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September 2, 2022

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 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts [CMS-1770-P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (PFS) Proposed Rule. 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.

General Comments – Cuts

CMS estimates the CY 2023 PFS conversion factor (CF) to be $33.0775, which reflects the budget neutrality adjustment under section 1848(c)(2)(B)(ii)(II) of the Act (i.e., -1.55 percent), the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and the expiration of the 3.00 percent increase for services furnished in CY 2022. This means that CY 2023 CF is calculated as though the 3.00 percent increase for the CY 2022 conversion factor had never been applied. The CY 2022 CF was 34.6062 with the 3.00 percent increase, but the CY 2023 was calculated based on the CY 2022 CF without the increase, which would have been 33.5983 which makes the actual reduction in the conversion factor 4.5%. These changes, combined with PayGo cuts, result in an estimated 8.5 percent cut to cardiac and thoracic surgeons for CY 2023. This figure does not account for the impact from other factors such as sequestration or inflation.

The most widespread specialty impacts of the relative value units (RVUs) changes are generally related to the dynamic driven by the payment system being subject to a budget neutrality requirement with no built-in mechanism for inflationary or other increases in resources for the Medicare PFS. These disruptions occur when there are changes to RVUs for specific services, often work RVUs, sometimes due to adjustments resulting from the misvalued code initiative and other times the result of large codes

set overhauls as we have recently seen with the work RVUs for evaluation and management (E/M) services. As we have seen on numerous occasions, this instability can also be created with changes in policy or input data related to the practice expense (PE) RVUs (e.g., updated clinical labor pricing) and malpractice RVUs. These changes are only warranted if CMS recognizes the inherent connectedness of the values of these services and applies a consistent policy throughout the PFS and recognizes the relativity of the services. Therefore, to keep consistent with CMS' own past policy, STS recommends that CMS apply the commensurate values for the office/outpatient E/Ms, inpatient E/Ms, and discharge day management visits packaged in the procedural global payments. This has been CMS' policy every time E/M services have undergone a significant overhaul. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into the global procedural fees and now for CY 2023 to apply the valuation changes to the hospital visits and discharge day in the global codes.

The cuts CMS proposes to make to physician payments cannot be sustained regardless of the amount or the specialty, and this will be reflected in decreases in physicians available to care for Medicare patients and most importantly the quality of care that physicians can provide to their patients and increasing physician burnout. **Medicare payments to hospitals have a two percent yearly increase built in, but doctors do not. While this is always problematic, it is particularly devastating during a period of hyperinflation.** Most Medicare payment systems rely on annual payment updates that are anchored in the market basket for that sector designed to reflect the cost of delivering services. According to CMS, a "market basket is described as a fixed-weight, Laspeyres-type index because it measures the change in price, over time, of the same mix of goods and services purchased in the base period" and goes on to further state, "CMS market baskets reflect input price inflation facing providers in the provision of medical services."[1] But this is not true for physicians. The inpatient hospital market basket is used to update the Medicare Inpatient Prospective Payment System, the Hospital Outpatient Prospective Payment System, the Hospice Prospective Payment System, and, through CY 2023, the Ambulatory Surgery Center Payment System. While our members and other physicians are furnishing the clinical services in these precise facilities, CMS and statute make no accommodation to reflect the increased costs of physician practices. This will add further to the economically driven re-engineering of the physician practice landscape driving procedural specialties into hospital employment, further eroding the basis for physicians to fulfill their societal responsibilities as a profession. This is all the more reason that the Agency must make sound policy in the areas in which it has authority, and thus, **STS calls on CMS to update global surgical payments commensurate with increases to E/M RVUs. Further, we urge CMS to work with Congress to provide a positive update to the Medicare conversion factor in 2023 and all future years.**

Payment Provisions of the Proposed Rule for the Physician Fee Schedule (PFS)

Rebasing and Revising the Medicare Economic Index (MEI)

[1] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, *FAQ - Market Basket Definitions and General Information*, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf (updated May 2022; accessed August 30, 2022).

CMS proposes to rebase and revise the MEI (using data from 2017) based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians. While CMS believes that the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in furnishing physicians' services, CMS proposes to delay the implementation of the proposed rebased and revised MEI cost weights for both PFS rate setting and the proposed CY 2023 Geographic Practice Cost Index (GPCI). CMS solicits comments on the proposed delay and potential use of the proposed updated MEI cost weights in future years to recalibrate the RVU shares and to update the GPCI cost share weights, which were last realigned to the revised MEI weights in the CY 2014 MPFS final rule.

Since the inception of the Resource Based Relative Value Scale (RBRVS), CMS has used data about physicians' earnings and their practice costs obtained from the American Medical Association (AMA). The current MEI weights for physician work, PE and professional liability insurance (PLI) are based on the AMA's Physician Practice Information (PPI) Survey 2006 data. The CMS proposal primarily shifts payment allocation away from physician work (50.9% to 47.3%) and increases the PE payment allocation (44.8% to 51.3%) and significantly decreases the payment allocation for PLI (4.3% to 1.4%).

This proposal redistributes physician payment from physician work to the business side of healthcare. For example, the proposed shift in payment weights from physician work to PE principally favors Diagnostic Testing Facility (+13%), Portable X-Ray Supplier (+13%), Independent Laboratory (+10%) and Radiation Therapy Centers (+6%) to the detriment of Cardiac surgery (-9%), Thoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%) and Anesthesiology (-5%). This proposal is particularly problematic from a policy perspective as physicians face uncertainty about the Medicare conversion factor and continue to suffer from burnout. STS believes that CMS should be doing more to emphasize the importance of the work physicians provide, rather than direct resources away from their individual contributions.

In addition to significant specialty redistribution, geographic redistribution would also occur as CMS proposes to modify weights of the expense categories (employee compensation, office rent, purchased services and equipment/supplies/other) within the practice expense GPCI. A significant reduction in the weight of office rent from 10.2% to 5.9% would lead to reductions in the payment to urban localities and increases to payment in rural areas and states with a single GPCI.

Lastly, CMS has not adequately demonstrated that the implications of geographical differences combined with reweighting PLI are well understood. CMS should expand its impact analysis and consider how significant decreases in PLI payment may negatively impact geographical areas with relatively high PLI premiums.

The changes in the MEI that CMS has proposed are almost entirely related to the category weights. A change in the price proxy is recommended for just one of the cost categories which accounts for only 2 percent of the index. CMS is not proposing a change to the productivity adjustment. The proposed changes in the category weights are primarily derived from the Census Bureau's 2017 Service Annual Survey (SAS) for the "Offices of Physicians" industry, which was not designed with the purpose of updating the MEI. As a result, there are key areas (physician work, nonphysician compensation and medical supplies) where CMS must use data from other sources to work around this important gap.

Several of the flaws in utilizing the SAS data for this purpose, include:

- Seven percent of the revenue for "Offices of Physicians" on the 2017 SAS was from non-patient care sources (e.g., grants, investment income) and, while it should be excluded, any expenses associated with these sources cannot be removed from CMS' calculations.

- The SAS for "Offices of Physicians" includes payroll and benefits for all staff combined, but the MEI has separate cost categories for physician and non-physician compensation. Non-physician compensation in the MEI is further broken out by staff type. Based on 2017 data, CMS states that 63.2% of employee compensation for "Offices of Physicians" is for physicians and qualified healthcare professionals (QHPs), so it is missing compensation for a large segment of the physician population (practice owners). To compensate, CMS is proposing to estimate total compensation for practice owners as a share of practice net income from the 2017 SAS (the difference between total revenue and total expense which amounted to $44.9 billion out of $490.9 billion in revenue for 2017). The share of net income proposed is the estimated percent of patient care physicians that are owners (46.5%), averaged from the 2016 and 2018 AMA Physician Practice Benchmark Surveys, resulting in an estimated $20.9 billion in compensation for owners. CMS' estimate of $20.9 billion in compensation for owners represents just 10% of total compensation for all physicians and QHPs ($203.8 billion), which is dramatically out of line with any reasonable estimate since nearly half of physicians in the United States are owners.

- CMS used data to split out the US Census SAS data using the "Offices of Physicians" category. However, only 64% of employed physicians are in this category in both the US Census SAS and Bureau of Labor Statistics datasets. This analysis excludes 36% of physicians who are employed in other health care settings, such as hospitals. For example, the "General Medical and Surgical Hospitals" category was not included in CMS' analysis and this category includes 158,880 employed physicians, according to the 2017 data. Hospital-based physicians have a higher proportion of physician earnings and PLI cost relative to other practice costs, as many of these other costs are the responsibility of the hospital or other facility. The CMS proposal greatly underrepresents the cost share of physician work and PLI relative to PE due to this inappropriate exclusion.

- In the current MEI, CMS excludes expenses for separately billable supplies and drugs. The 2017 SAS for "Offices of Physicians" has a single category for Medical Supplies without any breakout for the separately billable component. To estimate separately billable supply and drug expense, CMS proposes to age forward AMA-Physician Practice Information (PPI) results for these expenses and then compare the estimated total to Medical Supplies expense from the SAS (finding that 80% of Medical Supplies expense is for separately billable medical supplies or drugs). There are two problems with the CMS proposed approach: 1) The measures used to age expenses forward are not entirely appropriate (using growth in Medicare Part B drug spending when an all-payer measure would be better) and do not account for inflation ; and 2) totals estimated from two entirely different surveys are being compared when those surveys may have different populations and methods (for example, the wording of the questions and direction on what to include in the category could be entirely different).

