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May 21, 2019

The Honorable Chuck Grassley
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Grassley and Wyden,

On behalf of The Society of Thoracic Surgeons, I write to thank you for hosting the May 8, 2019 hearing titled, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead." We appreciate your continued oversight on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA).

Founded in 1964, STS is an international not-for-profit organization representing more than 7,000 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

Merit-based Incentive Payment System (MIPS)

MACRA was designed to promote value (quality/cost) rather than simply rewarding physicians for the volume of service they provide. This means the Centers for Medicare and Medicaid Services (CMS) must be able to effectively measure quality. STS has been a pioneer in this space with the STS National Database (the Database) that recently received the John M. Eisenberg Patient Safety and Quality award from the National Quality Forum (NQF) and The Joint Commission. The Database, established in 1989, includes subspecialty registries for adult and pediatric cardiac surgery, mechanical circulatory support, and general thoracic surgery. Using data from the registry, STS has developed risk models and NQF-endorsed composite performance measures for all of its subspecialties and major procedures to help providers guide their improvement initiatives. These measures are the basis for the Society's highly successful voluntary public reporting program.

Unfortunately, none of this expertise is being utilized in the Merit-Based Incentive Payment System (MIPS). As practices continue to consolidate, an increasing number of surgeons work under larger, multi-specialty and often facility-based groups. Since these groups often opt to participate in federal quality reporting programs at the hospital or group practice level (i.e., at the Taxpayer Identification Number level), the individual clinicians in these practices are

increasingly losing autonomy over the selection of measures and reporting mechanisms that are most relevant to their specific specialty and patient population. This arrangement means that cardiothoracic surgeons are not able to influence their own personal quality scores as their hospitals or groups may elect to report on quality measures that are insignificant or irrelevant to cardiothoracic surgery. This will result in a number of problems for physicians, patients, and the Medicare program:

a. MACRA was founded on the principles of promoting and incentivizing quality care throughout health care. However, without utilizing cardiothoracic surgery specific quality measures, CMS fails to incentivize quality in one of the specialties that has the largest impact on Medicare beneficiaries and is one of the largest cost centers in the Medicare program.

b. Without utilizing measures specific to cardiothoracic surgery, cardiothoracic surgeons are not able to quantify their value to their employers and may have their contribution to the overall performance of the hospital diminished.

STS has urged CMS to ensure that specialists, including physicians employed by hospitals or group practices, have the option to report on quality metrics that are germane to their practice. CMS has adopted a policy whereby physicians can report via multiple mechanisms and have their MIPS scores calculated based on the highest reported score. This policy fails to give adequate incentive for physicians to report on the quality measures that are most relevant to them. Until CMS levels the playing field and recognizes the value of true quality measurement, the MIPS program will fail to realize its purpose of incentivizing high value care.

Alternative Payment Models (APMs)

Medicare Claims Data

The Quality Payment Program (QPP) that was derived from the MACRA statute was intended 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 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. These datasets would also help us to develop and adequately benchmark novel APM concepts and advance the value proposition throughout the Medicare program. Unfortunately, the programs CMS has offered to implement that section of statute are not working.

Section 105(b) of MACRA requires CMS to provide Qualified Clinical Data Registries (QCDRs) with access to Medicare data for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety. CMS initially decided not to issue rulemaking on this section of the law based on its assertion that QCDRs currently can request Medicare claims data through the Research Data Assistance Center (ResDAC) data request process. This position ignored the fact that Section 105(b) is intended to provide QCDRs with access to Medicare data for quality

improvement purposes, not just clinical research, and that the broad and continuous access needed for quality improvement purposes is fundamentally different than the access to Medicare data for research purposes provided by ResDAC. In subsequent rulemaking, CMS decided to treat QCDRs as "quasi-qualified entities" for purposes of obtaining access to Medicare claims data for quality improvement, but maintained that QCDRs should use the ResDAC application process for research.

