AMERICAN COLLEGE of CARDIOLOGY

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September 9, 2024

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 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

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 CY2025 Physician Fee Schedule and Other Changes to Part B Payment Policies proposed rule. The College's comments focus on multiple new code proposals, telehealth policy, 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 $33.2875 to $32.3562. This is a 2.8 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 2025 will be 3.6 percent. Whether independent or employed,

physician practices and their affiliated health systems cannot continue to absorb increasing costs to run their practices while reimbursements continue to decrease.

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.

In their June 2024 Report to Congress, MedPAC addresses the gap between the costs of providing care and Medicare payment and states, "[t]his larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely." MedPAC also expressed concern about how the lack of an inflation-based update for physician payment is exacerbating the site of service differential, which distorts competition and could increase vertical consolidation, increasing spending by the Medicare program, patients, and taxpayers. **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 2025. Practice costs are estimated to increase 3.6% in 2025, worsening the gap between the Medicare physician payment update and the real costs to practice.**

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.

II.D. Payment for Telehealth Services

As limited by law, CMS makes no proposals to extend geographic and location waivers for telehealth services under section 1834(m) of the Social Security Act beyond December 31, 2024. The College recognizes that limitation yet feels compelled to highlight the important role these flexibilities have played in recent years. The ACC and the broad house of medicine support legislation under consideration in Congress to extend those flexibilities. **We urge CMS to be ready to implement that policy if/when it passes.**

Cardiovascular and Pulmonary Rehabilitation

As in the CY 2024 rulemaking cycle, CMS again acknowledges receiving multiple requests to permanently add Cardiovascular and Pulmonary Rehabilitation services to the Medicare Telehealth Services List on a permanent basis. CMS instead proposes to continue to include these services on the Medicare Telehealth Services List through CY 2025 on a provisional basis while conducting a comprehensive review of this and several other services for potential permanent addition to the list.

The ACC thanks CMS for acknowledging the safety and efficacy of Cardiovascular and Pulmonary Rehabilitation services and extending these services on a provisional basis through 2025. The College continues to strongly recommend these services be added to the permanent Medicare Telehealth Service List.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

CMS proposes to amend the definition of "interactive telecommunications system" to allow for audio-only services to be provided to a beneficiary in their home (when the patients home is a permissible originating site) if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined previously, but the patient is not capable of, or does not consent to, the use of video technology. **The ACC supports this proposal.**

Distant Site Requirements

CMS proposes to continue to allow a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2025. **The ACC strongly supports this proposal and encourages CMS to make this policy permanent.**

Direct Supervision via Use of Two-way Audio/Video Communications Technology

Noting concerns about an abrupt transition to the pre-public health emergency (PHE) policy that defines direct supervision to require the physical presence of the supervising practitioner considering newly established practice patterns during the PHE, CMS proposes to again extend the amended definition of direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. **Since the beginning of the PHE, the ACC has supported this flexibility and appreciates this extension**.

Proposal to Permanently Define "Direct Supervision" to Include Audio-Video Communications Technology for a Subset of Services

In this rule, CMS proposes to update the definition of direct supervision to allow for "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26: (1) services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and (2) services described by CPT code 99211 (*Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional*). This incremental approach would allow virtual presence for services that are inherently lower risk.

The ACC previously commented in support of direct supervision via two-way audio/video communications technology and supports the proposal to apply this updated definition to a subset of services in 2025. In response to comment solicitation a year ago, the ACC noted that applying that approach for certain services that are nearly always performed in entirety by auxiliary personnel could prove a conservative approach to test such a change 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 that is utilized for patients with cardiovascular disease is G0166 for a session of external counter-pulsation 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 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 or 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 in future rulemaking as long as other members of the cardiovascular care team are appropriately trained and licensed.

II.E. Valuation of Specific Codes

New Telemedicine Evaluation and Management (E/M) Service Codes

The CPT Editorial Panel created 17 new codes to represent various E/M services when performed via telemedicine. There were codes analogous to existing E/M codes for straightforward, low, medium, and high medical decision-making visits with separate versions for new and established patients as well as when performed via audio-video and audio-only means. There was also a code, 9X091, created to replace G2012 for a brief, technology-based communication.

In reviewing this new code set the agency notes that codes 9X075-9X090 describe services that would otherwise be furnished in person, and as such are subject to 1834(m) of the Act. Therefore, per statute, if these codes were added to the Medicare telehealth services list, they would have to be assigned RVUs equal to their corresponding non-telehealth E/M services. While including codes 9X075-9X090 at their RUC recommended values in the proposed rule via Addendum B, the agency proposes assigning these codes a Procedure Status indicator of "I", meaning there is a more specific code that should be used for purposes of Medicare. The direction is to use the existing office/outpatient E/M codes with the appropriate POS code to identify the location of the beneficiary and, when applicable, the appropriate modifier to identify the service as being delivered via telemedicine.

CMS did recommend acceptance of the CPT code 9X091 for *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*. The agency noted that, like the G2012 code it is replacing, 9X091 would be considered a communication technology-based service that is not subject to the requirements of section of the Act applicable to Medicare telehealth services.

The ACC along with dozens of other national medical societies spent considerable resources in surveying and valuing this large family of new codes twice. This significant endeavor was undertaken to arrive at a consensus agreement of the medical field as to the most fair and accurate valuation of E/M services being done via telemedicine. This evolution within CPT coding has been shown necessary in the wake of the COVID-19 PHE, which brought to light the advances in patient care access that could be achieved with the expansion of telemedicine. The College understands the statutory restrictions CMS notes in the proposed rule regarding active implementation of work and PE RVUs for these codes. **The College encourages CMS to finalize publication of the relative values for these services so they may be used upon a change in status indicator should future statutory changes allow. The College also encourages finalization of the proposed RUC-recommended work RVU of 0.30 for CPT code 9X091.**

PE-only replacement code for Heart Failure System

Responding to stakeholder concerns, CMS proposes creation of a PE-only replacement code, GMEM1 *(Provision of replacement patient electronics system (for example, system pillow) for home pulmonary artery pressure monitoring including provision of materials for use in the home and reporting of test results to physician or qualified health care professional)*. This code is intended to report the replacement cost of the external reader that patients use to acquire and transmit data from an implantable wireless pulmonary artery pressure monitor. Patients receive a reader when they undergo implant of a wireless pulmonary artery pressure sensor as part of CPT code 33289 *(Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed)*.

In working to understand the proposal, the ACC discovered that a stakeholder had approached the agency about two different topics related to wireless pulmonary artery pressure sensor services that may have become entangled in this proposal. The first is that payment for replacement of the external reader used by the patient to transmit information gathered by the implant has been challenging, and an application was submitted to obtain a code for the equipment to allow payment as durable medical equipment (DME). The second is that—when performed in the hospital outpatient setting—payment to the hospital for the technical side of remotely interrogating the device is not possible because that code—93264 *(Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional)*–is assigned a status indicator that precludes payment. If it is the case that these related topics were inadvertently comingled, these are two different obstacles that need two different solutions.

Regular data acquisition and transmittal is necessary to optimize care of these heart failure patients. With time, a reader meets the end of its useful life or may be lost or damaged. A replacement must be obtained to avoid rendering the implanted device useless. As described in the fee schedule proposed rule, it appears new code GMEM1 is intended to reflect the cost of the reader. It is not clear why such a piece of equipment would not be treated as durable medical equipment. **The ACC believes payment for a replacement reader as DME would be the most appropriate way to address this need.** Though the College is not familiar with exact pricing, payment to date has been sought and occasionally obtained using DME code L9900, with payment anecdotally ranging from $3,000 to $5,000.

Further, it appears from the proposal there is some misunderstanding of what occurs in clinical practice. The phrase, "including provision of materials for use in the home and reporting of test results to physician or qualified health care professional," appears unnecessary, unless it is simply meant to allow for an initial check when the patient first receives the new reader. The proposed code descriptor would include elements of physician and clinical staff work that are already described by CPT code 93264 that is reported when the device is interrogated to inform care modifications for heart failure patients.

In the CY 2025 hospital outpatient prospective payment system (OPPS) proposed rule[1] addenda files, CMS assigned GMEM1 to APC 5741 for Level 1 Electronic Analysis of Devices. The national payment rate for 5741 is $36.90. That is nowhere near a sustainable payment for a piece of equipment that costs many times more than that. However, that amount would be plausible to reflect the technical work by clinical staff to gather and analyze data from a transmission. That work is reported using code 93264. However, 93264 is assigned status indicator M in OPPS Addendum B, "Items and services not billable to the FI or MAC." If the agency is seeking to pay a hospital for the technical component of 93264, the simplest approach would be to assign status indicator Q1 to 93264—similar to other device interrogation codes—and assign it to APC 5741.

