



September 9, 2024

Chiquita Brooks-LaSure, MPP  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1807-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P)

Dear Administrator Brooks-LaSure:

On behalf of the over 90,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule published in the *Federal Register* on July 31, 2024.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of our members' performance is measured and paid for under the provisions of this rule, the ACS has a vested interest in the MPFS and Quality Payment Program (QPP). With our more than 100-year history in developing policy recommendations to optimize the delivery of surgical services, lower costs, improve program integrity, and make the U.S. healthcare system more effective and accessible, we believe that we can offer insight to the Agency's proposed changes to the MPFS and QPP. Our comments below are presented in the order in which they appear in the rule.

## **PROVISIONS OF THE PROPOSED RULE FOR THE MPFS**

### **Determination of Practice Expense (PE) Relative Value Units (RVUs)**

#### ***Adjusting RVUs To Match PE Share of the Medicare Economic Index (MEI)***

The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practice costs. The MEI measures changes in the prices of resources used in medical practices, such as labor (both physician and non-physician), office space, and supplies. These resources are grouped into cost categories, and each

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cost category is assigned a weight (indicating the relative importance of that category) and a price proxy (or proxies) that CMS uses to measure changes in the price of the resources over time. The MEI also includes an adjustment to account for improvements in the productivity of practices over time.

From 1975, when payments reflected the usual, customary, and reasonable charge payment methodology, through 1993, the year after implementation of the Resource Based Relative Value Scale (RBRVS), the physician earning component was 60 percent and the PE component, including professional liability insurance (PLI) costs, was 40 percent. These initial weights were derived from data obtained from the American Medical Association (AMA). In 1993, the MEI components were updated using AMA data and then proportioned to 54.2 percent physician work, 41 percent PE, and 4.8 percent PLI. Currently, the allocation is 50.9 percent physician work, 44.8 percent PE, and 4.3 percent PLI. In the CY 2023 MPFS, CMS finalized a policy to rebase and revise the MEI to reflect more current market conditions faced by physicians in furnishing services. As part of this policy, CMS sought to dramatically shift payment allocation away from physician earnings (work) to PE—47.3 percent physician work, 51.3 percent PE, and 1.4 percent PLI—using non-AMA data from 2017. The current MEI weights are based on data obtained from the AMA Physician Practice Information (PPI) survey. This survey was last conducted in 2007/2008 and collected 2006 data. Changes in MEI weights over time are shown in the table below.

**Table 1: MEI Cost Weight Changes**

MEI Components	1975-1992	1993	Pre-MEI Rebase	Post-MEI Rebase
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(included w/ PE)	4.8%	4.3%	1.4%

Despite finalizing the rebasing and revising of the MEI, CMS has delayed implementation of using 2017-based MEI cost weights for CY 2025 rate setting, both in light of the AMA’s current PPI data collection efforts and because the methodological and data source changes to the MEI would have significant impacts on MPFS payments.

The ACS acknowledges that the data currently utilized for the MEI are outdated, and we understand the need for consistent and timely updates to practice cost data. **However, we are extremely concerned that CMS’ proposal to update MEI weights under a budget neutral paradigm will create significant disruptions to physician payment, as such a drastic increase to the MEI PE component will in turn devalue physician work. We support the Agency’s proposed delay to MEI updates for CY 2025 and believe such updates should continue to be postponed until data from the AMA’s PPI survey are made available to CMS to inform MEI changes.** In the future, all significant data updates (e.g., PPI survey results, supply and equipment pricing, and clinical labor pricing) should occur simultaneously and should be phased in to avoid abrupt impacts to individual services and specialties.

**Valuation of Specific Codes**

***Intra-Abdominal Tumor Excision or Destruction (CPT codes 4X015, 4X016, 4X017, 4X018, and 4X019)***

In May 2023, the CPT Editorial Panel created five new codes—CPT codes 4X015-4X019—to describe

the sum of the maximum length of intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s) excised or destroyed. These new CPT codes will replace existing CPT codes that described tumor excision or destruction based on the size of the single largest tumor, cyst, or endometrioma removed, no matter the number of tumors. CMS proposes the Relative Value Scale (RVS) Update Committee (RUC)-recommended work RVUs of 22.00 for CPT code 4X015, 28.65 for CPT code 4X016, and 34.00 for CPT code 4X017. **We agree with CMS’ decision to accept the RUC work RVU recommendations for these three codes.**

**4X018 and 4X019**

The Agency disagrees with the RUC-recommended survey median work RVUs for CPT codes 4X018 and 4X019 and instead proposes work RVUs based on the survey 25<sup>th</sup> percentile, as shown in the table below.