While we appreciate that CMS has made some effort to provide QCDRs with an alternative means of accessing Medicare data, treating QCDRs as quasi-qualified entities does not allow the type of access contemplated by Section 105(b) of MACRA. To perform data analysis for quality improvement purposes and patient safety, QCDRs require long-term and continuous access to large Medicare datasets so that they can better track clinical outcomes longitudinally. In drafting Section 105(b) of MACRA, Congress was aware of this need and, as such, specifically directed CMS to provide QCDRs with Medicare claims data. Qualified entity status lasts for only three years and continued participation in the program requires re-application by submitting documentation of any changes to the original application. If the re-application is denied, CMS will terminate its relationship with the qualified entity. In addition, Medicare fee-for-service files are released quarterly on an approximate 5.5 month lag. Qualified entities must pay for each set of data they receive, which can become cost prohibitive over time.

Further, the quasi-qualified entity program covers only the "quality improvement" portion of a QCDR's access to claims data. If the same QCDR wanted to facilitate research combining cost and claims information, that QCDR would have to submit a separate application to ResDAC. In fact, if the QCDR already had the claims data in question through the quasi-qualified entity program, it would still need to apply and pay ResDAC for the same data. The ResDAC application is duplicative, time-consuming, and costly, with a significant lag between application approval and delivery of data.

At the same time, every new payment model released by CMS and the Center for Medicare and Medicaid Innovation (the Innovation Center) includes a provision that hospitals and qualified participants should be able to access their own claims information and any additional information deemed necessary by the participant. Clearly, CMS understands the value of price transparency in health care, yet it is failing to implement statute that speaks to that purpose. If CMS is truly interested in using its existing authority to provide information on the value of health care to the Medicare population, it will take another look at how it is implementing Section 105(b) of MACRA. Absent that ideal scenario, CMS should provide claims data to the providers with a straightforward breakdown of inpatient costs, provider costs, post-acute care costs, home health costs, readmission rates, and costs. Given these data and local or regional (not necessarily national) benchmarks, providers (and patients) will have an idea where care can improve and where there are opportunities to improve efficiency. If benchmark prices from big data are created, the methodology employed should be clear and include relevant stakeholders in the development.

Physician-focused Payment Model Technical Advisory Committee (PTAC)

MACRA was founded on the principles of incentivizing value over volume. As such, considerable emphasis was placed within MACRA on development of and participation in alternative payment models (APMs). Specifically, Congress created the physician-focused payment model technical advisory committee (PTAC) to both improve transparency at the Innovation Center and increase the variety, efficacy and number of APMs, in hopes of maximizing the number of physicians and medical specialties able to participate. STS was prepared to offer a physician focused payment model (PFPM) to both the PTAC and the Innovation Center for consideration and implementation. Because of our unique resource – the Database – we believed that we would be able to demonstrate to CMS a payment model capable of rewarding physicians for increasing the quality of care they provide and reducing resource use. Unfortunately, the APM pathway has become extremely complicated and difficult to navigate. According to legal review by the office of the Assistant Secretary for Planning and Evaluation, under current statute, PTAC is not able to provide technical assistance to stakeholders during APM development. Without this assistance, APMs eventually fail to navigate the complexities of getting a proposed APM from development through PTAC review and on to Innovation Center implementation. Although Congress attempted to address this concern with language added to the Balanced Budget Act of 2018, PTAC has indicated that it is still not able to provide technical assistance and data analyses to stakeholders who are developing proposals for its review. Additional technical corrections may be needed to provide the PTAC with more flexibility in this regard.

Bundled Payment for Care Improvement – Advanced (BPCI-A)

A notable success of MACRA implementation has been our recent collaboration with the Innovation Center on the development of quality measures for two episodes of care contained in BPCI-A. Unlike our experience with other APMs, staff from the Innovation Center proactively sought, and utilized feedback from stakeholders on how to adequately measure quality within a payment bundle. The result is that the Innovation Center is looking to implement episodes under BPCI-A that rely on clinical data registries for true quality reporting.

The failed mandatory Coronary Artery Bypass Graft (CABG) episode payment model (EPM) provides a perfect example of why this is so important. Under the proposed CABG EPM, CMS intended to use two quality measures: a patient assessment of care and all-cause mortality. It is understandable that CMS would identify these measures because they are easy to quantify with the tools they have available. However, they do not paint an adequate picture of quality. The mortality rate for CABG is already at 2%. We questioned how CMS planned to distinguish among EPM participants if 98% of them were already hitting the prescribed quality benchmark.

