



September 3, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; CY2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare Economic Index Updates; and Quality Payment Program Updates

Submitted via www.regulations.gov

Dear Administrator Brooks-LaSure:

The American College of Cardiology (ACC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the CY2023 Physician Fee Schedule and Other Changes to Part B Payment Policies proposed rule. The College's comments focus on multiple code specific values, changes to valuations methodologies including PE/PLI RVU's and the Medicare Economic Index (MEI), the Medicare Shared Savings Program (MSSP), the Quality Payment Program (QPP) and the continued integration of interoperable health information technology. The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 56,000 members is to transform cardiovascular care and to improve heart health. The ACC bestows credentials upon cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards, and guidelines. The College also provides professional medical education, disseminates cardiovascular research through its world renowned JACC Journals, operates national registries to measure and improve care, and offers cardiovascular accreditation to hospitals and institutions. For more, visit acc.org.

Code Specific Values

Cardiac Ablation

The American Medical Association (AMA) Relative Value Scale Update Committee (RUC) identified CPT code 93656 with Medicare utilization over 10,000 that increased by at least 100% from 2014 through 2019. In January 2020, the RUC recommended to refer this issue to the CPT Editorial Panel in May 2020 for revision and bundling. Technology and clinical practice have changed since

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these codes were developed in 2011. Based on the billed together data for these and related codes, the specialty societies recommended referral to CPT to update code descriptors and likely bundle services now commonly performed together, such as 3D mapping. In October 2020, the CPT Editorial Panel revised one code (93653) to bundle with 3D mapping and to include “induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus,” and another (93656) to add 3D mapping and “left atrial pacing and recording from coronary sinus or left atrium” and “intracardiac echocardiography including imaging supervision and interpretation” to their descriptors.

The surveying specialties had submitted a letter to the CPT Editorial Panel in December 2020 requesting that the coding changes for these services to be rescinded for CPT 2022 due to the specialty’s concern that the RUC survey respondents may have been confused about the coding changes. In February 2021, the CPT Editorial Panel Executive Committee did not rescind their changes, which were among the coding changes for CPT 2022. Since the request to rescind the changes was not considered by CPT until after the January 2021 RUC meeting and January 2021 was the last RUC meeting of the CPT 2022 cycle, the RUC had recommended for these services to be valued as interim for CPT 2022 and that the codes would be resurveyed and reviewed at the April 2021 RUC meeting.

In the CY2023 MPFS, CMS proposes work RVU reductions to cardiac ablation services that are in addition to cuts already implemented in CY2022. The CY2023 proposed values are even lower than those recommended by the RUC to CMS. Reductions of this magnitude will have devastating consequences for patient access to these services and on the entire field of cardiac electrophysiology. The resulting payment cuts, including a 40% reduction from 2021 for the most affected service—atrial fibrillation (AF) ablation code 93656—will reshape care pathways for beneficiaries long into the future. **The ACC urges CMS to reconsider the work RVUs proposed for CY2023 and urges the agency to implement rates that recognize the complexity, intensity, risk to the patient, mental effort, additional years of training (since 2017, 2 years of fellowship training in addition to 3 years of general cardiology; other recognized sub-specialties are 1 additional year), and physical effort of the operator (including regular exposure to ionizing radiation) of these services.**

CMS noted in the proposed rule that summed times and values of the newly bundled services, 93653 and 93656) were much greater than the RUC proposals, suggesting it did not feel the new values are enough of a reduction commensurate with time. The values CMS proposes create work RVU reductions that are nearly linear with the reductions in time, which fails to recognize the increased intensity of these services. In one instance—code 93656 for AF ablation—the work RVU decrease is actually *larger* than the reduction in time. Such a result indicates that the proposed values are too low and fail to recognize the intensity of the services. As discussed in greater depth below, these services are more intense after the time reductions in the less intense portions of the procedures. The resulting bundled codes are more intense (more work per minute) than the individual codes done separately. The bundled codes are more intense because multitasking is required to perform the bundled services in parallel.

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It is also worth noting that cardiac arrhythmia disorders treated by ablation, such as atrial fibrillation (AF) disproportionately affect certain racial/ethnic minorities, particularly Blacks, Hispanics and Asians, as well as underserved communities where health disparities already exist. A recent study showed that Black and Hispanic Medicare patients with AF have a higher unadjusted risk of death (46% and 11%) and stroke (66% and 21%) than White patient.¹ The proposed further reductions would exacerbate access to treatment and put patient's health at risk.

Another unintended consequence of the payment cuts is the impact on the field of electrophysiology (EP). In the U.S. there are 3000 physicians certified in EP, while the number of patients with AF is expected to double from 6 million to 12 million by 2030. Due to the high-intensity and risk of ablation procedures, an aging work force, limited ACGME certified training positions, an additional two-years of EP training is required on top of 10 years of medical training for cardiology and internal medicine. EP fellowships are already facing unfilled slots because of the time commitment. This has disproportionately discouraged women from entering the field (less than 10% of electrophysiologists are women, although women represent approximately a quarter of all cardiology trainees). The steep reductions discouraging new cardiologists entering the sub-specialty, if implemented, will present another barrier to meeting the growing demand for these cost-effective, quality of life improving, and life-enhancing procedures.

The vast majority of EP's are employed by health systems, universities, or governmental agencies. Reduced physician reimbursement, compounded by general inflation and reduction in the conversion factor, creates a financial loss that is absorbed by these institutions that are already operating at small margins due to financial constraints caused by the COVID-19 pandemic. The shortage of EPs will also lead to narrow provider plan networks, further compromising the availability of timely access to ablation services. This is especially concerning in rural areas where provider shortages are already a challenge. We are concerned that CMS will not succeed in its efforts to advance health equity while inadvertently imposing access barriers to care at the same time.

93653 Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry.

CMS disagrees with the RUC recommendation of 15.00 work RVUs with an intra-service time of 120 minutes and total time of 199 minutes which was the 25th percentile of the RUC survey. The Agency instead proposes to use a comparator code of 37229, *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same*

¹ Tamirisa KP, Al-Khatib SM, Mohanty S, Han JK, Natale A, Gupta D, Russo AM, Al-Ahmad A, Gillis AM, Thomas KL. Racial and Ethnic Differences in the Management of Atrial Fibrillation. CJC Open. 2021 Sep 13;3(12 Suppl):S137-S148. doi: 10.1016/j.cjco.2021.09.004. PMID: 34993443; PMCID: PMC8712595.

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vessel, when performed, with a work RVU of 13.80, intra-service time of 120 minutes and total time of 188 minutes.

Comparison to this service is appropriate only insofar as it has an identical 120 minutes of intra-service time. What the comparison fails to incorporate is the differences in intensity for 93653. Both services are challenging, but ACC contends that a service performed directly on the beating heart is significantly more challenging and with greater risk than a service performed in an artery of a lower extremity. In addition to being a more intense service, 93653 typically involves 11 more minutes of total time which was not captured by CMS' proposal. 37229 is performed 75% of the time in the physician office setting rather than the facility setting. Comparison to codes with similar times that were identified by the RUC and societies are more instructive and more useful for relativity comparisons.

The actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much greater feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied, and has to incorporate all the real time intra-procedural imaging data that is captured in the bundled code. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now more efficient and effective, but also because of that, the risk of causing collateral injury from the energy delivered during the ablation is higher with each lesion treated. For instance, the ablation treatment is much more intense in terms of risk of heart block and esophageal injury; the risk of tamponade is 0.5% to 1%, sometimes leading to shock or arrest or emergency surgery. Furthermore, while the physician is obtaining many more data points to create the 3-dimensional map, the physician still needs to make sure every one of those points are accurate as review of points is not automated.

Code 93653 is typically the most intense service to perform among the three base codes in this family (93653, 93654 and 93656). CPT code 93653 is typically performed on a young patient who does not have other conditions and the ablation site occurs very close to the patient's innate conduction system. There is an approximately 0.5 percent to 1 percent risk of causing heart block requiring a permanent pacemaker; the risk of tamponade is .5% to 1%, sometimes leading to shock or arrest or emergency surgery. The time when the physician is applying radiofrequency energy is extraordinarily intense as opposed to the other two ablation services, 93654 and 93656, which are longer procedures on generally sicker patients and the intensity is more spread out over time.

To justify a value of 15.00, the RUC compared the survey code to top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that both services involve an identical amount of intra-service time and that 80 percent of the survey respondents who selected the top key reference code also indicated that the survey code is a

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more intense and complex procedure to perform. However, the reference code involves more total time. The RUC also compared the survey code to 2nd key reference code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, intra-service time of 90 minutes, total time of 183 minutes) and noted that the survey code involves much more intra-service time and somewhat more total time. 75 percent of the survey respondents who selected this reference code indicated the survey code was more intense and complex, however, the RUC recommendation of 15.00 has a lower intensity than the reference code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93653 should be valued at the 25th percentile work RVU as supported by the resurvey.

Out of concern that even the RUC recommendation fails to fully capture the intensity, complexity, and risk of this service, **the ACC urges CMS to apply the RUC survey median of 18.00 RVUs for 93653 based on additional supporting services and recognition of the intensity, complexity, and risk of the service.** With an intra-service time of 120 minutes, a total time of 199 minutes, and a survey median of 18.00 RVUs, 93653 is similar to codes 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* that has 120 minutes intra-service time and 210 minutes total time, and 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* that has 120 minutes intra-service time and 208 minutes total time. Each of these are catheter procedures in the cardiac space with work RVUs of 17.97 that support the median survey RVU of 18.00. This value accommodates a reduction for bundling and efficiency without aggressively pushing a 38%-cut in two years. At a minimum, the Agency should revert to the RUC recommendation of 15.00 RVUs.

93654 Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed.

CMS disagrees with the RUC recommended work RVU of 18.10 with 200 minutes of intra-service time and 291 minutes of total time for CPT code 93654. However, the Agency does agree with work RVU incremental increase from 93653 to 93654 of 3.10 RVU. CMS proposes a work RVU for CPT code 93654 of 16.90 – which is 3.10 RVU above the CMS recommended RVU for CPT code 93653 of 13.80.

As the CMS proposed valuation for 93654 is based on an RVU interval off the CMS proposed RVU for 93653 which the ACC has stated above was derived from an erroneous code comparison, the College also feels this value is incorrect. It is inconsistent for CMS to disregard the survey outcomes in one area—the 25th-percentile work RVU—but to adopt the survey values in another area—the

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increment of work between services at the 25th-percentile work RVU. If the survey is useful for setting an increment of value between services, it should also be relied upon to establish values at the 25th-percentile. Finally, comparison to codes with similar times that were identified by the RUC and societies are more instructive. As such, 93654 should remain 3.10 RVU above 93653, but at the RVU of 18.10 rather than 16.90.

The actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury; the risk of tamponade is .5% to 1%, sometimes leading to shock or arrest or emergency surgery. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

Ventricular tachycardia patients are the most complicated, often with hemodynamic instability and recurrent heart failure admissions. These patients typically have an implantable defibrillator. The defibrillator must be turned off prior to the procedure and the patient requires more pre-service evaluation time to make sure that they are hemodynamically stable prior to and throughout the procedure.

To justify a work value of 18.10, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 20 more minutes of intra-service time and 21 more minutes of total time. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200 minutes, total time of 355 minutes) and noted that although both services involve an identical amount of intra-service time, it would be appropriate to value the survey code somewhat lower due to the disparity in total time. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93654 should be valued at the 25th percentile work RVU as supported by the resurvey. **The ACC urges CMS to accept the RUC recommended work RVU of 18.10 for CPT code 93654.**

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a

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spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)

CMS disagrees with the RUC recommended work RVU of 7.00 for CPT code 93655 with 60 minutes of intra-service and total time which was the 25th percentile of the RUC survey. The Agency instead proposes a work RVU of 5.50 based on comparator CPT code 22854 (*Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect*), also with 60 minutes of intra-service and total time. The Agency believes this service is a better comparison code to 93655 than the RUC recommended CPT add-on code 93592 (*Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device*) with a work RVU of 8.00 and an intra-service and total time of 60 minutes, and to CPT add-on code 34820 (*Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral*) with a work RVU of 7.00 and an intra-service and total time of 60 minutes.

Comparison to this service is appropriate only insofar as it has an identical 60 minutes of intra-service and total time. What the comparison fails to incorporate is the differences in intensity for 93655, and comparison to codes with similar times that were identified by the RUC and societies as more instructive. These other services are squarely in the cardiovascular space and more useful for relativity comparisons.

To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93655 should be valued at the 25th percentile work RVU as supported by the resurvey. **The ACC urges CMS to accept the RUC recommended work RVU of 7.00 for CPT code 93655.**

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed

CMS disagrees with the RUC recommended 17.00 work RVUs with 180 minutes of intra-service time and 263 minutes of total time which was the 25th percentile of the RUC survey. The Agency does agree with work RVU incremental increase from 93653 to 93656 of 2.00 RVUs. They propose

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a work RVU for CPT code 93656 of 15.80 – which is 2.00 RVU above the CMS recommended RVU for CPT code 93653 of 13.80.

As the CMS proposed valuation for 93656 is based on an RVU interval off the CMS proposed RVUs for 93653 which the ACC has stated above was derived from an erroneous code comparison, the College also feels this value is incorrect. It is inconsistent for CMS to disregard the survey outcomes in one area—the 25th-percentile work RVU—but to adopt the survey values in another area—the increment of work between services at the 25th-percentile work RVU. If the survey is useful for setting an increment of value between services, it should also be relied upon to establish values at the 25th-percentile. Comparison to codes with similar times that were identified by the RUC and societies are more instructive. As such, 93656 should remain 2.00 RVU above 93653, but at the RVU of 17.00 rather than 15.80.

The actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury; the risk of tamponade is .5% to 1%, sometimes leading to shock or arrest or emergency surgery. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

To justify a value of 17.00, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that both services involve an identical amount of intra-service time, whereas the reference code involves slightly more total time and is also slightly more intense to perform. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200, total time of 355) and noted that the reference code involves 20 more minutes of intra-service time and 92 more minutes of total time, justifying a lower valuation for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to this survey code. The RUC concluded that CPT code 93656 should be valued at the 25th percentile work RVU as supported by the resurvey.

Out of concern that even the RUC recommendation fails to fully capture the intensity, complexity, and risk of this service, **the ACC urges CMS to apply the survey median of 21.50 RVUs for**

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93656 based on additional supporting services and recognition of the intensity, complexity, and risk of the service. With an intra-service time of 180 minutes, a total time of 263 minutes, and a survey median of 21.50 RVUs, 93656 is similar to codes 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* that has 180 minutes intra-service time and 270 minutes total time and 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* that has 135 minutes intra-service time and 223 minutes total time. Each of these are catheter procedures in the cardiac space with work RVUs of 24.39 and 21.70, respectively, that support the median survey RVU of 21.50. This value accommodates a reduction for bundling and efficiency without aggressively pushing a 40%-cut in two years. At a minimum, the Agency should revert to the RUC recommendation of 17.00 RVUs.

93657 *Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)*

CMS disagrees with the RUC recommended work RVU of 7.00 for CPT code 93657 with 60 minutes of intra-service time and total time which was the 25th percentile of the RUC survey. The Agency instead proposes a work RVU of 5.50 based on comparator CPT code 22854, *Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect*, also with 60 minutes of intra-service and total time. The Agency believes this service is a better comparison code to 93655 than the RUC recommended CPT add-on code 93592 (*Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device*, with a work RVU of 8.00 and an intra-service and total time of 60 minutes, and to CPT add-on code 34820 (*Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral*, with a work RVU of 7.00 and an intra-service and total time of 60 minutes).

