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September 10, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Submitted via www.regulations.gov

Dear Administrator Oz:

The American College of Cardiology (ACC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the CY2027 Medicare Physician Fee Schedule (MPFS) policies addressed in the proposed rule. The College's comments will focus primarily on the Ambulatory Specialty Model (ASM), new and revised Current Procedural Terminology (CPT) code valuations, practice expense relative value units (RVUs) methodology, the Quality Payment Program (QPP), the Medicare Shared Savings Program (MSSP), and multiple Requests for Information (RFIs).

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.

Determination of PE RVUs

Proposed Modifications to the PE Formula

For CY 2027, CMS proposes four significant modifications to the indirect practice expense methodology:

1. Utilization Adjustments
Utilization is a key component of the PE methodology, influencing both the development of PE RVU pools and the determination of specialty mix for individual CPT codes. Historically, utilization has been

adjusted to account for factors such as modifiers, geographic variations, and payment policies including the multiple procedure payment reduction.

For CY 2027, CMS proposes a new approach whereby utilization would be adjusted by calculating the ratio of allowed charges to the national Physician Fee Schedule payment amount for each claim line. CMS would also apply this methodology to adjust time inputs within the PE formula.

CMS states that these changes would have only a minimal effect on resulting PE RVUs. However, CMS has not published separate analyses showing the impact of this proposal on individual services or specialties. While the utilization data file made available by CMS reflects the newly adjusted utilization figures, these data suggest substantial utilization changes for pathology, independent laboratories, and physical and occupational therapy services. It remains unclear how these significant utilization shifts translate into changes in PE RVUs across specialties and services.

2. Indirect PE Allocation Methodology
CMS proposes expanding the indirect PE allocation methodology by using the combined value of physician work RVUs and clinical labor inputs, rather than the greater of the two, for all services except those with 10-day and 90-day global periods. CMS does not provide a clear rationale for introducing an exclusion of 10-day and 90-day global periods in the proposed rule. Furthermore, CMS has not published code-specific or specialty-specific impact information that would allow stakeholders to understand the implications of this proposal.

3. Elimination of the Indirect Practice Cost Index
CMS proposes to phase out the Indirect Practice Cost Index (IPCI) over a two-year transition period. The IPCI was originally adopted to ensure that specialty-level indirect practice costs reported through the PPI survey were appropriately reflected within the PE methodology. CMS contends that improvements in direct practice expense data and allocation methods now justify eliminating the IPCI. At the same time, CMS raises concerns regarding the age of the survey data used to construct the IPCI.

However, components of the same survey data, including PE per hour and the allocation of direct versus indirect costs, continue to be used within the PE methodology. CMS has not provided code-level or specialty-level analyses that would allow stakeholders to evaluate the impact of removing the IPCI.

4. Practice Expense Stabilization Factor
CMS proposes implementing a PE stabilization factor for services that are not new, revised, or revalued. Under this policy, PE RVUs for eligible services would be limited from changing by more than five percent relative to the prior year.

CMS indicates that this policy is intended to mitigate potential volatility associated with the proposed IPCI phaseout and help preserve stability for services that otherwise would be expected to remain relatively unchanged. CMS also notes that the existing limitation on reductions in total RVUs, currently capped at 19 percent, would continue to apply after the stabilization factor is implemented.

However, CMS has not identified which codes would be subject to the stabilization factor in CY 2027. Nor is it clear which services may experience reductions in future years as a result of this policy. Without this information, stakeholders cannot adequately assess the long-term implications of the proposal.

ACC Perspective

The ACC is concerned that CMS has not provided sufficient information for stakeholders to meaningfully assess the effects of these four complex and interrelated proposals. The ACC generally supports policies that promote predictability and stability in physician payments. Transitions and safeguards that reduce abrupt year-to-year fluctuations in RVUs can help protect physician practices and maintain patient access to care. To the extent feasible, these principles should be applied broadly across services. Nonetheless, CMS has historically released impact analyses for major practice expense methodological changes. In this rulemaking, stakeholders are asked to evaluate multiple intertwined modifications without access to detailed analyses showing the individual effect of each proposal at the code or specialty level.

In addition, key aspects of CMS's rationale remain unclear. For example, CMS does not provide an explanation for excluding services with 10-day and 90-day global periods from the proposed indirect allocator modification. Without greater transparency and more detailed data, stakeholders cannot fully understand the consequences of the proposed changes. **Accordingly, the ACC urges CMS to postpone implementation of these practice expense proposals until a future rulemaking cycle in which detailed specialty-specific and code-specific impact analyses are available for each proposed modification.**

The ACC also encourages CMS to revisit the findings of the Physician Practice Information (PPI) Survey. The AMA's multi-year effort to collect updated physician practice data provides the most current information available regarding physician practice expenses and physician work hours. CMS previously stated in the CY 2026 Proposed Rule that it intended to work with stakeholders, including the AMA, to evaluate whether and how these data should be incorporated into future Physician Fee Schedule rate-setting.

While the ACC appreciates CMS's efforts to simplify the PE methodology, we continue to believe that CMS should work with the ACC, AMA, and other stakeholders to evaluate how the 2024 PPI data can be incorporated into future policymaking to ensure that physician practice costs and physician work effort are accurately reflected. The ACC also supports CMS's proposal to continue utilizing the 2006-based MEI cost shares for CY 2027 until the agency completes its evaluation of the 2024 PPI data and determines the most appropriate path forward.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Professional and Technical Components
CMS explains its posting of a new public use file that displays the split of professional and technical components for services that are not billable with TC and 26 modifiers as a new effort in price transparency. CMS seeks to facilitate more consistent comparisons across services and settings through

this new resource, noting that payment variation and opaqueness "may complicate efforts to advance site-neutral payment policies aimed at reducing incentives for hospitals to acquire physician practices and limit site-of-care decisions based on financial considerations."

The new file may be useful to aid some in understanding the professional and technical components of services that may not be billed with TC and 26 modifiers. This information is already present—in a different format—in Appendix B, and ACC believes many stakeholders are already familiar with the components of these services. For instance, the new public use file shows Level 3 E/M visit 99213 to have a global non-facility PE RVU of 1.44, a professional non-facility PE RVU of 0.29, and a technical non-facility PE RVU of 1.15. In Appendix B, the same global non-facility PE RVU of 1.44 is displayed. The facility PE RVU is displayed as 0.29—this is the same as the non-facility PE RVU because it is essentially the indirect PE component of the services. The technical PE component would be the difference between the global PE and professional PE technical components, or 1.15. Insofar as this re-presentation of these inputs is more understandable to stakeholders, it appears to be accurate based on services reviewed by the ACC. It would be more useful if CMS confirmed the systemic approach it used or explained in greater detail how it developed the resource, if the sample calculation above is not correct.

As it relates to advancement of site-neutral policies, the ACC reiterates its longstanding principles for site-neutral payments:

- Changes to Medicare payment should prioritize patient access, quality and value of care.
- Approaches to remove unnecessary and/or unexpected cost to patients and the health care system, including equity across outpatient ambulatory settings, should be discussed.
- Significant changes to address payment disparities between sites of service must be phased in over time to safeguard the stability of the health care system.
- Proposals must consider the financial impact of changes on the stability of the health care system, particularly those providing care to underserved populations.
- Site of service payment policies must be aligned with programmatic and systemic changes to avoid unnecessary complexity and promote the successful transition to a value-based payment system.
- Any payment differences across sites should be related to documented differences in the resources needed to ensure patient access and high-quality care.
- Medicare payments for all sites of care should account for costs related to emergency capacity, compliance with regulatory requirements, geographic differences, quality improvement activities, higher need populations, or other factors relevant to a site of service.

Global Surgery Packages

In the CY 2015 PFS final rule CMS finalized a policy to transition all 10-day and 90-day global period codes to 0-day global periods, allowing any post-operative visits furnished after the day of procedure to be

billed separately from the procedure. This policy was prohibited from implementation by the MACRA law, and CMS was instead directed to collect data on how to best value these 10- and 90-day global codes.

Data was collected through a research contract with RAND and was based on reporting of CPT code 99024 *(Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*). This collection effort was limited to practices with 10 or more practitioners and the code used for the data collection had no associated payment rate. The data collected showed that 4 percent of 10-day global codes and 67% of 90-day global codes had one or more post-operative visits occur during the global period.

CMS proposes to pause the data collection required under MACRA currently performed by RAND via the 99024 code submissions as they feel sufficient data has been collected in this manner and believe the process may be an undue burden on affected practices. CMS questions whether the data collection should be done in a more robust fashion, having all providers report the 99024 code rather than the current select sample. The agency requests comment on what other data sources might aid the effort to appropriately value 10- and 90-day global codes and what revaluation strategies they might consider for future rulemaking.

The ACC appreciates the agency's desire to only pay for services that are actually performed and their efforts in pursuing this relative to the 10- and 90-day global codes. We would be surprised if a non-reimbursable CPT code available only to select practices in less than 20% of states has provided sufficiently accurate data. Providers are far less likely to submit a code for no payment regardless of the larger goal of accurate reimbursement practices.

The ACC appreciates CMS's concern for undue physician burden and has no objection to the discontinuation of the collection of data via select practices' submission of CPT code 99024. With the same consideration for undue physician burden in mind, **we also oppose the proposal to collect data in this fashion from all providers.**

CMS may obtain more accurate data if there were some financial incentive for reporting services that would otherwise have no reimbursement – either by design as with 99024, or by rule as with any E/M code performed by the same provider during the 10- or 90-day global period. There could be a small RVU reimbursement applied to these E/Ms billed with 99024 or with some to-be-defined modifier to incentivize participation.

Regarding potential revaluation strategies for future rulemaking regarding 10- and 90-day global codes, the College urges careful consideration. If CMS were to eventually implement a change akin to the 2015 plan of shifting all 10- and 90-day global codes to 0-day global codes it would be nearly impossible to appropriately value these codes in a timely fashion. One could not simply remove the full RVUs of any included post-operative visits for several reasons. First, the values built into the codes were based on the RVUs of the E/M codes at the time of valuation and they have been revalued upward since then in most cases. Further, the valuation process was developed to account for overlap in portions of these services, so the full value of the included E/M codes are not completely represented in the 10- or 90-day global

codes' RVU. Making such a dramatic shift as an eventual full transition of all 10- and 90-day global codes to 0-day globals would require all affected codes to go through the RUC survey and valuation process which would not be feasible in a single rulemaking cycle.

Payment for Medicare Telehealth Services

Telehealth Flexibilities and Modifiers
Congress has extended telehealth flexibilities stemming from the COVID-19 Public Health Emergency several times since 2020, most recently in the Consolidated Appropriations Act, 2026 (CAA). CMS proposes updates to align regulations with those directed by Congress. The CAA extends the flexibilities for Medicare telehealth services to remove the geographic restrictions, expand the list of acceptable originating sites, and expand the array of practitioners eligible to furnish telehealth services until the extended date of December 31, 2027, delays the in-person visit requirements for mental health services furnished through telehealth until the extended date of January 1, 2028, and extends the flexibilities to allow audio-only Medicare telehealth services until the extended date of January 1, 2028. The ACC supports the revisions proposed to align regulations with these statutory changes.

The CAA also requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. These modifiers will not affect payment and are required for claims for telehealth services that are furnished through a virtual telehealth platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and for claims for telehealth services that are furnished incident to a physician's or practitioner's professional service. In accordance with the CAA, CMS proposes creation of new modifiers BB and BC. The ACC agrees these new modifiers comport with Congressional intent and looks forward to future instructions on use of these modifiers on the CMS website through sub-regulatory guidance.

Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence
In the CY 2026 PFS final rule, CMS finalized permanently allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in different locations. CMS proposes refining this policy for CY 2027 to mitigate logistical complexities in scenarios where either the teaching physician or resident is already in the same physical location as the beneficiary. The updated policy would allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location—in the same room—as the beneficiary. The ACC appreciates this new flexibility and suggests that CMS clarify that both avenues of virtual presence are allowed. Specifically, these services should be billable via virtual presence when either the teaching physician or resident is in the room with the patient and when the teaching physician, resident, and patient are in different locations.

Efficiency Adjustment

CMS notes in the proposed rule that the efficiency adjustment finalized in the CY 2026 MPFS was applied to RUC recommended values submitted during 2026 prior to the finalization of the policy.

The ACC reiterates concerns about the efficiency adjustment policy. As noted in previous comments, the ACC understands the general premise of applying a productivity adjustment to the PFS as this is done in both the inpatient and outpatient hospital payment systems. The key difference in these scenarios of course, is that the inpatient and outpatient hospital payment systems also receive an annual inflation-based update that is only partially offset by the productivity adjustment for a net gain in total reimbursement. **The ACC reiterates its position that if this efficiency adjustment based on productivity statistics is to be applied to the PFS then it should be accompanied by an inflation-based update to both the conversion factor and the budget neutrality threshold.**

Beyond the flaws in the methodology of the efficiency adjustment policy as noted above and in prior comments, the fact that this reduction was applied to codes that already had their values reduced by revaluation during the five-year look back is especially egregious. The stated purpose of the efficiency adjustment was to account for what CMS felt were accrued efficiencies to procedures done over many years that led to what the agency felt was overpayment. While not addressing all codes simultaneously, the RUC has a routine mechanism to address potentially misvalued codes in the form of numerous review screens under its Relativity Assessment Workgroup (RAW). The RAW reviews and potentially refers codes for resurvey if there is reason to believe the value may be inappropriate. Many codes were revalued and reduced significantly during the five-year look back period of the efficiency adjustment. These codes' updated efficiency was determined by renewed survey data in which times went down and RVUs were reduced. Yet, they were hit with an additional reduction from the efficiency adjustment. **This double-dipping of efficiency reduction in value is unjust and should be rectified by removing the efficiency adjustment reductions from codes that had their work RVUs reduced by revaluation during the five years leading up to the policy implementation.**

The chart below is not an exhaustive list but demonstrates some of the more significant work RVU reductions incurred by cardiovascular codes during the five-year look back period which were then further diminished by the efficiency adjustment.

Code	Descriptor	Re-valuation Year	% Revaluation Reduction	% EA reduction	Total 5-year % reduction
93654	Ablation	2021	-8.35%	-2.50%	-10.63%
93655	Add'l ablation	2021	-26.67%	-2.50%	-28.53%
93656	Ablation	2021	-14.01%	-2.50%	-16.14%
93657	Add'l Ablation	2021	-26.67%	-2.50%	-28.53%
33340	Left Atrial App.	2024	-26.79%	-2.50%	-28.64%
92920	Angioplasty	2024	-15.23%	-2.50%	-17.36%
92924	Arthrectomy	2024	-13.71%	-2.50%	-15.84%
92928	Stent	2024	-8.76%	-2.50%	-11.04%

Cardiac Contractility Modulation (CCM) (CPT Codes 33X01, 33X02, 33X03, 33X04, 33X05, 33X06, 33X07, 33X08, 33X09, 33X10, 33X11, 93X01, 93X02, 93X03, 93X04)

The CPT Editorial Panel approved a new family of 11 Category I CPT codes for insertion, removal, and replacement of CCM systems, generators, and leads along with a set of four codes for programming and

interrogation of the systems. CMS proposes to accept the RUC recommended work RVUs and practice expense inputs for all codes in this family.

The ACC supports CMS's proposal to accept all recommended work RVUs and practice expense inputs for the new CCM code family.

Transcatheter Tricuspid Valve Implant, Edge-to-Edge Repair (CPT Codes 33X50, 33X51, and 33X52)

CMS proposes to reject the RUC recommendations for all three tricuspid valve repair and replacement codes, reducing them significantly in each case. For 0-day global codes 33X51 and 33X52 the agency justifies much of their reduction by removing a post-operative visit including 55 minutes of associated work time which was included in the value of the code. CMS notes that, "0-day global periods are specifically defined to include only post-operative care that takes place on the day of the procedure itself without incorporating any post-operative days." This statement is incongruous with the existing Medicare Physician Fee Schedule and precedent set by CMS rulemaking.

