50% to 75% with the Partial QP threshold increasing from 40% to 50%. For Medicare patients, the QP threshold will increase from 35% to 50% and the Partial QP threshold will increase from 25% to 35%.

The ACC does not recommend making QP determinations at the individual clinician level as many cardiologists will not qualify and recommends instead to continue calculating QP determinations at both the APM entity and the individual level. Under the current MSSP exclusivity rule, cardiologists are unable to meet statutory thresholds within step 2 of 42 CFR 425.306. To enable cardiac specialists to reach QP threshold requirements, the ACC is proposing that CMS allow these clinicians to have the flexibility to participate in more than one Shared Savings Program.

Proposals to Adjust ACO Risk Adjustment

Proposal to Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap

CMS is proposing to modify the calculation of the regional component of the three-way blended benchmark update factor for agreement periods beginning on January 1, 2024, and subsequent years. This modification would cap the prospective HCC risk score growth in an ACO's regional service area between benchmark year three and the performance year. With this modification, the cap on regional score growth would be applied independently of the cap on an ACO's own prospective HCC risk score growth so that this cap in an ACO's regional service area would be applied whether or not the ACO's prospective risk score growth was capped.

The intended effect of this proposed regional risk score growth cap would increase the regional component of the update factor for ACOs in regions with aggregate regional prospective HCC risk score growth above the cap. ACOs in regions with aggregate regional prospective HCC risk score

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growth below the cap would ideally not be affected by this proposal. By connecting the risk score growth within an ACO's assigned beneficiary population and its accompanying geographic region, this proposal is ideally expected to improve the accuracy of the regional update factors for ACOs in regional service areas with high-risk score growth. **The ACC believes that capping the regional score growth would incentivize ACOs who serve underserved patient populations to continue serving these higher risk Medicare beneficiaries. The ACC has multiple members who are part of ACOs in regions with aggregate regional prospective HCC risk score growth above the cap. This proposal supports the CMS strategic objective to increase the number of beneficiaries in care relationships with more accountability for quality care.**

Proposed Modifications to the Shared Savings Program's Benchmarking Methodology — Negative Regional Adjustment

CMS believes that mitigating the impact of the negative regional adjustment would result in higher benchmarks for ACOs and bolster performance in MSSP. Under this new proposal, ACOs that may face a negative overall adjustment to their benchmark would benefit by not receiving a negative downward adjustment. **The ACC supports this proposal because members in ACOs that have negative regional adjustment amounts can benefit from no longer having the prior savings amount offset by the negative regional adjustment amount.**

Proposal to Add a Step Three to the Step-Wise Assignment Methodology Used to Assign Beneficiaries to ACOs

To better account for beneficiaries who receive primary care from a nurse practitioner, physician assistant or a clinical nurse specialist during the 12-month assignment window and who received at least one primary care service from a clinician, CMS is proposing to add these additional Medicare FFS beneficiaries to ACOs, including within underserved areas. **The ACC supports this proposal as it will increase access for beneficiaries by assigning more Medicare fee-for-service patients to ACOs in underserved areas.** Beginning in PY 2025 and subsequent years, CMS is proposing to add a new step three that utilizes a proposed extended timeframe of 24 months to identify additional beneficiaries for assignment. Allowing for a longer timeframe would increase the number of beneficiaries, especially in more rural areas. Additionally, these beneficiaries are oftentimes more likely to be disabled, enrolled in Medicare Part D or live in areas with higher ADI scores. The proposed changes would affect the downstream aspects of the Shared Savings Program that rely on assignment populations and assignable populations that identify for an ACO's regional service area.

Modifications to Advance Investment Payment Policies

CMS is planning to refine modifications to the Advance Investment Payment (AIP) policies to better prepare for an initial implementation of AIP beginning on January 1, 2024. CMS is proposing to support ACOs that are prepared to progress to performance-based risk by allowing them to advance to two-sided model levels within the BASIC track's glide path beginning in year three of the agreement period. CMS also is proposing to recoup advance investment payments from the shared

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savings of an ACO that wishes to renew early to continue participating in the Shared Savings Program instead of directly recouping the payments from the ACO. CMS also is now proposing to require ACOs to report their plan updates and send information directly to CMS in addition to publicly reporting the information. Additionally, CMS is proposing an addition to the policy where an ACO receiving AIPs can seek reconsideration review of all payment calculations beginning on January 1, 2024. **While the ACC understands that CMS plans to implement the AIP, these proposals will require additional reporting steps for the ACOs which would be burdensome and not beneficial in receiving payments in a timely manner. The ACC encourages CMS to consider proposals that would reduce extra steps for ACOs and instead allow for increased flexibility.**