As DME coding and payment are separate from the OPPS and MPFS, **the ACC urges officials at the Agency to coordinate across payment systems to ensure a mechanism to pay for a reader is instituted so patients in need of replacements can optimize their heart failure management.** If CMS determines that one path for this is or must be payment of a replacement recorder through OPPS, APC 5741 is inadequate for that purpose. One approach inside OPPS could be assignment to a New Technology APC. Based on the one invoice obtained and shared below, that would be APC 1528 for services with costs between $5001-$5500. Other invoices obtained by or provided to CMS may indicate a higher or lower amount. For the MPFS, should CMS finalize payment through the fee schedule rather than through DME, as recommended, contractor pricing of GMEM1 to pay for the cost of external reader replacement may be acceptable, but contractors should be prepared for invoices and pricing in the range described above.

[1] https://www.federalregister.gov/documents/2024/07/22/2024-15087/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical

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INVOICE

[redacted]

Date: 09/03/2024
Bill Number: 000009891811
Grand Total: 6025.00

Service Dates	Procedure Description	Unit Amount	Supply Units	Extended Amount
10/18/2023	CardioMEMS Patient Electronics System	5,000.00	1	5,000.00
10/18/2023	WiFi Adaptor	25.00	1	25.00
			Grand Total	6,025.00

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Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-on for Infectious Diseases (HCPCS code GIDXX)

CMS proposes creation of a new add-on code that would be reported to recognize the time and work associated with diagnosis, management, and treatment of infectious diseases that may not adequately be captured in current hospital inpatient or observation E/M codes, noting that infectious diseases are unique in that they present infection control risks for the patient and close contacts, including healthcare staff, that require attention to safely care for the patient. The service is expected to be primarily reported by physicians with specialized infections disease training. CMS predicts that GIDXX utilization would be 2.5% of the utilization of G0316 *(Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416). (Do not report G0316 for any time unit less than 15 minutes))*, or about 7,900 times in 2025.

The ACC does not doubt that executing the various elements described in the proposed code descriptor of GIDXX *(Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases consultant, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment. (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, or subsequent)* likely entails particular, and possibly lengthy, work by the treating infectious disease specialist. Similar to proposals to create unique codes for atherosclerotic cardiovascular disease (ASCVD) risk assessment and management, the ACC appreciates the intention of recognizing undervalued care and the notion that certain care may require coding granularity that exceeds what is available through the suite of existing E/M codes.

However, the ACC wonders whether the creation of new services in this manner will prove unsustainable. In this rule, 24 new G codes proposed by CMS amount to roughly $105 million of new spending that doesn't currently exist and that must be offset by reductions to the conversion factor. Deployment of G2211 for 2024 rulemaking required meaningful reductions to the conversion factor that the profession is still navigating.

Additionally, it is not clear what the criteria are for a stakeholder to obtain a code for additional payment in this manner. One could envision someone contending that providing care for patients with cardiac disease or cancer or diabetes requires particular skill, knowledge, and work that exceeds the scope of the existing E/M codes that should be paid additionally through a new, add-on G code. **The ACC cautions that additions such as GIDXX should not be undertaken lightly, and that since such G codes seem to have become increasingly common in recent years, it would be helpful for CMS to offer guidance and transparency to stakeholders about how it approaches instances where it identifies such shortcomings.**

Cardiac Computed Tomography (CT) Services

In the 2025 OPPS proposed rule, CMS discussed how a recent change in billing edit rules could impact cost reporting and payment for cardiac CT services in the hospital outpatient setting and asked for feedback on several considerations for how hospitals might now perform and report these services with greater latitude.[2] The ACC responded to questions posed in the proposed rule and also urged the agency to make a change in ambulatory payment classification (APC) from APC 5571 to 5572 in 2025 for CPT codes 75572, 75573, and 75574. This change would appropriately recognize additional costs necessary to perform cardiac CT that are different from a traditional thoracic CT. Should CMS follow that recommendation in OPPS rulemaking, a corollary change would be necessary in the physician fee schedule, as these advanced imaging services are affected by the cap policy from Section 5102(b)(1) of the Deficit Reduction Act of 2005 that caps payment of advanced imaging services in the physician fee schedule at the same rate as the OPPS payment. Currently, assignment of these codes to APC 5571 limits fee schedule payment to the same amount. **The ACC raises this issue with the hope that an increase in the OPPS payment is not overlooked in the fee schedule and can be seamlessly integrated in 2025.**

II.G. Enhanced Care Management

Cardiovascular Risk Assessment and Risk Management

CMS proposes to expand upon the successful CMS Innovation Center's Million Hearts® model which reduced rate of death from any cause for medium and high-risk beneficiaries by four percent, as well as reduced the risk of death from a cardiovascular event (heart attack or stroke) by eleven percent. The agency proposes new G-codes for atherosclerotic risk assessment (GCDRA - *Administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment for patients with ASCVD risk factors on the same date as an E/M visit, 5-15 minutes, not more often than every 12 months)* and atherosclerotic risk management services (GCDRM – *ASCVD risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at medium or high risk for CVD (>15 percent in the next 10 years) as previously determined by the ASCVD risk assessment; ASCVD-Specific care plan established, implemented, revised, or monitored that addresses risk factors and risk enhancers and must incorporate shared decision-making between the practitioner and the patient; clinical staff time directed by physician or other qualified health care professional; per calendar month*). The proposed rule notes it would be reasonable and necessary to perform the ASCVD risk assessment on a patient that has at least one predisposing condition to cardiovascular disease that may put them at increased risk for future ASCVD diagnosis. These conditions could include but are not limited to obesity, a family history of CVD, a history of high blood pressure, a history of high cholesterol, a history of smoking/alcohol/drug use, pre-diabetes, or diabetes. As the definition notes, patients who receive the ASCVD risk management services would require being at medium to high risk of CVD defined as greater than 15% risk over the next 10 years, have no current CVD diagnosis nor any history of heart attack or stroke.

[2] https://www.federalregister.gov/d/2024-15087/p-713

The ACC is pleased to see the impact of the Million Hearts® program and applauds CMS for taking action to build on this success to benefit cardiovascular health in the Medicare beneficiary population. The College does have questions and seeks clarifications on this proposal. First, the College recommends specific clarification on the requirement of a patient receiving the GCDRM services not having an ASCVD diagnosis. Variability exists in ASCVD diagnoses with a range of severities. Could CMS provide a list of exclusionary or non-exclusionary ASCVD diagnoses? For the new assessment and management codes to be reimbursed is documentation of the predisposing condition(s) in the practitioners note sufficient, or are diagnosis codes corresponding to the predisposing conditions required to be submitted on the claim form?

Utilization estimates for the GCDRA code show the expectation that this code will be reported primarily by primary care practitioners, which makes sense. For the GCDRM code, the utilization estimates show an expectation that cardiologists will perform the majority of these services. It would seem a normal protocol, and in some cases a requirement, for a primary care practitioner to assign some CVD diagnosis to a patient prior to referral of the patient to a cardiologist. As such, if a primary care practitioner performed the ASCVD risk assessment, that patient had medium to high risk of ASCVD over the next ten years, and the primary care practitioner referred the patient to a cardiologist for ASCVD risk management services, the GCDRM code may be unintentionally disqualified from use given the current proposed language.

Second, CMS proposes to value both of these codes through direct crosswalks to other services that include modest, but meaningful, amounts of physician and clinical staff time. GCDRA includes 15 minutes of physician intra-service work time, 15 minutes of clinical staff time, 15 minutes of equipment time for an exam table, and an educational booklet. GCDRM includes 5 minutes of physician intra-service time, 2 minutes post-service and 13 minutes clinical staff time. These assumptions and the resulting valuation appear somewhat arbitrary and potentially problematic. For instance, it may not be the case that a clinician spends 15 minutes assessing a patient in addition to clinical staff spending 15 minutes. The ACC doesn't recommend changes to the proposed valuation, having been unable to discover specific information to inform alternative valuations, but urges the agency to consider whether these valuations are accurate and may need revision in the final rule or in future years.

Strategies for Improving Global Surgery Payment Accuracy

Several commissioned reports by CMS over the last decade have indicated to the agency that a low percentage of office visits bundled into the value of 10-day and 90-day global codes are not being performed. Further, CMS analysis indicates that transfer of care agreements and modifiers (-54, -55, -56) which would indicate distinct portions of a 10-day or 90-day global code being performed by different practitioners are used extremely rarely. When used, they are almost exclusively reported by ophthalmologists. In order to "pay more accurately for services and to 'right-size' the valuation of PFS services based on how practitioners currently furnish these services" the agency proposes several policy changes. First, CMS proposes to require the use of the appropriate transfer of care modifier for all global surgical packages in any case when a practitioner plans to furnish only a portion of the global package. This would apply to instances when a formal, documented transfer of care is executed (current policy) and for informal, non-documented but expected, transfers of care. Additionally, CMS is proposing to create a new HCPCS G code, GPOC1, to represent the additional time and resources employed by a practitioner

who did not perform the surgical procedure, is not from the same group practice or specialty provides follow-up post-operative care for the procedure and has not engaged in a formal transfer of care agreement. This proposed add-on code would only be reported with an office or other outpatient E/M visit for a new or established patient once per 90-day global procedure.

