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The mission of the American College of Cardiology and the American College of Cardiology Foundation is to transform cardiovascular care and improve heart health.

October 12, 2017

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

Re: Medicare Program: Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models: Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)

Dear Administrator Verma:

The American College of Cardiology (ACC) appreciates the opportunity to comment on the proposed cancellation rule for Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models (CMS-5524-P) published in the August 15, 2017 Federal Register.

The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 52,000 members is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards and guidelines. The College operates national registries to measure and improve care, offers cardiovascular accreditation to hospitals and institutions, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications.

General Comments:

ACC requests that CMS review the College's prior comment letters on CMS-5519-P (9/30/2016) and on CMS-5519-IFC (April 18, 2017) for themes expressed on behalf of our members. Also, ACC is a co-signer of an August 30, 2017 letter along with the American Heart Association and the American Association of Cardiovascular and Pulmonary Rehabilitation. The letter requests a discussion with CMS focused on how the cardiac rehabilitation model could be redesigned to move forward and provides useful results specifically citing the benefits of this therapy for patients.

The College believes that value-based payment models have significant potential to enhance patient care and shares the CMS goals of improving quality of care while lowering the costs for Medicare beneficiaries. ACC appreciated CMS initiatives in the prior rules to create pathways to reward specialists for delivering quality care through value-based payment models. In the cancellation proposed rule CMS noted that providers interested in participating in Advanced APM's may have that opportunity to engage during calendar year 2018 via the new voluntary bundled payment model(s) (also referred to as BPCI 2.0). ACC is specifically requesting that CMS be transparent and seek input/guidance of specialty societies in the design of the model prior to soliciting applications and securing participant agreements. Timeliness is particularly important to give providers adequate time to prepare and transition into a BPCI 2.0 arrangement for calendar year 2018. Similar to the current BPCI initiative, which included a number of cardiovascular conditions, ACC is supportive of a CMMI offering beyond AMI and CABG episodes. CMS also should remain mindful of the potential for bias selection for a voluntary model and ensure safeguards are incorporated into the model design to account for this.

The ACC disagrees with the CMS statement in the proposed cancellation rule that "we do not anticipate that our proposal to cancel the EPMs and cardiac rehabilitation incentive payment model prior to the start date of those models will have any costs to providers." Since the EPM final rule was issued in January 2017, providers in the selected Metropolitan Statistical Areas (MSAs) have incurred infrastructure and human resource costs in preparation for implementation. This provides additional rationale on why CMS must proactively seek input of specialty societies, such as ACC, in a timely manner to ensure investment protection for our members that opt to participate in the future BPCI 2.0 initiative.

ACC's specific comments on the proposed cancellation rule are organized into two sections: cardiac rehabilitation payment initiative and episode payment model for AMI, respectively.

Cardiac Rehabilitation Incentive Payment Initiative:

ACC was disappointed that CMS proposed cancellation of the cardiac rehabilitation incentive payment initiative, especially in light of the statement within the proposed rule that "we also note the strong evidence base and other positive stakeholder feedback that we have received regarding the CR incentive payment model."

While CMS noted that reconsideration of the stakeholder feedback for a potential voluntary initiative may be considered in the future, there is no mention of this in the recently released CMMI RFI on new direction. The College provided extensive comments in the September 30, 2016 letter on potential improvements to the proposed cardiac rehabilitation incentive payment initiative and requests that CMS carefully consider these for future planning purposes. Specific comments focused on site-specific vs. condition-specific physician supervision waiver, opportunities to use the incentive payment to support beneficiary engagement incentives to promote a heart healthy lifestyle and lower patient co-payments for services and considering sharing of incentive payments between appropriate institutions.

The College thanks CMMI for responding to our August 30, 2017 request for a meeting on November 6, 2017 to engage in meaningful dialogue on future initiatives directed toward patients for

much needed, but underutilized, cardiac rehabilitation and intensive cardiac rehabilitation services. The ACC requests that CMS consider expanding the conditions for a cardiac rehabilitation incentive payment initiative beyond AMI and CABG to benefit a larger segment of patients with cardiovascular disease.

The ACC also remains committed to our support for the passage of H.R. 1155/ S. 1361 bills introduced to expand access to cardiac rehabilitation by allowing physician assistants, nurse practitioners and clinical nurse specialists to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs across the U.S. as noted in our prior comment letters.

Episode Payment Model - AMI:

To reinforce the themes from the College's prior comment letters specific to the AMI episode payment model it is our belief that:

Establishing clinical homogeneity by limiting inclusion to the most clinically similar subset of patients allows for meaningful comparisons and would provide CMS with the opportunity to clearly evaluate the impact of EPM's on patient care and outcomes. In prior comment letters and discussions the ACC highlighted the need to limit the AMI model to STEMI patients discharged under AMI MS-DRG's and PCI MS-DRG's with an AMI ICD-10 CM code only in the principal diagnosis code position. If both STEMI and NSTEMI patients were included, ACC strongly recommended limiting the AMI model to patients with a Type 1 MI. The September 30, 2016 and April 18, 2017 letter(s) explained ACC's rationale in detail and we request that CMS review those comments again in the development of an AMI BPCI 2.0 model;

The potential for unintended consequences for patient selection must be addressed. In addition to ESRD, ACC strongly recommends excluding cardiogenic shock and sepsis patients in the design of a BPCI 2.0 AMI episode. That subset of patients generally has a higher mortality rate in comparison to other cardiac conditions. Additional detail on the rationale can be found in the September 30, 2016 comment letter;

Collaboration with ACC to improve patient care coordination through the use of available resources for care coordination including ACC quality programs and our well-established registries has great potential to improve the quality of patient care while potentially lowering costs for patients. In ACC's April 18, 2017 comment letter, the College highlighted two programs: Patient Navigator and Surviving AMI (SAMI). ACC welcomes the opportunity to work with CMS to make these resources available to participants in future CMS offerings; and

The National Cardiovascular Disease Registry (NCDR) captures measure data used for quality performance reporting. The College strongly advocates for the use of the NCDR registries to support measurement efforts for the future models being proposed. Additional background on NCDR's registry suite is discussed within the April 18, 2017 comment letter.

Conclusion:

ACC is committed to working with CMS and providers to enable success in the value-based payment environment. The College looks forward to ongoing discussion and collaboration with

CMS in creating opportunities for cardiologists and the cardiovascular team to participate in Advanced APM's and other value-based payment initiatives. Finally, the College continues to support delivery and payment models the encourage increased access to cardiac rehabilitation and intensive cardiac rehabilitation services. The ACC appreciates CMS consideration of the comments in this letter as well as the focus areas noted in our prior comment letters (9/30/2017 – CMS-5519-P and 4/18/2017 – CMS – 5519 – IFC). If you have any questions or would like additional information regarding any recommendations, please contact Rhonda Taller, Team Lead, Payment Reform Advocacy, at (202) 375-6550 or rtaller@acc.org.

Sincerely,

Mary Norine Walsh, MD, FACC
President