AMERICAN COLLEGE of CARDIOLOGY

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June 5, 2026

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

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

The American College of Cardiology (ACC) appreciates this opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the FY2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule. The College's comments focus on MS-DRG updates, NTAP and the proposed alternative NTAP pathway repeal, Inpatient Quality Reporting program measures, Value-Based Purchasing, Electronic Prior Authorization, Electronic Clinical Quality Measures and Interoperability.

The American College of Cardiology (ACC) is a global leader dedicated to transforming cardiovascular care and improving heart health for all. For more than 75 years, the ACC has empowered a community of over 60,000 cardiovascular professionals across more than 140 countries with cutting-edge education and advocacy, rigorous professional credentials, and trusted clinical guidance. From its world-class JACC Journals and NCDR registries to its Accreditation Services, global network of Chapters and Sections, and CardioSmart patient initiatives, the College is committed to creating a world where science, knowledge and innovation optimize patient care and outcomes. Learn more at www.ACC.org or connect on social media at @ACCinTouch.

Proposed Changes to Medicare Severity Diagnosis Related Group (MS-DRG) Classifications

WiSE® CRT System: CMS reviewed a submitted request to reassign the WiSE® CRT System, (ICD-10-PCS code X2HN37B) when billed in combination with XHH80HB (Insertion of ultrasound transmitter and battery for endocardiac pacing electrode into chest subcutaneous tissue and fascia, open approach, new technology group 11), from MS-DRGs 242, 243, and 244 (Permanent Cardiac Pacemaker Implant with MCC, with CC, without MCC) to MS-DRGs 228 and 229 (Other Cardiothoracic Procedures with and

without MCC) which currently houses leadless pacemaker procedures. When billed as a standalone service, this system is assigned to MS-DRGs 264 (Other Circulatory System O.R. Procedures).

The requestor argued that the WiSE® CRT system, as an implantable cardiac pacing system that delivers left ventricular endocardial pacing without the use of wires or leads going into the heart, is more similar to a leadless pacemaker than a pacemaker with leads and therefore should be grouped as such.

CMS agreed that leadless pacemakers and the WiSE® CRT System electrode are clinically coherent in that both eliminate the need for traditional, wire-based leads that run from the device to the heart muscle to transmit electrical impulses to the heart. **The ACC supports the CMS proposal to move the WiSE® CRT System service, X2HN37B, when billed in combination with XHH80HB from MS-DRGs 242, 243, and 244 to MS-DRGs 228 and 229; and when billed as a standalone service from MS-DRG 264 to MS-DRGs 228 and 229 for better clinical and resource utilization alignment.**

This review also prompted CMS to identify overlap in clinical similarity and resource utilization between MS-DRGs for cardiac pacemaker revision and cardiac pacemaker replacement and proposes to delete the existing MS-DRGs for each (258, 259, 260, 261, 262) and replacing them with new combined MS-DRGs (210, 211). **After reviewing the data CMS provided on the cost and length of stay for the services involved, the College finds this to be a reasonable update.**

Proposed New Technology Add-on Payments (NTAP) via Alternative Pathways

The College reviewed and supports the Agency proposals to implement NTAP for the cardiovascular devices presented. These include the CARA system, the GORE® VIABAHN® FORTEGRA venous stent, InVision Precision Cardiac Amyloid, Micro Medical Solutions MicroStent/MicroStent XL peripheral vascular stent system, NEXUS® Aortic Arch stent graft system, OmniaSecure™ MRI SureScan™ Lead Model 3930M, PMcardio® STEMI AI ECG Model, SAPIEN M3 transcatheter mitral valve replacement system, Trilogy™ transcatheter aortic valve regurgitation system, ViaOne™ Epicardial Access System, and VUNO Med-DeepCARS®.

Proposed Repeal of the Alternative Pathway for NTAP and Outpatient Prospective Payment System Device Transitional Pass-Through

The ACC has several concerns regarding the proposed repeal of the alternative pathway for NTAP and the OPPS Transitional Pass-Through (TPT) payment systems. First, the College supports the expedition of new technologies that can help save and improve patient lives which was the initial intent of creating the alternative pathway for NTAP. The program originally offered a pathway for alignment between the FDA process to expedite new technologies to the public with CMS efforts to provide the best care for their beneficiaries. The agency reiterated its commitment to unifying the efforts of these agencies in the announcement of the Regulatory Alignment for Predictable and Immediate Device (RAPID) pathway. It appears incongruous to promote alignment for coverage of devices through the RAPID program while simultaneously decoupling the requirements for allowing access to breakthrough technologies to CMS beneficiaries.