The ACC supports any reasonable effort to ensure accurate and appropriate valuation of procedures within the Medicare Physician Fee Schedule. To that end, we feel this an appropriate time to reiterate the Colleges' support for implementation of the RUCs prior recommendation that the full increase of work, physician time, and practice expense inputs for inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day. Whatever additions or deletions of packaged office visits may or may not be made to 10-day and 90-day global procedures, the incorporated office visits should reflect the current values of those codes.

Should CMS opt to implement the proposal to expand required usage of the transfer of care modifiers and subsequent reimbursement adjustments, it should not apply to any services that have the multiple procedure reduction modifier -51. The -51 modifier already reduces the payment for second and subsequent services to remove payment for post-operative care. Applying a 50 percent reduction and a -54 surgical care only modifier reduction on top of that would duplicate the reduction and be inappropriate.

III.G.4 Prepaid Shared Savings

The American College of Cardiology sees the benefits to ACOs of receiving their anticipated earned savings pre-paid throughout the performance year. However, the ACC opposes the component of this proposal which dictates the way in which an ACO can use this savings. In particular, we are concerned by the mandate of 50 percent or greater of clinician earned savings being allocated to direct patient care not otherwise covered by traditional Medicare (meals, transportation, dental etc.). This is likely to produce multiple administrative and financial harms for ACOs. ACOs themselves are best able to determine optimal uses for their earned shared savings. The constraint which dictates how at least 50 percent of prepaid saving be used will prevent most ACOs from taking advantage of the early distribution of their expected savings and the associated advantages.

III.G.7.d Mitigating the Impact of Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity on the Shared Savings Program Financial Calculations

The ACC appreciates and supports this formalization of the intentions of the rule "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023" for ongoing years. We believe this provision will indeed protect the ongoing accuracy and integrity of the Medicare Shared Savings Program as well as provide financial protections to ACO and the clinicians aligned with them.

III.J. Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS is soliciting feedback on the design of a future ambulatory specialty model, which would utilize the Merit-based Incentive Payment System (MIPS) Value Pathways, or MVP, framework. The ACC appreciates the opportunity to provide feedback and insights on the CMS Innovation Center's development towards the incorporation of MVPs to improve ambulatory specialty care. The College continues to agree with the need to transition away from traditional fee-for-service payment structure to incentivize accountable care arrangements based on high quality care.

Given this context, the College must underscore the current state of cardiovascular practice and its involvement in MIPS, while also addressing potential challenges in integrating MVPs into primary and specialty care models. It is important to note that the majority of cardiovascular MIPS participants are associated with large hospitals, health systems, and multi-specialty practices. Based on the CMS 2022 Quality Payment Program Experience Report, 81% of cardiovascular participants are reporting their MIPS scoring through practices/arrangements with 21-200+ members. Currently, approximately 70-80% of cardiologists nationwide are affiliated with hospital, health system, or large multispecialty groups.

Given the significant number of cardiovascular professionals employed by and/or aligned with large, multispecialty organizations, the College questions whether these cardiovascular clinicians will have the opportunity to participate in the various specialty-focused MVPs. Many health systems and multispecialty groups are reporting their MIPS data together or have formed accompanying accountable care organizations (ACOs) to participate in Medicare Shared Savings Program and/or ACO Realizing Equity, Access, and Community Health (REACH) which include their primary care, cardiology and other specialty clinicians. Those ACOs and health organizations have taken the responsibility for reporting their MIPS data on behalf of their clinicians.

As a result, the ACOs primarily report preventative and screening-type quality measures to cover the majority of their covered population. From the 2022 QPP Experience Report, 9 of the Top 10 Reported Measures for All MIPS Participants and All Cardiovascular Participants are the same.

Quality Measures	**#**
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	484
Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Group	479
Controlling High Blood Pressure	236
Colorectal Cancer Screening	113
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	134
Falls: Screening for Future Fall Risk	318
Breast Cancer Screening	112
Preventive Care and Screening: Influenza Immunization	110
Preventive Care and Screening: Tobacco Use: Screening and Cessation	226

Within this proposed rule, CMS is requesting feedback on a potential framework for transitioning MIPS reporting to mandatory MVPs. Unfortunately, the current state of cardiology practice within large multispecialty group could greatly impact the participation rates. Furthermore, an increasing number of ACOs are shifting the MSSP Participation Tracks into those accepting higher levels of upside and downside risk like Track E and ENHANCE. Those tracks are classified as Advanced APMs under QPP and would allow the ACO consolidate their quality measurement and exempt their ACO-affiliated clinicians from MVP participation. The College is strongly concerned that those ACO-affiliated cardiovascular professionals would be removed from the MVP program.

With the majority 80% participating with ACOs, the remaining 20% of cardiovascular professionals in solo and small practices would be mandated to participate in the Advancing Care for Heart Disease MVP. The ACC is greatly concerned that such a small number of clinicians would skew the data results and comparisons for the quality and cost measurements. The College roughly estimates that no more than 30% of cardiovascular participants would submit and participate in the CV-associated MVP in the current cardiovascular practice environment.

Participant definition

Cardiology has several specialty classifications currently participating in the QPP-MIPS program. The specialty types include cardiology (clinical/general), adult congenital, advanced heart failure & transplant, cardiac surgery, interventional, and cardiac electrophysiology. Care responsibility and collaboration among the various cardiology types vary between practice types and settings.

Cardiovascular practices and departments often triage, assess, and prioritize new and established patient referrals and direct them to the most appropriate specialty type. Clinical cardiology can often play the role of CV primary care, ordering tests, performing diagnostic imaging, reviewing medications, referring to other cardiology specialties. While other CV specialists, like cardiac surgery and interventional, might be more procedural-based and tend to the patient pre-, intra-, and post- care.

Depending on the practice workforce and needs, any CV specialists can facilitate the longitudinal care for their patients and should not be siloed into chronic care clinicians and proceduralists. The variety of roles and responsibilities per practice can create unintended consequences within an individual-focused payment model. The College strongly encourages the agency to incorporate practice-level participation for cardiology to promote the inclusion of the entire CV care team.

MVP performance assessment

The ACC has been an active participant and developer of cardiovascular performance and quality measures for decades. The College believes that assessing care processes and outcomes are vital to practicing high quality cardiovascular care while ensuring the measurement and comparisons are in the appropriate level of attribution. The importance of optimal cardiovascular team-based care cannot be reduced, thus, the ACC strongly encourages performance measurement at the practice-level. As stated previously, cardiology has several specialty classifications, each playing in a unique and complementary role in the patient's care journey.

Cost

The College is of the opinion that most cardiovascular clinicians would report through the Advancing Care for Heart Disease MVP. Currently, the MVP includes the following 5 cost measures:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Heart Failure
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
- Medicare Spending Per Beneficiary (MSPB) Clinician
- Total Per Capita Cost (TPCC)

It is important to note that later in this letter, the College provides additional comments on the 2025 proposed changes to cost measure: Inpatient Percutaneous Coronary Intervention (PCI) (currently named ST-Elevation Myocardial Infarction [STEMI] Percutaneous Coronary Intervention [PCI]).

Overall, the College feels that CMS should consider that the Total Per Capita Cost (TPCC) measure may be redundant and suboptimal, especially in MIPS and with MVPs that already include an alternative episode-based cost measure. In the 2020 proposed MIPS rule, CMS justified including the revised TPCC measure because there were no other primary care measures available. However, in 2024, this justification is no longer valid, as there are now a number of chronic condition episode-based cost measures either in the program or in development that assess the costs of primary care. Moreover, any MVPs focusing on chronic conditions should encourage investment in preventive services, which are crucial for the shift towards value-based care. Including TPCC in its current form could unfairly penalize physicians who successfully improve the utilization of preventive services. This is because TPCC measures total costs in the same year as services are provided, without accounting for the long-term cost-saving benefits of preventive care. Thus, the current TPCC methodology does not accurately reflect the value of preventive services.

The TPCC measure also uses outdated CPT coding specifications. This could significantly affect the measure's reliability and validity, leading to inaccurate results and unintended consequences for physicians and physician groups. Additionally, with monthly benchmarking for the measure, there is a lack of meaningfulness and alignment between monthly TPCC measures and quality measures, which are scored annually. Concerns about potential double counting of costs within the TPCC measure and other episode-based measures persist. CMS should provide more detailed information about the overlap between cost measures in the annual experience report. Measure exclusions should occur at the specialty level, rather than the service level, to ensure that MVPs and subgroup reporting remain voluntary. Moreover, any MVPs that include preventive services should not be penalized if these measures and services are utilized, as they may incur higher costs initially, but will lead to cost reductions over time.

Finally, the measure relies on retrospective claims data, which may take months or even years to become available. This time lag limits the measure's ability to provide timely feedback to healthcare providers and stakeholders, hindering their ability to identify and address cost drivers promptly. Real-time or near-real-time data would be more useful for proactive interventions and cost management strategies.