Comparison to this service is appropriate only insofar as it has an identical 60 minutes of intra-service and total time. What the comparison fails to incorporate is the differences in intensity for 93657, and comparison to codes with similar times that were identified by the RUC and societies as more instructive. These other services are squarely in the cardiovascular space and more useful for relativity comparisons.

To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93657 should be valued at the 25th percentile work RVU as

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supported by the resurvey. **The ACC urges CMS to accept the RUC recommended work RVU of 7.00 for CPT code 93657.**

Ablation Family Summary

The RUC recommendations for these services were built around the survey 25th-percentile work RVUs. Work RVUs for these services below those levels—as proposed by CMS—risk all of the negative consequences described above. **The RUC-recommended values described above in detail should be the floor for any final decision here, and ACC fears even that will be problematic.** Rates *higher* than the values recommended by the RUC would be a superior outcome, going further to correctly recognize the work of these services relative to other highly complex procedures in the fee schedule. A traditional mechanism to do that exists in the work that has already been completed on these services. **The ACC urges CMS to finalize work RVUs at the survey medians for SVT ablation code 93653 and AF ablation code 93656, but at a minimum to use the RUC recommendations for this family.**

93662 Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

As CMS did not state that they reviewed code 93662 either during the CY 2022 rulemaking period or in the CY 2023 NPRM, we would like to share the following rationale for increasing this service based on the RUC recommendation submitted in April 2021 which provides new clinical information relative to when this service was last reviewed. The RUC recommendation from the April 2021 RUC meeting would represent an increase compared to the current CY 2022 CMS value.

In the CY 2021 Medicare Physician Payment Schedule Final Rule, CMS' rationale for not accepting the RUC recommendation and instead implementing a lower value for 93662 was the 45 percent decrease in total time from when the service was previously surveyed in 2000. CMS' 1.44 work value was derived from using a work value crosswalk to code 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)*. Unfortunately, the coronary IVUS crosswalk code (92979) that CMS had used to determine an alternate valuation was flawed because the nature of the services performed, intensity and work involved are different, with intracardiac echocardiography (ICE) and intravascular ultrasound (IVUS) performed in different parts of the heart for different reasons. Coronary IVUS is performed inside the coronary arteries to guide diagnostic catheterization and/or percutaneous coronary interventions. IVUS looks at one structure in a single plane, in/out of the coronary artery wall. It is assessing a fixed structure whereas ICE is assessing multiple structures dynamically during the associated procedures.

ICE is used to provide high-resolution real-time visualization of cardiac structures—atrial septum, valves, pulmonary veins, left atrial appendage—for continuous monitoring of a catheter location within the heart in four dimensions—in/out, rotation, anterior/posterior, left/right. It commonly

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guides trans-septal puncture where the operator creates a hole in the septum of the heart to gain access to the other cardiac chambers on the other side of the heart and is useful for early recognition of procedural complications, such as pericardial effusion or thrombus formation. ICE remains highly technical in nature and requires the patient to be anesthetized, which is not required in IVUS use. ICE is most used with atrial fibrillation ablations, a highly technical and challenging service, this reinforces the intensity of ICE.

The RUC recommendation for CPT code 93662 was based on the survey 25th percentile work RVU from robust survey results of 42 cardiologists as well as a favorable comparison to code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and intra-service time of 20 minutes) and MPC code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and intra-service time of 30 minutes). Both reference services bracket code 93662 in both physician work and time. **The RUC urges CMS to accept a work RVU of 2.53 for CPT code 93662.**

Endovascular Pulmonary Arterial Revascularization

In February 2021, the CPT Editorial Panel approved a new family of Category I CPT codes to describe percutaneous endovascular repair of pulmonary artery stenosis (PAS) by stent replacement, a developing approach that has improved outcomes for some patients, particularly small children. Since other peripheral vascular angioplasty and stenting interventions were formerly the only possible method of procedure for treating PAS, endovascular pulmonary repair is not uniquely delineated in CPT due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. CPT codes 338X3-338X7 were surveyed together for the October 2021 RUC meeting.

Over the last 20 years, advancements in stent technology have provided physicians with the opportunity to perform endovascular repair of pulmonary artery stenosis by stent placement on a broader patient population, specifically now to small children. Stents are smaller and conducive to a wider range of medical procedures, and physicians are no longer limited to only using balloon angioplasty for treating PAS in children. For procedures involving pulmonary artery stenosis on pediatric patients, the application of endovascular repair using a stent was an obstacle and a technological impossibility until recently.

There are three relationships throughout the family that demonstrate the work, time, and related complexity between the family of codes. The first is an increase in time and work as the codes move from unilateral to bilateral, with increased time and work for bilateral procedures. The second is an increase in work as the codes move from “normal native” connections to “abnormal” connections. Lastly, while there is not an increase in time as the codes move from "normal native" connections to "abnormal" connections, there is an increased amount of work that is attributable to the increased intensity of these services in patients with abnormal connections. The increased intensity is

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attributed to complex angiographic interpretations and the possibility of additional lesions therefore increasing the medical decision-making required to perform the service, whereas in a healthy child with normal connections, that complexity doesn't exist.

For this entire code family, CMS failed to properly justify the decrease to each code and neglected to take the survey into consideration. The unjustified reduction of work RVU to the entire family has inevitably distorted relativity among similar code families. Moreover, the CMS comparison codes given throughout the section do not seem to be selected based on a clinical comparison of the work as the intensity does not match, or come close, to the intensity of each surveyed code. The RUC would encourage CMS to review the survey results from 34 interventional and pediatric interventional cardiologists for CPT code 338X5 and 35 for CPT codes 338X3, 338X4, 338X6, and 338X7 who accurately valued the work required to perform this service. It is important to note that the survey was robust and without flaw, and thus, there is little credence for CMS to claim overvaluation of the survey median throughout this family. The RUC did not use the survey 25th percentile due to physician input that the pulmonary arteries are vastly different when compared to systemic arteries in terms of difficulty, risk, and complexity. For example, the pulmonary arteries have very thin walls, which are more easily subject to dissection and perforation while performing this procedure on an actively beating heart. Furthermore, a pulmonary artery obstruction can cause circulatory collapse and obstructive shock, a rapidly lethal condition.

338X3 Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral

CMS disagrees with the RUC recommendation of 14.00 RVUs for 338X3 which was the median survey response. CMS asserts that the median survey value is too high for the survey time compared to similar codes. CMS proposes a work RVU of 11.03 from the survey 25th-percentile work RVU which the agency supports by comparison CPT code 61650 *Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory*, with a work RVU of 10.00 and CPT code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel*, with a work RVU of 12.32, 90 minutes of intra-service time and 233 minutes of total time.

Comparison to these services is appropriate only insofar as each service has an identical 90 minutes of intra-service time and similar/identical total times. They are both also endovascular services, which makes direct comparison more relevant. What the comparison fails to incorporate is the differences in intensity for 338X3, and comparison to codes with similar times that were identified by the RUC and societies as more instructive. These other services are squarely in the cardiovascular space and more useful for relativity comparisons. Said another way, yes, the median survey work RVU value is higher than some other codes with similar times. The decision to recommend that value was not made lightly, and was felt to appropriately value the skill, intensity, risk, and physical effort to provide the service.

To justify the value of 14.00, the RUC compared the surveyed code to key reference codes 92928, *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major*

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coronary artery or branch (work RVU= 10.96, 76 minutes of intra-service time, and 135 minutes of total time) and 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time and 210 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and intensity required to perform these services and therefore maintains relativity. CPT code 338X3 is a unilateral procedure where the patient has normal native connections; the intensity required to perform this service is consistent with the supporting references codes and comparable to the median survey results.

For additional support, the RUC referenced the Multi-Specialty Points of Comparison (MPC) code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intra-procedural road-mapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 13.75, 90 minutes of intra-service time and 166 minutes of total time) and CPT code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, 90 minutes intra-service time, and 183 minutes of total time) and noted that the surveyed code exactly matches the intra-service time established for these two supplementary codes. The intensity to perform the service for the MPC, comparison code, and surveyed code appropriately align in terms of their work RVU, therefore maintaining relativity in the Medicare Physician Payment Schedule. **The ACC urges CMS to accept a work RVU of 14.00 for CPT code 338X3.**

338X4 Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral

CMS disagrees with the RUC-recommended work RVU of 18.00 for CPT code 338X4 *Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral*. The agency contends that the RUC recommendation of the survey median appears to be high compared to codes with similar times. CMS proposes the survey 25th percentile work RVU of 14.50 supported by reference CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle, and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure*, which has a work RVU of 14.24 and the same intra-service time of 120 minutes and a total time of 235 minutes.

Comparison to this service is appropriate only insofar as it has an identical 120 minutes of intra-service time and similar total time. What the comparison fails to incorporate is the differences in intensity for 338X4. Both services are challenging, but ACC contends that placing a stent in the pulmonary artery of a pediatric patient to treat pulmonary artery stenosis is significantly more challenging and with greater risk than debriding skin. Comparison to codes with similar times that were identified by the RUC and societies are more instructive. These other services are squarely in the cardiovascular space and more useful for relativity comparisons.

To justify the value of 18.00, the RUC compared the surveyed code to key reference code CPT codes 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time, and 210 minutes

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of total time) and determined that the surveyed code is appropriately supported by this reference service based on the similar physician work and time required to perform these services. Being that this a bilateral procedure for a patient with normal native connections, the 120-minute intra-service time allocation for 338X4, along with the measured intensity required to perform this service, are consistent with the supporting reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time, and 208 minutes of total time). The RUC selected this reference code based on the similarities of physician work required to perform the service compared to the surveyed code. While the codes have identical intra-service time, the total time for the surveyed code is slightly higher, suggesting that they should be valued similarly, although the surveyed code should maintain a slightly higher work RVU. **The ACC urges CMS to accept a work RVU of 18.00 for CPT code 338X4.**

338X5 Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral

CMS disagrees with the RUC-recommended work RVU of 17.33 for CPT code 338X5, *Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral*, which was the survey median and proposes the 25th percentile work RVU of 14.00. The agency indicates that the survey median “appears to be high compared to codes with similar times.” CMS asserts that a work RVU of 14.00 is supported by a reference CPT code 61640, *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel*, which has a work RVU of 12.32 and the same intra-service time of 90 minutes and a higher total time of 233 minutes.

Comparison to this service is appropriate only insofar as it has an identical 90 minutes of intra-service time and similar total time. What the comparison fails to incorporate is the differences in intensity for 338X5. Both services are challenging, but ACC contends that placing a stent in the pulmonary artery of a pediatric patient with abnormal connections to treat pulmonary artery stenosis is significantly more challenging and with greater risk than an initial vessel balloon dilatation. Comparison to codes with similar times that were identified by the RUC and societies are more instructive.

To justify the value of 17.33, the RUC compared the surveyed code to CPT codes 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, 135 minutes of intra-service time, and 223 minutes of total time) and 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.75, 135 minutes of intra-service time, and 203 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. The RUC discerned that 338X3 and 338X5 are both unilateral procedures and require 90 minutes of intra-service time; however, there is larger amount of physician work required due to increased

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intensity and greater medical complexity of these services when patients have abnormal connections versus normal native connections.

For additional support, the RUC also referenced CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes intra-service time, and 210 minutes of total time) which has similar total time to the surveyed code but a lower intensity. The RUC recognized similarities between these services, although the surveyed code still requires more physician work to perform the service as the RUC discerned above. Additionally, it was determined that the surveyed code was valued appropriately within the family to maintain relativity based on the description of work related to abnormal connections. **The ACC urges CMS to accept a work RVU of 17.33 for CPT code 338X5.**

338X6 Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral

CMS disagrees with the RUC-recommended work RVU 20.00 for CPT code 338X6, *percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral*, which is the RUC survey median and proposes a work RVU of 14.50. The Agency indicates that the survey median “appears to be high compared to codes with similar times.” CMS agrees that the relative difference in work between CPT codes 338X4 and 338X6 is equivalent to the RUC-recommended interval of 2.0 RVUs. As such, CMS proposes a work RVU of 16.50 for CPT code 338X6, based on the recommended interval of 2.0 additional RVUs above their proposed work RVU of 14.50 for CPT code 338X4. A CMS supports this valuation with reference CPT code 11005. CPT code 11005 (*Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure*) which has a work RVU of 14.24 and the same intra-service time of 120 minutes and a higher total time of 265 minutes.

As the CMS proposed valuation for 338X6 is based on an RVU interval off the CMS proposed RVU for 338X4 which the ACC has stated above was derived from an erroneous code comparison, the College also feels this value is incorrect. Comparison to codes with similar times that were identified by the RUC and societies are more instructive. As such, 338X6 should remain 2.00 RVU above 338X4, but at the RVU of 20.00 rather than 16.50.

To justify the value of 20.00, the RUC compared the surveyed code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, 180 minutes of intra-service time, and 270 minutes of total time) and noted that the surveyed code requires less physician work and time to perform and is thus appropriately valued lower. The RUC also compared the surveyed code to the second top key reference code 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU= 10.96, 76 minutes of intra-service time and 135 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. Being that the surveyed code is a bilateral procedure for a patient with abnormal connections, there is increased intra-service, in addition to a greater intensity of physician work required. Therefore, the RUC determined that a higher work RVU would be

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appropriate relative to the other codes in this family. This valuation is consistent with the supporting key reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 33745 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt* (work RVU= 20.00, 92 minutes intra-service time, and 207 minutes of total time). The RUC reviewed the differences in intra-service time and intensity of physician work and determined that the total time required to perform this service and the longer skin-to-skin time warrant a similar RVU. **The ACC urges CMS to accept a work RVU of 20.00 for CPT code 338X6.**

338X7 Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (list separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended RVU of 7.27 for CPT code 338X7, *Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections*, which was the survey median and proposes the 25th percentile work RVU of 5.53 instead. The agency indicates that the survey median “appears to be high compared to codes with similar times.” CMS asserts that a work RVU of 5.53 is supported by reference CPT code 57267, *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment, vaginal approach)* which has a work RVU of 4.88 and the same time of 45 minutes.

Comparison to this service is appropriate only insofar as it has an identical 45 minutes of intra-service and total time. The comparison fails to incorporate the differences in intensity for 338X7, and comparison to codes with similar times that were identified by the RUC and societies as more instructive. These other services are squarely in the cardiovascular space and more useful for relativity comparisons.

To justify the value of 7.27, the RUC compared the surveyed code to CPT code 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt* (work RVU= 8.00 and 60 minutes of intra-service time/total time) and determined that the surveyed code appropriately relates to this service based on the intensity of physician work and intra-service time required to perform these services.

For additional support, the RUC referenced CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device* (work RVU= 8.00 and 60 minutes of intra-service time). The RUC recognized similarities in the intensity of physician work for these services despite differences in intra-service time; ultimately, this comparison was determined to be in line with the

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survey results and supports the proposed work RVU. **The ACC urges CMS to accept a work RVU of 7.27 for CPT code 338X7.**

Pulmonary Angiography

In May 2021, the CPT Editorial Panel revised CPT code 93568 to include “nonselective” and “arterial” in its long descriptor and created four new Category I CPT Codes to report injection procedure during cardiac catheterization including imaging supervision, interpretation, and reporting for selective pulmonary arterial angiograph (unilateral and bilateral) and for selective pulmonary angiography of each distinct pulmonary vein and from an arterial approach. CPT add-on codes 93563-93567 were surveyed as part of the same code family for the October 2021 RUC meeting.