Modifications to Shared Savings Program Eligibility Requirements

Shared Governance Requirement

Currently, CMS has not granted ACOs an exception to the rule that at least 75% of an ACO’s governing body must be held by ACO participants. They established the 75% rule to ensure that governing bodies are participant-led and able to meet program goals while allowing for a partnership with non-Medicare enrolled entities to provide necessary infrastructure for ACO formation and administration. Therefore, CMS is proposing to remove the option for ACOs to request extensions to the 75% requirement. **The ACC does not support this modification as ACOs should have the flexibility to request an extension if needed which will allow for continued participation in MSSP.**

Appropriate Use Criteria for Advanced Diagnostic Imaging

In this proposed rule CMS reviews in great detail all the efforts that have been made since 2015 to establish and implement the Appropriate Use Criteria (AUC) program as required by the Protecting Access to Medicare Act (PAMA). The agency also details all the reasons why full implementation of the AUC program is not practicable.

Reasons for this conclusion include:

- **Real-time Claims-based Reporting:** After many attempts and years of input by internal and external experts, the Agency has determined that this requirement of the Act is an “insurmountable barrier” to fully operationalizing the AUC program.
- **Accuracy of Claims Data:** As CMS claims processing system is unable to fully automate editing advanced diagnostic imaging claims, there is a substantial risk to reporting accuracy as the furnishing physician performing the service and attesting to the credibility and accuracy of the information will in many cases have little to no affiliation with the ordering physician. This could lead to an entity facing audit or post-payment review that was due to actions beyond the furnishing physician’s control.
- **Effect on Medicare Beneficiaries:** Due to the myriad of complications in identifying claims subject to the AUC and ensuring the ordering physician correctly reports the use of

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the AUC and the recognition of the use of an AUC by the furnishing physician, the process would likely contribute to many Medicare beneficiaries becoming financially responsible for services inappropriately denied payment and/or possibly have their services delayed.

The ACC applauds the Agency for recognizing the insurmountable barriers to full implementation of the AUC process as well as the detrimental effects the program would have on physicians, hospitals, imaging facilities, and most importantly, patients. **The ACC firmly supports CMS's proposal to pause efforts to implement the AUC program for reevaluation and rescind current regulations.** The College believes the program should be permanently withdrawn and will continue to work with members of Congress to remove this statutory requirement.

While the College supports this proposal to remove the arduous requirements of the AUC program, we agree with CMS's assertion that "clinical decision support tools can be beneficial in assisting with clinical decision making and we encourage continued use of clinical decision support in a manner that best serves and assists clinicians."

Updates to the Definitions of Certified Electronic Health Record Technology (CEHRT)

CMS proposes revisions to the CEHRT definitions in the Medicare PI Program and the Quality Payment Program to support the proposed transition from the historical state of year themed "editions" to the "edition-less state" in the ONC HTI-1 proposed rule. In comments submitted to the Office of the National Coordinator for Health IT (ONC), the ACC stated it agrees the previous naming convention of "year themed editions" inaccurately implied the age and outdatedness of the certification criteria and became confusing to know which edition was required for program adherence. **The College thanks CMS for working to align with ONC and proposing to modify the certification criteria to make it more clear for EPs to know which CEHRT system they should use to adhere to program requirements.**

Transforming the Quality Payment Program

Quality Payment Program Vision and Goals: Request for Feedback

CMS is soliciting information on additional opportunities for clinicians to continuously improve care as well as recommendations for future measure reporting or performance standard requirements. The College strongly supports the importance of continuous care improvement for cardiovascular clinicians. From the College's inception, the ACC has played a key role in the development of cardiovascular practice guidelines, clinical data registries, and educational classes as well as evidence-based quality and performance measures.

Based on member feedback and the annual performance data reporting, some of the primary concerns the ACC has related to multiple CMS quality reporting and value-based care programs like BPCI-A are the frequent requirement changes and the need to rapidly adapt to them. Frequent requirement changes create significant confusion and administrative burden for the clinicians and their practices, often driving practices to hire outside consultants to ensure compliance and adoption

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of perpetual administrative changes. These changes hinder the process for improvement when the underlying datasets are different year over year, causing an inability to compare performance.

As MIPS reporting transitions to MVPs, the College strongly encourages CMS to create a level of stability to its quality programs with a solid foundation which will not require frequent requirement changes. The ACC recommends at least a 2-4 year “no change” rule to provide clinicians with the assurance that they can participate in an appropriate MVP and identify areas of care for improvement which will ultimately improve patient outcomes.

