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August 30, 2019

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (August 14, 2019)

Dear Administrator Verma,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Fiscal Year (FY) 2020 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.

The below comments address the following sections of the PFS Proposed Rule:

General Comments

We urge CMS to consider the unintended consequences of continuing to take money out of – or only notionally increase – the pool of resources available to physicians and effectively divert it to hospitals. The proposed physician fee schedule conversion factor of 36.0896, which reflects the budget neutrality adjustment and the 0 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA), is confounding and detrimental to our shared goals of improving care for Medicare beneficiaries. Physicians, who were supposed to have been able to count on five years of positive updates under MACRA, have seen actual annual conversion factor updates representing mere fractions of a percent. Further, while MACRA promised opportunities for physicians to develop new alternative payment models (APMs) designed to improve value in health care and benefit patients, physicians, and Medicare alike, very few physicians, and an even smaller percentage of specialists, have been able to avail themselves of APMs and their highly publicized associated bonus payments.

Still CMS has seen fit to award hospitals and others whose payments are based on market-basket increases of over 1 to 2 percent during the same time period. One might conclude that there is only one health care marketplace. It is nonsensical to think that, as other costs go up, physician reimbursement should go down. However, CMS is now proposing a conversion factor that is essentially the same as it was in 1999. When accounting for inflation, this has resulted in a dramatic decrease. As the pool of money available to physicians shrinks, the Medicare program is pitting provider against provider and threatening access to care. All the while, hospitals have access to more and more resources. It is no wonder that a majority of practicing cardiothoracic surgeons are now employed by hospitals or health systems. Employment is quickly becoming the only way to achieve any predictable economic stability from one year to another. In so doing, Medicare is ceding its authority to create a meaningful, value-based health care system to hospital administrators and closing itself off to significant physician-led reform.

II. Provisions of the Proposed Rule for the PFS

C. Determination of Malpractice Relative Value Units (RVUs)

Proposed Methodological Refinements

CMS proposes the following methodology changes to its calculation of MP RVUs:

- *Using a broader set of filings from the largest market share insurers in each state, beyond those listed as "physician" and "surgeon," for more comprehensive data*
- *Combining minor and major premiums to create the service risk group*
- *Utilizing "partial and total imputation" for a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings*

Overall, STS commends CMS on its attempts to improve the premium data collection process. However, STS has a number of concerns with these proposals and with the underlying data from the CY 2020 Medicare PFS Proposed Update to the geographic practice cost index (GPCIs) and MP RVUs Interim Report that are being used to support them. Of significant concern is that

the Agency's proposal to combine minor surgery and major surgery premiums to create the surgery service risk group - which it claims will yield a more representative surgical risk factor - is methodologically flawed. As the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) comments explain, policymakers have attempted to define "minor" and "major" surgery for years without success. CMS has selected an arbitrary definition of "minor surgery" for any CPT code in the 10000-69999 section of CPT with RVUs of less than 5.00, which is misguided. For example, cardiothoracic surgery has 14 codes with a ZZZ global period and work RVUs lower than 5.00 that are clearly a component of major surgery and should be removed from the list. If CMS intends to collect data at the minor vs. major surgery level, the data should reflect the different risk factors for those specialties and be specifically applied to codes defined as minor vs. major surgery.

More striking, however, is the data that CMS has used to support its analysis. Per the interim actuarial report *Table 8.B Volume-weighted distribution of 2019 Physician Work RVUs by Service Risk Type by CMS Specialty* contains significant errors:

Thoracic Surgery	**Cardiac Surgery**	**Cardiology**
• *Total Work RVUs – All Services: 5,562,108* • *Major Surgery*: 75.9% • *Minor Surgery*: 6.3% • *Non-Surg*: 17.9%	• *Total Work RVUs – All Services: 64,295,007* • *Major Surgery*: 18% • *Minor Surgery*: 1.8% • *Non-Surg*: 80.2%	• *Total Work RVUs – All Services: 64,295,007* • *Major Surgery*: 18% • *Minor Surgery*: 1.8% • *Non-Surg*: 80.2%

It is not accurate for either Thoracic or Cardiac Surgery that the share of total "non-surgical work RVUs" is 80%. The notion that less than 20% of services performed by cardiac surgeons are major surgery is clearly incorrect. In reality, cardiac surgery's share of surgical RVUs (codes in 10000-69999 range) is 83%, leaving 17% as the correct share of total "non-surgical work RVUS." Cardiology's share of total "non-surgical work RVUs" is 87%. CMS' efforts for improved data collection are appreciated, but the application of these data into computing the PLI RVUs is significantly flawed.

That CMS relied on faulty data to reach a policy recommendation to combine major and minor surgery puts the entire policy into question. STS recommends that CMS abandon this approach. However, if CMS intends to pursue the distinction of minor vs. major surgery in premium data collection, the data should reflect the different risk factors for those specialties and specifically applied to codes defined as minor vs. major surgery. In addition, CMS should provide for public comment its analysis of the projected implications as well as justifications for the proposed changes before implementing changes of this magnitude.

Expected Specialty Overrides for Low Volume Service Codes
For CY 2020, CMS proposes to clarify specialty assignment for a list of cardiothoracic services, in particular CMS believed there was a mistake in previously crosswalking the codes to cardiac surgery and now proposes to crosswalk them to thoracic surgery.

The Society appreciates that CMS finalized a proposal in the CY 2018 Medicare Physician Payment Schedule *Final Rule* to use a list of expected specialties instead of the claims-based specialty mix for low volume services (fewer than 100 allowed services in the Medicare claims data), and apply these overrides for both the practice expense (PE) and professional liability insurance (PLI) valuation process. The expected specialty list, *Proposed Rule*: *Anticipated Specialty Assignment for Low Volume Services,* has been updated to include a column indicating if the service-level override is being applied for CY 2020.

Based on RUC analysis, the codes listed below are additional low-volume cardiac and thoracic surgery services that should be added to the low volume service-level override list:

CPT	Description	3 Year Average Medicare Utilization *	CY2020 NPRM PLI RVU	RUC CY2017 Low Volume Override Recs	2018e Medicare Claims Top Specialty	STS Recommended Specialty Crosswalk
32486	Sleeve lobectomy	97	10.12		THORACIC SURGERY	THORACIC SURGERY
32491	Lung volume reduction	29	5.86	THORACIC SURGERY	THORACIC SURGERY	THORACIC SURGERY
32900	Removal of rib(s)	94	5.63	THORACIC SURGERY	THORACIC SURGERY	THORACIC SURGERY
33203	Insert epicard eltrd endo	97	3.22		CARDIAC SURGERY	THORACIC SURGERY
33320	Repair major blood vessel(s)	87	4.27	CARDIAC SURGERY	THORACIC SURGERY	THORACIC SURGERY
33927	Impltj tot rplcmt hrt sys	1	11.03		CARDIAC SURGERY	THORACIC SURGERY
33935	Transplantation heart/lung	6	20.43	CARDIAC SURGERY	CARDIAC SURGERY	CARDIAC SURGERY

***adjusted to avoid double counting claims with assistant at surg, co-surg or team surg modifiers**

The Society appreciates that CMS has proposed a permanent solution to a consistent problem that we have noted in previous proposed rules – the incorrect assignment of a variety of low-volume services to the wrong specialty. However, there continues to be general confusion

about the distinction between cardiac and thoracic surgery. Table 1 of the CY 2020 proposed rule lists a number of services that had been assigned to Cardiac Surgery in 2019 after our comments. CMS now proposes to permanently reassign them to Thoracic Surgery. The Society provided information on the expected specialty for these codes when the expected specialty list was developed and has been consistent in our comments over the past several years as to the correct specialty assignments for these codes. We once again ask that CMS correctly and permanently assign the codes listed in Appendix A of this letter to cardiac surgery. Because CMS finalized a policy in 2018 to apply service-level overrides to both PE and malpractice (MP), rather than one or the other category, reclassification of the services identified in Appendix A from cardiac surgery to thoracic surgery the proposed assignment incorrect and could adversely impact the PLI RVUs.

In addition, while the malpractice risk factor for both cardiac surgery (6.06) and general thoracic surgery (6.48) is naturally very similar, it is unclear why the thoracic malpractice risk factor is slightly higher than the cardiac surgery malpractice risk factor.

D. Geographic Practice Cost Indices (GPCI)

CMS has not updated the GPCIs since 2018, and therefore, CMS proposes that the CY 2020 adjustments will be phased in at ½ of what would otherwise be made. The proposed CY 2020 GPCIs can be found in Addenda D and E on the CMS website. CMS notes that while there are permanent statutory floors that do not allow for the GPCI work factor to go below 1.5 for services furnished in Alaska and 1.0 in frontier states (as defined by statute), the statutory provisions that prevent a GPCI work factor from going below 1.0 in all other localities is set to expire on December 31, 2019.

STS objects to policy proposals that could have a dangerous impact on rural areas, where hospitals are already closing at alarming rates due to economic strife. In taking advantage of the expiration of the physician wage GPCI floor while proposing negative PE and MP adjustments, CMS is proposing significant cuts to rural providers. GPCI payment cuts are only exacerbating the physician workforce shortages prevalent in rural America. The GPCI formula needs to account for the unique practice needs of rural providers. Failure to address these concerns could devastate rural communities already in crisis.

I. Physician Supervision for Physician Assistant (PA) Services

CMS proposes to redefine the physician supervision requirement for services delivered by a PA to state that the supervision requirement is met when "the PA furnishes their services in accordance with state law and state scope of practice rules for PAs in a state in which the services are furnished, with medical direction and appropriate supervision as provided by state law in which the services are performed." CMS also stated that if there is no state law governing physician supervision of PA services, "the physician supervision required by Medicare for PA services would

be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services."

STS supports this proposal.

J. Review and Verification of Medical Record Documentation

CMS proposes to "establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team."

STS supports this proposal.

K. Care Management Services

Chronic care management (CCM) services are comprehensive care coordination services per calendar month, furnished by a physician or non-physician practitioner (NPP) managing overall care and their clinical staff, for patients with two or more serious chronic conditions. There are currently two subsets of codes: non-complex chronic care management, and complex chronic care management. CMS believes that CCM services, especially complex CCM services, continue to be underutilized. CMS believes that refinements may be necessary to improve payment accuracy, reduce unnecessary burden, and help ensure that beneficiaries who need CCM services have access to them.

