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September 6, 2024

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1807-P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Calendar Year (FY) 2025 Medicare Physician Fee Schedule (PFS) Proposed Rule. Founded in 1964, STS is a not-for-profit organization representing more than 7,700 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

General Comments – Sustainability of Medicare Reimbursement

CMS estimates the CY 2025 PFS CF to be $32.3576, which reflects the statutory update of 0.00% as outlined in the Medicare Access and CHIP Reauthorization Act (MACRA), a positive budget neutrality adjustment (0.05%), and the expiration of the 2.93% update provided under the Consolidation Appropriations Act, 2024 (CAA, 2024).

STS is deeply concerned that this proposed rule perpetuates the ongoing trend of systematically diminishing Medicare reimbursements. As operational and overhead costs for medical practices continue to rise significantly, Medicare reimbursements have been on a steady decline for several decades. This growing disparity not only places a heavy financial burden on medical professionals but also jeopardizes the sustainability of practices that countless patients depend on for their healthcare needs. When reimbursements fail to keep up with rising costs, both the viability and quality of patient care are at serious risk.

The American Medical Association (AMA) reports that since 2001, Medicare physician payments have fallen by nearly 30% when adjusted for inflation. This contrasts sharply with other healthcare sectors that receive annual inflation-based updates. Physicians face a complex array of reductions, including annual negative conversion factor adjustments due to budget neutrality requirements, an ongoing sequestration reduction, the threat of PAYGO, the loss of alternative payment model (APM) bonus payments, and up to 9% penalties under the Quality Payment Program (QPP). This year alone, cardiothoracic surgeons are confronting a 3.2% reduction, surpassing the amount indicated in CMS' impact table, and greater than most other specialties. Such reductions are unsustainable, particularly for a specialty like cardiothoracic surgery, which the Health Resources and Services Administration (HRSA) projects will experience the largest physician shortfall of any specialty by 2035, with only a 69% adequate supply of physicians.[1]

While STS acknowledges that many of these challenges are beyond CMS' control and would require congressional action for a full resolution, they should nonetheless inform CMS' approach to the physician fee schedule. We strongly urge CMS to collaborate with Congress to ensure a positive adjustment equal to the rate of inflation to the Medicare conversion factor in 2025 and in future years. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, higher-quality care.

Payment Provisions of the Proposed Rule for the Physician Fee Schedule

Determination of Practice Expense (PE) Relative Value Units (RVUs)

PE Methodology and Professional Liability Insurance (PLI) RVUs – Expected Specialty Overrides for Low Volume Service Codes

In 2018, CMS first implemented a policy recommendation from the AMA Relative Value Scale (RVS) Update Committee (RUC) to use single specialty override assignments for the assigned PLI risk premiums and indirect practice expense for very low volume services (those with an average of less than 100 Medicare utilization over the past 3 years). The purpose of this policy is to avoid inappropriate PLI and PE RVUs stemming from occasional small errors in the specialty utilization data. For CY 2024, four new eligible codes were added to this list of cardiothoracic surgery low volume services as identified by the RUC.

STS appreciates CMS' continued policy of using expected specialty overrides for certain low volume services. Adding these codes to the Specialty Assignment for Low Volume Services list ensures that the risk for the appropriate specialty is reflected in the professional liability for the code. Assigning the correct specialty to these codes avoids the major adverse impact on PLI RVUs that result from errors in specialty utilization data magnified in representation (percentage) by small sample sizes. In addition, the proposed specialty overrides also ensure appropriate application of the expected indirect practice expense for each service.

[1] https://data.hrsa.gov/topics//health-workforce/workforce-projections

We agree with the codes included in the Anticipated Specialty Assignment for Low Volume Services list provided as part of the supporting documentation in the Proposed Rule. The codes STS and the RUC have requested in the past are included in the list and the overrides have been applied to the malpractice and PE RVUs for the codes in Addenda B of the Proposed Rule.