Transcatheter aortic valve replacement (TAVR), CPT code 33361, which is also a 0-day global period procedure describing a heart valve replacement procedure, includes a post-operative visit in its value and was finalized in CMS rulemaking. Altogether, the College is aware of 39 0-day global period codes which contain a post-operative visit and were finalized in CMS rulemaking representing 3% of all 0-day global codes. These include: skin debridement codes 11004-11006, thoracoscopy codes 32601-32609, TAVR codes 33361-33366, ECMO codes 33951-33986, 31561, 32997, 33988, 33989, 52301, 61640, 61737, and 77789. While codes among this list were originally valued as far back as 1995, the College points to a detailed rationale for inclusion of such a post-operative visit from 2021. In its RUC-recommended valuation of CPT code 61737 (*Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)*) a post-operative visit was included, noting that the LITT codes "have 0-day global periods which typically do not allow for an E/M visit on the same day as the procedure. However, unlike CPT code 61736, CPT code 61737 typically involves a full two-midnight admission, as reflected by the survey respondents, which justifies the same-day E/M visit." The RUC confirmed that CPT codes 33X50 and 33X51 cross the two-night threshold and that, while not typical for 0-day global codes, CMS has allowed for a post-operative visit in these instances.

As such, the College strongly urges CMS to include a subsequent hospital visit (CPT code 99233) for CPT codes 33X50 and 33X51 in accordance with the survey data and CMS precedent for these specific circumstances.

33X50

CMS proposes valuing CPT code 33X50 for transcatheter tricuspid valve replacement (TTVR) at 17.52 via crosswalk to CPT code 93591 (*percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve*). The agency justifies this by stating that the recommended value for 33X50 of 24.38 is "far higher than any other 0-day global code with similar time values on the PFS." Of course, this is based on the

procedure time with the post-operative visit removed. With the appropriate post-operative visit included as it should be per our explanation above, 33X50 is in line with the survey key reference of 33477. We understand that while 33X50 with the post-op visit included has nearly the exact same total time (275 minutes) as 33477 (271.5 minutes) that the intraservice time for 33X50 (120 minutes) is notably lower than 33477 (175.5 minutes). However, we note here that 83% of survey respondents who selected 33477 as the top key reference service indicated that 33X50 was somewhat more or much more intense/complex than 33477. 54% of these respondents specifically noted that it was much more intense/complex than 33477. Physicians who perform this service clearly indicated that 33X50 is a much more intense/complex procedure than reference code 33477 which explains the gap in intensity as measured by IWPUT which is formulated from the intra-service time.

CMS further rationalizes the 33X50 valuation in stating that "most codes with 120 minutes of intra-service time and approximately 220 minutes of total time were valued around a work RVU of 13.00-15.00." This statement also refers to the service without the 55 minutes of time for the post-op visit. Further, while this is the average range for codes with a 0-day global period with these times, reducing a code's value simply to better align with an average is antithetical to the idea of a relative value system. Cardiovascular procedures performed in a beating heart are consistently recognized among the most intense and complex procedures performed within the PFS. These codes should be at the top of most ranges in which they appear. CMS finalized updated values for several percutaneous coronary intervention (PCI) codes in the 2026 PFS Final rule noting that they set new upper ranges for multiple codes in their global period and time range. Reducing a code's value simply to avoid setting a new high RVU in the global period and time range is not a credible rationale and again, betrays the concept of relativity.

Aside from concerns with the rationale to reduce the recommended work RVU for 33X50 we also take specific issue with the crosswalk chosen by CMS. 93591 was an option on the survey for respondents to choose as the key reference service for 33X50. Instead of choosing this code, the second most common choice of comparator was CPT code 93590. This second key reference service has a work RVU of 21.16 and, while it has a slightly higher intra-service time of 131.63 minutes versus 120 minutes for CPT code 33X50, a majority of respondents rated CPT code 33X50 as somewhat or much more intense/complex than CPT code 93590, supporting the higher intensity/complexity measure for the surveyed code.

The ACC reiterates that there is precedent and ample empirical evidence to include a post-operative visit in this 0-day global code, thus making the removal of time from 33X50 unwarranted which disqualifies the CMS proposed crosswalk. **The College maintains that the RUC recommendation of 24.38 work RVUs for CPT code 33X50 is appropriate and urges CMS to accept and finalize the value.**

33X51

Regarding CPT code 33X51 for transcatheter tricuspid edge-to-edge repair (T-TEER) CMS proposes a valuation of 17.06 which the agency states is, "based on the recommended interval of 0.46 RVUs." There is no rationale for the valuation of 33X51 other than maintaining the 0.46 work RVU interval between 33X51 and 33X50. The RUC does not value codes via intervals to or from other code values. RUC recommendations are based on analysis of empirical data from surveys taken by physicians who perform these services and their comparisons to existing codes to establish relativity within the PFS. There was no

mention of an incremental difference between 33X50 and 33X51 in the RUC rationale for either code's recommended value. Further, if this method of valuation, which we oppose, was implemented it would follow that the tenets of relativity ought to be applied proportionally rather than as the static RVU differential amount. In other words, the 33X51 recommended value of 23.92 is 1.9% less than the 33X50 recommended value of 24.38. Therefore, if following this flawed methodology, 33X51 should be valued at 1.9% less than the CMS proposed value of 17.52 for 33X50, which would be 17.19.

We refer to arguments made above as to why the recommended post-operative visit should be included in 33X51. The RUC recommendation for 33X51 was based on the survey 25th percentile work RVU which, at 23.92 RVUs, was bracketed between the first key reference service of 33477 at 24.38 RVUs and 93590 at 21.16 RVUs. 33X51's lower intra-service time than either key reference services represents an implied higher intensity/complexity of the code versus the comparators. This comports with the survey findings. 88% of respondents who chose 33477 as the key reference service found 33X51 to be somewhat or much more intense/complex than 33477 with 55% specifically finding it much more intense/complex. 67% of respondents who chose 93590 as the key reference service found 33X51 to be somewhat or much more intense/complex than 93590 with 40% specifically finding it to be much more intense.

The ACC maintains that CPT code 33X51 is appropriately valued at the 25th percentile work RVU with a post-operative inpatient visit as supported by the survey. **The ACC urges CMS to accept a work RVU of 23.92 for CPT code 33X51.**

33X52

CMS recommends a reduction from the RUC recommended value of 33X52 of 8.00 to 6.34 via crosswalk to CPT code 22552 (*Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace*). CMS contends that the recommended work RVUs of 8.00 for 33X52 "placed it far higher than almost any other add-on code with similar time values on the PFS, with the sole exception of CPT code 61642 *(Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory)* which is an outlier valuation at work RVU of 8.66." The agency also states that "most add-on codes with approximately 50 minutes of total time were valued around a work RVU of 3.00-5.00 and there was only a single code valued higher than work RVU of 6.34."

The College has multiple concerns with this rationale for the valuation of 33X52. First, in a system based on relativity, there are no such things as outliers that can be dismissed in this fashion. If a code is valued significantly higher than other codes of the same global period with similar time that is simply a recognition that the code is that much more intense and complex to perform. It is a data point in the system of relativity and establishes one end of the relative scale. As neurologic and cardiac codes are commonly valued in all global periods among the most intense and complex services, it is not surprising that a neurosurgery procedure would serve as the high end of the relativity scale in this case. It would also follow that a complicated cardiovascular procedure would fit into the relative scale below a neurosurgical procedure yet well above many other codes in the same global period.

The validity of the statement that most add-on codes with "approximately" 50 minutes of total time are

valued between 3.00-5.00 work RVUs depends on one's definition of approximately. Applying a range of 40 to 60 minutes of total time for add-on codes (re: ZZZ global period), there are ten codes with a work RVU greater than 6.34 with five cardiovascular codes having work RVUs 6.50 or above. Endovascular revascularization codes 37293 and 37291 have work RVUs of 6.50 with total times of 60 minutes. These peripheral procedures are inarguably less intense/complex than operating on a valve inside the heart. Notably, the current highest valued cardiovascular add-on procedure with between 40-60 minutes of total time is 93592 *(Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* which is an add-on code to CMS's proposed crosswalk for 33X50 and has a work RVU of 7.80 with a total time of 58.5 minutes. While we support the survey results indicating that 33X52 is more intense/complex than 93592, it appears clear this would serve as a much more appropriate crosswalk if the RUC recommendation was not accepted than the proposed 22552.

The ACC maintains that 33X52 is appropriately valued at the RUC survey 25th percentile work RVU of 8.00. **The ACC urges CMS to accept a work RVU of 8.00 for CPT code 33X52**.

Percutaneous Transcatheter Closure, Left Atrial Appendage (CPT Code 33340)

The RUC recommendation for work RVUs of CPT code 33340 was to maintain the current value of 9.99. CMS notes that the survey intra-service time was reduced from 70 minutes to 62 minutes. The agency proposes a value of 9.00 for 33340 via crosswalk to CPT code 37271 (*(Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel)* to account for the reduced intra-service time.

The cross-walked code, 37271, does not carry the same level of procedural risk as LAAC. CPT 33340 involves transseptal puncture, catheter manipulation within the left atrial appendage, and deployment of a permanent endocardial implant adjacent to critical structures with attendant risks of pericardial effusion/tamponade, device embolization, and thromboembolic complications that have no comparable danger in a peripheral endovascular atherectomy procedure. Additionally, as more and more Intracardiac Echocardiography (ICE) is being done, the intensity of the procedure has increased, as the operator also has to manage a conscious patient rather than a sedated patient.

CPT code 33340 was surveyed for both April 2024 and January 2026 RUC meetings, a relatively brief span of time for code valuation review. For this reason, the ACC contends that the reduction in intra-service time should be evaluated against the 90 minutes in place at the time of the April 2024 survey, rather than viewed only in isolation against the most recent survey. The January 2026 survey resulted in an intra-service time of 62 minutes, representing a 31.1-percent reduction from the 90 minutes in place for the April 2024 survey. If that reduction were applied proportionately to the original work RVU of 14.00, the resulting value would be 9.66 work RVUs. CMS has repeatedly acknowledged in this proposed rule that while decreases in physician time may support a reduction in work RVUs, the reduction does not need to be strictly proportional. Leaving the current value of 9.99 RVUs in place would represent a 28.6% reduction in RVUs from the original 14.00, not far from the 31.1% overall reduction in intra-service time.

Alternatively, reducing the RVU to 9.00 would equate to a 35.7% reduction in RVUs from the original 14.00 value. The CMS recommended 9.00 RVU would represent a 4.6% greater reduction than the total intra-service time reduction from April 2024 to January 2026. Meanwhile, the recommended RVU of 9.99 equates to just 2.4% below the proportional reduction in intra-service time over that same time span. Accordingly, the ACC believes maintaining the current value of 9.99 work RVUs for CPT code 33340 addresses the reduction in time while preserving recognition of the intensity and complexity of the service. **The ACC urges CMS to accept the RUC recommended work RVUs of 9.99 for CPT code 33340.**

Treatment of Incompetent Veins (CPT codes 36470, 36741, 36465, 36466, 36473, and 36474)

CMS proposes to accept the RUC recommended work RVUs for CPT codes 36465, 36470, 36471, 36473, and 36474. **The ACC supports CMS accepting the RUC recommended values for these codes.**

CMS proposes reducing the RUC recommended and current value for CPT code 36466 (*Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg),* of 2.93 work RVUs down to 2.62 via crosswalk to CPT code 57156 (*Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy*). CMS notes that the survey showed a 14% reduction in intra-service time and 11% reduction in total time for 36466 as their rationale for the reduction in RVU.

The code descriptor for 36466 did not change prior to this resurvey. However, the typical patient vignette presented to survey respondents did change. The earlier vignette identified incompetence of the great and small saphenous veins but described treatment of the great saphenous and anterior accessory saphenous veins. The current vignette corrects that inconsistency and describes treatment of the **great and small saphenous veins**, which more accurately represents the typical patient for the service.

That distinction has consequences for physician work. Treatment of the small saphenous vein presents different technical considerations because of its posterior location. Depending on the patient's anatomy and clinical circumstances, treatment may require repositioning of the leg or placement of the patient in the prone position. The small saphenous vein is also generally smaller and can be more difficult to access under ultrasound guidance, with a less favorable orientation for visualization and treatment.

We believe there being a new, clarifying typical patient vignette for the resurvey essentially de-couples the intensity rating of the original survey from the new. While the time did decrease, we believe the corrected vignette revealed that the accurately described typical procedure is of a higher intensity than the former. As such, **the College recommends CMS accept the RUC-recommended value of 2.93 for CPT code 36466.**

Intracoronary Drug Delivery Balloon Services (CPT codes 9XX04 and 9XX07)

CMS proposes to accept the RUC recommended work RVUs for 9XX07 *(Percutaneous transcatheter therapeutic drug-delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), single major artery and/or its branches*) of 4.38. **The ACC supports CMS accepting the RUC recommended value for 9XX07.**

CMS proposes to lower the work RVU for 9XX04 (*Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, single major coronary artery and/or its branch(es)* from the RUC recommended, survey median 10.00 to the survey 25th percentile of 8.05. This proposed valuation introduces a distinct contradiction. The descriptor of 9XX04 includes all the work of current CPT code 92920 (*Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)),* in addition to the work of applying the drug-coated balloon. 92920 is currently valued at 8.14. Therefore, the proposed valuation of 9XX04 would be lower than a service that is wholly included in 9XX04 and is not separately reportable. The RUC made the uncommon decision of recommending the survey median precisely because applying the 25th percentile would cause this definitional and rank order anomaly.

Aside from the obvious contradiction of the work of 92920 being included in 9XX04 yet having a higher value, we also contend that 9XX04 is a more intense and complex procedure than 92920. 9XX04 requires additional inflation time and is used in more high-stakes situations, chiefly bifurcation stenting, in-stent restenosis often with multiple layers of stent, and lesions that stents cannot reach due to tortuosity. With 92920, if balloon position is not optimal one simply deflates it and moves it. With 9XX04, the operator must align the positioning of the balloon to disperse the drug. When 92920 is performed, it is usually with one balloon. When 9XX04 is performed, lesion preparation almost always precedes placement of the drug-coated balloon using a different standard balloon typical of 92920.

The survey results and expert analysis show that the work of performing 9XX04 is substantially similar to the work of CPT code 92928 *(percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments)* as prior to application of the efficiency adjustment 92928 had an intra-service time of 60 minutes and a work RVU of 10.00 – exactly the recommendations made for 9XX04. While we maintain that 9XX04 should be finalized as recommended by the RUC, 92928 at its current work RVU of 9.75 and intra-service time of 58.5 minutes would serve as a much more rational valuation via crosswalk than the proposed survey 25th percentile of 8.05. **The ACC urges CMS to finalize the work RVU for 9XX04 at the RUC recommendation of 10.00.**

Endoluminal Coronary Intravascular Ultrasound (IVUS) (CPT codes 92978 and 92979)

CMS disagrees with the RUC recommended work RVUs for CPT codes 92978 and 92979. CMS proposes a work RVU of 1.40 for 92978 via crosswalk to 93572 *(Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; each additional vessel (List separately in addition to code for primary procedure)*). CMS proposes a work RVU of 1.04 for 92979 based on the same incremental RVU differential between the RUC recommended values for 92978 and 92979 of 0.36 RVUs.

