Excerpt from ACC Comment Letter on CY2026 Medicare Physician Fee Schedule Proposed Rule submitted Sept. 11, 2025:

Ambulatory Specialty Model for Heart Failure

For over two decades, the ACC has been and remains committed to assisting our cardiovascular clinicians' transition to value-based cardiology care through creation of practice guidelines, appropriate use criteria, expert consensus statements and other recommendations. The College appreciates CMS and its Center for Medicare and Medicaid Innovation (CMMI) for their willingness to collaborate and respond to questions and feedback on prior quality and innovation models, including the Medicare Acute Care Episode Demonstration, Merit-based Incentive Payment System (MIPS), the original Bundled Payments for Care Improvement (BPCI), and BPCI-Advanced. Such engagements have provided improved alternative payment model experiences for our cardiovascular members.

Since establishing its first principles for pay-for-performance in the early 2000s, the College has prioritized ensuring that quality and value assessments are measured and rewarded at the practice level rather than the individual clinician. Over the years, the ACC, cardiology training programs, and medical practices have developed and cultivated the importance of team-based cardiology care. As a core tenet, each member (cardiologist, CV sub-specialist, advanced practice nurse, imaging technician, pharmacist, and administrative staff as well as other medical specialties including primary care) serve vital roles to ensure the patient receives high quality cardiovascular care with access to necessary and timely medical attention, appropriate testing and medications. **Because of these important roles, we strongly encourage the assessment and evaluation of CV clinicians' performance occur at the level of a team/practice and not at the level of an individual clinician. Therefore, the College believes that the Ambulatory Specialty Model (ASM) as it is currently proposed to only include cardiologists as participants would create significant complexities for attribution, scoring, and comparison to other physicians.**

Additionally, it is vital for the model's participants to be incentivized, when appropriate, to follow well-established practice guidelines and recommendations including patients following guideline-directed medical therapy (GDMT), which will be discussed later in this comment letter. We are very concerned that the model, as currently proposed, has the potential to create adverse incentives to lower the cost of HF care in order to maximize scoring, and most significantly, would negatively affect patient care and outcomes. Furthermore, the ACC has significant reservations about the proposed model due to its inherent structure, which would result in nearly half of participating cardiologists receiving a negative payment adjustment if their performance scores fall below the median, regardless of any improvements in care quality or cost efficiency.

Considering the ongoing, productive collaboration between the College and CMMI, the following comments highlight areas of needed attention from clinical and practice perspectives with the overall aim to improve the current program.

Proposed Length of Model Test

CMS proposes that the ASM will run from January 1, 2027, through December 31, 2031, for the performance years, with corresponding payment years spanning January 1, 2029, through December 31, 2033. The College appreciates the five-year length of the model test, which allows for an adequate period for participation and data collection. It will be vital for CMS to provide timely and actionable data to all participants to allow adequate time for review, analysis and performance improvement throughout the course of the model.

Proposed Mandatory Participation

The College recognizes that CMMI's goal in proposing a mandatory program is to ensure broader participation and more consistent, applicable data than has been possible under voluntary models such as BPCI-Advanced or the MIPS Value Pathways (MVP). In those programs, participation was readily subjected to selection bias and limited sample size, as well as the option to withdraw before the end of the programs.

As seen in the QPP/MIPS, solo and small practices with limited resources and infrastructure may be disadvantaged in a five-year model, leading to lower participation and engagement. If mandatory participation is finalized, the College strongly urges CMMI to proactively reach out to those potentially disadvantaged participants who may face greater scoring penalties.

Proposed Participants/Heart Failure Cohort

Specialty Type Identification

We are concerned that CMS's proposed methodology for identifying ASM participants, particularly for the heart failure (HF) cohort, overly narrows eligibility by focusing on "cardiology" while excluding relevant cardiology subspecialists who provide essential components of HF care. This limited focus risks undermining the clinical validity and fairness of performance comparisons under the ASM model. Heart failure care is largely multidisciplinary and cannot reasonably be attributed to a single clinician.

As currently proposed, CMS would determine clinician specialty based on the plurality of Medicare Part B claims, which may inadvertently exclude certain subspecialists who play a key role in HF care, such as advanced HF/transplant cardiologists (Medicare Specialty Code C7) or those with dual specialties. For example, a clinician with a mix of general cardiology and HF claims could be misclassified if the largest share is only slightly higher for a general specialty code. Moreover, excluding subspecialists from ASM participation would not reflect the real-world team-based care models used in HF management. Initial diagnosis may occur in primary care, during a hospitalization, or with non-invasive cardiologists; but confirmation and subtyping typically require cardiology input. Advanced practice nurses may also be involved early in the care of the patient.