- The dramatic decrease in the weight for PLI cost seems unrealistic. In 2021, the Medicare physician payment schedule allowed charges were $91 billion. If PLI payment only represented

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

STS agrees with CMS that the implementation of the proposed update to the MEI cost weights for both PFS rate setting and the proposed CY 2023 GPCIs be delayed, allowing stakeholders the opportunity to review and comment on the proposed rebased and revised MEI cost share weights and their potential redistributive impacts. STS encourages CMS to collaborate with the AMA on their efforts to collect new PPI based on 2022 cost data from physician practices. The AMA survey to collect physician practice cost data is expected to begin in 2023. **To ensure consistency and reliability in physician payment, STS urges CMS to postpone any changes or updates to the MEI weights until the new AMA survey data are available.**

Determination of PE RVUs

PE RVU Methodology and PLI RVUs – Expected Specialty Overrides for Low Volume Service Codes

STS commends CMS on their continued efforts to ensure that the list of expected specialties is correctly and consistently applied for the low volume service-level overrides each year. STS fully supports CMS' policy to use expected specialty service-level overrides for both PE and malpractice (MP) for certain low volume services. Application of the specialty overrides for low volume services ensures that the expected indirect PE is appropriately represented. The policy also ensures that the malpractice risk inherent to a code is reflected in the malpractice risk of a singularly qualified specialty. Specialty assignment to these low volume codes prevents major adverse impact on PLI RVUs resulting from errors in specialty utilization data that is magnified by small sample size such as congenital cardiac surgery.

STS agrees that CMS should continue to use a three-year average for identifying services with fewer than 100 Medicare claims for the expected specialty override. However, to avoid *undercounting or overcounting of certain services*, we encourage CMS to adjust the utilization to interpret any CPT modifiers (-50, -55, -62, -80). *Adjusting the eligibility analysis to appropriately interpret certain CPT modifiers would improve the targeting of this policy so that very low volume services that would benefit from the policy would receive the override.* The "Override Applied?" column in the Proposed CY 2023 list of *Anticipated Specialty Assignment for Low Volume Services* shows that the override will not be applied for the following cardiothoracic surgery codes: **33140, 33238, 33254, 33363, 33910, 33916, 33953, 33983, 35271 with the anticipated specialty of Cardiac Surgery and 32442, 32540, 32654, 32672, 32800, 32900, 39503, 43341, 64746 with the anticipated specialty of Thoracic Surgery**. STS is concerned that this could be an error related to the unadjusted utilization numbers.

STS has commented on this issue in previous years and has recommended many cardiothoracic surgery codes, many of which represent congenital cardiac procedures for children that meet the low volume criteria be included on the list. **STS is pleased to see that the Proposed CY 2023 list of *Anticipated Specialty Assignment for Low Volume Services* includes all the recommended codes that STS has**

submitted over the years. However, STS would once again like to point out as we have in previous years that the specialty assignment for a significant number of cardiothoracic surgery procedures have been incorrectly identified by CMS as "Thoracic Surgery" instead of "Cardiac Surgery" as the low volume specialty override. We recognize that this effort is likely futile based on CMS' stated decision to decline correcting the specialty designation changes. However, we feel it is prudent and clinically responsible to point out the difference, once again, in cardiac surgery and thoracic surgery in an attempt to ensure that the correct specialty override is applied to the low volume codes; recognizing that the cardiac surgery MP risk factor is actually less than the thoracic surgery MP risk factor, meaning that we are actually asking CMS to apply the lesser of the two values to our own codes.

STS specialty crosswalk recommendations for changing the override specialty from thoracic surgery to cardiac surgery are based on the clinical concept that codes that are considered "cardiac" in nature, are those procedures performed on the heart, great vessels, and surrounding structures and should be designated with the override specialty of "Cardiac Surgery." Codes that are considered "Thoracic Surgery" include procedures performed on the lungs, esophagus, chest wall and mediastinum and should be designated with the override specialty of "Thoracic Surgery."

For these reasons, STS is recommending that the override specialty for a significant number of the low-volume cardiothoracic surgery codes in the list, many of which represent congenital cardiac procedures for children, be changed to cardiac surgery. We continue to be baffled by CMS' premise that the Specialty Society that represents the physicians that perform these services should be disregarded in favor of an incorrect assignment that was finalized in previous rule making.

In the CY 2020 MPFS Final Rule CMS states that "CMS previously finalized through rulemaking a crosswalk to the thoracic surgery specialty for a series of cardiothoracic services that typically had fewer than 100 services reported each year (see, for example, the CY 2012 PFS final rule (76 FR 73188–73189))." CMS goes on to state "However, we noted that for many of the affected codes, the expected specialty list for low volume services incorrectly listed a crosswalk to the cardiac surgery specialty instead of the thoracic surgery specialty. We proposed to update the expected specialty list to accurately reflect the previously finalized crosswalk to thoracic surgery for these services." It is difficult for us to understand why CMS refuses to recognize the clinically accepted definitions of cardiac surgery and thoracic surgery in assigning the low volume specialty overrides for cardiothoracic surgery services, when they have repeatedly been notified that there is nothing accurate about CMS' previously finalized crosswalk to thoracic surgery for these codes. The CPT code descriptions clearly identify those procedures that are cardiac in nature and those that are thoracic in nature, which is further supported by the placement of these codes in different sections of the CPT Book under different headings (respiratory, cardiac and esophageal).

As a matter of principle, STS has included a table in Appendix A with a list of codes that should be designated as "cardiac surgery" instead of "thoracic surgery" for the purposes of the low volume specialty overrides for PE and MP for the reasons outlined above.

STS reviewed the RVS Update Committee's (RUC) PLI Workgroup analysis of all codes that meet the low-volume criteria to receive a specialty override under this CMS policy for CY 2023. STS supports the addition of the 64 low volume codes with proposed expected specialty overrides that were identified and submitted by the RUC. Specifically, **STS supports the addition of the following two codes to the**

CMS list of anticipated specialty assignment for low volume services in the NPRM *(CY 2023 PFS Proposed Rule Anticipated Specialty Assignment for Low Volume Services):* 33406 with the designated specialty of cardiac surgery and 43112 with the designated specialty override of thoracic surgery.

Clinical Labor Pricing Update

CY 2023 represents the second year of a four-year transition to update clinical labor prices that will be completed in CY 2025. **STS also encourages CMS to update pricing data on a more frequent basis for all direct PE inputs, to minimize the impact on adjustments in the future.** PE comprises 44.8 percent of the physician payment and the pool of this payment is fixed by statute and the current proposal increases the total direct PE pool by 30 percent which results in a significant budget neutrality adjustment. Increasing payment for clinical labor shifts funds that were previously directed to supplies and equipment which disproportionately impacts the budget neutrality component within the PE RVUS for physician services with high-cost supplies and equipment. There is an underlying unfairness that the real increase in clinical labor costs is not recognized through an update to the conversion factor. STS encourages CMS to carefully consider policy changes to PE that inappropriately and disproportionally diminish the importance of PLI, which adversely disadvantages this important component of physician reimbursement. **STS calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2023 and all future years and to establish allowances to increase or override budget neutrality adjustments for circumstances that add or shift larges amounts money and negatively impacts most physicians, such as this change, as well as the the proposed MEI, dental and E/M changes.**

New Clinical Staff Pre-Time Package for Major Surgical Procedures

STS worked with the RUC Practice Expense Subcommittee in developing a new pre-service clinical staff time package for major surgical procedures that have 000 – or 010-day global periods. Major surgical procedures that have shorter global periods (e.g., ECMO Cannula insertion, removal, and repositioning procedures, TAVR procedures, diagnostic thoracoscopic lung procedures) and are provided in the inpatient setting may still require the same amount of clinical staff time as procedures with 090-day global periods. To address this issue, the RUC established an additional pre-service clinical staff time package "Comprehensive Use of Clinical Staff" to provide an option for procedures performed in the facility-setting with 000- or 010-day global periods that require pre-service clinical staff time that is equivalent to 090-day global procedures.

The new pre-service package allows a mechanism for new major surgical procedures that are assigned 000- or 010-day global periods or procedures that change from 090-day to 000 or 010-day global periods to assign the appropriate pre-service clinical staff time associated with the procedure. **STS encourages CMS to recognize and apply the new "Comprehensive Use of Clinical Staff" pre-service time package as appropriate.**

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

As part of CMS' proposal to rebase and revise the Medicare Economic Index (MEI) to reflect more

current market conditions faced by physicians in furnishing physicians' services, CMS explains its belief that the MEI is the best measure available of the relative weights of the three components in PFS payments under the PFS (work, PE and professional liability insurance). CMS believes the RVUs used in developing rates should reflect the same weights in each component as the MEI to assure that the PFS payments reflect the relative resources in each of these components as required by statute. In the past, CMS held work RVUs constant and adjusted the PE RVUs, the professional liability insurance (PLI) RVUs and the CF to produce the appropriate balance in RVUs among the PFS components and payment rates for individual services. This was done by modifying steps 3 and 10 in the PE methodology to adjust the aggregate pools of PE costs (direct PE in step 3 and indirect PE in step 10) in proportion to the change in the PE share in the rebased and revised MEI cost share weights and recalibrating the relativity adjustment in step 18 (adding the direct PE RVUs to the indirect PE RVUs and applying the final PE budget neutrality (BN) adjustment). However, given there are significant proposed methodological and data source changes to the MEI for CY 2023 and significant time has elapsed since the last rebasing and revision of the MEI, CMS proposes to delay the adjustments to the PE pools in steps 3 and 10 and the recalibration of the relativity adjustment in step 18 until the public has an opportunity to comment on the proposed rebased and revised MEI.