STS remains committed to coordinated, team-based care. Many patients who require cardiothoracic surgery are chronically ill with multiple comorbid conditions. Chronic care management is an essential aspect of care for these patients prior to and following cardiothoracic and can improve patient outcomes.

N. Valuation of Specific Codes

The changes considered by CMS for the pericardiocentesis, pericardial drainage, pericardiotomy and aortic grafting procedures among others in the CY2020 MPFS proposed rule only address the time associated with the procedures. As in the past, CMS is overlooking the intensity component and its role in valuation of the procedures. In the CY 2020 PR under Section II (A)(1)(A) regarding the development of work RVUS, CMS states the following: "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." Section1848(c)(2)(C)(i) 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 required in furnishing the service.'' By consistently ignoring the intensity of services and evaluating them solely on the time it takes

to perform the procedures, CMS is going against their directive. The current fee schedule is based on magnitude estimation and there are subtle differences in each procedure that can lead to variations in how specific codes are valued. The intensity of a procedure is characterized by added technical skill, physical and mental effort additional judgment and stress involved and should be considered in addition to the time associated with procedures.

In arriving at its proposed work RVU recommendations, CMS appears to use fabricated mathematical adjustments to physician time ignoring physician survey data, clinical expertise, and magnitude estimation. STS encourages CMS evaluate the intraoperative work intensity for codes relative to other highly intense services in the fee schedule rather than just considering the intra-service and total times. As STS has pointed out in the past, the creation of increments of RVUs between code pairs to try and create streamline implied relationships is not substantiated. The current fee scheduled is based on magnitude estimation and there are subtle differences in each procedure that can lead to variations in how they are valued.

Pericardiocentesis and Pericardial Drainage (CPT Code 3X000, 3X001, 3X002, and 3X003)

Code	Long Descriptor	CMS Proposed work RVU	RUC-recommended work RVU
3X000	**Pericardiocentesis, including imaging guidance, when performed**	**4.40**	**5.00**
3X001	**Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly**	**4.62**	**5.50**
3X002	**Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age, or any age with congenital cardiac anomaly**	**5.00**	**6.00**
3X003	**Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance**	**4.29**	**5.00**

CPT Code 33015 was originally identified by the RUC's Relativity Assessment Workgroup for review due to its negative IWPUT. This code has the most negative IWPUT of -0.1484 out of all CPT and HCPCS codes in the entire Medicare PFS with more than 1,000 claims. The negative IWPUT indicates a very anomalous relationship between the current work value and current physician time. A severely negative IWPUT indicates that ratio of current total times to the current work RVU is inaccurately high and therefore these values should not be referenced when reviewing a potentially misvalued service. For CPT 2020, the CPT Editorial Panel replaced

two codes with four new codes to describe periodcardiocentesis drainage procedures differentiated by age and to include imaging guidance. Code 33015 is a 090-day global service that will be deleted and replaced with three new codes (3X001-3X003) all of which will be 000-day global services. For CMS to compare the incorrect physician time of 33015 to newly bundled codes is severely misguided.

CPT code 33010 *Pericardiocentesis; initial* is being deleted and will be reported with code 3X000 which now includes image guidance. CPT codes 3X001-3X003, which will replace code 33015, will also now include image guidance. While CPT code 33010 was on the RUC's first Five-Year Review agenda, no action was taken. The work RVU and times are from the Harvard study. Since that time, other similar services that involve a lower amount of physician work have been reviewed by the RUC and CMS, and now have higher values. For example, top key reference code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* has work RVU = 3.12.

At the January 2019 RUC meeting, the RUC reviewed and accepted compelling evidence arguments (incorrect assumptions in prior valuation, rank order anomaly, and a change in patient population) agreeing that the current pericardiocentesis and pericardial drainage codes are likely misvalued. Code 33015 currently has a very general code descriptor, was valued under the Harvard study, and has a negative IWPUT. As such, **the crosswalk or methodology used in the original valuation of this service is unknown and not resource-based, and the significant changes made to these codes make it invalid to compare the current time and work to the surveyed time and work. The source time for 33015 is Harvard, implying that the time was merely extrapolated and not measured directly.**

3X000

For CPT Code 3X000, CMS disagrees with the RUC-recommended work RVU of 5.00 and proposes a work RVU of 4.40 based on a direct work RVU crosswalk to CPT code 43244 *Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices* (work RVU= 4.40, intra-service time of 30 minutes, total time of 81 minutes). The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 45385 *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU= 4.57, intra-service time of 30 minutes, total time of 68 minutes) and code 31276 *Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed* (work RVU= 6.75, intra-service time of 45 minutes, total time of 98 minutes). CMS' proposed intensity reduction, relative to the RUC recommendation, would make this service out of rank order with other services in the MPFS including CMS' proposed crosswalk code. CPT code 3X000 is one of the more intense procedures that interventional cardiologists perform, with two of the most common complications being either laceration of the coronary artery or puncturing the right ventricle, either of which can be fatal and is clinically a much more intense service to perform than 43244. **STS urges CMS to accept the RUC-recommended work RVU of 5.00 based on survey data for CPT code 3X000.**

3X001

For CPT Code 3X001, CMS disagrees with the RUC-recommended work RVU of 5.50 and proposes a work RVU of 4.62 based on a direct work RVU crosswalk to CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra-service time of 30 minutes, total time of 79 minutes). The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference code 93456 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization* (work RVU= 5.90, intra-service time of 40 minutes, total time of 108 minutes) and code 31276 *Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed* (work RVU= 6.75, intra-service time of 45 minutes, total time of 98 minutes). Code 3X001 is typically emergent and more intense as the patient has acute hemodynamic instability, where 52334 represents a planned procedure with less intensity.

In addition, the increment of CMS' proposed values (0.22) results in an IWPUT for 3X001 that is only 5 percent higher than 3X000, which does not align with the relative increased difficulty and additional work involved in performing 3X001. CPT code 3X001 includes all the work of 3X000 with the addition of suturing an indwelling catheter in place and the work of managing that catheter which also results in providing additional documentation and instructions for care of the drain relative to 3X000. **STS urges CMS to accept a work RVU of 5.50 based on survey data for CPT code 3X001.**

3X002

For CPT Code 3X002, CMS disagrees with the RUC-recommended work RVU of 6.00 and proposes a work RVU of 5.00 based on the survey 25th percentile value. Code 3X002 is for the drainage of pericardial fluid from a small child. The increased intensity for this service relative to the other services in this new family of codes occurs due to less space for the fluid to accumulate and a smaller target-zone for the needle. The IWPUT of 0.1161 proposed by CMS creates a rank order anomaly of the intensity within this family because it is nearly identical to the proposed IWPUT for the relatively less intense service to perform 3X000.

The RUC recommendation using a direct work RVU crosswalk from code 31603 *Tracheostomy, emergency procedure; transtracheal* (work RVU= 6.00, intra-service time of 30 minutes, total time of 105 minutes) maintained the appropriate rank order for pediatric/congenital pericardial drainage within this new family of codes. Code 45390 *Colonoscopy, flexible; with endoscopic mucosal resection* (work RVU= 6.04, intra-service time of 45 minutes, total time of 83 minutes) also referenced by the RUC supports the RUC-recommended value. **STS urges CMS to accept the RUC-recommended work RVU of 6.00 for CPT code 3X002.**

3X003

For CPT Code 3X003, CMS disagrees with the RUC-recommended work RVU of 5.00 and proposes a work RVU of 4.29 based on the survey 25th percentile value. The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to reference codes 45385 *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU= 4.57, intra-service time of 30 minutes, total time of 68 minutes) and code 31276 *Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed* (work RVU= 6.75, intra-service time of 45 minutes, total time of 98 minutes) which appropriately bracket the RUC recommendation. The RUC-recommended value for 3X003 maintains rank order within this family of codes. **STS urges CMS to accept the RUC-recommended work RVU of 5.00 for CPT code 3X003.**

Pericardiotomy (CPT Codes 33020 and 33025)

Code	Long Descriptor	CMS Proposed work RVU	RUC-recommended work RVU
33020	**Pericardiotomy for removal of clot or foreign body (primary procedure)**	**12.95**	**14.31**
33025	**Creation of pericardial window or partial resection for drainage**	**11.84**	**13.20**

33020

The RUC identified CPT code 33025 via the Negative IWPUT screen and CPT code 33020 was added to the review as part of this family. CMS misstated which code was identified via the RUC screen in the *Proposed Rule*. CMS disagreed with the survey 25th percentile recommendation of 14.31 work RVUs for CPT code 33020 and instead is proposing a crosswalk to CPT code *58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.95 and 60 minutes intra-service time). CMS noted that the current time for CPT code 33020 is decreasing compared to the new survey data and the new total time is the same as 58700.

The current time source for 33020 is Harvard, implying that the time was merely extrapolated and not measured directly. As with other Harvard-valued codes, it is invalid to compare the current time and work to the surveyed time and work because the crosswalk or methodology used in the original valuation of this service is unknown and not resource-based.

Although CPT code 33020 does not rise to the level of critical care, it represents a higher intensity procedure treating acutely ill patients who have typically encountered some type of trauma such as car accident, knife wound, cardiac catheter lab perforation, or other type of injury resulting in the need for intensive short-term care prior to and immediately following the

procedure. CPT code 58700, which CMS chose as a crosswalk, represents a less intense non-emergent procedure for a patient with complaints of mid-cycle pain, dysparunia and dysmenorrhea who has gotten progressively worse and is not responding to medical therapy. CPT code 33020 requires more physician work and is more intense because during both the pre-service and intra-service time, continual monitoring of the patient's hemodynamics is required due to the risk of imminent cardiac tamponade. CPT code 33020 is performed via a median sternotomy, at which time the surgeon must be prepared for the possibility of profound hemodynamic collapse and/or the emergent establishment of cardiopulmonary bypass. The pericardium is opened and blood clots and possibly foreign bodies are evacuated from the pericardial sac. Careful exploration for the source of the hemopericardium is performed. The atria, ventricles, and great vessels are all carefully examined to ensure that there are no cardiac or great vessel injuries. Hemostasis is assured, chest tube(s) placed in the pericardial sac, and the sternum is closed with wires. The abdominal fascia, skin and subcutaneous tissue are irrigated and closed in layers. The sternal exposure and closure add additional complexity and risk to the procedure as does the proximity of the procedure to the heart.

