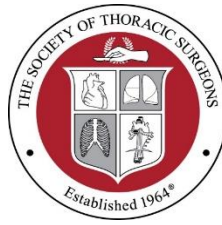


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June 14, 2024

The Honorable Ron Wyden
Chair
Senate Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide feedback on the important issues raised in the Senate Finance Committee's white paper "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." Founded in 1964, STS is a not-for-profit organization representing more than 7,700 surgeons, researchers, and allied healthcare 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.

We thank you for issuing this white paper that addresses the critical issue of Medicare physician payment and its impact on patient care. STS appreciates the opportunity to share our perspective on the policy reforms needed to ensure streamlined clinician payment systems while maintaining quality healthcare.

Conversion Factor and Budget Neutrality Updates

STS is profoundly disappointed that the Centers for Medicare and Medicaid Services (CMS) continues the longstanding trend of systematically devaluing Medicare reimbursements. While the operational and overhead costs for medical practices continue to rise significantly, especially during the wake of the COVID-19 pandemic, Medicare reimbursements have been on a declining trend for several decades. As addressed in the white paper, unlike with other Medicare payment systems, the Physician Fee Schedule (PFS) includes no inflation-related annual adjustments. Without an annual payment update, physicians have watched inflation-adjusted payments decline 26 percent from 2001 to 2023. At the same time, per-beneficiary spending has grown substantially faster than the Medicare Economic Index (MEI) or PFS updates.

This widening gap puts undue financial strain on medical professionals and threatens the sustainability of practices that countless patients rely upon for their healthcare needs. It's imperative to recognize that when reimbursements do not keep pace with escalating costs, the viability and quality of patient care are potentially at risk.

For these reasons, we urge the Committee to provide physicians with much needed fiscal stability by requiring CMS to provide an annual inflation-based payment update based on the full MEI.

In addition to the lack of inflationary update, physician payments are further eroded by flaws in the budget neutrality system. Unfortunately, it is not uncommon for CMS to vastly overestimate utilization assumptions related to new services. As the Committee noted, the most prominent example of this occurred when transitional care management (TCM) services were added to the PFS in 2013. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization, however, turned out to be just under 300,000 claims for the first year and it was still less than one million claims after three years. As a result of this overestimation for TCM services alone, Medicare physician payments were reduced by more than \$5.2 billion from 2013 to 2021. Once these reductions to the conversion factor are made, they are never reinstated, even though it is clear that actual utilization was far lower than projected. The result in these circumstances is not budget neutrality, but rather permanent and unjustifiable Medicare cuts to physician payments across-the-board.

We recommend that Congress specifically include a lookback period that would require CMS to reconcile utilization assumptions with actual claim data, with CMS adjusting the conversion factor as appropriate. Additionally, Congress should limit budget neutrality adjustments in any given year to 2.5%, so when changes cause large disruptions to the PFS, they do not cause abrupt changes in CF calculations in any given year.

STS also believes the budget neutrality threshold should be raised to match its original inflation adjusted amount. The current threshold of \$20 million was enacted into law in 1989, when total Medicare spending was far lower. As proposed by the AMA and in legislation in the House, raising the threshold amount to \$53 million and increasing it every 5 years by the cumulative increase in MEI allow for greater flexibility in determining pricing and policy changes for services without triggering across-the-board cuts.

Alternative Payment Models (APMs)

Since the Advanced APM pathway was introduced under the Medicare Access and Chip Reauthorization Act (MACRA), it has been primarily geared towards primary care with limited participation options for specialists. The physician community has devoted significant effort into developing well-designed APM proposals consistent with the goals of MACRA. Unfortunately, seven years after passage of MACRA, most specialists are unable to participate in an APM designed for the patients they treat, nor are they equipped to accept downside risk.

To facilitate specialist participation in Advanced APMs, CMS, through the Center for Medicare and Medicaid Innovation (CMMI) should test and approve Advanced APMs that have been endorsed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). STS in conjunction with the American College of Surgeons (ACS) submitted an APM which was never brought forward to CMMI for testing. Without the introduction of new models that are designed and tested by specialists, our members are continuously denied the opportunity to participate in Advanced APMs and will be forced into MIPS reporting.