Payment Methodology

Currently, most MIPS participation and positive payment adjustments across all of medicine are driven by the largest practices, organizations and health systems based on the previous QPP Experience Reports. While about 50% of solo clinicians and just under 20% of small practices with 2-15 members are not reporting their data nor actively participating in the MIPS program in CY 2022.

College members frequently report that the current MIPS positive adjustment rates are insufficient to justify the investment of practice and staff resources for smaller practices. The College strongly urges CMS to proactively engage with smaller practices to better understand the resources they require to participate and succeed in any new ambulatory specialty care model.

Care delivery and incentives for partnerships with accountable care entities and integration with primary care

In this RFI, CMS is looking to explore how an ambulatory specialty model could encourage model participants to better engage with primary care providers engaged in care coordination activities in the MCP model, Shared Savings Program, and other current and future accountable care models. As stated previously, most CV professionals already have an existing affiliation with or a part of an ACO entity. While most arrangements do not agree upon care pathways for the various specialties and disease categories, the ACC strongly recommends that medical specialty practice guidelines, appropriate use care and other expert consensus documents be the primary focal point for any care pathway.

Over the years, cardiology practices have developed and implemented innovative "disease clinics" to address their patients' needs for immediate medical attention and potentially avoid hospital and emergency department visits. These clinics care for patients needing attention for heart failure, atrial fibrillation-warfarin and hypertension. They can arrange patient visits both in-office and virtual visits within hours to a few days. Some provide 24-hour access with telehealth services.

The patient care provided in these clinics is often not reimbursed for various reasons and can be a financial loss for the practices, however the practice staffs believe in the promise to treat patients quick and efficiently while avoiding more cost downstream. The College would request any new ambulatory specialty care model to include these innovative clinics with appropriate payment for the services rendered.

Health information technology and data sharing

The College appreciates the opportunity to provide feedback on potential opportunities and challenges for accountable care, primary care and specialists to maximize the use of health IT and data sharing within a new care model. This RFI referenced the opportunity to utilize the publicly released QPP Experience Report Public Use Files for comparison of quality measurement comparison. Annually, the ACC uses these data files to create cardiology-focused reporting and presentations for the College member leadership. We find the existing raw Experience Report data sheets and forms complex and cumbersome. They require weeks or months of staff time to extract and develop usable data.

The complexity of the Experience Report files for the ACC is exacerbated when comparing the specific local data requested by a potential referring physician. The College is focused on a significant cohort of clinicians and their data which would be more difficult for medical practice staff reviewing data for clinicians in the patient's local area. Most organizations, especially solo and small practices, would not have the resources to commit to such an intensive project. **The ACC strongly encourages CMS to develop a web-based comparison tool that can filter the large experience report data fields by local area, specialty type, and comparison categories.** It will be important to engage with the medical community to best understand their specific needs for this data.

To address the need for timely and actionable data, the College recommends the inclusion of data related to patients' current care, including medications, test results, visits, and potential care gaps in practice guidelines as well as the ability to exclude contraindications for those patients. Such data allow more clinicians to proactively address needed and missing care as well as review potential inappropriate care.

Health equity

The ACC strongly supports the CMS Innovation Center goal to improve access to high-quality, patient-centered care for all patients. Of course, there are numerous cardiovascular disease categories including ischemic heart disease, peripheral valvular disease and structural valve disease is ripe for improvement in access and availability. The specific care gaps vary by community and individual patient including adequate access to qualified clinicians, appropriate testing, standard of care therapies and medications. The College is committed to identifying and addressing the health disparities to improve the community's health. The College encourages CMS to collaborate with local clinicians, patients, hospitals, community workers to identify and better understand the needs of the various communities and construct an ambulatory specialty care model that can directly address those gaps in care. An innovative project can be the previously described "disease clinics" which greatly improve access to care, decrease waiting times and offer after-hours care through telehealth visits. The clinics can reduce emergency visits and office overcrowding.

Additionally, any ambulatory specialist model should support clinicians, practices and ACOs researching their local gaps in care. A cardiology practice in the Pacific Northwest found that their patients of a specific race/ethnic group were inconsistent with scheduling post-procedure follow-up visits within the recommended timeframe. Such findings can best aim clinics and case managers to improve their follow-up visits in this population. The College strongly encourages CMS to incentivize both the disparity research and actions to address the gaps in care.

Multi-Payer Approach

Over the past 5 to 6 years, the College has contacted numerous Medicare Advantage Organizations (MAOs), commercial payers and accountable care organizations to better understand their current approaches and various models for accountable cardiovascular specialty care. Most admitted to not having a significant or distinct cardiovascular program. Others are incorporating the cardiology care with the existing primary care ACOs. **The ACC strongly urges CMS to publish any details on existing MAOs or ACOs specialty care models received from this RFI.**

Any proposal to develop and implement a new ambulatory special model should align with any existing model used by commercial, Medicaid, Medicare Advantage plans. The College implores the agency to explore any opportunities to reduce clinician and practice burden related to this model and other plans' models.

Sunsetting of Traditional MIPS and Transition to MVPs RFI

As CMS considers fully transitioning from MIPS to MVPs by 2029, we commend the ongoing dialogue between CMS and stakeholders, particularly specialty societies, on creating MVPs that are more inclusive and clinically relevant. Ensuring clinicians' readiness to report MVPs by 2029 will depend on addressing current gaps in quality and cost measures, tackling issues with topped-out measures, providing robust support and resources, implementing effective transition strategies, and enhancing technology and workflow integration.

Although CMS has already adopted a phased approach to implementation, additional time may be required, particularly for smaller practices. According to the most recent CMS Experience Report for the 2022 performance year, solo and small practices continue to face challenges with MIPS reporting requirements and lag behind their peers in larger health systems and practices in terms of overall quality scores and subsequent payment adjustments. It is crucial for CMS to consider the unique challenges faced by smaller practices and offer them tailored support.

Moreover, the effective integration of clinical data into existing EHR workflows and the standardization of data collection units are essential components of this transition. This includes the necessity for larger incentives to offset the investments required for participation, the provision of real-time, actionable data, the availability of claims data for measure developers, and the need for funding measure development or providing resources to support established measures. Additionally, alignment across programs will be crucial for a cohesive transition. By addressing these considerations, CMS can facilitate a smoother and more successful transition to MVPs, ensuring that clinicians are adequately prepared and supported throughout the process.

Revised MVP Framework

The ACC recognizes that there is not a universal MVP approach suitable for every medical specialty. Additionally, CMS aims to limit the number of MVPs to avoid burden and complexity in reporting. However, we strongly believe that a condition-stratified MVP framework, which aligns quality and cost measures, can address many concerns associated with the current MVP methodology. This revised framework would consider the diverse care provided by subspecialists and different patient populations, and it would also cater to independent and small physician practices by maintaining the finalized flexibilities for small practice scoring.

Rather than the existing method of listing quality measures in the MVP by Measure ID, we agree with the American Medical Association's prior proposal that CMS organize quality measures into categories that pertain to specific patient conditions or episodes of particular treatments. Cross-cutting quality measures, such as depression screening and advance care planning, should be placed in a separate category. Cost measures and relevant improvement activities should be integrated into the same condition or procedure

categories. For instance, an episode-based cost measure for a specific condition or procedure should be grouped with the quality measures for that condition or procedure.

This approach ensures that cardiologists, as it would work with other specialists, can better align their efforts in providing high-quality care with cost efficiency, addressing the unique needs of their patient populations. For example, in the "Advancing Care for Heart Disease" MVP, the quality measures should be grouped based on their relevance to specific heart conditions, such as coronary artery disease, heart failure, atrial fibrillation, or other heart conditions. These groups could then be further divided into categories related to the medical management of the condition or interventional procedures, such as percutaneous coronary intervention (PCI) or ablation.

Consequently, the heart failure cost measure would be placed in the same category as the quality measures applicable to heart failure, and the PCI cost measures would be categorized under interventions related to coronary artery disease. This design will allow a broader array of clinicians to report under the MVP without increasing the number of standalone MVPs, thereby promoting a cohesive set of measures while ensuring comprehensive cardiovascular care is accounted for.

A broad MVP can bridge current measure gaps until more specific cardiovascular measures are created. Alternative measures for non-patient facing cardiovascular clinicians should also be considered, such as diagnostic cardiologists. This could involve developing measures that assess the quality and outcomes of diagnostic procedures and interpretations, ensuring these clinicians can also participate in MVPs. Supporting the exploration of statutory flexibilities that allow for the reweighting of performance categories or other adjustments will recognize the unique roles of non-patient facing cardiovascular clinicians.

A broad MVP that encompasses all cardiovascular subspecialties could simplify the reporting process, reducing administrative complexity, encourage team-based care, ensuring consistency across the specialty, and providing flexibility for practices with diverse cardiovascular services. However, this approach may not adequately capture the unique aspects of care provided by different cardiovascular subspecialties, potentially resulting in less meaningful performance data and missed opportunities for targeted quality improvement. Furthermore, it may include measures that are not relevant to all cardiologists, diluting the focus on critical aspects of care for specific conditions or procedures.

