STS Headquarters
633 N Saint Clair St, Suite 2100
Chicago, IL 60611-3658
(312) 202-5800
sts@sts.org

Washington Office
20 F St NW, Suite 310 C
Washington, DC 20001-6702
advocacy@sts.org

June 10, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes [CMS-1833-P]

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) Proposed Rule. Founded in 1964, STS is a not-for-profit organization representing more than 7,800 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.

Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Concomitant Single Valve Procedure with Open Surgical Ablation

In response to a request to reassign cases involving a single open surgical valve procedure with an open surgical ablation (currently assigned to MS-DRGs 219, 220, and 221) to MS-DRGs 216, 217, and 218, CMS proposes to maintain the current structure and titles (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with major complication or comorbidity (MCC), with complication or comorbidity (CC), and without CC/MCC) of MS-DRGs 216, 217, and 218.

STS agrees that cases involving a single open surgical valve procedure with open surgical ablation procedures, which generally do not include cardiac catheterization, should not be reassigned to MS-DRGs 216, 217 and 218 which include cardiac catheterizations. However, despite repeated analyses over the years recognizing the higher costs associated with cases involving a single open surgical valve procedure combined with open surgical ablation, the measures taken by CMS, such as revisions to the Surgical Hierarchies in FY 2022 and the creation of MS-DRG 212 in FY 2024, have not effectively addressed the increased resource demands of these procedures. STS appreciates CMS's continued review of this issue and encourages the agency to consider alternative methods of addressing the increased costs associated with these procedures, such as the creation of new MS-DRGs, to ensure clinical coherence and more accurately reflect resource utilization.

Transcatheter Aortic Valve Replacement (TAVR) Procedures for Aortic Regurgitation

CMS is proposing to maintain the GROUPER logic for MS-DRGs 266 and 267 and to maintain the title of MS-DRG 215 (Other Heart Assist Implant). This proposal is in response to a request to reassign cases reporting TAVR procedures for aortic regurgitation (AR) from MS-DRGs 266 and 267 (Endovascular Cardiac Valve Replacement with or without MCC, respectively) to MS-DRG 215 (Other Heart Assist System Implant), which the requester believed to be more clinically and cost cohesive. Additionally, CMS was asked to revise the title of MS-DRG 215 to 'Other Heart Assist System Implant or Endovascular Cardiac Regurgitant Valve Replacement Procedures'. In response to this request, CMS conducted its analysis using claims data and found that TAVR cases for aortic regurgitation appear more closely aligned with cases in their current assignment.

STS agrees that TAVR represents a reasonable treatment option for some patients with AR, a serious cardiac condition that if not treated can gradually worsen and lead to left ventricular enlargement and heart failure. However, there is recent data that shows surgical aortic valve replacement (SAVR) may be more appropriate for patients with symptomatic severe AR. Additionally, STS believes that the heart team is essential for all patients undergoing TAVR, regardless of the indication, to ensure that patients are treated with the most appropriate intervention based on their clinical diagnosis and presentation. Patients requiring heart assist devices tend to present with more severe illnesses and require greater resource utilization and longer lengths of stay than those patients undergoing TAVR for AR. Therefore, reassigning the AR TAVR patients to MS-DRG 215 would not be clinically coherent. Since the data surrounding the best treatment for patients with severe AR with TAVR versus SAVR is still evolving, STS encourages CMS to monitor these patients and to continue to collect data to inform of potentially increased resource utilization and costs associated with treatment to determine if MS-DRG changes need to be made in the future.

Complex Aortic Arch Procedures

CMS is proposing to create a new base MS-DRG, 209 (Complex Aortic Arch Procedures), to account for the greater clinical resources that are required to these procedures. CMS received multiple requests to review assignment of codes that describe aortic arch procedures to the following MS-DRGs: 216, 217,218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, with CC and without CC/CCC respectively), 219, 220, 221 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC, with CC and without CC/MCC, respectively). Upon review of the data, CMS did not believe the suggestions from the requestors adequately addressed the issues CMS identified and went on to further review the requests in light of each. CMS found that the average costs of these complex aortic arch procedures, are higher when compared to the average costs of all cases in MS-DRGs 216, 217, 218, 219, 220, and 221.

STS agrees with and is supportive of CMS' proposal to create new MS-DRG 209 (Complex Arch Procedures) to account for the increased treatment difficulty, clinical similarity, and resource use, associated with these procedures. As indicated by CMS, patients undergoing complex aortic arch procedures reflect a complex patient population that requires increased resource utilization and costs associated with their care. Creation of the new MS-DRG and its placement in the surgical hierarchy will ensure that this group of complex patients will be clinically coherent and appropriately account for the increased resource use and complexity required to care for them.