In the Federal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) proposed rule that was recently released, CMS proposed mandatory participation in a new value-based payment model Transforming Episode Accountability Model (TEAM). STS appreciates that CMMI has developed this new model which aims to align financial incentives while improving care coordination at the hospital level. We also appreciate that this model is focused on specialty medicine, where limited APM options exist

under the Quality Payment Program (QPP) (i.e., Advanced APMs). **While we do have concerns about the roll out and mandatory nature of TEAM, we believe that clinicians required to participate in this model, or any other hospital level model, should also receive credit at the individual level through Advanced APM status.**

Additionally, as CMS continues to move towards value-based payments, **STS believes it is pivotal that accommodations are made for first time participants to help ensure a broader and more diverse array of participants.** This is especially necessary for smaller, rural, or safety-net hospitals. In a study of hospitals that participated in the Bundled Payments for Care Improvement (BPCI) Advanced model, 44.6% of participants dropped out of at least one bundle. These hospitals were more often for-profit, smaller, and located in areas of lower supply of skilled nursing and inpatient rehabilitation centers.¹ It is clear from lessons learned in previous models that CMS should incorporate into their models a method to account for the investment and infrastructure start-up costs associated with transitioning to an APM. Outside of some provisions for safety-net hospitals, CMS fails to appropriately and broadly account for these investment resources needed to redesign care delivery to align with the incentives of a model.

Merit-based Incentive Payment System (MIPS) Reform

Since its beginning in 2017, participation in MIPS has shown to be burdensome and costly for providers. Data demonstrate that compliance with MIPS costs \$12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks.² Part of this issue is that the four performance categories in MIPS are siloed and require additional resources to report. The cost category presents further challenges as physicians have little control or input in how their scores are calculated and no real mechanism to dispute any misallocations that may arise. Instead of multiple categories and measures that do not align, more emphasis should be placed on the value of clinical data registries that measure quality using clinically relevant metrics. It should be recognized that physicians who report quality measures via clinical data registries meet, or at a minimum contribute, to the quality, promoting interoperability, and improvement activity MIPS categories.

The measures contained in the STS National Database are National Quality Forum (NQF)-endorsed and were developed specifically for cardiothoracic surgeons by cardiothoracic surgeons to measure relevant and necessary clinical data for the purpose of quality improvement. However, many measures in the STS National Database are largely not included in CMS quality reporting programs due to the requirements needed to fit the CMS models. For example, while CMS uses percentage rates to compare performance, the STS National Database uses a composite quality rating system to illustrate performance. The composite rating system adjusts for both performance rate and the corresponding confidence intervals to give a more accurate representation of performance. It also allows for a more holistic view of quality and performance by measuring a combination of procedures and outcomes. **Instead of CMS performing calculations on MIPS measures, they should rely on clinical data registries to provide their own**

¹ Joynt Maddox KE, Orav EJ, Zheng J, Epstein AM. Characteristics of Hospitals That Did and Did Not Join the Bundled Payments for Care Improvement–Advanced Program. *JAMA*. 2019;322(4):362–364. doi:10.1001/jama.2019.7992

² Bond AM, Schpero WL, Casalino LP, Zhang M, Khullar D. Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes. *JAMA*. 2022;328(21):2136–2146. doi:10.1001/jama.2022.20619

measures with more sophisticated statistical analyses, or alternative methods of representing performance measurement data. By doing this, CMS will have access to data more reflective of the differentiation of performance between providers and more relevant quality measurement.

Additionally, facilities and providers are already collecting this data for performance improvement purposes. The STS National Database alone contains more than 9 million cardiac surgery procedure records and has more than 3,800 participating physicians, including surgeons and anesthesiologists, representing more than 95% of all adult cardiac surgery hospitals across the United States. By not tapping into this resource, CMS is missing out on the most relevant, useful data for cardiac and thoracic surgery while doubling provider reporting burden.

RVU Integrity

Two of the main factors that contribute to determining the physician work RVU are time and intensity. Time is an objective measure while intensity tends to be more subjective and can vary within and across specialties. The American Medical Association RVS Update Committee (RUC) utilizes standardized surveys to gather data from practicing physicians across the United States which provides a uniform methodology to obtain data across specialties.