In contrast, condition or procedure-specific MVPs can ensure that quality measures and activities are highly relevant to the specific type of care being provided. This enhances the meaningfulness of the data collected and supports targeted quality improvement. Additionally, this approach allows cardiologists and related subspecialties to focus on the most pertinent quality measures, leading to more accurate and relevant performance assessments. However, developing and managing multiple MVPs for various conditions and procedures increases the complexity of the program and could be burdensome for practices that offer a wide range of cardiovascular services.

There is also a risk of fragmentation, where clinicians may have to report on multiple MVPs, increasing the administrative burden and potentially leading to inconsistencies in reporting. In time, and as more quality measures are developed, we believe condition or procedure-specific MVPs may be of value and provide a simpler approach to reporting.

A hybrid approach could involve the use of one general cardiovascular MVP that covers common quality measures and activities relevant to all cardiologists and subspecialists, serving as a foundational pathway for the specialty (i.e., Advancing Care for Heart Disease). Subspecialty-specific MVPs via the creation of condition or procedure-specific MVPs for key cardiovascular subspecialties (e.g., electrophysiology, interventional cardiology, heart failure) can also be created. CMS could potentially limit these condition and procedure-specific MVPs to focus only on high-cost areas, or areas where quality improvement is otherwise needed. Practices can then choose the most appropriate MVP(s) based on their specific services and patient population.

By adopting a hybrid approach, cardiologists and subspecialists can balance the need for comprehensive, relevant performance measurement with the practical considerations of managing administrative complexity. This strategy supports meaningful quality improvement while providing flexibility for practices to tailor their reporting to their specific clinical services.

Mandatory Subgroup Reporting

CMS defines single specialty and multispecialty groups under MIPS based on Medicare Part B claims data. A single specialty group includes one specialty type, while a multispecialty group has two or more specialties. MIPS eligible clinicians can check their participation status via the QPP Participation Status Tool, although this tool does not indicate group specialty designations. CMS uses PECOS and claims data for public reporting and MIPS eligibility determination.

Starting in the CY 2026 performance period, TINs with multiple specialties will be classified as multispecialty groups, necessitating the formation of subgroups for MVP participation, potentially causing redundant reporting, especially in multidisciplinary primary care practices. To address this, CMS proposes allowing group practices to self-identify as single or multispecialty groups, promoting team-based care, reducing duplicative reporting, and more accurately reflecting the scope of care provided. We agree with the approach of providing flexibility for a group practice to determine and inform CMS of their specialty composition.

The ACC appreciates CMS' proposal to consider subgroup reporting under MIPS as a way for clinicians to report the most clinically meaningful measures to their practice. While the College strongly encourages this reporting structure as a way for specialist groups to report meaningful measures as part of a multispecialty group, we recognize that it may also result in administrative complexity. The College has supported CMS' prior proposals to begin subgroup reporting as a voluntary option.

Proposed Subgroup Reporting Limits

Establishing limits on the number of clinicians per subgroup based on the size of the overall group TIN in an MVP could help manage the complexities of reporting and ensure more precise performance measurement. For a multispecialty group TIN with less than 100 clinicians, considering a limit on the maximum size of a subgroup to 50 clinicians might help maintain manageability and focused reporting. Similarly, for a multispecialty group TIN with 100 or more clinicians, placing limits on the minimum size of a subgroup could ensure meaningful subgroup formation and avoid overly broad or diffuse reporting.

These limits could encourage multispecialty groups to report more than one MVP, thereby enhancing the relevance and specificity of performance data while promoting accountability and continuous improvement across various specialties within the group. This approach aligns with the goals of ensuring accurate performance assessment and meaningful participation in MIPS.

For cardiovascular care, especially those specialists working in large practices or health systems, establishing limits on the number of clinicians per subgroup based on the size of the overall group TIN in an MVP can be beneficial. Large practices and health systems often have a diverse range of cardiovascular subspecialties, such as interventional cardiology, electrophysiology, heart failure, and general cardiology. Limiting the size of subgroups can ensure that each subgroup remains focused and manageable, allowing for more targeted and relevant performance measurement. Establishing limits on subgroup sizes aligns well with small-team structures already in place at many health systems, facilitating smoother implementation and adherence to MIPS reporting requirements.

As with other aspects of the QPP, phased implementation of these subgroup requirements can help groups gradually adapt to the new reporting structure, easing the transition and reducing the immediate burden. Initial phases could start with fewer subgroups, expanding as the system matures and groups become more accustomed to the requirements. Data-driven adjustments, using data from Medicare Part B claims and PECOS, can continuously assess the effectiveness and burden of subgroup reporting, allowing CMS to make informed adjustments. Accurate subgroup data can also enhance patient care by facilitating better-informed referrals and tailored treatment plans based on the specific expertise of different cardiologists within a practice. Feedback from practices about their experiences can provide valuable insights for refining the approach.

There are concerns, however, about the increased operational complexity and administrative burden that mandatory subgroup reporting could impose, particularly on large multispecialty practices. The additional complexity could detract from clinical care and require significant resource allocation, including the need for more staffing and technological resources. Balancing comprehensive reporting with the associated burden requires flexibility in implementation.

Practices may be more likely to support these proposals if allowed to self-identify their specialty composition and adjust subgroup structures as needed to reflect actual practice patterns and care delivery models. Recognizing that most cardiovascular specialists work in large practices or health systems, it is crucial that CMS provides clear guidelines and adequate support to facilitate the transition to mandatory subgroup reporting. This support could include technical assistance, streamlined reporting processes, and integration with existing health IT systems.

As CMS further explores subgroup reporting, we ask that the Agency determine the potential impact this may have on other policies and programs that rely on the use of a TIN for identification purposes, such as the Stark Law. While the creation of new TINs based on MVP may be feasible for some groups, limitations with current regulations impacting TIN structure may create challenges for others.

For example, CMS states that subsets of a group under the same TIN could form subgroups, but subgroups cannot be formed if clinicians are part of different TINs. Given the importance of

engaging in care coordination under value-based payment models, some cardiovascular practices that manage a patient in the outpatient setting seek ways to align incentives with hospitalists and other care providers outside of the practice who may manage the patient during an acute care episode. Based on interpretations of the Stark Law, these practices have not been able to engage in such arrangements as assignment under different TINs prohibits recognition of these cross-setting teams as a "group practice" under current regulations.

The ACC recognizes that changes beyond this proposed rule may be needed to permit eligible clinicians in multiple TINs to form a subgroup or APM Performance Pathway (APP) group. The issue regarding APM Entities' eligibility to form subgroups for MVPs or APM Performance Pathway (APP) participation due to the complexity of multiple TINs and EHR systems remains relevant. While CMS acknowledges the administrative complexity, the need to address subgroup reporting for APM Entities remains. This concern is particularly important for clinicians involved in MIPS APMs that do not qualify as Advanced APMs or those who do not meet the Qualifying Participant thresholds for Advanced APMs.

The ACC emphasizes the need for CMS to explore options for subgroup reporting for clinicians in APM Entities, allowing them to report measures more pertinent to their clinical specialties. Many existing APMs, such as the Medicare Shared Savings Program, focus on population-level, primary care quality measures that may not adequately reflect specialty-level performance. Lowering thresholds for APM participation and allowing subgroup reporting would enable clinicians to report the most meaningful measures for their practice areas.

Small Practices

Forming subgroups in small practices may not be as meaningful as it is for larger, multispecialty groups. In small practices, clinicians often share similar roles and responsibilities, which reduces the need for distinct subgroups. For example, in a small cardiovascular practice, all clinicians may engage in overlapping areas of care, such as patient consultations, diagnostics, and follow-ups. Creating subgroups in such a setting could introduce unnecessary complexity without significantly enhancing the granularity of performance data. Additionally, small practices typically operate with limited administrative and financial resources. The added burden of forming and maintaining subgroups might detract from direct patient care activities. Streamlined and efficient reporting processes are crucial to avoid overwhelming small practices with administrative tasks.

In scenarios where subgroups are practical, they can provide more specific performance information. In larger practices or groups with a wider array of services, subgroups can help isolate performance data relevant to specific specialties or service lines, offering patients clearer insights into the quality of care for specific conditions or procedures. Detailed performance data broken down by subgroups can empower patients to make more informed healthcare decisions. For instance, if a subgroup specializes in heart failure management, patients with heart failure can choose providers based on precise performance metrics relevant to their condition, enhancing their ability to select the best possible care.

For clinicians, subgroup-specific performance data can highlight areas needing improvement more precisely. It enables targeted quality improvement initiatives, fosters peer comparisons within subspecialties, and encourages professional development tailored to specific practice areas. While the

formation of subgroups may be less meaningful for small practices due to overlapping roles and limited resources, in larger or more diverse settings, subgroups can provide valuable, detailed performance information that benefits both patients and clinicians. Small practices should be able to focus on streamlined, efficient reporting that accurately reflects their care quality without the unnecessary complexity of subgroups.