Beyond access to latest technology for beneficiaries and regulatory alignment, the College is concerned this repeal will hinder current and future innovation. The repeal is proposed to begin with FY2028 applications. This allows essentially zero notice to device manufacturers of this change for the FY2028 application window. These technologies often take 5 or more years to develop and expected reimbursement plays a major role. Removing the alternative pathway for enhanced reimbursement with this brief amount of notice could have significant negative impacts on availability of life saving or improving technology in the immediate future. Further, the lack of sufficient notice for manufacturers to adjust their plans and potential losses could reduce credibility in such government funded programs supporting new technology which could hinder innovation in the long term.

The ACC urges CMS to discard the proposal to repeal the alternative pathway for NTAP or delay the repeal. A delay should be followed by an RFI in either the next OPPS or IPPS proposed rule calling for stakeholders to opine on what potential consequences would come from this change as well as what alternative plans could address the CMS concerns prompting this proposal as well as stakeholder concerns.

Proposed Adoption and Modification of Five Mortality Measures in the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs

The ACC appreciates the opportunity to comment on the proposal to adopt and modify the MORT–30–AMI, MORT–30–HF, and MORT–30–CABG measures within the Hospital Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs. ACC has long supported the use of outcomes-based measures, including mortality, as important indicators of care quality and patient outcomes. **Overall, the College is supportive of CMS's efforts to modernize these measures, including the proposal to expand the measure cohorts to include Medicare Advantage beneficiaries and to update the risk adjustment methodology.** These changes reflect the evolving Medicare population and advancements in analytic approaches, and they have the potential to improve the reliability and representativeness of these measures across hospitals.

At the same time, we encourage CMS to provide additional clarity and safeguards as these updates are implemented. Greater transparency is needed regarding the proposed transition of these measures between programs. Specifically, CMS proposes to adopt the modified mortality measures in the IQR Program beginning with the FY 2028 payment determination, remove them from IQR beginning with FY 2032, and subsequently incorporate them into the VBP Program. While the College understands that this approach is intended to allow for public reporting prior to use in a pay-for-performance context, the transition pathway is not intuitive. Additional clarity is needed regarding how data generated during the IQR period will inform future VBP scoring, as well as how hospitals should interpret performance results during this interim phase. CMS should clearly communicate expectations to ensure that hospitals are not effectively subject to shadow performance assessment prior to formal inclusion in VBP.

The inclusion of Medicare Advantage beneficiaries in the measure cohorts is supported, as this change better reflects the current Medicare population and may improve measure reliability, particularly for lower-volume hospitals. However, given known differences in coding practices, data completeness, and care patterns between Medicare Advantage and Fee-for-Service populations, ACC encourages CMS to continue

monitoring for any unintended impacts on measure performance. To support transparency and trust in the measures, CMS should consider providing stratified analyses or supplemental reporting that allows stakeholders to better understand any differences across populations over time.

CMS's efforts to improve risk adjustment methodologies is also supported by the College, including the transition from hierarchical condition categories to more granular ICD-10–based modeling. Ensuring that mortality measures adequately account for patient complexity is critical, particularly for cardiovascular conditions such as heart failure and for procedures such as CABG that often involve high-risk patients. ACC encourages CMS to maintain transparency regarding the variables and methodology used in these updated models and to continue evaluating whether the models sufficiently capture clinical severity, including factors such as frailty and complex comorbid conditions. Ongoing monitoring will also be important to ensure that the measures do not inadvertently discourage the treatment of higher-risk patients. Greater reliance on ICD-10 codes increases sensitivity to coding variation and documentation practices, however, which could result in variations in coding intensity rather than true patient complexity. This could penalize clinicians who under-code, or reward those who do so aggressively.

ACC encourages CMS to continue closely monitoring the impact of these changes on small, rural, and lower-volume hospitals. While the inclusion of Medicare Advantage beneficiaries may help offset the shorter performance period, it will be important to ensure that reliability thresholds, case minimums, and reporting approaches do not inadvertently disadvantage these providers.