CPT code 58700 is much less complex and is accomplished via an abdominal approach involving an exploratory laparotomy and a partial or total excision of one or both of the fallopian tubes. Hemostasis is assured and the abdominal incision is irrigated and closed in layers. Code 33020 has a four-day length of stay with a more complex visit pattern and subsequent hospital visits of 99233, 99232, 99231 and 99238 while code 58700 has a three-day length of stay with subsequent hospital visits of 99232, 99231 and 99238. This further supports the increased intensity of code 33020 over code 58700. All factors support the point that CPT code 33020 requires more physician work and is more intense and complex than CPT code 58700.

CMS' proposed reduction is unwarranted. CMS should rely on valid survey data which was supported by key reference service 35860 *Exploration for postoperative hemorrhage, thrombosis or infection; extremity* (work RVU = 15.25 and 60 minutes intra-service time) and CPT code 33202 *Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)* (work RVU = 13.20 and 65 minutes intra-service time). Both reference service codes represent other cardiac surgery procedures that are more representative in intensity then code 58700. **STS urges CMS to accept the RUC-recommended work RVU of 14.31 based on the survey data for CPT code 33020.**

33025

CMS disagreed with the survey 25th percentile work RVU recommendation of 13.20 for CPT code 33025. The Agency indicated that, based on RUC survey results and the time resources involved in furnishing these two procedures, they agree that the relative difference in work RVUs between CPT codes 33020 and 33025 is equivalent to the RUC-recommended incremental difference of 1.11 less work RVUs. CMS is proposing a work RVU of 11.84 based on that calculation and references CPT code 34712 *Transcatheter delivery of enhanced fixation devices(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision*

and interpretation (work RVU = 12.00 and 60 minutes intra-service time). CMS noted that the current time is decreasing compared to the new survey data.

The current time source for 33025 is from the Harvard studies and as outlined above, it is inappropriate **to compare the current extrapolated time and work to the surveyed time and work**. The CMS proposed recommendation is invalid because it represents a simple mathematical calculation that is neither based on survey data nor directly crosswalked to any service. **The use of valuation based on increments inaccurately treats all components of the physician time as having identical intensity and is incorrect. The clinical information provided by the RUC should be used to justify the changes in physician work intensity.**

While both procedures are complex and of high intensity, CPT code 33025 has a greater intensity due to the additional complexity of the management of the exposure and invasion of the pericardium. CPT code 33025 typically requires a midline upper abdominal incision and the xiphoid is exposed and resected, the phrenic nerve(s) are protected, and a portion of the pericardium is resected. Hemostasis is assured. The abdominal wall fascia is closed with interrupted suture and the subcutaneous layers are irrigated and the remainder of the wound is closed in layers. Code 34712 is a transcatheter procedure that does not require any surgical incision. Instead, an introducer needle used to access the vessel and place the fixation anchor(s) in the aortic endograft to seal the endoleak. Fluoroscopic guidance and contrast are utilized to confirm deployment position. Both procedures represent the treatment of complicated patients as demonstrated by the 3-day lengths of stay. Code 33025 has a subsequent hospital visit and discharge pattern of 99233, 99231 and 99238 and code 34712 has a has a subsequent hospital visit and discharge pattern of 99232, 99231 and 99238 showing that the initial post-op care for 33025 is more complex. The types of approaches involved and the resection of a portion of the pericardium also support the higher intensity of code 33015. Pericardial windows are generally performed in patients where catheter-based pericardial interventions have failed or a portion of the pericardium is required for histopathologic and microbiologic examination. CPT code 33025 will require insertion of a chest tube and monitoring of fluid drainage from the pericardial sac and/or chest. CPT code 34712 requires monitoring of the arterial access sites, but no drainage tubes are required.

CMS' proposed reduction is unwarranted. CMS should rely on valid survey data which was supported by the survey second key reference service, CPT code 33202 *Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)* (work RVU = 13.20 and 65 minutes intra-service time) and CPT code 67039 *Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation* (work RVU = 13.20 and 60 minutes intra-service time), which requires the same physician work and intra-service time to perform. **STS urges CMS to accept the RUC-recommended work RVU of 13.20 based on survey data for CPT code 33025.**

Transcatheter Aortic Valve Replacement (TAVR) CPT Codes 33361, 33362, 33363, 33364, 33365 and 33366)

The TAVR codes were flagged by the RAW for review as new technology codes with 3 years of available Medicare claims data (2013, 2014 and preliminary 2015 data) at the October 2016 RUC meeting. The RAW determined that the technology for these services was evolving, as the typical site of service had shifted from being provided in academic centers to private centers, and the RUC-recommended that CPT codes 33361-33366 be resurveyed for physician work and practice expense. CPT codes 33361-33366 are currently the only codes on the PFS where the -62 co-surgeon modifier is required 100 percent of the time. In addition, the national coverage determination was updated in July 2019 allowing the use of TAVR for the treatment of symptomatic aortic valve stenosis.

These six codes were surveyed and reviewed at the April 2018 RUC meeting using a survey methodology that reflected the unique nature of these codes. The RUC-recommended work RVUs of 22.47 for CPT code 33361; 24.54 for CPT code 33362; 25.47 for CPT code 33363; 25.97 for CPT code 33364; 26.59 for CPT code 33365 and 29.35 for CPT code 33366 represent value decreases for all six codes. While CMS expressed concerns that the RUC-recommended work RVUs does not match the decreases in surveyed work time, they recognized that the technology is still evolving and that there will be greater intensity on the part of the practitioner with this particular new technology. **STS appreciates CMS' recognition of the complexities of this evolving technology and agrees with their proposal to accept the RUC-recommended work RVUS for all six of these codes.**

Aortic Graft Procedures (CPT Codes 338XX, 338X1, 33863, 33864, 338X2, and 33866)

Code	Long Descriptor	CMS Proposed work RVU	RUC-recommended work RVU
338XX	**Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection**	**63.40**	**65.00**
338X1	**Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg, aneurysm)**	**45.13**	**50.00**
33863	**Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)**	**58.79**	**59.00**

Code	Long Descriptor	CMS Proposed work RVU	RUC-recommended work RVU
33864	**Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub procedure)**	**60.08**	**63.00**
338X2	**Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)**	**60.88**	**65.75**
33866 (33X01)	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	17.75	17.75

In May 2018, the CPT Editorial Panel approved the deletion of two codes and addition of four new codes to distinguish between repairs for aortic dissection and repairs for aortic diseases other than dissection. The specialty societies voluntarily created the new aortic hemiarch code (33866) to address concerns with inappropriate coding for this service. Due to the nature of these code revisions, the RUC's recommendation for these codes resulted in an overall work savings that should be redistributed back to the Medicare conversion factor.

338XX

For CPT Code 338XX, CMS disagrees with the RUC-recommended work RVU of 65.00 and proposes a work RVU of 63.40 based on a direct work RVU crosswalk to CPT code 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* (work RVU= 63.40, intra-service time of 300 minutes, total time of 1,194 minutes). The RUC recommendation was based on the median work RVU from robust survey results and careful review of all underlying clinical attributes of the procedure.

Deleted code 33860 is a more general code that was used for several distinct aortic disease states including both emergent procedures (e.g., repairs for aortic dissection) and planned procedures (e.g., repair for aortic diseases other than dissection). New code 338XX is only the subset of 33860's volume that is emergent in nature, which accounts for only 30 percent of cases that were previously attributed to 33860, which CMS correctly proposed in their utilization crosswalk estimates. However, it appears that CMS may have some confusion with

the change in the coding structure since they compare the surveyed physician time for code 338XX to that of 33860 which represents a combination of patients 30% of the time undergoing an emergent procedure and 70% of the time a planned procedure.

The physician work involved in performing an ascending aortic grafting for aortic dissection is extremely intense and complex and distinctly different from ascending aortic grafting for other diseases. CMS chose to compare 338XX to 61697. However, if you compare code 338XX to other cardiac surgery codes with the same intra-service time of 300 minutes and similar total times, the rank order for the intensity of 338XX is representative compared to the other cardiac surgery procedures.

It is unclear why CMS rejected the RUC recommendation and instead picked an arbitrary low volume crosswalk, last reviewed almost 15 years ago, with a work RVU only 2.5% less than the RUC recommendation. Furthermore, this selected crosswalk is also not an appropriate comparator as 338XX involves 3 critical care visits, whereas the crosswalk code 61697 does not include any critical care. **STS urges CMS to accept the RUC-recommended work RVU of 65.00 based on survey data for CPT code 338XX.**

338X1

For CPT Code 338X1, CMS disagrees with the RUC-recommended work RVU of 50.00 and proposes a work RVU of 45.13 based on a direct work RVU crosswalk to very low volume code 33468 *Tricuspid valve repositioning and plication for Ebstein anomaly* (work RVU= 45.13, intra-service time of 240 minutes, total time of 806 minutes; 7 Medicare claims for 2018e). The RUC recommendation was based on the 25th percentile work RVU from robust survey results and careful review of all underlying clinical attributes of the procedure. The RUC strongly supported its recommendation with comparison to top key reference code 33430 *Replacement, mitral valve, with cardiopulmonary bypass* (work RVU of 50.93, intra-service time of 232 minutes, total time of 913 minutes). Even though this reference code involves more total time, both services involve a similar total amount of physician work as the higher intensity of the survey code mitigates the difference in total time.