Heart failure diagnosis and management can include B-type natriuretic peptide (BNP) testing, echocardiography, risk assessment, medication titration, and comorbidity management. These occur across multiple clinicians and settings, with varying workflows depending on local resources. For example, primary care providers (PCPs) generally manage comorbid conditions, cardiologists adjust

HF medications and monitor therapy, nurses and advanced practice providers staff the heart failure clinics and education programs, and subspecialists such as electrophysiologists, interventional cardiologists, nephrologists, and endocrinologists contribute based on patient complexity. If attribution is based narrowly on primary diagnosis codes or the first clinician encounter, it risks artificially reducing measured HF incidence and misclassifying which clinician is responsible for outcomes. This reality results in a "messy middle" of shared responsibility with a team-based approach, where multiple providers contribute to diagnosis, stabilization, and longitudinal management. Accountability for costs is similarly distributed across team members, including imaging, procedures, hospitalizations, medications, and post-acute care.

Based on our experience with the CMS Quality and Resource Use Reports (QRUR), we found that many physicians are not classified correctly with their most recent specialty classification. Often, physicians keep their initial specialty designation (general cardiology) when starting at a new practice and often do not update it when their daily clinical practice evolves into a cardiology subspecialty classification of interventional cardiology, electrophysiology, advanced heart failure and transplant. The College often sends members reminders to update their specialty types in PECOS for Medicare and other payers.

Therefore, we caution against limiting eligibility or performance assessment strictly by specialty code. Specialty codes based on plurality of claims can be misleading, especially for multi-specialty providers or those working across different locations. CMS should also clarify how clinicians who move TINs mid-year will be tracked and how credit (or penalties) will follow them. To more accurately identify the managing clinician, CMS could supplement the specialty code with additional information, such as HF diagnosis and E/M mix, patient relationship codes, registry/QCDR participation, and relevant board certification to identify the clinician managing the patient.

In addition, under the proposed ASM, an individual clinician who assigns billing rights to multiple TINs would be treated as separate participation entities and required to meet reporting requirements for each applicable NPI/TIN combination. The College believes that such a rule creates an unneeded and concerning level of complexity for clinicians and their practices. We strongly encourage CMMI to follow the MIPS structure which calculates the clinician's scoring for each TIN, then selects the higher score and omits the lower scores for assessment and comparison. If CMS finalizes NPI-level mandatory participation, selected participants should receive a preview period for attribution/comparator assignment, a formal reconsideration mechanism to correct specialty designation and episode attribution, the ability to exclude non-managing episodes, and protection from penalties during the appeals period. **Ultimately, the ACC strongly recommends CMS assess participants at the practice or TIN level which would support the current standard of practice.**

<u>Episode Based Cost Measure (EBCM) Volume Threshold</u>

To promote consistency between MIPS/MVPs and the ASM, the College supports CMS's use of the HF EBCM to determine ASM participation eligibility. Building on the attribution considerations, the proposed 20-episode volume threshold may also raise challenges. While 20 episodes may be a

reasonable starting point, it may not adequately reflect the variability in cardiologists' practice patterns across rural, urban, or hospital-based settings. Subspecialists who manage HF patients episodically or as part of a team may fall below this threshold, despite delivering meaningful care.

Several physician members of the ACC participated in the HF cost measure field testing process through CMS' consultant, Acumen. Based on the current cost measure's attribution methodology, the data showed that cardiology was attributed to just over 51% of HF cases. Other specialties such as internal medicine, interventional cardiology, family practice, nurse practitioner, and cardiac electrophysiology accounted for approximately 48%.

Considering the field-testing attribution results and the ASM as proposed, only half of the HF patient population would be attributed to a cardiology specialist with the other half being allotted to a cardiologist who may not be actively managing a patient's specific longitudinal HF care. The College is greatly concerned that this attribution process will greatly impact long standing patient and physician relationships as well as clinician to clinician collaboration. A more accurate approach would be to attribute the patients at the TIN level rather than the individual physician level to recognize the shared accountability across the multidisciplinary team and the system of care for the management of patients with HF.

Selection Methodology

In a recent analysis published in the *Journal of the American College of Cardiology*, it was found that nearly half of U.S. counties do not have a practicing cardiologist.[1] Additionally, 86.2% of rural counties had no cardiologists, and the average round-trip distance to the nearest cardiologist was 16.3 miles vs 87.1 miles in counties with and without cardiologists, respectively. CMS has also asserted that more than one-third of the CBSAs (359 out of 959) would be excluded completely from selection, because there were no clinicians in those areas who had the minimum number of episodes in the year 2024 analysis.

The lack of practicing cardiologists is apparent to some communities of Medicare beneficiaries, especially rural areas. The round-trip distance to a cardiologist as well as the location of the patients' medical services can be considerable factors for participating in the ASM. For an attributed patient with HF, there is a strong presumption that longer distances indicate the patient is less likely to receive most of their medical care near the attributed cardiologist, especially with urgent visits and hospital admissions.