CMS also indicates that they believe it is necessary to establish a roadmap toward more routine PE updates and signals its intent to move to a standardized and routine approach to valuation of indirect PE, which will be included in future rulemaking. With this in mind, CMS seeks comment on the following:

- *Potential approaches to design, revision, and fielding of a PE survey that foster transparency (for example, transparency in terms of the methods of survey design, the content of the survey instrument, and access to raw results for informing PFS rate setting).*
- *Mechanisms to ensure that data collection and response sampling adequately represent physicians and non-physician practitioners across various practice ownership types, specialties, geographies, and affiliations.*
- *Any alternatives to the above that would result in more predictable results, increased efficiencies, or reduced burdens.*
- *Cadence, frequency, and phase-in of adjustments for each major area of prices associated with direct PE inputs (Clinical Labor, Supplies/Equipment).*

STS works closely with the AMA through the RUC to assign value to PE for cardiac and thoracic surgery. **STS supports CMS collaborating with the AMA on behalf of cardiothoracic surgeons and other providers on a new PPI cost survey based on 2022 data.** The AMA PPI data has been utilized by CMS for 50 years in updating the MEI and 30 years in updating the RBRVS and provides the most reliable source of information on which to base future changes. The AMA engaged multiple vendors and committed significant resources in conducting a pilot study and planning a new effort which was postponed until physician practices resumed to normalcy after the COVID-19 public health emergency (PHE). It is anticipated that 2022 data could be collected, beginning in mid-2023. **STS agrees that all significant data updates (PPI Survey results, supply and equipment pricing, and clinical staff wage rates) should occur simultaneously and should be transitioned to avoid abrupt impacts to individual services and specialties. We understand the need for consistent and timely updates to the practice cost data and look forward to the development of a mechanism to update these data on a more frequent basis.**

Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation

CMS seeks public comment on strategies to improve the accuracy of payment for the global surgical packages under the PFS, which will be used to inform future rulemaking. Specifically, CMS continues to be concerned that its current valuations of the global packages reflect certain E/M visits that are not typically furnished in the global period, and thus, are not occurring. CMS believes RAND has adequately responded to critiques of its methodologies and findings but continues to welcome any comments from the public on ideas for other sources of data that would help the agency assess global package valuation (including the typical number and level of E/M services), as well as CMS' data collection methodology and the RAND report findings.

STS is supportive of identifying services that are not performed, or not performed at the level of payment, and taking steps to eliminate those payments**. However, we disagree with CMS' blanket assumption that postoperative care that is valued into the global surgical package is not being provided**. We are steadfastly committed to the concept that postoperative E/M by the surgeon is critically important to the care and overall well-being of our patients. STS believes that physicians are professionally bound to the fundamental principle that it is medically necessary, and indeed a patient expectation, that surgeons evaluate patients on a daily basis while in hospital following a surgical procedure, and from time-to-time as an outpatient, until recovery is assured. The 010- and 090-day global service period for surgical procedures is a longstanding cost-effective method, allowing surgeons to provide the necessary related care to their patients before and after surgery. It is important to recall the historical rationale for the global surgical reimbursement mechanism, which was to minimize any economic incentives for itinerant surgery and fee splitting. The global period also limits administrative burden for both the provider and payor allowing both to focus on the needs of the patient.

The postoperative global period provides for a bundled payment for postoperative visits and other services by the surgeon. With this single payment the patient is generally treated by the surgeon for all surgery-related problems without additional billing. Since RBRVS was instituted, the in-hospital care delivery model has changed: hospitals now utilize critical care specialists, hospitalists, and a team approach to augment "routine" post-procedural patient care. of this change has been driven by a change in the patient population which is now older and sicker and a growing movement by patient safety advocates to provide round the clock coverage and appropriate non-surgical specialty care for this increasingly frail patient population. STS continues to believe that this care model augments rather than replaces the post-operative care delivered by the operating surgeon because there is simply more care required to achieve the high-quality results demanded by the patients as well as private and governmental regulatory entities. In the context of improved medical knowledge and capabilities and an expanded patient population, **we believe that the combined cognitive input from different members of the multi-disciplinary team (including surgeons, critical care specialists, and various subspecialists when appropriate) is medically necessary and fundamental to the team approach that improves outcomes, decreases complications and cost, and improves quality. Post operative surgical care delivered by multiple providers during a global period is medically necessary and not duplicative of the work of the surgeon.**

In the CY 2023 Proposed Rule, CMS indicates that they believe that RAND has adequately responded to critiques of its methodologies and findings. However, STS and others continues to have substantial concerns with the RAND reports and maintain that CMS cannot make informed decisions about the future of global surgical payments based on these flawed studies.

In December 2018, authors from RAND published an article in the Annals of Surgery discussing the results of their data collection efforts that had been described in the CY 2019 proposed rule. This was the first effort to analyze what CMS had already acknowledged to be flawed data. While the authors recognize data limitations, they nevertheless drew conclusions.

STS does not believe that RAND sufficiently addressed all the concerns raised by the AMA and other commenters about the study methodology. Despite evidence that participation varied widely by specialty and state; the difficulty the Agency and RAND had matching procedures to CPT code 99024; and the number of assumptions that RAND had to make to justify their findings, CMS accepted their findings. Many variables might have explained the limited and/or intermittent participation of eligible physicians but RAND made no effort to control for them. In addition, the dataset is potentially not representative since practices with 10 or more practitioners were excluded. We do not believe that this dataset can reasonably be used to forecast any overall trends.

In limited follow-up to the RAND study, STS found that despite education efforts by the Society, very few of the providers in the participating states knew about the mandatory reporting initiative. In their *Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods Final Report* RAND indicates that "During the study period, 46.3 percent of 40,017 practitioners expected to report post-operative visits reported one or more post-operative visits using HCPCS code 99024." This means that 54% of physicians in the nine states who were eligible to participate, did not report. RAND makes an inappropriate, and frankly outlandish assumption that these physicians did not provide any visits in any surgery's global period.

In addition, in the CY 2019 Proposed Rule, CMS noted that ***thoracic surgeons*** performed two hundred and ***seventy-six 10-day global procedures*** with only forty 99024 codes reported and ***cardiac surgeons*** performed ***one hundred forty-four 10-day global procedures*** with only twenty-five 99024 codes reported. CMS must be aware that there are no 10-day global procedures on the list of codes for mandatory reporting that would typically be performed by cardiac or thoracic surgeons. In fact, all of the codes that would typically be attributed to cardiac and thoracic surgery from the mandatory reporting list were 90-day global codes (32480, 32663, 33405, 33426, 33430, 33533 and 33860). It is unclear how CMS determined that these 10-day global procedures should be attributed to cardiac and thoracic surgery respectively. Were they assigned by procedure or by specialist designation? If they were designated by the procedure, then there was clearly an error in the data collection that completely negates the validity of the study. If it was assigned by specialist designation, how is it that CMS intends use data about procedures that are not typically performed by cardiac or thoracic surgery to alter the values of other procedures that are germane to the specialty? How would that be remotely relevant?

Any one of these reasons would be justification to conclude that the data collection method was faulty, yet CMS and RAND persisted in their assertion that the post-operative visits simply were not taking place. We urge CMS NOT to make any fee schedule adjustments based on the analyses completed by RAND on this topic.

It is also completely irresponsible for CMS, or a contractor of CMS, to suggest that reimbursement for cardiac and thoracic surgery is over-valued by upwards of 20%. That simply cannot be rational. Extensive cuts to cardiothoracic or any surgical specialty may make it impossible for surgeons to continue to

practice at all. The effect of such a change on Medicare beneficiaries would be devastating. The impact on the Fee Schedule would be irreversible.

The repercussions of such a shift would be felt for years to come. Thousands of medical students choose their medical specialties each year. If cardiothoracic and other surgical specialties after additional years of training no longer offer a financially stable career, those students will be forced to choose other non-surgical specialties that will better allow them to pay off their compiling and debilitating student loans. In both the short and long term, Medicare beneficiaries with some of the most lethal health conditions such as coronary artery disease and lung cancer, stand to lose access to value-based care if CMS continues to minimize surgeons' contributions to patient care.

The RAND report itself notes that,

> The number and type of visits are not used by the RUC or CMS to directly value a given procedure in RVUs. Instead, this information is used to inform the discussion. The valuation is made for the entire procedure as a whole, including pre-operative care, the procedure itself, immediate post-operative care, and post-operative visits in the global period[2].

STS suggests that CMS consider whether each individual 10- and 90-day global surgical period, as a whole, is truly over-valued by these unimaginable margins. CMS and the RUC have developed a process to identify and review potentially misvalued services using objective screens, public comment, and CMS code selection**. STS believes that the RUC Relativity Assessment Workgroup is the best way forward to identify and revalue potentially misvalued codes, including review of the global service period.**

Changes to Health Care Delivery and Payment for E/M Services

For yet another year, STS is also concerned with CMS' continued refusal to apply the same RUC-recommended values to E/M services that are imbedded in the global surgical codes as it does to stand-alone, in-office E/M visits. CMS' failure to apply the RUC-recommended increases for the revised E/M office visit codes for CY 2021, CY 2022 and potentially for CY 2023, which now also includes recommended increases to the hospital visits and discharge day management visits, to the post-operative visits embedded in the 10- and 90-day global surgical payment represents a conscious bias against surgeons and proceduralists and is knowingly and effectively destroying the relativity of the fee schedule as well as violating the law requiring that all physicians should receive the same payment for the same service.

STS is concerned that CMS' continued refusal to incorporate all the RVU increases to the E/M visits (office/outpatient visits, hospital visits and discharge day management visits) unfairly disadvantages and penalizes surgeons who are providing equivalent care to patient's as other physicians providing non global period services. By continuing to not do so, CMS:

- Disrupts the relativity in the fee schedule: CMS is arbitrarily changing the values for some E/M office visit services, but not others, disrupting the relativity between codes across the Medicare physician fee schedule. This relativity was mandated by Congress, established in 1992, and has

been refined over the past 27 years. Historically (1997, 2003 and 2011), CMS itself has ensured this relativity between office/outpatient E/Ms and those associated with global surgical codes by increasing the value to global services commensurate with, and identical to, increases in office / outpatient E/M because of the direct relationship between the codes in the significant revaluations of office/outpatient E/Ms.

- Creates specialty differentials: Per the Medicare statute, the "Secretary may not vary the…number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. CMS' ongoing non-compliance with the law is disturbing, and we ask by whose authority are they able to knowingly remain non-compliant for yet another year.

- Ignores recommendations endorsed by nearly all medical specialties: The AMA-RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the post-operative visits of the global surgery codes for each CPT code with a global period of 10-day, 90-day and maternity codes. The RUC also recommends that the PE inputs should be modified for office visits within the global periods.