CMS proposes to implement the RUC recommendations for time and work for two codes in this family, 93568 and 93XX3. **The ACC agrees with those proposals and urges final implementation of the proposed values for 93568 and 93XX3.** However, the Agency proposes values that go below the RUC recommendations for the other eight codes in this family. For the new codes, the explanation offered is that other services were felt to be “better comparators.” For the existing codes, a reduction in time was noted and a similar statement that services with identical times and lower work RVUs were believed to be “better comparators.” The proposed values for these services ignore the relativity that was created using the recommended work RVUs within this code family and in relation to other relevant services in the fee schedule. **The ACC disagrees with the proposed work RVUs that go below the RUC recommendations and urges CMS to reconsider its proposals for these services after reviewing the comments below.**

Compelling Evidence

While only applicable to code 93568, for which CMS proposes the RUC-recommended values of the current work RVU with a reduced time, the compelling evidence arguments below are important context to also consider the values of the newly created pulmonary angiography codes that describe work in the congenital population. The value for the *non-selective* pulmonary artery angiography described in 93568 set a floor of sorts for the subsequent new codes that describe different *selective* pulmonary artery and pulmonary vein angiography services.

The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population, prior incorrect assumptions, and a change in technology/technique. The specialty noted that pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. The prior version of CPT code 93568, with the long descriptor stating *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)*, was created to describe pulmonary angiography with congenital, as well as non-congenital cardiac catheterization. It does not distinguish between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code does not capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right

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heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient.

Incorrect Assumptions The prior survey for 93568 included only traditional interventional cardiologists and had a vignette that was not explicitly for a pediatric patient. No pediatric/congenital interventional cardiologists were explicitly included in the prior survey even though the typical patient for selective pulmonary angiography is a pediatric patient. These services are predominantly performed by physicians who were not included in the prior survey.

Change in Technique Complex angiographic techniques have been performed for decades to delineate the pulmonary anatomy yet only a single general pulmonary angiography code was available to capture the work of both non-selective and selective pulmonary angiography. Pulmonary veins and Major Aortopulmonary Collateral Arteries (MAPCAs) were not considered when 93568 was created.

Change in Patient Population The specialty societies noted, and the RUC agreed, that diagnostic catheter studies were performed in children who were relatively healthier with simpler cardiac defects when the previous code structure was last valued a decade ago; children with more significant cardiac defects had fewer treatment options. As result of improvements in both technique and technology, the specialty has evolved, and the typical patient is now more complex.

The RUC concurred that there is compelling evidence that the physician work for these services has changed due to prior incorrect assumptions, change in technology/technique and a change in patient population.

93XX0 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 1.05 from the survey 25th-percentile for this service. Instead, the Agency proposes a work RVU of 0.63 by direct crosswalk to CPT code 78434 *Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)* that has an identical 11 minutes of time as “a good comparator code in terms of both the physician time, and due to the proportional work RVU, as compared to CPT code 93XX0.”

This reduced value that appears to be based solely on time fails to allow for an appropriate increase in work from 93568 to 93XX0 based on the intensity of the service. It also fails to recognize that the physician work of selective pulmonary angiography for cardiac catheterization that includes selective angiographic catheter positioning, injection, and radiologic supervision and interpretation is appropriately more work and work per unit of time than interpreting AQMBF imaging that takes 11 minutes. If CMS were to finalize its proposed value of 0.63, the work of selective catheter placement would have less work and a lower IWPOT than non-selective catheter placement code 93568. That creates a rank order anomaly within this family and supports using the survey-based, 25th-percentile value recommended by the RUC.

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Additionally, the presenting societies and the RUC agreed that the 25th-percentile work RVU was appropriate when compared to other services that involve selective catheter placement or injections. These comparisons are more clinically relevant than the crosswalk code CMS selected and bolster the society's recommendation that CMS revert to the RUC-recommended value of 1.05 for 93XX0. To justify a work RVU of 1.05, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that the surveyed code involves one more minute of time and should be assigned a slightly higher work value. The RUC also compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves less time to perform and less physician work, justifying a lower valuation than the top key reference service. The RUC's recommendation also assigns this service a physician work intensity between the top and second key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 1.05 for CPT code 93XX0.**

93XX1 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 1.78 from the survey 25th-percentile for this service. Instead, the Agency proposes a work RVU of 1.30 by a modified crosswalk to CPT code G0289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee (List separately in addition to code for primary procedure)* that has 20.5 minutes of time as "a better comparator add-on code." CMS starts with the G0289 work RVU of 1.48 for 20.5 minutes, and then reduces that value to make it match the 18 minutes of time from the RUC survey for 93XX1.

This is an unorthodox and unclear rate-setting methodology that should be set aside for the superior and reliable recommendations based on the physician work survey. G0289 is a CMS/Other code that seems to first appear in the CY 2003 fee schedule rule. It has never been surveyed and it is unclear how its time and RVU were set. It is billed several thousand times a year by orthopedic surgeons. CMS proposes that 2.5 minutes of reduced time is worth 0.18 RVUs, so apparently CMS used the IWPUT of 0.072 from the values of G0289 to adjust its time and value down to match the 18 minutes of 93XX1. (It may or may not be coincidence that the next code in this family—93XX2—would also have an IWPUT of 0.072 at the CMS proposed value based on direct crosswalk.) G0289 seems a poor comparator and this is a convoluted way to develop a work RVU when a reliable survey and comparators exist.

In contrast, to justify a work RVU of 1.75, the societies and the RUC agreed that the 25th-percentile work RVU was appropriate when compared to other services that involve selective catheter placement or transcatheter work. These comparisons are more clinically relevant than the crosswalk

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code CMS selected and bolster the society's recommendation that CMS revert to the RUC-recommended value of 1.75 for 93XX1. 93XX1 was compared to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 3 more minutes of total time and is less intense to perform, supporting the proposed value. It is also important to note that this is another catheterization code that has been valued by the RUC and is understood by the medical field. The RUC also compared the surveyed code to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service and total time of 20 minutes) and noted that although the surveyed code involves less time, it involves a moderately higher physician work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 1.75 for CPT code 93XX1.**

93XX2 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization. (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 1.84 from the survey 25th-percentile for this service. Instead, the Agency proposes a work RVU of 1.44 by direct crosswalk to CPT code 93598 *Measurement of output of blood from heart, performed during cardiac catheterization for evaluation of congenital heart defects (List separately in addition to code for primary procedure)* that has an identical 20 minutes of time as "a good comparator code in terms of both the physician time, and due to the proportional work RVU, as compared to CPT code 93XX2."

This reduced value that appears to be based solely on time fails to allow for an appropriate decrease in work from subsequent code 93XX3 to 93XX2 based on the intensity of the service. 93XX3 and 93XX2 both have 20 minutes of time. Both are complicated angiography services performed in the pediatric congenital population. There was an appropriate 0.08 decrement from 93XX3 to 93XX2 that accounted for differences in the service despite identical times. This proposal and those of the two codes prior disrupt a well-designed rank order in the family.

In this instance, the comparison to another congenital catheterization service allows for reasonable comparisons that demonstrate the merits of the RUC-recommended value. (The ACC notes, 93598 was a pending code and could not be used for comparison a year when the RUC met. Further, CMS also reduced this code below the RUC recommendations, in what consistently feels to cardiology members like a consistent drumbeat to lower values derived by member surveys with physician input to the lowest possible value based on time alone.) Thermodilution studies are more similar to the placement of non-selective angiography than to the selective angiography described by this code. Based on the additional intensity of selective angiography alone, it would be appropriate from a

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relativity perspective to utilize the RUC-recommended 25th-percentile work RVU recommendation of 1.84.

Instead, to justify a work RVU of 1.84, the presenting societies and the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 5 more minutes of total time and less intense physician work, supporting the proposed lower value. The RUC also compared the surveyed code to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service and total time of 20 minutes) and noted that although both services typically involve an identical amount of time, the surveyed code is a more intense service to perform inside a congenitally-diseased heart than inside an extremity vein. The reference service is typically performed on an adult patient and under only local anesthesia, whereas the surveyed code is typically performed on a highly complex pediatric patient. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 1.84 for CPT code 93XX2.**

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

Beginning with this code, the rest of the services discussed as part of this family are existing services that were reviewed in concert with the CPT changes to 93568 and creation of 93XX0-93XX3. CMS disagrees with the RUC-recommended work RVU of 1.11, the current value for this service. Instead, the Agency proposes a work RVU of 1.00 by direct crosswalk to CPT code 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)* that has an identical 15 minutes of time as “good comparator in terms of both the new physician time and due to the proportional work RVU, as compared to CPT code 93563.”

CMS notes in its brief discussion of this approach that the 15-minute service time is a reduction from 25 minutes. It is true that the service time did fall without a reduction in the recommended work RVU. The ACC believes arbitrary reductions made by CMS in the prior valuation have already more than accounted for this time reduction. This history was discussed by the RUC and the societies, and it does not appear CMS considered it in addition to the reduction in time. When this service was last reviewed in 2010, the RUC recommended 2.00 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the work RVUs for the prior component codes, considering any multiple procedure reduction that would apply under CMS policy at that time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation; the recommended physician

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time was implemented as well. CMS's decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC proposed to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation. It would have also been reasonable to recommend the survey 25th-percentile value of 1.32, which would have been a reduction from 2.00 roughly commensurate with the reduction in time from 25 to 15 minutes.

To justify a value of 1.11, the societies and the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time and involve a similar, but slightly more intense, amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 1.11 for CPT code 93563.**

93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 1.13, the current value for this service. Instead, the Agency proposes a work RVU of 1.03 by direct crosswalk to CPT code 31632 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* that has an identical 18 minutes of time as “a good comparator in terms of both the new physician time and due to the proportional work RVU, as compared to CPT code 93564.”

CMS notes in its brief discussion that survey service time of 18 minutes is a 7-minute reduction from the current 25 minutes time, and that typically a time reduction would result in some work reduction. As with 93653, the ACC believes arbitrary reductions made by CMS in the prior valuation have already more than accounted for this small, time reduction. The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 2.10 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the prior work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS's decision in 2010 fully decoupled the

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relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 1.13, the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/ or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that the surveyed code involves somewhat more time to perform. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/ or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that the surveyed code involves more time, though both services involve a similar amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. It also correctly maintains a small increment above the recommended value of 93653. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 1.13 for CPT code 93564.**

93565 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 0.86, the current value for this service. Instead, the Agency proposes a work RVU of 0.50 by direct crosswalk to CPT code 64421 *Injection(s), anesthetic agent(s) and/ or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)* that has an identical 10 minutes of time as “a good comparator code in terms of both the new physician time and due to the proportional work RVU as compared to CPT code 93565.”

CMS notes in its brief discussion that survey service time of 10 minutes is a reduction from the current 20-minute time, and that typically a time reduction would result in some work reduction. As with 93653 and 93564, the ACC believes arbitrary reductions made by CMS in the prior valuation have already more than accounted for this time reduction. The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 1.90 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

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To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/ or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/ or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 0.86 for CPT code 93565.**

93566 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 0.86, the current value for this service. Instead, the Agency proposes a work RVU of 0.50 by direct crosswalk to CPT code 64421 *Injection(s), anesthetic agent(s) and/ or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)* that has an identical 10 minutes of time as “a good comparator code in terms of both the new physician time and due to the proportional work RVU as compared to CPT code 93566.”

CMS notes in its brief discussion that survey service time of 10 minutes is a reduction from the current 20-minute time, and that typically a time reduction would result in some work reduction. As with 93653 and 93564, the ACC believes arbitrary reductions made by CMS in the prior valuation have already more than accounted for this time reduction. The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 0.96 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was lower than the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is already a reduction from the RUC's previous recommendation.

To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/ or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the

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surveyed code to CPT code 93572 *Intravascular Doppler velocity and/ or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 0.86 for CPT code 93566.**

93567 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)

CMS disagrees with the RUC-recommended work RVU of 0.97, the current value for this service. Instead, the Agency proposes a work RVU of 0.70 by direct crosswalk to CPT code 74248 *Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)* that has an identical 10 minutes of time as “a good comparator code in terms of both the new physician time and due to the proportional work RVU, as compared to CPT code 93567.”

The presenting specialties noted during RUC discussions that, relative to CPT codes 93565 and 93566 which also typically involve 10 minutes of time, 93567 is a more intense service to perform. CPT code 93567 is typically provided to a relatively sicker and older adult population compared to codes 93565 and 93566, due to there being a greater risk of rupture and catheter passes are more tortuous in the senior population. There is a higher likelihood of a calcified aorta and risk for the dislocation of aortic plaque. Finally, when working in the aorta, extra care must be taken to avoid the iatrogenic introduction of air into the vasculature.

CMS notes in its brief discussion that survey service time of 10 minutes is a reduction from the current 15-minute time, and that typically a time reduction would result in some work reduction. In a scenario where the code values of 93563-93566 are set at the RUC-recommendations, the difference in intensity is appropriately reflected in the work RVU of 0.97. The ACC believes arbitrary reductions made by CMS to other codes in the 2010 valuation and now in this valuation disrupts the rank order and scale in the family. Further, comparison to the specific crosswalk code based on the identical times masks the differences in intensity that are apparent. Manipulating a catheter inside the heart to obtain images requires a higher level of intensity and risk than directing the movement of a patient who has swallowed contrast material to various positions to obtain radiographic and fluoroscopic imagery.

To justify a value of 0.97, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/ or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the

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surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that though the surveyed code typically involves one less minute of intra-service time, it is a slightly more intense service to perform; it is warranted to have both services have a similar valuation. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. The RUC concluded that the value of CPT code 93567 should be maintained at 0.97 RVUs as previously accepted by CMS and supported by the current survey. **The ACC recommends CMS reconsider the values and new insights offered here and finalize a work RVU of 0.97 for CPT code 93567.**

External Extended ECG Monitoring

CMS proposes to adjust the price of supply input SD339, *extended external ECG patch, medical magnetic tape recorder*, based on submission of additional invoices to \$245.69. CMS previously set a price of \$200.15 in CY 2022 rulemaking but did not move forward with national pricing for these services pending the opportunity for additional feedback from stakeholders. With additional understanding from that feedback and this pricing refinement, CMS also proposes to implement national pricing for extended external ECG monitoring codes 93241, 93243, 93245, and 93247 that include SD339.

The ACC supports CMS's proposal to provide national pricing in CY 2023 based on the proposed supply inputs as a positive step forward. These external extended ECG monitoring codes have been contractor-priced since their first publication in the 2021 CPT book. This proposal should ease access for these services are accessible for Medicare beneficiaries. However, the ACC encourages CMS to continue to work with the providers of this technology—including review of comments during this cycle—to ensure national rates account for the cost of these services should additional refinement be necessary.

Remote Interrogation Device Evaluation

G2066 pricing is a topic about which the ACC has written and spoken in the past. CMS opted to create and implement code G2066 as contractor-priced rather than adopt direct practice expense pricing for codes 93297 and 93298 in CY 2020 physician fee schedule rulemaking. This service has been priced between roughly \$120-\$200 by MACs for a long time, both as G2066 and its predecessor 93299. To see it reduced to \$21 abruptly by one MAC via an announcement on a website this spring was disruptive and problematic.