<u>Quality Data Reporting Requirements for Specific Providers</u>

Proposed Changes to the Medicare Promoting Interoperability Program

RFI on Changing the Query of PDMP Measure from an Attestation-Based Measure to a

Performance-Based Measure

CMS seeks public comment to potentially inform future rulemaking to change the Query of PDMP measure from an attestation-based measure ("yes" or "no") to a performance-based measure (numerator and denominator), as well as alternative measures designed to more effectively assess the degree to which participants are utilizing PDMPs.

We do not believe changing the Query of PDMP measure from an attestation-based to a performance-based measure is in alignment with the Administration's emphasis on reducing regulatory burden. Transitioning to a performance-based approach would increase reporting complexity and administrative workload without clear evidence that it would lead to improved clinical outcomes. We encourage CMS to consider alternative strategies to assess PDMP utilization that do not impose additional burden on providers.

RFI Regarding Data Quality

CMS is seeking feedback on challenges and potential solutions related to the collection of high-quality data. CMS defines data quality as the degree to which health information is accurate, complete, timely, consistent, and reliable. According to CMS, poor data quality poses direct threats to patient safety, especially when providers, including eligible hospitals and CAHs, treat patients based on inaccurate or incomplete information. CMS wants to both encourage and support eligible hospitals' use of modern technologies and standards to ensure data are usable, complete, accurate, timely, and consistent.

Unique Device Identifiers

STS is supportive of recent efforts to expand the definition of unique device identifiers (UDI) for standardized data collection across. Standardized data collection of UDIs allows for better device tracking, increased patient and device safety, and higher quality data. STS currently maintains the STS National Database, the largest cardiothoracic surgical database in the world. The Database has four components, each focusing on a different area of cardiothoracic surgery—Adult Cardiac Surgery, Congenital Heart Surgery, General Thoracic Surgery, and Mechanical Circulatory Support. Currently, the Adult Cardiac Surgery Database (ACSD) contains more than 8 million cardiac surgery procedure records and has more than 3,800 participating physicians, including surgeons and anesthesiologists, representing more than 95% of all adult cardiac surgery hospitals and practices across the United States.

Information gathered from the database is used for improving the quality of adult cardiac surgery, facilitating the generation of new knowledge, informing patients and their families regarding the risks of surgery, and providing data to multiple national governmental and non-governmental agencies. Expanding the UDI field in certified EHR technology (CEHRT) would allow STS to more thoroughly report UDIs on the devices we collect for research and reporting purposes as requested by the Food and Drug Administration (FDA). Additionally, expanding the UDI field in CEHRT, would allow STS to expand UDI data capture on temporary mechanical circulatory assist devices, as well as better assist industry partners with post-approval studies as required by the FDA. As CMS quality programs require CEHRT, we believe they could be influential in attaining this update.

To ensure accuracy for improved data quality, STS strongly recommends that scanning UDIs into the electronic health records (EHR) be required. In our experience with the STS National Database, there is an increased burden on sites that manually enter complex UDIs and often lead to typographical errors. To account for this, STS only receives UDIs from sites that scan into the chart to avoid errors that render the UDI data unusable. As

a result, the STS ACSD currently only captures approximately 30% of the heart valve device UDIs and 15% of ventricular assist device UDIs.

Imaging Interoperability Standards

Another opportunity to improve data quality relies on strengthening the standardization and interoperability of medical imaging data through broader and more consistent adoption of the Digital Imaging and Communications in Medicine (DICOM) standard.

DICOM is the internationally recognized standard for the formatting, storage, and transmission of medical imaging and associated metadata.[1] It supports a wide array of data types, including patient demographics, imaging protocols, discrete measurements, and unique device identifiers (UDIs), all of which are critical for outcomes research, quality reporting, and regulatory monitoring. DICOM's structured format allows for integration of imaging data into EHRs.

Despite its utility, DICOM adoption remains incomplete and inconsistent, particularly in subspecialty imaging domains. Devices often claim DICOM compliance yet support only a limited or proprietary subset of its features.[2] For example, a device may conform to the storage of images, while omitting key metadata elements like UDIs or measurement annotations. This fragmented implementation undermines interoperability and limits the usefulness of imaging data for downstream applications.