Given these concerns and the current attribution method in the HF EBCM, the College urges CMS to reconsider how geographic areas are assigned to clinicians. Attribution should reflect the physician delivering the dominant portion of a patient's HF care, rather than defaulting to the only cardiologist involved in the care arrangement. We are very concerned about scenarios where the ASM participating cardiologist meets the required number of services to satisfy the EBCM attribution standard, yet the patient lives more than 50 miles away and receives most care from a

[1] Kim JH, Cisneros T, Nguyen A, van Meijgaard J, Warraich HJ. Geographic Disparities in Access to Cardiologists in the United States. *J Am Coll Cardiol.* 2024;84(3):315-316. doi:10.1016/j.jacc.2024.04.054

local primary care physician and hospital. The distant cardiologist should not be attributed to that patient.

Lastly, the current ASM proposal introduces a very complex and potentially burdensome attribution method for a cardiologist participant. The participant and their practice will need to determine the patient's insurance status for traditional Medicare and the number of claims filed per 180 days as well as the number of prescriptions written for the patient. Finally, if the patient receives most of their HF services within the geographically selected area, the ACC requests that this process be made easier to track and identify the ASM areas as well as the attributed patients. We also ask that CMS study the applicability and utilization of patient relationship codes, which are coded by a clinician to indicate their level of involvement with the patient's care to factor into patient attribution.

Proposed ASM Performance Assessment Approach, Data Submission Requirements, and ASM Performance Category Requirements and Scoring

ASM Performance Categories

We appreciate CMS's effort to align the ASM scoring framework with existing MIPS structures, as well as the overall goal to improving value. However, shifting individual clinicians into a model where 100% of scoring rests on Quality and Cost for a small heart-failure cohort is a sharp departure from prior MIPS and MVP experience. In the recent 2023PY QPP Experience Report, data shows that cardiologists have been slow to adopt and submit the Advancing Care for Heart Disease MVP: 731 registered, yet only 38 cardiovascular clinicians received a final score in the 2023 performance year. Launching a mandatory, two-sided risk model that relies heavily on similar measurement and attribution mechanics raises concerns. While this MVP provides an important foundation, current participation trends highlight a need to optimize and provide further education on the MVP and this ASM to better support cardiologists in transitioning to value-based care.

Data Submission Requirements

We are concerned that requiring data submission strictly at the TIN/NPI level, rather than allowing group, subgroup or registry-level aggregation, may underrepresent the team-based, multispecialty nature of cardiovascular care. Cardiologists often participate in shared care models where improvement activities or interoperability efforts are implemented at the practice or health system level. CMS should consider allowing reporting at the TIN level for certain performance categories to better reflect the collaborative nature of specialty care delivery.

Proposed Quality ASM Performance Category

Quality Measures

The ACC supports the inclusion of condition-specific, clinically relevant quality measures in the ASM HF cohort, particularly CMS's effort to align the model with contemporary HF care. The proposed set covers several essential measures, such as evidence-based medications, blood pressure

(BP) control, and functional status. That said, a few updates would make the set more guideline-concordant and fair in a two-sided risk model without adding burden.

The measure set would benefit from the inclusion of newer therapies such as statins and SGLT2 inhibitors in order to align with current therapy, as well as updates to topped-out measures. We refer the agency to the *2020 ACC/AHA Clinical Performance and Quality Measures for Adults With Heart Failure* for guidance on current pharmacological treatment as well as quality and performance metrics for HF, as these are reliable, valid, and are based on evidence-based guidelines. If feasible, a single GDMT composite would keep burden low, but consideration should be given to exceptions to meeting individual components of such a measure.

We recommend CMS allow scoring flexibility to avoid penalizing clinicians for isolated gaps in care delivery. Mandating that clinicians report on all five measures in the ASM HF set raises concerns about feasibility and data completeness. Not every measure applies to every patient, and missing data, exclusion bias, and reporting burden could distort performance results. For example, cardiologists often care for hospitalized CHF patients that do not fit neatly into groups where GDMT has been studied. One of these groups is post-CABG patients who may not tolerate certain GDMT drugs. This may inappropriately skew the GDMT compliance of cardiologists because post-CABG patients should not be given every type of medication in the GDMT arsenal. This nuance may vary widely from cardiologist to cardiologist

A more practical approach would be to allow the physician to select between 3-5 measures relevant to their patients. We also urge CMS to ensure alignment between quality and cost scoring to avoid duplicative accountability under the HF EBCM. It should be noted that the proposed quality measures account for patients younger than 65, while the cost measure is for those above that threshold.

CMS should also clarify whether the proposed medication-based measures would apply to all HF patients under a clinician's care, or only to those attributed to the clinician under the ASM. Applying these measures broadly across all HF patients could significantly increase reporting burden and create misalignment with the attributed cost population, while limiting them to the attributed cohort may raise issues of sample size and representativeness. Clear guidance is essential to ensure consistent application and fair assessment. Similarly, the College strongly encourages broad flexibility or an established glide path for ASM participants on collecting, validating, and submitting their quality measurement data. According to the 2023PY QPP Experience Report, MIPS quality measures #5 and #8 were reported by participants only 1,197 and 1,008 times, respectively, with comparable results in previous performance years. Such low reporting volumes and limited engagement raise concerns about data accuracy and the reliability of these measures.