In the 2020 rulemaking cycle, the ACC along with the Heart Rhythm Society undertook the development of direct practice expense inputs for the TC of 93297 and 93298 through the AMA RUC process based on discussions with vendors and members and comparison to other services. For 93297, those inputs included 40 minutes of clinical staff time, 40 minutes of equipment time, and 10 sheets of paper. For 93298, those inputs included 76 minutes of clinical staff time, 76 minutes of equipment time, and 10 sheets of paper. Stakeholders commented to CMS those inputs would produce inadequate payment and CMS created G2066 to fill the gap of deleted 93299. There

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may still be improvements that could be made to the PE inputs that could help the agency adopt national pricing. It could also be the case that the practice expense formula produces artificially low payment amounts in this instance.

Based on recent activity by MACs and various stakeholders, it is ACC's understanding the direct practice inputs proposed by the RUC would produce national pricing that is higher than what many MACs pay through their contractor fee schedules, but lower than the highest MAC rates. **The ACC urges CMS to revisit and reconsider the previous RUC-recommended direct practice expense inputs for proposal in next year's rulemaking cycle.**

Expiration of PHE Flexibilities for Direct Supervision Requirements

Cardiac rehabilitation (CR) and pulmonary rehabilitation programs are an important part of recovery for those with chronic heart and lung disease and who deal with acute events and exacerbations of their conditions. After hospitalization, it is the standard of care to provide outpatient cardiac or pulmonary rehabilitation services, consisting of exercise and education. These interventions have been shown to reduce rehospitalization and all-cause mortality, as well as improve quality of life and lifestyle choices so patients may better self-manage these chronic conditions.

The ACC previously supported a proposal by CMS in CY 2021 rulemaking to allow the statutory provision regarding direct physician supervision of cardiac and pulmonary rehabilitation programs to be met by the virtual presence of the physician via real-time, two-way audio/visual telecommunications technology. That proposal was not finalized to allow CMS to consider the matter further. Although CMS notes in the 2023 proposed rule that it is not proposing to make virtual direct physician supervision permanent, the Agency continues to seek information on whether such a flexibility should be made permanent, or whether it would be more appropriate on a permanent basis to allow the virtual presence of the physician only for a subset of services due to potential concerns over patient safety.

CMS states that after December 31 of the year in which the PHE ends, the pre-PHE rules for direct supervision at § 410.32(b)(3)(ii) would apply. At the end of this temporary program, patient access and adherence to these valuable programs will end if CMS chooses not to make permanent the ability for virtual presence of the physician to provide direct supervision via real-time, audio/visual telecommunications technology. **The ACC recommends CMS make permanent the ability of the physician to meet the direct supervision requirement outlined in the Medicare statute via real-time, audio-visual telecommunications technology in the final CY 2023 physician fee schedule rule so Medicare beneficiaries can continue to receive these high value rehabilitation treatments.**

CMS seeks comment specifically on whether virtual direct supervision is safe or whether it would be a more appropriate option to designate only a subset of services to receive virtual direct supervision. The ACC and others have separately provided studies that showcase the effectiveness and safety of virtual CR and PR services that we believe make a strong case for CMS to make the option of direct virtual physician supervision permanent. The studies demonstrate virtual and hybrid delivery of CR

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services and virtual PR services for individuals with COPD provided by staff are safe, improve health outcomes and adherence, and address barriers to access. Based on the importance of these programs in improving patients' lives and their quality of life, we believe the studies speak for themselves in addressing CMS' concerns.

CMS should not restrict virtual direct physician supervision to a subset of services. The decision on whether to provide direct supervision through the virtual presence of the physician via real-time, two-way audio/visual telecommunications should be left up to the physician. Physicians are best positioned to determine whether virtual direct supervision can be provided safely and effectively to their patients based on their medical needs, and they should be given the flexibility to make those decisions on a case-by-case basis.

In previous comments, stakeholders stated that with more than 97 percent of CR and PR programs in the hospital outpatient setting, it is critical that virtual direct supervision be an option for *both* the outpatient and physician office setting on a permanent basis. This is especially important because emerging data suggests a further benefit of PR: a reduction in mortality. Previously shared studies provide clear evidence that the quality and safety of CR and PR services are not negatively affected when provided via telecommunications technologies and should provide a pathway for CMS to make the option of direct virtual physician supervision permanent.

Evaluation and Management (E/M) Visits

The ACC applauds the Agency for proposing the work RVU recommendations for the hospital inpatient or observation codes, nursing facility codes, home or residence visit codes, emergency department visits and prolonged services codes developed by the AMA RUC. This was the result of significant collaboration by an AMA-convened workgroup that brought together more than 30 specialty societies involved in surveying these services. CMS's acceptance will lead to a significant reduction of administrative burden given the streamlined descriptions that allow for better recognition of the resources involved in these visits as they are performed today. **The ACC recommends that CMS finalize the recommendations for all the E/M visits.**

Office Visits Included in Codes with a Surgical Global Period

As stated in previous communication with the Agency, the ACC believes it is appropriate for consistency in the fee schedule to apply the increased 2021 valuation of the office E/M visits to the visits incorporated in the surgical global packages and disagrees with the CMS decision to not apply the office E/M visit increases to the visits bundled into global surgery payment. The ACC further recommends that CMS apply the office E/M visit increases to the office visits, hospital visits and discharge day management visits included in the surgical global payment, as it had done historically before two years ago.

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Prolonged Services

CMS proposes to create new G codes (GXXX1, GXXX2 and GXXX3) to describe prolonged services for hospital, nursing facility and home visits, as the agency believes the CPT reporting guidelines for prolonged service 993X0 will lead to duplicative payment and confusion regarding total time spent per patient. This proposal mirrors CMS policy finalized for non-payment of 99417 in 2021 with a substitution to report G2212 *Prolonged service office or other outpatient* instead. In addition, CMS proposes to make CPT codes 99358 and 99359 in-valid for Medicare purposes in 2023 as they assert it would cause confusion and invite duplicative billing.

The proposals in this rule create two different methodologies for reporting prolonged services, which creates administrative burden, increases potential improper reporting and is counter to the principles espoused in the Proposed Rule for the 2019 Medicare Physician Payment Schedule and the guiding principles of the CPT/RUC Workgroup on E/M.

It is imperative that physicians have one set of clear codes and guidelines to report prolonged services. While the CPT/RUC Workgroup on E/M will reconvene to discuss if revisions are needed to the CPT codes and guidelines, it would be preferable for CMS to reconsider the proposed policy related to prolonged services and rely on the current CPT codes and guidelines.

Split (or Shared) Services

The ACC appreciates CMS's proposal to delay, until January 1, 2024, the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. **We urge CMS to allow physicians or QHPs to bill split or shared visits based on time or medical decision-making.** The ACC understands the CPT/RUC Workgroup on E/M will convene to address clarification and definitional requirements for split or shared visits that could advance improvements in this space.

Cardiologists have a history of close collaboration with other clinicians to provide physician-led, team-based patient care. Patients benefit from the collaboration of physicians and QHPs who care for patients in hospitals, skilled nursing facilities, and other facilities. However, billing based on the physician or QHP who performs more than 50 percent of the total time of the visit will disincentivize and jeopardize the continuation of these care relationships and eliminate the value and clinical advantage of Team Based Care. This also undermines the need for clinicians to work at the top of their license and training. There is significant variability in how much time it takes to perform elements of the visit based on factors such as the level of training and expertise of the physician and QHP. Using medical decision making to direct the management of the patient's care determines the course of treatment for the patient, but it typically does not require the most time. Just as is the case now, the physician or QHP who performs these critical elements of the visit should be able to bill for it.

While CMS believes time-based billing is auditable, CMS has a long history of auditing E/M services based on documentation in the medical record substantiating appropriate billing based on history,

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exam, and medical decision-making. CMS would still be able to use these same program integrity levers to audit split or shared visits billed on the basis of time or medical decision-making.

The ACC strongly urges CMS not to disrupt team-based care in the facility setting and to revise the split or shared visit policy to allow the physician or QHP who is managing and overseeing the patient's care to bill for the service.

Professional Liability Insurance (PLI)

CMS seeks comment on the proposed methodological improvements to the development of the professional liability insurance (PLI) premium data. CMS contracted with the Actuarial Research Corporation (ARC) to update the PLI premium data, as CMS had also done for CY 2020, and has provided the *CY 2023 Medicare MFS Proposed Update to the GPCIs and PLI RVUs Interim Report* as part of its supporting documentation to the *Proposed Rule*. The *Interim Report* describes proposed methodologic changes related to the approach for the imputation of missing professional liability premiums. CMS also proposes to change from using risk factor score, which benchmarked each specialty to the physician specialty with the lowest premiums, to a risk index score which benchmarks each specialty's premiums to the volume-weighted average of all specialties. CMS noted its understanding that this change to a risk index had no change on the actual PLI RVUs, however, it appears that this change may have in fact contributed to a technical error impacting all CPT/HCPCS codes with the Professional Component/ Technical Component split (as described later in this section). CMS and ARC described the data collection process for this CY 2023 update as generally following the process used for the CY 2020 update, with minor methodologic improvements, and further success in collecting specialty-specific data.

The ACC appreciates the apparent improvement in data collection to ensure that as much specialty-specific data as possible is used to reflect the most accurate trends in professional liability premiums. In some previous update cycles, suboptimal data collection produced skewed PLI factors. CMS has come much closer to achieving comprehensive data for the first time, as all non-MD/DO health care professionals now have a proposed premium that much more closely reflect the actual premiums these specialties typically pay.

PLI RVU Specialty Mix and Technical Corrections for Codes with Professional Component/ Technical Component Split

Imaging and diagnostic services are generally comprised of two components: a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently or by different physicians or facilities, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service PLI RVU equals the sum of the payment for the TC component (reported separately using the -TC modifier) and PC (reported separately using -26 modifier).

For CY 2022 (and every year prior), virtually every global service with a PLI RVU greater than 0.02 (e.g. any PLI RVU that was large enough to split more than just 0.01 and 0.01), had a large majority

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of the PLI RVUs allocated to the PC component (reported using -26 modifier), and only a relatively small amount allocated to -TC only reporting. This long-standing precedent aligns with the updated risk premiums for specialties, as for example, the CMS' 2023 normalized risk premium rate for diagnostic radiology is \$21,889 whereas the updated risk premium rate for an independent diagnostic testing facilities (IDTFs) is only \$379.

Due to an apparent technical error, this relationship has inverted as most -26 modifier PLI RVUs, which typically represent a vast majority of the claims, have decreased by -75% or more, whereas most - TC only PLI RVUs have greatly increased. TC only reporting only represents a small subset of claims for most services. **This technical error has collectively reduced the aggregate allowed charges for PLI RVUs for all specialties by more than \$110 million for CY 2023. The ACC recommends CMS identify the root cause of this technical error and to correct it for CY 2023. If CMS is unable to identify and resolve the error, the ACC recommends that CMS delay implementation and apply the previous methodology for PC/TC codes until the technical error is corrected.**

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

CMS has long been precluded from paying for dental services, though an exception exists for payment to be made under Medicare Part A when hospitalization is required because of a beneficiary's underlying medical condition or the severity of the dental procedure. Additionally, payment is made for dental services that are an integral part of a covered primary procedure for dental services such as wiring of teeth for reduction of a jaw fracture, tooth extraction for radiation treatment, or oral exam on inpatient basis as part of comprehensive workup prior to renal transplant surgery.

After reconsideration of existing policies some view as unnecessarily restrictive, CMS proposes to clarify and amend its existing interpretation of statute to pay for dental services under Parts A and B when "the dental service is inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services..." Specific proposed examples include dental or oral exam as part of a workup prior to organ transplant, cardiac valve replacement, or valvuloplasty, and the diagnostics and treatments necessary to eliminate oral/dental infections before those procedures.

The ACC appreciates CMS's thoughtfulness in considering these updates to its payment rules for dental care. It is well established that chronic diseases disproportionately impact Medicare beneficiaries and impose a substantial cost on the federal government. It is also well established that untreated oral microbial infections are closely linked to a wide range of costly chronic conditions, including diabetes, heart disease, dementia, and stroke. In addition, oral diseases have been documented by researchers and medical specialty societies as precluding, delaying, and even jeopardizing medical treatments such as organ and stem cell transplantation, heart valve repair or replacement, cancer chemotherapies, placement of orthopedic prostheses, and management of autoimmune diseases.

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The ACC supports CMS’s proposed expansion of dental care in this rule, finding it consistent with relevant guidelines to assess and remediate oral health issues before valve procedures. Dental infections and poor oral health increase the risk of infection in a newly implanted heart valve. Patients can have primary bacterial endocarditis or, worse, prosthetic valve endocarditis secondary to neglected dental health and chronic dental abscesses. These are life-threatening situations that could be prevented with payment for medically necessary oral/dental health therapies. At the same time, while the ACC believes that targeted coverage of these specific dental services will improve outcomes, CMS should proceed cautiously and be guided by strong evidence when to conserve scarce resources as it considers additional services in the future under the newly proposed process, which seems appropriate at this juncture.

Public Comment Solicitation on Strategies for Updates to Practice Expense Data Collection and Methodology

As it describes a constant need for inputs to update the fee schedule, CMS solicits public comments on how practice expense data may be best collected and utilized. CMS previously contracted with RAND to devise and assess potential improvements to allocate indirect practice expense. Through discussion and suggested topics for feedback in the rule, CMS signals an intention to move toward standardized and routine valuation of indirect practice expense, with any new approaches proposed in future rulemaking.

The ACC appreciates the need for this data to be updated on some regular basis. In comments below regarding proposals to the Medicare Economic Index (MEI), the ACC urges CMS to postpone the disruption MEI proposals could have while the AMA and stakeholders undertake a new data collection in this space as a follow-up to the Physician Practice Information Survey (PPIS).

Cardiologists, practices, and patients were negatively impacted—in some cases significantly so, depending on practice patterns—by the previous PPIS and the ACC firmly believes improvements must be made in future data collections. While the strong physician input has served well to value physician work, we believe that there should be a more sophisticated review of the payment mechanisms for technical services. Many cardiovascular services saw payments cut dramatically after the PPIS. For the most part, this was the result of formula changes made in regulation by CMS. The most important element of this was a decision to include PPIS as a data element that determined the payments for services. This survey indicated that cardiologists’ practice costs had reduced dramatically when all other specialties had significant increases over the same period. Other changes like this contributed to a widely divergent payment difference between services provided in the hospital and the physician practices, leaving many cardiologists with no choice but to serve as hospital employees, leading to increased costs. We would not support payment changes that make it even more difficult for physicians to continue to work in private practice, especially when it results in higher costs for patients and the Medicare program. **CMS and the AMA should work closely with specialties as a new PPIS data collection is undertaken to ensure incongruous results are not deployed to the detriment of clinicians and patients. In the absence of a reliable extant data set, a survey similar to the PPIS will again be necessary.**

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Ideally, updates from a PPIS, supply pricing, equipment pricing, and clinical staff wage rates could occur regularly without creating burdens on clinicians with a transition phase-in to avoid sudden shifts in pricing for individual services and specialties. A reasonable cadence might be a 5-year rolling basis, with 20% of the resulting updates phased in each year, though there are a wide array of possibilities for frequency and transitions.