STS recommends that CMS add the following codes with the indicated specialty to the Anticipated Specialty Assignment for Low Volume Services list for CY 2025:

- **32036** - THORACIC SURGERY (2023 NPRM Util - 74; 3-yr Vol Avg – 82; 2022 - Thoracic Surgery – 72.6%, Cardiac Surgery – 10.7%)
- **33366** - CARDIAC SURGERY (2023 NPRM Util - 99; 3-yr Vol Avg – 79; 2022 - Cardiac Surgery – 29.0%, Thoracic Surgery – 19.4%, Interventional cardiology – 25.8%, Cardiology – 25.8%)
- **33415** - CARDIAC SURGERY (2023 NPRM Util - 116; 3-yr Vol Avg – 89; 2022 - Cardiac Surgery – 48.6%, Thoracic Surgery – 42.9%)
- **43122** - THORACIC SURGERY (2023 NPRM Util - 75; 3-yr Vol Avg – 78; 2022 - Thoracic Surgery – 75.0%, Cardiac Surgery – 5.0%)
- **60522** - THORACIC SURGERY (2023 NPRM Util - 98; 3-yr Vol Avg – 95; 2022 - Thoracic Surgery – 76.0%, Cardiac Surgery – 18.8.0%, General Surgery – 4.2%)

Our recommendation is based on the analysis performed by the AMA RUC to identify newly eligible codes that meet the criteria to receive a specialty override for CY 2025.

Adjusting RVUs To Match PE Share of the Medicare Economic Index (MEI)

CMS finalized significant methodological and data source changes to the MEI in the CY 2023 PFS final rule. Due to the significant elapse in time since the last rebasing and revision of the MEI in CY 2014, CMS proposed a continued delay of the implementation of the finalized CY 2023 rebased and revised MEI. This is consistent with efforts to balance payment stability and predictability while incorporating new data through more routine updates. CMS continues to monitor other data sources and will propose any changes to the MEI in future rulemaking, as appropriate.

STS supports CMS' decision to continue postponing the implementation of MEI changes that would re-weight the distribution of work, practice expense, and professional liability insurance RVU components within the resource-based relative value scale (RBRVS). If implemented, the changes would result in significant redistribution within physician payment. Instead, CMS should allow for the review of data from the Physician Practice Information (PPI) Survey that is being conducted by the AMA to better inform these updates. The AMA anticipates results from the PPI Survey will be available in early 2025, revealing valuable information on physician and other health care professional compensation, practice costs, and direct patient care hours worked.

If the AMA PPI survey data proves insufficient, STS strongly recommends that CMS seek alternative, more current data sources to rebase and revise the MEI. The MEI weights used for CY 2023, which are based on data from the 2017 US Census Bureau's Service Annual Survey (SAS), are outdated and should not be relied upon for updates. Regardless of the results from the AMA PPI survey, CMS should prioritize using more recent data to ensure accuracy in the MEI calculation.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Expiration of Geographic and Originating Site Waivers

The current law permitting patients to access telehealth services from anywhere in the country—without the need to visit a medical facility—and to receive these services at home, is set to expire at the end of 2024. Without additional Congressional action to extend these flexibilities, most Medicare telehealth services will only be available if patients are in a medical setting within a rural area, with the exception of services related to mental health and substance use disorders.

STS encourages CMS to collaborate with Congress to either extend or permanently revise the geographic and originating site waivers, enabling patients to access all telehealth services from their homes, not just those related to mental health or substance use disorders. This flexibility has demonstrated significant benefits by providing patients, particularly those in rural areas or facing socioeconomic barriers, with more accessible alternatives for receiving medical care.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS proposes to continue lifting frequency limits for subsequent hospital care services (CPT 99231-99233), subsequent nursing facility visits (CPT 99307-99310), and critical care consultations (G0508 and G0509) furnished via telehealth through CY 2025.

STS appreciates and supports CMS' proposal to continue lifting the frequency limits for these services through CY 2025 and encourages CMS to make this a permanent policy change.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

CMS proposes to expand on the policy previously adopted that allowed audio-only services for patients receiving telehealth for mental health conditions by creating a new permanent policy allowing audio-only telehealth services for services delivered to patients in their home if the physician is capable of using audio-video but the patient does not have or does not consent to video use.

We commend CMS for continuing to broaden the scope of telehealth services coverage and reimbursement and particularly for the proposal to include the use of two-way, real-time audio-only communication technology. This proposal particularly benefits traditionally underserved patient populations and geographic locations. In many situations, audio-only telehealth provides the only means for essential care, especially for those who do not have adequate internet coverage or have difficulty operating a computer.

Distant Site Requirements

In response to stakeholder concerns, CMS extended the flexibility for distant site telehealth practitioners to bill from their currently enrolled location instead of their home address when providing telehealth

services through CY 2024. CMS proposes continuing to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

STS is supportive of this proposal to protect the privacy of telehealth practitioners. Further, we believe it is necessary that this flexibility to bill from a provider's currently enrolled location for telehealth purposes extend past CY 2025. It is not practical, workable, or safe to require a provider to publicly report their home address as their practice location. Medicare providers should not be compelled to share their personal information, especially when it relates to their home address. In our current environment where threats against healthcare professionals have markedly increased, the safety and privacy of physicians must be paramount.

Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025

CMS proposes to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. CMS also proposes to adopt a permanent definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for a subset of incident-to services that are nearly always performed in entirety by auxiliary personnel and are considered low risk by their nature. CMS is also proposing to continue its current policy allowing teaching physicians to virtually supervise residents, for services furnished virtually where the patient, resident, and teaching physician are all in separate locations through 2025.

STS supports CMS' proposal to continue direct supervision of cardiac and pulmonary rehabilitation programs and other qualifying services via real-time, two-way audio/visual telecommunications technology through CY 2025. This provides Medicare beneficiaries the option to receive cardiac and pulmonary rehabilitation services that can improve their lives through various modalities that best suit the patient. STS also supports CMS' proposal to continue its current policy allowing teaching physicians to virtually supervise residents, for services furnished virtually where the patient, resident, and teaching physician are all in separate locations through CY 2025.

Additionally, STS appreciates CMS' decision to adopt a permanent definition of direct supervision that allows the supervising practitioner to be 'immediately available' through real-time audio/video communications technology (excluding audio-only) for a subset of services that are predominantly provided by auxiliary personnel as incident-to services. CMS should continue to expand the permanent list of services when clinically appropriate. In doing so, CMS must consider the clinical circumstances, supervisee experience-level, and type of supervisee (resident or different non-physician practitioner types) as factors that should influence the extent to which virtual supervision is appropriate.

Valuation of Specific Codes

Telemedicine Evaluation and Management (E/M) Services

CMS proposes to publish the sixteen new Current Procedure Terminology (CPT) codes and RUC recommended values without revision for telemedicine office visits in CY 2025 with a procedure status indicator of "I" which means that there is a more specific code that should be used for the purposes of Medicare. CMS explains that they interpret section 1834(m) of the Social Security Act as only allowing it to pay for telemedicine services that are the same as services provided in-person and to pay the same rates regardless of the modality used. If finalized physicians will continue to report office/outpatient telemedicine visits with the established office/outpatient E/M visits codes (99202-99215) and use modifiers indicating if the patient is in their home or if the service is audio-only for Medicare patients.

STS is concerned that CMS' proposal related to reporting telemedicine office visits creates multiple ways to report the same service depending on the payor, which may cause confusion and lead to reporting errors. CMS' proposal could result in additional administrative burden for physicians.

Enhanced Care Management

Advanced Primary Care Management (APCM) Services (Healthcare Common Procedure Coding System [HCPCS] codes GPCM1, GPCM2, and GPCM3)

CMS proposes to establish and pay for three new G-codes that describe a set of care management services and communication technology-based services (CTBS) furnished under a broader application of advanced primary care that aim to encompass a broader range of services and simplify the billing and documentation requirements as compared to existing care management and CTBS codes.

We believe that the complexity of care is consistent across all medical disciplines. However, CMS continues to introduce new—and often redundant—HCPCS Level 1 and 2 codes for certain specialties (such as primary care) to cover various care management services (including principal, chronic, and complex care management, transitional care management, psychiatric collaborative care management, behavioral health care management, and general care management) and not others. CMS does not apply the same approach to proceduralists. We are concerned by the Agency's failure to create additional coding and reimbursement mechanisms to address the increased complexity, intensity, and work involved in intraoperative and postoperative care for the same patients when a procedure is required. These new codes that favor certain specialties over others contradict the Omnibus Budget Reconciliation Act of 1989 which created the Medicare PFS to divide payments more equitably among providers, regardless of specialty.[2]

Strategies for Improving Global Surgery Payment Accuracy

For CY 2025 CMS is proposing to require the use of the existing transfer of care modifiers (-54, -55, -56) for all 90-day global surgical packages in any case when a practitioner (or group practice) expects to furnish only the procedure portion of a global package when there is a formal, documented transfer of care (current policy) and when there is an informal, non-documented but expected, transfer of care. CMS believes this proposal would prevent duplicative Medicare payment for postoperative care because the global surgical package payment would be adjusted based on the appended modifier, and payment for postoperative care would not be made both as part of a global surgical package and through separately billed E/M visits.

[2] Grimaldi PL. Medicare fee schedule in place. Health Prog. 1990 Apr;71(3):54-8. PMID: 10106616.