The surveying societies presented and the RUC accepted the current work RVUs of 1.76 for 92978 and 1.40 for 92979 despite a notable reduction in total time. When IVUS was created in 1996 it was used as a diagnostic tool and imaging modality. It is now typically used to guide endovascular interventions. This change in usage is potential evidence of changes in the intensity and complexity of the service which is confirmed in the survey data. Regarding intensity, IVUS involves a rigid device for which the physician

must stretch open the vessel to allow passage. The device is larger than a typical flexible balloon wire used for arterial procedures, making the service more intense/complex. The chart below illustrates where the IVUS codes would reside in order of intensity as measured by IWPUT with the RUC recommended RVUs. We believe this is the appropriate rank order for IVUS relative to these PCI procedures.

Code	Description	Global	Work RVU	Intra Time	IWPUT	Total Time
92941	PCI during AMI	000	12.41	65	0.1706	130
92937	PCI thru bypass	000	11.02	65	0.1449	143
92930	Cplx Stent	000	12.00	75	0.1389	152
92924	Atherectomy	000	9.88	60	0.1379	138
92920	Angiography	000	8.14	48	0.1376	123
92928	Stent	000	9.75	60	0.1365	136
92933	Ang./Stent/Athr.	000	11.64	75	0.1338	153
92978	IVUS initial	ZZZ	1.76	15	0.1173	15
92979	IVUS additional	ZZZ	1.40	13	0.1077	13
92945	CTO ante/retro	000	15.00	130	0.1030	208
92943	CTO	000	13.35	120	0.0979	198
92972	IVL	ZZZ	2.90	30	0.0967	30
93571	FFR Initial	ZZZ	1.76	20	0.0880	20
93572	FFR additional	ZZZ	1.40	16	0.0875	20
92973	Thrombectomy	ZZZ	1.71	20	0.0855	20

92978 and 92979 represent IVUS performed in a coronary vessel. CPT codes 37252 and 37253 represent the same services when performed in a non-coronary vessel and are valued at the same work RVUs of 1.76 and 1.40 as 92978 and 92979. To value coronary IVUS significantly below non-coronary IVUS would dissolve relativity between these codes within the PFS.

The ACC urges CMS to accept the RUC recommended RVUs of 1.76 for 92978 and 1.40 for 92979.

The College also notes that, as with our arguments above regarding 33X51, we disagree with making any valuation based on a nominal incremental difference in RVUs alone. That being said, if CMS were to proceed with this methodology, we believe a proportionate RVU should be used rather than the static nominal differential. The recommendation of 1.40 for 92979 is 20.5% less than the recommendation of 1.76 for 92978. Therefore, if using CMS proposed methodology, 92979 should be 20.5% lower than the proposed 92978 crosswalked RVU of 1.40, which would be 1.11.

Remote Physiologic Monitoring

CMS proposes significant changes to Medicare payment and coverage policies for Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services, largely in response to concerns by the Office of the Inspector General (OIG) about program integrity, patient oversight, and fragmented care. The ACC limits its comments to RPM as cardiologists have not generally provided RTM as it is currently constructed.

First, while RPM has only been available to established patients, CMS solidifies a requirement for performance of a separately reportable, initiating visit in association with the onset of RPM. RPM services must be initiated by the billing practitioner during a face-to-face (in-person or telehealth) visit. Services that do not involve a face-to-face visit by the billing practitioner or are not separately payable under Medicare cannot be used as the visit for RPM initiation. If RPM is not discussed with the patient at that visit, that visit cannot count as the initiating visit for RPM. The RPM initiating visit itself can be separately billed.

The ACC agrees that RPM enhances patient care when it is layered on top of an existing care relationship. Cardiology patients most commonly benefit from RPM as an additional tool to manage hypertension or heart failure. Two refinements of this policy could improve both patient care and fraud/abuse concerns. The first would be to **allow a prior encounter during the preceding 12 months to meet the face-to-face visit, similar to chronic care management services**. This would ensure a clinician-patient relationship exists without creating the burden of an otherwise unnecessary visit. The second refinement would be to **require RPM management services be provided by the clinician/practice who ordered and initiated it**. This would address concerns raised in the OIG report about misalignment of initiation with patient management without compromising the high-quality care already provided by many.

Second, CMS proposes to restrict third-party monitoring companies from providing RPM services to prevent companies from "cold calling" beneficiaries and allowing an environment of fragmented care with little physician oversight. The ACC appreciates the desire to rein in this type of activity yet **strongly urges CMS not to finalize the exclusion of third-party vendors.** RPM vendors provide a large proportion of technical monitoring services to patients. Capacity does not exist for practices and clinics to take on this burden exclusively utilizing in-house clinical staff and supplies/equipment starting January 1, 2027. Such a change would massively disrupt patient care. This type of change would also be less meaningful should a requirement like the one suggested above to link initiation of RPM with performance of RPM take effect.

Third, citing a lack of data regarding the typical device used in the provision of RPM services that may have led to possible overpayment, CMS proposes to decrease the PE RVUs for RPM services using crosswalks to other services or by eliminating PE RVUs entirely. If finalized, these changes would result in significant payment reductions in 2027. The ACC recommends it would be preferable to collect the needed data rather than to reduce payments for the services without any data to serve as a foundation for revised RVUs. **The ACC recommends CMS not finalize these RVU changes and instead work to better understand the actual inputs through coordination with stakeholders and the AMA RUC.**

Fourth and finally, CMS explains it is considering creation of simplified, bundled G codes to replace the larger family of RPM codes. In the proposal, this would address administrative complexity and OIG findings that some beneficiaries do not receive all required service components.

- GRPM1:RPM initial set-up and patient education
- GRPM2: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), per calendar month, including:

  ++ Device(s) supply with daily recording(s) or programmed alert(s) transmission.
  ++ 2 or more days of data transmission.

++ Treatment management services, requiring at least one real-time interactive communication with the patient/caregiver; time totaling at least 20 minutes.

The ACC believes this coding paradigm for RPM/RTM oversimplifies the services in a way that would make it difficult for practices to provide and bill for them, and urges CMS not to deploy new, bundled RPM G-codes at this time. For instance, such a proposal assumes no third-party vendor role in providing these services, a proposal ACC has already recommended CMS not finalize. Additionally, CMS proposes to value these services via crosswalk at rates similar to the reductions proposed to the current RPM services. As with those revaluation proposals, the ACC urges CMS to not make arbitrary payment reductions for 2027, but to work with stakeholders to understand the costs of providing these services. For instance, during its last revaluation in January 2025 the AMA RUC included a recommendation that the cost of a digital remote physiologic monitoring device app be included in monthly supply codes 99445 and 99454. If services have evolved further, the way to address those changes is more information, not aggressive payment reductions or code bundling.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

The ACC appreciates the recognition of resources required to provide ongoing care for patients with a serious or complex condition in the initial creation of the G2211 code. The College understands the effort to make the increased reimbursement somewhat proportional to the level of work performed as defined by the level of E/M service billed, as well as using a further enhanced version of the code as a tool to incentivize Accountable Care Organization (ACO) participation.

However, we are concerned with the proposal to eliminate the HCPCS code and replace it with two modifiers to enhance the E/M reimbursement by 16% for non-ACO participants and 32% for ACO participants. A large majority of cardiologists are paid according to the RVUs they produce throughout the year. Many other physicians work under similar arrangements throughout the country as well. It is our understanding that when payment is enhanced via a modifier, the amount of money remitted to the billing institution is increased, but no additional RVUs are credited. In this scenario, if the proposal is finalized the practice or employer hospital or health system will see increased revenue from the percentage modifier boost while the performing physician will in many cases not receive any additional reimbursement. In fact, since under the current system affected doctors have seen increased reimbursement, under this proposal they would likely see a decrease in compensation.

In order to not reduce compensation for a large portion of physicians beyond the conversion factor and other cuts to reimbursement, the ACC urges CMS not to finalize this proposal to eliminate the G2211 complexity add-on HCPCS code, replacing it with modifiers.

The ACC encourages CMS to consider alternative means to achieve its goals regarding G2211 without the reduction in RVUs credited to physicians utilizing the code. ACC offers **the following potential approaches**:

- Creating a modifier to enhance payment of G2211 for ACO participants. While the enhancement beyond the G2211 payment would not be credited to the physician, the initial RVUs would and non-ACO participating docs would carry on as they do now.

- Creating a G code for higher- and lower-level E/Ms as add-ons. G2211 could apply to level 1-3 E/Ms with a specified RVU and a newly created, higher RVU, G code could apply to level 4 and 5 E/Ms.
- Create a G code for each level E/M for both ACO participating and non-ACO participating physicians. While this would create a large number of new codes it would address the proportionality of reimbursement and incentivization of ACO participation sought by the agency while still ensuring the physicians are compensated for the additional work.

Shared Medical Appointment (HCPCS code GSMAS)

CMS proposes to create a new HCPCS code GSMAS for shared medical appointments (SMA). The purpose of these appointments would be to improve beneficiaries' management of chronic conditions in a setting that would also create "opportunities for patients to learn from and share self-management strategies with one another, improving access to care, incorporating nonpharmacologic treatment approaches, enhancing the overall quality of care and helping reduce emergency department visits." The SMAs would be led by a physician or qualified nonphysician practitioner, provide care for 2-10 patients and be billed once per patient, per session.

The ACC appreciates CMS creating new and innovative ways to broaden access to patient care and education on managing chronic diseases. **The College supports the intent and definition of the GSMAS code that could be valuable for hypertension, hypercholesterolemia, heart failure, and other cardiovascular patients. The College also supports the proposed valuation of GSMAS as a combination of the work RVUs and practice expense inputs of a Level 3 established patient E/M code 99213 with a work RVU of 1.30 and multiple family group behavior management/modification code 96202 with a work RVU of 0.43 for a total work RVU of 1.73. The College appreciates and supports the proposal that GSMAS be added to the Medicare Telehealth list to make this service more widely available to beneficiaries.**

CMS rightfully notes that to participate in a SMA a beneficiary must consent to confidentiality terms as personal health information would be discussed in a group setting. To ensure appropriate compliance and expeditious adoption and usage of this new service, the College suggests that CMS establish clear directions for what should be included in this consent form or, better yet, create and disseminate a template of the form.

One concern the ACC has with the SMA proposal is the fact that a separately identifiable E/M code for a beneficiary could not be billed on the same day as the GSMAS code. While we understand the desire not to double count time and effort, we note two instances where billing an E/M and the GSMAS on the same date would seem appropriate. First, as the point of the GSMAS code is to deliver chronic condition management care to patients beyond what needs to be handled in a formal E/M office visit setting it would stand to reason that the most convenient time for a patient to attend such a visit would be on a date when they are already visiting the doctor's office. The proposed regulation gives the specific example of titrating Type 2 diabetes medication as something that would not be appropriate for a GSMAS visit, while

education on improving nutrient composition for a patient with Type 2 diabetes would fit the codes' purpose. If a patient were already at the doctor's office to titrate their medications it would be most convenient, and lead to the greatest usage of this new code, to allow the patient to attend the SMA on the same date without reduction to the incentive to the practice for performing the SMA. The other instance in which we envision legitimate billing of an office E/M on the same date as an SMA would be if an acute condition for a patient becomes evident during an SMA which requires an immediate and separately identifiable E/M service by the same practitioner. An instance of acute need should not be delayed to another day, and we do not believe the patient's participation in an SMA should reduce the reimbursement to the practitioner for a legitimate separately identifiable office visit.

Finally, it is unclear what assumptions were made to estimate utilization of GSMAS in 2027. However, addenda tables show that CMS estimates 410,100 unadjusted allowed services would be provided in 2027. Without understanding how this utilization estimate was developed, the ACC cautions that this number is likely too high and will result in resources being removed from the fee schedule. The volume estimate of GSMAS is roughly one third the 2025 utilization of Level 1 existing patient visit code 99211. This may or may not be a coincidence, but it seems unlikely that uptake will occur at such a high initial rate. The importance of these assumptions was demonstrated again recently when CMS estimated G2211 to be used nearly 84 million times in 2024 when ultimately the number was around 25 million. Over $1 billion was set aside for G2211 services in the fee schedule that never materialized. To avoid a parallel outcome here, the ACC urges CMS to reduce its volume estimates and do so in a transparent manner.

PE RVUs for artificial intelligence enabled coronary plaque analysis (AI-CPA), CPT code 75577

The ACC urges CMS to maintain the current non-facility PE RVUs of 29.40 for AI-CPA and to finalize the proposed work and malpractice RVUs, which are largely consistent with CY 2026 values.
Although the Proposed Rule does not discuss this service, Addendum B proposes reducing the non-facility PE RVUs for CPT code 75577 from 29.40 in CY 2026 to 27.94 in CY 2027. This reduction appears to result from a change to CPT code 77373, which CMS used as the crosswalk when establishing the non-facility PE RVUs for CPT code 75577 effective January 1, 2026. The IPCI associated with CPT code 77373 and radiation oncologists is proposed to decrease from 1.323 to 1.107, reducing the PE RVUs. The ACC urges CMS not to apply this reduction to CPT code 75577.

Doing so would be inappropriate because radiation oncologists neither furnish AI-CPA services nor report CPT code 75577. AI-CPA is performed and interpreted by cardiologists and radiologists, whose practice costs are unaffected by the proposed IPCI change. A crosswalk is intended to approximate the relative resources of a service when it is first valued. It is not a permanent linkage that should automatically transmit every subsequent adjustment made to the crosswalk code, particularly when those adjustments have no relevance to the service being valued. Because the proposed IPCI reduction does not change the resources required to furnish AI-CPA, it should not affect the non-facility PE RVUs assigned to CPT code 75577.

This proposal also highlights a broader concern regarding transparency. When CMS proposes to revise a code's RVUs because of a change affecting the code used as its crosswalk, the agency should explain both the proposed adjustment and its rationale in the rule's preamble. CMS provides stakeholders with its

reasoning when it initially establishes a crosswalk so interested parties can evaluate and comment on the methodology. The same level of transparency should apply when CMS later proposes changes that alter the values produced by that crosswalk. In this instance, stakeholders identified the change and infer its cause by assembling information from the addenda and supporting files. That approach does not provide a meaningful opportunity for stakeholder review and comment.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

We appreciate CMS's continued efforts to address potential duplicative payment when a separately identifiable E/M service is furnished on the same day as a procedure. However, we do not believe the proposed 50-percent reduction appropriately reflects the actual overlap in physician work and practice expense between these services.

By definition, an E/M service reported with modifier -25 is a significant, separately identifiable service that is above and beyond the usual preoperative and post-operative work associated with the procedure. The purpose of modifier -25 is to distinguish medically necessary evaluation and management work that is not already included in the procedure valuation. Therefore, the existence of modifier -25 inherently indicates that the E/M service contains substantial work that is distinct from the procedural service.

CMS states that efficiencies exist when an E/M visit and procedure are furnished on the same day and proposes to reduce payment for the lower-valued service by 50 percent. However, the proposal does not provide evidence demonstrating that one-half of the physician work, clinical staff time, or practice expense associated with a separately identifiable E/M service is duplicative of the procedure. While some overlap may occur, such as patient check-in, rooming, or limited elements of history and examination, it is difficult to conclude that these efficiencies account for 50 percent of the resources associated with a distinct E/M visit.

In many specialties, the E/M service reported with modifier -25 involves evaluation of a new problem, assessment of treatment options, review of medical history, risk assessment, informed decision-making, and documentation that extends well beyond the work inherent in the procedure itself. The overlap between these activities and the procedure's global package is often relatively limited. As a result, a 50 percent reduction may substantially underpay services that CMS otherwise recognizes as separately identifiable and medically necessary.

CMS specifically requests comment on whether an alternative reduction, such as 25 percent, would be more appropriate. If CMS determines that a payment adjustment is warranted, a smaller reduction would more reasonably reflect the limited efficiencies gained when services are furnished during the same encounter. However, 25% would also be an essentially arbitrary selection.