Measuring Emergency Care Access and Timeliness in the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs RFI

Improving emergency department access and timeliness, particularly given the well-documented impact of (Emergency Department) ED crowding and boarding on patient outcomes, is an important goal for CMS. ACC agrees that challenges with ED visits are often driven by system-level factors, including inpatient bed availability, staffing, and care coordination across departments. These issues warrant greater attention within quality measurement programs.

While ED boarding is linked to inpatient capacity constraints, several components of the measure (i.e., wait times, patients leaving without being seen, and overall ED length of stay) may be influenced by factors outside the direct control of inpatient teams. This may lead to unintended consequences and misaligned incentives. CMS should evaluate how responsibility for performance is assigned and ensure that any future measure reflects shared accountability across the care continuum rather than attributing outcomes to a single setting.

There are also concerns regarding the use of a composite measure that aggregates multiple distinct outcomes into a single performance score. The four numerator components (wait time, patients leaving without evaluation, boarding time, and total ED length of stay) reflect different operational challenges and may require different interventions. In addition, defining a numerator event based on the occurrence of any one of these components treats all events equally regardless of severity, which may not accurately reflect meaningful differences in hospital performance or patient impact. These timing thresholds (e.g., 4 hours for boarding) may oversimplify performance by treating materially different scenarios as equivalent.

Further, the exclusion of ED observation stays from certain numerator components may introduce inconsistencies in how similar patient experiences are classified and could create unintended incentives related to patient status designation. Combining these elements into a single measure may obscure underlying drivers of poor performance and limit the ability of hospitals to target meaningful improvements. CMS should consider whether these components are better assessed as separate measures or whether additional stratification is needed to support actionable insights.

Finally, there is the potential of unintended consequences associated with this measure, including incentives to avoid higher-risk or more complex patients, shifts in admission or observation practices, or other operational changes that may not ultimately improve patient care. **Given the importance of timely treatment for cardiovascular emergencies, including acute myocardial infarction and decompensated heart failure, it is critical that any measure in this area supports appropriate clinical decision-making.** ACC is also concerned that certain timeliness thresholds could unintentionally incentivize premature disposition decisions in patients presenting with high-risk cardiovascular symptoms or other clinically complex conditions, where longer ED evaluation periods may be appropriate to support accurate diagnosis, monitoring, and treatment planning. **Ultimately, we agree that improving ED access and reducing delays in care may ultimately benefit patients presenting with cardiovascular emergencies and support efforts to improve timely emergency care delivery.**

Proposed Adoption of the Hospital Harm-Postoperative Venous Thromboembolism eCQM

ACC agrees that postoperative venous thromboembolism (VTE) is a clinically meaningful and potentially preventable complication and supports efforts to advance outcome-based measurement that better reflects patient safety and quality of care. One important consideration is the continued evaluation of the 30-day attribution window. While the use of a 30-day timeframe is consistent with other CMS measures, postoperative VTE events occurring after discharge may be influenced by factors beyond the hospital's direct control, including patient adherence, outpatient follow-up, and care transitions. ACC recommends that CMS continue to assess whether this timeframe appropriately attributes outcomes to inpatient care and consider whether stratified reporting (for in-hospital versus post-discharge events) would improve interpretability and fairness.

Although the measure incorporates several clinical risk factors, including comorbid conditions and procedure types, additional variables may be necessary to fully account for patient complexity, particularly for high-risk surgical and cardiovascular populations. ACC encourages CMS to maintain transparency in the risk adjustment methodology and to continue refining the model to ensure fair comparisons across hospitals treating more complex patients.

We also recommend continued monitoring for unintended consequences. As noted in the pre-rulemaking process, there is potential for behavioral responses such as increased or inappropriate use of anticoagulation therapy in response to outcome-based accountability. CMS should closely monitor such effects and consider complementary measures or safeguards to ensure that efforts to reduce VTE do not inadvertently introduce new patient safety risks.

Stakeholders raised concerns regarding potential overlap with other measures, such as PSI-12 (Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate), and the extent to which the proposed eCQM would meaningfully replace or improve upon existing approaches. CMS should clearly articulate how this measure fits within the broader measure set and ensure that adoption results in true alignment and reduction of redundancy rather than duplication.