- Inappropriately relies on section 523(a) of MACRA: In the CY 2021 PFS proposed rule, CMS refers to its decision in the CY 2020 PFS final rule to not make changes to the valuation of the 10- and 90-day global surgical packages to reflect the increased values for the office/outpatient E/M visit codes while the agency continues to collect data on the number and level of post-operative visits included in global codes as required by MACRA. The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from applying the RUC-recommended incremental increases to the office/outpatient E/M codes to global codes. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. In addition, it is inappropriate for CMS to rely on the implementation of MACRA, which passed in 2015, as a reason to refrain from making necessary updates. CMS continues to make and/or defer policy decisions, such as their proposal to bundle critical care visits with procedure codes that have a global surgical package in the 2021 proposed rule, under the premise of continued assessment of values for global surgery procedures including the number and level of pre and postoperative visits. CMS is arbitrarily making or deferring changes to code valuations and payment policy in a manner that suits their needs as opposed to applying the guidance in a consistent manner.

Determination of Malpractice Relative Value Units (RVUs)
CMS' calculation methodology for the CY 2023 MP or professional liability insurance (PLI) RVUs largely parallels the process last used in the CY 2020. They have proposed some methodological improvements to the development of the PLI premium data and are seeking comments on these proposals. Refinements include proposed methodologic changes related to the approach for the imputation of missing professional liability premiums and utilization of a true PLI risk index calculated as a ratio of the specialty's national average premium to the volume-weighted national average premium across all specialties, vs. a ratio of a specialty's national average premium benchmarked to the physician specialty with the lowest premiums. CMS indicates that their proposed changes to the PLI risk index had no

change in the actual PLI RVUs but anticipate that the change will increase consistency with calculation of the PLI RVUs.

STS appreciates CMS' continued efforts at improvement in specialty-specific data collection moving them closer to obtaining updated premium data for all physician specialties and other health care and facility providers in all fifty states, to ensure the most accurate PLI premiums. **STS directs CMS to the AMA RUC comment letter which offers specific recommendations and comments related to the proposed methodological refinement**s, including recommendations for CMS to implement the new CY 2023 PLI premium data for all professions without a 3-year transition. Delaying implementation prolongs the large systematic overvaluation of the PLI RVUs for the services predominantly performed by professions with newly available premium data, as well as the systematic underpayment of all other Medicare specialty codes, as all PLI RVUs share the same PLI RVU pool in MFS rate setting methodology.

STS also agrees with concerns articulated in the AMA RUC letter regarding the possible technical error impacting all CPT/HCPCS codes with the Professional Component/ Technical Component split, which has collectively reduced the aggregate allowed charges for PLI RVUs for all specialties by more than $110 million for CY 2023. The global PLI RVU for PC/TC codes should reflect the combined specialty mix for the physicians and other qualified healthcare professionals that perform these services, based on the specialty mix of all physician or other QHP specialties for the aggregate of global only claims and -26 modifier claims. STS recommends that CMS identify the root cause of this technical error and to correct it for CY 2023. If CMS is unable to identify and resolve the error, delay implementation, and apply the previous methodology for PC/TC codes until the technical error is corrected. And lastly, STS agrees with the RUCs comments and recommendations to further improve the total and partial imputation methodology to develop a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings.

Valuation of Specific Codes

CMS describes its methodology for establishing work relative value units (RVUs), including what data are reviewed and how those data are assessed. CMS explains that its reviews of recommended work RVUs and time inputs generally include, but have not been limited to, a review of information provided by the RUC, the HCPAC, and other public commenters, medical literature, and comparative databases, as well as a comparison with other codes within the PFS, consultation with other physicians and health care professionals within CMS and the Federal Government, as well as Medicare claims data. CMS also assesses the methodology and data used to develop the RVU recommendations submitted by the RUC and other public commenters and the rationale for the recommendations. CMS also highlights a variety of methodologies and approaches used to develop work RVUs, including survey data, building blocks, crosswalks to key reference or similar codes, and magnitude estimation. CMS explains that many stakeholders, namely the RUC and various specialty societies, have expressed concerns over the years with CMS' ongoing adjustment of work RVUs. CMS notes that it does not ignore the AMA RUC-recommended work RVUs; rather, it uses them as starting point in making refinements using various methodologies and data derived from the AMA RUC survey process.

STS continues to have significant concerns that CMS does not have a consistent, clinically valid methodology established for its supposed finement of survey-based data and agreed-upon work RVU valuation recommendations from the AMA RUC and the representative specialty societies. CMS has a

history of opting, instead, for various methodologies to support CMS' targeted and typically lower value for a procedure. Although, through the RUC process, significant clinical expertise is used in developing the work RVU recommendations, CMS accepted only 75% of the RUC's work RVU recommendations submitted for CY 2023.

STS is one of the many stakeholders that has commented several times in the past that CMS is overlooking the statutory-required intensity component and its role in valuation of the procedures. Section II (A)(1)(a) of this rule regarding the development of work RVUs states: "*As specified in section 1848(c)(1)(A) of the Act, the work component of physicians' services means the portion of the resources used in furnishing the service that reflects physician time and* ***intensity [emphasis added]***." Section1848(c)(2)(C)(i) of the Act further specifies that ''*the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time* ***and intensity*** *[emphasis added] required in furnishing the service*.'' Despite their denial, CMS continues to treat all components of physician time (pre-service, intra-service, post-service, and post-operative visits) as having identical intensity and inconsistently applies intensity it to only certain services under review which creates inherent payment disparities in the relative value payment system.

The RUC and other stakeholders have consistently called upon CMS to accept the clinical expertise and input from practicing physicians which is provided through the RUC process and when CMS recommends a different value, the RUC and clinical experts provide a clinical rationale to justify their rejection, in contrast to CMS' often random appearing calculation that allows them to achieve their desired decrease in value. The RUC-recommended values include clinical input from practicing physicians when valid surveys were conducted and have undergone rigorous review by the specialty society committees and a review of magnitude estimation and cross-specialty comparison by the RUC. When developing recommendations for physician work RVUs, the RUC and specialty societies use objective data (the surveys) and clinical expertise to determine a recommended work value. CMS representatives are present for the RUC discussions and the presentation of supporting information, and the RUC clinical rationale and data related to the code recommendations are provided to CMS. However, when CMS rejects the recommended valuations, they rarely, if ever, include any clinical rationale to support their revised (almost always decreased) value recommendation.

Throughout CMS' proposals on the valuation of specific codes for 2023, they continue to use a vast array of possible mathematical calculations to arrive at a seemingly arbitrary value, rather than seeking a valid, clinically relevant relationship that preserves relativity. CMS uses flawed methodologies to arrive at valuations which may include time ratios, reverse building block adjustments, and incremental adjustments. Importantly, these techniques are not uniformly applied across all codes in the PFS and therefore distort and undermine the important relativity relationships across the PFS. There are several scenarios where CMS selects to apply an arbitrary combination of inputs which may include total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC-recommended work RVUs, work RVUs from CMS-selected crosswalks, and work RVUS from a base code, among others. Often, these systematic changes involve comparing the RUC-recommended physician times to the existing CMS physician times that are proxy data and not reflective of any surveyed data from practicing physicians.

Not surprisingly, the various methodologies used by CMS to predominantly support decreased work RVU recommendations for codes. This has the appearance of seeking a pre-determined arbitrary value from

the vast array of possible mathematical calculations, rather than seeking a consistent valid, clinically relevant relationship that would preserve relativity.

For the CY 2023 Proposed PFS, some examples of the varied methodologies that CMS has chosen at random to recommend value decreases to the values recommended by the RUC and the representative specialty societies and in turn casting doubt on the physicians who perform the services include the following:

1) The **anterior abdominal hernia** repair codes were identified by a RUC screen and the specialty society referred the codes to the AMA CPT to create a family of new codes that better describe these procedures as performed in current practice. This included recommending that the code family be assigned a 000-day global period instead of the current 090-day global period for the codes. CMS rejected the RUC recommend values for this entire family of codes instead combining different methodologies to reach their reduced values.

   For this family of procedures, codes (157X1, 49X02, 49X03, 49X04, 49X05, 49X08, 49X09) were valued as outpatient services and as such, they are subject to the 23-hour stay. CMS *disagreed with the RUC-recommended work RVUs for these codes "because the RUC did not completely apply the 23-hour policy calculation (finalized in the CY 2011 PFS final rule (75 FR 73226)) in formulating its recommendations." However, this policy* was not previously implemented by CMS when other services eligible for the 23-hour stay policy were reviewed between CY 2012 and CY 2021 and CMS accepted the RUCs process for applying the 23-hour stay policy during this time frame.

   In their review of these codes, CMS ignored the fact that the RUC recommendations for outpatient services already fully takes into account CMS' 23-hr stay policy via magnitude estimation. Codes 49X06, 49X10, 49X11, 49X12, 49X13, 49X14, which are considered the base codes for this family, were identified by survey respondents and the RUC as typically being inpatient procedures and correspondingly the 23-hour policy was not applied. In the CY 2023 Medicare Physician Fee Schedule NPRM, CMS states that they consider these CPT codes as being services that "…describe outpatient services for purposes of billing". However, in the CY2023 Hospital Outpatient Prospective Payment NPRM, CMS is proposing to add these services to its Inpatient Only list and proposes to assign these services to the status indicator "C".

   CMS inappropriately used a reverse building block methodology to achieve their recommended work value reductions for this family of codes. STS, the RUC, and many other national specialty societies have repeatedly commented that it is inappropriate to systematically reduce work RUVs utilizing a reverse building block methodology or any other purely formulaic approach for services valued using magnitude estimation. Use of the reverse building block methodology disregards the RUC and CMS' longstanding approach to code valuation using magnitude estimation.

   CMS also utilized a methodology of calculating intra-service time ratios, which is the ratio of the intraservice time of a current hernia repair code and the intraservice time of the surveyed hernia code, to account for changes in time for these codes. The CMS recommendation does not take into account the nuanced variables that occur when physician times are updated in the

Medicare payment schedule. The ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of preservice and the length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes.

STS would like to reiterate that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation.

CMS also identified crosswalk codes that have similar physician times to further support their recommended values. However, crosswalk codes that they selected appear to only be based on the service having similar time and CMS did not provide any clinical rationale for why the service they selected is an appropriate comparator.

