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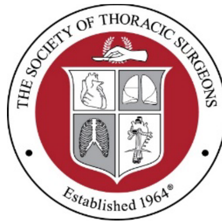

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October 31, 2022

The Honorable Ami Bera, M.D.
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Larry Bucshon, M.D.
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Kim Schrier, M.D.
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Michael C. Burgess, M.D.
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Earl Blumenauer
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Brad Wenstrup, D.P.M
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Bradley Scott Schneider
Member of Congress
U.S. House of Representatives
Washington, DC 20510

The Honorable Mariannette Miller-Meeks, MD
Member of Congress
U.S. House of Representatives
Washington, DC 20510

Re: Medicare Access and CHIP Reauthorization Act (MACRA) Request for Information (RFI)

Dear Representatives Bera, Buchson, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks;

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the MACRA RFI. Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,600 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.

This RFI seeks feedback on actions Congress could take to stabilize the Medicare payment system, without dramatic increases in Medicare spending, while ensuring successful value-based care incentives are in place. Responses could address (but are not limited to):

1. *the effectiveness of MACRA;*
2. *regulatory, statutory, and implementation barriers that need to be addressed for MACRA*
3. *to fulfill its purpose of increasing value in the U.S. health care system;*
4. *how to increase provider participation in value-based payment models;*

5. *recommendations to improve the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs.*

Below are STS's recommendations for overcoming barriers to MACRA.

Data Registries and Quality Measurement

One of the largest roadblocks to effective participation in MACRA is the limited access to meaningful measures for providers to use for participation. For specialists, and especially for thoracic surgeons, MIPS does not provide clinically relevant and meaningful measures.

The STS National Database serves as an example of a clinically relevant platform with actionable quality improvement/measurement of outcomes. The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has four components—the Adult Cardiac Surgery Database, the General Thoracic Surgery Database, the Congenital Heart Surgery Database, and the Intermacs Database (mechanical circulatory support), as well as the STS/ACC TVT Registry (transcatheter aortic valve replacement and transcatheter mitral valve repair). Not only does the STS National Database contain decades of clinical outcomes data, but up until 2022, it was a designated Qualified Clinical Data Registry (QCDR).

STS has long been an active stakeholder in the Centers for Medicare and Medicaid Services (CMS) QCDR policies. Unfortunately, due to a pattern of increasingly burdensome requirements placed on QCDRs, STS had to forfeit the QCDR designation. This forfeiture of QCDR means that we are no longer able to offer our surgeons a pathway with which to report for MIPS. Given the decades of experience the STS National Database has in collecting and tracking quality data, we are particularly frustrated with CMS' increasingly burdensome and unreasonable requirements for QCDRs to maintaining their QCDR status. QCDR policies have eliminated important measures for cardiothoracic surgeons and placed overly burdensome audit and data submission requirements on QCDRs. The result of CMS' burdensome and irrelevant measures is that CMS developed measures for reporting have no actionable meaning to cardiothoracic surgeons. Additionally, CMS has asked QCDRs to pay for and perform increasingly onerous audits. At the same time, CMS payment policies are pushing more and more cardiothoracic surgeons into hospital employment. Many hospital-employed surgeons are not aware that their employers are reporting on their behalf, under their specific tax ID number, using measures that are completely unrelated to cardiothoracic surgery. As the number of STS members participating in MIPS quality reporting continues to decline, the value proposition of QCDRs is absent, which seems antithetical to the Congressional intent of this reporting mechanism.

STS has participated in physician quality reporting since its inception. The use of existing real world clinical registry data for quality measurement is crucial to reduce provider burden and provide quality measures that are meaningful to patients and surgeons. STS presents the following specific concerns to CMS:

- Mandating QCDR reporting of Promoting Interoperability (PI) measures and Improvement Activities (IA) shift additional burden and expense to QCDRs.
- Requiring specific data validation requirements. STS reiterates that QCDRs have rigorous internal quality data standards which should be recognized and accepted by CMS. The proposed additional requirements are unnecessarily duplicative, burdensome, and costly.
- Requiring QCDRs conduct data validation audits with specific obligations and targeted audits for errors is duplicative and adds substantial expense to an already rigorous STS audit process. The STS National Database uses an external auditing firm to conduct audits for 10% of participating

sites at significant six figure expense to the organization. CMS requirements for provider level audits add to this financial burden, are time consuming, and do not enhance overall data quality or validity. STS opposes these additional requirements. Given the rigorous internal quality data standards already present in the STS registries, STS opposes this proposal as it brings additional and unwarranted burden to the Society and surgeon members.

CMS must reduce the burden and expense placed on QCDRs so that specialty-specific, clinician-led registries are able to capture relevant, actionable data for better performance measurement, improvement and transition to value-based health care delivery.