While CMS indicates that testing was conducted across several electronic health record systems, stakeholders have raised concerns regarding variability in data capture, particularly for post-discharge events and across health systems with differing levels of integration. Without stronger interoperability capabilities and consistent cross-system data exchange, it may be difficult to accurately capture outcomes for patients receiving care across multiple health systems. There should be continued evaluation of the measure's feasibility across diverse hospital settings, and provision of clear guidance and support to ensure consistent and accurate reporting.

Finally, we support CMS's proposal to remove the VTE-1 (VTE-1: Venous Thromboembolism Prophylaxis) and VTE-2 (Intensive Care Unit VTE Prophylaxis) eCQMs, contingent upon the adoption of a well-functioning outcome measure. Transitioning from process measures to an outcome-based approach has the potential to reduce reporting burden while maintaining focus on meaningful patient outcomes.

Proposed Adoption of Advance Care Planning eCQM

ACC supports the importance of advanced care planning, shared decision-making, and documentation of patient goals and preferences. These conversations are especially important for patients with advanced cardiovascular disease, serious comorbidities, or complex treatment options.
At the same time, advance care planning is a sensitive and individualized clinical process. CMS should ensure that the proposed eCQM supports meaningful patient-centered communication and does not reduce advance care planning to a documentation exercise. The measure should respect patient preferences, clinical timing, health literacy, and the possibility that some patients may decline or defer these conversations. Thus, ACC recommends that CMS test the measure across diverse hospital settings and patient populations to ensure that it is reliable, equitable, clinically meaningful, and feasible to report.

Proposed Removal of the Discharged on Antithrombotic Therapy Electronic Clinical Quality Measure from the Hospital Inpatient Quality Reporting Program (IQR)

ACC recognizes CMS's rationale for proposing the removal of the Discharged on Antithrombotic Therapy (STK-02) eCQM from the Hospital Inpatient Quality Reporting Program beginning with the FY 2030 payment determination, given evidence that the measure is topped out and no longer distinguishes meaningful differences in hospital performance. At the same time, ACC emphasizes the continued importance of appropriate antithrombotic therapy at discharge as a key component of high-quality stroke care and encourages CMS to ensure this aspect of care remains addressed through other measures within the program. **As CMS considers transitioning away from this measure, ACC recommends continued monitoring to confirm that removal does not result in unintended declines in performance and that remaining measures in the stroke portfolio, particularly those focused on outcomes and early inpatient management, adequately capture quality across the care continuum.**

Monitoring should occur for at least two years following removal to assess any changes in prescribing rates.

Proposed Modifications to Excess Days in Acute Care Measures in the Hospital Inpatient Quality Reporting Program Measure Set

ACC supports CMS's proposed modifications to the Excess Days in Acute Care (EDAC) measures for acute myocardial infarction and heart failure, including the expansion to include Medicare Advantage beneficiaries and shortening of the performance period from three to two years, as these updates better reflect the current Medicare population and improve the timeliness of reporting. At the same time, ACC encourages CMS to continue monitoring for differences between Medicare Advantage and fee-for-service populations that may affect comparability, and to ensure that measure reliability is maintained particularly for lower-volume hospitals. ACC also recommends continued refinement and transparency of risk adjustment methodologies, including consideration of factors such as social risk, outpatient access, and availability of post-acute and specialty care, which may influence outcomes beyond a hospital's direct control, while also evaluating the potential for variation in coding practices to affect performance.

Outcomes captured within the 30-day post-discharge window, including emergency department visits, observation stays, and readmissions, may reflect broader system-level factors. Clarity is needed around whether the measure is intended to capture all post-discharge utilization or only preventable utilization, as these represent fundamentally different quality objectives. It should also be evaluated whether counting each emergency department visit as a full day may overstate acute-care utilization, particularly for brief or low-intensity encounters.