We recommend that CMS either: (1) maintain current payment policy; or (2) perform an analysis of these procedural combinations to quantify the actual magnitude of duplication to discern a specific and valid level of reduction in these circumstances.

Current Procedural Terminology (CPT) Request for Information

In the proposed rule, CMS issued a request for information regarding the CPT code set and the RUC process by which the AMA and participating national medical societies develop and recommend relative value units for CPT codes to CMS for consideration. The RFI contained five specific questions we will offer comment on below.

1. What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.

A monopoly by a private business over an industry that has great effect on the public is usually detrimental to the public. For instance, if there were a monopoly on public transportation by a private business that business could, and likely would, raise prices with impunity which would have a demonstrably negative impact on the public. In this instance, the subject of the "monopoly" is a non-profit 501(c)6 organization maintaining a uniform standard of coding which provides numerous public goods at significant expense to itself. The AMA's status as a non-profit 501(c)6 entity precludes it from generating profit distributed to private individuals or shareholders and mandates its profits must be reinvested solely to advance the organization's tax-exempt purpose.

Per the AMA's publicly available annual report, it earns approximately $300M per year from various income related to ownership of the CPT code set. The compensation of the 9 highest paid CEOs of healthcare and pharmaceutical companies in 2025 was $318M.[1] In 2025, Medicare expenditures were approximately $1.118T per the CMS National Health Expenditure fact sheet.[2] At that amount, $300M represents less than 0.026% of the annual Medicare expenditure. From this perspective, the implication that the revenue collected by the AMA for performing the task of creation and maintenance of the CPT code set incentivizes care diversion, stalls innovation or any other negative consequence in the healthcare field appears misplaced.

While $300M is a large sum of money, it is not an amount that could be considered significant in relation to the entirety of public and/or private healthcare spending in this country. Further, the CPT code set serves a public good. The AMA did not seize this so-called monopoly; it was tasked with maintaining a uniform code set that federal statute required. Having a uniform, nationally standardized code set for medical procedures allows every payer, clinician, vendor, government agency to all communicate in a common vernacular. This allows for much more efficient billing and payments, research, and **the** review and detection of fraud, waste and abuse.

2. What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical

[1] 23 highest-paid healthcare CEOs: Wall Street Journal
[2] NHE Fact Sheet | CMS

necessity in the CPT-4 code development process?

The CPT code set is a uniform language of medical procedures for all parties to use for consistency. The codes are not intended to influence whether any provider performs a particular service on a particular patient nor whether a public or private payer reimburses such a service as medically necessary or not. The purpose of the code set is to provide a uniform understanding of procedural definitions to allow more efficient communication regarding medical necessity between patients, payers, practitioners, etc.

3. A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002 (a) (5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services?

The College does not believe that any alternative currently exists that could serve all the functions of CPT-4 to practically allow for continuation of our nation's healthcare system as presently constructed. Further, even if there were such a code set, or a set that could be augmented to serve this function, or if technology could quickly create a wholly new code set; this would still have massive negative ramifications to patients, providers, payers and the economy. Such an undertaking would likely take years and cost billions of dollars. Beyond the cost of time and money, there would be a sacrifice of six decades of vital research on medical procedures and their efficacy that would be rendered moot. This would no doubt set back innovation and evolution of care to an incalculable degree.

4. What objective alternatives exist or could be developed to maintain a more objective process to the current AMA CPT and RUC committee process?

The CPT portion of this question was addressed in question 3. Regarding the RUC, we do not believe any viable, let alone better, alternatives currently exist. In the preamble to this RFI, CMS notes that MedPAC has stated that CMS has, "over-relied on specialty societies with a financial stake in the process," and recommended that CMS establish a "separate group of experts to make payment recommendations." This presents a catch-22. To access **the expertise** on the current resources **necessary** to perform a specific medical procedure would **logically restrict the pool of such experts to those** actively performing the services in question. However, anyone who is actively performing the services that are to be valued would have a financial stake as they would be reimbursed for their work. Likewise, it would be difficult to accept someone as an expert on a service if they are neither trained in nor performing the service. The system, as it is set up now, seeks out any conflicts of interest such as a physician performing a service having a financial relationship with a manufacturer of an involved device or any similar conflicts. The initial arguments are presented by practitioners who perform the services, but are then reviewed by a committee of a wide variety of experts in the medical field in general. All of the committee members have medical knowledge, but they are not all directly financially incentivized by each code being brought up for valuation. For instance, the RUC has a permanent seat for dermatology. The dermatologist representing their specialty on the RUC will vote on all code valuations including a neurosurgical procedure. The dermatologist has no financial stake in the reimbursement of a neurosurgical procedure.

5. What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MSDRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

While bundling does exist within CPT and the physician payment system, bundling at the same level as hospital payment is impractical. Beyond episode-based bundles, other grouping and payment architectures exist along a spectrum of increasing aggregation: per-visit or per-diem payment; blended fee-for-service and population-based payment; and fully capitated or global-budget arrangements, as reflected in Medicare Advantage and total cost of care accountable care organization models. Each aggregates spending at a progressively higher level, but none eliminates the need for granular procedural coding beneath it. Capitated and population-based models continue to rely on encounter-level CPT/HCPCS and ICD-10 data to attribute patients, construct benchmarks and target prices, risk-adjust payment, measure quality, and reconcile performance.

In conclusion, the College acknowledges that there could and should be reforms to the CPT and RUC system as they both evolve along with medical practice and current technologies. However, the College also firmly believes that no viable, practical alternative exists nor could one be furnished at any reasonable cost in any reasonable timeframe. Following similar inquiries in recent rulemaking, the AMA has already made significant adjustments in response to CMS comments. The RUC publicly publishing its recommendations to CMS as soon as they are delivered rather than after the next proposed rule is released was a tremendously impactful move towards greater transparency. We believe more reforms are possible that will benefit all stakeholders. As such, we encourage CMS to cease searching for replacements for CPT and the RUC and instead channel those efforts into expanding dialogue, research and stakeholder engagement to improve the existing system.

Ambulatory Specialty Model

The ACC remains committed to the transition to value-based care models to accelerate the delivery of effective and efficient cardiovascular care and achieve optimal patient outcomes. Our ASM comments will be divided into two sections: ACC member feedback and perspective covering the model's overall framework and requirements, followed by comments on the proposals and modifications from the CY2027 MPFS proposed rule.

Feedback from Preliminary ASM Participants

Since the initial ASM proposal was included in the proposed rule, the College actively contacted practices in selected geographic areas and preliminary participants to promote awareness of the model and help ensure participants were prepared for implementation. Additionally, the College has engaged with the Center for Medicare and Medicaid Innovation (CMMI) project team to better understand the model's goals, structure, and requirements as well as offer recommendations and constructive feedback to improve

the model. Simultaneously, the ACC began developing educational ASM resources and tools to help cardiovascular professionals and their practices prepare for participation.

The ASM outreach offered the opportunity to gain insights from the ACC members, potential ASM participants and cardiovascular practice administrators to understand their awareness of the model's requirements, implementation and participation readiness, and encountered challenges. Responses came from demographically diverse cardiologists including solo and small practices to large multispecialty health systems. Based on our member interviews, the major concerns center around the following areas:

- Alignment with practice guidelines
- Team-based care vs. Individual accountability
- Participation selection
- Data sharing and transparency
- Quality Data and Submission
- Payment Structure

The ACC and our members appreciate CMS's goal of incorporating more specialty-focused innovation models aimed at improving the quality of patient care and outcomes and reducing avoidable costs of care. The treatment of heart failure (HF) is one of the highest cost medical conditions for Medicare and has well-established care gaps and opportunities for optimization and cost savings. Both Medicare, with the Hospital Readmission Reduction Program, and the ACC's practice guideline for the management of HF as well as the Hospital to Home Initiative, have a history of spotlighting the importance of proactively addressing these gaps. These programs and projects have identified key areas of gaps and needed improvement including post-hospital discharge follow-up, symptoms management, and medication adherence.

Addressing these gaps in care will require detailed planning to achieve enhanced communication with patients, clinician care coordination, utilization of technology tools and patient buy-in. In our view, ASM for HF may lead to an oversimplification of the complexity of the disease and numerous challenges to overcome these gaps in care. **As a result, the College has significant concerns about finalizing ASM for Heart Failure as proposed with the initial performance year scheduled to launch in January 2027. We urge delay of the program until changes in these areas can be made, and further urge the agency to provide an educational and testing period of at least 12-months when any program does commence to allow for these improvements to be piloted.**

Aligning with Practice Guidelines

Feedback from practicing cardiologists, HF experts and their practice staff have confirmed our concerns with the current ASM framework, design, and bonus and penalty structure. ASM focuses on individual physician attribution rather than on a collaborative practice/team structure and model. The model lacks alignment with the recommendations in the 2022 ACC/American Heart Association/Heart Failure Society of America Guideline for the Management of Heart Failure and does not include the data sharing necessary to improve care for the applicable HF patients and track their related costs. Additionally, the

model misses the mark on the care complexities related to these HF patients and the clinicians involved in their care.

ACC vigorously supports improving patient outcomes and reducing unnecessary costs but also believes the primary objective for the model should be to promote the delivery of guideline-directed heart failure care. Evidence-based therapies and care coordination have been shown to improve outcomes, yet the model focuses heavily on penalties rather than incentives for adoption of proven practices. CMS should ensure that the program rewards adherence to established clinical guidelines and quality improvement efforts. Patients should be discharged on guideline-directed medical therapy (GDMT), and incentives should target performance in this area.

The ACC believes any HF value-based care initiative must incorporate the most recent practice guideline to enable clinicians, patients, payers, and other integrated stakeholders to align on shared goals and patient outcomes. Because total cost of HF care accounts for 50% of the current ASM overall score, CMS should establish a clear baseline for care delivery and medication access. The current cost measure may discourage guideline-directed medical and device therapy, while failing to recognize that quality outcomes, including longevity, often accrue over several years rather than within a single performance year.

Team-Based Care vs Individual Accountability

Heart failure care is delivered by multidisciplinary teams, yet ASM attributes performance and financial risk to individual clinicians. In ACC's comments on the CY 2026 MPFS Proposed Rule, we noted that the cardiovascular community has spent more than two decades advancing a team-based approach to cardiovascular care, particularly for patients with heart failure. These patients frequently have multiple co-morbidities, including atrial fibrillation, diabetes, chronic kidney disease, and obesity, making their care extraordinarily complex.

Additionally, the cost drivers for managing patients with heart failure are multifaceted and include hospitalizations and readmissions, post-acute care utilization, growing prevalence of HF and associated comorbidities, advanced therapies and devices, medication costs and fragmented care, and inadequate disease management. Simply selecting individual physicians to be held financially responsible for these complexities is dismissing the core dilemma. Managing these key cost drivers will require significant collaboration and shared outcomes amongst patients, medical clinicians, hospitals, health systems, payers, and medical technologists**.**

Effective management of each heart failure patient requires collaboration, with each medical professional fulfilling their role to improve that patient's outcomes. We have heard feedback from cardiovascular clinicians practicing in rural and underserved areas, as well as those facing specialist shortages, that fewer resources are available to support care coordination and model requirements than larger health systems or academic centers. By attributing a patient's care to a single cardiologist, the ASM does not reflect the current standard of care. **The College strongly urges CMS to restructure the ASM to reflect team-based care for HF patients through practice- and/or group-level attributions rather than attribution to an individual clinician.**

Participation Selection

Following the release of the preliminary ASM participant list on the CMS data website in February, the ACC received substantial feedback from members who asserted they had been incorrectly included in the model due to discrepancies between their primary specialty designation and the specialty used for participant identification. Based on this feedback, ACC researched and compared the preliminary list with publicly available physician specialty data from the NPI registry and PECOS enrollment. We found that roughly 540 of 2610 physicians (approximately 20%) had a primary PECOS specialty designation other than cardiovascular disease/cardiology and therefore should have been excluded from the program.

From our ongoing meetings and discussions with the CMMI ASM project team and clarifications within the CY 2027 MPFS Proposed Rule, we believe this issue has been found and addressed by prioritizing Medicare PECOS specialty data rather than the previously used MIPS dataset. In our research, the PECOS has been found to contain more accurate and updated specialty data compared to the MIPS reported information. We appreciate the agency's diligence and commitment to resolving this issue as well as its proposal to establish a process for excluding physicians who recently updated their specialty designation.

Based on this estimated removal of ~540 physicians from the preliminary ASM for HF participant list, the College questions if the remaining 2100 clinicians would generate sufficiently robust data for the first performance year of 2027, given the substantial bonuses and penalties proposed.

Since the selection data for Performance Year 2027 is based on claims data from 2025 and non-preliminary list clinicians will not be added in 2027, we anticipate that the HF cohort would lose additional participants due to changes in employment and location, retirements, and death over those 2 years. The College is concerned about the feasibility of the first performance year. Therefore, **ACC requests that CMS reverify that the estimated 2100 participants would meet model specifications**.

Data Sharing and Transparency

Given that the ASM cost measure accounts for 50% of the overall performance score, ACC members have expressed significant concern about being held financially accountable for costs that are often outside their direct control. These concerns are compounded by the lack of timely, detailed, and actionable data needed to understand, monitor, and effectively manage the underlying cost drivers that will ultimately determine their performance under the model. The College asks CMS to develop and share patient cost data and trends that are sufficiently granular and frequent enough for providers to adjust to the claims data. Without CMS sharing this vital information in a consistent manner, participants will have little opportunity to compare individual patient activity and historical trends, identify care gaps and opportunities for improvement, and effectively manage total cost of care.

CMMI has established their ability to provide regular data feedback as frequently as monthly for models including TEAM (Transforming Episode Accountability Model) and IOTA (Increasing Organ Transplant Access) Model. Similarly, the College encourages CMMI to develop a monthly ASM data dashboard version of the CMS 2011-2015 Supplemental Quality and Resource Use Reports (QRURs), which were provided to medical group practices with payment-standardized, risk-adjusted cost information on the

management of their Medicare fee-for-service (FFS) patients based on episode of care. In addition, clinicians would benefit from a real-time overview of their patients' medical claims including clinician and hospital visits, medications, diagnostic tests, procedures, and therapies. This data dashboard would allow clinicians to actively monitor their patients' utilization of medical care related to HF.

Specifically, ASM for HF participants will need monthly data dashboards with the following data:

- Supplemental QRUR-style episode data and comparisons when applicable
- Total HF cost of care (PMPY or episode-based)
- Cost trend (12-24 months)
- Number of attributed HF patients
- Cost per patient
- Readmission rate
- ED utilization rate
- Inpatient admission rate
- Mortality
- Cost Breakdown by Care Setting
    - Inpatient Medical/Surgical
    - Emergency Department
    - Outpatient Facility (including ASC)
    - Professional Services
    - Home Health
    - Skilled Nursing Facility (SNF)
    - Inpatient Rehab (IRF)
    - Long-Term Acute Care (LTACH)
    - DME & Remote Monitoring
    - Pharmacy
- Patient Risk Stratification
    - Segment patients
        - Low-risk
        - Medium-risk
        - High-risk
    - Potential factors:
        - HCC risk score
        - Prior admission history
        - CKD
        - Diabetes
        - CAD
        - COPD

        - Age bands
- Pharmacy Analytics
    - GDMT utilization
        - ARNI
        - ACEi/ARB
        - Beta blockers
        - MRA
        - SGLT2 inhibitors
    - Medication adherence
    - Pharmacy spend
    - High-cost medication users
    - Medication gaps after discharge
- Post-Discharge Performance
    - 7-day follow-up
    - 14-day follow-up
    - 30-day readmission
    - ED revisit
    - GDMT optimization after discharge
    - Home health referral completion
- Aggregate cost comparisons by care setting and medications.