CMS seeks input on incentives to move providers into APMs. The College believes providers will want to see financial incentives offered for achieving pre-specified quality and cost targets. These incentives can take the form of bonuses, shared savings, or enhanced reimbursement rates based on performance. In terms of burden reduction, streamlining administrative processes and reducing paperwork associated with APM participation will allow for more time to focus on patient care. Access to performance data can help clinicians identify areas for improvement and enhance their care delivery. Offering risk mitigation measures to providers who are transitioning from fee-for-service to APMs can ease providers into a new payment model and reduce the fear of financial losses. APM-specific training and support should be offered to providers on how to succeed in APMs. This support can include workshops, webinars, and ongoing guidance on care coordination, quality improvement, and cost management. The ACC also believes stable, long-term contracts with guaranteed revenue streams should be available for providers who commit to APMs.

Predictable revenue can make it more attractive for providers to invest in care transformation efforts. Access to additional resources and technical support, such as care coordinators, data analysts, and population health management tools should also be provided. These resources can support providers in delivering high-quality, efficient care. High-performing providers should be recognized publicly and promoted in their success in APMs. Positive reputational benefits can then attract other providers to participate in APMs. CMS should emphasize the alignment between APMs and patient-centered care models. When providers see that APMs reward better patient outcomes and improved patient experiences, they are more likely to engage. CMS can also help facilitate opportunities for providers to network and share best practices with peers who are already successful in APMs. Learning from others' experiences can increase confidence and knowledge about the benefits of APM participation.

Promoting Interoperability Performance Category

Certified Electronic Health Record Technology Requirements

CMS proposes revisions to the CEHRT definitions in the Medicare PI Program and the Quality Payment Program to support the proposed transition from the historical state of year themed “editions” to the “edition-less state” in the ONC HTI-1 proposed rule. In comments submitted to the Office of the National Coordinator for Health IT (ONC), the ACC stated it agrees the previous naming convention of “year themed editions” inaccurately implied the age and outdatedness of the certification criteria and became confusing to know which edition was required for program

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adherence. **The College thanks CMS for working to align with ONC and proposing to modify the certification criteria to make it more clear for EPs to know which CEHRT system they should use to adhere to program requirements.**

Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective

CMS proposes minor changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective by proposing to modify the second exclusion criterion to state that any MIPS eligible clinician who does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period can claim the second exclusion. **The ACC thanks CMS for ensuring clinicians who do not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period are not unfairly punished and penalized under the PI performance category.**

Changes to the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) Measure

Starting in CY 2024, CMS proposes to amend the SAFER Guides measure to require MIPS eligible clinicians to conduct this self-assessment annually, and attest a “yes” response, accounting for completion of the self-assessment for the High Priority Practices SAFER Guide. Eligible clinicians who report “no” will result in a score of zero for the whole Promoting Interoperability performance category. **While the ACC has been supportive of the development of measures that promote cyber security and EHR safety including the creation of the SAFER Guides measure, the College is concerned that CMS is prematurely making a “yes” response required before data showing the number of clinicians that were able to successfully attest “yes” to this measure for CY 2022 and CY 2023 is made publicly available.** While the measure would not require MIPS eligible clinicians to attest to whether they have implemented any best practices “fully in all areas” as described in the High Priority SAFER Guide, nor will a MIPS eligible clinician be scored on how many of the practices they have fully implemented, **the ACC encourages CMS to keep the measure as a “yes/no” attestation for CY 2024 and provide all eligible clinicians with an additional year to prepare for successful attestation of completion for the self-assessment.** To further encourage the implementation of cybersecurity measures and best practices, CMS could create a Practice Improvement measure that aligns with this measure and provide Practice Improvement Performance Category points for implementing SAFER Guide practices. By doing so, CMS would promote more meaningful, harmonized measures across MIPS performance categories and encourage development of better cyber security and EHR safety practices.

Public Reporting on Compare Tool

In CY 2023, CMS finalized the addition of an indicator to the profile pages of clinicians who furnish telehealth services to established processes and coding policies to identify such clinicians. Among the originally proposed policies, we proposed using Place of Service (POS) code 02 (indicating telehealth) on paid physician and ancillary service (that is, carrier) claims or modifier 95 appended on paid claims. For CY 2024, CMS proposes to update the policy for identifying clinicians furnishing

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telehealth services, to remain current with CMS coding changes, without proposing and finalizing such coding changes via rulemaking.

CMS believes if they are limited to the codes specifically finalized via rulemaking, the codes used to inform the telehealth indicator may be incomplete or outdated when they refresh the telehealth indicator on clinician profile pages throughout the year, resulting in users of the Compare tool receiving incorrect information. The ACC appreciates CMS' diligence in ensuring that information available to patients is as accurate as possible and supports efforts to ensure only up to date, complete information is available to Compare tool users. To that end, the ACC believes **it is important that CMS provide clinicians and groups with the ability to review and update any postings to physician compare tools, including telehealth service availability, to ensure they are correct.** Clinician review is a valuable mechanism for ensuring the information contained on comparison tools is correct.

Proposed Measure Additions

Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)

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.