One way to enhance RVU development is to prioritize real-world time data over surveyed time data, when available. Establishing criteria to certify real-world time data as reliable and accurate is essential. Once qualified, this data should be the primary source for valuing physician work. Currently, the RUC and CMS use real-world time data only in a secondary capacity, giving precedence to survey data. By not using real-world data as the primary source, CMS is missing out on a more accurate and scientific approach to valuing physician work.

Real-world sources of time could include data from established clinical data registries, hospital operating room time logs, and/or electronic medical records to name a few. CMS must ensure consistency in measurement across all sources. For example, clinical data registries, such as the STS National Databases, require that the skin incision time and skin closure time be captured for each procedure. This differs from associated anesthesia time, which includes time prior to the skin incision and after skin closure for the same procedure. Anesthesia times include time spent from the induction of anesthesia through getting the patient to the recovery room.

Calculating intensity is more complicated than time, and often the physicians performing the procedures need to establish this measure within and across the fee schedule. While the AMA RUC does take this into account in its deliberations, it may be helpful to review different methodologies to establish more reliable factors when considering valuation.

CMS regularly ignores or overlooks the role of intensity in valuing procedures, often relying more on changes in time to determine changes in value to procedures. Decreases in the time it takes to perform a procedure do not solely justify decreases in reimbursement for a code. There are many factors that can result in an overall decrease in time that does not equate to a decrease in the complexity or intensity of a procedure. Technological advances, physician experience, and other factors can result in time savings without impacting the complexity of the procedure. Not only does it stay constant, but at times the intensity increases because the complexity of the patient population has changed. For example, many patients that require open surgical interventions may be older, have more comorbidities and/or have had multiple less invasive interventions prior to the surgical procedure. It is important that

both CMS and the RUC consider all these aspects in their evaluation of new, revised and potentially misvalued procedures. CMS is present for the RUC deliberations and when they disagree with the RUC recommendations, they are not required to provide rationale for their decisions. **CMS needs to provide transparency into the rationale and methodologies used when recommending decreases in values.**

Additionally, when CMS does disagree with recommended values for a procedure, the specialty societies and/or interested parties have no recourse to appeal the decisions. When CMS previously used Refinement Panels, stakeholders would often find that the Refinement Panel largely agreed with the RUC recommended values, only to have CMS disregard this finding without a transparent justification. There should be a pathway to appeal CMS determinations, such as the use of Refinement Panels, but any appeal process must have more authority than in the past.

It may be reasonable to have a third-party entity review the practices and methodologies of the RUC to identify areas for improvements and to lend credibility to their important work. If employed, the third party should be unbiased, meaning it is an entity not commonly employed or influenced by either the AMA or CMS. Key areas that could be examined by third-party entities might include some of the following:

- Review of the RUC survey process to ensure that it meets universally recognized survey and statistical standards;
- Review or development of criteria that would certify real-world time data used in lieu of survey data when available and recognized by both the RUC and CMS;
- Development of alternative methodologies to measure procedural intensity and complexity;
- Recommending an updated approach to the Refinement Panel system of appeals;
- Review and standardization of alternative methodologies to value a service when survey data is insufficient for a procedure; and
- Review of education and outreach materials that specialty societies utilize with their members to improve the rate and quality of survey responses.

Telehealth

Data collected during COVID-19 demonstrates the positive impact telehealth has had on both patient clinical outcomes and patient experiences. A study by the National Institutes of Health (NIH) found telemedicine to be beneficial in both acute care and chronic disease management. Results from the study suggest that it is equivalent to in-person care for health outcomes in certain conditions and may also decrease short-term hospital and emergency department utilization. Additionally, research shows that the use of telehealth provides access to care despite geographic barriers, reduces burden on medical infrastructure, and lessens exposure to infectious diseases for all participants. Advances in technology and the advent of more sophisticated equipment has increased the extent of patient monitoring via telemedicine and has resulted in increased physician and patient satisfaction. Enacting permanent telehealth policy will help provide more predictability and help foster greater investment into this critical tool.

Currently, many essential Medicare telehealth flexibilities are set to expire on December 31, 2024. The **STS appreciates the Committee's strong commitment and supports its ongoing efforts to enact a**

permanent extension of these flexibilities. This is essential to ensure that patients can maintain a stable relationship with their health care provider, especially in rural and underserved communities.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer C. Romano". The signature is fluid and cursive, with the first name being the most prominent.

Jennifer C. Romano, MD, MS
President