CMS Proposal on Updates to the Medicare Economic Index (MEI)

CMS proposes to dramatically shift payment allocation away from physician earnings (work) to practice expense (47.3% Physician Work, 51.3% Practice Expense and 1.4% PLI) using data from new sources. From 1975, when payments reflected the usual, customary, and reasonable charge payment methodology, through 1993, the year after implementation of the Resource Based Relative Value Scale (RBRVS), the physician earning component was 60% and the practice expense component, including professional liability insurance (PLI) costs, was 40%. These initial weights were derived from data obtained from the AMA. Currently, the allocation is 50.9% Physician Work, 44.8% Practice Expense and 4.3% PLI.

MEI History

	1975-1992	1993	Current	Proposed
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(incl with PE)	4.8%	4.3%	1.4%

The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. The AMA has begun the process of performing an updated PPIS survey. The process was initiated in 2020 but delayed to avoid anomalies potentially caused by the COVID19 Public Health Emergency (PHE). It is expected that formal collection of 2022 data will begin in 2024.

CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey (SAS). However, the Agency will not implement these new weights in 2023 as it seeks additional comments due to significant redistribution.

ACC has several concerns with the proposed MEI updates including: the shift of payment allocation away from physician services towards practice expense, potentially detrimental geographic redistribution of payment allocations, potential under-valuing of malpractice expense and gaps in reliable physician-specific data from the proposed new input sources.

Shift away from physician work to practice expense:

- Analysis has shown that the proposed shift in payment weights from physician work to practice expense principally favors Diagnostic Testing Facilities (+13%), Portable X-Ray Suppliers (+13%), Independent Laboratories (+10%) and Radiation Therapy Centers (+6%) to the

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detriment of Cardiothoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%) and Anesthesiology (-5%).

- Modest increases occur to specialties who provide services in the office with extremely expensive disposable supplies embedded into physician payment. Primary Care would face decreases (Family Medicine (-1%), Geriatrics (-2%), Internal Medicine (-2%) and Pediatrics (-2%).
- In summary, this proposal appears to redistribute physician payment from physician work to the business side of healthcare.

Geographic Redistribution:

- In addition to significant specialty redistribution, geographic redistribution would also occur, as CMS proposes to modify weights of the expense categories (employee compensation, office rent, purchased services and equipment/supplies/other) within the practice expense Geographic Practice Cost Index (GPCI).
- A significant reduction in the weight of office rent from 10.2% to 5.9% would lead to reductions in the payment to urban localities and increases to payment in rural areas and states with a single GPCI.
- CMS's impact analysis should also be expanded to consider how significant decreases in PLI payment may negatively impact geographical areas with relatively high PLI premiums.

Professional Liability Insurance:

- The dramatic decrease in the weight for PLI cost appears impractical. In 2021, the Medicare physician payment schedule allowed charges were \$91 billion. If PLI payment only represented 1.4% of this payment, total Medicare spending on its share of these premiums and self-insured actuarial costs would be \$1.274 billion.
- With more than one million physicians and other health care professionals billing Medicare, this would compute to Medicare paying an average of \$1,275 per individual.
- Assuming Medicare represents approximately 25% of physician payment, an understated \$5,100 in PLI premium cost results.
- This is in direct contradiction to the volume weighted PLI premium costs of \$21,700 computed by CMS elsewhere in the Proposed Rule. It appears that a 4-5% PLI weight is more appropriate than the proposed 1.4%.

Concerns with New Data Sources:

- The proposed changes in the category weights are primarily derived from the Census Bureau's 2017 SAS for the "Offices of Physicians" industry, which was not designed with the purpose of updating the MEI. As a result, there are key areas (physician work, non-physician compensation and medical supplies) where CMS must use data from other sources to work around this important gap.

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- Seven percent of the revenue for “Offices of Physicians” on the 2017 SAS was from non-patient care sources (e.g., grants, investment income) and any expenses associated with these sources cannot be excluded.
- The SAS for “Offices of Physicians” collects payroll and benefits for all staff combined but the MEI has separate cost categories for physician and non-physician compensation. Non-physician compensation is further broken out in the MEI by staff type. CMS is proposing to use the Bureau of Labor Statistics’ (BLS) 2017 Occupational Employment and Wage Statistics (OEWS) data to estimate the share of SAS personnel costs that apply to physicians (including qualified health care professionals (QHPs)) and non-physicians. Based on the 2017 OEWS, CMS states that 63.2% of employee compensation for “Offices of Physicians” is for physicians and QHPs. CMS appears to have misclassified registered nurse salaries in this estimate.
- Additionally, the OEWS only covers employees, so it is missing compensation for a large segment of the physician population (practice owners). To compensate, CMS is proposing to estimate total compensation for practice owners as a share of practice net income from the 2017 SAS (the difference between total revenue and total expense which amounted to \$44.9 billion out of \$490.9 billion in revenue for 2017). The share of net income proposed is the estimated percent of patient care physicians that are owners (46.5%), averaged from the 2016 and 2018 AMA Physician Practice Benchmark Surveys, resulting in an estimated \$20.9 billion in compensation for owners. CMS’s estimate of \$20.9 billion in compensation for owners represents just 10% of total compensation for all physicians and QHPs (\$203.8 billion), which is problematic since nearly half of physicians in the United States are owners.
- CMS used BLS data to split out the US Census SAS data using the NAICS 6211 “Offices of Physicians” category. However, only 64% of employed physicians are in this category in both the US Census SAS and BLS OEWS datasets. This analysis excludes 36% of physicians who are employed in other health care settings, such as hospitals. For example, the NAICS 6221 “General Medical and Surgical Hospitals” category was not included in CMS’ analysis and this category includes 158,880 employed physicians according to the 2017 BLS OEWS data. Hospital-based physicians have a higher proportion of physician earnings and PLI cost relative to other practice costs, as many of these other costs are the responsibility of the hospital or other facility. The CMS proposal greatly underrepresents the cost share of physician work and PLI relative to practice expense due to this inappropriate exclusion.
- In the current MEI, CMS excludes expenses for separately billable supplies and drugs. The 2017 SAS for “Offices of Physicians” has a single category for Medical Supplies without any breakout for the separately billable component. To estimate separately billable supply and drug expense, CMS proposes to age forward AMA-PPI results for these expenses and then compare the estimated total to Medical Supplies expense from the SAS (finding that 80% of Medical Supplies expense is for separately billable medical supplies or drugs). There are two problems with the CMS proposed approach: 1) The measures used to age expenses forward are not entirely appropriate (using growth in Medicare Part B drug spending when an all-payer measure would be better, and using measures of inflation (CPI and PPI from BLS) to age spending); and 2) totals estimated from two entirely different surveys are being compared when those surveys may have different populations and methods (for example, the wording of the questions and

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direction on what to include in the category could be entirely different).

In conclusion, given all these concerns with the proposed MEI rebasing and revision, and in light of the fact that the AMA's efforts to perform an update to the PPIS which may alleviate many of these concerns are already underway, the ACC believes it would be most prudent to delay any adjustments to the MEI index until the AMA survey is complete. **We urge CMS to collaborate with the AMA on this new data collection effort to ensure consistency and reliability in physician payment. Updates to MEI weights should be postponed until new AMA survey data are available. It is anticipated that the new data collection effort would begin in 2023 and be based on 2022 data.**

Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

Advance Investment Payments

The ACC applauds CMS' proposal to incorporate the option in the Shared Savings Program to make advance shared savings payments to certain ACOs. This proposal would allow for providers in rural and underserved areas to join ACOs and succeed within the program. Giving these ACOs the opportunity to promote equity through addressing patient needs and social needs is key.

Under the new proposal, CMS will allow an eligible ACO that is new to MSSP and identified as rural or low revenue to receive a one-time fixed payment of \$250,000 and quarterly payments subsequently for the first two years of the 5 year agreement period. These quarterly payments would be based on a score set to 100 if a beneficiary is dually eligible for Medicare and Medicaid. Payments will be capped at 10,000 assigned beneficiaries. CMS proposes that the advance investment payment would be recouped once the ACO were to begin achieving shared savings in their current agreement period and next agreement period if a balance persists. However, if the ACO were to not achieve shared savings CMS would recoup the funding except if the ACO were to terminate during the agreement period which would result in the ACO receiving advance investment payments. **The ACC thanks CMS for proposing this approach as it will allow ACOs to use the advance investment payments to improve infrastructure, increase staffing and provide care for underserved populations.**

Transition to Performance-Based Risk

CMS is proposing that for agreement periods beginning on January 1, 2024 and in following years, that ACOs inexperienced with performance-based risk will be able to participate in one 5 year agreement under a one-sided shared savings model by entering into the BASIC track glide path and remaining in Level A for the duration of the agreement. According to the proposal, these ACOs may potentially be able for a second agreement period within the BASIC track glide path with two additional years under a one-sided model before transitioning to two-sided risk. For the performance years beginning on January 1, 2023 and in subsequent years, CMS is proposing to allow ACOs

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participating in Level A or B the option to continue in the BASIC track glide path for the duration of their agreement.

Additionally, CMS is proposing that agreement periods beginning on January 1, 2024 and in following years will no longer have the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track. **The ACC appreciates CMS creating these proposals with the goal that smaller providers in rural and underserved areas will have more time to transition to two-sided risk. In previous years, quick and mandatory adaptation of two-sided risk models was a barrier for some of our members' health systems in participating in MSSP.**

Reducing the Effect of ACO Performance on Historical Benchmarks and Strengthening Incentives for ACOs Serving High Cost of Care Populations

CMS has developed several proposals that will ensure that rebased benchmarks do remain accurate and serve as a baseline when benchmark years correspond to the performance years of the ACO's preceding agreement period. These proposals will require ACOs to beat their own performance and ensure that the benchmarking methodology results in benchmarks of sufficient value to encourage program entry and continued participation by ACOs. **The ACC thanks CMS for creating these proposals that will reduce the effect of ACO performance on historical benchmarks and increase options for ACOs caring for high-risk populations.** These proposals will allow for a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs and reduce the impact of the negative regional adjustment. These proposals will be incorporated into the agreement periods beginning on January 1, 2024.

Adjusting ACO Benchmarks to Account for Prior Savings

CMS is proposing to incorporate an adjustment for prior savings that would apply for renewing and re-entering ACOs that were reconciled for one or more performance years in the three years prior to the start of their agreement period. This adjustment would help to set an ACO's benchmark on an amount that reflects the success in lowering growth in expenditures while meeting the program's quality performance standard. **The ACC applauds CMS for returning a dollar value to benchmarks through prior savings adjustments in order to help address an ACO's effects on expenditures.** This proposal will help ensure that high performing ACOs have incentives to stay in the Shared Savings Program for a long term. Based on this proposal, CMS will adjust an ACO's benchmark based on the higher amount of either the prior savings adjustment or the ACO's positive regional adjustment which in turn would offset negative regional adjustments for ACOs.

Reducing the Impact of Negative Regional Adjustments

CMS has developed two policy changes designed to limit the impact of negative regional adjustments on ACO historical benchmarks. These policies were designed to further incentivize program participation among the ACOs that serve high cost beneficiaries. One proposal reduces the cap on negative regional adjustments from -5% of national per capita expenditures in Parts A and B

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services under the original Medicare FFS program to -1.5%. CMS also is proposing to decrease the negative regional adjustment amount after the cap is applied to the regional adjustment.

Calculating County FFS Expenditures to Reflect Differences in Prospective Assignment and Preliminary Prospective Assignment with Retrospective Reconciliation

Currently, CMS uses risk adjusted county level FFS expenditures that are determined based on expenditures for assignable beneficiaries for the calendar year that corresponds to the relevant benchmark to calculate factors based on regional FFS expenditures used in establishing and updating an ACO's benchmark. Over the last two years, this approach has created a systematic bias in calculations using county-level expenditures that favor ACOs under prospective assignment.

To remove this bias, CMS is proposing to calculate risk-adjusted regional expenditures using county-level values computed using an assignment window consistent with an ACO's assignment methodology selection for the performance year. Therefore, for an ACO that selects prospective assignment, CMS would use an assignable population of beneficiaries identified based on the calendar year assignment window. **The ACC thanks CMS for developing this proposal that would remove selection bias in calculating expenditures.**

Increasing Opportunities for Low Revenue ACOs to Share in Savings

CMS is proposing that the eligibility criteria be expanded for agreement periods beginning on January 1, 2024 and in subsequent years for lower revenue ACOs participating in the BASIC track. This new expansion would encompass these ACOs even if they do not meet the minimum savings rate requirement. **The ACC supports the expansion of this eligibility criteria for low revenue ACOs.**

Under this proposal, eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate will receive half of the maximum sharing rate for their level of participation. For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but at the same time meet the proposed alternative quality performance standard, the sharing rate would be further adjusted according to the proposed sliding scale approach for determining shared savings. **The ACC supports this proposed approach as it would provide payments to ACOs with the largest need for shared savings such as smaller rural ACOs and focus on underserved populations. This proposal would allow for investments in care design and quality improvement efforts.**

Impact of Public Health Emergency for COVID-19 on ACO Expenditures

CMS has collected data over the last two years that demonstrates that ACOs have extreme declines in spending in 2020 that rebounded in 2021. Therefore, the historical benchmarks averaged across both 2020 and 2021 represent a reasonable basis from which to update ACO spending targets in future years. To further alleviate the adverse effects of the PHE for COVID-19, CMS has promised to utilize a three-way blend of the national regional growth rates.

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Options for Addressing Concerns about an ACO's Assigned Beneficiaries on Regional Fee for Service Expenditures

In the past year, CMS has received notice that including an ACO's assigned beneficiaries in the determination of the ACO's regional expenditures has resulted in lower benchmarks for ACOs. Therefore, CMS has proposed a new set of benchmarking policies to ideally reduce the impact of the ACO's assigned beneficiaries in the region. CMS also proposes to adjust the benchmark for prior savings. **The ACC agrees with CMS' proposal to expand the definition of the ACO regional service area to use a larger geographic area in determining regional FFS expenditures.**

Proposed Benchmarking Policies for CMS Web Interface Measures for PY 2022, 2023 and 2024

In the 2022 PFS final rule, CMS extended the CMS Web Interface for PYs 2022, 2023 and 2024 for reporting under the APP. However, benchmarking policies that were used to establish quality measure benchmarks in the Shared Savings Program prior to the implementation of the APP were sunset during the 2020 performance year. CMS is proposing to amend a regulation which governs the ACO quality performance standard for the performance years that begin on or after January 1, 2021 with language that allows for a performance benchmark and a minimum attainment level for each CMS Web Interface measure. This proposal also establishes a point scale for the measure.

Reducing Administrative Burden

Marketing Information

The ACC supports CMS' proposal to remove the requirement for ACOs to submit marketing materials for CMS to review prior to being used. The elimination of this requirement would be effective starting on January 1, 2023 and for the following years. Taking away this requirement would help to reduce the administrative burden of ACOs but would also allow ACOs to have more time to prepare marketing materials to be used in the future.

Beneficiary Notifications

The ACC applauds the efforts of CMS to educate beneficiaries on all benefits of value-based care through working with consumer advocates to develop new strategies that communicate these benefits to Medicare beneficiaries. In recent years, the current requirement for ACOs to notify beneficiaries annually has created burdens that ACOs have reported. The proposal to modify requirements for ACOs to provide a beneficiary notice prior to or during the first primary care service visit annually to provide the notice at the primary care service visit once during an agreement period. This proposal also adds a stipulation that the follow-up beneficiary communication should happen within 180 days after the beneficiary notice is provided. This proposal would take effect beginning on January 1, 2023 and in following years. **The ACC believes that the change to**

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beneficiary communication will lead to a deeper understanding of the content in written notice and will allow beneficiaries more time to ask questions that they may have.