Grafting of the ascending aorta for aortic disease other than dissection is a significantly more challenging surgical procedure then code 33468 because of the complex decision making and surgical skill involving both the extent of aortic resection and the separate technical aspects associated with aortic valve surgery - in this case resuspension. In addition, tricuspid valve repositioning and plication of Ebstein anomaly (33468) most often requires no significant surgical resection – either of cardiac or aortic tissue. CMS stated that they "…do not believe it adequately reflects the recommended decrease in physician time" without providing any actual comparison. The change in total time from 931 minutes to 778 minutes is in close proportion to the change in value from the current value of 59.46 for the deleted code to the RUC recommendation of 50.00 and the change in intra-service time is proportional to the change in work value as well. **STS urges CMS to accept the RUC-recommended work RVU of 50.00 based on survey data for CPT code 338X1.**

33863

For CPT Code 33863, CMS disagrees with the RUC-recommended work RVU of 59.00 and proposes a work RVU of 58.79 based on the code's current value. CMS noted that the reason for their reduction in value of 0.4 percent was due to the RUC recommending the 75th percentile intra-service time, which we acknowledge is atypical. However, the Agency is proposing to accept the intra-service time in the NPRM's CMS time file and the Agency's rationale neglected to acknowledge or account for the STS Database intra-service time showing a mean time of 298 minutes and a median time of 322 minutes, which strongly support the RUC's recommended 75th percentile intra-service time of 300 minutes. Furthermore, CMS has requested for this service to be resurveyed, although it appears that CMS did not examine the information in the RUC rationale about the STS database times which strongly support the RUC-recommended time. Given this additional information the STS requests that CMS consider this supportive additional information and implement the RUC recommendation of 59.00 work RVUs. The RUC recommendation was based on the 25th percentile work RVU from robust survey results and careful review of all underlying clinical attributes of the procedure. The RUC strongly supported its recommendation with comparison to top key reference code 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)* (work RVU of 59.00, intra-service time of 300 minutes, total time of 866 minutes). **STS urges CMS to accept the RUC-recommended work RVU of 59.00 based on survey data supported by STS Database time data for CPT code 33863.**

33864

For CPT Code 33864, CMS disagrees with the RUC-recommended work RVU of 63.00 and proposes a work RVU of 60.08 based on the code's current value. CMS noted that the intra-service time did not change, and the total time decreased slightly. CMS' proposed value for 33864 however would not have appropriate relativity compared to their proposed value for 33863. The David procedure (33864) involves more difficult and intense work than the Bentall procedure (CPT code 33863), as this procedure involves replacing the aortic root and ascending aorta, but unlike CPT code 33863, attempts to preserve the patient's own native aortic valve – a procedure far more complex and skill-intensive than aortic valve replacement as done in 33863. The increment of the RUC recommendations between these two services is 4.00 RVUs, whereas the increment for the CMS proposed values is only 1.29 RVUs, which is not sufficient to account for the difference in work between these two services. The STS Database intra-service time for 33864 has a mean time of 308 minutes and a median time of 320 minutes.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and careful review of all underlying clinical attributes of the procedure. The RUC strongly supported its recommendation with comparison to top key reference code 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)* (work RVU of 59.00, intra-service time of 300 minutes, total time of 866 minutes). 78 percent of the survey respondents that selected this key reference indicated that the survey code is more

intense and complex to perform. **STS urges CMS to accept the RUC-recommended work RVU of 63.00 based on survey data supported by STS Database time data for CPT code 33864.**

338X2

For CPT Code 338X2, CMS disagrees with the RUC-recommended work RVU of 63.00 and proposes a work RVU of 60.88 by adding the increment between the RUC recommendations for 338X1 and 338X2 to the CMS proposed value for 338X1. CMS' rationale for rejecting the RUC recommendation for 338X1 is flawed as described above and it should not be used as the basis to derive a new value for 338X2.

CMS noted that the reason for their rejection of the RUC-recommended value was the RUC recommending the 75th percentile intra-service time. However, the Agency is proposing to accept that same intra-service time in the NPRM's CMS time file and the Agency's rationale neglected to acknowledge or account for the STS Database intra-service time showing a mean time of 390 minutes and a median time of 400 minutes, which strongly support the RUC's recommended intra-service time of 368 minutes. It appears that CMS did not examine the information in the RUC rationale about the STS database times which strongly supports the RUC-recommended time. Given this additional information the RUC requests that CMS consider this supportive additional information and implement the RUC recommendation of 65.75 work RVUs.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and careful review of all underlying clinical attributes of the procedure. The RUC strongly supported its recommendation with comparison to top key reference code 33877 *Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass* (work RVU of 69.03, intra-service time of 324 minutes, total time of 1110 minutes). 72 percent of the respondents that selected this key reference code indicated that the survey code was more intense and complex to perform. **STS urges CMS to accept the RUC-recommended work RVU of 65.75 based on survey data supported by STS Database time data for CPT code 338X2.**

Practice Expense

CMS is proposing to refine the direct PE inputs for CPT codes 338X1, 33863, 33864 and 338X2 to align with the number of post-operative visits. Specifically, CMS proposes to add 12 minutes of clinical labor time to account for "Discharge day management." STS agrees with CMS' proposed direct PE clinical labor refinement for these codes.

O. Comment Solicitation on Opportunities for Bundled Payments under the PFS

CMS states that it is interested in "exploring new options for establishing PFS payment rates or adjustments for services that are furnished together" and cites several examples of bundled payment models that are being tested by the Center for Medicare and Medicaid Innovation (the Innovation Center). CMS seeks comment on "opportunities to expand the concept of bundling to

recognize efficiencies among physicians' services paid under the PFS and better align Medicare payment policies" to improve individual health care, improve the health care of communities, and lower costs.

Bundled payment policy is predicated on the notion that bundles will facilitate care coordination and better coordinated care will improve quality and reduce cost. Alternative payment models should change *how* we pay for care in addition to changing *what* is being paid for. We are grateful that CMS, through the Innovation Center, has sought to collaborate with cardiothoracic surgeons in implementing the next phase of the Bundled-Payment for Care Improvement – Advanced (BPCI-A) initiative. However, we are afraid the success of this experiment may be muted by implementation issues, and not due to the nature of the collaboration. Other CMS bundled payment efforts in cardiothoracic have failed, not because cardiothoracic surgeons are unwilling to try new payment models, but because CMS had proposed to use quality measures that were essentially meaningless. For example, the proposed CABG Episode Payment Model, which was never implemented, was intended to use all-cause mortality, and little else, to measure quality. CABG mortality is already very low – approximately 2 percent. Attempting to distinguish performance differences using this measure alone would be statistically challenging and would yield few high or low performing outliers. Importantly, the 11 individual measures in the STS CABG Composite and the overall composite measure methodology are all endorsed by the National Quality Forum (NQF) and have undergone careful scrutiny by quality measure experts. We are grateful that the BPCI-A program is looking to incorporate this more meaningful measure, among others.

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data, and feedback of the risk-adjusted data provided to the individual practice and the institution, will provide the most powerful mechanism to change and improve the practice of cardiothoracic for the benefit of patients. We firmly believe that if we are able to create a clinical/financial tool by combining the STS National Database with claims data, we can help hospitals and surgeons to improve quality and generate savings in the hospital setting. Further, providing that level of support will also assist the system in reducing post-acute care costs by ensuring that providers have the ability to identify best practices that can help keep patients from requiring care at a Skilled Nursing Facility or Inpatient Rehabilitation Facility to begin with.

The STS National Database has facilitated advancements in many aspects of health care policy, including public reporting of health care quality measures, medical technology approval and coverage decisions, and even saving money by helping cardiothoracic surgeons to find more efficient and effective ways to treat patients. We have regional examples of combining STS

National Database data with claims information, such as the Virginia Cardiac Services Quality Initiative (VCSQI).

VCSQI is an example of how a model, based on the current 90-day global payment period, has already been operationalized. In existence since 1993, the VCSQI currently has amassed a database by combining the STS National Cardiac Database for Virginia with the patient's UB-04 financial record for over 100,000 patients undergoing cardiac surgery in that region. That database therefore combines the patient's clinical outcome with his/her financial cost record for over 98 percent of all patients undergoing cardiac surgery in Virginia. Evidence-based protocols for treatment of post-operative atrial fibrillation, transfusion reduction in cardiac, early extubation following open heart surgical procedures, and glucose management have saved approximately $90 million dollars in reduction of post-operative mortality and morbidity in cardiac surgery. Such an organization and ability to track and measure outcomes would be readily able to pilot models of alternative payment methodology. Future iterations of this tool could also be linked with other sources of clinical data like the American College of Cardiology's National Cardiovascular Data Registry (NCDR®) to facilitate a longitudinal, population management payment model.

If the agency's objective is to create value in health care, indeed, the most valuable tool for patients who are interested in making proactive choices about their health care is value transparency. Fortunately, the STS Database already provides for quality transparency through STS Public Reporting online. If CMS were to adequately implement Section 105(b) of MACRA (Pub. L. 114-10), we would have access to Medicare claims data, or the cost denominator of the value equation.

Finally, it is worth pointing out that CMS has considerable experience with bundled payment in the form of global surgical payments. Yet while CMS touts the advantaged of bundled payment to facilitate better care coordination, it simultaneously seems intent on dismantling global surgical payments. The policy argument supporting bundled payments is that care provided under bundled payment is greater than the sum of its parts. CMS should remember this when it considers the value of the surgical global.

P. Payment for Evaluation and Management (E/M) Visits

CMS has elected to incorporate recommendations on the valuation and documentation requirements for E/M office visits provided by the American Medical Association Relative Value Update Committee (AMA-RUC). However, CMS has declined to use the new E/M office visit values to update values for 10- and 90- day global surgical periods.

STS agrees with the CMS proposal to adopt the E/M office visit framework developed by the CPT Editorial Panel effective January 1, 2021. STS also agrees with CMS' decision to accept the RUC recommended work values, physician times and practice expense costs for the new E/M code structure. However, we have significant concerns with CMS' proposal to create the

Medicare-specific add-on code GPC1X 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 codes 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.

The Society reiterates its strong opposition to the CMS proposal not to incorporate the adjusted values for the revised office/outpatient evaluation & management (E/M) codes into the post-operative visits bundled into the global surgical payments. By failing to apply the RUC-recommended increases for the revised E/M office visit codes for CY 2021 to the post-operative visits embedded in the 10- and 90-day global surgical payment, CMS proposes to implement these values in an arbitrary, piecemeal fashion and is effectively destroying the relativity of the fee schedule and violating the law requiring that all physicians should receive the same payment for the same service.

Failure to apply the increased value of E/M office visit services into the post-operative visits of the global surgical codes with the update will:

- *Disrupt the relativity in the fee schedule*: CMS is effectively 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.

- *Create 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."[1] 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.

- *Ignore recommendations endorsed by nearly all medical specialties*: The 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

[1] 42 U.S. Code §1395w-4(c)(6).

post-operative visits of the global surgery codes for each CPT code with a global of 10-day, 90-day and MMM (maternity). The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods.

