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August 23, 2023

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 Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction [CMS–1786–P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Founded in 1964, STS is a not-for-profit organization representing more than 7,900 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.

OPPS Conversion Factor Update

CMS proposes to increase the CY 2024 OPPS conversion factor (CF) to $87.488. This generates a general overall increase of 2.8%. The overall increase (before budget neutrality adjustments) is based on the proposed hospital inpatient market basket increase of 3.0% minus a productivity adjustment of 0.2%. Per usual, CMS proposes that if more recent data becomes available, it will use the updated data to alter the conversion factor in the OPPS final rule with comment period.

STS supports the 2.8% increase in hospital outpatient payments. However, in comparison, this increase illuminates our profound disappointment that the CY 2024 Medicare Physician Fee Schedule (MPFS) continues the longstanding trend of systematically devaluing Medicare reimbursements for physicians. The operational and overhead costs for medical practices continue to rise significantly, especially in the wake of the COVID-19 pandemic, meanwhile Medicare physician reimbursements have been on a declining trend for several decades. This widening gap not only puts undue financial strain on medical professionals, but also threatens the sustainability of practices that countless patients rely upon for their healthcare needs. It is imperative to recognize that when reimbursements do not keep pace with escalating costs, the viability and quality of patient care are potentially at risk.

According to the American Medical Association (AMA), Medicare physician payments have lagged 26% behind the rate of inflation growth since 2001. This is in stark contrast to other healthcare sectors who regulatory receive inflation-based updates. Reductions to physician reimbursements are multifactorial and continue to compound. In addition to facing negative conversion factor adjustments each year triggered by budget neutrality requirements, physicians face ongoing sequestration reductions, the threat of PAYGO, the loss of alternative payment model (APM) bonus payments, up to 9% penalties as part of the Quality Payment Program (QPP), and more. In just this year, cardiothoracic surgeons are facing a reduction exceeding 3%. These levels of reductions are not sustainable, especially for a specialty like cardiothoracic surgery which Health Resources and Services Administration (HRSA) recently projected will have the largest projected shortfall of any physician specialty evaluated by 2035, with an 69% adequate supply of physicians within the specialty.[1]

While STS recognizes that many of these factors are outside of CMS' control and would require congressional intervention to fully address, the increase CF in the OPPS proposed rule highlights the stark differences between facility and provider payments. We urge CMS to rectify this inequity and work with Congress to provide a positive update to the MPFS conversion factor in 2024 and all future years.

Services That Would Be Paid Only as Inpatient Services

Changes to the In-Patient Only (IPO) List

For CY 2024, CMS proposes no services for removal from the IPO list. However, CMS requests comment on the potential future addition of the following codes:

- ***CPT 7X000** (Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic)*
- ***CPT 7X001** (Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report)*
- ***CPT 7X002** (Placement, manipulation of transducer, and image acquisition only)*
- ***CPT 7X003** (Interpretation and report only).*

We support the maintenance of the IPO list which provides appropriate safeguards to protect patients. The IPO list ensures that inherently high-risk procedures can be performed on an inpatient basis, regardless of the hospital length of stay, without the increased risk of medical review. Diminishing the IPO needlessly creates increased compliance and audit risk for procedures that clearly necessitate being inpatient procedures. Additionally, we support the inclusion of the above codes (CPT 7X000-CPT 7X003) in the IPO list for CY 2024 and beyond. Most importantly, we believe it is essential for the health and safety of patients that the IPO list be maintained appropriately to ensure that patients are receiving services in the proper settings.

Nonrecurring Policy Changes

Supervision by Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac Rehabilitation, Intensive Cardiac Rehabilitation and Pulmonary Rehabilitation Services Furnished to Outpatients

In CY 2023 rulemaking and in order to align OPPS policy with MPFS telehealth policy, CMS finalized that pulmonary and cardiac/intensive cardiac rehabilitation could be furnished to beneficiaries during

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

the PHE in hospitals under direct supervision where the supervising practitioner is immediately available to be present via two-way, audio/visual communications technology. Because statute has provided that these services will remain on the Medicare Telehealth Services List through 2024, CMS proposes to extend the parallel OPPS policy through 2024. CMS seeks input on whether there are safety and/or quality of care concerns regarding adopting this policy beyond the current or proposed extensions and what policies CMS could adopt to address those concerns if the policy were extended beyond 2023.