CMS also is proposing to clarify their current policy that states that all ACO participant practices and facilities need to post signage that notifies beneficiaries of their participation in an ACO, what that means for their care and the ability to decline claims data sharing and voluntary alignment to primary care providers. **The ACC recommends beneficiaries be notified during the proposed 180-day period to reduce burden on ACOs and mitigate confusion.**

Data Sharing

CMS is proposing to update their data sharing regulations to add a clause that allow ACOs acting as organized healthcare agreements to request aggregate reports and beneficiary-identifiable claims data from CMS. This proposal would also allow ACOs to structure themselves as an organized health care facility to reduce the burden with reporting MIPS CQMs. This proposal would be effective for performance years beginning on January 1, 2023 and following years.

Updating the ACO Beneficiary Assignment Methodology

CMS is proposing several revisions to the definition of primary care services that are used for beneficiary assignment. CMS plans to implement new prolonged service codes and new chronic pain management codes to ensure that the Shared Savings Program assignment methodology remains consistent with billing and coding guidelines. These proposed changes would begin on January 1, 2023 and in following years.

MSSP/APM Performance Pathway (APP), Social Drivers of Health (SDOH) Measures

Like CMS, the ACC is committed to advancing equity in the delivery of healthcare to reduce disparities in cardiovascular practice. We are pleased that CMS has included two beneficiary-level SDOH measures for consideration in the IPPS program: *Screen Positive Rate for Social Drivers of Health* and *Screening for Social Drivers of Health*. These represent an important first step in providing appropriate services to patients and addressing the lack of standardized SDOH measures and interventions in CMS programs. The ACC further supports these measures with the recognition that aside from patient outcomes, SDOH frequently impact physicians' ability to provide adequate care, contribute to burnout, and deter participation in risk-sharing payment models. We also agree with CMS' proposed approach to first implement these measures through voluntary reporting. The ACC believes that an additional benefit of accountability in SDOH is that it would lead to further participation in alternative payment models (APMs). The availability of additional SDOH data could inform improvements in the development and refinement of risk-adjustment models used in measures and programs. The ACC recommends these measures be clearly linked to a strategy for implementation and indicative of improvement of the risk factors as described within the measure specifications. As such, infrastructure is needed to support the coordination and implementation of needed services for patients, and it is hoped that patients can be matched with the appropriate resources for their continued care.

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The ACC has several concerns with the measures as written and reviewed under the Measures Application Partnership (MAP) review process. First, the measure developer did not provide evidence demonstrating that these processes are linked to improvements in health outcomes. In addition, the measures do not outline specific, standardized tools for facilities to use (e.g., The Accountable Health Communities Screening Tool). CMS will need to consider recommendations for standardization in terms of data collection, or whether to allow flexibility among facilities in their data collection and implementation efforts. Many facilities may not be equipped or prepared with the necessary resources and tools to address patient needs. Alternatively, some facilities may already be actively addressing patient needs in the community and may need to reconcile the ideal approach. Lastly, we caution against any undue burden on data collection among patients and providers. While we recognize there are limitations with these measures, we believe they can be improved over time through CMS's annual measure review process and can provide the structure for similar measures in other quality programs. In all, these measures can begin to provide important data on the prevalence of several factors impacting better patient outcomes. Additional SDOH should be considered for the future such as education (both patient and physician (e.g., bias training)), technology access, and medication cost and access. Finally, we are hopeful that the implementation of these measures may lead to improved technologies, community-based infrastructures, and further integration of healthcare and social services.

MVP Maintenance Process and Engagement with Interested Parties

We agree with CMS' proposal to modify the MVP maintenance process such that interested parties and the public would be able to submit their recommendations for potential revisions to established MVPs on a rolling basis throughout the year. For example, several measures in the Chronic Disease Management MVP may also apply to cardiologists. Understanding CMS' thoughts around this MVP and others that may involve cardiovascular care, would provide groups such as the ACC with a better sense of which clinicians and patient populations may be captured in each MVP category. We applaud CMS' proposal to host public facing webinars and allow interested parties to voice their feedback on those revisions.

Advancing Care for Heart Disease MVP

The ACC appreciates CMS' efforts to alleviate the administrative burden of MIPS, streamline quality reporting, and support clinicians in the to move to Alternative Payment Models (APMs). While the College agrees that the MVP and subgroup reporting proposals offer the opportunity for cardiologists to focus on more clinically meaningful measures under MIPS, we urge CMS to proceed cautiously with these proposals to ensure that they do not inadvertently create additional confusion and complexity for participating clinicians and groups.

In the past, the ACC has recommended to CMS to consider how best to construct MVPs for specialties which are inclusive of several subspecialties, such as cardiology. We have observed in the proposed rule that CMS aims to broaden the scope of the Advancing Care for Heart Disease MVP by adding measures relevant to the clinical care of electrophysiology, heart failure, and interventionalist subspecialists. However, it remains unclear as to whether a single MVP for

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cardiology that encompasses all cardiovascular care would be most beneficial to clinicians and patients, or if creating discrete MVPs by subspecialty/patient population is more beneficial. We recommend that CMS and its contractors review data by clinician type to discern if there are any observable differences in performance.

The ACC also recommends that CMS provide timely access to data on quality, cost, and population health measures, which are key to identifying opportunities for MVP development. When recommending measures for the MVPs, it is helpful to know how many clinicians/groups are currently reporting a measure, the specialty breakdown of reporting, and whether a measure is approaching topped out status or if there is still room for improvement. Having this information allows the ACC to identify measures that are both clinically relevant, but also likely to be reported by participants so that CMS reaches its necessary sample thresholds.

Quality Measures

As noted earlier this year, the ACC agreed with the addition of the following measures:

- **Q326: Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy.** Note that the measure steward, AHA, may not submit the measure for re-endorsement due to changes in guidelines.
- **Q377: Functional Status Assessments for Heart Failure**
- **Q392: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation**
- **Q393: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision**

While we recognize the influence of depression in cardiovascular health, we do not fully agree with the addition of the proposal to add **Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan.** Cardiologists and the respective subspecialties typically do not treat, assess, or monitor mental health care, as this traditionally lies within primary and behavioral care clinicians.

We appreciate CMS' updates to the **Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure** for the Merit-based Incentive Payment System Program measure in order to mitigate a number of concerns raised by the public and other stakeholders. These include changes to the measure specifications that address the issue of heart failure severity by excluding patients at advanced stages of heart failure (e.g., those with LVADs, on home inotropic therapy, prior transplant or end stage renal disease); and further by risk adjusting for AICDs (defibrillators), systolic heart failure, comorbidities (including chronic kidney disease), and for frailty/disability. We also appreciate the 21-case minimum to mitigate concerns about risk adjustment for clinicians with higher caseloads of patients with more complex heart failure (the measure would be initially reported only for MIPS eligible cardiology TINs (i.e., MIPS TINs with at least one cardiologist) with a 21-patient case minimum), as well as the exclusion of

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advanced heart failure/transplant specialists for attribution. Finally, we appreciate CMS' proposal for this measure to be initially reported only for MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities that include at least 1 cardiologist during the CY 2023 performance period/2025 MIPS payment year. We do continue to have several concerns with this measure, however, as we have noted in prior comments. These include attribution; APPs who may be considered primary care but provide care in a cardiology practice; and unintended consequences.

ACC noted in a prior letter that many TINs in large organizations comprise both primary and specialty practices and therefore it is not entirely clear how attribution might be determined. This may be of concern, for example, with Advanced Practice Practitioners who are often considered primary care but may also be in a cardiology practice. In this scenario, if a cardiology-specific APP has the most patient touchpoints, attribution could fall within primary care while in fact the cardiology practice is driving costs. It is not clear if a Cardiology APP visit would count as a primary care visit, or a second visit to the cardiologist, for example. Another example is an electrophysiologist who sees an appropriately referred patient for a device and sees that patient twice in one year (e.g., the initial consultation, a follow-up visit), she will now "own" the heart failure care for the year over the primary care provider, based on attribution logic. CMS could explore that possibility that APPs could form subgroups, but this remains unclear as a potential solution. Another consideration is how telehealth visits will impact attribution. Given the total costs of heart failure care and the volume of encounters with this patient population, it is important to clarify and consider how attribution would be affected.

Finding the appropriate attribution for heart failure care and other chronic conditions is challenging and will not lead to a perfect algorithm. While MIPS was designed to cater to individual clinicians, attribution of the individual provider for complex conditions and complex systems of care, including heart failure patients, is difficult to achieve and does not accurately reflect patient outcomes. Especially with this patient population, consideration must be given to the fact that operational and clinical processes are increasingly team-based and assessing admission rates via a single clinician (or clinician groups), again elucidates the issue of attribution.

Overall, we suggest to CMS that going forward, measures should offer rewards for reduced hospitalization, which would include considerations for team-based care. CMS should also consider the potential for unintended consequences due to failure to manage the competing risk of death. That is, patients may be sent home instead of admitted to the hospital, whereby admissions are seen as a risk of penalty. There should not be incentives for physicians to select alternative codes, avoid high-risk patients, or fail to admit patients when necessary. We emphasize that metrics should be linked to quality of care and account for any consequences that are tied to rewards and penalties. CMS could achieve the same goals by turning its focus to clinician-level metrics that focus on providing guideline-directed medical therapy (GDMT) and improving management of hypertension and diabetes, including dietary management, weight reduction, and enrollment in a disease management program, which each have the potential to reduce hospitalizations by making our patients healthier. As CMS considers these and comments from other stakeholders on this measure, we would welcome the opportunity to continue to participate in further refinements and assist in considerations of other approaches to measurement.

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Cost Measures

We remain concerned with attributing broad-based downstream costs to clinicians or practices who provided care at an earlier point in time, particularly at the individual clinician level. Cost measures should only be attributed at the group/practice level or higher instead of with individual clinicians. It is difficult to account for the variety of influences on the costs of care, which may be attributable to the actions of an entire care team as well as a patient's individual environmental, social, and economic factors. We also remain concerned that cost measures are an average of different cost measures, especially for clinicians who may be part of a multidisciplinary TIN.

We continue to support the exclusion of clinicians from attribution based on their practice patterns or specialties and allowances for a specialty adjustment to account for the fact that costs vary across specialties and across clinician groups with varying specialty compositions. Cost measures should also risk-adjust for social determinants of health as appropriate and be within a clinician or group's reasonable ability to influence the outcome.

The ACC supports the notion that if a cost measure is unavailable or does not apply, the preference is to reweight the cost category to another performance category or categories over the utilization of the MSPB or TPCC measures. However, if an alternative cost measure must be included in the event that an episode-specific measure cannot be triggered, the ACC's preference is to utilize the MSPB Clinician measure and not the TPCC measure. The main factor in our preference for this measure over TPCC is that the cost of services provided to a beneficiary during an MSPB Clinician episode are calculated in the period immediately prior to, during, and following the beneficiary's hospital stay rather than the overall cost of care delivered to a beneficiary that focuses more on primary care. In addition, the measurement period is limited to 30 days after the procedure or event, rather than one year beyond the candidate event as with the TPCC measure.

To succeed at reducing the costs of care, we recommend that cost data be provided to clinicians not only in real-time, but also be reported in actionable theme categories (such as complications, Part D Drugs, Laboratory, Outpatient Visits, Diagnostic Imaging, etc.) with detailed data and information that could be utilized to drive improvements in costs. For example, in the recent field testing of the Heart Failure cost measure under development by CMS and Acumen, the "Cardiopulmonary Procedures / Interventions" category is too broad to help drive any decisions around how to potentially manage costs. A breakdown of other costs into groups such as cardiac catheterization, EP procedures (e.g., ICD/CRT, AF ablations), and TEER/TAVR would provide stakeholders with a more specific blueprint for where spending is occurring. It is also unclear if this theme also includes surgery, TAVR, and resynchronization therapy; we would recommend that the report clarify this if additional detail is provided.

Another example would be to break out the Part D drugs category into drug types or drug categories to provide additional actionable data around prescribing practices. However, we continue to note that medications should be prescribed based on the specific patient's needs and preferences and

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remain concerned around holding clinicians accountable for the costs of Part D drugs without measuring the impact on quality and outcomes.

Cost data is likely to be complex, and methodological constructs related to cost such as resource use, care episodes, attribution, and benchmarks will likely require straightforward explanations as to how they are calculated and how they affect patient care. Therefore, it is key to pair education along with detailed cost data. Clinicians can make more of an impact on costs if they can see the impact of their practice patterns through cost measures that are within their control. CMS should also consider how data sources could be utilized at the point-of-care and within the regular practice workflow, as these can also affect treatment decisions.

Developing Quality Measures that Address Amputation Avoidance in Diabetic Patients Request for Information

We appreciate that CMS is exploring the possibility of developing quality measures to address concerns related to increasing rates of lower extremity amputation (LEA) and the known disparities among Black, Native American, and Hispanic patients. The development of such measures is an important step in addressing the burden of amputation and improving outcomes for PAD patients at risk.

As CMS has noted in the RFI, disparities remain vast among certain patient populations. In developing any measures, factors such as geographic variation, health insurance coverage, access to care, income, race, and other variables should be examined and created as part of the risk-adjustment profile. CMS may also wish to consider the development of patient-reported outcome measures that assess needs such as preparation for living with an amputation, pain management, financial challenges, etc. While composite measures may be useful in that they essentially summarize the multidimensional complexity of care through a single measure, they may not, however, elucidate the true nature of differences in the collected information, and may be burdensome for providers to report.

In addition, measures should be integrated into electronic health records and delivery of care processes to ensure that reporting burdens are minimized and standardized. We would also advocate for CMS to encourage institutions to maintain or participate in a registry that includes outcomes after peripheral revascularization and rates of amputation. The National Cardiovascular Data Registry's® PVI Registry™ assesses the prevalence, demographics, management and outcomes of patients undergoing lower extremity peripheral arterial catheter-based interventions and may serve as an excellent resource for clinicians.

It is unclear whether such measures should be used in MVPs, especially any composite measure, due to the potential for reporting burden and potential overlap with other measures. We encourage CMS to continue conversations with relevant stakeholders in the development of these measures and for the continued exploration of level of measurement (e.g., clinician, group), addressing health equity, unintended consequences, and assessment of burden.

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Subgroup Reporting

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

Proposed Subgroup Reporting Limits

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

For example, CMS proposes that subsets of a group under the same TIN could form subgroups, but subgroups cannot be formed if clinicians are part of different TINs. Given the importance of engaging in care coordination under value-based payment models, some cardiology practices that manage a patient in the outpatient setting seek ways to align incentives with hospitalists and other care providers outside of the practice who may manage the patient during an acute care episode. Based on interpretations of the Stark Law, these practices have not been able to engage in such arrangements as assignment under different TINs prohibits recognition of these cross-setting teams as a "group practice" under current regulations.

The ACC recognizes that changes beyond this proposed rule may be needed to permit eligible clinicians in multiple TINs to form a subgroup or APM Performance Pathway (APP) group. The College asks that CMS explore how to address this scenario and continue to ensure that the introduction of TIN-based subgroup reporting does not create administrative complexity for clinicians and groups.