CMS is requesting feedback from interested parties on potential methods for revising payment allocations to better reflect current medical practices and conventions for postoperative follow-up care. They aim to identify a procedure-specific, data-driven approach to distributing shares within the global package payment, ensuring it more accurately represents the resources required.

STS supports CMS' goal of ensuring that payments to practitioners and the relative values assigned to global surgical packages accurately reflect the resources involved in providing these services. However, we believe this proposal does not accomplish that objective.

STS is very concerned that revising the transfer of care policy for global packages to include informal, non-documented but expected transfer of care will add another layer of complex, confusing administrative burden to all practitioners without any corresponding benefits. Any requirements to use partial provision modifiers, such as the transfer of care modifiers, to document these forms of appropriate sharing of care will lead to data that can be easily misinterpreted to suggest that important perioperative care is not being provided by the procedural physician.

One of the reasons the global packages were originally instituted was to disincentivize the unprofessional practices of itinerant surgery and fee-splitting, both of which result in substandard surgical care. STS firmly believes that transferring the care of a patient post-surgery to an unqualified provider is not only unethical but also a serious breach of professional standards, as detailed in the principles set forth by the American College of Surgeons.[3]

- The responsibility for the patient's postoperative care rests primarily with the operating surgeon.
- The operating surgeon maintains a critical role in directing the care of the patient.
- It is unethical for a surgeon to relinquish responsibility for postoperative surgical care to any other physician who is unqualified to provide similar care.
- The surgeon's responsibility extends throughout the surgical illness.

Institutionalizing a system where the surgeon only provides care in the operating room and transfers the routine postoperative care to physicians outside of the surgical team will result in inferior, if not negligent, care. STS acknowledges that other specialists should be involved when a patient has relevant complications, such as the development of renal failure or neurologic complications following surgery. But these types of complications are not "routine," and the current procedural RVUs are not valued to include management of such complications. The current valuations only include routine postoperative care.

Surgical patients often have underlying medical conditions which need to be reevaluated by their primary provider post-surgery. While patients may return to their routine care providers after surgery, this does not mean that the post-op care of the patient has been transferred to that practitioner. Patients that undergo cardiac surgery typically still have underlying cardiac disease, such as atherosclerosis, heart failure, arrythmias, or hypertension that requires cardiologist follow up. Patients with lung cancer often have surgery to resect the cancer but may still require follow-up with their pulmonologist or oncologist for reevaluation of their treatment plan. The RUC, with broad support from

[3] https://www.facs.org/about-acs/statements/#iie)

STS and others, stated that perioperative care by other providers is not duplicative, but rather represents appropriate team care in the modern practice setting.

Additionally, STS has concerns about how CMS plans to identify an informal transfer of care. CMS needs to provide clarity on how they will adjudicate claims if they receive incomplete or differing claims from the surgeon and the physician in charge of postoperative management. For example, if CMS receives a claim with a -55 modifier appended to a surgical code from a practitioner that has "taken over" the postoperative management of the patient, but there is no corresponding claim from the surgeon with a -54 modifier indicating that they provided only the surgical care. How would a provider informally assuming the postoperative care outside of the surgeon's group practice know what to code and whether the surgeon has coded the transfer of care? Additionally, what if the surgeon who performed the procedure is still involved with or providing the routine postoperative care to the patient? It is typical for the surgeon to be involved in postoperative care. Without clear instructions of transfer of care protocols, there is room for confusion and miscoding. CMS also needs to clarify the expectations for the practitioner assuming the follow-up care and ensure that all follow-up care is incorporated into the global period.

Further, CMS needs to provide clarity on which provider assumes liability associated with postoperative care. Surgeons have extensive postoperative care training allowing them to monitor, anticipate, and treat issues to mitigate complications. It is unrealistic, presumptive, and irresponsible to believe that all providers are equally equipped to predict and prevent postoperative complications based on notes in a medical chart. In particular, cardiothoracic surgeons go through at least 6-8 years of additional training and this policy assumes that any/all providers are equally equipped to manage their cases.

This ambiguity could also expose practitioners to the risk of unintentional billing errors, potentially leading to accusations of fraudulent billing. Practitioners may unintentionally miscode services or fail to properly document care transitions, which could result in audits, penalties, and legal actions. This lack of clarity not only adds an administrative burden but also creates an environment where practitioners might be held accountable for honest mistakes, further complicating the delivery of care and placing undue stress on the healthcare system.

If CMS implements the policy as proposed, payment adjustments should be applied only to the primary procedure performed. Adjustments should not apply to any services that have the -51 modifier since payment for the second and subsequent services has already been reduced to remove payment for postoperative care. It would be inappropriate to apply the 50% multiple procedure reduction and the reduction for the -54 surgical care only modifier as that would result in a duplicate reduction.