In addition to the demands placed on specialty societies, measure stewards, and registry owners to run registries, there is an additional challenge of incorporating appropriate measures for specialists. The measures contained in the STS National Database are National Quality Forum (NQF)-endorsed and were developed specifically for cardiothoracic surgeons by cardiothoracic surgeons to measure relevant and necessary clinical data for the purpose of quality improvement. However, the measures in the STS National Database are largely not included in CMS quality reporting programs due to the requirements needed to fit the CMS models. For example, while CMS uses percentage rates to compare performance, the STS National Database uses a composite quality rating system to illustrate performance. The composite rating system adjusts for both performance rate and the corresponding confidence intervals to give a more accurate representation of performance**. It also allows for a more holistic view of quality and performance by measuring a combination of procedures and outcomes. CMS needs to consider using more sophisticated statistical analyses, or alternative methods of representing performance measurement data that are more reflective of the methods used by clinician-led registries in order to allow for better differentiation of performance between providers and more relevant quality measurement.** The STS National Database alone contains more than 7 million cardiac surgery procedure records and has more than 3,800 participating physicians, including surgeons and anesthesiologists, representing more than 90% of all adult cardiac surgery hospitals across the United States and Canada. Thoracic surgeons are readily reporting data to the STS National Database and receiving quality feedback. By not tapping into this resource, CMS is missing out on relevant, useful data for thoracic surgery while doubling provider reporting burden.

Advanced Alternative Payment Models

CMS has made it clear through financial incentives and messaging that the goal within the Quality Payment Program (QPP) is to encourage providers to prioritize value-based care by participating in APMs instead of the traditional MIPS program. However, after performance year 2022/payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become Qualifying APM Participants (QPs). **If CMS is determined to have providers continue the transition from fee-for-service and MIPS participation into value-based care through APM participation, Congress will need to reauthorize and consider an increase in the 5 percent APM Incentive Payment**. Participation in an APM requires substantial investment in information technology and human resources. For example, practices may need additional staff and technical resources to provide enhanced care management. . Practices may also have a harder time recruiting physicians into risk-based models and may need the incentive payment for negotiations. Without additional incentive, surgeons are unlikely 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 money through MIPS reporting than through APM participation, which contradicts CMS' long-term goal.

Since the Advanced APM pathway was introduced, it has been primarily geared towards primary care with limited participation options for specialists. The physician community has devoted significant effort to develop well-designed APM proposals consistent with the goals of MACRA. Unfortunately, seven years after passage of MACRA, most specialists are unable to participate in an APM designed for the patients they treat, nor are they equipped to accept downside risk. APMs targeted towards specialist participation will not be introduced for use in the QPP before the 5 percent bonus expires, meaning specialists will not have received an opportunity to earn the bonus. **Providing meaningful incentives for Advanced APM participation for specialists as well as primary care providers may encourage more providers to take on down-side risk and prioritize value-based care. Minimally, to facilitate specialist participation in Advanced APMs, Congress needs to approve the continuation of the 5 percent bonus payment. Additionally, CMS, through the Center for Medicare and Medicaid Innovation (CMMI) should test and approve Advanced APMs that have been endorsed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).** STS in conjunction with the American College of Surgeons (ACS) submitted an APM which was never brought forward to CMMI for testing. Without the introduction of new models, specialists are continuously denied the opportunity to participate in Advanced APMs and a large percentage of providers eligible to participate in the QPP will be forced into MIPS reporting.

MIPS Value Pathways (MVPs)

CMS developed the MVP to serve as a bridge from MIPS to APM participation. CMS envisions that MVP reporting will complement APM Performance Pathway (APP) reporting such that it will enhance performance measurement and available information while minimizing additional burden.

STS supports CMS' effort to reduce clinician burden and offer a pathway for more clinicians to transition to alternative payment arrangements, however, we have strong concerns that the MVP framework lacks the specificity and applicability to truly affect change. By attempting to fit the MVP model into the current MIPS framework, CMS fails to provide a meaningful and less burdensome participation pathway for specialists or to provide a practical glide path to APMs. It is critical that CMS recognize multi-category measures that simultaneously address two or three MIPS performance categories, such as quality measures reported to clinician-led data registries that may also earn a clinician credit for the Improvement Activities or Promoting Interoperability categories. If the MVP framework too closely resembles the MIPS program, there is limited incentive to participate. **Transitioning to MVPs should provide more actionable data and information that prepares providers for more advanced models. 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.**

Additionally, if the MVP framework is designed to help transition providers out of MIPS and into APMs, there should be an opportunity for surgeons to participate in APMs. A subset of thoracic surgeons is eligible to participate in the BPCI+ model, however, STS has reservations in encouraging our membership to participate in an APM rather than MIPS due to uncertainty in how APM payments are distributed and how surgeons will be affected. With the 5 percent incentive for APM participants expiring and little to no opportunity for specialists to participate in APMs, there is no incentive for providers to invest in new methods and other requirements associated with APM reporting.

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Senior Manager of Regulatory Affairs, at mpeltzman@sts.org or 202-787-1221 should you need additional information or clarification.

Sincerely,

John H. Calhoon, MD
President