- *Defy section 523(a) of Medicare Access and CHIP Reauthorization Act (MACRA)*: CMS points to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to E/M office visit codes to post-operative visits of the global surgery codes. However, by changing the relative value of all 10- and 90-day global procedures, CMS is universally altering the relative value of all codes based on no data at all, while at the same time, arguing that it does not have the data it needs to make a change.

  CMS cannot have it both ways. One might infer that CMS is relying on the content of the RAND reports that cannot stand up to rigorous scrutiny, to justify its refusal to update post-operative visits bundled into the global surgical codes. CMS must maintain the status quo by maintaining the relativity of the bundled global surgical payments unless validated evidence demonstrates the need for additional changes. The RAND reports do not stand up to scrutiny.

STS has strenuous concerns with the RAND reports included, by reference, in the rule.

We first saw data on CMS' efforts to collect data on global surgical services in the Physician Fee Schedule proposed rule for CY 2019. CMS reported raw data from its first data collection effort. From July 1, 2017 to June 30, 2018, CMS required groups with ten or more practitioners in nine states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island) to record code 99024 to reflect any post-operative visit performed during the global period for 293 common procedure codes.

In the 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. ***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. All of the codes that would typically be attributed to cardiac and thoracic surgery from the mandatory reporting list are 90-day global codes (32480, 32663, 33405, 33426, 33430, 33533 and 33860).*** The 90-day global procedures show that 77% and 79% of thoracic and cardiac surgeries, respectively, included at least one reported 99024 visit. 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 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?

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. Commentary from the American Academy of Dermatology Association et.al., established, for the record, the following concerns related to causes of under-reporting that we also shared:

- The mandate to report 99024 layered new administrative burdens on practices.
- There was significant confusion about which physicians were required to report and the duration of the reporting period.
- Collection of 99024 contradicts specialty society coding education.
- Billing clearinghouses typically don't recognize zero charge bills. Some practices encountered difficulties reporting 99024, as this code lacks value ($0.00), so attempts to report the code in many practices and EHR systems are blocked by the software.
- Excluding small practices from the data collection requirement, while alleviating an administrative burden, could have skewed the results.

In limited follow-up, STS found that despite education efforts by the Society, very few of the providers in the participating states knew about the mandatory reporting initiative. Any one of these reasons would be justification to conclude that the data collection method was faulty, yet CMS and RAND persisted in their analysis that the post-operative visits simply were not taking place.

Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90- Day Global Periods

Once again, RAND recognizes limitations in its data collection methodology but insists on drawing conclusions without offering adequate mitigation of the concerns raised. RAND further assumes that, just because a surgeon did not report 99024, that the visit did not take place. The "sensitivity analysis" performed by RAND assumes that, just because a physician reported 99024 once, they will do so again for the same patient. There are a number of reasons why that would not be the case including confusion over the requirements and electronic or billing department interference as discussed above.

The CY 2019 proposed rule stated that cardiac and thoracic surgeons reported at least one 99024 visit 84% of the time. Subsequent RAND publications make reference to the Society's efforts to educate its members about CMS data collection efforts in hopes that we could contribute to accurate valuation of global services[2]. However the RAND report titled, "Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods" does not reference either specialty at all, leaving one to assume that they are included in the 32.9% associated with "all other specialties." This may be attributable to how RAND conducted

[2] Krantz, Ashley M., Teague Ruder, Ateev Mehrotra, and Andrew W. Mulcahy. 2019. *Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods.* RAND Corporation. p. 8

its analysis and what data may have been erroneously left out due to a misinterpretation of coding practices. RAND stated that it only evaluated "clean" procedures or global periods during which another procedure was not reported. Only 5.9% of coronary artery bypass graft (CABG) surgery is performed as a single-vessel procedure. However, it is coded as a single vessel CABG with add-ons for additional vessels. ***If RAND interpreted the additional vessels as additional procedures and therefore discarded all multi-vessel CABG procedures, that means that RAND discarded 94% of the instances of one of the most common procedures performed by a cardiac surgeon.*** RAND also excluded claims with assistant at surgery modifiers (-80, 81 or -AS). Cardiac and thoracic surgery procedures utilize an assistant at surgery for the majority of procedures. This is specifically true for the procedures that were required for mandatory reporting.

With so many questions and flaws in the methodology used to analyze the data, it would be irresponsible for CMS to make any policy changes based on these data and analyses.

Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90- Day Global Periods

Congress required CMS to collect data on the number and value of post-operative visits provided in the global surgical period. This survey was CMS' attempt to collect information on the value of the post-operative visits because recording 99024 would only provide a tally. We would refer CMS to the comments provided by the RUC about this survey as none of the procedures that were included in the survey are remotely relevant to cardiothoracic surgery. That CMS would attempt to glean anything from this analysis that could be applied broadly across all types of surgery is folly and imminently harmful. That said, we are once again concerned that RAND would identify considerable limitations in its methodology but insist on drawing wide-ranging conclusions all the same.

Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods

Again, we refer CMS to the detailed comments from the RUC. However, we would point out that it is wholly irresponsible for CMS, or a contractor of CMS, to suggest that reimbursement for cardiac and thoracic surgery is over-valued by upwards of 20%. If CMS intends to cut payments for cardiothoracic surgical procedures by more than of 25% (Cardiac Surgery: -.20.6% (projected cut to global payment) – 7% (E/M impact) = -27.6% Thoracic Surgery: -19.8% - 7% = -26.8%), it may become 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 would be felt for years to come. Thousands of medical students choose their medical specialties each year. If cardiothoracic surgery is no longer a financially stable career, those students will be forced to choose other specialties that will better allow them to pay off their debilitating student loans. In both the short and long term,

Medicare beneficiaries with some of the most lethal health conditions – coronary artery disease and lung cancer – stand to lose access to value based care if CMS continues down this path.

STS originally opposed the un-bundling of global surgical payments because of its impact on patient care. The first RAND report 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[3].

Therefore, CMS needs to consider whether each individual 10- and 90-day global surgical period, as a whole, is truly over-valued by these unimaginable margins. Further, if we are going to start reimbursing healthcare through bundled payments then value must be measured in overall quality over overall cost.

III. Other Provisions of the Proposed Regulations
C. Expanded Access to Medicare Intensive Cardiac Rehabilitation (ICR)

CMS proposes to expand ICR coverage to include beneficiaries with chronic heart failure and providing for modifications to covered cardiac conditions for ICR, in addition to CR, as specified through a national coverage determination (NCD).

STS supports the proposal to expand ICR coverage to include patients with chronic heart failure. Further, we support the proposal to incorporate future expansions of ICR coverage into the NCD process. This proposal is consistent with our commitment to team-based care designed to ensure that patients do not fall through the cracks. In addition, this proposal is consistent with the priorities of the Innovation Center with is working to proliferate payment models that integrate cardiac rehabilitation.

J. Advisory Opinions on the Application of the Physician Self-Referral Law

CMS proposes to allow favorable advisory opinions on the applicability of the physician self-referral law to a specific physician arrangement to serve as precedent for arrangements that are indistinguishable in all material aspects from the original physician arrangement.

STS supports this proposal. Proliferation of successful value-based care initiatives is a goal that we share with CMS. Removing this barrier to applying models that have already been proven to be successful and within the bounds of the physician self-referral protections, will help us to share and implement best practices.

[3] Ibid

K. CY 2020 Updates to the Quality Payment Program
3. MIPS Program Details
a. Transforming MIPS: MIPS Value Pathways Request for Information

CMS proposes to create MIPS Value Pathways (MVPs) as a QPP participation framework that would align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS for specific specialties or conditions. CMS proposes to define a MVP as a subset of measures and activities which may include, but would not be limited to, administrative claims-based population health, care coordination, patient-reported, and/or specialty/condition specific measures. MVPs would include measures and activities such that all four MIPS performance categories are addressed, and each performance category would be scored according to its current methodology. MIPS-eligible clinicians participating in an MVP would no longer be able to select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a clinician specialty or condition. CMS intends to continue to integrate new MVPs so that eventually, all MIPS eligible clinicians would have to participate through an MVP or a MIPS APM.

CMS proposes to adhere to the following four guiding principles as it defines MVPs:

1. *MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.*
2. *MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.*
3. *MVPs should include measures that encourage performance improvements in high priority areas.*
4. *MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.*

Overall, STS appreciates the intent of the MVP framework. We support efforts to better streamline the Merit-Based Incentive Payment System (MIPS), reduce unnecessary administrative burden, provide more relevant participation options for specialists, and to provide enhanced feedback and other performance data that will help clinicians eventually transition to risk-based APMs. However, our biggest concern is that CMS seems to be trying to fit this framework within the current MIPS construct, which not only fails to provide a meaningful participation pathway for specialists, but also fails to provide a practical glide path to APMs. We recognize that CMS must work within the statutory limitations of MACRA; however, we also believe that it could consider more innovative and holistic approaches to quality measurement and improvement without overstepping its authority. If CMS is serious about the need to move away from siloed activities and measures and towards an aligned set of measure options more relevant to a clinician's scope of practice that is also meaningful to patients, then at a very minimum, it should 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 count as other types of MIPS metrics. As currently proposed, the framework connects MIPS performance categories under a common theme, but fails to truly streamline the program by maintaining four distinct categories along with each category's unique set of metrics, reporting requirements, and scoring rules. If CMS does not take this critical step and the program continues to evolve under a rigid process with no room for experimentation, it will fail to secure clinician buy-in and more importantly, it will fail to result in meaningful improvements in patient care.

STS also is concerned that the MVP framework represents yet another significant shift in the operation and rules of MIPS, which might confuse or otherwise discourage clinicians. While we believe that the QPP is in need of fundamental improvements, we also believe that the MVPs need to be carefully implemented and developed with ongoing specialty society input. CMS should start simple by pilot testing the framework in practices that treat a single condition, focus on a relatively homogenous patient population, and have existing measures and activities. Over time, CMS can begin to develop more complex MVPs that recognize team-based approaches to care and/or rely on more innovative measures.

Finally, there are many holes in the current framework, which will require careful thought. We request that CMS meet regularly with relevant stakeholders over the next year to discuss these issues in more detail, rather than simply developing proposed policies based on feedback compiled from this rushed rulemaking cycle. Implementation of this new framework should also occur gradually, based on pilot testing and in a voluntary manner so that clinicians comfortable with the current program can remain on that pathway.