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Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument

CMS proposes to add this measure due to its significance in filling a gap in maternal care. We are supportive of the inclusion of this measure as it will help promote education and awareness of CVD risk in pregnant and post-partum patients.

Proposed Measure Removal

Removal of Cardiac Stress Imaging Not Meeting Appropriate Use Criteria

CMS proposes the removal of this measure as a quality measure from MIPS because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying, making this measure extremely topped out. The ACC agrees with the removal of this measure from MIPS.

MIPS Value Pathways

The ACC sees limitations in MVPs ability to address the goal of streamlining and simplifying MIPS requirements. Despite ample possibilities to reduce complexity and customize the use of health IT for various care episodes or conditions, MVPs retain the same four distinct performance categories, each with its own scoring methodology. Surprisingly, the PI requirements remain identical for both MIPS and MVPs. Despite the availability of episode-based cost measures, MVPs persist in incorporating the challenging Total Per Capita Cost measure. Additionally, there is significant apprehension that the additional reporting burdens associated with MVPs, including the formation of subgroups, will overshadow the incremental changes implemented so far (e.g., reporting four instead of six quality measures). This concern raises the prospect that the program's challenges will not be resolved, but rather compounded.

Advancing Care for Heart Disease MVP Changes

CMS proposes the addition of the following measures in the Advancing Care for Heart Disease MVP. We address each of these additions in the text below.

- Q006: Coronary Artery Disease (CAD): Antiplatelet Therapy. This MIPS quality measure assesses that patients diagnosed with CAD are prescribed aspirin or clopidogrel.
- 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%). This MIPS quality measure assesses those patients diagnosed with CAD, in addition to a prior myocardial infarction or current or prior LVEF \leq 40%, are prescribed an ACE or ARB.
- Q487: Screening for Social Drivers of Health, which addresses health equity.
- TBD: Gains in Patient Activation Measure (PAM®) Scores at 12 Months. This proposed MIPS quality measure ensures capture of the patient voice and experience of care related to

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the patient's understanding and confidence in the ability to manage their health and be an active partner in their health care journey.

In the cost measure category, CMS also proposes to add the following two cost measures:

- MSPB Clinician. This MIPS cost measure applies to clinicians providing care in inpatient hospitals, including cardiac care.
- Heart Failure. This episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage and treat heart failure.

We agree with the additions of Q006: Coronary Artery Disease (CAD): Antiplatelet Therapy and 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

Like CMS, the ACC is committed to advancing equity in the delivery of healthcare to reduce disparities in cardiovascular practice. We are pleased that CMS has included one beneficiary-level SDOH measure for consideration in the Heart Disease MVP: *Screening for Social Drivers of Health*. This is an important step in providing appropriate services to patients and addressing the lack of standardized SDOH measures and interventions in CMS programs. The ACC further supports this measure with the recognition that aside from patient outcomes, SDOHs frequently impact clinicians' ability to provide adequate care, contribute to burnout, and deter participation in risk-sharing payment models. We also agree with CMS's proposed approach to first implement this measure through voluntary reporting.

The ACC believes that an additional benefit of accountability in SDOH is that it would lead to further participation in APMs. The availability of additional SDOH data could inform improvements in the development and refinement of risk-adjustment models used in measures and programs. The ACC recommends this measure be clearly linked to a strategy for implementation and indicative of improvement of the risk factors as described within the measure specifications. As such, infrastructure is needed to support the coordination and implementation of needed services for patients, and it is hoped that patients can be matched with the appropriate resources for their continued care.

The ACC has several concerns with the measure as written and reviewed under the Measures Application Partnership (MAP) review process. First, the measure developer did not provide evidence demonstrating that these processes are linked to improvements in health outcomes. In addition, the measure does not outline specific, standardized tools for facilities to use (e.g., The Accountable Health Communities Screening Tool). CMS will need to consider recommendations for standardization in terms of data collection, or whether to allow flexibility among facilities in their data collection and implementation efforts. Many facilities may not be equipped or prepared with the necessary resources and tools to address patient needs. Alternatively, some facilities may already

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be actively addressing patient needs in the community and may need to reconcile the ideal approach. Lastly, we caution against any undue burden on data collection among patients and clinicians.

While we recognize there are limitations with this measure, we believe it can be improved over time through CMS's annual measure review process and can provide the structure for similar measures in other quality programs. In all, this measure can begin to provide important data on the prevalence of several factors impacting better patient outcomes. Additional SDOH should be considered for the future such as education (both patient and clinician (e.g., bias training)), technology access, and medication cost and access. Finally, we are hopeful that the implementation of this measure may lead to improved technologies, community-based infrastructures, and further integration of healthcare and social services.

Gains in Patient Activation Measure

The ACC is in agreement with the addition of this measure with some caveats. Elevated PAM® scores signify patients who actively participate in their healthcare and possess confidence in managing their health, potentially leading to better cardiovascular outcomes. This measure sheds light on patients who excel in self-management and underscores the significance of strong doctor-patient communication.