The College believes that access to comprehensive data from multiple sources, including medical practices, hospitals, and payers is essential for success in a value-based care model such as ASM. Once this level of data transparency and reporting begins, ASM participants should be provided at least a 12-month grace period to educate themselves on their data and the accompanying comparisons. Without these data, the opportunity for real-time improvement of patient care will be hindered, and participating physicians will be placed at a significant disadvantage.

Tangentially, such a HF data dashboard would be greatly beneficial to clinicians and patients outside of ASM and across medicine including hospitals, primary care, and other HF clinicians. While the supplied information would not reveal the causation of care gaps and avoidable readmission, it would provide several launching points for researching and experimenting to identify improvement opportunities. The College would be interested in partnering with CMS, CMMI, and key stakeholders to develop a dashboard for the various clinicians caring for HF patients.

Quality Data and Submission

Physicians included on the ASM preliminary list and their practice administrators reached out to the College to share their apprehension with meeting the ASM Quality Performance Category reporting requirements within the current electronic health record (EHR) infrastructure handling their MIPS or

other Quality Payment Program (QPP) process. Although the selected HF quality measures are relatively familiar to those for clinicians through the MIPS program, participants report significant challenges preparing for data collection and test reporting. Several members noted that navigating the administrative and EHR infrastructure within their practices and health systems to identify the appropriate personnel responsible for ASM implementation has proven difficult.

Because MIPS offers multiple mechanisms for submitting quality data to CMS, many ASM participants remain uncertain how their individual data will be collected and submitted within their practices' current structure. For example, most cardiovascular professionals submit MIPS data at the group level through their EHRs. In large health systems and multi-specialty practices, important questions remain around participants' access to individual performance data and whether EHR vendors will support the necessary submissions at the individual clinician level. The College is very concerned that both access to quality data and the internal practice mechanics of data submission will present significant barriers for individual clinicians required to participate in ASM.

ASM participants in the HF cohort will be scored on five selected quality measures. Of those, four must be collected and submitted by the model participants. After several interviews with preliminary participants and their practice administrators, we concluded that while those four quality measures are currently included in MIPS, there is uncertainty related to the ability of their EMRs to calculate these measures at the individual level regardless of practice size. The independent and health system practices agreed that more time is needed to assess and confirm their reporting capabilities. **The College requests that CMS survey ASM participants and their practices to determine the readiness level for the mandated requirements.**

Payment Structure

The College is greatly concerned with the ASM's upside, downside, or break-even payment structure, under which nearly half of participants will receive a financial penalty up to -9% for all Medicare Part B services regardless of actual patient outcomes or total cost of HF care. The ASM participants' limited exposure to past quality performance and little to no Total Cost of Care data has caused significant uncertainty and limits the ability of participants to identify potential areas for improvement.

The proposed payment adjustments apply to all care provided by participants, without regard for the percentage of care provided to HF patients or the quality of care provided for other heart and cardiovascular diseases. Such a structure does not appropriately align incentives with CMMI and ACC's shared goal of improving patient outcomes.

Under the proposed design, clinicians may receive up to a 9% positive payment adjustment, incur up to a 9% negative payment adjustment, or remain payment-neutral based on their performance relative to the broader ASM HF cohort. A potential 9% penalty represents a significant financial cliff for individual clinicians, particularly for those practicing in solo and small groups, as demonstrated by annual MIPS Experience Report data. Even with the bonus points for small practices and proposed points for those in rural areas, such a severe penalty could jeopardize the stability and survival of those small practices. Additionally, the impact of penalties is augmented and that of bonuses is minimized by the removal of

savings from the system. **While the College appreciates CMMI's attempt to mitigate this risk by providing bonus points for small and rural participants, we strongly urge CMMI to restructure the model to eliminate or reduce these cliffs which could threaten the viability of some practices.**

In summary, the ACC strongly recommends the following modifications to ASM for HF before the program commences:

- Include at least one educational and testing year before financial accountability begins.
- Prioritize incentives to promote following and achieving recommendations found in the ACC/AHA Guideline for the management of heart failure.
- Reduce or phase in the financial bonus and penalty structure during the first two performance years.
- Limit bonuses and penalties to the HF care measured by the program.
- Provide participants with actionable, timely attribution and cost-of-care data to support health outcomes and successful participation.
- Incorporate practice- or group-level attribution that better reflects the team-based nature of heart failure care.
- Clarify quality reporting and data submission requirements, including the assurance that EHR vendors can support individual participant reporting.

Based on our member feedback and significant operational uncertainty surrounding compliance with the ASM requirements, the College strongly urges CMS to reconsider the current structure, including individual attribution framework, limited data transparency and the award and penalty methodology. The College further recommends that the first year of the model be designated as a no-risk educational and testing period to allow participants to better understand program requirements and performance expectations. Implementing these changes would necessitate postponing the current January 1, 2027 start date.

The following sections include ACC comments on the CY 2027 ASM Proposals.

ASM Participant Exceptions

CMS established that there may be limited circumstances in which an ASM participant selected for participation for an ASM performance year should be excepted from certain ASM requirements for that ASM performance year and should consequently be excepted from the application of an ASM payment multiplier to the ASM participant's Medicare Part B payments for covered professional services during the corresponding ASM payment year. In addition to the current exception due to a change in the reassignment of billing rights (change in TIN), CMS is proposing to develop several exception processes including ASM heart failure participants who meet certain specialty type redesignation requirements

The College supports creating these exception processes and strongly encourages CMS to develop a standardized online tool that allows participants and designated staff to submit exception requests along

with supporting documentation and forms if applicable, and to receive status updates and estimated review completion dates. We also recommend that this online tool generate a date and time stamped confirmation receipt emailed to the submitter.

Exceptions Due to TIN Changes

CMS proposes that an ASM participant who stops reassigning billing rights to the TIN used to select them as an ASM participant **before the applicable ASM performance year** must notify CMS in writing no later than 60 days after the start of the applicable ASM performance year; after receiving such notice, the agency may determine an exception to specified ASM requirements applies for the ASM performance year.

As mentioned previously, ACC strongly recommends that CMS create an online tool for these ASM exception requests and remove the "in writing" requirement due to potential mishandling of the documentation and an inability to receive status updates and confirmation receipts. The College supports the proposed "no later than 60 days" notification regulation for TIN changes prior to the start of the ASM performance year, provided the ASM participant list release date remains in early July. If the participant list is delayed and misses the July timeframe, we strongly encourage CMS to provide flexibility in the 60-day rule.

CMS also proposes that an ASM participant who stops reassigning billing rights to the TIN the agency used to establish participation in ASM **during an ASM performance year** would not be required to reassign billing rights to a new TIN during the same ASM performance year to be eligible for an exception from specified ASM requirements. Further, CMS proposes to clarify that an ASM participant changing TIN during the specified ASM performance year would be required to provide written notice of the change in TIN within 30 days of stopping reassignment of billing rights to the ASM participant's TIN. The College supports this 30-day notification rule during an ASM performance year with our recommended online submission tool. Any other submission process via USPS mail or email should allow notification within at least 60 days of stopping billing rights reassignment.

Exceptions Due to Heart Failure-Related Specialty Type Redesignations

To apply for an exception, CMS proposes that an ASM heart failure participant who redesignated their primary specialty type through an approved Medicare enrollment application (either PECOS or CMS-855 form paper application) would need to provide CMS written notification of the approved redesignation, along with verification of board certification in the newly designated primary specialty type, within 30 days of the effective date of the approved redesignation. **ACC supports this proposed application process to provide ASM exceptions for selected HF participants that change their primary specialty designation away from cardiovascular disease. In addition to the participant requests, the College urges CMS to proactively review the PECOS data to verify specialty designation changes for HF participants on a regular basis.**

Effect and Duration of Exceptions to Specific ASM Performance Requirements

CMS proposes to specify that an ASM participant with an approved exception for an ASM performance

year would (i) not be subject to performance assessment, data submission, and final scoring for the applicable ASM performance year, (ii) not be subject to payment adjustments for the corresponding ASM payment year, (iii) not be eligible for Medicare waivers under the model for the ASM performance year, and (iv) not be eligible for the CMS-sponsored model arrangements and patient incentives safe harbor for the period for which CMS determines the exception applies.

An exception related to a TIN change would be effective on the CMS-determined date and apply only for the applicable ASM performance year. **ACC understands that the TIN change exceptions are not intended to remove ASM participants from the test period; however, it is important for CMS to clarify the effect on exceptions resulting from moving away from an ASM geographic area, retirement and death. Additionally, the College is very concerned about the level of requirements and data submissions necessary after reassigning billing rights and moving to a new TIN.**

An exception related to specialty type redesignation would be effective on the CMS determined date and would apply for the applicable ASM performance year and for all remaining ASM performance years in test period, as the agency believes it is unlikely that the ASM participant would revert to their previous primary specialty type during the test period. **The College agrees with the agency's assessment that a cardiologist changing to a sub-CV specialty like interventional cardiology, electrophysiology, advanced heart failure and transplant, or adult congenital heart disease would rarely return to cardiovascular disease. These ASM participants should be removed from the entire ASM test period.**

ASM Participant Terminations

The Standard Provisions for Mandatory Innovation Center Models apply to ASM. These provisions include monitoring, compliance, and remedial actions that CMS may take. In this proposed rule, CMS proposes to include an additional remedial action specific to ASM whereby the agency could terminate a selected individual's participation in the model if CMS determines that one or more grounds for remedial action has occurred. Such grounds include failure to comply with model terms or applicable Medicare requirements, threatening the health or safety of a patient, submitting false data or making false representations in connection with the model, or undergoing a change in control that presents a program integrity risk. CMS also proposes to terminate participation if the agency determines continued participation would be inconsistent with the purpose of ASM or applicable law. Although the College has significant concerns with the current model structure, we support and share the overall aims to improve HF care and outcomes and reduce avoidable costs of care. It is essential for all participants to be committed to these goals and diligently work towards them.

Quality ASM Performance Category Data Submissions for ASM Participants in Small Practices

CMS proposes technical edits to its finalized policies on data submission for the quality ASM performance category intended to clarify that ASM participants in small practice have the option to submit ASM quality measure data at either the group (TIN) or individual (TIN/NPI) level. From the annual CMS QPP Experience Reports, small practices consistently have the lowest level of engagement and performance scoring in the MIPS program. These practices often lack the advanced technological infrastructure and

resources needed to provide data utilized by larger practices. The College believes that small practices should have the option to report their quality data at either the practice or individual level.

Improvement Activities (IA) ASM Performance Category Data Submission

The current IA group-level requirement for attestation that all ASM participants in a TIN completed the IAs, while reducing administrative burden, could result in unintentionally lowering the score for some participants in certain circumstances. Therefore, CMS proposes to allow an ASM participant to submit data for the IA ASM performance category at either the group or individual level. The College supports providing flexibility to allow ASM participants to report data for this and all categories at either the practice or individual level.

Multiple Submissions for Quality ASM Performance Category for Small Practices

CMS proposes that if the agency receives any quality ASM performance category data at the group level from an ASM participant in a small practice, the agency will score the group-level submission and assign that score to all individual ASM participants in the practice, and any individual-level submission received from ASM participants in that practice would not be scored. Due to the disadvantaged position that small practices experience in MIPS, the College believes CMS should take the higher score if multiple submissions are received.

Scoring and Benchmarks for Quality Measures

CMS proposes to score all administrative claims-based quality measures at the individual (TIN/NPI) level, regardless of eligibility to report quality measures at the group level. Since these measures do not require ASM participants to submit data, CMS believes this approach will not affect burden placed on small group practices while focusing accountability on the individual specialist. The College requests the agency share more information to create transparency into the differences in the individual and group level measure calculations, as well as the resulting score of the measure.

Quality ASM Performance Category Scoring Incentive for Voluntary Patient-reported Outcome (PRO) Data

CMS proposed a voluntary data submission and scoring incentive for ASM participants to report PRO data using PROMIS instruments and, as applicable, other CMS-specified PRO instruments. CMS will add five points to an ASM's participant's quality ASM performance category score for an applicable ASM performance year if the participant submits beneficiary level PRO data that meets CMS-established criteria. The additional points could not cause the quality score to exceed the maximum quality score otherwise available under the model. The College acknowledges that cardiologists and their patients are actively utilizing PROMIS-Plus-HF [Patient Reported Outcomes Measurement Information System Plus-Heart Failure] and appreciates the opportunity to voluntarily report data for added quality ASM performance category points.

Proposed Update to CEHRT Definition

CEHRT is defined for purposes of ASM as technology that meets the requirements set forth in MIPS regulations. CMS is proposing updates to the definition of CEHRT under MIPS. If finalized, those updates would be incorporated for purposes of ASM. The College supports the standardization of CEHRT across CMS programs.

Electronic Prior Authorization Measures in the Health Information Exchange (HIE) Objective

Like CEHRT, CMS is proposing to update their HIE Objective across CMS programs like MIPS which proposes to add the electronic prior authorization measures. While the College supports the standardization of measures which can reduce administrative burden and complexity, we express some reservations and questions related to these specific measures later in the MIPS section of this comment letter.

Final Score

The methodology for determining the final score differs from that used under MIPS. Unlike MIPS, CMS will calculate a final score based on the quality and cost performance categories scores and then consider negative scoring adjustments based on the IAs and PI performance categories scores. Additional points will be added to the final score for complex care (up to 10 points) and for participants that are part of small practices (10 points for ASM participants in small practices, 15 points for solo practitioner ASM participants).

There are data submission requirements for participants to receive a final score. Those who do not meet the requirements will receive a final score of zero (resulting in the maximum negative payment adjustment in the ASM payment year). Those who meet the data submission requirements to receive the final score but cannot be measured on quality or cost will not receive a final score (resulting in a neutral payment adjustment).

As mentioned previously, there is considerable uncertainty related to the ability of participants to collect and submit quality measure data information due to various reasons including current EHR functionality. The College recommends that CMS actively monitor the data submission process to identify the rate of submission success and failure, particularly for clinicians and practices consistently reporting for MIPS and MVPs. The need for monitoring and subsequent adjustment exemplifies the benefit of beginning the program with an education and testing period and the ACC strongly reiterates that suggestion. Additionally, we again ask CMS to survey participants on their process and possible hurdles they are experiencing.

Proposed Rural Scoring Adjustment

CMS proposes the addition of a rural scoring adjustment in the calculation of an ASM participant's final score beginning for the 2027 ASM performance year. Five points would be added to the final score of an ASM participant who (i) is in a rural area, and (ii) meets the requirements to receive a final score greater

than zero for an applicable ASM performance year. CMS would apply the same definition and determinations of a "rural area".

ASM participants in rural areas would still be eligible for the ASM small practice or solo practitioner scoring adjustment as well as the complex patient scoring adjustment if they meet the applicable eligibility criteria for those adjustments.

Currently the College lacks the necessary information and comparison data on this proposal and suggests that CMS investigate the anticipated scoring differences between rural and non-rural ASM participants before implementing this scoring adjustment.

ASM Performance Report

CMS will provide a notification (called an ASM performance report) to each ASM participant for each ASM performance year which would include the following: (i) measure-level scores for each measure required under each performance category, (ii) performance category-level scores, (iii) complex patient scoring adjustment, as applicable, (iv) small/solo practitioner scoring adjustment, as applicable, (v) final score, (vi) applicable ASM payment adjustment factor, and (vii) ASM payment multiplier for the applicable ASM payment year. These reports will not have any protected health information or personally identifiable information of beneficiaries.

To align with the proposals discussed above regarding the voluntary PRO data reporting incentive and rural scoring adjustment, CMS proposes to also include in these ASM performance reports information on whether the ASM participant receives (if finalized) the quality ASM performance category scoring incentive for voluntary reporting of PRO data as well as information on (if finalized) their rural scoring adjustment, if applicable.