Additionally, CMS needs to specify whether a provider will be reimbursed at the stand-alone E/M rate or the discounted E/M value of the global package as CMS did not include the E/M increases into the global packages. If CMS is concerned with correctly valuing the services in the global package, rectifying that inequity is a good start. STS again urges CMS to implement the full increase of the work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239) and office/outpatient visits (99202-99215) into the global surgical period for each CPT code with 010 and 090 day global periods per the RUC's prior recommendation and as has been done historically.

If CMS moves forward with these proposed changes, broad multispecialty education is going to be necessary. Implementation by January 1, 2025 is unrealistic.

Post-op Care Services Add-on Code

CMS proposes to establish a new E/M add-on code, GPOC1, to capture the additional time and resources spent providing postoperative care by a physician who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement.

The proposed descriptor for GPOC1 is as follows: Postoperative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 090-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:

- *Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation*
- *Research the procedure to determine expected postoperative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).*
- *Evaluate and physically examine the patient to determine whether the postoperative course is progressing appropriately.*
- *Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established).*

CMS estimates $320k in total Medicare allowed charges for GPOC1 in CY 2025. CMS is proposing this as an add-on code with a ZZZ, a work RVU of 0.16 (with 5.5 minutes of work time and no direct PE inputs).

STS has concerns with the proposed post-op care services add-on code, GPOC1. The code is complex and ambiguous in its description and the criteria for its use. If we agree that these services are not duplicative, then they should be compensated using the E/M guidelines. An add-on code is duplicative as the work described will also be inherent in the level of service selected by the provider.

Again, CMS needs to provide clarity on the use expectations for GPOC1 and whether it is appropriate for informal transfers of care versus formal transfers. Additionally, CMS should better outline the difference between informal and formal transfers of care.

Regardless of the formality of the transfer, practitioners taking over patient care must be in communication with the operating surgeon regarding the procedure, outcomes and expected postoperative course to avoid unnecessary risk. Research cannot replace the expertise provided by the operating surgeon. It would be unreasonable and dangerous for CMS to expect a practitioner taking over postoperative care to research and understand all the aspects of postoperative care, including complications, within the assumed 5.5 minutes of work time. Setting that precedence would be grossly irresponsible and put patients at risk of harm and is out of touch with the realities of the time constraints on providers.

Lastly, we reiterate our concerns stated above that coding between the surgeon and the postoperative care provider may differ and CMS needs to be forthcoming about how those situations will be handled.

Updates to the Quality Payment Program

The Role of MIPS Value Pathways (MVPs) in Transforming MIPS

In an effort to develop a timeline for the full transition to MVPs, CMS is seeking feedback through this request for information on clinician readiness for MVP reporting and MIPS policies needed to sunset traditional MIPS and fully transition to MVPs in the CY 2029 performance period/2031 MIPS payment year.

As CMS explores various approaches to enable all MIPS eligible clinicians to report MVPs, it seeks comment on options, such as:

- *Expand previously finalized MVPs to include different specialties included in care delivery for patient populations;*
- *Expand previously finalized MVPs to include subspecialties;*
- *Develop MVPs based on multiple specialty measure sets;*
- *Develop MVPs based on cross-cutting and broadly applicable measures;*
- *Develop MVPs for non-patient facing MIPS eligible clinicians.*

STS continues to have concerns about whether there will be adequate MVPs for specialists and ensuring that the measures included in MVPs are meaningful to providers. CMS developed MVPs to serve as a bridge from MIPS to APM participation and to enhance performance measurement and available information while minimizing additional burden.

While we support CMS' effort to reduce clinician burden and offer a pathway for more clinicians to transition to alternative payment arrangements, we have strong concerns that the MVP framework lacks the specificity and applicability to truly affect change. By attempting to fit providers into MVPs that reports only nonspecific, broadly applicable measures, CMS fails to provide a meaningful and less burdensome participation pathway for specialists. Additionally, data captured by those broad measures does little to improve quality and create meaningful comparison between providers. If CMS is going to develop broader MVPs that measure multiple subspecialties on the same measures, we will need a clearer definition of subgroups and the reporting requirements to ensure CMS is comparing providers appropriately. Until we have a better understanding of this, STS encourages CMS to provide flexibility in subgroup reporting to allow multispecialty provider groups to report based on their unique needs.

