AMERICAN COLLEGE of CARDIOLOGY

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August 25, 2026

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

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots

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 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment system (OPPS) policies addressed in the proposed rule. The College's comments will focus primarily on ambulatory payment classifications (APCs), software as a medical device, the inpatient only (IPO) list, the covered procedures list (CPL), the 340B program, and the hospital and ASC quality reporting programs.

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.

Proposed Updates Affecting OPPS Payments

Diagnostic Radiopharmaceutical Packaging Threshold Update

In CY2025 rulemaking CMS established a threshold of $630 per day cost of diagnostic radiopharmaceuticals above which these materials would be reimbursed separately. This threshold was to

be adjusted in future rulemaking based on the producer price index (PPI) for pharmaceuticals for human use, prescription (BLS series code WPUSI07003). In following this plan, the threshold for diagnostic radiopharmaceuticals per day use was raised to $655 for CY2026 and is proposed to be raised to $665 for CY2027. **The College supports this proposed increase and appreciates recognition of inflation on medical costs.**

Proposed OPPS APC Group Policies

Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies

The Nuclear Medicine and Related Services APC series was created as part of the broader APC restructuring and consolidation in the CY 2016 OPPS/ASC final rule. With the change to pay separately for diagnostic radiopharmaceuticals with estimated per day costs higher than a packaging threshold specific to diagnostic radiopharmaceuticals, the estimated cost of services assigned to the Nuclear Medicine and Related Services APC series across the various APC levels became less distinct, particularly between Levels 3 and 4. Given the relative proximity of the APC geometric mean costs and the clinical and cost similarities of the services between the APCs in the Nuclear Medicine and Related Services series, CMS proposes to reorganize the Nuclear Medicine and Related Services APC series.
Cardiac PET codes 78431-78433 had for many years been assigned to new technology APCs as CMS aptly recognized that the most clinically aligned nuclear medicine APCs (5591-5594) did not adequately address the resource costs of these services. However, the restructuring proposed to the nuclear medicine APCs in this rule would make APC assignment appropriate for these cardiac PET services, which is what CMS proposes. For CY2026 CPT codes 78431 and 78433 were assigned to APC 1522 with a payment rate of $2,250.50. CPT code 78432 was assigned to APC 1517 with a payment rate of $1,550.50. CMS proposes to reassign all three codes to Level 4 Nuclear Medicine and Related Services APC 5594 with a proposed payment rate of $2,452.09.

The ACC has argued in multiple prior rulemaking comments that CPT code 78432, being of greater resource usage than 78431, should never have been assigned to a lower paying APC. **As such, the College supports the proposed reassignment of the cardiac PET codes 78431, 78432, and 78433 to Level 4 Nuclear Medicine and Related Services APC 5594.** More broadly, the restructuring of the APC series appears to restore reasonable distinction between the different APC levels without massive disruption to high-volume services or notable violations of the two-times rule, and support for incorporation of these PET codes into clinical APCs hinges on **finalizing other changes to the APC family which amended the reimbursement to be suitable for these services.**
LimFlow TADB procedure CPT Code 0620T

The ACC supports the proposed reassignment of CPT code 0620T from new technology APC 1580 with a payment rate of $45,000.50 to new technology APC 1581 with a payment rate of $55,000.50 based on the latest available cost data.

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT/CPT Code 75577)

Coronary atherosclerotic plaque assessment via CPT Category III code 0625T had been assigned to new

technology APC 1511 with a payment rate of $950.50. This service has been deleted by CPT and replaced with Category I code 75577. Given the absence of any data for the new CPT code 75577 and existing data for 0625T, CMS proposes to maintain the service in new technology APC 1511. **The College supports the proposed assignment of CPT code 75577 to new technology APC 1511.**

Fractional Flow Reserve Derived from Computed Tomography (FFRCT, CPT code 75580)

FFRCT, CPT code 75580, is among the SaMS codes being transitioned from standard APCs to new technology APCs in this proposed rule. 75580 is proposed to move from Level 4 Diagnostic Tests and Related Services APC 5724 to New Technology APC 1510 with a proposed payment rate of $850.50.