While the proposed ASM Performance Report should suffice as the end of year report, it is vital for participants to have access to detailed attributed patient-level data for their auditing purposes.

MIPS Value Pathways (MVPs)

Transition to MVP Reporting and Retirement of Traditional MIPS

CMS proposes to continue its transition toward MVP-based reporting by adding three new MVPs, bringing the total to 30 and expanding coverage to approximately 98 percent of MIPS-eligible clinicians. CMS also proposes to sunset traditional MIPS reporting beginning with the CY 2029 performance period/2031 payment year, while maintaining traditional MIPS through CY 2028. ACC supports the goal of creating more clinically relevant and specialty-focused reporting pathways but believes MVPs must be sufficiently mature, accessible, and operationally feasible before eliminating traditional MIPS as a reporting option. The transition should be based on demonstrated readiness rather than a predetermined date.

Although cardiovascular participation in MVPs increased from 2023 to 2024 (38 to 285 participants, respectively), overall participation remains limited relative to the broader clinician population that will

eventually be required to transition. ACC's analysis of Performance Year (PY) 2024 data continues to show substantial differences in MIPS participation and performance by practice size. Small and solo practices were less likely to submit data and experienced substantially greater downside risk than larger practices. CMS should evaluate new reporting and scoring policies for their differential effects on smaller practices and avoid introducing requirements that increase reliance on technical infrastructure or administrative resources that may not be equally available across practice settings. On the other hand, large cardiology and multispecialty practices face requirements to organize and report through subgroups, which can increase IT, data management, and administrative burden for practices that otherwise operate as integrated groups. These and other implementation challenges warrant further evaluation before all eligible clinicians are required to transition to MVP reporting.

Clinicians must also have access to innovative and specialty-driven measures that meaningfully reflect the care they provide. Qualified Clinical Data Registry (QCDR) measures play an important role in addressing gaps that may not be captured by broadly applicable MIPS measures, particularly in specialties such as cardiology where care spans multiple settings, conditions, procedures, and levels of patient complexity. ACC encourages the development of a process for incorporating QCDR and other specialty-developed measures into MVPs and to ensure that quality, cost, and population health measures are appropriately aligned. Restricting measure choice without ensuring adequate specialty-specific alternatives could reduce the clinical relevance of MVP reporting and limit its value as a tool for quality improvement.

Advancing Care for Heart Disease (ACHD) MVP

Developing, testing, and implementing new measures is a resource-intensive process that requires sufficient evidence, data infrastructure, feasibility testing, and stakeholder input.
With that in mind, ACC appreciates CMS's continued efforts to improve the ACHD MVP and supports its modular structure, which allows clinicians to select clinical groupings that better reflect their practice. Building on these positive changes, we offer several recommendations to enhance measure applicability and participation opportunities within the MVP.

ACC supports the retirement of the (1) Coronary Artery Disease (CAD): Antiplatelet Therapy, (2) CAD: Beta-Blocker Therapy–Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction, and (3) Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy measures following the 2026 performance year. While these measures address important evidence-based therapies that remain foundational to cardiovascular care, their topped-out performance, evolving clinical guidelines, and loss of measure stewardship make them understandably no longer suitable as quality improvement goals. Clear pathways are needed for the development and implementation of updated cardiovascular quality measures that incorporate current guideline-based care, appropriate clinical exclusions and patient complexity, and secondary prevention and stroke-risk reduction.

Additional clinical areas worthy of consideration include:

- electrophysiology measures that assess therapeutic success, complication rates, ablation safety, symptom improvement, rhythm control, anticoagulation outcomes, and post-procedure care;
- general cardiology and coronary artery disease measures that capture secondary prevention and patient outcomes, and appropriate use of guideline-directed therapies;

- heart failure measures that reflect current guideline-directed medical therapy, longitudinal medication optimization, meaningful outcomes, and timely follow-up;
- advanced heart failure and transplant (e.g., LVAD/VAD management, advanced HF therapies, cardiac amyloidosis);
- interventional and structural cardiology measures related to TAVR, transcatheter mitral and tricuspid interventions, and PCI, such as length of stay, procedural complications, hemodynamic performance, follow-up rates, and repeat procedures;
- and Adult Congenital Heart Disease

ACC appreciates CMS's continued efforts to incorporate outcome, functional, and patient-reported measures, particularly where these data can be captured through existing EHR, clinical decision support, or registry infrastructure without additional manual reporting burden.

The relationship between quality and cost measurement also warrants continued enhancement. For example, clinicians in the heart failure grouping may appropriately provide guideline-directed medications, follow-up, testing, or other services to improve outcomes, but may end up disadvantaged when those activities generate extra costs captured by the cost measure. Thus, cost performance may reflect patient complexity, comorbidities, social risk, access to care, and services provided by other clinicians or facilities. Attribution methodologies ideally will identify services and costs reasonably within a clinician's control, as well as quality and cost measures that work together to encourage high-value care rather than create conflicting incentives.

Participation and Performance
Although the number of participants who received their final score from the ACHD MVP increased between 2023 and 2024, overall reporting rates continue to remain low. Approximately 75% of cardiovascular clinicians who utilized the MVP pathway selected the ACHD MVP. Participation was concentrated in general and interventional cardiology. CV clinicians also participated in the Value in Primary Care and Focusing on Women's Health MVPs. These trends demonstrate growing engagement with MVP reporting while also highlighting the need to ensure that the Heart Disease MVP offers clinically relevant pathways across the full range of cardiovascular subspecialties.

The mean final score among clinicians in the ACHD MVP was approximately 84 in 2024, and MVP participants achieved overall scores similar to those participating in traditional MIPS. However, many clinicians who reported through an MVP ultimately received their final score through traditional MIPS rather than the ACHD MVP. As CMS moves toward phasing out traditional MIPS, it should explore the reasons for this pattern and whether it reflects measure availability, scoring policies, reporting practices, or other barriers. Examining participation and performance by clinical grouping, subspecialty, practice size, and reporting method would help identify whether certain clinicians face barriers that should be addressed before the ACHD MVP becomes the primary reporting pathway.

Core Measures
ACC supports CMS's goal of identifying core measures that facilitate meaningful comparison but is concerned that the three proposed core measures may not be applicable across the diverse cardiovascular subspecialties expected to participate in the ACHD MVP. The measures are:

- Q441 Ischemic Vascular Disease All-or-None Outcome Measure,
- Q492 Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure, and
- the proposed LDL-C Monitoring and Management measure.

Some cardiovascular clinicians may have limited opportunity to influence these measures in a way that meaningfully reflects their practice. We appreciate CMS's attestation process, however, for allowing clinicians to attest that no core measures are applicable.

The LDL-C outcome measure for patients with clinical atherosclerotic cardiovascular disease (ASCVD) reflects an important evolution toward assessing meaningful patient outcomes rather than solely evaluating whether therapies were prescribed. Achievement of LDL-C targets is closely associated with reduced cardiovascular risk and aligns with guideline-directed secondary prevention. As CMS considers implementation, the agency should ensure the measure remains aligned with contemporary cholesterol management guidelines and appropriately accounts for patient complexity, treatment intolerance, medication-access barriers, shared decision-making, and circumstances in which multiple clinicians contribute to a patient's lipid management. Appropriate exclusions, exceptions, attribution methodologies, and operational feasibility considerations will be important to ensure the measure can be implemented fairly and consistently across practice settings. Inclusion of this measure better reflects a comprehensive cardiovascular prevention strategy and advances the transition from process-based measurement toward assessment of clinically meaningful cardiovascular risk-factor control.

Cost Measures
ACC continues to encourage CMS to evaluate whether cost measures included in the Heart Disease MVP appropriately reflect clinician accountability and align with the clinical groupings in which they are used. Total Per Capita Cost, Medicare Spending per Beneficiary, and episode-based cost measures may be influenced by patient complexity, comorbidities, social risk, local care delivery systems, and downstream utilization outside the clinician's control. As CMS expands MVP reporting, cost attribution should accurately reflect the care clinicians can reasonably influence and should not discourage appropriate evidence-based treatment or the care of medically complex patients. CMS should provide data on the number of clinicians attributed to multiple cost measures and examine whether overlapping attribution creates duplicative or conflicting accountability for the same patients, services, or episodes of care. Current cost measure data should be shared with MIPS participants in anticipation of MVP reporting.

Future Considerations
Because CMS intends MVPs to provide patients with useful information when selecting clinicians, additional information on MVP performance should be displayed in a manner that is understandable and clinically meaningful. Given the differences in clinical focus and measure availability across cardiovascular subspecialties, patients should be able to understand what an MVP score represents and its limitations when comparing clinicians.

Hypertension MVP

ACC appreciates CMS's continued efforts to develop a condition-focused MVP that emphasizes prevention, chronic disease management, and cardiovascular risk reduction. We continue to support the concept of a hypertension-focused pathway and recognize the significant burden hypertension places on patients, clinicians, and the healthcare system. However, many of the concerns raised during the MVP candidate feedback process remain relevant and warrant further consideration before implementation.

While blood pressure control is a critically important outcome, the Controlling High Blood Pressure (Q236) measure remains tied to a threshold of less than 140/90 mm Hg, which does not fully align with current ACC/AHA hypertension guidelines for many patient populations. In addition, the measure does not recognize meaningful clinical improvement, appropriate treatment intensification, or longitudinal progress toward blood pressure control. Management often requires repeated visits, medication titration, lifestyle modification, and patient engagement over time. We encourage CMS to explore measures that recognize sustained control or improvement trajectories, rather than relying exclusively on a single threshold-based outcome measure. A different approach will better reflect the longitudinal nature of hypertension management and the incremental progress that often occurs before guideline-recommended targets are achieved.

ACC appreciates CMS's proposal to include the Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management measure within the MVP. Effective hypertension management is closely linked to overall cardiovascular risk reduction, and lipid management remains one of the most effective interventions for preventing myocardial infarction, stroke, and other ASCVD events.

ACC notes that several measures included in the MVP may overlap conceptually or operationally. For example, the proposed Ischemic Vascular Disease (IVD) All-or-None Outcome Measure includes blood pressure control, smoking cessation, statin therapy, and other components that are also represented elsewhere in the MVP. CMS should evaluate whether this overlap creates duplicate accountability, increases reporting burden, or disproportionately influences performance scoring without providing additional clinical value.

As hypertension management increasingly relies on out-of-office blood pressure assessment, ACC encourages CMS to continue exploring opportunities to incorporate validated home blood pressure measurements and ambulatory blood pressure monitoring (ABPM) into future quality measurement efforts when appropriate infrastructure exists. Current practice increasingly depends on out-of-office blood pressure monitoring to support accurate diagnosis, treatment adjustment, and long-term management. Future MVP development should reflect this growing role while avoiding unnecessary reporting burden.

MVP Scoring Request for Information

ACC supports CMS's goal of ensuring fair comparisons across MVPs and recognizes that differences in measure sets, clinical focus, and patient populations may warrant consideration as CMS moves toward full MVP implementation. However, fairness across MVPs should not be defined by achieving similar score distributions if underlying differences in performance are clinically meaningful. Any new scoring

methodology must remain transparent and predictable so clinicians can understand how performance translates into scores and payment adjustments. CMS should provide clear educational materials, public benchmarks, and tools that allow clinicians to assess their performance during the performance year.

Normalization based on relative performance could reduce the connection between actual improvements in quality and cost performance and resulting score changes, particularly when improvements occur broadly across participants. Scoring should continue to recognize absolute achievement and improvement rather than rely primarily on relative rankings. If CMS determines normalization is necessary, ACC recommends applying it at the performance category level so that adjustments can be targeted to categories where differences across MVPs have been demonstrated.

Any normalization methodology must account for structural differences across MVPs, including participation levels, measure maturity, patient populations, clinical focus, and measure characteristics. Specialty-focused MVPs may have small participant pools that produce unstable distributions and year-to-year variation. In addition, topped-out measures may cause small differences in performance to have disproportionate effects under a relative scoring methodology. Clinicians should not face higher or lower payment adjustments simply because their clinically appropriate MVP has different scoring characteristics from those available to other specialties. CMS should publish minimum participant thresholds, assess the effect of topped-out measures, and specify how scoring would work when reliable comparisons cannot be made. Relative normalization could also encourage clinicians eligible for multiple MVPs to consider expected scoring distributions rather than selecting the MVP most relevant to their practice.

Given the potential impact on scores and payment adjustments, ACC recommends that CMS test any proposed normalization methodology before implementation. CMS could calculate normalized scores in parallel with the existing methodology during an informational scoring period without using the normalized results to determine payment adjustments. This would allow CMS and stakeholders to assess reliability, year-to-year variation, clinician understanding, effects on MVP selection and participation, and other unintended consequences before adopting the methodology for payment purposes.

Proposal to Designate MIPS/MVP Core Measures

ACC appreciates CMS's goal of improving comparability and transparency through a core measure framework. However, a mandatory core-measure requirement could limit the flexibility that has been a central feature of the MVP approach. Cardiovascular clinicians practice across a wide range of subspecialties, and a limited set of required measures may not adequately reflect the diversity of cardiovascular care. These concerns are particularly relevant in the ACHD MVP, where procedure-specific cost measures for interventions such as PCI and cardiac device implantation are paired with relatively few corresponding subspecialty-specific quality and outcome measures. This imbalance could result in clinicians being held accountable for highly specialized costs without corresponding measures that capture the quality and outcomes of the care associated with those services. Requiring clinicians to report a core measure that is only broadly related to cardiovascular care may not provide meaningful information about the quality of care they deliver.

If CMS finalizes this policy, core measures should be clinically meaningful, attributable to clinician action, and applicable to the clinicians expected to report them. ACC appreciates the proposed small practice exemption as well as the option for clinicians without an applicable core measure to attest to that circumstance and report a substitute measure. The process should be straightforward and low burden, and clinicians using this pathway should not be disadvantaged in scoring or payment.

Fast Healthcare Interoperability Resources (FHIR)®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs - Request for Information

ACC supports CMS's long-term vision for FHIR-based digital quality measurement but urges CMS to ensure that the necessary data infrastructure is in place before transitioning measures to mandatory FHIR-based reporting. A significant barrier to advancing digital quality measurement is not the measures themselves, but the data needed to support them. Healthcare data remain fragmented across EHRs, payer systems, laboratories, and other sources. Even when relevant data are available, differences in completeness, consistency, and structure can make reliable quality measurement and reporting difficult. These challenges are particularly relevant for cardiovascular measures that rely on laboratory results generated outside the reporting clinician's organization. For measures such as LDL-C Monitoring and Management and Ischemic Vascular Disease Optimal Control, clinicians may have limited visibility into whether external laboratory data are exchanged in a complete, timely, and standardized manner. CMS should assess the availability and reliability of structured laboratory and other data exchange across care settings before requiring FHIR-based reporting for measures that depend on these data.

As CMS advances this transition, ACC strongly encourages the agency to build on existing specialty registry infrastructure. QCDRs and specialty registries such as the National Cardiovascular Data Registry® capture clinically nuanced information that may not be consistently available through standard EHR workflows. These registries also support continuous quality improvement, benchmarking, and measure development. CMS should preserve viable pathways for specialty-led QCDR measures throughout the transition and ensure that clinically meaningful specialty-specific reporting options are not lost simply because equivalent measures or data capabilities are not yet available through FHIR-based reporting.

These considerations are especially important for specialty-specific procedural measures. Electrophysiology measures, including those assessing atrial fibrillation ablation complications and cardiac implantable electronic device infections, may rely on clinical and procedural data elements that have historically been captured more effectively through specialty registries than standard EHR workflows. Before establishing mandatory FHIR-based reporting requirements for these measures, CMS should demonstrate that the necessary data elements can be consistently captured, exchanged, and incorporated into measure calculations across relevant practice settings.