Finally, there will likely be a need for active support from ASM participants' practices, health systems, and EMR vendors to accurately collect data for provider-reported measures. Given the previously noted low reporting rates, many MIPS participants place little emphasis on these measures. Contributing factors may include insufficient staff training, limitations in EMR infrastructure, and concerns about the reliability of reported results. Since ASM participants are

required to report these measures starting in their first year, the College requests a reasonable transition period to support successful data submission.

The ACC offers the following comments on specific measures:

1. #492 – Risk-Standardized Acute Unplanned Cardiovascular Admissions (Claims-Based)

Attribution at the TIN/NPI level, particularly for specialists working in team-based settings, may misrepresent individual accountability for admissions that are influenced by broader social risk factors or primary care coordination. CMS should monitor for unintended disparities and ensure risk adjustment accounts for factors outside cardiologists' direct control. Additionally, CMS should clarify how #492 scoring will interact with COST_HF_1, to prevent overlapping penalties for the same utilization events across quality and cost domains.

2. #008 – Beta-Blocker Therapy for LVSD (Process)

This is a foundational GDMT measure that has strong evidence behind it. That said, beta-blocker use is widely adopted and nearing topped-out status in many reporting situations. CMS could consider transitioning this measure toward an outcomes-based construct (e.g., persistence, adherence, or optimization of dosing), particularly if it is to be retained across the duration of the model. In addition, this measures patients only with reduced ejection fraction.

3. #005 – ACEi/ARB/ARNI Therapy for LVSD (Process)

ARNIs have a demonstrated benefit in patients with HFrEF. However, similar to #008, CMS should explore ways to evolve the measure over time, particularly since it is topped-out. A composite adherence measure or PRO-linked construct may more effectively reflect the value of GDMT in practice, rather than relying on prescription documentation.

4. #236 – Controlling High Blood Pressure

While blood pressure management is important to HF control, #236 is also influenced by documentation workflow issues and patient noncompliance. We suggest updating it with risk stratification or digital quality components to address disparities and other challenges, and also consider accepting home/remote BP. Additionally, CMS should clarify whether a missed reading due to a single skipped visit or lack of patient engagement would disproportionately impact performance scores under ASM.

5. #377 – Functional Status Assessment for Heart Failure

Functional status is a key aspect of patient-centered care and an independent predictor of readmission and mortality. Scoring this measure in the ASM, however, risks penalizing clinicians for limitations in data capture rather than care quality. In the 2023PY, only a handful of CV clinicians (8 total) reported this measure, with an average score of three points (max 10). This indicates feasibility

and benchmarking issues, not performance. CMS should phase this in as reporting-only, or possibly an improvement activity.

We recommend CMS prioritize development of a validated PRO-PM (e.g., based on the Kansas City Cardiomyopathy Questionnaire [KCCQ] or the Minnesota Living with Heart Failure Questionnaire [MLHFQ]) and pilot its use early in the ASM program. This would demonstrate a meaningful shift from documentation-based processes to measures of patient experience and lived health outcomes. However, it should be noted that the KCCQ and MLHFQ require purchasing licensing for their use in clinical settings. In addition, different data sources (EMR vs. registries) produce inconsistent outputs. Until these challenges are resolved, functional status assessment should be approached cautiously to avoid inequitable scoring.

Other Measures Under Consideration

We appreciate CMS's thoughtful consideration of additional measures for the ASM HF cohort. We recommend against including Patient Activation Measure (PAM #503) at this time due to concerns about burden, access, and questionable attribution. Similarly, while advance care planning is important, we agree that #047, Advanced Care Plan, is better suited for primary care settings and not ideal for attribution to cardiologists. We support CMS's decision not to include the Multiple Chronic Conditions (MCC) admissions measure (#484), which is insufficiently targeted to HF care. Finally, CMS could include #243 (Cardiac Rehab Referral) as an optional or adjusted measure, given its strong clinical value and evidence base, provided CMS addresses access-related inequities. These inequities could be addressed by including numerator credit for things such as e-referral or documented patient choice/clinical contraindication, applying hardship exceptions for no available or distant programs, and stratifying results by geography or dual-eligibility. It could also be considered for Improvement Activity credit.

Data Completeness Requirement of 75 Percent

We support CMS's goal of ensuring that quality measure results are based on a representative sample of patients. **However, we recommend caution in implementing a strict 75% data completeness threshold without appropriate flexibilities for specialty clinicians.** In cardiology, clinicians often provide episodic, consultative, or co-managed care, particularly in hospital-based or multispecialty group settings. In these cases, full documentation of all required fields may not be consistently available to the cardiologist, despite high-quality care being delivered. We also stress that since this requires reporting from individual clinicians who may not be well-versed in reporting these specific measures, some flexibilities should be implemented, especially in the first year or two. A phase-in approach (e.g., 50% in PY1, 60-65% in PY2, etc.) will help keep the spirit of reporting while avoiding burden or inequity.