STS agrees with CMS that its approach to MVPs must offer a sufficient number of MVPs to allow clinicians to report on measures and activities relevant to their practices without developing so many MVPs that reporting is diluted and developing benchmarks is hampered. At the same time, in most cases, we believe it would be inappropriate to develop a single MVP per specialty. For example, an MVP centered on cardiac surgery would likely be too broad due to the diversity of procedures performed, conditions treated, and heterogeneity in patient populations cared for by cardiac surgeons.

As a first step to developing MVPs, we urge CMS to consult with specialty societies and their designated clinical experts to help identify clinically appropriate MVPs. It is critical that this initial step not only rely on relevant clinical expertise, but that it occur in a transparent manner. Initial MVPs should focus on relatively simple conditions or clinical areas and rely on existing measures and activities in order to recognize investments made in these metrics to date and clinician familiarity with them. Over the longer term, once initial MVPs are assembled and pilot tested, CMS can work with stakeholders to refine and improve sets of applicable measures and activities and eventually progress to more complex episodes.

CMS would like to establish a methodology that allows it to identify and assign in advance the relevant MVP(s) for MIPS eligible clinicians or groups and require the clinician or groups to report on those MVPs. CMS is also considering approaches to assigning MVPs to multispecialty groups that are inclusive of the different specialties providing care to patients. Clinicians and groups who would not have an applicable MVP for the 2021 MIPS performance period would continue the current process of reporting MIPS measures and activities for the four performance categories.

STS strongly opposes mandatory assignment of clinicians and groups to MVPs, at least initially. Accurate determinations regarding the clinical focus of a practice or individual clinician will be extremely difficult, especially if based on administrative data such as PECOS, which is not always up to date. Current trends in physician employment and practice consolidation will make it especially challenging to accurately assign clinicians to an MVP. CMS should work with relevant stakeholders to attempt to assemble clinically appropriate MVPs and to test different methods of assignment. We envision a process whereby CMS suggests the most appropriate MVP for a clinician and/or group, perhaps based on an algorithm(s) that accounts for clinician type, care setting, patient population, practice patterns, and other factors. The clinician or group would then be able to choose whether or not to rely on the MVP as its participation pathway (similar to how they currently have a choice as to whether to rely on a MIPS specialty measure set). This would give CMS time to work with relevant stakeholders to refine the MVPs and the assignment algorithm based on the accuracy of the initial results.

Administrative Claims-Based Population Health Measures
In addition to measuring clinicians on a unified set of measures and activities around a condition or specialty, CMS also would incorporate a set of administrative claims-based quality measures that focuses on population health/public health priorities. These measures would be applied whenever there is a sufficient case minimum. CMS believes this combination of administrative claims-based measures and specialty/condition specific measures would streamline MIPS reporting, reduce complexity and burden, and improve measurement.

STS strongly cautions against the use of administrative claims-based population health measures for multiple reasons:

- These measures are typically not relevant to specialists.
- They are limited by the information captured in claims, which is structured for billing purposes, and are limited to Medicare fee-for-service patients, which excludes other payer patients. As a result, these measures do not always provide an accurate or complete picture of a clinician's entire practice and patient base.
- They require a large sample to produce reliable results, which presents challenges in a clinician focused program that allows for participation by individuals and groups with relatively few patients in a specific measure denominator.
- They do not result in actionable feedback for improvements at the individual clinician level.

While we appreciate CMS' efforts to minimize clinician reporting burden, we do not believe that population health measures are an appropriate solution for physician-level accountability programs such as MIPS. While these measures might be relevant to some primary care providers, we urge CMS to work with specialty societies, such as STS, to determine if there are more appropriate ways to evaluate care provided by specialists. For many years now, STS has been urging CMS to provide greater access to Medicare claims data so that we can link it with our own clinical data to track outcomes and perform risk-adjusted, scientifically valid analyses regarding quality and patient safety. Over the last year, we have been working with the Innovation Center, whose staff agreed that bringing together clinical data from STS National Database and Medicare claims data could hold legitimate value for Medicare beneficiaries, the Medicare program at large, and practicing cardiothoracic surgeons. We view the merging of such data as a potential alternative to population health measures that could also reduce reporting burden while providing a more practical stepping stone to participation in specialty-focused APMs, such as BPCI-Advanced.

CMS views interoperability as a foundational element that should apply to all clinicians, regardless of MVP. As such, all measures currently in the Promoting Interoperability performance category would initially be applicable to each MVP unless exclusion applies. However, in future years, CMS may consider customizing the Promoting Interoperability measures in each MVP.

While we appreciate CMS' recent efforts to simplify the requirements and scoring of this category, we are frustrated that it still focuses primarily on EHR functionality versus what some clinicians would view as truly meaningful applications of technology to improve patient care. The category also continues to rely on an all-or-nothing approach that forces clinicians to report on measures that may not be relevant to their practice. As CMS contemplates MVPs as a way to hone in on specific conditions or patient populations, it is critical that CMS work with specialty societies to update this category to allow for more flexibility and to develop a more diverse inventory of metrics that reflects innovative ways of sharing electronic health data to improve clinical outcomes, such as data collection and applied analyses from clinical data registries.

CMS is interested in using the MVP approach as an alternative to sub-group reporting. Under this approach, multispecialty groups would report on multiple assigned or selected MVPs at the group level.

Stakeholders have long requested that CMS provide an option under MIPS where a portion of a group could report as a separate sub-group on measures and activities that are more applicable to the sub-group and be assessed and scored accordingly based on the performance of the sub-group. STS very much supports efforts to expand participation options for specialists and subspecialists and to more comprehensively capture the range of the items and services furnished by the group practice. At the same time, there are fundamental policies embedded in the current program that continue to de-incentivize the use of more specialty-specific

measures, such as CMS' ongoing removal of specialty specific measures, scoring caps for measures that lack benchmarks, and policies that make it increasingly difficult for qualified clinical data registries (QCDRs) to serve as MIPS-qualified registries. If these policies are not also addressed, few specialists will take advantage of more focused sub-group reporting.

CMS requests comment on what scoring policies can be simplified or eliminated with the introduction of MVPs.

STS believes that there are multiple ways to simplify and reduce burden by streamlining scoring, including:

- Providing cross-category credit.
- Minimizing the use of different reporting requirements and scoring methodologies across the four MIPS performance categories.
- Relying on Yes/No measure attestation as much as possible, but particularly for the Promoting Interoperability measures, which would align with how clinicians attest to Improvement Activities.
- Giving credit for engagement. We support simplifying the MIPS scoring methodology, but believe that CMS needs to continue recognizing clinicians who take the time to report data under MIPS. One option would be for CMS to automatically provide a base set of points for reporting measure data, with additional points based on performance. This would simplify the scoring rules of the category, but also could help to spur clinician engagement in the program and incentivize the development and use of specialty-specific measures, including those that currently lack benchmarks.
- Reducing the number of quality measures a clinician must report, especially if CMS continues to remove specialty-specific measures.

CMS proposes to provide enhanced data and feedback to clinicians. Although the details surrounding this proposal are vague, it appears that CMS intends to analyze existing Medicare data so that it can provide clinicians and patients with more information to improve health outcomes. CMS hopes this enhanced feedback, along with other aspects of this framework, will help remove move APM participation barriers and help clinicians and practices prepare to successfully manage risk and build out their quality infrastructures.

As we noted earlier, STS has long been advocating for improved access to Medicare claims data. However, claims data in isolation will not provide cardiothoracic surgeons with the information they need to make meaningful improvements in quality and cost-effectiveness. Claims-based feedback provided under MIPS and other legacy programs to date has proven to be confusing and not actionable for clinicians. STS supports CMS providing enhanced access to data, but we request that it work with stakeholders, such as STS National Database, to determine the best applications of those data, including how best to harness the power of clinical data registries.

CMS believes that its performance measurement efforts, including MVPs, should focus more on patient-reported measures, including patient experience and satisfaction measures and clinical outcomes measures, when feasible.

STS supports the use of PRO measures. However, we request that CMS recognize the time and resources it takes for clinicians to collect such data, compared to most other process-oriented or structural measures of care. We urge CMS to make them eligible for cross-category credit where appropriate (e.g., PROs collected via a patient portal accessed via a registry or EHR might be eligible for credit under the Quality, Promoting Interoperability, and potentially even the Improvements Activity category if the data were used to implement changes in practice).

CMS is also looking at ways that it can gather and display information that is most useful to patients. CMS discusses potentially developing and reporting on Physician Compare a "value indicator" representing each clinician's performance on cost, quality, and the patient's experience of care. While we support efforts to improve the type and format of information provided to patients, we question how this proposal is different from current MIPS composite scores posted on Physician Compare. We caution against making available to the public too many data points since this could confuse patients and providers. We also strongly oppose CMS publicly reporting patient experience of care data until it has been carefully tested and provided to clinicians first for confidential feedback.

c. MIPS Performance Category Measure and Activities

While cardiothoracic surgeons believe that aspects of MIPS are fundamentally flawed and in need of improvement, our members also value consistency. Year-to-year changes to the program confuse clinicians and patients, divert limited resources to administrative processes that do little to improve patient care or experience, and prevent accurate long-term assessments of participation and performance trends. As CMS continues to work with stakeholders to truly overhaul the program through the implementation of the MVP framework, it needs to also maintain a consistent traditional MIPS pathway and avoid constantly shifting targets. In the sections below, we discuss specific MIPS proposals for 2020.

CMS proposes the following shifts in the MIPS performance category weights over the next three years:

2020 performance period:	*2021 performance period:*	*2022 performance period:*
• Quality: 40% • Cost: 20% • Promoting Interoperability: 25% • Improvement Activities: 15%	• Quality: 35% • Cost: 25% • Promoting Interoperability: 25% • Improvement Activities: 15%	• Quality: 30% • Cost: 30% • Promoting Interoperability: 25% • Improvement Activities: 15%

STS understands that this gradual shift in the weight of the Quality category to the Cost category is meant to prepare clinicians for 2022, when CMS is required to weight each of those categories at 30 percent. However, STS strongly urges CMS to retain the 15 percent weight for the Cost category in 2020, and to remain flexible with this category for the next three years due to ongoing issues related to existing cost measures, the ongoing development and testing of episode-based measures, and the need for additional education and outreach so that clinicians can better understand these measures (see additional comments in the Cost section below). As we have stated in the past, clinicians have far more direct control over quality measures than they do over the current set of cost measures and the category weights should reflect this.