Given these challenges, ACC recommends a phased implementation strategy that includes testing opportunities, parallel reporting pathways, and ongoing evaluation of measure and infrastructure readiness before mandatory adoption. Developing, testing, and implementing FHIR-based measures requires significant time and coordination among clinicians, EHR vendors, registries, and other technology partners. Clinicians should not face payment consequences due to limitations in interoperability, external data exchange, health IT capabilities, or measure availability that are outside their control.

Removal of IA_PM_2 - Anticoagulant Management Improvements

ACC understands CMS's rationale for proposing removal of IA_PM_2 (Anticoagulant Management Improvements) as clinical practice and anticoagulation management strategies continue to evolve, particularly around the increased use of direct oral anticoagulants (DOACs). However, CMS should continue to monitor whether important aspects of anticoagulation safety, adherence, and stroke prevention remain appropriately represented within the Quality Payment Program.

MIPS Promoting Interoperability Performance Category: CEHRT and Program Simplification

ACC supports CMS's efforts to streamline MIPS Promoting Interoperability requirements by removing duplicative reporting obligations and aligning CEHRT requirements with ONC certification policies. Continued coordination between CMS and ONC can help reduce unnecessary administrative burden and promote consistent technology requirements for clinicians.

MIPS Promoting Interoperability Performance Category Modifications

Add an Electronic Prior Authorization for Prescription Drugs Measure

ACC supports efforts to reduce the administrative burden and delays in patient care associated with prescription drug prior authorization. Cardiovascular clinicians frequently encounter prior authorization requirements for medications, including lipid-lowering therapies and other specialty treatments, and a reliable electronic process has the potential to reduce administrative burden and improve timely access to appropriate therapy. However, electronic prior authorization does not address the underlying burden associated with prior authorization requirements, and clinicians should not face additional penalties through the Promoting Interoperability program for an administrative process that is substantially dependent on payer, pharmacy benefit manager, health IT vendor, and other external capabilities.

Accordingly, ACC does not support making the new measure an all-or-nothing Promoting Interoperability requirement upon implementation in CY 2028. CMS should initially make the measure optional or bonus-based while evaluating adoption, functionality, implementation costs, workflow integration, and clinician experience. Moreover, there should be appropriate exclusions to protect clinicians when necessary capabilities or payer participation are unavailable.

ACC recommends a phased implementation approach that allows sufficient time for adoption, testing, and evaluation before considering whether the measure should become mandatory. During this period, CMS should assess whether electronic prior authorization actually reduces administrative burden, shortens approval times, and improves patient access to prescribed medications rather than simply shifting existing administrative requirements into electronic workflows.

Existing Electronic Prior Authorization Measure for Medical Items and Services

ACC supports CMS's proposal to make the Electronic Prior Authorization measure for medical items and services optional and eligible for 10 bonus points for the CY 2027 performance period. This approach encourages adoption while recognizing that clinicians remain dependent on payer application programming interface (API) readiness, certified health IT availability, vendor implementation, and workflow functionality that are often outside the clinician's control. Flexibility for small, rural, and under-resourced practices is needed as electronic prior authorization capabilities continue to mature.

RFI on Future Performance-Based Prior Authorization Measures

As CMS advances complete electronic prior authorization workflows, future measure requirements should reflect how prior authorization functions in practice. Clinicians should be required to use only those certified capabilities necessary to complete a particular transaction rather than every possible component of the electronic workflow. For example, a clinician should not fail a measure when an authorization is resolved electronically without requiring additional documentation or a separate submission step. There are numerous costs associated with purchasing, licensing, integrating, testing, and maintaining prior authorization functionality. Requirements that force practices to purchase expensive products or maintain separate workflows solely for MIPS reporting should be avoided.

ACC recommends retaining attestation-based reporting until electronic prior authorization is broadly available across payers and performance can be captured automatically without requiring practices to manually track and reconcile individual transactions. If CMS later moves to a performance-based measure, it should include only prior authorization requests that can realistically be completed electronically. The payer must support the required electronic process, the clinician's certified health IT must be capable of completing the transaction, and necessary information must be exchangeable electronically. Clinicians should not be held accountable for failures resulting from payer, pharmacy benefit manager, vendor, or technical limitations beyond their control.

Future measurement should focus on whether electronic prior authorization reduces administrative burden and improves timely access to care, rather than simply whether an electronic transaction occurred. CMS should evaluate factors such as payer response times, requests for additional information, technical failures, denials, manual workarounds, and delays in patients receiving medications, services, or testing. ACC supports continued development of standardized electronic prior authorization but urges CMS to maintain a phased implementation approach with appropriate exclusions and demonstrated readiness before making these measures mandatory components of the PI performance category.

Quality Scoring

ACC supports CMS's proposal not to apply the 7-point topped-out measure scoring cap to required MIPS core measures. Clinicians should not be disadvantaged when reporting measures that CMS itself requires for program participation. Applying the defined topped-out benchmark methodology helps ensure fair scoring while preserving participation options for specialties facing limited measure choice.

Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

ACC appreciates CMS's efforts to improve the interpretability and usefulness of publicly reported quality information. We agree that a rating system in which most clinicians receive similar ratings may provide limited value to patients and clinicians. However, any transition to a standard deviation-based methodology should prioritize statistical reliability and validity, transparency, and patient comprehension. A revised methodology should identify meaningful differences in quality rather than simply produce greater separation among clinicians. This is particularly important in cardiovascular care, where years of quality improvement may result in high performance and relatively limited variation on some measures. Greater differentiation in Star Ratings should not make small statistical differences appear clinically meaningful when they are not.

Any revised methodology should also appropriately account for patient complexity, social risk factors, case volume, and other factors that may influence performance. Cardiologists frequently care for patients with advanced heart failure, multiple chronic conditions, frailty, and significant barriers to care. Ratings should distinguish differences in clinician performance from those attributable to underlying patient risk. For administrative claims-based measures in particular, CMS should ensure that attribution methodologies appropriately reflect the extent to which clinicians can reasonably influence the outcomes or utilization for which they are being assessed. CMS should evaluate the reliability of a standard deviation-based approach for smaller practices and clinicians with lower case volumes, particularly when modest changes in performance could result in substantial changes in Star Ratings.

Because Star Ratings are intended to support beneficiary decision-making, CMS should clearly communicate what the ratings represent and the significance of differences between categories. Caution is warranted when applying this methodology to cost measures, where performance may be influenced by factors outside an individual clinician's control. Public reporting of cost performance should not inadvertently discourage clinicians from treating medically complex patients or providing appropriate, evidence-based cardiovascular care. Before adopting Star Ratings for cost measures, CMS should also evaluate whether a star-based display can clearly communicate what cost performance represents and what factors are within an individual clinician's control.

Impact analyses showing how ratings would change under the proposed approach would be helpful, including results by specialty, practice size, geographic region, patient complexity, and case volume. Stakeholders should have an opportunity to assess whether the methodology produces more useful differentiation while maintaining reliability and avoiding unintended bias. Overall, Star Ratings should accurately reflect meaningful differences in quality, support informed patient decision-making, and fairly represent clinician performance.

Alternative Payment Model (APM) Qualifying Participant (QP) Status

ACC is concerned that applying QP and Partial QP determinations at the TIN/NPI level could increase complexity and reporting burden for clinicians who practice across multiple organizations. Under the proposal, a physician could be exempt from MIPS under one billing arrangement while remaining subject

to MIPS under another, creating confusion regarding reporting requirements and payment implications. This may disproportionately affect specialists, including cardiologists, who commonly furnish services across multiple care settings and billing organizations. In some cases, clinicians who currently qualify as QPs could be required to resume MIPS reporting for services billed through non-APM affiliated TINs, potentially reducing incentives to participate in Advanced APMs.

Prior to finalizing this policy, CMS should provide data on the number and types of clinicians expected to be affected, including analyses by specialty, practice arrangements, and TIN affiliations. ACC also encourages CMS to examine the impact on specialties with multiple TIN relationships and provide clear guidance regarding QP determinations, MIPS participation requirements, and payment adjustments across different billing arrangements.

ACC appreciates CMS's goal of better aligning incentives with participation in Advanced APMs. However, CMS should consider alternative approaches that address concerns about incentives extending to non-participating organizations while preserving a single clinician-level QP determination. This approach would recognize successful participation in an Advanced APM while avoiding additional complexity and reporting burden for clinicians practicing across multiple organizations.

Updates to the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Measure

ACC supports the proposed updates to the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure, which better align the measure with current clinical guidelines and focus measurement on patients most likely to benefit from statin therapy.

- Clinical ASCVD Population: ACC supports expanding the measure to include adults aged 18 years and older with established clinical ASCVD. This change aligns with secondary prevention guidelines and ensures younger patients with premature ASCVD are appropriately captured.
- Removal of Prediabetes from the Denominator: ACC supports removing patients with prediabetes from the denominator. Statin therapy decisions should be based on overall ASCVD risk and clinical judgment rather than prediabetes alone.
- Pregnancy Exclusion: ACC supports adding pregnancy as a denominator exclusion across all collection types to reflect appropriate clinical considerations regarding statin therapy during pregnancy.
- Additional Considerations: CMS should ensure the final specifications capture the full range of clinical ASCVD recognized in current guidelines, including coronary, cerebrovascular, and peripheral arterial disease, while preserving shared decision-making and clinical judgment.

Medicare Shared Savings Program (MSSP) Proposals

Refining Quality Reporting Requirements

CMS proposes to continue refining MSSP quality reporting by aligning quality measures across Medicare programs, maintaining and updating measures relevant to chronic disease management and prevention,

and emphasizing clinically meaningful outcomes. The proposal continues CMS's broader effort to harmonize quality requirements across MSSP, MVPs, and other quality reporting pathways while supporting accountability for population health outcomes. ACC supports CMS's efforts to simplify and align quality reporting requirements across Medicare quality programs. These modifications can lessen administrative burden and allow clinicians to focus on quality improvement rather than compliance activities. Measures should also appropriately account for patient complexity and clinical risk, especially since cardiologists frequently care for patients with multiple chronic conditions and advanced cardiovascular disease.

Proposal to Extend the Availability of the MIPS Clinical Quality Measures (CQMs) Collection Type and the MIPS CQM Reporting Incentive for Shared Savings Program ACOs

ACC supports CMS's decision to delay mandatory FHIR-based digital quality reporting and provide a phased transition period. Given ongoing variation in FHIR implementation across health systems, EHR vendors, and reporting entities, flexibility in reporting pathways should be maintained until reliable and consistent FHIR-based reporting can be demonstrated. ACC also urges caution before sunsetting the MIPS CQM collection type in PY 2030, as many clinicians and ACOs continue to rely on existing reporting infrastructure that may not yet be fully replicable through FHIR-based reporting.

As CMS advances digital quality measurement, FHIR-based reporting should build on existing specialty registry infrastructure rather than create duplicative reporting pathways. Specialty registries remain an important source of clinically detailed cardiovascular data for quality improvement and reporting. CMS should also ensure transparency into the data sources and methodologies used to calculate performance scores and provide technical assistance, testing opportunities, and clear implementation guidance. Successful adoption will depend on the readiness of clinicians, EHR vendors, data aggregators, and other technology partners that support data exchange and measure calculation.

Proposal to Extend the Scoring of Shared Savings Program ACOs Reporting Medicare CQMs Using Flat Benchmarks

ACC supports CMS's continued use of flat benchmarks for Medicare CQMs during the transition to digital quality measurement. Extending flat benchmarks may help prevent score changes that reflect evolving reporting methodologies rather than true changes in clinical performance. This is particularly important for measures such as Controlling High Blood Pressure (Quality ID 236), where reliable assessment depends on consistent capture of clinical data across care settings. As reporting infrastructure matures, CMS should periodically reassess the appropriateness of flat benchmarks and evaluate whether observed performance changes reflect improvements in care or differences in data capture and reporting methods.

Proposal for Shared Savings Program ACOs to Report Using the Medicare electronic Clinical Quality Measures (eCQMs)

Collection Type

ACC supports CMS's proposal to allow Shared Savings Program ACOs to report quality measures using the Medicare eCQM collection type. Providing multiple reporting pathways during this period of transition promotes flexibility and allows organizations to select the approach that best aligns with their technical capabilities and existing infrastructure. This flexibility is particularly important as ACOs prepare for broader adoption of digital quality measurement and reporting.

As CMS implements the Medicare eCQM collection type, ACC encourages the agency to ensure that the new reporting pathway is interoperable with specialty registries and other established quality reporting infrastructure. Specialty registries provide clinically meaningful data that support cardiovascular quality measurement and improvement. CMS should build on these existing investments where possible and avoid duplicative reporting requirements that could increase administrative burden without improving the quality or usefulness of reported data.

Request for Information: Specialty Care in the Shared Savings Program

ACC supports CMS's efforts to strengthen specialist engagement within the MSSP while maintaining the central role of primary care in beneficiary attribution and longitudinal care management. Specialty clinicians play an important role in influencing quality, outcomes, and resource use, particularly for patients with complex chronic conditions. In cardiovascular care, specialists often manage patients over extended periods and influence hospitalizations, testing, procedures, medication use, and other drivers of outcomes and spending.

Available evidence suggests cardiologist participation may contribute to lower spending, but participation alone is insufficient to improve quality performance. Prior research found that ACOs with cardiologist participation were associated with greater reductions in Medicare spending among beneficiaries with cardiovascular disease. [3] More recent research found no differential improvement in cardiovascular quality measures among outpatient cardiology practices participating in MSSP ACOs compared with nonparticipating practices.[4] Together, these findings suggest that specialist participation alone is insufficient to improve performance and that accountable care models must provide meaningful incentives, actionable performance information, and quality measurement approaches that reflect specialist contributions to patient care.

ACC encourages CMS to proceed cautiously with modifications that incorporate specialists directly into beneficiary assignment methodologies. Specialty care relationships vary substantially across conditions and

[3] Sukul D, Ryan AM, Yan P, Markovitz AA, Nallamothu BK, Lewis VA, Hollingsworth JM. Cardiologist participation in accountable care organizations and changes in spending and quality for Medicare patients with cardiovascular disease. *Circ Cardiovasc Qual Outcomes.* 2019;12(9):e005438. doi:10.1161/CIRCOUTCOMES.118.005438.

[4] Spatz ES, Oddleifson DA, Kayani J, et al. Accountable care organization participation and cardiovascular care quality. *JAMA Cardiol.* 2025;10(6):545-554. doi:10.1001/jamacardio.2025.0381.

practice settings and do not always function in the same manner as primary care relationships. However, some specialists who manage complex chronic conditions may serve as a beneficiary's principal longitudinal clinician. Patients with heart failure, advanced cardiovascular disease, congenital heart disease, and other complex conditions may receive frequent and ongoing management from cardiovascular specialists. CMS should explore approaches that recognize these longitudinal relationships while preserving the foundational role of primary care in accountable care models.

Specialists should be evaluated on conditions and episodes of care that they can meaningfully influence rather than being held accountable for a beneficiary's total healthcare spending. Condition-specific approaches may better align accountability with clinical responsibility while supporting collaboration between specialists and primary care clinicians. Any specialty-focused benchmarks should appropriately account for patient complexity, low patient volumes, and cost variability and should complement, rather than replace, existing ACO total cost of care benchmarks.

Meaningful specialist engagement also requires access to timely, actionable performance information and incentives that reflect specialists' contributions to patient outcomes. Specialists should receive clinically relevant data on utilization, outcomes, and costs for the populations they manage and have opportunities to share in the benefits generated through improved care coordination and outcomes. Performance information should be reliable, appropriately risk adjusted, supported by transparent methodologies, and designed to support prospective care management and quality improvement.