2) The **Endovascular Pulmonary Arterial Revascularization** codes represent a new family of Category I CPT codes to describe percutaneous endovascular repair of pulmonary artery stenosis (PAS) by stent replacement. Technological advancements in stents have led to smaller stents, which can now be used in children and a broader patient population, expanding the range of medical procedures in which they can be used. CMS rejected the RUC-recommended work RVUs once again recommending lower work values for this entire code family. For this family of codes, the Agency provided no clinical rationale at all stating only that the RUC recommendation for each code "…appears to be high compared to codes with similar times…" and provided a single reference code with similar times and values to CMS' proposed value. Not only did CMS not provide any clinical rationale for their recommended changes, they also only considered time in their valuation recommendation, once again ignoring the intensity of these procedures in relation to other codes in the family and the fee schedule. Increased intensity for these procedures is due to the pulmonary arteries being vastly different structurally compared to systemic arteries in terms of difficulty, risk, and complexity. For example, the pulmonary arteries have very thin walls, which are more easily subject to dissection and perforation while performing this procedure on an actively beating heart. Furthermore, a pulmonary artery obstruction can cause circulatory collapse and obstructive shock, a rapidly lethal condition.

3) CMS once again uses an intra-service time ratio to support their recommended work value reductions to the **Percutaneous Arteriovenous Fistula Creation** codes. Technological advancements have emerged enabling less invasive approaches that utilize percutaneous image-guided methods to approximate a target artery and vein using magnets. The two new CPT codes describe the creation of an arteriovenous fistula in an upper extremity via a percutaneous approach. CMS is proposing to delete two G codes (G2170, G2171) which they created in 2020, and replace them with the two new CPT codes (368X1 and 368X2). CMS rejected the RUC-recommended values for these codes because they were among the highest RVUs when compared to *other codes with similar time values.* Instead of using a direct crosswalk valuation, CMS recommended a lower value based on an intra-service time ratio calculation that uses the second key reference service and MPC code from the RUC survey for the first code. However, CMS did not consider the intensity of physician work associated with this service.

For the second code, CMS agreed that there was a difference in work between the codes stating that "*it is important to maintain an appropriate intra-family relativity". To account for the difference in work, CMS* calculated an incremental difference of 2.10 RVUs between the codes as that was the interval between the two codes based on the RUC-recommended values. CMS applied the 2.10 interval to the CMS recommended value for 368X1 which resulted in a recommended value that was less than the surveys 25th percentile. CMS offers no rationale that warrants the RVU to fall below the survey 25th percentile.

4) The **Cardiac Ablation Services codes** were identified through a RUC screen and referred to CPT in 2020 to update the codes to reflect current practices and bundling for services frequently performed together. In December 2020, the specialty societies appealed to CPT to rescind the changes due to concerns that there was confusion about the coding changes. However, in February 2021 the CPT Editorial Panel Executive Committee did not rescind the CPT changes. The revised codes (93653-93657) were surveyed, and the RUC submitted a final recommendation for CY 2022 in May 2021. However, CMS opted to delay consideration of these recommendation until the CY 2023 cycle.

   For this family of codes (93653, 93654, 93655, 93657, 93613, 93621, 93622), CMS proposes the RUC-recommended value for some of the codes, decreases to the RUC-recommended values for some of the codes and to maintain the CY 2022 value for some of the codes. For many of the codes in the family, CMS indicated that the reason for their rejection of the RUC-recommended value was based on a review of services with similar intra-service and total times, although they did not list any specific reference codes. Once again, CMS used a combination of methodologies to come up with their proposed values for this family of codes. These included direct crosswalks based only on physician times without providing any clinical rationale or context supporting their proposed alternative value. In applying their crosswalks, CMS didn't account for all the differences in time between the codes. CMS also ignored the intensity difference between their crosswalk code and the surveyed code, even though the RUC provided increased intensity rationale for the surveyed codes. CMS also used incremental time increases which were derived by adding the increment between the RUC recommendations for the surveyed codes and adding the derived interval in RVUS between the codes to the proposed CMS value based on CMS' proposed crosswalk value for the first code.

   CMS proposes to maintain the current (CY 2022) work values for some of the codes even though they opted to reduce the work value for those codes for CY 2022 without any review of the RUC's April 2021 recommendations. To support their CY 2023 value recommendation, CMS uses a reference code simply noting that it is a better comparator then the two reference codes selected by the RUC and specialty societies, which are more comparable reference codes to the survey code, because they are more similar and are also performed by cardiovascular providers. CMS also didn't account for all of the nuances that occur to the work values when revised codes bundle services that were previously reported separately. Additionally, CMS contradicts itself in recognizing the increased work and time associated with bundling the codes, but they discount the intensity by deeming the RUC-recommended work value as high compared to the current value, which has less time than the sum of time for all of the codes added together.

STS urges CMS to accept the RUC-recommended values for all the new and revised codes for CY 2023.

Evaluation and Management (E/M) Visits

STS was one of 30 specialty societies that collaborated with the AMA Workgroup in revising and surveying services for the hospital inpatient or observation codes, discharge day management and prolonged services codes. Adoption of the framework developed by the CPT Editorial Panel for these services as well as the other revised E/M services (nursing facility codes, home or residence visit codes, emergency department visits) will result in significant reduction in provider administrative burden with descriptions that allow for better recognition of the resources involved in these visits**. STS recommends that CMS finalize the RUC recommendations for all these E/M visits.**

The Society reiterates its strong opposition to the CMS proposal not to incorporate the adjusted values for the revised office/outpatient E/m visits. See our Comments on this issue in the *Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation* portion of this letter. STS urges CMS to apply the adjustments to the office/outpatient E/M visits, hospital visits and discharge day management visits into the post-operative visits bundled into the global surgical payments, as it has done historically on several different occasions.

In a general statement, CMS mentioned the Congressional prohibition on payment of G2211 (Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)) until January 1, 2024. As part of its discussion, CMS states, "To the extent we are proposing to adopt the RUC-recommended values for Other E/M visits beginning for CY 2023, we do not agree with the RUC that the current visit payment structure among and between care settings fully accounts for the complexity of certain kinds of visits, especially for those in the office setting, nor do they fully reflect appropriate relative values, since separate payment is not yet made for G2211."

STS has significant concerns with CMS' proposal to create the Medicare-specific add-on code G2211 for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient's single, serious, or complex chronic condition. CMS indicated that the complexity add-on code is needed because they have concerns that the code set "still does not appropriately reflect differences in resource costs between certain types of office/outpatient E/M visits." Since the revised E/M office visits codes have not been implemented yet, there is no data to support this claim.

STS appreciates that physicians should have a way to identify outlier patients where additional payment is warranted, regardless of service performed (surgical or office visit). However, the creation of this add-on code will have a significant impact on the Physician Fee Schedule, redistributing more than $1.5 billion between specialties. STS urges CMS to reconsider or at least postpone the implementation of this add-on code until data is available from the revised E/M office visits and CMS utilize the data to identify potential gaps that need to be addressed.

As with the office/outpatient E/M visits, CMS is proposing to create three new G codes (GXX1, GXXX2 and GXXX3) to report prolonged services for hospital, nursing facility and home visits, due to concerns that the CPT guidelines regarding total time spent per patient are confusing and will lead to duplicative

payment. STS would like to remind CMS that the entire purpose in revising the E/M codes has been to make the codes more clinically relevant and to reduce the administrative burden on physicians. CMS was included in the process to revise the E/M codes and develop new guidelines for these services but did not provide this feedback at that time. Instead, CMS has proposed even more add-on codes creating an even more complicated coding situation for physicians and payors.

Having two sets of prolonged services codes is confusing, increases the administrative burden on physicians and payors, and lends itself to miscoding. STS encourages CMS to work with AMA E/M Workgroup to address any concerns with the revalued E/Ms and to accept the CPT codes and guidelines and the RUC-recommended values for all the newly created prolonged services codes, including code 99417 for the office/outpatient prolonged services E/M code.

Split (or Shared) Services

CMS states that it has been policy that when a service has been furnished by both a physician and a non-physician practitioner (NPP) that the physician can submit the claim for the service if the physician delivered the "substantive portion" of the service. CMS previously finalized for CY 2023 that "substantive portion" would be defined as "more than half of total time." CMS acknowledged the numerous comments it received about the implementation of this policy, including "practice patterns where the physician does not spend half or more of the time with the patient" and also concerns about needed IT and documentation practice changes that were not ready for a January 1, 2023 implementation. CMS stated that it continued to believe that "more than half of total time" was still appropriate, but that they would delay implementation of this policy to give stakeholders additional time for the new E/M changes to take place and allow for additional opportunity to provide comments that CMS could consider for future rulemaking. CMS proposes to delay the effective date of the "substantive portion" policy until January 1, 2024. As such, the CY 2022 policy states that the substantive portion can be "one of the three key components (history, exam, or MDM)" or more than half of the total time spent by the physician and NPP.

STS supports CMS delaying the requirement that only the physician or QHP who spends more than half of the total time with the patient during a split or shared visit can bill for the visit until January 1, 2024. STS believes that billing based on the physician or QHP who performs more than 50 percent of the total time of the visit will disincentivize and jeopardize the continuation of physician-led, team-based patient care. This approach is confusing and adds unnecessary complexity to the process. By mandating the practitioners track and document time for split/shared visits, CMS is in essence, forcing practitioners into picking time as the billing criterion for these visits as opposed to medical decision making which was a significant change in the revised E/M codes. To have both practitioners track time, decide which of them is the substantive provider, communicate this determination with each other and then have the billing provider decide between billing the split/shared visit on total time is not practical for most practitioners and creates a significant administrative burden. To require practitioners to document and track their time over the course of the day and be aware of the other practitioner's time spent with the patient over the course of the day is unrealistic.

While we understand CMS' need to ensure that both practitioners are providing appropriate services to the patient, we believe that there are more practical and less burdensome methods which can achieve this goal. Additionally, not all time spent is equivalent in terms of provider work. There is significant

variability in how much time it takes to perform elements of the visit based on factors such as the level of training and expertise of the physician and QHP. If the NP spends greater than 50 percent of the total time gathering the appropriate history and doing the directed physical exam, CMS is claiming that is more valuable than the time spent by the physician on medical decision making. There is no basis for this assumption. By pursuing this policy, CMS is yet again relegating provider reimbursement to purely time and ignoring intensity.