STS continues to believe that it is important that quality and costs are directly measured and attributed utilizing specialty specific models in a value-based system. STS has repeatedly offered to work with CMS to develop specialty specific models using the STS National Database. As it is currently designed, the MIPs program has created silos between quality and costs, which does not allow any true measure of the relationship since the cost measures are not directly tied to any quality monitoring. While the development of the specialty specific episode-based cost measures is a step in the right direction, without a mechanism to tie the episodes to quality of care there is no way to ensure that the cost measures are impacting the quality of care.

(1) Quality Performance Category

In this rule, CMS proposes to eliminate 55 measures from MIPS in 2020, which would represent over 20 percent of measures in the program. CMS' proposal includes the removal of the following two measures developed by STS:

- *#165: Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate*
- *#166: CABG: Stroke*

CMS considers the actions captured by these measures to be a standard of care that has limited opportunity to improve clinical outcomes given extremely high performance. For #165, which is an inverse measure, the average performance is 0.5 percent for the MIPS CQMs (i.e. registry) collection type. For #166, which is also an inverse measure, the average performance is 1.3 percent for the MIPS CQMs collection type. As such, both of these measures meet CMS' definition of "highly topped out."

In general, we are very concerned about CMS' proposal to remove such a large number of measures and believe this will further impact the ability of specialists to participate fully and meaningfully in the program. This proposal also sends a signal to specialty societies that they should re-evaluate any future investment in the development of new MIPS measures.

In regards to the removal of extremely topped out measures, such as #165 and #166, we remind CMS that a high performance rate on a specific measure does not necessarily mean that a measure is not meaningful. There are certain measures that are such a high priority or so critical for patient safety that it is appropriate for every physician to aim for, and maintain, top performance. Removing these measures may create serious unintended consequences including negative effects on patient care, and could also make it difficult to track performance on these measures over time.

We also are concerned about the data and analytics used to make these topped out determinations. CMS' extremely topped out policy, as well as its phased removal policy for other topped out measures, currently relies on data from the first two years of MIPS. Since these were transition years (particularly 2017, when the pick-your-pace approach was employed, but also 2018, when CMS finalized changes to the low-volume threshold), they are not a representative sample of how physicians are actually performing on quality measures. Reporting requirements and performance thresholds have changed every year, making it nearly impossible to make accurate determinations about topped out performance. Additionally, CMS does not conduct any examinations of variation among subgroups. For example, CMS does not consider whether performance varies by group vs. individual reporting, by practice setting, by geography, by volume of cases, or by physician experience with quality reporting under Medicare. Furthermore, low reporting rates are not always an indication of a low value measure. Some measures may only be reported by a small number of clinicians and yet that small number represents a significant percentage of those caring for the patients to which the measure applies. We strongly urge CMS to evaluate these important factors when assessing topped out status and making measure removal determinations.

CMS notes that it will take other factors into consideration when considering the removal of a topped out measure, such as whether the removal would impact the number of meaningful measures available to a specialist or if the measure addresses an area of importance to the agency. However, there is little discussion in this rule about whether and how other factors were considered for each measure proposed for removal. We request that CMS be more transparent and thorough in its consideration of these measure removal proposals in the future.

In searching for a solution to address topped out measures that are retained in the program, CMS seeks feedback on potentially increasing the data completeness threshold for extremely topped out measures. We appreciate CMS looking for solutions that would allow it to retain topped out measures. However, we are concerned that this policy does not address the need to more thoroughly evaluate the accuracy and breadth of topped out performance. If CMS decides to increase data completeness thresholds for these measures, it must simultaneously conduct more thorough and granular analyses of topped out performance. Another alternative would be to roll topped out measures into a composite. By linking them to other similar measures, it could reduce reporting burden and potentially encourage more clinicians to report on the measure. Composites would also make sense within the context of the with MVP framework.

Measures with No Benchmark
Beginning with the 2020 performance period, CMS proposes to remove quality measures that do not meet case minimum and reporting volumes for benchmarking for two consecutive years (i.e., do not have a minimum of 20 individual clinicians or groups who reported the measure to meet the data completeness requirement and the minimum case size of 20 applicable cases). This policy would apply to traditional MIPS measures, as well as QCDR measures.

While this policy would not directly impact any STS measures at this time, we believe that CMS should maintain as broad of an inventory of measures as possible so that specialists have the opportunity to select measures that are most relevant to their patient populations. Rather than removing measures without a benchmark, CMS should instead adopt more flexible participation and reporting policies that incentivize the reporting of specialty-focused measures, such as allowing a portion of a group to report as a separate sub-group on measures and activities that are more applicable to the sub-group (as discussed in the context of the MVP framework).

Further, CMS should recognize national benchmarks that already exist for registry measures rather than trying to generate benchmarks from a smaller sample of MIPS participants. Nearly 96% of the cardiac surgery programs in the country currently report to the STS National Database. Given the robust nature of our registry, we have true national benchmarks that we would love to be able to share.

CMS proposes to add one new population health administrative claims-based quality measure for the 2021 MIPS performance year titled, All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions. This is a risk-adjusted outcome measure that uses the outcome of acute, unplanned admissions to assess care quality. It includes Medicare fee-for-service beneficiaries aged 65 years or older who have two or more of the following nine chronic conditions: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease or asthma, (6) depression, (7) diabetes, (8) heart failure, and (9) stroke or transient ischemic attack. This measure would be calculated based on data available from MIPS eligible clinicians' billings on Medicare Part B claims and would not require separate data submission to CMS. This measure is currently used under the Medicare Shared Savings Program (MSSP) and would be adapted for use under MIPS prior to implementation. The delayed implementation date would allow time to further refine the measure analytics prior to implementation within the program.

As discussed earlier in the context of the MVP framework, we appreciate CMS' efforts to minimize clinician reporting burden, but we do not believe that population health measures are an appropriate solution for a physician-level accountability programs such as MIPS. In regards to the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions measure specifically, we strongly urge CMS to not incorporate this measure until it has been reviewed

and recommended by both the Measure Applications Partnership (MAP) Coordinating Committee and the NQF. In addition, some of the conditions listed here are not actually chronic conditions. For example, acute myocardial infarction, is, by definition, acute and therefore not chronic.

Thoracic Surgery Specialty Set
STS appreciates CMS addressing the majority of the concerns identified by STS in our September 10, 2018 Comments for the CY 2019 proposed rule. We note that measure #317 *Screening for High Blood Pressure and Follow-Up Documented* is still included in the Thoracic Surgery Specialty Set. Per our comments last year, **STS does not believe this measure is appropriate for the Thoracic Surgery Specialty Set and requests its removal for CY 2020. Blood pressure management is outside of the scope of practice of cardiothoracic surgeons.**

STS disagrees with CMS' proposal to remove the following measures from the Thoracic Surgery Specialty Set:

- **#165 Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate**
- **#166 Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG)**

(2) Cost Performance Category

For 2020, CMS proposes to incorporate revised versions of the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per Beneficiary (MSPB) measure, to maintain the eight episode-based cost measures approved for 2019, and to add ten more episode-based cost measures, including:

- *Non-Emergent Coronary Artery Bypass Graft (CABG)*
- *Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation*

STS appreciates the collaborative work that has gone into refining the TPCC and MSPB measures and believes that important updates were made to improve the attribution methodologies. These include excluding certain clinicians from the TPCC measure who mainly deliver certain non-primary care services (e.g., surgeons), as well as creating a separate attribution methodology under the MSPB measure for surgical and medical patients and removing costs that are unlikely related to the clinician. Nevertheless, we continue to have concerns with the relevance and appropriateness of these measures for a clinician level accountability program. Most clinicians still lack a clear understanding of these measures, question whether the measures capture costs over which they have direct control, and question how they can use the data to effect change.

For the TPCC measure, in particular, the MAP Coordinating Committee provided a final recommendation of "do not support for rulemaking with potential for mitigation" due to multiple ongoing concerns, including the lack of available information on the measure's validity

testing. In regards to the revised MSPB measure, although the MAP conditionally supported it pending NQF endorsement, it cited various ongoing concerns with the measure, such as the need for ongoing testing to ensure the measure demonstrates validity and reliability at the individual clinician level. The MAP also voiced concern that neither the original or revised version of the measure has been reviewed by NQF, limiting the public's ability to determine the validity of the changes to the measure. Furthermore, the MAP raised concerns about double counting clinician costs across the TPCC, MSPB and episode-based cost measures and challenges it faced getting access to field test data. Given these unresolved concerns, we request that CMS consider removing the TPCC measure from MIPS. To avoid double accountability, we also recommend that CMS exclude clinicians from the MSPB measure if they are found to have a sufficient number of attributed cases under one or more of the episode-based cost measures that captures inpatient costs.

STS believes episode-based cost measures are a step in the right direction and appreciates the transparent and inclusive process under which they were developed. However, the field-testing period has been rushed, which has resulted in confusion and has prevented clinicians from providing meaningful feedback. We strongly urge CMS to continue to make improvements to the field-testing period, including better education and outreach and a longer period for accessing reports and providing feedback.

STS supports the development of attribution models that are specific to cardiovascular surgery. STS feels strongly that the STS National Database should be used to help with the development of the risk adjustment methodologies and variables and that claims data should not be used for the risk adjustment for the episodes. STS offered to work with CMS to utilize the STS Database in this capacity and is disappointed that CMS decided to use claims data instead.

In regards to the Inpatient COPD Exacerbation measure, specifically, we would like to point out that one of the exclusions for this episode is any patient who has received lung surgery (lung resection) in the pre-trigger period (i.e., 120 day look-back). However, the exclusion sheet only list two CPT codes, 32663 and 32668, which is a woefully inadequate list for lung resection CPTs. According to our members who served on the Clinical Subcommittee and Workgroup, the intent was to exclude patients who may have undergone any lung surgery and ended up having a "readmission" for COPD exacerbation, as this would complicate the comparisons concerning cost performance. As currently specified, the measure exclusion list does not adequately capture patients who have undergone lung surgery/resection and should be excluded from this measure. The full list of lung resection CPT codes that should be added to the "Exclusion Details" tab list is provided in Appendix B. The same logic for episode exclusion that was included for 32663 and 32668 should be applied to all of the lung resection codes listed in Appendix B.