We believe FFRCT to have comparable resource usage and be clinically similar to CPT code 75577 which is proposed to be placed in New Technology APC 1511 with a payment rate of $950.50. **The College recommends CPT code 75580 for FFRCT be placed in New Technology APC 1511 for consistency**.

Cardiac Computed Tomography Angiography (CCTA – CPT Codes 75572-75574)

The ACC supports CMS's proposal to continue assigning cardiac computed tomography angiography services to APC 5572, Level 2 Imaging with Contrast. This assignment appropriately reflects the clinical complexity and resource requirements of cardiac computed tomography angiography, the only noninvasive test for suspected coronary artery disease with Class I, Level A evidence in the AHA and ACC chest pain guidelines.

Cardiac computed tomography angiography remains underutilized in the Medicare population, in part due to historical underpayment and billing restrictions. In prior years, hospitals were not permitted to bill with cardiology revenue codes, which distorted cost data and resulted in assignment to a lower-level APC. CMS appropriately corrected this issue in CY 2025 using its equitable adjustment authority. The College urges CMS to maintain APC 5572 assignment for CY 2027, continue applying equitable adjustment authority for several years as claims data stabilize, and issue clear program instructions confirming that cardiology revenue codes are appropriate for these services.

Leadless Pacemaker Services (0795T, 0796T, 0801T, 0802T, 0823T, 0824T)

CMS proposes APC assignment updates for four of six Category III CPT codes that describe dual-chamber leadless pacemaker procedures. All six are currently assigned to Level 4 Pacemaker APC 5224 with a payment rate of $21,369. Codes to report insertion of dual-chamber leadless pacemaker system (0795T) and removal and replacement of a dual-chamber leadless pacemaker system (0801T) are both proposed for placement in Level 2 ICD APC 5232 with a payment rate of $35,204. These services have geometric mean costs of $38,070 and $37,091, respectively. Codes to report insertion of a right atrial leadless pacemaker to upgrade to a dual-chamber system (0796T) or to insert a right atrial leadless pacemaker for single-chamber pacing (0823T) are both proposed for placement in Level 1 ICD APC 5231 with a payment rate of $25,052. These services have geometric mean costs of $29,675 and $25,089, respectively. The ACC appreciates CMS's responsiveness to incoming cost data and reassignment for these four services in a manner that is clinically coherent and places services with similar costs together.

For comprehensiveness and clinical consistency, the ACC suggests that codes to report removal and replacement of a single-chamber right atrial leadless pacemaker as a component of a dual-chamber system (0802T) and removal and replacement of a single-chamber right atrial leadless pacemaker for single-chamber pacing (0825T) should also be placed in APC 5231. These codes have similar costs for a new right atrial leadless pacemaker as codes 0796T and 0823T above. These services have geometric mean costs of $25,089 and $26,773, respectively, which also align well with 0796T and 0823T.

OPPS Payment for Devices

Transitional Pass-Through Applications

WiSE® CRT System

The ACC supports CMS in proposing to approve the WiSE® CRT System for device pass-through payment status for CY2027.

Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

340B Drug Program Amendments

CMS proposes to reduce Medicare Part B payments for certain separately payable outpatient drugs and biologicals acquired through the 340B Program requiring pharmaceutical manufacturers to sell outpatient drugs at discounts to eligible health care organizations and safety-net hospitals that serve low-income and uninsured patients. The proposal seeks to align OPPS drug payment for 340B hospitals with hospital acquisition costs the agency determined to be approximately 33.4% below the average sales price (ASP). This is a change from paying for 340B drugs at the generally applicable OPPS drug payment rate of ASP plus 6%. CMS estimates this change will reduce payment for 340B by $4.85 billion in 2027, savings that are redistributed to all hospitals paid under OPPS through increased rates for non-drug items and services and contribute to payment increases for many services.

The 340B program has grown significantly over time amid concerns that the program is not well targeted, does not share savings directly with patients, and incentivizes hospitals to make acquisitions to bolster revenue from 340B discounts. Nonetheless, revenue from 340B bolsters care for underserved populations as it was originally targeted toward disproportionate share hospitals and federally qualified health centers. These and other hospitals will generally see reductions from this redistributive policy while hospitals without significant 340B exposure will see only increases.