Denominator exceptions could be created (e.g., an "unknown/not available" data element) when information is not accessible to the cardiologist so that incomplete records are not considered "failures". To ensure fair and feasible participation, we urge CMS to maintain flexibility in reporting

options for the ASM model. Clinicians should be allowed to report via registries or other validated mechanisms, not just through EHR-derived eCQMs, particularly while digital infrastructure continues to evolve. We also recommend CMS provide clear technical guidance, allow for a transition period, and consider hardship exemptions for clinicians facing issues with vendors or barriers with integration into workflows.

Scoring, Benchmarking

We appreciate CMS's attempt to align quality scoring with established methodologies from MIPS and MVPs, though some concerns are inherent with the methodologies proposed for the model. To begin, separate benchmarks by scoring types makes sense, though it may unintentionally penalize clinicians who adopt certain reporting pathways that perform differently due to measure specifications or data completeness. Given that the median performance of all participating physicians and the Part B payment amounts for each physician would not be known until after the performance year, this would be challenging for physicians to contemplate whether they will receive a penalty, bonus or no payment adjustment. We suggest that in the initial performance year, physicians in the ASM obtain scores similar to physicians in all Medicare pay for performance programs.

The proposed 20-participant threshold may still be insufficient to generate stable benchmarks for certain measures, so the College recommends safeguards or confidence intervals for measures that may demonstrate wide year-to-year swings. Clinicians will also need access to initial benchmark ranges early in the performance year to have a clear guide as to what would be considered meaningful improvement.

We understand CMS's hesitation to prematurely label measures as topped-out within the ASM due to the different reporting dynamics. However, for measures that are historically topped-out in MIPS, CMS should closely monitor whether similar patterns emerge and consider early mitigation strategies. These could include narrowing measure definitions, transitioning to outcome-focused specifications, or suppressing topped-out measures from final scoring to avoid clustering. We support CMS's proposal to remove measures from scoring if data are compromised by external errors (e.g., code omissions, EHR glitches, guideline changes). This policy will help maintain the accuracy and credibility of final performance scores. Even in a mandatory reporting environment, topped-out measures can reduce the meaningfulness of comparisons, especially when used for public reporting or financial adjustment.

Cost Measure

Because the HF EBCM was recently finalized for MIPS in 2024, we suggest closely monitoring measure performance and attribution accuracy before using it as a mandatory threshold for ASM participation. Using a newly implemented cost measure to trigger mandatory model inclusion raises concerns about unintended financial or participation consequences if the measure has not yet been fully validated in real-world practice.

Clinicians who manage medications, schedule follow-ups, or coordinate care might end up with higher total costs for a patient's care because those improvements can lead to more office and

virtual visits, diagnostic tests, home health services, or technology for remote monitoring. These are often the interventions that prevent emergency department visits and hospitalization admissions but may increase costs in the short term.

The College is very concerned about the inclusion of Part D medications and potential unintended consequences related to them. For fee-for-service Medicare beneficiaries, access to prescription medications varies widely, with many patients relying on supplemental coverage such as Medicaid or employer-sponsored retiree drug plans or otherwise paying out of pocket. In some cases, the ordering physician may provide limited samples or assist the patient in applying for a pharmaceutical manufacturer's patient assistance program.

The College strongly supports GDMT for HFrEF patients as outlined in the *2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure*, which recommends these four drug classes: renin-angiotensin-aldosterone system (RAS) inhibitors or angiotensin receptor-neprilysin inhibitors (ARNI), beta-blockers (BBs), mineralocorticoid-receptor antagonists (MRAs), and sodium-glucose cotransporter-2 (SGLT2) inhibitors. The guideline mentions that these "four pillars" of therapy work together to improve heart function, reduce hospitalizations, and decrease mortality by lowering the heart's workload and altering the progression of the disease.

Of the four drug classes, at least two can have significant patient costs and copays with and without prescription coverage, which can obstruct or halt the patient's ability to follow the recommended HF therapy. Furthermore, these variations in prescription coverage will cause fluctuations in the ASM HF costs of care. Those patients with adequate Part D coverage will count towards the patient's annual ASM HF spend, while those with third-party medication coverage or charity care will not be counted. This scenario may cause risk of penalty. There should be class-level adjustments or "carve outs" so that supporting GDMT does not worsen performance within the program. We recommend that CMS continue refining EBCM attribution, exclusions, and risk adjustment to ensure they reflect the nuances between cost and clinical appropriateness, especially in high-risk populations such as older adults with multiple comorbidities.

Additionally, the HF EBCM may not yet fully account for patient severity beyond HCC codes, such as frailty or social risk; region-specific care patterns (e.g., differences in access to post-acute care); and changes to outpatient care plans, which can increase costs but improve outcomes. We ask CMS to consider publishing more detail on how risk adjustment differs between MIPS/MVP and ASM versions of this measure, and whether additional refinements are being considered to avoid penalizing clinicians who take on more complex patients or improve care access.