STS strongly supports the concept that medical decision-making should continue to be used to direct the management of the patient's care to determine the course of treatment for the patient. We believe that the physician or QHP who performs medical decision-making component of the visit provides the most substantial contribution to patient care and should be the one that bills for the visit even if this does not require the most time spent for the visit. We urge CMS to continue to allow the physician or QHP who is managing and overseeing the patient's care to bill for the service and dismiss the concept of determining the billing provider for a split/shared visit solely on time. Allowing the managing physician or QHP who is overseeing the patient's care to bill for the services ensures continued quality of care for the patient and encourages further development of team-based care in the facility setting.

Payment for Medicare Telehealth Services

Requests to Add Services to the Medicare Telehealth Services List for CY 2023

CMS discusses Category 3 codes which were created for adding services to the Medicare telehealth services list on a temporary basis following the end of the PHE for the COVID-19 pandemic. This category describes services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under Category 1 or Category 2. CMS proposes to continue to allow certain telehealth services that would otherwise not be available via telehealth after the expiration of the PHE to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE to align with the timeframe of flexibilities according to Consolidated Appropriations Act, 2022 (CAA, 2022). CMS discusses the telehealth flexibilities that Congress has afforded in response to the PHE, along with flexibilities that Congress extended for 151 days after the end of the PHE for services that are on the Medicare Telehealth Services List as of March 15, 2021 (the date of enactment of CAA, 2022) indicating that they are providing notice that it intends to issue program instructions or other sub regulatory guidance to effectuate the changes described above, other than the proposed revisions to §410.78, in the near future given that the PHE end date could occur before the rulemaking process for the CY 2023 PFS is complete. CMS also proposes that Medicare telehealth services furnished on or before the 151st day after the end of the PHE will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier "95" and the place of service code that would have been reported had the service been furnished in-person. Medicare telehealth services occurring on or after the 152nd day after the end of the PHE will no longer require modifier "95" to be appended to the claim. However, the appropriate place of service (POS) indicator (02 – telehealth provided other than in a patient's home or 10 – telehealth provided in patient's home) will need to be included on the claim to properly identify the place where the service was furnished. CMS also proposes to align telehealth services billed with POS "10" and POS "02" to be paid at the same facility payment amount. Effective, Jan. 1, 2023 CMS is

proposing that physicians or other QHPs billing for telehealth services furnished using audio-only communications technology append modifier "93" to the claim.

STS encourages CMS' proposal to retain all Category 3 Services on the Medicare telehealth services list until at least 151 days after the expiration of the PHE. We remain confident that data collected during COVID-19 will demonstrate the positive impact telehealth has had on both patient clinical outcomes and patient experiences. As we have previously stated, there are some data to support that telehealth services play an important role in decreasing readmissions and emergency department treatments and providing rural patients with access to otherwise limited resources. Some VA studies have shown high patient satisfaction with telehealth services and no increase in mortality. Advances in technology and the advent of more sophisticated equipment has increased the extent of patient monitoring via telemedicine and has resulted in increased physician and patient satisfaction.

Anecdotally, many patients have reported to STS members that these services have enabled patients to feel more connected to their provider and engaged in the health care experience. Although this is likely true for all patients, we recommend CMS continue to broaden the scope of telehealth services coverage and reimbursement and particularly consider impacts to traditionally underserved patient populations and geographic locations. STS also encourages CMS to work with the AMA joint CPT/RUC Telemedicine Office Visits Workgroup and the specialty societies and provide input on their evaluation of available data to determine the appropriate next steps in developing accurate coding and valuation, as needed, for E/M office visits performed via audio-visual and audio only modalities.

CMS is proposing not to keep telephone E/M services on the telehealth services list after the 151-day post-PHE extension period other than for Medicare telehealth services as previously finalized.

While STS supports some provision of continued payment for audio-only visits in appropriate circumstances, we do not believe that audio-only is adequate for more complex visits. We acknowledge that use of audio-only visits during the COVID-19 PHE has demonstrated a legitimate benefit and as such continue to support maintaining these services on the telehealth services list through the end of the PHE while data is collected to determine which visits are suitable for audio-only and establish an appropriate payment rate. Suitable visits will likely be less complex than in-person visits and video visits and therefore compensation would not be at the same rate. **STS recommends that any audio-only services be sent through the valuation process to ensure that they are appropriately valued.**

STS also supports permanently extending the option for virtual supervision when clinically appropriate. Although clinical circumstances, supervisee experience-level, and type of supervisee (resident or different non-physician practitioner types) should influence the extent to which virtual supervision is appropriate, STS recognizes the benefits of continued virtual supervision. Virtual supervision continues to be effective and efficient in many clinical settings with both residents and non-physician practitioners. However, STS does suggest that after the COVID-19 PHE, video may be necessary in some, but not all, supervising roles. STS recommends that CMS make permanent the interim allowance for virtual supervision even after the conclusion of the COVID-19 PHE.

Other Non-Face-to-Face Services Involving Communications Technology under the PFS

Expiration of PHE Flexibilities for Direct Supervision Requirements

CMS states that certain Part B services are required to be furnished under specific minimum levels of supervision by a physician or practitioner and that professional services furnished on an "incident to" basis require direct supervision. For pulmonary rehabilitation services and for cardiac rehabilitation and intensive cardiac rehabilitation services, statutory requirements for immediate availability and accessibility of a physician are met if requirements for direct supervision are met. Outside the circumstances of the PHE, direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. "Immediate availability" requires in-person physical availability, not virtual availability. Through the March 31 interim final rule with comment, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring physical presence. CMS finalized continuation of this policy through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021. CMS reminds readers that after December 31 of the year in which the PHE ends, the pre-PHE rules for direct supervision would apply. This means that "telehealth services can no longer be performed by clinical staff incident to a physician's professional service."

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 in the final CY 2023 update to the physician fee schedule so Medicare beneficiaries can continue to receive cardiac and pulmonary rehabilitation services that can improve their lives. STS has signed on to a letter lead by the American Association of Cardiovascular and Pulmonary Rehabilitation with more detailed comments on this proposal.

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

Proposed Update to Current Payment Policies for Dental Services

Under current policy, payment under Medicare Parts A or B for any expenses incurred for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth (collectively, "dental services") is precluded. CMS believes that there are instances where dental services are so integral to other medically necessary services that they are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. Rather, such dental services are inextricably linked to the clinical success of an otherwise covered medical service and therefore are substantially related and integral to that primary medical service. CMS also believes that there are circumstances where the dental services are not inextricably linked to the clinical success of a covered service.

For these reasons, CMS is proposing and seeking comment on payment for other dental services performed as part of a comprehensive workup prior to organ transplant surgery, cardiac valve replacement, or valvuloplasty procedures that are similarly inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services. Additionally, CMS is

requesting comments on other types of clinical scenarios where the dental services may be inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services.

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.

Although STS supports Medicare coverage for dental services when medically necessary, we would like to note that some organizations in the medical community have reservations about the limited resources available and how this proposal may cause further reduction in the resources their providers receive. We understand this concern and would like to point out to CMS that budget neutrality continues to force providers to make difficult choices between the best options for patients and the value of services provided.

Quality Payment Program

Transforming MIPS: MIPS Value Pathway (MVP) Strategy

MVP Vision Overview

In the Proposed Rule, CMS states that MVPs will be available for voluntary reporting beginning with the CY 2023 MIPS performance period, with the intention for MVPs to become the only method to participate in MIPS in future years, although CMS has not yet finalized the timing for the sunset of traditional MIPS.

STS strongly believes that it is premature to move towards retiring the traditional MIPS pathway. More time is needed to develop, implement, and adopt MVP reporting. 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. There is currently no thoracic surgery MVP and the development of a

thoracic surgery MVP could take years before it is feasible to report. Until MVP reporting is available and accessible for all MIPS eligible providers, it is premature to consider the sunset of traditional MIPS.

RFI on MVPs and APM Participant Reporting

As CMS moves forward with MVP implementation, it continues to seek feedback on ways to better align clinician experience between MVPs and APMs, and to ensure that MVP reporting serves as a bridge 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 reiterates that while we support CMS' effort to reduce clinician burden and to 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 the MVP model into the current MIPS framework, CMS fails to provide a more meaningful and less burdensome participation pathway for specialists or to provide a practical glide path to APMs. As we previously stated, it is critical that CMS recognize multi-category measures that simultaneously address two or three MIPS performance categories, such as quality measures reported to qualified clinical 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 not a significant reason to participate. Transitioning to MVPs should provide more actionable data and information that prepares providers for more advanced models. CMS should engage specialty societies in the development of new MVPs to capitalize on their knowledge and experience with data collection and quality improvement to achieve this.

Additionally, if the MVP framework is designed to help transition providers out of MIPS and into APMs, there needs to be an opportunity for providers, particularly specialists, to participate in APMs. A subset of thoracic surgeons are 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% 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 of reporting.

MVP Development and Reporting Requirements

Development of New MVPs

CMS is proposing to broaden the opportunities for the public to provide feedback on viable MVP candidates by posting draft versions of MVP candidates on the QPP website to solicit feedback for a 30-day period. CMS would review all feedback and determine if any recommended changes should be incorporated into a candidate MVP before it's proposed in rulemaking. The Agency would not consult with the group or organization that submitted the original MVP candidate in advance of rulemaking.

STS supports CMS' proposal to allow more opportunities for the public to comment on MVP candidates with modification. We believe that CMS could extend the 30-day feedback period as many stakeholders will need time to appropriately review and determine whether an MVP may require

changes. **Additionally, we believe it is necessary that CMS consult with the steward of the MVP candidate before any changes are proposed in rulemaking.** Those groups or organizations who invested time and money into developing MVPs often have specialized expertise and should be further consulted before the MVP is proposed and potentially finalized in rulemaking.

MVP Maintenance Process and Engagement with Interested Parties

The MVP maintenance process provides interested parties with the opportunity to recommend changes to finalized MVPs for CMS to consider in future rulemaking. In the CY2022 PFS Final Rule, CMS finalized the process to submit recommended changes to previously finalized MVPs by sending an email to CMS detailing the recommended changes for the MVP, by performance category. They are now proposing to expand opportunities for interested parties to participate in MVP maintenance to include an annual public webinar to discuss potential MVP revisions that have been identified as feasible.