Nonetheless, there are limitations to consider. The measure's scope is confined, overlooking crucial factors such as socioeconomic status, healthcare access, and comorbidities. As a survey-based tool, there exists the possibility of response bias, and implementing and administering it may present challenges due to time and resource constraints. The PAM® Scores at 12 Months quality measure offers valuable insights into patient activation and self-management in cardiology patients. However, 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.

Medicare Spending Per Beneficiary Clinician Measure

During the July 2020 committee deliberations of the National Quality Forum's Cost and Resource Use Committee, several major concerns with the MSPB-Clinician measure were raised. These included the ability to attribute a care episode to multiple clinicians and clinician groups; low reliability in testing for individual clinicians; the lack of adjustment for social risk factors; the questionable ability to predict downstream costs after a hospitalization; and whether the measure is useful or meaningful to beneficiaries in terms of distinguishing clinician performance. While Acumen did address the concerns outlined by the committee, we believe caution should be exercised in the utilization of this measure and the fact that the measure failed to receive endorsement from the consensus-based entity.

Attribution at the individual clinician level remains technically challenging, despite improvements to the attribution methodology. Often, clinicians are unaware of facility-level efforts to improve, especially if it pertains to “one-off” shared patients and when there is no routine sharing of responsibility for patient costs. Attribution to multiple clinicians/clinician groups, especially on a

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retrospective basis, leaves 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 onto administrative staff. This lack of specificity is an impediment to helping clinicians/practices TINs quickly identify where the key areas are that drive overall differences in spending, which ultimately will improve QI efforts. As such, the burden is then on the clinician 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.

Attribution for surgical procedures seem to follow a different set of rules: A few select surgical MS-DRGs are attributed using the 30% E&M rule, rather than a main procedure. During these surgical DRGs, the clinician(s) caring for the main disease process typically drive the care for the patient as opposed to the proceduralist who performed the primary procedure. Assignment at the group level is more desirable, and it has been shown that quality is not always tied to better care from an individual clinician. Early-career clinicians may also inadvertently take on sicker patients, or utilize more services, tests, etc., thus driving up costs. Assignment at the tax identification number (TIN) or sub-TIN level versus utilizing national provider identifier (NPI) is more appropriate.

Accountability at the clinician or small group level on this measure may lead to undesired effects of clinicians avoiding patients with social risk factors. There is a great deal of variation across practices (TINs) and individual clinicians in the extent to which they care for people with social risk factors. While it may not have much of an impact on average, it is at the tails of the distribution where the effects are more apparent. Risk adjustment does not change the scores for most providers in most cases, but it does have an impact for those with large fractions of patients with social risk factors. Clinicians typically do not have control over their TIN assignments, and they are generally used for financial and billing purposes and not intended for quality improvement programs.

Participation in a Virtual Group may be one solution to the cost category conundrum for specialists. Virtual groups are typically a combination of two or more Taxpayer Identification Numbers (TINs) that choose to form a virtual group for the performance year, with no limit on the number of TINs. Individuals, groups of less than 10, or a combination of both can be utilized. This approach may make it more beneficial in creating more reasonable attribution for drivable costs and quality measures.

The measure broadly follows CMS's Hierarchical Condition Category (HCC) risk adjustment model, which is not sensitive to social risk factors as that data is not typically available from claims. It appears that gender and dual-eligibility status are utilized as SES proxies. At the time of testing, the risk adjustment model showed R-squared results ranging from 0.09 to 0.64 across the different groupings of providers. We suggest use of the Area Deprivation Index (ADI) be considered; it is readily available in terms of publicly reported data and is more robust in providing a better sense of the true social needs of patients.

Finally, we suggest incorporating the patient perspective in the measure, if appropriate and feasible, though this would likely require data beyond claims. Advanced-analytics models that predict patient

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readmission risk and guide intervention strategies are another critical technology opportunity that may supplant the prior suggestion, however. Associated quality measures could include assessments such as patient reported outcomes measures (PROMs) and discharge/post-discharge patient engagement at the facility level. The first few days of discharge provide a critical opportunity for care coordinators to engage with patients on activities including scheduling PCP or specialist follow-up visits, ensuring adherence to taking medications, identifying discharge destination preferences, and addressing potential barriers to healthcare access.

Heart Failure Cost Measure

The College continues to have concerns that due to the complexity and heterogeneity of this patient population, any cost measure for heart failure (HF) has the potential to create unintended consequences impacting the ability to provide guideline-directed care. We have provided comments to the CMS contractor, Acumen, on this measure in the past, but share them here as well.