We also agree with CMS' concerns about measuring subgroups cost scores based on their affiliated group score and how this may prevent the ability to generate more granular, clinically specific data about performance. We look forward to CMS' proposed potential solutions in the future. One related recommendation is to allow for a scoring hierarchy, in which CMS would give the subgroup the higher of their subgroup or group score for these measures as an incentive to form subgroups. Again, we urge some forethought into preventing additional program complexity, but we do not want to see practitioners disincentivized from participating due to the cost performance category.

MIPS Quality Performance Category Health Equity Request for Information

The ACC appreciates the administration's focus on health equity and CMS' action to evaluate and implement initiatives in reducing disparities, including this RFI for measuring healthcare disparities.

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We are fully committed to addressing issues affecting racial and ethnic minority groups, indigenous people, members of religious minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, older adults, rural populations, and others. The ACC strives to educate its membership about these pervasive topics and is actively working to increase the diversity of the cardiovascular workforce.

The ACC is committed to improving equity considerations in medicine and understands persistent racial and ethnic gaps in processes and outcomes of care are an ongoing failure in the healthcare community, including in cardiovascular care. By requesting information from stakeholders on methods for measuring healthcare disparities and stratifying measures across CMS quality programs, CMS could provide clinicians and patients with valuable information to inform medical decision making and help reduce disparities in care that currently exist. **While there may be some initial hesitation among providers, practices, and health systems in implementing additional measurement initiatives, we think these are important steps in addressing how SDOH impact health outcomes. We agree that these approaches will allow for individualized quality improvement efforts, tracking of improvements, and drive an overall improvement in decreasing disparities.**

Capturing Health Equity Needs

Pursuing health equity should ensure that all people are able to obtain the highest standard of care while also addressing the needs of those with greater risks of poor health due to certain determinants of health (DOH). These DOH are interdependent, complex, and under constant change, but nonetheless factor into the conditions in which people live and ultimately their health status. Meaningful progress will require collaboration among a multitude of stakeholders, including clinicians, health systems, federal and local policymakers, payors, and others. We applaud CMS for coordinating efforts on data collection and measure stratification methods, including the work put forth by agencies such as the OMB, CDC, Public Health Information Network, ONC, and NQF. CMS may also wish to consider the adoption of an indexing or scoring function by which certain patients may be deemed to have a higher risk. Ideally, such a score or index could be implemented in both EHRs and registries.

Fundamental to improving health outcomes and addressing inequities is performance measurement. As CMS is considering the potential future inclusion of other broad health equity measures in MIPS and MVPs, a comprehensive approach to improvements in health equity will involve a multitude of measures and reflect the needs of all stakeholders, but most importantly that of the patient. Equity measures should consider that patient care improvements will likely fall onto more than one member of the care team. Responsibility should be undertaken at all levels of the care team, and clinicians should be encouraged to see equity as a professional competency. It is important for health systems or a practice to have the ability to implement these mechanisms in the first place, however. Patient needs are self-perceived and may reflect a current health state, beliefs, and continuity of care, among other factors.

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Fundamentally, measures should be developed when disparities in care are known to exist in certain populations or that pertain specifically to disparities in care. This means that measures should reflect the evidence base on the relationship between a social risk factor and health or health care outcome. Overall, measures should reward reducing disparities, improve performance (in relation to benchmarks for at-risk patients), and meet absolute quality thresholds. CMS should consider whether measures should be designed to avoid unintended consequences such as worsening quality or disincentivizing providers and/or health systems to improve equity. We believe that measures should not be used for accountability purposes but rather for quality improvement.

Actionable Information and Links to Improving Care

Once CMS has determined additional measures to include in MIPS and/or MVPs, efforts should be made to align them across CMS programs, states, commercial payers, and other industry actors. We recognize that CMS considers recommendations from organizations such as the NCQA, NQF, and others to inform their policy decisions, and we encourage the continued use of these resources to leverage the ability to create standards and uniformity.

Some of the bigger challenges in performance measurement in health equity are the incompleteness, lack of integrity, and lack of standardization of underlying data. In addition, challenges remain in how data is shared and audited across various entities. The existence of accurate data will not ensure that steps will be taken to mitigate gaps in quality care, eliminate or reduce inequities, or alter health care needs, however. Given these and other challenges with data collection and reporting, the first step of stratifying process measures may need to continue indefinitely before moving to outcomes measures that are designed to assess disparities. CMS will need to consider how the data will be actionable, such that tools, strategies, and interventions are tailored to meet the needs of individuals and populations. Dissemination of these lessons learned, tools, and strategies of what has worked and how best to implement them will be a cornerstone in moving forward with improved patient care that meets the needs of all patients.

Outcomes in CV care could be designed by starting with common procedures (e.g. TAVR, CABG) in cohorts defined by SDOH factors. (Sample analysis: percent of non-white population in a primary service region vs percent non-white who undergo “procedure X”). CMS will also need to consider that quality measurement should be equal for clinicians across all practice types (e.g., solo, group, large health system). For example, it is likely that clinicians in large organizations will be at an advantage due to their resources, whereas solo private practices or small groups will not have the ability to facilitate or foster improvements in areas affecting health equity.

Lack of Risk Adjustment Limitations

The ACC recognizes that health equity-focused data collection alone will be a significant effort and appreciates CMS’ commitment to requesting additional information from the public. Relevant sociodemographic factors should be utilized in an analysis unless there are conceptual reasons or empirical evidence indicating that adjustment is not appropriate or necessary. Analysis should also consider unintended consequences of stratification for the patient population, providers, health

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plans and systems if measures are used in accountability programs such as pay-for-performance or public reporting. The ACC agrees that risk adjustment may help identify patient populations and targeted quality improvement strategies for those most vulnerable to health inequities; however, we also agree with CMS about the unintended consequences that may result if data are inaccurate. For example, risk adjustment for social factors using historical associations may reinforce disparities and perpetuate the problem.

Approaches for Measuring Health Equity

The ACC supports CMS' efforts to improve the standardization and collection of SDOH to improve our understanding of additional factors that may influence health outcomes. Resources such as the NQF MAP Health Equity Advisory Group and Best Practices for Testing Risk Adjustment Models white paper may be useful in determining the appropriate socioeconomic risk factors and highlight considerations such as standardization, resource availability, and implementation issues. We applaud CMS' efforts to date in working with experts from external organizations in the development and use of health equity data and algorithms.

The College believes that data collection efforts should go beyond examining race and ethnicity and include a host of other risk factors to better inform clinicians of patient outcomes. The "Heart Disease and Stroke Statistics - 2021 Update"² provides a variety of examples of SDOH which impact cardiovascular disease. Other factors for consideration include access to healthy food, structured racism, income, occupation and work condition, education level, physical and leisure activity, gender, cultural beliefs, language, number of social contacts, family support, citizenship status, neighborhood social cohesion, air pollution, number of household members, sleep quality, health insurance status, and access or distance to appropriate medical care (such as in the case of door to balloon times). We also believe that poverty plays a significant role in evaluating quality and outcomes, which can be measured via zip+4 code. Assessing poverty could also be available through dual Medicare/Medicaid eligibility. While these additional elements may be beyond the scope of the proposed RFI, it is also important to factor in data about the pathophysiology and natural history of a disease or condition, genetic and hormonal influences, disease or condition symptoms, general stressors (which is critical in their impact on CV disease) optimal diagnostic testing, and benefits and risks of therapeutic interventions. Baseline cardiovascular county rates of cardiovascular-related mortality should also be considered.

As CMS examines race, ethnicity, and other disparities at the practice level, it may also be helpful to identify those aspects of practice that are under a clinician's control but not influenced by SDOH, such as procedural complications. Clinicians may also be able to exert influence in the areas of completion of implicit bias training, appropriate health literacy level education resources, discussion of economical options for healthy diet and exercise, and directly asking patients about SDOH in general.

² Virani SS, Alonso A, Aparicio HJ, et al. Heart Disease and Stroke Statistics-2021 Update: A Report From the American Heart Association. *Circulation*. 2021;143(8):e254-e743. doi:10.1161/CIR.0000000000000950

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Use of Consistent Tools for Data Collection

CMS has noted in the past that self-reported sociodemographic data is the gold standard. However, many clinicians already find it difficult to collect this information from their patients due to workflow issues, resource constraints, or patient reluctance to disclose, for example. Clinicians and administrative leadership must be aligned in the commitment to collect or manage disparity initiatives; as with all quality initiatives, these must not be burdensome with either costs or time. Additionally, a lack of data standardization in SDOH measures hinders collection efforts and prevents necessary data liquidity. Integrated health systems might have a better ability to enact change or to collect data, whereas smaller practices might have fewer resources to do this. **In addition, CMS should also consider how clinical registries such as the NCDR[®], could serve as partners in collecting this type of data. Consistent data collection is a necessary component of implementing equity-focused measures. The ACC believes CMS should ensure efforts to develop and collect SDOH data should align with other federal initiatives through improved standardization.** This will improve semantic interoperability and allow for more nuanced and useful applications of SDOH data.

The ACC has a rich history of using real world data from its national clinical registry programs to understand historical patterns of clinical treatment compared to evidence-based science. Research based on clinical registry data has contributed to the medical literature highlighting gaps and disparities in quality of care and patient outcomes, including by race. The College has been – and remains – fully committed to developing quality improvement initiatives to address such gaps or disparities.

Nonetheless, the College is fully aware that treatment gaps can be lessened or exacerbated when “real-world,” or observational, data are used to inform risk stratification and treatment decisions. Biases can also be reflected in historical datasets, including those influenced by social, cultural, economic, and other variables. Thus, great vigilance is needed by all health care stakeholders, especially medical professional societies. Learning how this data can be turned into information within the context of medical decision-making is crucial.

The ACC is supportive of finding ways in which data collection tools can serve as the starting point for conversations and shared treatment decisions with each unique patient. The goal for each of these tools is to encourage appropriate clinical treatment while avoiding the harm of unnecessary treatment. The starting point for such decisions must always be the individual patient. Tools can help inform how similar patients might fare with a particular course of treatment based on the best available science, but ultimately, the clinician and patient must assess together how to manage that person’s health. It is important to keep the patient in mind as part of any expanded data collection effort. Many patients may have questions as to how data related to their sociodemographic background is important to their care. Ensuring that beneficiaries feel comfortable sharing this information with clinical and administrative staff should be the top consideration of any health equity initiative, as well as how this information is stored. Beneficiaries also want to feel protected in that this information will not be used against them or negatively impact their diagnostic or treatment plan.

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The ultimate goal of the ACC is to equip clinicians and patients with as much information as possible to guide the development of a shared, effective care plan. The ACC/AHA guidelines repeatedly emphasize the importance of shared decision-making, wherein the clinician and patient discuss the goals and risks of treatment and customize a care plan that accounts for the values of the patient. While risk stratification is an important part of the strategy, judgement on the part of the clinical staff is fundamental as part of the workflow. Community partnerships, teamwork, care coordination, and exchange of health information also may inform and create a culture of shared decision-making.

Future Efforts to Reduce Health Disparities

The ACC appreciates CMS' work to address the longstanding healthcare disparities that have come to light during the COVID-19 pandemic. The College agrees that there is value in developing new measures as well as refining existing measures and programs to address health equity. Tying these measures to value-based models such as MSSP and the QPP can certainly incentivize improvements in the care of underserved populations; however, the College encourages CMS to proceed cautiously in order to ensure that any health equity focused incentives truly serve the patient population. As part of this effort, CMS should also identify solutions to common barriers in care. For example, the ACC has long advocated for access to regular cardiac rehabilitation services following an acute cardiac event or procedure. However, many beneficiaries report being unable to complete a full course of rehabilitation due to the \$20 copay per visit or challenges with transportation to a facility. CMS should determine how to ensure beneficiary access to services such as cardiac rehabilitation, which have the ability to improve patient outcomes in the long-term.

The ACC recognizes that achieving health equity will require collaboration across stakeholders outside of the medical community and CMS. Community organizations and local entities will be crucial to addressing needs related to food, housing, employment, and other socioeconomic support that have an impact on beneficiary health and access to care. While impacting some of these factors will be a challenge for clinicians, the ACC remains committed to working with CMS to determine how to engage the broader beneficiary and stakeholder community to holistically address disparities in care.

CMS should also continue to monitor the effects of pay-for-performance programs on incentives. The literature has supported the observation that providers that care for disadvantaged patient populations tend to underperform their peers in metrics utilized in pay-for-performance programs. Not only are resources then directed away from providers who need them the most, providers may then be incentivized to avoid these disadvantaged patient populations. Incentives must be developed in such a way that they are equal among providers regardless of socioeconomic status of their patient populations.

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Researchers in one recent study were able to demonstrate this using a novel approach for altering incentive payments.³ In their work, they utilized a standard incentive payment allocation, but then utilized post-adjusted payments based on predefined patient or provider characteristics. Adjustments were specifically based on the population with low socioeconomic status or the per member per month capitation payment. Providers were divided into categories based on this information (e.g., disadvantaged, intermediate, and advantaged). This allowed for providers across the spectrum to receive an equal payment (i.e., resources), regardless of their proportion of SES patients. One advantage is that current measurement processes would not need to be modified. It should be noted however that this is not a one-size-fits-all approach, in that multiple strategies may be required.

There is a dual responsibility of the cardiovascular clinician to address the consequences of racial and structural injustice and its manifestation in health disparities. Specialists may be the only primary point of contact for a patient, so their participation should be expected. The clinician's first obligation is to provide the best possible care to each patient. Patients present bearing the burdens of society as it is, not as we wish it to be. By understanding how these social burdens manifest as clinical risk, clinicians can endeavor to attenuate that risk at the individual patient level. However, the ACC also believes it has a responsibility to address the structural drivers of this disparity, with the ambition of reducing the variation in risk across race by reducing the social and structural disparities which drive it.

As CMS continues to evaluate its quality reporting programs and determine methodologies for Measuring Healthcare Disparities and using measure stratification, the ACC stands ready to provide any necessary input and clinical expertise to ensure potential performance differences are both meaningful and accurate. The College thanks CMS for beginning to examine these important topics and looks forward to continued collaboration in developing policies and programs that reduce disparities in care.

MVPs and APM Participant Reporting Request for Information

To ensure that the MVPs serve as the intended glide path to APM participation, CMS must consider ways to provide clinicians with the ability to understand their performance on all measures, particularly the foundation-level hospital admissions measures (*Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups (NQF #3495)*), the *Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (NQF #3597)*), and cost measures.

Although the College has continued concerns related to the specific measures, which will be discussed later in this letter, we recognize that many APMs currently utilize these or similar measures for cost and quality performance. **Therefore, in order to ensure that MVPs truly serve as a glide path to APM performance, the ACC strongly recommends that CMS support clinicians with the data necessary to understand performance on these measures.**

³ Damberg CL, Elliott MN, Ewing BA. Pay-for-performance schemes that use patient and provider categories would reduce payment disparities. *Health Aff (Millwood)*. 2015;34(1):134-142. doi:[10.1377/hlthaff.2014.0386](https://doi.org/10.1377/hlthaff.2014.0386)

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In addition, the ACC recommends implementation of a “hold harmless” informational period in which CMS provides participants with their benchmark performance. These reports should include drill-down data to each clinician within a practice, similar to the data provided by the Quality and Resource Use Reports (QRURs) under the Value-Based Modifier Program and the field test reports distributed in the early stages of QPP cost measure development.