Proposed Updates to the Electronic Prior Authorization Measure

ACC appreciates CMS's efforts to advance electronic prior authorization as part of broader interoperability goals and supports the continued development of standardized, API-based workflows to improve efficiency and reduce administrative burden. ACC also supports the proposed modifications to the Electronic Prior Authorization measure, including clarifying updates to the measure language and the shift from discharge-based to encounter-based timing. **ACC strongly supports CMS's proposal to make the measure optional and eligible for bonus points in CY 2027, recognizing that hospitals, health IT developers, and payers will require additional time to fully implement and operationalize electronic prior authorization capabilities.**

The College agrees that promoting the adoption of electronic prior authorization is important; however, the overall volume of prior authorization requirements imposed by health insurers must also continue to decline. Several large national insurers including Aetna, CIGNA, and UnitedHealthcare have committed to eliminating prior authorization requirements for a significant number of medical tests, procedures, and medications. Efforts to reduce unnecessary prior authorization are essential to improving patient access to timely and appropriate care. UnitedHealthcare's recent press release on the change noted that 92% of authorizations are approved in less than 24 hours. That sounds impressive, but a better system would not require review of so large a portion of services that will ultimately be approved anyway.

From a cardiovascular care perspective, timely access to diagnostic testing, imaging, and procedures is critical. Prior authorization processes can introduce delays that affect patient outcomes and care coordination if not properly implemented. Successful implementation of this measure depends not only on hospital readiness, but also on the availability, consistency, and functionality of payer APIs, which may vary significantly across markets. As CMS considers future expansion of this measure, including potential performance-based approaches, ACC encourages a cautious and phased approach that ensures an established framework, minimizes administrative burden, and accounts for factors outside of hospital control. Continued flexibility will be essential to support adoption while avoiding unintended consequences. E**lectronic prior authorization processes should support time-sensitive cardiovascular services where prompt diagnosis and intervention are essential.**

In addition, prior authorization requirements for inpatient drugs present a well-documented risk in cardiovascular care, where delays in initiating guideline directed medical therapy can affect patient outcomes, increase length of stay, and contribute to preventable complications and readmissions. ACC/AHA clinical practice guidelines recommend prompt initiation of anticoagulants, antiplatelets, statins, etc., for example. If CMS were to proceed with including drugs in the measure, it should be designed to capture not only if electronic PA was used, but also the time that has elapsed between a PA request and payer determination. Outcomes of each PA request should be captured to identify bottlenecks and payer compliance, including tracking denial rates by drug class. Drugs already approved on a hospital's formulary should be exempt from PA entirely, since this should be sufficient review for administration. **Overall, however, ACC strongly opposes the inclusion of medications administered during hospitalization in the measure and urges CMS to refrain from finalizing this consideration.**

Proposal to Adopt a Unique Device Identifier for Implantable Medical Devices Measure in the Public Health and Clinical Data Exchange Objective

ACC supports CMS's proposal to adopt a Unique Device Identifier (UDI) measure for implantable medical devices, as standardized device identification has significant potential to improve patient safety, post-market surveillance, and care coordination, particularly in device-intensive areas such as cardiovascular care. The routine capture of UDIs for devices such as pacemakers, implantable cardioverter-defibrillators, and structural heart devices can enhance traceability, support timely response to recalls, and strengthen real-world evidence generation.

At the same time, ACC encourages CMS to take a phased and flexible approach to implementation, recognizing variability in workflow integration and device capture practices across care settings, including catheterization laboratories and procedural environments. Data accuracy and completeness are critical to realizing the value of UDI capture. Stakeholders have noted challenges locating and abstracting UDI information when documentation is inconsistent or not readily accessible within the EHR. CMS should support standardized and accessible UDI documentation practices to facilitate accurate data capture and reduce abstraction burden. ACC also encourages alignment of UDI capture efforts with existing clinical registries and data systems to promote interoperability and minimize duplicative reporting burden. As CMS considers future evolution toward performance-based measures, a gradual approach will be important to ensure that requirements align with infrastructure readiness and do not impose undue burden on providers.

Proposed Changes to the Medicare Promoting Interoperability Program

ONC Health IT Certification Program Proposed Updates Relevant to the Medicare Promoting Interoperability Program

CMS proposes to remove four certification criteria from the Medicare Promoting Interoperability Program's certified electronic health record technology (CEHRT) definition effective January 1, 2027 including family health history, patient health information capture, automated numerator recording, and automated measure calculation. The proposed change would allow functionality that is already widely embedded in EHR products, and removing these certification references could reduce health IT developer testing/certification burden without changing hospitals' underlying reporting obligations.