Trigger Event Codes: We find it challenging to envision a situation in which CPT trigger confirming codes for a clinician other than a physician would prompt an episode for HF unless the patient's HF is already known to the clinician (e.g., 99304, 99324). Similarly, telephone and internet assessments are unlikely to trigger a diagnosis of HF, and thus we recommend their removal from the trigger list (e.g., 99425). Additionally, while certain diagnosis codes for cardiomyopathies are included, others are omitted.

Categorizing Subtypes of HF: The ACC proposes that the categorization of HF 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 HF are captured, excluding patients with conditions like end-stage renal disease that may present with HF-like symptoms but have a different underlying condition.

Due to the progressive nature of HF, accurately placing patients on their syndrome trajectory based on claims data or staging systems remains challenging. Additionally, diagnosing, treating, and assessing outcomes for HFpEF patients pose difficulties due to the limitations of claims data, which do not provide detailed information on left ventricular ejection fraction (LVEF) or distinguish between different types of HF, despite frequently using codes for systolic, diastolic, acute, and chronic Congestive HF (CHF).

The ACC encourages Acumen to explore the potential use of modeling as a proxy to assess EF classes for HF patients. Researchers have demonstrated the ability to differentiate patients with a suitable level of sensitivity, specificity, and positive predictive value. This differentiation could prove valuable not only in evaluating health outcomes but also in understanding healthcare utilization and costs among HF patients.

Furthermore, the ACC suggests reviewing the recently updated Universal Definition and Classification of HF, which offers a revised definition of HF and a classification based on LVEF.

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This revised classification may enhance patient risk stratification, leading to improved treatment indications and assessment of guideline-directed medical therapy.

Risk-Adjustment: Moreover, it is essential to consider excluding or implementing risk-adjustment for the following codes. The College expresses concern that attributing certain patients to a HF cost measure might have unintended consequences, penalizing clinicians who treat patients where HF is an underlying condition or populations for which strong evidence-based measures for quality outcomes are lacking.

The first set of codes to consider for exclusion pertains to I50.3 and its subcodes, which represent the family of exclusively diastolic HF codes. Given the absence of outcomes data on optimal care for diastolic dysfunction, it would be prudent to exclude this category. Doing so would eliminate the common situation of "volume overload from inadequate dialysis" frequently miscoded as diastolic HF, especially since most end-stage renal disease patients exhibit diastolic dysfunction. These codes that should be excluded are:

- I5030 Unspecified Diastolic (Congestive) HF
- I5031 Acute Diastolic (Congestive) HF
- I5032 Chronic Diastolic (Congestive) HF
- I5033 Acute on Chronic Diastolic (Congestive) HF

Similarly, other codes that merit consideration for exclusion or risk-adjustment (instead of attribution) are I50.8 and its subcodes, except for I50.814 (Right HF Due to a Left HF) and I50.82 (Biventricular HF). This group comprises the "other HF" codes. For instance, assessing performance for "high output failure" within this series may not be desirable, as there is no established treatment for this small subset of patients. Excluding such cases could benefit treating clinicians by mitigating additional complexities. Furthermore, the accuracy of risk-adjustment for dialysis remains uncertain, and if deemed unreliable, it should be removed.

Despite these recommendations, the ACC reiterates the difficulty of creating a cost measure for chronic HF, evident in the coding structure that highlights the heterogeneity of this patient population.

Attribution: The ACC believes that attribution of care for a complex longitudinal condition such as HF to a single clinician under MIPS will have inherent flaws. Even at the group level, attribution remains a challenge when care crosses a continuum of time and patients see a variety of clinicians in multiple settings, or even by clinicians under multiple 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.

The ACC 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

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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.

Advanced Practice Provider Attribution: Cardiologists, primary care clinicians, clinician assistants, advanced practice nurses, and other specialties make up the care team for a chronic HF patient. As more clinicians implement team-based approaches, advanced practice providers (APPs) are engaging in more patient encounters that lead to better patient management. Because of this, the ACC recommends excluding APP encounters in the attribution process, as there is the potential for individual APPs to be attributed full costs of care for the episode. If APP encounters must be included, then they should be benchmarked to the appropriate cardiology specialty and not default to primary care attribution. We would further recommend creating subgroups based on clinician type in order to group like clinicians with each other as an enhancement of the data, which currently encompasses all clinician types in one TIN.

Subspecialty Attribution: Based on feedback from ACC members, many have noted that electrophysiologists are typically singled out in the “top five” list of high-cost providers in a TIN based on their field report data. EPs are one of many highly specialized and technical subspecialties in the cardiovascular service line. Not only does the EP implant a device, they are also responsible for monitoring and adjusting the device over time. While the EP manages this aspect of the patient’s care, they are often not the primary clinician responsible for overall management of HF.