Next, the College request clarification on how benchmarking will be applied when the same measure is used in different models but with distinct clinician populations. Specifically, the HF cost measure was originally developed across a broad base, including attribution to other clinicians. In measure testing, the top five attributed specialties (percent of all episodes) were: cardiology (54.1%), internal medicine (14.8%), interventional cardiology (7.9%), cardiac EP (7.9%), and family practice (5.7%). While cardiology carries the majority of attributed episodes, the distribution across a range of

specialties demonstrates that this measure impacts a broad set of clinicians beyond the primary specialty. CMS could show how benchmarks shift to illustrate these differences.

Benchmarking that compares only cardiologists could make the rankings higher or lower than they should be, especially for individual clinicians, which could make scores less consistent and possibly misleading. We recommend CMS share these effects, particularly since the proposed methodology is designed with performance bands relative to median costs ± standard deviations. During measure testing, the measure did meet the "high" reliability threshold at the TIN level (0.71 at a 20-case threshold), reliability at the individual clinician (TIN-NPI) level was lower at 0.62. This falls below CMS' 0.7 "high" reliability threshold, indicating that a meaningful proportion of variation in scores at the individual level is attributable to statistical noise rather than true differences in performance. Using a measure with only moderate reliability for high-stakes individual scoring could lead to misleading conclusions and unintended consequences.

CMS should also consider that the cost measure includes patients with preserved ejection fraction and not reduced ejection fraction as referenced in the two medication quality measures. CMS should either stratify the costs results by EF phenotype or add HFpEF-appropriate quality measures. If CMS intends to move forward, we strongly encourage development of a more granular, specialty-specific benchmarking approach that reflects clinical realities and avoids applying measures validated in one population to another with different practice patterns and patient profiles.

Proposed Improvement Activities

We understand CMS's aim to strengthen coordination between specialty and primary care and to ensure health-related social needs are addressed. These are the right priorities for patients with chronic cardiovascular disease. To be successful, however, the activities should align with how specialty teams work daily, minimize new documentation burden, and avoid holding specialists accountable for tasks that are more suitable for primary care. We offer the following comments on the two improvement activities:

Improvement Activity 1 (IA-1): Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening

Specialists can confirm the PCP on file, share a visit summary, and verify whether an annual HRSN screen exists, but should not be expected to conduct or manage HRSN screening in full. There should be clear exceptions, so specialists aren't penalized if a patient declines a PCP, lives in a PCP shortage area, or the PCP declines the screening. Also, a clinician should receive full credit via simple proof from the EHR/HIE plus a visit summary sent to the primary care physician within "X" number of days. This would avoid requiring the clinician to submit lengthy narratives. CMS could advise which HSRN screening tools are acceptable and provide the appropriate documentation so vendors can integrate these tools into a clinician's workflow.

Improvement Activity 2 (IA-2): Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements

Many specialists share patients with dozens of PCP groups. CMS should allow one CCA at the TIN or health-system level to satisfy IA-2, rather than separate agreements with each PCP office. In addition, specialists should not be penalized for PCP action nor inaction. Credit should be applied only to what the specialist can control and not whether the PCP responds.

The College strongly encourages CMS and CMMI to develop improvement activities with real-time actionable data that permits the physician and their care team to review and provide real-time data to improve patient care and/or office protocols. Similar to BPCI-Advanced, MIPS, and MVPs, physician and patient attribution data from the ASM will not be available for review until two years after the performance year. Physicians caring for HF patients can be much more impactful and improve patient outcomes with current, actionable data. Typical data delays can be frustrating when seeing information from the past which could have improved a patient's care.

Promoting Interoperability

The College appreciates CMS following the well-established MIPS process for this performance category. As the model progresses over the performance years, we request a review of this category's usefulness for improving care for HF patients along with saving costs for the Medicare system.

Performance Category Weights and Scoring

Requirements to Receive a Final Score

Cost and Quality Weighting: We recognize CMS's goal of aligning incentives around cost containment and clinical outcomes through equal weighting of cost and quality categories (50% each). However, cardiologists may face challenges such as patient complexity, referral patterns, or post-acute care needs, especially given the nature of HF. Assigning 50% of the final score to cost is a significant departure from MIPS and MVP frameworks. This high-cost weighting may inadvertently penalize providers delivering guideline-directed, necessary care. In addition, the corresponding quality measures are highly limited in terms of contextualizing the costs. When cost measures dominate the final score without balancing outcome or appropriateness measures, the model risks promoting cost-cutting over clinical quality. The high-cost weight could disincentivize participation in managing complex patients. CMS could lower the cost weight to 30%, then raise it in increments over time. Also, since the IA and PI categories function solely as compliance checks, the potential for large negative adjustments could undermine otherwise strong performers in the cost and quality categories. Some clinicians, for example, may face structural or operational barriers to meeting IA or PI requirements in full.

Lack of Reweighting: The proposal to avoid reweighting and instead issue neutral payment adjustments when scores cannot be generated (due to case minimums or data availability) may reduce

administrative complexity but limits flexibility. In cases where valid quality or cost scores cannot be produced, we suggest allowing participants the opportunity to supplement with available IA or PI scores to avoid being entirely unscored.