Along with the AMA and many other medical societies, STS has expressed serious concerns about the fundamental lack of stakeholder engagement during MVP development. Specialty societies have encountered many barriers to MVP development which results in less opportunity for collaboration with CMS in developing MVPs. These barriers include lack of applicable MIPS measures that apply to the specialty, lack of benchmarks for existing QCDR measures, and lack of relevant cost measures. At this point in the MVP implementation process, it is simply too early to contemplate a timeline for sunsetting traditional MIPS by the 2029 performance period. The agency needs additional time to work collaboratively with stakeholders to develop a proper MVP framework that results in more clinically relevant and meaningful performance data for specialties and subspecialties, as well as patients.

STS has faced our own obstacles with MVP development due to issues with a lack of applicable measures and benchmarking concerns. Currently, cardiothoracic surgery measures are included in the Surgical Care MVP. While we are appreciative of CMS' effort to develop an MVP that allows for cardiac surgery participation, it was created without guidance or input from STS or the other included

specialties. The cardiothoracic measures included are only appropriate for cardiac surgeons, meaning a large portion of our specialty, general thoracic surgeons, remain without an MVP. Additionally, CMS did not incorporate the feedback provided by specialists when publishing the Surgical Care MVP in this proposed rule. STS, along with many other groups, provided extensive feedback on the structure of the Surgical Care MVP candidate with suggestions on how to improve it. If CMS plans to expand on previously finalized MVPs, it is important that they work with specialty societies to ensure MVPs are clinically relevant to the providers they are measuring.

Importantly, transitioning to MVPs should provide more actionable data and information that prepares providers for more advanced models. One concept cannot be overstated: CMS should engage specialty societies directly in the development of new MVPs to capitalize on their knowledge and experience with data collection and quality improvement.

CY 2025 MVP Development and Maintenance

Development of New MIPS Value Pathways (MVPs)

CMS proposes six new MVPs, including a new Surgical Care MVP that includes measures for Coronary Artery Bypass Graft (CABG) procedures, breast cancer, colorectal surgery and neurology.

As we stated above, STS is very disappointed that CMS maintained the Surgical Care MVP as it was published in the Surgical Care MVP candidate. STS and many other surgical specialties expressed concerns about the Surgical Care MVP candidate which lumps multiple surgical subspecialties into a general surgical framework. The Surgical Care MVP lacks the specificity and applicability to impact the providers reporting it. By attempting to fit general surgery, cardiothoracic surgery, gastroenterology, neurosurgery, and orthopedic surgery measures into one MVP model, CMS fails to provide a meaningful pathway for specialists to be measured. The measures included in the model are not "limited, connected, or complementary" as emphasized by the current MVP Guiding Principles. The MVP is muddied by including measures across distinct populations without consideration of how these populations are treated in practice and does not allow for significant comparison or quality improvement. For the MVP to make more clinical sense and be more representative of team-based care, we believe the CABG measures should be moved to the Advancing Care for Heart Disease MVP.

While STS appreciates the flexibility CMS offers by requiring only four reporting measures, significant issues persist with the specific measures included in the surgical MVP for different specialties. For example, a cardiothoracic surgeon could meaningfully report on the four CABG measures included in the model. However, none of the CABG measures included in the Surgical Care MVP have historical benchmarks and could result in a quality score of zero if benchmark calculation criteria are not met. To earn a higher score, a cardiothoracic surgeon would be required to report on less specialized measures within the MVP such as Q357: Surgical Site Infection and Q358: Patient-Centered Surgical Risk Assessment and Communication. This presents another issue as the more general measures like Q357 and Q358 are considered topped out and limit the performance points available to a surgeon. The measures available in the MVP do not allow for a high achieving performance score regardless of a provider's actual performance.

MVP Requirements and Scoring

Improvement Activities Performance Category in MVPs

CMS proposes to remove references to high- and medium-weighted improvement activities in MVPs and to instead update MVP scoring to assign 40 points for each improvement activity so that one activity would provide full credit for the category for MVP Participants.

CMS' proposal to eliminate references to high- and medium-weight improvement activities and instead assign 40 points for each improvement activity in MVPs is a positive step towards reducing administrative burden and complexity. Standardizing the scoring system so that a single improvement activity can fulfill the entire category requirement simplifies the process for participants and minimizes the need for extensive documentation and tracking of multiple activities. STS appreciates CMS' efforts to reduce complications and support more effective and efficient participation in the MVP program.