As a result, systems that are technically "DICOM-compliant" may be incompatible in practice, preventing seamless data exchange between imaging devices, PACS, and EHRs.[3] These issues obstruct clinical workflows, hinder registry reporting, and delay innovation in data science applications. If CMS is looking to improve data quality, better DICOM standardization and utilization is required. CMS should work with the Assistant Secretary for Technology Policy (ASTP) to integrate DICOM standards into the Certified Health IT program, requiring certified EHRs and PACS to support full DICOM functionality.

Access to Federal Claims Data

Clinician-led clinical data registries, such as the STS National Database, are crucial for enhancing quality improvement and conducting significant health care research. A clinician-led clinical data registry is a repository that is led by clinicians and is designed to collect detailed, standardized data on medical procedures, services, or therapies for diseases or conditions and provide feedback to participants. These registries are pivotal in gathering quality and clinical outcomes data to inform value-based care and must adhere to stringent quality and privacy standards to be effective.

However, the data collected by clinician-led clinical data registries are limited. For example, the STS National Database is restricted to a narrow 90-day or less post-treatment window. This constraint severely restricts our ability to monitor patient outcomes beyond this brief period, hindering the evaluation of long-term effectiveness. Therefore, it is critically important for registries to supplement their data with claims data to

---

[1] National Electrical Manufacturers Association (NEMA). **Digital Imaging and Communications in Medicine (DICOM) Standard**. https://www.dicomstandard.org

[2] Chiang MF, Campbell JP, et al. **The Case for Standards in Ophthalmic Imaging to Enable Artificial Intelligence**. *Trans Vis Sci Tech.* 2021;10(7):23. https://doi.org/10.1167/tvst.10.7.23

[3] Koff DA, Bak P. Implementing DICOM standards: a user's perspective. *J Digit Imaging*. 2012;25(5):635–641. https://doi.org/10.1007/s10278-012-9490-3

assess the impact of interventions over extended period. In fact, Section 105(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directs CMS to provide Medicare claims data to registries for linkage with clinical outcomes data for risk-adjusted, scientifical analyses and research to support quality improvement or patient safety.

If provided meaningful access to federal claims data, clinician-led clinical data registries would better track patient outcomes over time, better assess the safety and effectiveness of medical treatments, and provide the information to assess the cost-effectiveness of alternative therapies.

One of the key barriers to accessing federal claims data is the Virtual Research Data Center (VRDC). While the VRDC is intended to serve as a platform through which registries can access Medicare claims data for research, its use is often limited. The process is slow, complex, and prohibitively expensive. Data access through the VRDC is restricted to narrowly defined research projects, and approvals can take months—or even years—without any assurance of success. The high cost alone often deters registries from pursuing access. To improve access to claims data, we urge CMS to eliminate VRDC fees and collaborate with stakeholders to develop a more affordable and efficient pathway. Overcoming these challenges is essential to enabling clinician-led registries to continue driving improvements in clinical outcomes and healthcare quality.

Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare

CMS seeks answers to the following questions:

- *Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?*
- *Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?*
- *Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?*

STS strongly urges CMS to review and reform several existing regulatory requirements that impose excessive administrative burdens on physicians and surgical practices without corresponding improvements in patient care or program integrity.

Merit-Based Incentive Payment System (MIPS)

MIPS, established with the intention of rewarding high-quality, cost-effective care, has instead become a burdensome administrative exercise for providers with little demonstrated benefit to patient outcomes. Despite being in place since 2017, there is little evidence that MIPS has meaningfully improved health outcomes or reduced avoidable healthcare spending.[4]

At the same time, the cost of compliance is staggering. Physicians are forced to divert time and resources away from patient care to meet complex and often irrelevant reporting requirements. One study found that

[4] https://jamanetwork.com/journals/jama/fullarticle/2799153

compliance with MIPS costs physicians approximately $12,800 and 202 hours per year.[5] CMS itself estimated that MIPS reporting requirements for CY 2025 would consume nearly 587,000 hours and cost the healthcare system over $70 million.

For specialists, the shortcomings of MIPS are even more pronounced. The program's one-size-fits-all approach fails to capture the clinical complexity and nuances of specialty care. Cardiothoracic surgeons, for example, are evaluated through generic quality measures that do not reflect the procedures they perform or the outcomes that matter in their field. As a result, MIPS fails to offer meaningful insight into actual quality or performance and instead rewards compliance over clinical excellence.