Technological advancements and an aging population are expected to drive growth for EP services, signaling those costs will continue to rise and further target EPs and other interventionalists in the cost domain. Treatment provided under the care of an EP who provides patients with the right treatment based on evidence-based guidelines may prove beneficial in the long-term clinical outcomes of patients despite potential higher costs of care. Much of this cost is related to the cost of the device or treatments used and not the work provided by the EP, which continues to be subject to cuts under the Physician Fee Schedule.

We encourage CMS and Acumen to consider unintended consequences of specialists and subspecialists being identified as high-cost providers. While this may not necessarily have an impact on the overall placement of a group within the MIPS cost distribution, the ACC is concerned that it may lead to inaccurate assumptions that these “high-cost” clinicians are providing low-quality care. We urge CMS to examine the reasons driving high-cost designations and to determine how to mitigate the impact this may have on the ability to provide the best care for the patient.

Assigning Costs to the Episode Group: As our members have reviewed their data, it appears that any potential savings are often eradicated by the use of a small number of cardiac procedures that cost more than the national average. Since these higher-than-average costs are medically necessary, it will be a challenge for our members to make changes to improve costs. Again, these costs may be out of the control of the individual clinician and dependent on a multitude of factors. The ACC continues

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to urge that any cost measure be counterbalanced with relevant clinical quality measures to show the full picture of cost and outcomes.

Based on member feedback, we recommend that the “Service Use and Cost by HF Clinical Theme” areas (Table 3 of mock field test report) be further refined to provide clinicians with more actionable information. Specifically, the “Cardiopulmonary Procedures/Interventions” theme is too broad to help drive any decisions around how to potentially manage costs. A breakdown of other costs into groups such as cardiac catheterization, EP procedures (e.g., ICD/CRT, AF ablations), and interventional valve therapies would provide stakeholders with a more specific blueprint for where spending is occurring. It is also unclear if this theme also includes surgery, TAVR, and resynchronization therapy; we would recommend that the report clarify this if additional detail is provided.

Finally, it would be more constructive to break out the “Part D” drugs category into drug types or drug categories to provide additional actionable data around prescribing practices. However, we continue to note that medications should be prescribed based on the specific patient’s needs and preferences and remain concerned around holding clinicians accountable for the costs of Part D drugs without measuring the impact on quality and outcomes. Since HF is a complex syndrome which often presents with comorbidities, it is essential to consider that many patients are often on multiple medications. This usually means that patients will require additional follow-up visits to assess medication tolerance, titration, and effectiveness. Consideration should also be given to the potential that patients may have to substitute or forego certain therapies due to cost or lack of insurance coverage (e.g., Angiotensin Receptor-Nepriylsin Inhibitors), and access and adherence issues, for example.

These scenarios can have an influence on cost and patient outcomes and vary from patient to patient. Therefore, Acumen and CMS should closely monitor the impact of the HF cost measure to ensure that it does not negatively impact patient access to appropriate medications and medication management.

Overall Risk-Adjustment: The College continues to underscore the importance of exploring how to incorporate data on social determinants of health to assess their impact on patient cost and quality outcomes. Dual eligibility status could be one such method, but other variables should be explored. We continue to recommend the incorporation of social determinants of health and health equity factors, when possible, especially as they relate to cost and outcomes.

Aligning Cost with Quality: The ACC strongly recommends the alignment of cost measures with quality measures to ensure that the quality of care is not negatively impacted by attempts to control cost. Much of HF patient care occurs in the outpatient setting and as such, measures of care in this setting remain appropriate and deserve consideration for alignment. One caution is that since many patients are seen on an outpatient basis, this may also result in admissions of more complex patients, and thus may increase readmissions. Any cost measure must avoid penalizing clinicians for medically necessary admissions of complex patient cases. At a minimum, the ACC recommends the following quality measures for consideration to align with any cost measure for chronic HF:

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- QCDR measure ACCPIN3: HF: Patient Self Care Education
- CMS #008: Beta Blocker use for LV dysfunction
- CMS #005: ACEi/ARB/ARNI use for LV dysfunction
- CMS #236: Controlling high blood pressure

Quality of life, care coordination, reducing disparities in care and outcomes for racial and ethnic minorities, palliative and end-of-life care, patient education, disease management programs and safety measures should also be tied to HF as these are important considerations for chronic disease management.

Overall Considerations of the Heart Failure Cost Measure: The College continues to emphasize consideration of the heterogeneity of the heart failure population, as well as the impact of health inequities, patient clinical complexity, and social determinants of health on differences in average costs. We would also caution against any overall or specific unintended consequences of the measure, most notably if the measure could potentially inhibit guideline-directed care. A revision of the AHA/ACC/HFSA Guideline for the Management of Heart Failure was released in 2022. We encourage CMS and the Acumen team to consider the new update to ensure that the cost measure promotes optimal patient care in accordance with the guideline.