STS strongly supports the decision by CMS in previous rulemaking to allow the statutory provision regarding direct supervision of cardiac and pulmonary rehabilitation programs to be met through virtual presence via real-time, two-way audio/visual telecommunications technology. Additionally, we strongly recommend CMS make permanent direct supervision through virtual presence via real-time, audio-visual telecommunications technology beyond CY 2024 so beneficiaries can continue to receive cardiac and pulmonary rehabilitation services that can improve their lives.

OPPS Payment for Dental Services

For CY 2024, CMS proposes to assign 229 additional dental codes to clinical Ambulatory Payment Classifications (APCs) to enable them to be paid for under the OPPS when payment and coverage requirements are met.

STS supports the CMS proposal to include coverage for dental services as part of a comprehensive workup for the services proposed as well as other covered medical services that are linked to and produce better outcomes from dental services. It is 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.

Despite these factors, most Medicare beneficiaries do not currently receive oral/dental care even when medically necessary for the treatment of Medicare-covered diseases. In fact, Medicare coverage extends to the treatment of all microbial infections except for those relating to the teeth and periodontium. Moreover, the lack of medically necessary oral/dental care heightens the risk of costly medical complications, increasing the financial burden on Medicare, beneficiaries, and taxpayers. For example, when a patient presents with very poor dentition, the cardiothoracic surgeon frequently requests a dental consult to help ensure that the patient has the best possible outcome for any cardiac or general thoracic surgical procedure. Poor oral hygiene increases the risk of infection in a newly implanted heart valve. In addition, cardiothoracic surgeons often find that their patients 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 if Medicare would cover medically necessary oral/dental health therapies.

Payment Policies Under the ASC Payment System

Proposed Changes to the List of ASC Covered Surgical Procedures for CY 2024

CMS proposes to update the ASC CPL by adding 26 dental surgical procedures to the list for CY 2024, noting these would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and would not be expected to require active medical monitoring and care of the beneficiary at midnight following the procedure.

STS supports this proposal and reiterates our comments above that coverage for dental services is part of a comprehensive workup for the services proposed as well as other covered medical services that are linked to and produce better outcomes from dental services.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Adoption of New Measures for the Hospital OQR Program Measure Set

CMS proposes to re-adopt the Hospital Outpatient Department (HOPD) Procedure Volume measure with modification, with voluntary reporting beginning with the CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. The sole modification to this measure is that instead of collecting and publicly displaying data surrounding these eight broad categories, CMS would more granularly collect and publicly display data reported for the top five most frequently performed procedures among HOPDs within each category. The top five procedures in each category would be assessed and updated annually as needed to ensure data collection of most accurate and frequently performed procedures.

STS, along with the American College of Surgeons and many other physician organizations, does not support the use of volume measures in the OQR program. We caution CMS that surgical volume is not an indicator of quality and could encourage the use of inappropriate interventions. Providing quality requires understanding the clinical appropriateness of a procedure for each specific patient, the risk profile for each patient, and the overall outcomes that meet patient expectations. Measuring volume alone, without a proper framework, may lead to information that could impact patient trust, especially to the most vulnerable in high-risk public hospitals or rural care, where access and choice to high-quality care needs improvement.

Additionally, measuring volume in the absence of quality (or as a proxy) is a step away from CMS' goal to transitions to value-driven care instead of volume-driven care. **As we have seen from clinical registry data like that of the STS National Database, it is not appropriate to assume that performing a high case volume of certain procedures always equates to better outcomes. It is important to understand volume, patient risk profiles, price, and quality collectively to make an informed decision.**

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,

Thomas E. MacGillivray, MD
President