A more effective and less burdensome alternative is already in place: physician-led, specialty-specific clinical data registries. These registries, such as the STS National Database, collect detailed, clinically relevant data that directly informs quality improvement and patient safety. Most providers are already participating in these registries because they provide actionable feedback, benchmarking, and support continuous improvement in a way MIPS never has. Allowing providers' participation credit by reporting directly to these registries would streamline quality reporting, reduce the administrative burden, and enhance the accuracy and relevance of performance measurement.

Global Surgical Package Post-Operative Data Reporting (CPT 99024)

Since July 1, 2017, CMS has required reporting of postoperative evaluation and management (E/M) visits using CPT® code 99024, based on the assumption that post-operative follow-up care included in the surgical global package is not being consistently provided. However, this data collection initiative has proven ineffective, yielding incomplete and misleading information. If continued, it risks leading to unjustified payment reductions based on flawed data and incorrect assumptions. STS strongly urges CMS to rescind this reporting requirement until a more accurate, reliable, and lower-burden method of evaluation is identified.

While STS supports the principle of identifying services that are not furnished or not performed at the level of payment, we fundamentally disagree with CMS's underlying assumption that postoperative care embedded in global surgical payments is being neglected. Post-operative E/M by the operating surgeon is not only a longstanding expectation but a clinical imperative. Surgeons are professionally and ethically obligated to care for their patient's following surgery, both in the hospital and in the outpatient setting, until recovery is assured. This care is critical to patient safety, surgical outcomes, and overall well-being.

Despite these realities, CMS has relied heavily on flawed studies by RAND to justify continued postoperative visit reporting. STS and other stakeholders maintain that the RAND methodology is fundamentally unsound. The data collection was based on HCPCS code 99024 reporting, yet participation in the pilot was low and highly variable across specialties and states. RAND failed to control for numerous variables, including awareness of the mandate, practice size, and the complexity of matching reported codes to procedures. Notably, practices with 10 or more practitioners were excluded from the study—further undermining the representativeness of the dataset.

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

In follow-up, STS found that even with significant educational efforts, many physicians were unaware of the reporting requirement. RAND's conclusion, that physicians simply did not provide postoperative visits, is not only unsupported but implausible. Their assumption that non-reporting equates to non-performance is unjustified and contradicts the standard of care in surgical practice.

Furthermore, the classification of procedures by RAND and CMS appears fundamentally flawed. For example, in the CY 2019 Proposed Rule, CMS attributed 10-day global procedures to cardiac and thoracic surgeons—despite the fact that no typical cardiac or thoracic surgery codes fall under the 10-day category. Codes commonly performed by these specialists, such as 33405, 33426, 33533, and others, are all 90-day global procedures. This misclassification undermines the validity of the conclusions drawn about surgeon behavior and service provision in these specialties.

The implications of basing payment policy on these deeply flawed assumptions are significant. Any attempt to revise the valuation of global surgical services based on this unreliable data would be inappropriate and potentially harmful. CMS must recognize the limitations of the RAND studies and the inherent flaws in the reporting mechanism using CPT code 99024.

Medicare Appropriate Use Criteria

STS recommends a full rescission of the Appropriate Use Criteria (AUC) requirement, which imposes a redundant, prior-authorization-like burden on providers while offering limited clinical benefit. The program has been paused since 2022, when CMS acknowledged the associated risks and implementation challenges. While the underlying goal of promoting the appropriate use of advanced diagnostic imaging is valid, we agree with CMS that the AUC program is not the appropriate mechanism to achieve this objective.

The AUC mandate has proven impractical and incompatible with the typical clinical workflow. Most physicians already recognize the value of clinical decision support and routinely apply its principles to improve the quality, safety, efficiency, and effectiveness of care. Importantly, many clinicians are actively using clinically relevant tools developed by professional specialty societies as evidence by the use of the eight evidence-based risk calculators created by STS. These tools are widely adopted in cardiothoracic surgery and have demonstrated effectiveness in guiding care decisions, improving outcomes, and informing patients.

Rather than imposing additional administrative requirements, CMS should support and promote the continued use and development of trusted, specialty-driven clinical tools that are integrated into real-world practice. The AUC program, as designed, does not add meaningful value and should be fully rescinded.

Other Provisions Included in this Proposed Rule

Proposed Changes to the Transforming Episode Accountability Model (TEAM)

Mandatory Participation – Limited Deferment Period for Certain Hospitals

CMS proposes to establish a cutoff date after which new hospitals or hospitals that begin to meet the definition of a TEAM participants would not be required to participate immediately.