The ACC appreciates CMS's desire to pay accurately for drugs but suggests such a policy change could be made in a less drastic way to avoid harm to the hospitals originally intended to benefit from the program. A phase-in period of several years would give hospitals time to adapt to revenue shifts. Alternatively, other changes to narrow the scope of the program or increased transparency could also yield desirable policy outcomes with less disruption.

Services that Will Be Paid Only as Inpatient Services

In the CY2026 OPPS/ASC Final rule CMS codified its plan to eliminate the Inpatient Only list (IPO) over a three-year transition period with the list being fully terminated by January 1, 2029. 285 procedures were removed from the IPO list in the CY2026 OPPS/ASC Final rule. The CY2027 proposed rule would remove 637 of the remaining 1,438 services on the list. CMS proposes to leave what it deems to be the most complex procedures, including neurological, cardiovascular, solid organ, intestinal, and islet cell transplants, for the final phase of transition away from the IPO list. CMS has also solicited feedback on whether the transition of these final, more complex procedures warrant restructure of existing or creation of new APCs or C-APCs to allow for efficient OPPS payment for these services.

The ACC appreciates the agency recognizing the complexity of cardiovascular care and supports cardiovascular services being included in the final group of codes to transition off the IPO list. We do firmly believe that APC restructuring as well as creation of new APCs and/or C-APCs will be necessary to appropriately transition former IPO cardiovascular services to the OPPS payment system.

While CMS has stated its intent to phase out the IPO list over 3 years, the agency also notes that it plans for the list to be entirely eliminated by January 1, 2029. **The ACC recommends CMS issue proposed APC assignments as an RFI in the CY2028 OPPS rule along with detailed suggested amendments to the APCs/C-APCs to accommodate the transition of this last block of more complex services to inform final proposals in the CY2029 OPPS rule.** This would allow maximum time both for stakeholders and CMS to consider the intricacies of this transition and provide opportunities for stakeholders to comment on the initial proposal as well as any amendments made by the agency in response to feedback prior to finalization. This would also align with the stated deadline of January 1, 2029 for full elimination of the IPO list.

Nonrecurring Policy Changes

Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

CMS explains concerns about the volume growth of non-contrast imaging services provided in excepted off-campus PBDs and a belief that disproportionate growth in this setting stems from financial incentives rather than clinical considerations or anything related to the medical severity of the patient population treated in excepted off-campus PBDs. CMS notes that nonexcepted PBDs outnumber excepted PBDs about four to one, yet excepted PBDs accounted for about 80% of the total PBD volume of key services.

CMS proposes to extend a policy deployed in recent years to address perceived unnecessary volume increases to these services by lowering payment for any service codes assigned to the imaging without contrast ambulatory payment classifications (APCs) 5521, 5522, 5523, and 5524 and for multiple imaging composite APCs, 8004, 8005, and 8007 when provided at an off-campus PBDs excepted from section 603 of the Bipartisan Budget Act of 2015. In 2027, these services would receive Physician Fee Schedule equivalent payment rate of 40% of the amount that would otherwise be paid by OPPS.

The ACC appreciates the analysis and explanations provided by CMS in the proposed rule underpinning this proposal. **However, the College urges CMS to halt this proposal that would abruptly make large payment cuts that will diminish patient access, quality and value of care**. Volume trends and payment differentials alone do not indicate that services furnished in excepted PBDs are clinically unnecessary. The trends may indicate something, but this policy that affects all services in the APCs is too blunt and will harm complex care provided at OPDs. The lack of contrast in these services is a poor marker of clinical complexity, resource utilization, and imaging expertise. Specialized cardiovascular programs treat structural heart disease, hypertrophic cardiomyopathy, cardiac rhythm disorders, cardiac amyloidosis, cardio-obstetrics, and more in off-campus PBDs to bring care closer to patients. Patients seen in these venues are similar to those seen on the main campus.