Surgical Care MVP

The MVP for Surgical Care encompasses a variety of quality measures that seemingly aim to measure disparate specialties and therefore, unrelated procedures, raising concerns about the ability of the MVP to comprehensively assess the quality of surgical care across all specialties and procedures. This lack of specificity could potentially lead to a mismatch between the measures and the actual priorities of surgical practices.

Additionally, there is uncertainty about how the quality measures related to Coronary Artery Bypass Grafting (CABG) surgery align with the corresponding cost measure for non-emergent CABG procedures. While the MVP's quality measures primarily focus on clinical outcomes, they indirectly influence the cost-effectiveness of CABG surgery. However, clinical outcomes alone may not provide a comprehensive picture of resource utilization or costs, as factors like hospital length of stay and equipment usage significantly impact costs but may not be adequately captured by these measures. As with any of the cost measures, the focus on cost containment may inadvertently incentivize providers to limit necessary care or select patients based on cost considerations, potentially compromising patient outcomes or access to care.

Implementing one MVP for surgical care is challenging due to the complexity and diversity of surgical procedures and patient populations, making it difficult to design measures that effectively capture the breadth of surgical practice while remaining feasible for reporting. Furthermore, reporting for groups or larger health systems may add complexity for this MVP in that specific specialties would have to be teased out at the administrative level. The MVP also appears to lack benchmarks for certain measures, such as those related to CABG, which may discourage meaningful participation and hinder the MVP's effectiveness.

While the MVP for Surgical Care has the potential to improve the quality of surgical care, there are concerns regarding the relevance and alignment of its quality measures with the diverse landscape of medical practices. Addressing these concerns will be essential to ensure the effectiveness and meaningfulness of the MVP for Surgical Care.

Comments on Quality and Cost Measure Performance from PY2022

We wish to address a critical issue affecting cardiovascular specialists participating in the MIPS program: the inadequate representation of cardiovascular-specific measures. Many cardiovascular specialists are predominantly attributed to primary care measures, such as depression screening and immunizations, instead of measures directly related to cardiovascular care. This misalignment is largely because these clinicians are often part of large groups or health systems, leading to their attribution to broader cost measures as well, like diabetes management.

Based on an analysis of the six cardiovascular-related specialties (N=20,974, Cardiology, Interventional Cardiology, Electrophysiology, Cardiac Surgery, ACHD, Advanced Heart Failure and Transplant Surgery) in the 2022 Experience Report data, the top 10 quality measures reported were as follows:

Quality Measures	**# of CV Specialists Scored**
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	14,261
Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Group	14,056
Controlling High Blood Pressure	13,658
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	11,826
Colorectal Cancer Screening	10,936
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	10,538
Falls: Screening for Future Fall Risk	9,196
Breast Cancer Screening	8,800
Preventive Care and Screening: Influenza Immunization	8,349
Preventive Care and Screening: Tobacco Use: Screening and Cessation	8,055

The top 10 cost measures attributed to the six specialties were as follows:

Cost Measures	**# CV Specialists Attributed**
TPCC	12,269
Diabetes	11,165
MSPB	10,713
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	9,392
Elective Outpatient PCI	8,042
Sepsis	7,391
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	6,576
Screening/Surveillance Colonoscopy	6,060
Intracranial Hemorrhage or Cerebral Infarction	5,725
Femoral or Inguinal Hernia Repair	5,268
Others:	
Non-Emergent CABG	5,047
STEMI	2,792

The distribution of these measures indicates a misalignment between the quality and cost measures reported by cardiovascular specialists and their actual scope of practice. The prevalence of primary care-oriented quality measures among cardiovascular specialists suggests that the current MIPS framework does not adequately capture the specialized nature of cardiovascular care. Consequently, cardiovascular specialists are being evaluated on metrics that are not fully reflective of their expertise, which undermines

the primary intent of MIPS to deliver meaningful performance assessments that drive quality improvements within specific fields. This misalignment dilutes the unique contributions of cardiovascular specialists, leading to an inaccurate portrayal of their performance and potentially skewing incentive structures. **Therefore, it is essential to refine the quality and cost measures within MIPS to ensure they are more relevant to the actual clinical activities and expertise of cardiovascular-related specialties.**

Being attributed to inappropriate measures adds to the administrative burden for cardiovascular specialists, who must navigate and report on measures that do not align with their practice. This increased burden can lead to inefficient use of resources and detract from direct patient care activities. Simplifying and streamlining the reporting process by aligning measures with the specific roles and contributions of cardiologists would help mitigate this burden. CMS should continue to review and refine the attribution mechanisms to ensure that cardiovascular specialists are not unfairly assigned to primary care or non-cardiovascular cost measures. This can be achieved by developing more precise criteria for measure attribution that reflect the specific roles and contributions of cardiologists within large groups or health systems.

Proposed Changes to Quality Measures

Revisions to Population Health Measures

The proposed revisions to § 414.1365(d)(3)(i)(A) aim to improve the scoring process for MVP Participants by using the highest score of all available population health measures starting from the CY 2025 performance period/2027 MIPS payment year. This change can potentially benefit cardiovascular specialists by ensuring that their performance is assessed based on their best-performing metrics, which can enhance their overall scores and reflect their care quality more accurately.

This approach acknowledges that certain measures may lack benchmarks or fail to meet case minimum requirements, which could otherwise unfairly impact scores. By removing the requirement for MVP Participants to select a population health measure at the time of registration, the process becomes more streamlined and less administratively burdensome, making registration simpler for practices.

However, it is crucial to ensure that accurate and comprehensive data is available for all population health measures. The success of this proposal depends on the availability of reliable benchmarks and sufficient case numbers for these measures. Implementing these changes may necessitate additional resources and adjustments within practices, particularly concerning data management and reporting.

We urge CMS to provide clear guidelines and support to facilitate the transition to this new scoring system. While measuring improvement in population health is essential, introducing universal requirements without tailoring them to each MVP could add unnecessary complexity and may not effectively improve patient outcomes. For instance, population health measures focused on hospital care are not clinically relevant to ophthalmologists, and including these measures as a foundational layer creates confusion and concerns about their applicability for specialists, including primary care providers. This additional category introduces burdensome and uneven scoring rules that were never intended or required by Congress in the MACRA statute.

Population health measures are flawed for some applications; therefore, CMS should consider removing these as a foundational requirement, as they fail to accurately capture quality.

Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure Measure

CMS proposes a retroactive change because the measure was mistakenly made available at the individual clinician level in the CY 2023 PFS final rule, even though it was intended for groups, virtual groups, subgroups via an MVP, and APM Entities. This measure requires testing for validity, reliability, and risk adjustments at the individual clinician level, which has not been completed. The rationale for this proposed change is to ensure alignment with the measure's original intent and design, thereby preventing invalid and unreliable results that could arise from its use at the individual clinician level. This correction is in the public interest to avoid misrepresentation and potential misuse of the measure.

We support this proposed change as it ensures accuracy and validity by using the measure as intended, maintaining the integrity of performance assessments. Second, it aligns the measure's use with its tested and developed levels, namely groups, virtual groups, subgroups, and APM Entities. While we acknowledge that retrospective changes can create confusion or challenges for those who have already started adapting to the measure, the importance of maintaining valid and reliable performance measures outweighs these concerns. Additionally, while individual clinicians may miss out on insights and opportunities for improvement if the measure is not applicable at their level, the primary objective should be to ensure the integrity and reliability of the measure. Given the potential for misrepresentation and the critical importance of maintaining valid and reliable performance measures, we support the proposed change.

ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) measure with the newly titled Inpatient (IP) Percutaneous Coronary Intervention (PCI) Measure

CMS has proposed changes to this measure to include expanding the patient cohort to encompass PCI episodes beyond STEMI diagnoses, such as non-STEMI and PCI without STEMI or non-STEMI diagnoses. This expansion is based on testing that indicated similar cost profiles and clinician types for PCI episodes with and without STEMI, suggesting that a broader cohort would be appropriate. This change aims to apply the measure to a larger number of clinicians and beneficiaries.

The proposed modifications also involve the stratification of the patient cohort into sub-groups based on diagnoses, such as STEMI, non-STEMI, and other inpatient PCI episodes. This stratification seeks to address variations in cost and treatment pathways, allowing for a more precise assessment of clinician performance. While the broader cohort can enhance the measure's applicability, the increased variability in patient conditions and treatments must be considered. Additionally, the proposal excludes episodes with cardiac arrest and adjustments for patients with a history of tobacco use, which aims to ensure fairer evaluations by considering the additional complexity and costs associated with these conditions.

The implications include the potential benefits of a more comprehensive assessment of PCI procedures, fairer evaluations through stratification and risk adjustments, and improved data quality by addressing heterogeneity. However, these changes also introduce additional complexity in measure calculation and reporting, which might be challenging for some practices to manage.

Overall, we support these changes, as they aim to provide a more comprehensive, fair, and accurate assessment of costs associated with PCI procedures. Nonetheless, we suggest support and resources to manage the increased complexity in reporting the measure, and that ongoing evaluation and feedback mechanisms should be available to monitor the impact of these changes and address any emerging issues.