Complex Patient Scoring Adjustments

We support the inclusion of a complex patient scoring adjustment based on HCC scores and dual-eligible proportion, as it acknowledges the real-world challenge of caring for patients with significant medical and social risk factors. However, we note that the adjustment applies only at the final score level and does not influence individual performance categories, such as cost or quality. As a result, the scoring still risks penalizing clinicians whose quality or cost performance is negatively impacted by patient complexity.

HCC and dual-eligible status may not fully capture medical or social complexity. For example, patients with HF and multiple co-morbidities (e.g., cognitive impairment, frailty) may not have high HCC scores if diagnoses are not fully coded or incomplete. High-volume or hospital-based clinicians where hospital coders, not clinicians, determine how conditions are documented could be prone to incomplete documentation.

The proposed threshold of limiting the bonus only to those above the median may exclude clinicians serving moderately complex populations who may also experience significant care management burdens. We encourage CMS to improve transparency by clearly reporting how the adjustment is calculated and how clinicians can reduce risk. Given the high 50% weight assigned to cost performance in the ASM, we recommend evaluating whether the 10-point cap on this adjustment is sufficient to meaningfully offset penalties for those treating disproportionately high-risk populations.

Small Practice Scoring Adjustments

We support the proposed 10-point bonus for small practices and 15-point bonus for solo practitioners. This simple, transparent approach appropriately is a fair compromise for known disparities in reporting infrastructure, staffing, and capacity. Many rural cardiologists operate in small settings and this adjustment may be essential to keep them participating in the ASM. This is important given the high-cost performance weight (50%) and technological demands of reporting MVP-aligned quality measures. We understand CMS's rationale for not including a rural adjustment on top of the small practice bonus but recommend CMS monitor performance by geography in the early years of ASM to ensure rural practices are not disproportionately harmed.

Based on the 2023PY PUF data released earlier this year, solo practitioners had the lowest mean score (53.64) and the highest average penalty (-2.89%). They are also less likely to report or engage in MVPs and thus may be disproportionately penalized under a mandatory model like ASM. CMS should conduct impact modeling by practice size and location to avoid exacerbating disparities.

Final Score Calculation

Concentrating 100% of the base score in Quality and Cost for a relatively small heart-failure panel, then layering mostly negative "adjustments," creates volatility and departs from clinicians' MIPS/MVP experience. **The College suggests phasing in the Cost weight and applying a**

reasonable year-over-year glidepath to limit large swings; treating Improvement Activities and Promoting Interoperability as positive credit only (not deductions); adding reliability and volume safeguards that reweight when measure reliability is low or case counts are small (or allow TIN-level scoring); and publishing clear, detailed formulas, benchmarks, and reference populations. Finally, a pilot year is needed so clinicians can validate attribution and scoring before any payment risk applies.

Proposed ASM Payment Approach

Payment Approach

The College has identified potential issues with the proposed ASM payment approach. While several payment determining factors resemble those used in MIPS or other value-based purchasing programs that clinicians may already be familiar with, we have also identified significant differences that could hinder participants' ability to financially succeed in the model.

We believe that all ACC members who would be assigned to participate in the model can improve quality of care within the model and should be rewarded for improvements. Our membership prioritizes collaboration, often contributing their time, research, scholarship, and clinical insights to ensure all clinicians have the needed resources to provide optimal cardiovascular care. Given this priority, the College questions whether using a care model to drive competition between providers will result in nationwide collective care improvements for Medicare patients. This is especially troubling if the model financially punishes clinicians who are demonstrating improved care and saved cost, yet not realizing financial rewards due to competition built into the model. The ACC encourages CMS to consider potential unintended consequences such as clinician burnout, shifts of employment type, adverse patient selection, and decreased specialist collaboration during initial rulemaking rather than solely in a review period when unintended consequences might already have occurred.

Comparison of ASM Participant Performance

The ACC is supportive of the proposal that incentive pools and scoring should be distinct and separate for the Heart Failure and Lower Back Pain cohort. Comparisons made across two completely different chronic conditions would do little to inform participants or CMS about best practices that could lead to success in the model, savings for CMS, and improved patient care. The College notes that even within the HF cohort, fair comparison of participants is challenging.

The model should ensure fair attribution and reasonable risk. As was demonstrated in the cost measure testing, the 20 minimum case threshold should be sufficient for reliability. As we previously noted, while 20 episodes may be a reasonable starting point, it may not adequately reflect the variability in cardiologists' practice patterns across rural, urban, or hospital-based settings. Risk adjustment should include protection from outliers and ensure that there is a limited band for risk and a cap on the amount, so one atypical case does not disproportionately affect payment. Clinicians should have clear attribution rules, the ability to review/appeal patient panels, and transparent performance reports.

The ACC is troubled that cardiologists in the ASM will not have an established score that could be achieved to prevent the financial penalty. A performance threshold as utilized in MIPS to avoid penalty is needed in the ASM. The proposed approach does not reward high value care unless other clinicians in the cohort provide less high value care. A cardiologist earning top scores in quality, and no loss of points in improvement activities and promoting interoperability can only improve by "winning" at cost. A race for the bottom of cost could jeopardize care. A clinician who excelled in other areas but has a high-cost score should not incur a financial penalty in the ASM if they achieved a set performance goal built into the model.