The ACC appreciates CMS's continued efforts and attention to advance interoperable and standards-based exchange of health information as well as the effort to reduce duplicative reporting requirements within the Medicare Promoting Interoperability Program. The College supports the overarching goal of ensuring that certified electronic health record technology supports timely access to clinically meaningful information, facilities care coordination and enables more efficient quality reporting.

Proposal to Remove ONC Direct Review and ONC-ACB Surveillance Attestations and Proposal to Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures

CMS proposes the removal of the ONC Direct Review attestation and the optional ONC-Authorized Certification Body Surveillance attestation. CMS proposes removing these beginning with the CY 2026 EHR reporting period, with the change effective for the data submission period beginning January 1, 2027. CMS states that neither attestation requires a specific action during the EHR reporting period and removing them would reduce administrative burden while ONC oversight mechanisms would still exist outside the hospital attestation process.

Additionally, CMS proposes to remove two Support Electronic Referral Loops measures, Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information beginning with the CY 2028 EHR reporting period. CMS states that these measures are older C-CDA-based measures focused on sending and receiving/reconciling summary-of-care documents. The expectation is that removing these measures would streamline reporting and push the program toward newer, broader forms of exchange. As such, beginning in CY 2028, if finalized, the rule would require hospitals to satisfy the Health Information Exchange objective by using either the Health Information Exchange (HIE) bi-directional Exchange or Enabling Exchange Under TEFCA and satisfying the Electronic Prior Authorization requirement or claiming an exclusion.

The ACC is generally supportive of proposals that streamline program requirements, including the removal of attestations or measures that no longer meaningfully advance interoperability or that duplicate other federal oversight mechanisms. However, ACC encourages CMS to continue to monitor whether the

removal of referral-loop measures affects the exchange of information between hospitals, specialists, post-acute care providers, and other clinicians involved in longitudinal cardiovascular care.

More broadly, ACC urges CMS to ensure that changes to the Medicare Promoting Interoperability Program are implemented with appropriate flexibility, technical assistance, and phased timelines. Hospitals, particularly rural hospitals, critical access hospitals, safety-net institutions, and smaller facilities, may face significant challenges in meeting new interoperability requirements when EHR functionality, vendor updates, payer connectivity, or public health infrastructure are not yet fully mature. CMS should avoid holding hospitals accountable for failures attributable to third-party vendors, payers, or public health entities and should consider hardship exceptions or transitional policies where appropriate.

Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals Participating in the Medicare Promoting Interoperability Program

ACC supports CMS's continued efforts to align clinical quality measurement requirements across the Medicare Promoting Interoperability Program and the Hospital Inpatient Quality Reporting Program. Greater alignment can reduce duplicative reporting, simplify hospital workflows, and allow hospitals and clinicians to focus more directly on meaningful quality improvement.

The College also supports CMS's broader movement toward electronic clinical quality measures, provided that such measures are clinically meaningful, technically feasible, adequately tested, and implemented with sufficient lead time. As CMS continues to advance digital quality measurement, ACC urges the agency to account for the operational realities of hospitals, Critical Access Hospitals, EHR vendors, registries, and measure developers. ACC has previously emphasized that the transition to digital and FHIR-based quality measurement requires realistic timelines, technical assistance, and continued support for high-value reporting mechanisms such as clinical registries.

Implementation, Alignment, and Transition

ACC supports CMS's proposal to align eCQM adoption and removal across the Medicare Promoting Interoperability Program and Hospital IQR Program. Hospitals should not be subject to inconsistent measure specifications, timelines, or submission requirements across CMS quality programs.

CMS should provide a clear transition pathway so hospitals understand when existing measures will be retired, when new measures will be required, and how reporting expectations will align across programs. ACC also recommends that CMS provide voluntary testing periods, detailed implementation guidance, measure testing results, vendor readiness monitoring, and technical assistance. CMS should maintain appropriate flexibility for hospitals and CAHs that face barriers due to EHR limitations, infrastructure gaps, or other circumstances outside their control.

Conclusion

Thank you for your consideration of these comments from the ACC. The College appreciates the thought and effort that go into rulemaking and looks forward to future engagement on topics included in this and other rules and policy discussions. Please contact Matthew Minnella, Associate Director, Medicare Payment Policy at mminnella@acc.org if additional information would be helpful.

Sincerely,

Roxana Mehran, MD, FACC
President, American College of Cardiology