Similar to our comments above on the development of MVPs, **STS supports CMS expanding the opportunities for stakeholders to learn about and engage with CMS on established MVPs**. By including the public in MVP maintenance activities, CMS may have an opportunity to address some of the unintended consequences of a model and refine it for better outcomes.

Quality Performance Category

Data completeness threshold

For the CY 2024 and 2025 performance periods, CMS is proposing to raise the data completeness criteria from 70 percent to 75 percent. A MIPS eligible clinician or a group submitting QCDR measures, MIPS CQMs, or eCQMs would need to submit data on at least 75 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer. A MIPS eligible clinician or a group submitting data on Medicare Part B claims measures would need to submit data on at least 75 percent of the MIPS eligible clinician or group's patients seen during the corresponding performance period to which the measure applies.

While CMS may consider a five percent difference in data completeness to not be consequential for providers, this change increases provider burden in a program that is already burdensome. The increase in data completeness does not consider 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 EHR for MIPS reporting making the combining and calculating of MIPS data difficult. Additionally, STS does not believe that the increase percentage of data CMS receives is enough to make a meaningful difference for CMS' purposes. In that case, this proposal increases provider burden without any benefit to CMS. STS opposes the proposed increased data completeness threshold at the very least until the interoperability landscape allows data to seamlessly flow across settings and providers.

Selection of MIPS Quality Measures

For the CY 2023 performance period, CMS proposes nine new MIPS quality measures. Additionally, CMS is proposing to add the following two new measures to the Thoracic Surgery Measure Set: Unplanned Hospital Readmission within 30 Days of Principal Procedure and Screening for Social Drivers of Health.

STS supports CMS' proposal to include new quality measures into the MIPS program, allowing providers to have more choice in reporting measures that are relevant to their practice. Additionally, we support the inclusion of the two new measures in the Thoracic Surgery Measure Set, again, as long as providers continue to be able to choose the measures relevant to their practice. However, we want to note that the STS National Database, the leading registry for all of thoracic surgery, would not be able to calculate the Screening for Social Drivers of Health measure. We think it is important to share this to underscore the importance for provider choice in reporting meaningful measures and reducing provider burden.

RFI on MIPS Quality Performance Category Health Equity

As CMS considers possible future inclusion of additional health equity measures in MIPS in future years, CMS seeks comment on the following questions to better understand the type and structure of health equity measures that would be appropriate for the implementation in MIPS:

- *How would a measure best capture health equity needs under MIPS in the future?*
- *How would a measure's quality action provide actionable information and link to improvement in the quality of care provided to populations with health inequities?*
- *What, if any, would be the limitations in data interpretation if a future health equity-related measure would not be risk-adjusted?*
- *Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure?*

STS is deeply committed to the elimination of bias and disparities in healthcare in general and specifically in cardiothoracic surgery. While we appreciate CMS' goal of reducing healthcare disparities to advance health equity, we have concerns over the use of social risk information and patient demographics to measure physician performance. At this time, there are no widely adopted national industry standards for the collection of race, ethnicity, and language (REL) data or social determinants of health (SDOH) data. For example, the Office of Management and Budget (OMB) classifies race as: White, Black/African American, American Indian/Alaska native, Asian, native Hawaiian/other Pacific Islander; and ethnicity as Hispanic/Latino or non-Hispanic/Latino. While our organization utilizes the standards set by the Office of Management and Budget (OMB) in our own data collection efforts, we feel it is limiting and in need of modernization. OMB leading advocates have pointed out that existing standards do not account for the variation that exists within groups. As a result, racial and ethnic group disaggregation has been recommended as an important part of surveillance by researchers and policymakers in this field to resist homogenization of disparate groups.[3]

Similar standardization challenges exist for the collection of SDOH data. In July 2021, the Office of the National Coordinator for Health Information Technology (ONC) included SDOH data elements in the United States Core Data for Interoperability version 2 (USCDIv2), however, the use of USCDIv2 is voluntary and adoption is not widespread. Additionally, area-based indicators, such as zip codes, are a

[3] Kader, Farah, and Clyde Lanford Smith. "Participatory Approaches to Addressing Missing COVID-19 Race and Ethnicity Data." *International Journal of Environmental Research and Public Health* 18, no. 12 (2021): 6559.

more readily available, commonly used approach to account for SDOH. However, zip code areas are constructed to achieve efficient mail delivery, not to identify areas with similar sociodemographic status (SDS) and socioeconomic status (SES) features for biomedical research. Zip codes may include several dozen to more than a hundred thousand individuals, and they typically encompass far too broad an area to be considered a homogeneous SDS/SES grouping. Popular area-based indicators include those developed by the Area Deprivation Index (ADI). The ADI (available through the Neighborhood Atlas), was developed two decades ago and subsequently refined, adapted, and validated to the census block group/neighborhood level at the University of Wisconsin-Madison. This is widely regarded as one of the most comprehensive overall indicators of SDS/SES currently available, with 17 variables encompassing multiple SDOH domains. [4]

Given the challenges of inconsistent collection of health equity data, it cannot be accurately used to measure and compare performance. STS believes that there needs to be industry-accepted national standards in place prior to required collection and performance measurement of health equity data. Instead, voluntary reporting of health equity data could be beneficial in helping to establish industry-accepted standards. Moreover, STS would be interested in collaborating with CMS to help develop health equity data standards using the STS National Database which is continuing to develop and test new methodologies to capture health equity data. STS has recently acquired the ability to geocode a large majority of data records in the STS Adult Cardiac Surgical Database (ACSD), beginning with entries from 2008 and contingent only upon on the availability of a patient's street address. Through this mechanism, a census block group- level ADI score is now available for millions of STS ACSD records and will be used in future studies of race, ethnicity, and SDS/SES risk factors.

Improvement Activities Performance Category

New Improvement Activities

CMS proposes to add four new improvement activities for the CY 2023 performance period/2025 MIPS payment year and future years:

- *IA_AHE_XX titled "Use Security Labeling Services Available in Certified Health Information Technology (IT) for Electronic Health Record (EHR) Data to Facilitate Data Segmentation"*
- *IA_AHE_XX titled "Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients (LGBTQ+)"*
- *IA_EPA_XX titled "Create and Implement a Language Access Plan"*
- *IA_ERP_XX titled "COVID-19 Vaccine Promotion for Practice Staff"*

STS supports the inclusion of the four new improvement activities that were introduced in response to the Administration's goal of advancing health equity for all and address Priorities for Reducing Disparities in Health as described in the CMS Framework for Health Equity. We believe many providers are already performing similar activities in their practices and should be awarded MIPS credit for the work they are doing to advance health equity.

Promoting Interoperability Performance Category

[4] Shahian DM, Badhwar V, O'Brien SM, et al. Social Risk Factors in Society of Thoracic Surgeons Risk Models. Part 1: Concepts, Indicator Variables, and Controversies. Ann Thorac Surg. 2022;113(5):1703-1717. doi:10.1016/j.athoracsur.2021.11.067

Changes to the Query of Prescription Drug Monitoring Program (PDMP) Measure under the Electronic Prescribing Objective

Beginning with the performance period in CY 2023, CMS proposes to require MIPS eligible clinicians to report the Query of PDMP measure (which requires reporting a "yes/no" response) for the Promoting Interoperability performance category.

STS does not support requiring attestation to the Query of PDMP measure. The reporting of this measure is reliant on widespread availability of built out, functional PDMPs that seamlessly connect with provider EHR systems to avoid additional burdens. Additionally, CMS is continuing to work with industry and Federal partners to advance common standards for the exchange of information between relevant stakeholders. Until CMS has finalized providing the necessary services for a useful PDMP, STS feels that mandatory reporting for this program is not yet reasonable or appropriate.

MIPS Final Score Methodology

Scoring the Quality Performance Category – Administrative Claims Measures

Beginning with the CY 2023 performance period/2025 MIPS payment year, CMS proposes that it will score administrative claims measures using benchmarks calculated using performance period benchmarks. CMS believes this policy would allow for scores that are more reflective of current performance, while adding no additional burden to clinicians since these measures do not require the submission of data by or on behalf of clinicians.

STS agrees that performance period benchmarks are more appropriate for scoring administrative claims data if they represent current national practice. As we have seen during the COVID-19 PHE, the collection of administrative claims data can often change year to year and historical data is not always representative of the current environment. By calculating a measure score based on performance period benchmarks, CMS can better compare performance or cost with more representative data.

Complex Patient Bonus

In the CY 2018 QPP final rule, CMS finalized a complex patient bonus for MIPS eligible clinicians, groups, APM Entities, and virtual groups that submit data for at least one MIPS performance category during the applicable performance period, which will be added to the final score. In that same rule, CMS also established facility-based measurement for certain MIPS eligible clinicians, which provides that the Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the quality and cost performance categories. At that time, CMS did not address whether facility-based MIPS eligible clinicians would be eligible to receive the complex patient bonus. Thus, CMS proposes that beginning with the 2023 performance period/2025 MIPS payment year, a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category.

STS appreciates CMS' proposal to allow MIPS eligible clinicians who do not submit data for at least one MIPS category to receive the complex patient bonus. A large percentage of STS membership is

comprised of hospital-based providers who are exempt from reporting MIPS. We believe these providers should be rewarded for and encouraged to continue to treat patients with complex conditions. Policies such as this can help to reduce access to care issues and advance health equity by recognizing physicians who work harder to treat more complex patients.

Third Party Intermediaries General Requirements

QCDR Measure Approval Criteria

In a previous final rule, CMS required that all QCDR measures in the MIPS program be fully tested starting with the 2022 performance period. CMS is now proposing to delay the requirement for full measure testing to begin with the 2024 performance period. However, they are not changing the requirements that QCDR measures be fully tested prior to inclusion in an MVP.