Having these datasets would allow clinicians to identify potential errors in the collected claims data, such as clinicians who may be mistakenly assigned to a practice. In addition, the datasets would allow clinicians to see which services are attributed to their practice and determine where there are opportunities to improve care coordination with other clinicians. Access to this data and the ability to understand it and act on it in a timely manner continues to be a core element of successful APM participation. **The ACC reiterates the importance of establishing scoring and data sharing practices that support clinicians in becoming familiar with these claims-based foundation and cost measures if they are implemented in the MVPs.**

Currently there are disincentives for specialists to participate in APMs relating to a multitude of factors, including attribution, benchmarking methodology, and the bonus structure. Clinicians in general may not be aware of APMs, or how they work, as these decisions may often be left to administrators of large practices or health systems. Attribution currently rests largely with the plurality of primary care services. CMS could explore alternative means of attribution that would be more enticing to specialists. Specialists are also responsible for the care of higher risk patients with more complex conditions, causing additional disincentives since benchmarks of these programs likely will not be met. The patients under the care of specialists also tend to not be aligned with the goals of an ACO and therefore the advanced APM bonus does not apply as much for specialists. CMS could consider setting different thresholds for specialists by type to provide additional incentives for participation.

Updates to the Quality Payment Program

For CY 2023, CMS proposes minimal changes to the Quality Payment Program (QPP), choosing to promote program stability to encourage participation from providers. The College thanks CMS for working to reduce the administrative burdens associated with reporting QPP categories while continuously reexamining specific measures and categories to ensure they align with the larger strategic initiatives HHS is undertaking. The College also thanks CMS for thoughtful proposals surrounding the MIPS Value Pathways (MVP) programs and has drafted specific comments in response to proposals below.

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information

In the FY 2022 MPFS proposed and final rules, CMS proposed and refined the definition of digital quality measurement and the stated goal of moving to digital quality measurement for all CMS

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quality reporting and value-based purchasing programs. After soliciting stakeholder feedback, including comments submitted by the College, CMS provided additional clarification in this proposed rule on the timeline for transitioning to digital quality measurement and modified the proposed definition of digital quality measures (dQMs). **The ACC once again applauds the innovation direction HHS, CMS, the Office of the National Coordinator for Health IT (ONC), and other regulatory agencies are taking to help develop a health system that allows for data liquidity and digital quality measurement through standardization and interoperability efforts and thanks CMS for considering thoughtful comments submitted in response to these proposed changes.**

The College fully supports a fully interoperable, digitally connected care delivery system. However, to achieve this goal, CMS needs to implement these changes in a stepwise manner with thoughtful timelines that do not place unrealistic implementation requirements and costs on health care clinicians, health systems, and health information exchanges (HIEs) or registries, quality measure developers, and other sources of digital health information. **The ACC thanks CMS for clarifying that the transition to digital quality measurement will take place incrementally.** This approach allows for the development of a more thoughtful quality measurement system which does not impose overly expensive and burdensome requirements on the vast number of organizations and individuals who contribute to the current quality reporting system.

As shared in comments previously submitted to CMS, the College has partnered with the Chesapeake Regional Information System for our Patients (CRISP) to build upon known standards and systems to allow healthcare organizations which partner with the National Cardiovascular Disease Registries (NCDR) and other registries to accelerate the adoption of modern data standards and reduce provider reporting burdens. This effort is a multiyear project intended to develop a solution and an implementation guide for sites contributing to NCDR and other registry data collection, leverage the Substitutable Medical Applications, Reusable Technologies (SMART) on FHIR application programming interfaces (APIs), and work with health systems and their vendors to develop a pilot solution that will extract data according to the FHIR standard. **However, a complete cross walking of all quality measures contained in the NCDR registry suite will take time and resources the ACC currently does not have.** Clinical data registries, such as NCDR, are an essential component of quality measurement and data collection in the American health care system and are relied upon by patients, clinicians, institutions, medical device manufacturers, and regulatory agencies to inform clinical, cost, coverage, and quality decision making. As CMS embarks on the process to move fully to digital quality measurement in CMS quality reporting and value-based purchasing programs, **the College once again states how important it is that CMS provide sufficient time, resources, and technical assistance to quality measurement developers such as the ACC and data sources such as the NCDR to help with the transition.**

After receiving feedback, CMS further clarified and modified the definition of dQMs by noting “dQMs are quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems.” CMS notes “data sources for dQMs may include

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administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, laboratory systems, prescription drug monitoring programs (PDMPs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated data such as a home blood pressure monitor, or patient-reported health data), health information exchanges (HIEs) or registries, and other sources.” **The ACC remains concerned that the revised definition of dQMs is still overly broad and will not meet the stated aim of standardized and interoperable digital data collected from a single point and supporting multiple use cases. To achieve this, the ACC recommends CMS follow the approach of the 21st Century Cures Act and provide a more prescriptive definition of dQMs and require the information transmission take place “via a standardized, interoperable system.”** As CMS correctly notes, eCQMs meet the definition for dQMs in many respects, but limitations in data standards, requirements, and technology as well as proprietary and financial barriers have limited their interoperability and multiple standards are currently utilized for measurement and reporting. The current NCQA definition of dQM states measures have a “common standard for sharing health care information electronically.” While CMS has publicly stated the intent to pursue use of FHIR-based standards, the ACC calls on CMS to codify this into the definition of dQMs to ensure proper alignment across programs. In addition to codifying a more specific standard into the definition, CMS should work with stakeholders to develop more prescriptive standards for data sources dQMs utilize for measurement, including patient-generated data and lab data, which can be highly variable in accuracy and reliability while often not being interoperable without considerable manual work.

In addition to ensuring dQMs take place via a standardized, interoperable system, it is essential CMS ensure dQMs are clinically appropriate, useful, and do more than capture and transmit information. **CMS should ensure that dQMs have standardized input, measure, and display logic for consistent calculation and use.** By prescribing and enforcing uniform standards and measure logic, CMS can ensure that the information captured in the diverse array of information systems used by clinicians will provide real time, useful, and accurate information, leading to increased utility at the point of care and reduced burdens for measure display and reporting.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)–Request for Information

Following the passage of the 21st Century Cures Act, HHS has made considerable progress pursuing development of the Trusted Exchange Framework and Common Agreement (TEFCA). The ACC congratulates HHS, CMS, ONC, and the newly designated ONC Recognized Coordinating Entity (RCE) on these accomplishments and believes that TEFCA will help improve interoperability in the U.S. healthcare system by building on the regulations implemented under the CMS and ONC Cures Act final rules. While the real-world coordination between Qualified Health Information Networks (QHINs), health information networks (HINs), care practices, hospitals, public health agencies, and Individual Access Services (IAS) Providers has yet to be seen, the ACC is encouraged by the floor these networks will provide to encourage interoperability.

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In this RFI, CMS asks for feedback from stakeholders on opportunities to encourage participation and exchange under TEFCA including a proposed “Enabling Exchange Under TEFCA measure” in the Medicare Promoting Interoperability Program, and future expansion of TEFCA for payment and operations activities such as submission of clinical documentation to support claims adjudication and prior authorization processes. The ACC will provide more specific comments on proposed measures in the Promoting Interoperability Program later this in these comments but is supportive of efforts from CMS to encourage interoperability through incentives. Currently, TEFCA is limited in its uses, which will hinder adoption and utilization, but the College expects this to expand as the RCE gains experience and feedback from stakeholders and future interoperability regulations and capabilities go into effect with the implementation of additional Cures Act final rule provisions.

Participation in TEFCA utilizing FHIR-based exchange is also limited to existing use cases promulgated under FHIR standards. It is important that CMS continue to provide resources and technical expertise as well as continuously listen to stakeholder feedback to ensure regulations promoting FHIR-based exchange follow real world applications. The ACC encourages CMS and the RCE to work with stakeholders to ensure sufficient progress is made and additional use cases are tested sufficiently and applied in ways that encourage interoperability and reduce burdens clinicians face daily. CMS, the RCE, ONC, and other policy makers must ensure that standards, reporting criteria, and other regulations that govern information exchange align across agencies. This alignment is central not only to the successful deployment of interoperable systems but buy in and utilization of TEFCA networks.

Transforming MIPS: MVP Strategy

In previous rulemaking, CMS proposed making MVP reporting voluntary and self-assigned to allow clinicians the flexibility to participate at their discretion and become more comfortable with the MVP program, including allow for the development of additional MVPs. **The College thanks CMS for once again proposing to keep the MVP program voluntary and self-assigned for clinicians who wish to participate in the program.** While the ACC agrees with CMS’ intent to continue to promote value-based care through different reporting programs, the College believes clinicians should have the option to move towards MVPs when they are adequately prepared structurally, financially, administratively, or otherwise. **Additionally, the College thanks CMS for not finalizing the timing for the sunset of traditional MIPS reporting.** It will take time for clinicians to get used to MVP reporting, just like it took time for clinicians to adjust to the MIPS program when it started, and by not setting a hard date for the retirement of traditional MIPS reporting, CMS leaves eligible clinicians and groups with multiple reporting options.

Promoting Interoperability Performance Category

Proposed Changes to the Query of PDMP Measure and Related Policies

CMS proposes requiring the “Query of PDMP Measure” for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program as a “yes/no” attestation measure

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in CY 2023. This measure was an optional measure starting in CY 2021. In the past, stakeholders have expressed concerns to CMS that PDMP connectivity to EHRs and availability in all states made adoption of this measure premature. According to CMS, all 50 states and several localities host PDMPs. There have been increases in the number of PDMPs that are integrated with Health Information Exchanges (HIEs), EHRs, and/or Pharmacy Dispensing Systems (PDSs) and RxCheck, which is a free, federally supported interstate exchange hub for PDMP data, is available for use. It is important for clinicians to have access to interoperable electronic controlled substance information and the ACC believes access to this information can help save lives.

The College thanks CMS for taking the time to keep the PDMP measure optional until the ecosystem developed to allow for widespread PDMP measure use without adding undue burdens, costs, and potential penalties for clinicians. The ACC also thanks CMS for making the measure a “yes/no” attestation measure to allow for the use of a variety of technical solutions to conduct a query of the PDMP and recognizing that a numerator/denominator-based measure remains challenging. The College also thanks CMS for providing clinicians with two exclusions (eligible hospital or CAH that does not have an internal pharmacy that accepts electronic prescriptions for controlled substances and does not have a pharmacy within 10 miles that can or any hospital or CAH that cannot report the measure due to applicable laws).

Health Information Exchange (HIE) Objective: Proposed Addition of An Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)

As previously stated, the ACC congratulates HHS, CMS, ONC, and the newly designated ONC Recognized Coordinating Entity (RCE) on the establishment and building of TEFCA regulations. The College believes that TEFCA will help improve interoperability in the US healthcare system by building on the regulations implemented under the CMS and ONC Cures Act final rules. While the real-world coordination between Qualified Health Information Networks (QHINs), health information networks (HINs), care practices, hospitals, public health agencies, and Individual Access Services (IAS) Providers has yet to be seen, the ACC is encouraged by the floor these networks will provide to encourage interoperability.

While it will take some time for TEFCA to mature, use cases to develop, and the Framework to reach its true potential, the ACC supports efforts to encourage use of TEFCA and provide incentives for clinicians and health systems to build interoperability capabilities through the framework and agreement. **The creation of a HIE objective and an alternative measure for enabling exchange under TEFCA is one way CMS can work to encourage this participation. Additionally, by making this measure optional and worth the total amount of points available for the Health Information Exchange Objective, CMS is allowing systems and clinicians to become comfortable with TEFCA requirements before requiring participation.** This model has allowed newly created programs to mature and reduce burdens associated with participation requirements. The ACC thanks CMS for continuing to work to improve interoperability while remaining cognizant of the regulatory reporting burdens facing clinicians and health systems today.

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Modifications to the Public Health and Clinical Data Exchange Objective

CMS proposes modification to the public health and clinical data exchange objective by consolidating the current options of 1) pre-production and 2) validation into one option consisting of a completed registration to submit data, testing, and validation. Additionally, CMS proposes requiring that MIPS eligible clinicians may spend only one performance period at the Pre-production and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level in the next performance period for which they report a particular measure. The ACC understands CMS' intent for consolidating objective options and requiring progress from registration to validation to production to ensure eligible clinicians are actively engaged and adhering to the intent behind the public health and clinical data exchange objective by reporting. However, there may be justified reasons for eligible clinicians not progressing to the next option within the prescribed amount of time. **If an eligible clinician intends to progress to the next option but is prevented from doing so by external factors not included in one of the exceptions available for some of the measures, the College asks CMS to provide a good faith exclusion, like existing hardship exemptions, for eligible clinicians who are attempting to progress but are hindered due to circumstances outside of their control.**

QCDR Third Party Intermediaries General Requirements

For CY 2023, CMS proposes delaying the requirement for a QCDR measure to be fully developed and tested with complete testing results at the clinician level until the CY 2024 performance year. For CY 2022, the ACC requested a delay in this proposal, estimating it may take at least a year to develop a measure, which requires considerable input and work from both physicians and society staff. We are still under a PHE and hospitals, offices, and other stakeholders across medicine are still spending considerable time and resources treating patients, dealing with budget cuts, and coping with staffing shortages, all of which make full measure testing incredibly difficult. **Due to this, the ACC thanks CMS for once again delaying the requirement for full development and testing with complete testing results at the clinician level for QCDR measures.**

CMS proposes requiring QCDRs publicly post measure specifications no later than 15 calendar days following CMS's posting of approved QCDR measure specifications on a CMS website and that QCDRs need to confirm that the measure specifications they post align with the measure specifications posted by CMS. While 15 calendar days is historically what CMS has allotted QCDRs for posting their measure charts after measure specification posting, this is a difficult timeline for QCDRs to meet. This usually falls around the holidays at the end of the calendar year, when QCDRs are short on staff. Additionally, in certain calendar years, such as CY 2021, the due date for posting was on a federal holiday and CMS did not provide QCDRs with an extension, cutting the period shorter. **To provide QCDRs with sufficient time to meet regulatory timelines and ensure measure specifications are correctly posted, the ACC asks CMS to provide QCDRs with an additional week, or 21 calendar days, to post measure specifications.** This amount of time would be more appropriate and allow sufficient time for proper posting without undue burdens.

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Beginning with the CY 2024 performance period, CMS proposes terminating QCDRs and qualified registries that are required to submit participation plans during the applicable self-nomination period because they did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period and continue to not submit MIPS data to CMS for the applicable performance period. While the ACC does not have any concerns with this proposal, the College requests CMS clarify that termination for past reporting failures should not prevent a QCDR or qualified registry from reconsideration by CMS in the future should it choose to reapply for participation in the MIPS program.

Public Reporting on the Compare Tools hosted by HHS

For CY 2023, CMS proposes adding an indicator for clinician and group profile pages for clinicians who offer telehealth services to allow patients to search for and identify clinicians and groups who offer telehealth services. CMS proposes to identify these clinicians by using Place of Service Code 02 (indicating telehealth) on paid physician & ancillary service claims or modifier 95 appended on paid claims and use a 6-month lookback period and refresh the telehealth indicator on clinician profile pages bi-monthly.

The ACC appreciates CMS providing patients with additional tools to help them find clinicians who meet their needs, including offering telehealth services. Throughout the public health emergency (PHE), there has been steady growth and acceptance of telehealth services to help reach patients where they are. This is especially useful for patients who are unable to travel to a doctor's office and risk not receiving any care. **However, it is important that CMS provide clinicians and groups with the ability to review and update any postings to physician compare tools, including telehealth service availability, to ensure they are correct.** Clinician review is a valuable mechanism for ensuring the information contained on comparison tools is correct.

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

Sincerely,



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