Under the proposal, the following hospitals would have at least one full performance year (but no more than two years) of participation deferment:

1. *Any new hospital, as identified by CMS Certification Number, with an initial effective date after December 31, 2024, within the Medicare Provider Enrollment, Chain, and Ownership System located in a mandatory core-based statistical areas (CBSA), or;*
2. *Hospital that begins to satisfy the definition of TEAM participant and is located in a mandatory CBSA after December 31, 2024.*

STS appreciates CMS's proposal to allow a participation deferment period for new hospitals or those newly meeting TEAM participant criteria, as it provides necessary time for operational readiness and resource alignment. Granting at least one full performance year before mandatory participation helps ensure that hospitals can meaningfully engage with the model and accurately reflect performance, ultimately supporting better patient care.

Accounting for Future Changes to MS-DRGs and HCPCS

CMS proposes a standard, three-step approach to account for MS-DRG and HCPCS/APC changes by remapping and adjusting relevant MS-DRG/HCPCS episode types during the baseline period to estimate performance year costs. The 3-steps are:

1. *Identify diagnosis or procedure codes that are being moved from one MS-DRG or HCPCS/APC to another based on the inpatient or outpatient hospital final rules of the relevant performance year and then map these codes to the new or revised MS-DRGs or HCPCS/APCs.*
2. *Construct episodes using the remapped MS-DRG or HCPCS/APC triggers.*
3. *Adjust the standardized allowed amounts used in target price calculations, to account for changes in fee-for-service rates between the baseline period and performance year due to changes to MS-DRG or HCPCS/APC weights.*

Without specific modeling, STS cannot provide comment on the methodology proposed, however we support CMS's goal to account for MS-DRG and HCPCS/APC changes. Remapping and adjusting relevant codes promotes consistency and fairness in episode construction and cost estimation across performance years. It also ensures more accurate comparisons between baseline and performance periods, helping to maintain the integrity of target price calculations.

Hierarchical Condition Category (HCC) Risk Adjustment

CMS proposes changes to the HCC Risk Adjustment variable in TEAM, including extending the lookback period to 180-days, beginning with the day prior to the anchor hospitalization or anchor procedure. Under this proposal, the beneficiary would need to meet beneficiary inclusion criteria for the entire 180-day lookback period. The proposed methodology is consistent with the one used in the BPCI Advanced model.

STS supports extending the HCC risk adjustment look back period to 180 day as it allows for a more comprehensive assessment of patient risk by capturing a fuller clinical history. Aligning this methodology with the BPCI Advanced model also promotes consistency across alternative payment models and supports more

accurate benchmarking. However, we will reiterate our previous comment that risk methodology for payment should also include clinical data and the STS Risk Models (already utilized by CMS in other settings) can be a useful addition to the coefficients in the BPCI Advanced model.

Risk adjustment using clinical data has proven to be reliable and accurate. STS has developed robust, highly credible risk adjustment models for mortality and morbidity as clinical outcomes, but risk adjustment models for resource utilization are much less well developed. For example, clinical factors that are key to risk-adjustment cannot be ascertained using a 90-day lookback period using fee-for-service claims, meaning the HCC count approach proposed may not give adequate results. The STS Risk models do not have this limitation and will likely provide more reliable risk-adjustment. It is for this reason that access to Medicare claims data that are then combined with STS clinical data are so crucial for developing credible and statistically valid prospective payment systems that take into account the clinical variables that have a dominant effect on resource use.

Unfortunately, claims data alone have been demonstrated to have major flaws, but the combination of clinical and resource data will yield a much more valid and credible model for predicting resource use. We urge CMS to use the best possible tools available to provide accurate risk adjustment for this program to ensure there are no disruptions in access to care for participating hospitals. Use of the STS database as a tool to establish clinical risk corridors that define financial risk would be the most appropriate tool for patient safety. We recommend using the STS Risk Models, which are highly calibrated, based on granular clinical datasets and include many of the characteristics outlined in the TEAM and BPCI Advanced risk adjustment models. Without this tool, high-risk Medicare beneficiaries will certainly be disenfranchised from the medical care that they desperately need.

Episode length

In the FY 2025 Inpatient Prospective Payment System rule, CMS finalized its proposed 30-day post-discharge episode length, believing that a 30-day post-discharge episode length provides sufficient time for post-procedure management and care redesign, while limiting the risk of including care for other, unrelated conditions in the episode. CMS has not proposed any changes to the 30-day post-discharge episode length in the FY 2026 proposed rule.