It is also not clear that the PFS-equivalent rate would be sufficient to support safe, coordinated cardiovascular diagnostic care in that setting. Payment differences across sites should be related to documented differences in the resources needed to ensure patient access and high-quality care. Payment rates must account for costs related to emergency capacity, compliance with regulatory requirements, geographic differences, quality improvement activities, higher need populations, or other relevant factors.

Rather than implement this policy, CMS should first explore considerations such as clinical indications, patient characteristics, referral sources, geographic access, care coordination needs, and outcomes at the individual service level to inform future policies. These factors may demonstrate clinical reasons care has grown in OPDs differently than on hospital campuses. Tools such as accreditation, claims review, and others could also be utilized to address concerns about site volumes.

Should CMS opt to finalize this policy despite concerns from stakeholders, the College urges caution so changes do not diminish patient access, quality and value of care. A significant payment reduction of this nature could immediately disrupt care patterns. **As with other significant payment changes, new policies to address payment disparities between sites of service should be phased in over multiple years to safeguard the stability of the health care system.** For example, in 2019 CMS phased in a similar reduction in payment for clinic services over two years. A similar approach here would allow stakeholders to assess the financial impact of changes on the stability of the health care system and adapt. This will be particularly important for those providing care to underserved populations. CMS acknowledges the disruptive nature of the proposal since it includes an exemption for rural sole community hospitals from the policy.

CMS should also work to avoid unintended consequences from this change. One element of the proposal that appears problematic based on the text is that some services would be paid less than the PFS rate. As the PFS relativity adjuster reduces payment to 40% of the amount that would otherwise be paid by OPPS, there are instances where the policy would reduce payment for these services provided under the OPPS below the rate paid by the PFS for the same service. For example, an extracranial bilateral ultrasound study reported with code 93880 would be paid $271.13 under its standard APC rate and $108.45 under the proposed site-neutral rate of 40% of the APC. The technical payment under PFS is proposed to be $154.02. It is concerning that CMS explains the Deficit Reduction Act of 2005 only applies to services paid under the PFS, limiting payment to the lesser of the PFS or OPPS amount but does not affect payment for services furnished in PBDs. It appears CMS is saying that the PFS should not be considered a floor and

that OPPS payments would be allowed to be lower the PFS. **CMS should not allow the PFS-relativity-adjusted OPPS rate to fall below the actual PFS rate in instances where the 40% formula would create that outcome.**

OPPS Payments for Software as a Medical Service

Software as a Service (SaaS) has been discussed in several prior rulemaking cycles. CMS notes the rapid development of software-based technologies with novel functionalities, including artificial intelligence, that can support clinical decision-making in the outpatient and physician office settings. Seeking to avoid terminology confusion with other industries that also refer to SaaS for various cloud computing service models, CMS proposes to update its terminology to "Software as a Medical Service." (SaMS) The ACC understands the desire for clarity and believes the suggested terminology update helpfully and appropriately makes the sought distinction for the purposes of Medicare payment policy. It is also good to see consistency in this space, as the same terminology is proposed in the Medicare physician fee schedule proposed rule.

However, the proposed description of SaMS encompasses technologies that may perform substantially different clinical functions, such as image analysis, risk prediction, computer-aided detection, clinical decision support, and diagnostic analysis. As such, ACC recommends that CMS clarify the specific criteria it plans to use in determining whether a service qualifies as SaMS. Additionally, CMS should avoid grouping varying services together solely because they rely on software and computational analysis. In certain cases, a physician may need to assess whether the technology is appropriate for an individual patient, review the underlying clinical information, interpret the output, and then incorporate it into the diagnosis and treatment plan. The SaMS designation should not imply that software replaces physician judgement or encompasses the entirety of the clinical service provided.

More significantly, CMS describes longstanding efforts to develop a comprehensive and consistent approach to SaMS payment, given the novel and evolving nature of SaMS technologies. The ACC has responded to two prior requests for information on the topic in prior rulemaking cycles and recognizes that challenges remain regarding how best to structure payment. It is encouraging to see CMS note that, "current Medicare Part B payment systems for SaMS, including in the OPPS, are primarily designed to pay for services that rely on material resources, rather than technologies whose value is driven by proprietary algorithms and scalable, non-material costs. This creates difficulties in establishing appropriate valuation methodologies, as the current cost-based system often offers only limited transparency into underlying costs and may not effectively constrain pricing. Another challenge is determining how to account for the various ways in which these technologies are acquired and billed by hospital OPDs, particularly in cases with subscription- or license-based arrangements, as well as per-use or "per-click" fees, which raises concerns regarding program integrity." These observations echo prior ACC comments and offer encouragement that CMS is on a path to developing a payment mechanism that allows for adoption of new tools without creating an environment of many similar SaMS technologies seeking unique billing codes for proprietary algorithms that all operate on the same underlying data/inputs.