Incentive structures should likewise create a meaningful connection between specialists' contributions and financial or non-financial rewards. For example, cardiovascular specialists may improve outcomes and reduce avoidable hospitalizations and costs for patients with heart failure yet receive little recognition if the ACO as a whole does not achieve its overall savings benchmark. This disconnect may weaken incentives for continued specialist participation and engagement in accountable care efforts. Incentives should recognize improvements in outcomes, evidence-based care, care coordination, and avoidable utilization without creating pressure to reduce clinically appropriate specialty services. At the same time, ACOs should retain flexibility to structure arrangements based on their care delivery models.

Quality measurement should similarly focus on aspects of care that specialists can meaningfully influence. ACC notes that the current APP Plus measure set primarily reflects preventive care, chronic disease management, and care coordination activities commonly associated with primary care and may not fully capture the contributions of cardiovascular specialists. Future specialist-focused measurement should prioritize clinically meaningful, evidence-based, and actionable measures while leveraging existing specialty measures, clinical registries, and reporting infrastructure to minimize reporting burden. Specialty registries provide clinically detailed data and established quality improvement frameworks that could support future specialist measurement within ACOs.

Finally, MVPs were developed for MIPS and should not be adopted wholesale as a framework for specialist accountability within MSSP without evaluating whether individual measures and methodologies are appropriate for population-based accountability. Where relevant, CMS could incorporate selected specialty measures that complement broader ACO quality goals and reflect aspects of care specialists can meaningfully influence.

Shared Savings Program Certified Electronic Health Record Technology (CEHRT) Use Requirements

CMS proposes to revise the MSSP requirements for demonstrating use of Certified Electronic Health Record Technology (CEHRT) beginning in PY 2027. Under the proposed approach, an ACO could satisfy the CEHRT use requirement through one of three pathways: (1) reporting at least one applicable APP Plus Measure using the eCQM or Medicare eCQM collection type and meeting applicable data completeness requirements; (2) reporting at least one applicable APP Plus measure using appropriately certified health IT used to support quality measurement; or (3) attesting to at least ACO CEHRT use metric established by CMS. For PY 2027, CMS proposes metrics related to electronic prescribing, bidirectional health information exchange, and provider-to-patient electronic access.

ACC supports CMS's proposal to replace the current Shared Savings Program CEHRT requirements with a more flexible, ACO-specific framework. ACOs may include physicians across numerous practices, specialties, and EHR platforms, making aggregation of clinician-level Promoting Interoperability information administratively and technically burdensome. We agree that the Shared Savings Program should focus more directly on whether certified technology is meaningfully supporting health information exchange, quality measurement, prescribing, and patient access.

In addition, ACC is supportive of providing ACOs with multiple pathways to satisfy the CEHRT requirement. This approach better recognizes the diversity of ACO technical environments and should allow organizations to select the method that best reflects their existing infrastructure and clinical workflows.

As CMS finalizes this proposal, ACC encourages CMS to ensure that the available pathways remain genuinely equivalent and do not indirectly require use of a particular EHR vendor, proprietary platform, health information network, or technical architecture. ACC believes that physicians and ACOs should retain flexibility in selecting technologies that appropriately support their clinical needs.

Additionally, ACC recommends that CMS ensure ACOs are not held accountable for failures of technology infrastructure beyond their reasonable control. Successful electronic exchange depends on functionality provided by EHR developers, health information networks, APIs, other participating organizations, and CMS infrastructure. In cases where an ACO has taken reasonable steps to comply but technical limitations or failures outside its control prevent successful exchange or reporting, appropriate flexibility should be available.

Request for Information (RFI) on Duplicative Laboratory Testing, Imaging, and Result Sharing and Interoperability

Introduction

ACC appreciates the opportunity to provide comments to the Request for Information regarding duplicate laboratory testing, diagnostic imaging, result sharing, and interoperability. The College is supportive of

CMS's goal to reduce unnecessary duplicative testing and improve clinicians' access to diagnostic information across care settings. As CMS acknowledges, laboratory and imaging results often remain siloed within individual health systems, EHRs, imaging platforms, and other health information technology (IT) systems, leaving clinicians without timely access to crucial patient information. These gaps can contribute to delayed decision-making, repeat testing, and unnecessary costs.

At the same time, efforts to reduce unnecessary duplicative testing must be designed carefully. A repeat laboratory or imaging study is not necessarily clinically duplicative simply because a similar test was performed within a particular period of time, involved the same imaging modality, or was billed using the same CPT code. The need for repeat testing depends on the patient's clinical condition, changes in symptoms, progression of disease, treatment response, longitudinal surveillance needs, the protocol and acquisition quality of the prior study, and whether prior results and images are available in a clinically usable form when a decision must be made. As such, ACC believes that policies intended to reduce unnecessary utilization should preserve clinician judgement and should not create payment or administrative consequences when repeat testing is medically appropriate or is caused by failures in health information exchange.

The field of cardiology is image-dependent and therefore requires access to longitudinal health records of a patient to provide proper and efficient care. Cardiologists frequently care for patients who receive services across multiple health systems, hospitals, physician practices, and outpatient imaging centers that do not share a common picture archiving and communication system (PACS). Prior echocardiograms, stress tests, invasive angiography, coronary and structural CT studies, and other cardiovascular imaging may therefore be difficult or impossible to obtain when a patient is transferred, referred for specialty care, or seeks a second opinion.

In these circumstances, studies may have to be repeated not because the prior study lacked clinical value, but because the treating physician cannot obtain the prior images in a usable format when a decision must be made. ACC encourages that this underlying interoperability problem be addressed before imposing payment consequences intended to reduce duplicative testing.

Distinguish Unnecessary Duplication from Interoperability-Driven Repeat Testing

CMS seeks input on whether changes to payment policy, including billing clarifications, Medicare Administrative Contractor (MAC) edits, payment recoupment, or frequency limitations, could be used to address duplicative laboratory and imaging services. CMS is also asking if a test performed within a particular period should automatically be considered duplicative.

ACC urges CMS to proceed cautiously with such approaches. A repeat study is not necessarily clinically duplicative simply because the same or similar test was performed within a particular period of time. Time-based definitions alone cannot distinguish inappropriate duplication from clinically necessary repeat imaging when a patient's condition changes, disease progresses, treatment response must be assessed, or new symptoms emerge. Similarly, duplicative imaging should not be defined solely by CPT code or imaging modality. The same modality and code may reflect different acquisition protocols, diagnostic analyses, or clinical indications, and claims-based measures cannot reliably determine whether a repeat

study is duplicative without considering the specific clinical question being addressed.

As such, ACC believes that CMS should avoid establishing a universal time period, modality-based rule, or CPT-code-based standard under which a subsequent study is automatically considered duplicative. Any limitations on the frequency of repeat testing or changes in payment should be based on clinical evidence and include clear exceptions for medically necessary repeat testing, including longitudinal surveillance of ventricular function, valvular disease, aortic dimensions, cardiomyopathy, and outcomes following cardiovascular interventions. Additionally, physicians should have a straightforward means of documenting clinical justification without creating significant additional documentation, prior authorization, or appeals burden.

Importantly, ACC encourages CMS to distinguish unnecessary duplication from interoperability-driven repeat testing. CMS specifically asks how to account for cases in which repeat imaging occurs because prior images were unavailable for timely, standards-based reuse. Physicians should not face payment reductions, recoupment, quality consequences, or other penalties when they reasonably order a repeat study because prior images could not be located, accessed, transferred, or used in time to make an appropriate clinical decision. CMS should therefore not hold physicians responsible for repeat testing when the underlying issue is that a healthcare organization or health IT system failed to make existing diagnostic information accessible and usable. Instead, CMS should focus accountability on addressing the interoperability barriers that prevented the information from being available when it was needed.

CMS should also recognize that cardiac imaging differs from laboratory testing. Unlike many laboratory tests, cardiovascular imaging studies vary considerably based on acquisition technique, equipment capability, protocol selection, image quality, post-processing requirements, quantitative measurements, and interpretation. As a result, repeat imaging decisions require clinical judgment and cannot be accurately assessed using claims data alone.

Further, advanced cardiovascular imaging is not uniformly available across healthcare institutions. While echocardiography and single-photon emission computed tomography (SPECT) myocardial perfusion imaging are widely available, access to coronary computed tomography angiography (CCTA), cardiac magnetic resonance imaging (MRI), and positron emission tomography (PET) myocardial perfusion imaging remains more limited and often concentrated in specialized centers with variable equipment, protocols, and expertise. Patients frequently undergo initial imaging in community settings and later require advanced imaging, specialized protocols, subspecialty reinterpretation, or tertiary-center expertise. Policies intended to reduce duplicative imaging should therefore preserve appropriate community-to-tertiary referral pathways and should not create barriers to clinically indicated follow-up evaluation.

Ensure Imaging is Clinically Usable

ACC is strongly supportive of efforts to improve electronic access to diagnostic images across organizational boundaries. However, successful interoperability should be measured by whether a physician can meaningfully use the information in clinical care, not merely by whether an image, report, or link technically exists. Image accessibility alone does not guarantee clinical usability.

In a previous request for information from the Office of the National Coordinator for Health Information Technology (ONC), the agency recognized that providers may be unable to obtain full-resolution digital imaging and communications in medicine (DICOM) images and instead receive low-resolution, incomplete, or inferior representations, and that patients and clinicians continue to rely on CDs, DVDs, and other cumbersome exchange methods. ACC emphasizes that this issue is particularly important in cardiovascular imaging. A written report or static image may not contain sufficient information to evaluate a complex study. Physicians may need access to raw DICOM images, post-processing data, quantitative measurements, full-resolution source images, associated reports, and clinically important metadata to independently verify measurements, compare studies over time, perform additional measurements, conduct advanced post-processing, support three-dimensional (3D) reconstruction, plan structural heart interventions, or use emerging artificial intelligence applications. For example, in structural heart imaging, access to both the quantitative parameters and the underlying source data may be necessary to verify measurements that could influence treatment decisions.

Thus, ACC recommends CMS ensure that any minimum standard for imaging result shareability provides access to both a human-readable report and diagnostic-quality images and clinically important associated data when needed. DICOM is the international standard for communication and management of medical imaging information, and the standard specifically supports medical imaging in specialties including cardiology.

Prior imaging studies may be accessible but still clinically unusable. A study may need to be repeated when image quality is inadequate, relevant acquisition sequences are absent, quantitative data are unavailable, diagnostic images are incomplete, the study was performed using outdated technology or an inadequate protocol, or the original examination was not designed to answer the current clinical question. Repeating such studies should be recognized as medically necessary care rather than unnecessary duplication because appropriate repeat imaging can prevent false-positive, false-negative, or inconclusive results that lead to unnecessary downstream testing, referrals, procedures, delayed diagnoses, and inappropriate treatment decisions.

ACC also recommends that CMS consider accountability and quality benchmarks for imaging facilities. Facilities that routinely produce studies that cannot be clinically reused contribute to unnecessary downstream testing. CMS should consider benchmarking standards related to equipment capability, technology age, image quality, protocol adequacy, completeness of image acquisition, availability of required diagnostic sequences, and image-sharing performance. Responsibility for non-reusable studies should not rest solely with the receiving physician when prior examinations are inadequate, inaccessible, improperly acquired, or fail to address the clinical question. Accountability should primarily reside with the facilities and healthcare organizations responsible for image acquisition, protocol selection, data retention, and image sharing.

In addition, CMS asks whether participating entities should be required to provide a FHIR R4 DiagnosticReport and a human-readable PDF/A rendition as a minimum standard for shareability. The College continues to support FHIR-based standardization, however we recommend that CMS be cautious in treating DiagnosticReport and PDF/A alone as sufficient imaging interoperability. The FHIR R4 DiagnosticReport resource can carry diagnostic findings and reference an ImagingStudy or associated

images and can therefore play an important role in discovery and integration into clinical workflows. However, the underlying imaging data must also be accessible through appropriate imaging standards and infrastructure.

As such, ACC encourages CMS to work closely with ONC, clinicians, standards organizations, health IT developers, and imaging vendors to ensure that FHIR-based exchange complements established DICOM and DICOMweb capabilities rather than creating competing or duplicative change requirements.

Support Secure, Reliable, and Tested Exchange

In the request for information, CMS recognizes that national network participation alone will not resolve interoperability challenges and specifically identifies authentication, authorization, and patient matching as fundamental issues that must be addressed. As such, ACC supports secure mechanisms that allow a receiving physician to be reliably authenticated and authorized to access diagnostic information while protecting against unauthorized access.

In tandem, ACC believes that image access must also be accompanied by appropriate privacy, security, and identity safeguards. ACC is supportive of CMS's consideration of stronger conformance testing, certification approaches, and implementation guidance. Adopting the same standard does not always guarantee successful interoperability across different products. The DICOM standard itself recognizes that conformance facilitates interoperability but does not, by itself, guarantee that independently implemented systems will operate together successfully. Therefore, testing should evaluate real-world, end-to-end exchange across different vendors, PACS, EHRs, imaging centers, hospitals, and physician practices.

Implementation Costs

CMS asks whether incentives should support the adoption and implementation of imaging interoperability capabilities. While ACC is strongly supportive of a more universal process for sharing diagnostic images, the College is concerned about the potential financial and operational burden of implementing new requirements to achieve complete interoperability. ACC believes that CMS should implement interoperability expectations along with reasonable timelines for implementation, technical assistance, and appropriate financial support so organizations who may be resource-constrained or are smaller are not at a disadvantage compared to larger, better integrated health systems.

In addition, ACC recommends that CMS recognize that making an outside study available does not eliminate the physician work required to evaluate it. In some cases, particularly when patients are transferred or referred for complex specialty care, a cardiologist may need to conduct a detailed review or reinterpretation of an outside study before relying on it for treatment decisions. This work can require substantial physician time, particularly for complex cardiovascular imaging and 3D datasets, and may include validating quantitative measurements, performing additional post-processing, integrating findings across imaging modalities, confirming whether the prior study answers the current clinical question, and determining the most appropriate diagnostic strategy. Thus, ACC urges that as CMS develops policies intended to encourage reuse of existing images rather than repeat testing, it should consider whether payment policy appropriately recognizes reinterpretation, post-processing, and cardiovascular imaging

consultation services when medically necessary.

CMS should continue to promote secure image sharing and interoperability while recognizing the financial, technical, and operational challenges associated with implementing and maintaining image exchange systems. Those challenges may be especially significant for smaller practices, community hospitals, rural providers, and independent imaging facilities that lack the resources of large integrated delivery systems.

Summary

The ACC appreciates the opportunity to provide input on the Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing Interoperability from CMS. ACC is strongly supportive of CMS's goal to reduce unnecessary duplicate diagnostic testing. However, ACC emphasizes that in certain cases, repeat imaging is sometimes a symptom of inadequate interoperability rather than inappropriate utilization.

ACC encourages CMS to prioritize making prior diagnostic information timely, discoverable, secure, and clinically usable across organizational boundaries. Policies should preserve physician clinical judgement, distinguish medically necessary and interoperability-driven repeat testing from unnecessary duplication, protect appropriate longitudinal surveillance imaging and community-to-tertiary referral pathways, and protect physicians from adverse payment consequences when existing information cannot reasonably be accessed or clinically used at the point of care.
Additionally, ACC recommends that CMS advance national standards that support access to diagnostic-quality images, raw DICOM data, post-processing information, quantitative measurements, and associated reports; strengthen real-world conformance testing and security; provide implementation support for resource-constrained organizations; and consider appropriate quality benchmarks and accountability mechanisms for imaging facilities. Future policy should also account for evolving imaging technologies, including advanced analytics, post-processing tools, 3D reconstruction, and artificial intelligence, all of which depend on high-quality, standardized, and interoperable imaging datasets.

Conclusion

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

Sincerely,

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

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