It is critical that CMS consult the Workgroup to broaden this exclusion list prior to implementing this measure.

STS was involved in the development of the Non-Emergent CABG measure and feel that overall the measure is representative of the discussions with the clinical subcommittee. We have two specific areas of concern with the Measure Codes List.

1. Code 33406 *Replacement of aortic valve using human donor valve on heart-lung machine, open procedure* is included in the "Trigger Details" tab. STS recommends that this code be added to the "excluded" CPT list for non-emergent CABG. Unlike the other aortic valve replacement procedures that are included in the list (33405, 33410 and 33411), code 33406 adds a significant amount of complexity to the procedure and the patient's post-operative course. Patients that require a homograft typically have endocarditis. The presence of endocarditis significantly impacts the intra-operative time and post-operative care associated with these patients, which will dramatically impact the required resource utilization.
2. For the "Service Assignments," STS noted that "Post-Trigger" Stroke was assigned a service assignment window of "<15 days from trigger event." We have significant concerns with the 15-day window and feel that the window should be changed to "<7 days from trigger event." Most strokes that occur after cardiac surgery occur within the first 72 hours or up to 7 days while the patient is still in the hospital. Post-discharge strokes should not be attributed to the surgeon since they are more often a result of sub-optimal post-operative care that is out of the surgeon's control. For example, mismanagement of medications for blood pressure by another physician in patients that have underlying low-grade carotid artery stenosis could cause a stroke.

As we noted earlier, STS strongly urges CMS to retain the 15 percent weight for the Cost category in 2020, and to remain flexible with this category for the next three years due to the numerous ongoing issues related to existing cost measures, the ongoing development and testing of episode-based measures, and the need for additional education and outreach so that clinicians can better understand these measures. Clinicians have far more direct control over quality measures than they do over the current set of cost measures, and the category weights should reflect this.

(3) Improvement Activities Performance Category

CMS proposes to revise the attestation requirements for group practices participating in this category. Starting in 2020, a group or virtual group would be able to attest to an improvement activity only if at least 50% of MIPS eligible clinicians (in the group or virtual group) participate in or perform the activity. Furthermore, at least 50% of a group's NPIs must perform the same activity for the same continuous 90 days in the performance period.

STS strongly opposes this proposal. For one, it represents a significant change in the threshold for this category and yet another moving target at a time when the program could benefit from consistency. It also does not reflect the realities of clinical practice, where a specific Improvement Activity might only be applicable to 1 or 2 clinicians, yet still impacts a large portion of the practice's patients. We instead urge CMS to maintain its current policy where if

at least one clinician within the group is performing the activity for a continuous 90 days in the performance period, the group may report on that activity and all MIPS-eligible clinicians reporting as a group would receive the same score for that improvement activity. If CMS insists on raising the bar, then at the very least it should modify its proposal so that it relies on a lower threshold, which simply represents the percentage of clinicians in the group who satisfy an activity (i.e., *any* activity), rather than the same activity over the same 90 day period.

(4) Promoting Interoperability Category

STS recommends that CMS consider broadening the scope of the Promoting Interoperability category under MIPS, so that it recognizes innovative ways of harnessing, sharing, and otherwise employing health data to improve clinical outcomes. The current set of metrics focus heavily on EHR functionality, but largely ignores the more robust collection of data by registries and other uses of technology to track and improve care.

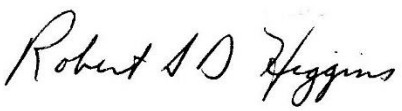
STS supports CMS' proposal maintain the Query of Prescription Drug Monitoring Program (PDMP) measure optional for 2020 and eligible for bonus points. We also greatly appreciate CMS proposing to remove the numerator and denominator for this measure and instead require a "yes/no" response. We urge CMS to adopt this data submission strategy for all measures in the Promoting Interoperability category. Furthermore, we support CMS' decision to remove the Verify Opioid Treatment Agreement measure beginning in 2020. We agree with CMS that the measure creates ongoing challenges due to it being vague, burdensome to measure, and not necessarily offering a clinical value to health care providers or supporting the clinical goal of supporting opioid use disorder treatments.

*CMS proposes to revise the definition of a hospital-based "group" so that such a group would be identified as hospital-based and eligible for reweighting of the Promoting Interoperability category if more than **75 percent** of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician (versus the current definition of 100 percent).*

This definition better reflects the realities of practice and aligns with the 75 percent threshold used by CMS in the definitions of facility-based MIPS eligible clinician and non-patient facing MIPS eligible clinicians.

Thank you for considering these comments. Should you have any questions, please contact STS Director of Government Relations Courtney Yohe at 202-787-1222 or cyohe@sts.org.

Sincerely,



Robert S.D. Higgins, MD
President

Appendix A
1

CPT Code	Anticipated Specialty (CY 2020)	STS Proposed Revision
31781	THORACIC	OTOLARYNGOLOGY
33251	THORACIC	CARDIAC
32486	MISSING FROM LIST	ADD to List - THORACIC
32491	MISSING FROM LIST	ADD to List - THORACIC
32900	MISSING FROM LIST	ADD to List - THORACIC
33203	MISSING FROM LIST	ADD to List - CARDIAC
33320	MISSING FROM LIST	ADD to List - CARDIAC
33414	THORACIC	CARDIAC
33468	THORACIC	CARDIAC
33470	THORACIC	CARDIAC
33471	THORACIC	CARDIAC
33476	THORACIC	CARDIAC
33478	THORACIC	CARDIAC
33502	THORACIC	CARDIAC
33503	THORACIC	CARDIAC
33504	THORACIC	CARDIAC
33505	THORACIC	CARDIAC
33506	THORACIC	CARDIAC
33507	THORACIC	CARDIAC
33600	THORACIC	CARDIAC
33602	THORACIC	CARDIAC
33606	THORACIC	CARDIAC
33608	THORACIC	CARDIAC
33610	THORACIC	CARDIAC
33611	THORACIC	CARDIAC
33612	THORACIC	CARDIAC
33615	THORACIC	CARDIAC
33617	THORACIC	CARDIAC
33619	THORACIC	CARDIAC
33620	THORACIC	CARDIAC
33621	THORACIC	CARDIAC
33622	THORACIC	CARDIAC
33645	THORACIC	CARDIAC
33647	THORACIC	CARDIAC
33660	THORACIC	CARDIAC
33665	THORACIC	CARDIAC
33670	THORACIC	CARDIAC
33675	THORACIC	CARDIAC
33676	THORACIC	CARDIAC
33677	THORACIC	CARDIAC
33684	THORACIC	CARDIAC
33688	THORACIC	CARDIAC
33690	THORACIC	CARDIAC
33692	THORACIC	CARDIAC
33694	THORACIC	CARDIAC
33697	THORACIC	CARDIAC
33702	THORACIC	CARDIAC
33710	THORACIC	CARDIAC

CPT Code	Anticipated Specialty (CY 2020)	STS Proposed Revision
33720	THORACIC	CARDIAC
33722	THORACIC	CARDIAC
33724	THORACIC	CARDIAC
33726	THORACIC	CARDIAC
33730	THORACIC	CARDIAC
33732	THORACIC	CARDIAC
33735	THORACIC	CARDIAC
33736	THORACIC	CARDIAC
33737	THORACIC	CARDIAC
33750	THORACIC	CARDIAC
33755	THORACIC	CARDIAC
33762	THORACIC	CARDIAC
33764	THORACIC	CARDIAC
33766	THORACIC	CARDIAC
33767	THORACIC	CARDIAC
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33770	THORACIC	CARDIAC
33771	THORACIC	CARDIAC
33774	THORACIC	CARDIAC
33775	THORACIC	CARDIAC
33776	THORACIC	CARDIAC
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33786	THORACIC	CARDIAC
33788	THORACIC	CARDIAC
33800	THORACIC	CARDIAC
33802	THORACIC	CARDIAC
33803	THORACIC	CARDIAC
33813	THORACIC	CARDIAC
33814	THORACIC	CARDIAC
33820	THORACIC	CARDIAC
33822	THORACIC	CARDIAC
33824	THORACIC	CARDIAC
33840	THORACIC	CARDIAC
33845	THORACIC	CARDIAC
33851	THORACIC	CARDIAC
33852	THORACIC	CARDIAC
33853	THORACIC	CARDIAC
33917	THORACIC	CARDIAC
33920	THORACIC	CARDIAC
33922	THORACIC	CARDIAC
33924	THORACIC	CARDIAC
33925	THORACIC	CARDIAC

CPT Code	Anticipated Specialty (CY 2020)	STS Proposed Revision
33926	THORACIC	CARDIAC
33927	MISSING FROM LIST	ADD to List - CARDIAC
33935	MISSING FROM LIST	ADD to List - CARDIAC
35180	THORACIC	CARDIAC
35182	THORACIC	CARDIAC

CPT Code	Anticipated Specialty (CY 2020)	STS Proposed Revision
36835	THORACIC	GENERAL SURGERY
43338	MISSING FROM LIST	ADD to List - THORACIC
96440	THORACIC	HEMATOLOGY/ ONCOLOGY

Complete List of Lung Resection Codes for the "Exclusions Detail" Tab for the Inpatient COPD Exacerbation Measure

- 32141 Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed
- 32440 Removal of lung, pneumonectomy;
- 32442 Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)
- 32445 Removal of lung, pneumonectomy; extrapleural
- 32480 Removal of lung, other than pneumonectomy; single lobe (lobectomy)
- 32482 Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)
- 32484 Removal of lung, other than pneumonectomy; single segment (segmentectomy)
- 32486 Removal of lung, other than pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)
- 32488 Removal of lung, other than pneumonectomy; with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)
- 32491 Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed
- 32503 Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)
- 32054 Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction(s)
- 32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial
- 32655 Thoracoscopy, surgical; with resection-plication of bullae, includes any pleural procedure when performed
- 32663 Thoracoscopy, surgical; with lobectomy (single lobe)
- 32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
- 32669 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)
- 32670 Thoracoscopy, surgical; with removal of two lobes (bilobectomy)
  32671 Thoracoscopy, surgical; with removal of lung (pneumonectomy)
- 32672 Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

Lung resection add-on codes

- +32506 Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
- +32507 Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
- +32667 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
- +32668 Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)