The ACC reiterates concern that the potential growth and cost of SaMS will rapidly increase and consume scarce health care resources. SaMS pricing models include subscription, usage-based, tiered, freemium, per-user, and flat-rate. It remains uncertain what constitutes an appropriate mechanism to set pricing for these

services. In every instance with which ACC is familiar, it is unknown what determines the price a facility or practice is billed for an individual SaMS. Beyond the traditional components of supplies, equipment, and labor, the price of a unit of SaMS analysis appears to be a black box for which derivation of the invoiced price is unknown. It may well prove necessary to require SaMS vendors to submit documentation of costs and pricing in some manner in order for these services to be reimbursable by Medicare.

For now, CMS proposes an interim payment policy in this rule to separately identify SaMSs. Fifty services would be identified through a new status indicator (O1) and separately paid using New Technology APC assignments. Twenty-six services would be moved from their current clinical APC assignments. CMS requests feedback on whether the new payment indicator O1 should function the same way as status indicator "S" or status indicator "T". The College supports the new "O1" status indicator for SaMS procedures having the same payment specifications as status indicator "S," allowing separate payment without a multiple procedure reduction. The College opposes the alternative on which CMS also requested comment, applying "T" status indicator treatment to "O1" services, which would not reflect the independent clinical value of these services and would risk underpayment that could compromise patient access. **CMS should finalize "S"-equivalent treatment for "O1" status indicator procedures.**

As the payment rates for the services in New Technology APCs approximate those of the clinical APC assignments, and CMS also proposes not to make changes to packaged services, this change appears a reasonable interim step to separately designate SaMS. The ACC is prepared to share additional feedback at any point and will look for additional policy proposals in future rulemaking by CMS.

Provisions of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR) and Pulmonary Rehabilitation (PR) Services to Hospital Outpatients in their Homes Via Audio and Video Real-Time Communications Technology

The College appreciates the agency recognizing cardiac rehabilitation and related services being allowed for hospital outpatients in their homes via audio/video real-time communications through December 31, 2027 under Section 6211 of the Consolidated Appropriations Act, 2026 and providing clarity via the updated FAQ at *https://www.cms.gov/medicare/coverage/telehealth*.

Hospital Outpatient Quality Reporting (OQR) Program

Proposed Updates to the Validation of Hospital Outpatient Quality Reporting Program Data
CMS proposes to add electronic clinical quality measure (eCQM) validation to the Hospital OQR Program and require hospitals selected for validation to meet a 75% accuracy threshold on both chart-abstracted measures and eCQMs to maintain compliance and avoid payment penalties.

ACC supports efforts to validate eCQMs and improve the accuracy and reliability of electronically reported quality data but encourages a gradual and thoughtful implementation approach. As CMS begins validating the ST-elevated myocardial infarction (STEMI) eCQM, the agency should ensure that validation methodologies adequately account for the complexity of emergency cardiovascular care workflows, including data originating from emergency medical service systems, transferring facilities, emergency departments, and cardiac catheterization laboratories. Because failure of the validation standard could

result in OQR program failure and loss of the full OPPS annual payment update, CMS should initially use validation results for educational and improvement purposes before imposing significant payment consequences.

ACC also recommends that CMS distinguish discrepancies attributable to clinical documentation from those resulting from EHR configuration, interoperability limitations, or health IT vendor software issues when developing validation methodologies and calculating hospital scores. Hospitals should not be held financially accountable for discrepancies arising from technology or interoperability failures outside of their control, provided they have exercised appropriate oversight and made good-faith efforts to identify and address such issues. Finally, CMS should continue to monitor reporting burden and provide sufficient implementation support as hospitals transition to expanded eCQM validation requirements.