Participants are likely to struggle in the ASM's proposed "tournament style" in which clinicians are competing against one another toward an unknown goal. A potential solution would be to use the median determined by the exchange function during the previous model year to compare participants. With this established and published median, participants would know clearly at which score they are ensured of no financial penalty.

ASM Risk Level

The ACC strongly recommends that ASM clinicians have the option for a first performance year in which a clinician can opt for a track with no downside financial risk, and corresponding lesser up-side potential. Such glide paths have been used in other CMMI models and have served to increase participant understanding of the model and its nuances. The ACC believes this is particularly important in the ASM, a mandatory model which is likely to include some clinicians with very little awareness and experience in care model participation. The ACC opposes the proposed increases to ASM risk levels in model years 3-5. The College believes risk level is another area where it is appropriate to mirror the MIPS program, with maximum penalties to clinicians of 9% in any model year. Later model years with proposed risk levels of 10-12% applied to the entirety of a participant's Part B claim is extreme and untested in other programs, even programs with voluntary participation. The ACC supports a steady risk level of 9% throughout the ASM test period.

ASM Redistribution Percentage

The ACC strongly opposes the proposed use of an ASM redistribution pool which would withhold a proposed 15% of the pool rather than distributing the pool in its entirety back to clinicians at risk in the model. As proposed, the collective of cardiologists in the model will experience a 1.3% decrease in their ASM payment adjustments in the model's first payment year with increases to as high as 1.8% if, as proposed, risk levels increase by the final model year. While clinicians could succeed in the model, as proposed this redistribution pool puts randomly selected mandatory participants at additional and unjust financial risk to build in cost savings for CMS. Like the MIPS program, the ASM should be budget neutral. We believe cardiologists in the model will succeed in reducing the cost of care to their HF patients and this will produce savings for CMS. Building CMS cost savings into the ASM by withholding any percentage from redistribution to participants is not an appropriate test of the model and its success.

Exchange Function

As CMS calculates ASM payment adjustments for participants, ACC suggests a cautious approach. As MIPS is the QPP program most familiar to cardiologists, CMS should utilize similar functions and calculation of payments in the ASM, a model largely built on MIPS structure. The College sees value in the use of a linear exchange function, not only for its familiarity but in the protection it could provide participants. The College opposes the use of a logistic exchange function for its lack of familiarity and for its selection for the purpose of pushing towards the extremes of payment adjustments in the model. As noted above, the College questions whether driving competition and high percentage payment adjustments will inherently improve care for the whole of Medicare HF patients. Accessible cardiovascular care is vital. The ASM should avoid driving a large number of the highest allowable financial penalties which might shutter practices, spur early clinician retirement, exacerbate clinician burnout or drive clinicians outside of rural settings and jeopardize this access.

Proposed Timely Error Notice Process

In regard to the notification of payment adjustment, we appreciate that CMS has a process for model participants to review their performance and appeal errors in data or calculations used to determine payments. The College believes that the 60-day window of the Quality Payment Program allotted for participants in the MIPS program should be mirrored in the ASM. Not only has a 60-day review timeline been standardized in MIPS, a 30-day window could inhibit a participant's thorough review.

Proposed Waivers of Medicare Program Requirements

The College appreciates CMS's consideration of waivers to facilitate success for participants in the ASM. We strongly support waiving MIPS participation for ASM participants for relieving reporting burden and allowing participants in the ASM to adjust focus to new reporting requirements. We believe this waiver should apply to any ASM participant identified for a model year, throughout the full course of any year they are identified as ASM participants.

The College is equally supportive of the proposed telehealth waivers which will help participants provide timely and efficient care to their patients. We believe these waivers are likely to help participants provide quality and cost-effective care to patients. Additionally, we recognize telehealth often enables access and care in a location patients prefer and believe this waiver could help achieve the College and agency's shared goal of prioritizing patient experience. The College notes that should expansion of telehealth services for Medicare patients be enacted by federal law, ASM participants' telehealth waiver should be no less restrictive than allowed by law.

We are generally supportive of the proposed ASM beneficiary incentives as the College believes that patients who take an active role in monitoring their HF benefit. Providing access to patient monitoring tools which enable this could drive improved results in the ASM. The College encourages CMS to reconsider the structure of this proposed beneficiary incentive. Clinician financed incentives could be problematic given varying practice resources and accessibility. We propose that all eligible patients in the ASM be provided with Medicare supplied blood pressure cuff, weight scales and other risk measurement tools to enable their active role in self-monitoring

HF. This equipment can potentially reduce the need for emergent care and hospital admission. Additionally, the ACC notes that previous models, such as the Enhancing Oncology Model, provide additional payments to specialists to support enhanced services. If specialists are to supply beneficiary incentives, CMS financial support for beneficiary incentives should be included.