Inclusion of the "Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood" MIPS Quality Measure

CMS proposes to include this quality measure to the MIPS Cardiology specialty measure set. In terms of relevance, this measure aligns with patient-centered care, crucial in areas such as heart failure, advanced cardiovascular disease, and end-of-life care. Ensuring patients feel heard and understood is a vital aspect of delivering compassionate and effective care. The measure also supports the broader movement towards a holistic approach to managing chronic conditions, ultimately improving patient satisfaction.

For practical implementation, cardiovascular specialists already engage in palliative discussions as part of comprehensive care plans for patients with advanced heart disease. Including this measure could formalize and incentivize these practices, potentially enhancing communication and patient outcomes. However, effective documentation and possibly additional training will be necessary to meet the measure's requirements without adding undue burden to clinicians.

Emphasizing the importance of patients feeling heard and understood can directly improve patient satisfaction and adherence to treatment plans, which is beneficial for outcomes in cardiovascular care. It is important to evaluate if this measure overlaps with existing ones or adds redundant reporting requirements, which could dilute the focus on more specific cardiovascular quality metrics.

Potential challenges include resource allocation, as small practices or those with limited resources may struggle to implement this measure without additional support. It is also important to ensure the measure is applicable to most patients and does not disproportionately affect subspecialties where it might be less relevant.

Data Completeness Criteria for the Quality Performance Category

We support the proposal to maintain the data completeness criteria threshold of at least 75 percent for two additional years.

Guiding Principles for Patient-Reported Outcome Measures in Federal Models, and Quality Reporting and Payment Programs RFI

We appreciate CMS's efforts to develop a robust framework that ensures the effective integration of these measures into quality reporting and payment programs. Below, we provide our comments on the proposed guiding principles and additional considerations.

Utilizing existing data systems for collecting and reporting PROMs is crucial to minimize administrative burdens. The emphasis on interoperability standards is particularly important for facilitating seamless data

sharing across various healthcare settings. We suggest that CMS also consider encouraging the adoption of standardized data formats to enhance compatibility across different EHR systems and providing guidance and support for smaller practices that may face challenges in upgrading their data infrastructure to meet these standards.

The rigorous testing of PROMs and PRO-PMs is essential for ensuring their reliability and validity. We support the requirement for psychometric testing and the development of digital measures (ePROs). Additionally, we recommend including patient and clinician feedback during the testing phase to ensure the measures are both clinically relevant and meaningful to patients while establishing a process for continuous validation and updating of measures to reflect advances in medical knowledge and changes in clinical practice.

Integrating PROMs into clinical workflows with minimal cost and administrative burden is vital. We suggest that CMS provide best practices and case studies on successful implementation strategies from various healthcare settings and offer financial incentives or grants to support the initial integration of PROMs into clinical workflows, particularly for resource-constrained practices. Additionally, we support making PROMs easily accessible to clinicians and care teams. To further this goal, CMS could develop a centralized repository of validated PROMs that is easily accessible and regularly updated and offer training and resources to help clinicians understand and effectively use PROMs in their practice. Open-access repositories of PROMs, similar to PROMIS, allow for widespread use and adaptation, and encourage the development of open-source tools that enable customization while maintaining core measure integrity. To accelerate the development of PRO-PMs, CMS could facilitate partnerships between academic institutions, healthcare providers, and technology companies to innovate and test new measures, and provide targeted funding and resources to support the development and testing of PRO-PMs.

Considering equity in the selection of PROMs is essential to avoid exacerbating disparities. CMS should ensure that PROMs are available in multiple languages and culturally appropriate formats and require the stratification of measure results by demographic factors to identify and address disparities.

CMS should strike a balance by promoting the use of broad PROMs for general quality improvement while supporting condition-specific PROMs where they add significant value, and encouraging the development of modular PROMs that can be tailored to specific conditions without the need for entirely new tools. CMS should ensure that PROMs are tailored to capture outcomes that are directly relevant to the specialists' fields. For example, cardiologists might be more engaged if the PROMs focus on heart disease management and outcomes rather than general health measures. Specialists can be involved in the development and selection of PROMs to ensure they address clinically meaningful outcomes.

We believe the guiding principles outlined are comprehensive. We commend CMS for its thoughtful approach to integrating PROMs and PRO-PMs into quality reporting and payment programs. By considering these guiding principles and additional recommendations, CMS can enhance the effectiveness of these measures, improve patient outcomes, and reduce administrative burdens on healthcare providers.

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

The CMS proposed changes include the removal of the 7-point cap for certain topped-out measures, beginning in the CY 2025 performance period/2027 MIPS payment year. This aims to offer fairer scoring opportunities for clinicians in specialties with limited measure choices, enabling them to achieve scores higher than the current cap for high performance on topped-out measures. Additionally, measures would be scored using a defined benchmark, rewarding high performance without capping scores at 7 points, with the highest achievable score set for performance at or above the 97th percentile. An annual analysis would determine which measures and specialty sets are impacted by limited measure choice, ensuring ongoing fairness and adaptation to changing measure availabilities and performance data.

The benefits of these changes include fairer scoring for clinicians in specialties with limited measure choices, as the removal of the 7-point cap addresses the disadvantage these clinicians face. This change encourages high performance by rewarding clinicians for maintaining and improving clinical quality, even in topped-out measures. The annual review and adjustment process also ensures flexibility and responsiveness to changes in measure performance and availability. There are concerns that clinicians might focus on measures with the highest potential scores, possibly neglecting other important areas of care.

Overall, the proposed changes would likely benefit clinicians and specialties facing limited measure choices, promoting fairness and high performance while ensuring ongoing adaptability through annual reviews. Monitoring the implementation and impact of these changes closely will be crucial to address any added complexity or unintended consequences that may arise.

Benchmark Methodology for Scoring the Cost Performance Category

Starting with the CY 2024 performance period, changes are proposed for the scoring methodology of the cost performance category in MIPS, set to take effect in the 2026 MIPS payment year. This new methodology will utilize standard deviation, median cost, and achievement points derived from the performance threshold. Clinicians whose average cost matches the median cost will receive an achievement point value equal to 10% of the performance threshold, equating to 7.5 points out of 10 based on a threshold of 75. Benchmarks will be set using standard deviations from the median cost, dynamically adjusting each year based on average costs and performance thresholds.

CMS uses the example of the Screening/Surveillance Colonoscopy cost measure with a median cost of $969.72 and a standard deviation of $135.35. Benchmark ranges will be established, with points awarded based on a clinician's average cost relative to these ranges. For instance, a clinician with an average cost of $1,104 falls within Range 6 and would earn between 6.0 and 6.9 achievement points. The scoring calculation formula will determine the exact points within the range, significantly influencing the clinician's final MIPS score.

The proposed changes aim to align scores more closely with actual performance, reduce negative impacts for clinicians with median costs, and increase average cost performance scores. However, the impact on specialists requires careful consideration. Specific cost measures will be used to evaluate clinicians'

performance, and scoring will be based on claims data, eliminating the need for additional data submission. Achievement points will be awarded based on performance relative to benchmarks set from all clinicians' data during the period. The cost performance category score will be calculated by summing all achievement points and dividing by the total available points, plus any cost improvement score.

The proposal could be beneficial as it simplifies data submission, ensures fair and consistent evaluation, incentivizes cost management, and includes potential improvements through cost improvement scores. However, the increased weight of the cost category to 30%, the benchmark setting requirements, potential disadvantages for complex cases, and the pressure to perform perfectly in other categories pose challenges. Therefore, we continue to encourage that there are adequate adjustments made for high-risk cases and flexibility for specialties with inherent cost challenges.

Establishment of the APP+ Quality Measure Set

The proposal aims to create the APP Plus quality measure set, incorporating all Adult Universal Foundation measures. This set aligns quality measures across CMS programs and reduces provider burden by streamlining and aligning measures, promoting preventive and primary care. CMS believes it will drive quality improvement and advance equity in healthcare.

Key elements of the proposal include alignment with the Universal Foundation, where measures focus on the health of broad population segments, promote equity by tracking disparities in care, and aid the transition to digital reporting of quality measures. Additionally, the proposal offers optional reporting for clinicians, allowing MIPS eligible clinicians, groups, and APM Entities to choose to report either the APP or the APP Plus quality measure set. The APP Plus set includes the existing APP measures plus additional measures from the Adult Universal Foundation. Incremental implementation is also a key feature, with new measures being added gradually to the APP Plus set. The focus on primary and preventive care emphasizes aligning with CMS's value-based care strategy.

From a cardiovascular specialist's perspective, the proposal offers several potential benefits. Aligning measures and reducing administrative tasks can streamline the reporting process for cardiologists, while the unified set of measures may drive improvements in care quality and outcomes. Tracking and addressing disparities can enhance care for diverse patient populations, and facilitating the shift to digital reporting can improve efficiency and data accuracy.