MIPS Performance Category Measures and Activities

Data Completeness Criteria

CMS previously finalized an increase in the data completeness criteria threshold from at least 70% to at least 75% following concerns expressed about CMS' proposal to increase it to at least 80%. In this rule, CMS proposes to maintain this higher threshold for two additional years.

STS commends CMS for the proposal to maintain the data completeness threshold at 75% for an additional two years. We appreciate the stability that this offers for the next two years. We warn that any increase in future years will negatively impact provider burden without any benefit to CMS. CMS should maintain the current threshold without any increase until an improved interoperability landscape emerges, allowing data to seamlessly flow across settings and providers. This is especially necessary for the many providers who work between multiple sites and have a more difficult time calculating the correct percentage of patients and submitting data. Not all sites within the same National Provider Identifier and Taxpayer Identification Number participate in MIPS or use the same registry or electronic health record (EHR) for MIPS reporting. This makes combining and calculating MIPS data difficult.

Selection of Quality Measures

For the CY 2025 performance period, CMS proposes to establish a measure set inventory of 196 MIPS quality measures, of which 193 are available in traditional MIPS and 3 are available only for utilization in MVPs. This includes Substantive changes to 66 MIPS quality measures. For the CABG Surgical Re-Exploration measure, CMS proposes to revise this measure to broaden the scope of cardiac complications that may require a return to the operating room following isolated CABG surgery.

Based on data published in the Annals of Thoracic Surgery, STS supports these revisions aiming to decrease surgical re-exploration following CABG surgery. Surgical re-exploration following a CABG surgery is a serious complication and impacts risk of mortality, new-onset renal failure, and increased blood use, which may adversely affect long-term survival.[4] Although rates of re-exploration after cardiac

[4] Tran Z, Williamson C, Hadaya J, Verma A, Sanaiha Y, Chervu N, Gandjian M, Benharash P. Trends and Outcomes of Surgical Reexploration After Cardiac Operations in the United States. Ann Thorac Surg. 2022 Mar;113(3):783-792. doi: 10.1016/j.athoracsur.2021.04.011. Epub 2021 Apr 17. PMID: 33878310.

surgery have significantly declined recently, it has been linked to much higher complications, mortality, and hospitalizations.

Improvement Activities Performance Category

New Improvement Activities

CMS proposes to add two new improvement activities for the CY 2025 performance period/2027 MIPS payment year and future years:

New activities:

- *IA_PM_XX, titled "Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake" would allow MIPS eligible clinicians to receive credit for establishing a process or procedure to increase rates of lung cancer screening.*
- *IA_PM_XX, titled "Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk" would allow MIPS eligible clinicians to receive credit for implementing a standardized, evidence-based cardiovascular disease (CVD) risk assessment and care management plan in their practices.*

As thoracic surgeons treating CVD, the leading cause of death in the United States[5], and lung cancer, the leading cause of cancer deaths, STS recognizes the need for increased preventative care in these areas. For that reason, STS supports the inclusion of the two new improvement activities that were introduced in response to the Administration's goal of streamlining the Inventory to include the most robust and clinically meaningful improvement activities. Lung cancer accounts for 25% of all cancer-related deaths, claiming more lives than breast, colorectal and prostate cancers combined. However, rates of lung cancer screening are exceptionally low. The national average rate of lung cancer screening for those at high risk is 5.8%.[6] Without proper preventative screening most lung cancer is diagnosed at a late stage when treatment options are expensive and unlikely to be successful in many cases. By including an improvement activity dedicated to increasing lung cancer screening uptake, we are hopeful more providers will be incentivized to screen high-risk patients to catch early-stage lung cancer when treatment options are the most effective.

Similarly, screening and treatment for CVD early can have lifesaving impacts on patients. An estimated 80% of CVD including heart disease and stroke, is preventable.[7] Early diagnosis and interventions aim to minimize the effects of CVD before any severe or irreversible damage occurs. This is why CMS' effort to increase preventative care to avoid the devastating results of cardiovascular disease is laudable.

Improvement Activity Scoring and Reporting Policies

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[5] Di Cesare M, Perel P, Taylor S, Kabudula C, Bixby H, Gaziano TA, McGhie DV, Mwangi J, Pervan B, Narula J, Pineiro D, Pinto FJ. The Heart of the World. Glob Heart. 2024 Jan 25;19(1):11. doi: 10.5334/gh.1288. PMID: 38273998; PMCID: PMC10809869.

[6] https://www.lung.org/media/press-releases/state-of-lung-cancer-2022#:~:text=Lung%20Cancer%20Screening%3A%20Lung%20cancer,has%20the%20lowest%20at%201.0%25.