The proposed CABG episode under BPCI-A intends to offer a far more robust quality measure: the STS-developed CABG Composite Score. The STS CABG Composite Score is calculated using a combination of 11 measures of quality divided into four broad categories or domains. Importantly, the 11 individual measures and the overall composite measure methodology are all endorsed by the NQF and have undergone careful scrutiny by quality measure experts. The four domains are:

- Risk-adjusted mortality.
- Risk-adjusted major morbidity, which represents the percentage of patients who leave the hospital with none of the five most serious complications (often referred to as morbidities) of CABG—reoperation, stroke, kidney failure, infection of the chest wound, or prolonged need to be supported by a breathing machine, or ventilator. Some of these complications, such as stroke or kidney failure, are just as important to many patients as whether they survive the surgery, as these outcomes profoundly impact quality of life. Overall, based on data from the Database, about 85 percent of patients are discharged with no such complications.
- The percentage of CABG procedures that include the use of at least one of the arteries from the underside of the chest wall—the internal mammary (or internal thoracic) artery— for bypass grafting. This artery has been shown to function much longer than vein grafts, which can become blocked over time.
- How often all of the four medications believed to improve a patient's immediate and long-term outcomes were prescribed. These medications include beta-blocking drugs prescribed pre-operatively, as well as aspirin (or similar drugs to prevent graft clotting), and additional beta-blockers and cholesterol-lowering medicines prescribed at discharge.

Without registries, CMS did not have a way to effectively measure quality for CABG, one of the most common procedures performed in the Medicare population and therefore one of the major Medicare cost centers. By working together, we have been able to design an episode that should be able to more effectively demonstrate value.

Other

Electronic Health Records (EHR)

Data-blocking by electronic health records (EHR) vendors remains a significant barrier to the provision of high quality health care. Additional provisions included in the 21st Century Cures Act address lack of interoperability among EHRs but also between EHRs and clinical data registries. The recent proposed rules on interoperability did not provide great detail on how these data-sharing concerns will be addressed. We urge Congress to continue to carefully monitor this implementation, with special interest in how the practice of data-blocking is inhibiting success under the QPP.

MIPS Payment Adjustments and APM Glide path

We agree with many of the panelists who testified about their concerns that Medicare payments have failed to keep up with inflation. We are also concerned that, due to the way MACRA has been implemented, many physicians have not had an APM available to them so they could not benefit from the statutory bonus Congress created to facilitate physicians' transition to APMs. We agree that Congress should intervene to replace the upcoming physician payment freeze with positive payment updates under MIPS and extend the APM bonus so more physicians have the opportunity to transition to APMs.

We strongly disagree with the testimony that CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M services while reducing payment rates for other services (e.g., procedures, imaging, and tests). We support the proposed E/M payment rate changes as proposed by the RVS Update Committee (RUC). As with any other rate changes, budget neutrality adjustments are required. We strongly urge the Senate Finance Committee to apply any budget neutrality adjustments across all specialties. Recent policy has continually favored primary care over other specialists (e.g., surgery, imaging and testing) to the detriment of these specialists. Our specialty society worked with primary care and others to help correct payment changes related to the work of all physicians. To favor primary care over other specialties in this circumstance would impact the integrity of the process. While we support primary care physicians and initiatives supporting them and their work, we do not support it at the expense of other specialists.

STS remains fully committed to improving the quality, safety, and efficiency of care for all patients. We had hoped that MACRA would help to move our healthcare system toward a value-based system. However, we remain frustrated with the implementation of MACRA. We hope that Congress and CMS can work together to truly measure quality and allow for more alternative payment models that reimagine how health care is delivered. We look forward to working with you on this issue. Please contact Courtney Yohe Savage, STS Director of Government Relations, at cyohe@sts.org or 202-787-1230 should you need additional information or clarification.

Sincerely,

Robert S.D. Higgins, MD
President