However, there are also potential drawbacks. The Universal Foundation measures are more relevant to primary care than cardiovascular specialists, making it crucial to ensure the measures accurately reflect the quality of care provided in cardiology and related specialties. Additionally, as practices might find some measures less applicable, this could affect their performance scores and incentives. The optional nature of the proposal means practices will need to assess the benefits and feasibility of adopting the APP Plus set compared to the existing APP measures.

We believe the measure set should include measures that are specifically relevant to cardiovascular care, ensuring performance assessments are meaningful and reflective of the quality of care provided by cardiologists and related specialists. Strategic adoption is another important consideration, with these specialists evaluating the benefits of adopting the APP Plus quality measure set and deciding whether it

aligns with their practice goals and patient care priorities. If the APP Plus measure set offers clear advantages in terms of quality improvement and reduced burden, it may be a beneficial choice and encourage more participation.

(4) Promoting Interoperability Performance Category in MVPs

CMS proposes to allow subgroups to continue to submit the affiliated group's data for the MVP Promoting Interoperability performance category for the CY 2025 performance period/2027 MIPS payment year and beyond. This continuation is based on feedback from clinicians related to challenges with the configuration of EHR systems for reporting Promoting Interoperability data at the subgroup level. **The ACC thanks CMS for continuously monitoring and listening to stakeholder feedback regarding MVP reporting policies and adjusting accordingly based on operational challenges within the EHR systems clinicians utilize under the Certified Electronic Health Record Technology (CEHRT) program.**

(iv) Improvement Activity Scoring and Reporting Policies

CMS proposes to eliminate the weighting of improvement activities effective for the CY 2025 performance period/2027 MIPS payment year and subsequent years, simplifying scoring in the Improvement Activity Category. CMS notes that the benefit to categorizing activities as high or medium weighted has greatly diminished as it made refinements and enhancements to the Improvement Activities inventory. After adding new activities to incorporate newly identified opportunities for clinical improvement, modifying existing activities to support changes in practice standards, and eliminating activities that are duplicative or that no longer promote a sufficient level of clinical improvement, it is difficult to differentiate high and medium weights. Instead, starting with the CY 2025 performance period, CMS proposes a majority of MIPS eligible clinicians would simply report two activities while MIPS eligible clinicians who are categorized as small practice, rural, in a provider-shortage area, or non-patient facing would now be required to report one activity. **The ACC supports this proposal and thanks CMS for their continued efforts in simplifying reporting for the MIPS program.**

However, while the ACC supports these efforts, the College wants to ensure that CMS continues to monitor the Improvement Activities category to ensure that activities available for reporting continue to directly benefit patient care. Higher-weighted activities may reflect more significant or innovative improvements and without this differentiation, it may be more challenging to distinguish between practices making substantial improvements and those meeting only minimal requirements. It is important that CMS balance the need for reduced reporting burdens with goals of continuous improvement that is directly beneficial to patient care.

(g) Request for Information Regarding Public Health Reporting and Data Exchange

As CMS notes, the COVID-19 public health emergency (PHE) highlighted the interdependencies of public health and healthcare, and the importance of timely, integrated, and interoperable data exchange across the health ecosystem to protect the health and safety of patients, populations, and the broader public. Access to timely, correct information was essential to health professionals as they worked tirelessly to help patients and save lives, especially early in the COVID-19 PHE. However, the importance of public

health reporting and data exchange is seen beyond PHEs as the continued advancement of reporting across different agencies, jurisdictions, and states is essential to the public health infrastructure. The ACC thanks CMS for coordinating with agencies such as the Centers for Disease Control (CDC) and engaging stakeholders to seek information to continue improving on electronic data exchange.

Questions for Goal #1: Quality, Timeliness, and Completeness of Public Health Reporting

Currently, the Medicare PI program requires eligible hospitals and CAHs to report their level of "active engagement," which requires attestation of reporting production data or in the process of validation. CMS notes this does not allow them to assess eligible hospitals and CAHs on the comprehensiveness, quality, or timeliness of the data they provide to PHAs. As CMS examines alternatives to the "active engagement" approach, they seek comments on requiring reporting of measures using numerators/ denominators and adding measures to include additional system-specific requirements.

While the College understands the need to collect more comprehensive data, including quality and timelines of data reported to PHAs, it is important for CMS to consider the scope of and difficulties that still exists when reporting to agencies. Without established universal standards for reporting to PHAs, the burden for reporting an unknown number of detailed measures could unfairly burden eligible hospitals and CAHs, overwhelming already overworked and burned-out staff. There are limitations that still exist in using singular data sets to meet all requirement needs and creating the number of measures needed to meet the needs of PHAs to sufficiently monitor health across the country would erase any progress CMS has made in the "meaningful measures" initiative. It is essential that CMS work to balance the need for specificity with the burden of reporting and need for standardization.

Instead, ONC should work with the CDC, PHAs, and other stakeholders to identify the scope of system specific measure requirements and determine what would be needed to complete bi-directional clinical data exchange and clearly report these findings. This includes, as will be detailed further below, the creation of a certification program for public health technologies used by PHAs to ensure they have the capabilities required to meet the needs for public health reporting. Outlining these findings and considerations in future rulemaking, such as additional requests for information, would help inform all stakeholders on the scope, benefits, and limitations of an evolving public health reporting program and provide additional informed feedback.

Questions for Goal #3, Increasing Bi-Directional Exchange with Public Health Agencies

The ACC strongly supports HHS' key goal of transitioning to, and use of, more modern, flexible approaches and networks that support data exchange between and across public health and healthcare to modernize the public health information infrastructure. This work should include a multitude of changes to program requirements and continued coordination between HHS, CMS, CDC, ONC and PHAs. One of these areas, as the CDC's Advisory Committee to the Director (ACD) and ONC's Health Information Technology Advisory Committee (HITAC) have recommended, would be the establishment of a certification criteria for public health technologies used by PHAs and implement a coordinated, phased approach to incentivize and eventually require their adoption. **The ACC supports these recommendations and encourages the development of these solutions to help enable bi-directional exchange with PHAs.** Just as ONC and CMS have coordinated to establish certification

criteria for CEHRT, payer requirements, and application programming interface requirements, the development public health technology certification requirements that align with the standards promulgated by the CEHRT, Promoting Interoperability, and Information Blocking requirements would greatly improve bi-directional exchange and help improve the quality, timeliness, and completeness of public health reporting.

As CMS notes, the HITAC recommended "that ONC establish certification criteria for technologies used by public health, focused on the certification of interoperability functions such as the exchange, access and use (inclusive of response to/acknowledgement) of (as appropriate) both correctly and not-correctly formatted/complete messages that are efficient (do not require "special effort") and effective (provides a common floor that addresses the relevant needs of the public health mission)." It stated, "the goal of certification criteria for public health technologies is to create a common floor to support the exchange of data inclusive of all providers and public health inclusive of the methods by which data are primarily electronically exchanged by Public Health Authorities."

In addition to creating certification requirements, agencies like the CDC and PHAs should consider methodologies to improve interoperability, including participating in the Trusted Exchange Framework and Common Agreement (TEFCA) to establish that common floor HITAC speaks of. The ACC understands TEFCA is still in its infancy and is not the panacea for all interoperability difficulties. Additional enhancements to the program, such as required standards use like FHIR and additional allowed Exchanged Purposes, are needed. **However, the College believes the establishment of a universal governance, policy, and technical floor for nationwide data exchange can only help improve PHA bi-directional exchange and CMS should continue to promote TEFCA's development and use in public health reporting and bi-directional exchange.**

Finally, CMS asks whether it should introduce a similar measure to the newly created "Enabling Exchange Under TEFCA" measure to allow providers to receive credit for the HIE objective by exchanging public health data through participation in TEFCA. While the ACC has supported efforts for CMS to incentivize participation in TEFCA and other programs so long as they are optional measures that afford providers choices that apply to their specialty, the College is concerned about the increased burdens associated with additional measure development. The College once again cautions CMS from creating too many measures in the name of specific use cases and while working to improve data exchange and interoperability, unintentionally exacerbate burnout and administrative burdens providers face every day.

g. MIPS Payment Adjustments

For CY2025, CMS proposes to continue using the mean of the final scores for all MIPS eligible clinicians from the CY 2017 performance period/2019 MIPS payment year to establish the performance threshold as 75 points for the CY 2025 performance period/2027 MIPS payment year. CMS also proposes to continue using the mean of the final scores for all MIPS eligible clinicians to compute the performance threshold for the 2027, 2028, and 2029 MIPS payment years. In discussion surrounding the impact a change from mean to median of final scores, CMS notes a change to the median of final scores as their methodology would have led to a 13-point increase in the performance threshold of 75 points. **The College thanks CMS for keeping the scoring methodology consistent as it promotes stability and the highest probability of successful participation in the MIPS program, especially at a time with**

continuing decreased reimbursement due budget neutrality and cuts to the conversion factor. As CMS evaluates options for sunsetting the MIPS program and transitioning to payment methodologies that focus on quality of care, continued stability and certainty are essential for practices.

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,

Cathie Biga, MSN, FACC
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