Although STS supports rigorous measure testing, we believe the level (clinician, facility, or group) should be decided by QCDR statisticians familiar with sample sizes and populations. STS anticipates that the proposed requirements for additional measure testing will add a level of complexity and cost that may drive QCDRs and registries out of the program. Due to the large and unreasonable burden placed on QCDRs, the STS National Database, which has decades of experience collecting and tracking quality data, has had to retract its status as a QCDR for MIPS reporting purposes. **For these reasons, we thank CMS for delaying this requirement and encourage the Agency to reconsider how they implement measure testing and other QCDR requirements in the future.**

Overview of the APM Incentive

RFI on Quality Payment Program Incentives beginning in Performance Year 2023

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) for a year. In performance year 2023/payment year 2025, the statute does not provide for any type of incentive for eligible clinicians who become QPs. Eligible clinicians who are QPs for a year are excluded from being considered as MIPS eligible clinicians, and thus, they cannot receive MIPS payment adjustments. CMS is seeking public comment on whether administrative action is needed beginning in the 2024 performance period/2026 payment year, and if so, what would be the best approach to address the multi-faceted issues that arise with the end of statutory authority for an APM Incentive Payment for QPs and the transition to the differential QP and general conversion factors beginning in the 2024 performance year/2026 payment year.

If CMS' goal is to encourage providers to prioritize value-based care by participating in APMs instead of the traditional MIPS program, then Congress will need to reauthorize the 5 percent APM Incentive Payment. 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. 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 money through MIPS reporting than through APM participation, which contradicts CMS' goal.

Since the Advanced APM pathway was introduced, it has been primarily geared towards primary care with limited participation options for specialists. 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. Continuing to incentivize participation in Advanced APMs will allow specialists to have the same earning potential as primary care providers and may encourage more providers to take on down-side risk and prioritize value-based care. To ensure specialist participation in Advanced APMs, Congress needs to approve the continuation of the 5 percent bonus payment and CMS, through the Center for Medicare and Medicaid Innovation (CMMI) need to more readily be testing and approving Advanced APMs that have been endorsed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Thank you for the opportunity to provide these comments. Please contact Courtney Yohe Savage, Vice President of Government Relations, at cyohe@sts.org or 202-787-1222 should you need additional information or clarification.

Sincerely,

John H. Calhoon, MD
President

Appendix A

Appendix A – STS Recommended Revisions to CY 2022 Anticipated Specialty List			
CPT Code	**CY 2023 Anticipated Specialty**	**2023 Override Applied?**	**STS Recommended Specialty and Action**
33203	THORACIC SURGERY	Yes	CARDIAC SURGERY
33251	THORACIC SURGERY	Yes	CARDIAC SURGERY
33320	THORACIC SURGERY	Yes	CARDIAC SURGERY
33406	THORACIC SURGERY		CARDIAC SURGERY - Add to list for CY 2023
33414	THORACIC SURGERY	Yes	CARDIAC SURGERY
33468	THORACIC SURGERY	Yes	CARDIAC SURGERY
33471	THORACIC SURGERY	Yes	CARDIAC SURGERY
33476	THORACIC SURGERY	Yes	CARDIAC SURGERY
33478	THORACIC SURGERY	Yes	CARDIAC SURGERY
33502	THORACIC SURGERY	Yes	CARDIAC SURGERY
33503	THORACIC SURGERY		CARDIAC SURGERY
33504	THORACIC SURGERY	Yes	CARDIAC SURGERY
33505	THORACIC SURGERY	Yes	CARDIAC SURGERY
33506	THORACIC SURGERY		CARDIAC SURGERY
33507	THORACIC SURGERY	Yes	CARDIAC SURGERY
33600	THORACIC SURGERY	Yes	CARDIAC SURGERY
33602	THORACIC SURGERY	Yes	CARDIAC SURGERY
33606	THORACIC SURGERY	Yes	CARDIAC SURGERY
33608	THORACIC SURGERY	Yes	CARDIAC SURGERY
33610	THORACIC SURGERY	Yes	CARDIAC SURGERY
33611	THORACIC SURGERY		CARDIAC SURGERY
33612	THORACIC SURGERY	Yes	CARDIAC SURGERY
33615	THORACIC SURGERY	Yes	CARDIAC SURGERY
33617	THORACIC SURGERY		CARDIAC SURGERY
33619	THORACIC SURGERY	Yes	CARDIAC SURGERY

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Appendix A – STS Recommended Revisions to CY 2022 Anticipated Specialty List			
CPT Code	**CY 2023 Anticipated Specialty**	**2023 Override Applied?**	**STS Recommended Specialty and Action**
33620	THORACIC SURGERY	Yes	CARDIAC SURGERY
33621	THORACIC SURGERY	Yes	CARDIAC SURGERY
33622	THORACIC SURGERY		CARDIAC SURGERY
33645	THORACIC SURGERY	Yes	CARDIAC SURGERY
33647	THORACIC SURGERY	Yes	CARDIAC SURGERY
33660	THORACIC SURGERY	Yes	CARDIAC SURGERY
33665	THORACIC SURGERY	Yes	CARDIAC SURGERY
33670	THORACIC SURGERY		CARDIAC SURGERY
33675	THORACIC SURGERY	Yes	CARDIAC SURGERY
33676	THORACIC SURGERY	Yes	CARDIAC SURGERY
33677	THORACIC SURGERY	Yes	CARDIAC SURGERY
33684	THORACIC SURGERY	Yes	CARDIAC SURGERY
33688	THORACIC SURGERY		CARDIAC SURGERY
33690	THORACIC SURGERY	Yes	CARDIAC SURGERY
33692	THORACIC SURGERY	Yes	CARDIAC SURGERY
33694	THORACIC SURGERY	Yes	CARDIAC SURGERY
33697	THORACIC SURGERY	Yes	CARDIAC SURGERY
33702	THORACIC SURGERY	Yes	CARDIAC SURGERY
33710	THORACIC SURGERY	Yes	CARDIAC SURGERY
33720	THORACIC SURGERY	Yes	CARDIAC SURGERY
33724	THORACIC SURGERY	Yes	CARDIAC SURGERY
33726	THORACIC SURGERY	Yes	CARDIAC SURGERY
33730	THORACIC SURGERY	Yes	CARDIAC SURGERY
33732	THORACIC SURGERY	Yes	CARDIAC SURGERY
33735	THORACIC SURGERY	Yes	CARDIAC SURGERY
33736	THORACIC SURGERY	Yes	CARDIAC SURGERY

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Appendix A – STS Recommended Revisions to CY 2022 Anticipated Specialty List			
CPT Code	**CY 2023 Anticipated Specialty**	**2023 Override Applied?**	**STS Recommended Specialty and Action**
33737	THORACIC SURGERY	Yes	CARDIAC SURGERY
33750	THORACIC SURGERY	Yes	CARDIAC SURGERY
33755	THORACIC SURGERY	Yes	CARDIAC SURGERY
33762	THORACIC SURGERY	Yes	CARDIAC SURGERY
33764	THORACIC SURGERY	Yes	CARDIAC SURGERY
33766	THORACIC SURGERY		CARDIAC SURGERY
33767	THORACIC SURGERY	Yes	CARDIAC SURGERY
33768	THORACIC SURGERY	Yes	CARDIAC SURGERY
33770	THORACIC SURGERY	Yes	CARDIAC SURGERY
33771	THORACIC SURGERY	Yes	CARDIAC SURGERY
33774	THORACIC SURGERY	Yes	CARDIAC SURGERY
33775	THORACIC SURGERY	Yes	CARDIAC SURGERY
33776	THORACIC SURGERY	Yes	CARDIAC SURGERY
33777	THORACIC SURGERY	Yes	CARDIAC SURGERY
33778	THORACIC SURGERY	Yes	CARDIAC SURGERY
33779	THORACIC SURGERY	Yes	CARDIAC SURGERY
33780	THORACIC SURGERY	Yes	CARDIAC SURGERY
33781	THORACIC SURGERY	Yes	CARDIAC SURGERY
33782	THORACIC SURGERY	Yes	CARDIAC SURGERY
33783	THORACIC SURGERY	Yes	CARDIAC SURGERY
33786	THORACIC SURGERY	Yes	CARDIAC SURGERY
33788	THORACIC SURGERY	Yes	CARDIAC SURGERY
33800	THORACIC SURGERY	Yes	CARDIAC SURGERY
33802	THORACIC SURGERY	Yes	CARDIAC SURGERY
33803	THORACIC SURGERY	Yes	CARDIAC SURGERY
33813	THORACIC SURGERY	Yes	CARDIAC SURGERY

Appendix A

Appendix A – STS Recommended Revisions to CY 2022 Anticipated Specialty List			
CPT Code	**CY 2023 Anticipated Specialty**	**2023 Override Applied?**	**STS Recommended Specialty and Action**
33814	THORACIC SURGERY		CARDIAC SURGERY
33820	THORACIC SURGERY	Yes	CARDIAC SURGERY
33822	THORACIC SURGERY	Yes	CARDIAC SURGERY
33824	THORACIC SURGERY	Yes	CARDIAC SURGERY
33840	THORACIC SURGERY	Yes	CARDIAC SURGERY
33845	THORACIC SURGERY	Yes	CARDIAC SURGERY
33851	THORACIC SURGERY	Yes	CARDIAC SURGERY
33852	THORACIC SURGERY		CARDIAC SURGERY
33853	THORACIC SURGERY	Yes	CARDIAC SURGERY
33917	THORACIC SURGERY	Yes	CARDIAC SURGERY
33920	THORACIC SURGERY	Yes	CARDIAC SURGERY
33922	THORACIC SURGERY	Yes	CARDIAC SURGERY
33924	THORACIC SURGERY	Yes	CARDIAC SURGERY
33925	THORACIC SURGERY	Yes	CARDIAC SURGERY
33926	THORACIC SURGERY	Yes	CARDIAC SURGERY
33927	THORACIC SURGERY		CARDIAC SURGERY
35182	THORACIC SURGERY	Yes	CARDIAC SURGERY
36455	THORACIC SURGERY	Yes	CARDIAC SURGERY
36835	THORACIC SURGERY	Yes	CARDIAC SURGERY
38382	THORACIC SURGERY	Yes	CARDIAC SURGERY