MVP Reporting for Specialists in Shared Savings Program ACOs - Request for Information (RFI)

In this Request for Information (RFI), CMS outlines the feedback received to date, indicating concerns that the current APP measure set for ACOs could disproportionately favor primary care and not align well with specialists' needs. Consequently, CMS seeks insights on effectively motivating specialists to engage in ACOs, specifically through reporting pertinent quality measures via MIPS Value Pathways (MVPs). We commend CMS for its commitment to enhancing specialist participation and for exploring the potential appeal of MVPs to specialists. Nevertheless, we believe this approach presents a dual challenge, and the integration of MIPS program elements into ACOs may introduce complexities.

A notable drawback of MVPs lies in the limitation of available quality measures, potentially failing to cater optimally to specialists' reporting requirements. Given the diverse subfields within cardiology, as an example, this constraint could pose difficulties in incentivizing the entire specialty to participate. Moreover, after analyzing CMS's Experience Report cardiology-specific quality measures, we found that the most frequently reported measures do not predominantly pertain to cardiovascular care. Rather, they mirror the measures reported by all eligible MIPS participants. Thus, it's plausible that utilizing these measures may not effectively attract specialists towards ACO participation. While it would entail more thoughtful discussion and consideration, 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.

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Performance Threshold Modification to Three Performance Periods

CMS is proposing to use the prior three performance periods, as opposed to one single period, to establish a performance threshold for final scores. While we do agree that it can provide a more comprehensive view of performance trends and stability, there are some potential drawbacks related to delayed feedback, adaptability to changing practices (e.g., release of new guidelines), and the timeliness of incorporating new evidence-based practices. The decision to use a longer timeframe should be carefully evaluated based on the specific goals of the MIPS program and its impact on clinicians' ability to continuously improve care. Clinicians may be uncertain about how their performance will be assessed in the future, which could impact their motivation to invest in quality improvement initiatives. While we agree this is an important step in utilizing a more comprehensive analysis, we think that CMS should delay any such implementation for the short-term, especially with the recent PHE.

Performance Threshold Increase for the CY 2024 Performance Period/2026 MIPS Payment Year

CMS is considering a notable adjustment by raising the performance threshold from 75 to 82 points. While this increase would extend across all three MIPS reporting avenues (traditional MIPS, MVPs, and the APP), and impact payment adjustments, it is important to acknowledge potential drawbacks. The introduction of proposed payment reductions, an absence of an inflationary update, and the prospect of heightened penalties attributed to the escalated performance threshold collectively contribute to an unsustainable scenario. The confluence of these changes may further exacerbate wariness in participation and the financial incentives provided by a higher adjustment might not be substantial enough to motivate significant changes in provider behavior. Smaller practices, in particular, might find it difficult to recoup the investment required for reporting.

Public Reporting of Cost Measures

CMS proposes to publicly report cost measure information on clinician and group-level profile pages beginning with the 2024 Performance Period/2026 MIPS Payment Year. While CMS has already conducted consumer testing of such information, we encourage continued testing not only with the patient/consumer population, but also with clinicians. Just as the cost measures that have been developed to date, we believe these should also be “field tested” with clinicians for their experience and perception. Opinions on public reporting can be nuanced, and clinicians’ views may evolve based on their experiences, the specific measures being reported, and the overall context of their use. A major concern stems from the recent release of the 2021 QPP data. After analyzing the public use file data, we found that the top measures reported by clinicians in the specialty of Cardiology were the same measures reported by ALL participants. In short, in most cases, the MIPS score assigned to a physician does not represent the quality or value of the services delivered by that physician; it represents the services delivered by a group of physicians in their group practice or ACO.

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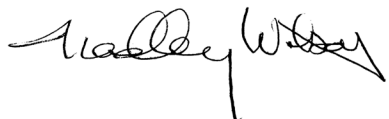
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Existing concerns surrounding specific cost measures like the Heart Failure cost measure, TPCC, and MSPB underscore a broader trend: cost measures, in general, are not yet ready for public disclosure and widespread use. CMS should weigh the drawbacks associated with publicly reporting cost measures, much like any other forms of publicly reported metrics. It's crucial to recognize that such measures can be susceptible to oversimplification and might not accurately capture the intricate nature of healthcare delivery. Clinicians may feel pressure to reduce costs in order to improve their "rankings", which could lead to cherry-picking of patients, undertreatment, or an aversion to risk. Clinicians may also feel less trust in what is being reported, and that the measures do not accurately reflect the value of their services. These measures add to the pressures clinicians face in managing costs and may impact professional satisfaction, giving them the sense that quality is not a priority in patient care.

Conclusion

Thank you for your consideration of these comments and the Agency's work on behalf of Medicare beneficiaries. Please contact Matthew Minnella, Associated Director of Medicare Payment Policy, at mminnella@acc.org should any additional information be needed.

Sincerely,



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