Ambulatory Surgical Center (ASC) Quality Reporting Program

Request for Information on Stratification of the All-Cause Transfer/Admission Measure in the ASC Quality Reporting Program

As cardiovascular care increasingly shifts from hospital outpatient departments to ASCs and other outpatient settings, the ability to accurately assess and interpret quality and safety outcomes in these settings becomes increasingly important. Advances in technology, procedural techniques, anesthesia, and same-day recovery pathways have enabled a growing number of cardiovascular procedures to be safely performed outside the traditional hospital setting. These procedures are expected to continue to grow over the coming years.

At the same time, CMS policies have expanded reimbursement opportunities for selected cardiovascular procedures in ASCs, contributing to continued growth in the use of these facilities. These include peripheral vascular interventions, cardiac implantable devices, electrophysiologic ablation, and percutaneous coronary intervention. Quality measurement approaches must also evolve to ensure that transfer and admission measures provide clinically meaningful, actionable, and appropriately contextualized information for patients, clinicians, and policymakers.

ACC generally supports the exploration of the phase-of-care stratification for the All-Cause Transfer/Admission measure, as the timing of a transfer can provide important context regarding patient safety, procedural risk, and care delivery processes. Implementation of this stratification will allow for better attribution of quality and safety. A patient sent to the hospital before a procedure because newly identified symptoms suggest acute coronary syndrome, decompensated heart failure, severe hypertension, or arrhythmia is different from a patient experiencing an intra-procedural complication. Thus, stratification could prevent appropriately cautious clinical decision-making from being interpreted as poor ASC performance. Also, transfers during a pre-procedure assessment may be interpreted as a successful safety process rather than a quality failure. Knowing when a transfer occurs might provide better insights into where improvement opportunities exist.

However, there are concerns about the potential for increased documentation and reporting burden, as ASCs will likely need additional processes to identify and document when a transfer occurs. Additionally,

consumers may misinterpret or misunderstand results, whereby a higher rate might reflect poor quality rather than good screening practices. If transfer rate volumes are small, this could also lead to small denominators and unreliable rates. As with many transfer and readmission measures, there is also the potential to discourage ASCs from treating medically appropriate patients with greater clinical complexity.

We recommend defining the procedural phases as follows: pre-procedure encompasses the time from patient arrival at the facility until the administration of sedation or anesthesia; intra-procedure encompasses the time from the initiation of sedation or anesthesia until the patient leaves the catheterization lab, operating room, or other procedural setting; and post-procedure encompasses the period from transfer to a recovery area through patient discharge.
As CMS considers refinements to the All-Cause Transfer/Admission Measure, we encourage the agency to draw on the National Cardiovascular Data Registry® (NCDR®) CV ASC Registry Suite, which currently collects and benchmarks discharge outcomes for diagnostic coronary angiography, PCI, and electrophysiology device procedures performed in ASCs. The registry's ongoing work measuring transfer-related outcomes can help inform clinically meaningful and operationally feasible approaches to measure refinement and phase-of-care stratification. Beginning in 2027, NCDR® will further enhance reporting through the collection of data elements related to canceled or aborted procedures, circumstances leading to transfers, and the phase of care at which transfers occur. These efforts reflect the clinical importance of distinguishing transfers that arise from appropriate patient assessment and safety protocols from those associated with procedural complications. Our cardiovascular registry data demonstrate that emergency transfers are uncommon but remain an important indicator of patient safety and appropriate escalation of care.

In sum, ACC generally supports exploration of phase-of-care stratification for the All-Cause Transfer/Admission measure, as the timing of a transfer can provide important context regarding patient safety, procedural risk, and care delivery processes. In particular, transfers identified during pre-procedure evaluation may reflect appropriate patient assessment and escalation rather than deficiencies in ASC performance. CMS should ensure that any stratification framework uses clinically meaningful definitions, minimizes reporting burden, maintains statistical reliability, and does not create incentives to avoid patients who are clinically appropriate for ASC-based cardiovascular procedures, but may have greater medical complexity than patients undergoing other common ASC services.

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