STS encourages CMS to reconsider the proposed 30-day episode length. We believe that 30-day episodes are too short for participants to effectively identify high-risk patients. Due to data lag in claims-based models, 30-day episodes would end before participants receive data on post-acute care. This short period limits the actionable costs included and the participant's ability to identify and address improvement opportunities.

Instead, CMS should keep the 90-day episode structure that has proven effective in the CJR and BPCI Advanced models. These models, grounded in academic research and real-world testing, support maintaining the current 90-day period which offers significant advantages for CMS, providers, and most importantly, patients. By capturing the comprehensive 90-day period, CMS can access the full scope of a beneficiary's care, enabling robust evaluation and continuity with prior models. This data helps CMS determine the optimal episode length for each clinical condition, which would be challenging with only 30 days of claims data. Providers will have sufficient time to manage follow-up care before transferring responsibilities. For example, most major surgeries require about six weeks for recovery, which means a 30-day period would miss critical post-acute

care to prevent complications. Lastly, patients would benefit from extended coordinated care. As CMS has stated, if the goal of the TEAM is to improve care coordination, then it is important that they track care coordination outside of the proposed 30-day period.

Keeping the 90-day episode also helps participants meet financial targets. All potentially actionable costs occur after the initial admission or procedure. To achieve the target, including the CMS discount, participants need to reduce post-acute care spending. If the episode length is cut to 30 days, all cost savings must happen within that period. For example, in BPCI Advanced episodes, over half of post-acute spending typically occurs between days 31-90. Therefore, a 30-day episode would require participants to double their savings within that reduced timeframe to meet targets. To provide participants the opportunity to design care delivery improvements and efficiencies, it is imperative that the model provide participants the space to focus on areas for improvement that are specific to that facility. To cut off a facility's access to demonstrating savings in days 31 to 90 will, for some facilities, doom them to penalties if they otherwise have a track record of efficiency in days 0 – 30.

Quality Measures

CMS has proposed one new patient reported outcome measure for TEAM. There have been no new procedure-specific measures included for TEAM reporting.

STS believes that data collection and the pursuit of quality improvement is necessary for all value-based payment models. Identifying appropriate quality measures is a vital component of the success of the TEAM. STS remains very concerned with the general measures that provide little information on CABG performance. While we appreciate CMS' efforts to streamline data collection for quality improvement by choosing measures that are already in effect in other programs, we do not feel the measures proposed are an appropriate benchmark for quality.

Instead, STS encourages CMS to utilize specialty specific measures that would better capture performance on the episodes proposed. Similar to the goals of TEAM, the BPCI Advanced model aims to promote seamless, patient-centered care throughout each clinical episode, regardless of who is responsible for a specific element of that care. Through the evolutions of BPCI Advanced, CMS determined that providers require a better indicator of the quality of CABG procedures than was provided through general surgical measures to account for differences in care that could lead to poor outcomes. The CMS Innovation Center added the CABG Composite Score (CMIT ID #1737) measure to the BPCI Advanced Model to provide a more complete reflection of care provided. STS urges CMS to reconsider the use of generic measures in the CABG episodes and to use the CABG Composite Score measure to better reflect care in the CABG episode.

The STS National Database™, Adult Cardiac Surgery Database (ACSD) registry has worked with leaders in the field to develop, test and implement the CABG Composite Score measure. The Society has a long history of rigorous real-world clinical data collection and quality improvement through the STS National Database and its component registries. Additionally, the ACSD is the largest cardiac surgical database in the world and includes information regarding over 9 million adult cardiac surgical operations.[6] For these reasons, we are uniquely

[6] Wyler von Ballmoos, M. C., Kaneko, T., Iribarne, A., Kim, K. M., Arghami, A., Fiedler, A., Habib, R., Parsons, N., Elhalabi, Z., Krohn, C., & Bowdish, M. E. (2024). The Society of Thoracic Surgeons Adult Cardiac Surgery Database: 2023 Update on Procedure Data and Research. The Annals of thoracic surgery, 117(2), 260–270. https://doi.org/10.1016/j.athoracsur.2023.11.016

qualified to determine the best methodology for measuring CABG procedures and have extensive data to support our recommendations. CMS should utilize STS as a resource for data collection and scoring of measures related to CABG. It is difficult for STS to believe that CMS can attest to the quality and outcomes of patients receiving CABG on only an all-cause readmission measure and a patient safety and adverse events composite measure. It is unclear how CMS can use these measures to truly evaluate whether the model has improved care for patients who have undergone a CABG.

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

Sincerely,

Joseph F. Sabik III, MD
President