[7] https://world-heart-federation.org/what-we-do/prevention/?petition=close

CMS proposes two changes to the traditional MIPS improvement activities reporting and scoring policies for the CY 2025 performance period/2027 MIPS payment year.

- *To eliminate the weighting of activities to simplify scoring. CMS has determined that the benefit to categorizing activities as high or medium weighted has greatly diminished.*
- *To reduce the number of activities to which clinicians are required to attest to achieve a score in the improvement activities performance category. MIPS eligible clinicians who participate in traditional MIPS would be required to report two activities (20 points each). MIPS eligible clinicians who are categorized as small practice, rural, in a provider-shortage area, or non-patient facing would now be required to report one activity (40 points). CMS also proposes that MVP participants would be required to report one activity.*

Similar to our response to this proposal in the MVP section above, STS is supportive of removing the different weights associated with improvement activities and instead assign the full 40 points necessary to meet the category requirement for each improvement activity. We recognize the positive step CMS is taking towards reducing administrative burden and complexity. By standardizing the scoring system so that a single improvement activity can fulfill the entire category requirement, the change simplifies the process for participants and minimizes the need for extensive documentation and tracking of multiple activities. STS appreciates CMS' efforts to reduce complications and support more effective and efficient participation in the MVP program.

MIPS Final Score Methodology

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

CMS proposes, that beginning with the CY 2025 performance period/2027 MIPS payment year, measures impacted by limited measure choice are not subject to the 7-point cap. CMS also proposes to that, beginning with the CY 2025 performance period/2027 MIPS payment year, CMS will publish a list in the Federal Register of topped out measures determined to be impacted by limited measure choice.

STS is supportive of the proposal to remove the 7-point cap on topped out measures when limited measure choice is available. Many subspecialties, including general thoracic surgeons, are at a disadvantage due to the limited selection of quality measures in the MIPS program to choose from and often are forced to report topped out measures, inherently limiting their chances at a competitive quality score. This proposal evens the playing field for surgeons with limited measure options, so they do not receive a quality score unrepresentative of their care.

While we appreciate that CMS recognizes the measuring limitations for topped-out measures, there are still scoring flexibilities needed for better representation of specialists. For example, we believe CMS needs to provide incentives for clinicians to report on measures without historical benchmarks if they want meaningful comparison for subspecialists. For performance year 2023, CMS finalized a policy to allow new measures in their first year to have a scoring floor of seven points and measures in their second year to receive five points. However, there are measures in the program that were introduced over two years ago that have not been benchmarked. These measures, like the CABG measures in the

MVP candidate, will not receive the benefit of this new policy and disincentivize providers to report. CMS should allow all measures without a historical benchmark to fall under the two-year scoring floor policy to reduce the risk of an unrepresentative poor quality score and encourage more clinically appropriate reporting.

Overview of QP Determinations and the APM Incentive

APM Incentive Payment

CMS proposes to add the payment year 2026 APM Incentive Payment amount of 1.88% of covered professional services payments as amended in the Consolidated Appropriations Act of 2024. Beginning with the CY 2024 performance year/CY 2026 payment year 2026, qualified participants (QPs) will also receive a higher PFS payment rate, calculated using the differentially higher "qualifying APM conversion factor" update, than nonQPs.

STS appreciates the actions taken by Congress and CMS to add a 1.88% APM incentive payment in payment year 2026. However, we do not feel that CMS or Congress have gone far enough to incentivize providers to participate in APMs going forward. If CMS' goal is to encourage providers to prioritize value-based care by participating in APMs instead of the traditional MIPS program, then the agency needs to work with Congress to reauthorize the APM Incentive Payment at its original 5% level. Participation in an APM requires additional investment such as significant transition costs, updated certified EHR technology, staffing, and more, that many providers need the bonus money to be able to afford. For example, practices may need staff to provide enhanced care management prior to receiving a potential bonus. Practices may also have a harder time recruiting physicians into risk-based models and may need the incentive payment for negotiations. A higher "qualifying APM conversion factor" will not adequately make up for the loss of the 5% bonus payment given that even with a higher conversion factor, physician payment is consistently decreasing. Without that additional incentive, providers may not be able to take on downside risk and will be forced to continue reporting through MIPS. Additionally, without the incentive payment, providers may stand to earn more through MIPS reporting than through APM participation, which contradicts CMS' goal.

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or Derek Brandt, Vice President of Government Relations at dbrandt@sts.org should you need additional information or clarification.

Sincerely,

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President