**Table 2: 4X018 and 4X019 Proposed Work RVUs**

CPT Code	Descriptor	RUC-Recommended wRVU	CMS Proposed wRVU
4X018	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm	45.00	40.00
4X019	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm	55.00	50.00

CMS states that, in comparison to deleted predecessor CPT code 49205, a total time ratio would suggest that the RUC-recommended median survey percentile work RVUs for CPT codes 4X018 and 4X019 are inappropriately high and should fall closer to the survey 25<sup>th</sup> percentile work RVUs. **We disagree with this comparison, as it fails to recognize the increased intensity and complexity of removing significant tumor burden (i.e., not just a single tumor) as represented by new CPT codes 4X018 and 4X019 relative to that associated with CPT code 49205 prior to its deletion.** As described in the summary of recommendation forms sent to CMS, the submitted compelling evidence indicated both the patient population and technology associated with the procedures described by CPT codes 4X018 and 4X019 has changed since the establishment of CPT code 99205 for work related to removal of a single tumor, cyst, or endometrioma greater than 10.0 centimeters in diameter. This new family of codes (CPT codes 4X015-4X019) removes endometrioma from the code descriptors and reflects the more complex work of cytoreductive surgery that reduces tumor burden, which has improved the prognosis of patients with peritoneal surface malignancies since the creation of the previous code family (CPT codes 49203-49205). The 4X015-4X019 code set represents more intense and complex time and work than was previously considered when CPT codes 49203-49205 were reviewed. When CPT code 49205 was created, the work described by these new codes was not possible and lives were lost that can now be saved, marking a positive and impactful advancement in the fight against cancer.

- **4X018 Reference Codes:** CMS references CPT code 69970 (*Removal of tumor, temporal bone*) to support its proposed value for CPT code 4X018 based on intra-service time and total time alone. **We disagree that this is an appropriate reference.** CPT code 69970 was valued 30 years ago, and it is not clear how the value for this low volume service was established at that time. Although CPT codes 4X108 and 69970 may both describe removal of tumors, CPT code 4X018 describes removal of multiple primary and secondary tumors with a total burden of 20.1 to 30 centimeters, which the

reference code does not include. CPT code 4X018 involves the removal of tumors not visible on preoperative imaging from critical structures (e.g., bowel, vessels, ureter) along with the dissection/removal of large tumors from critical structures (e.g., vena cava, aorta), all of which increase both the technical challenge of the operation and the degree of risk and potential for postoperative complications (e.g., fistulae, bleeding, thrombosis). The procedure described by CPT code 4X018 is significantly different than the removal of one tumor from a solitary structure with less postoperative risk.

CMS also references CPT code 33864 (*Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (e.g., David Procedure, Yacoub Procedure)*) to support its proposed value for CPT code 4X018. **We agree that this is an appropriate reference, as it supports a median work RVU of 45.00 for CPT code 4X018 given the higher work RVU and relative intensity/complexity of CPT code 33864.** While the anatomy of the heart is extraordinarily complex, CPT code 4X018 requires assessment and interpretation of the anatomy of multiple types of tissue and organs throughout the abdominal cavity to reduce postoperative complications.

As shown in the table below, the data for all codes reviewed in the past 15 years with a 90-day global surgical period and an intra-time of 300 to 320 minutes further indicate that the median work RVU of 45.00 is an accurate relative value for CPT code 4X018 when compared to other codes that describe significantly complex and intense work.

**Table 3: Comparison of 4X018 to Other 90-Day Global Codes**

RUC Year	CPT Code	Long Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	IM-POST	HV	OV
	<b>4X018</b>	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm	<b>45.00 (median)</b>	0.091	<b>814</b>	80	<b>310</b>	30	7	4
2016	<b>43286</b>	Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)	<b>55.00</b>	0.106	<b>957</b>	100	<b>300</b>	60	9	4
2018	<b>33863</b>	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	<b>58.79</b>	0.126	<b>838</b>	90	<b>300</b>	60	7	1
2010	<b>33412</b>	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	<b>59.00</b>	0.122	<b>866</b>	63	<b>300</b>	60	8	1
2009	<b>33782</b>	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation	<b>60.08</b>	0.126	<b>866</b>	63	<b>300</b>	60	8	1
2018	<b>33864</b>	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	<b>60.08</b>	0.130	<b>838</b>	90	<b>300</b>	60	7	1
2018	<b>33858</b>	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection	<b>63.40</b>	0.124	<b>911</b>	70	<b>300</b>	60	8	2

RUC Year	CPT Code	Long Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	IM-POST	HV	OV
2010	33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	64.00	0.124	986	63	300	60	14	1
2018	33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	64.00	0.125	998	95	300	60	11	1
2010	32852	Lung transplant, single; with cardiopulmonary bypass	65.50	0.084	1320	140	300	90	14	2

- 4X019 Reference Codes:** CMS references CPT code 69970 (*Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus*) to support its proposed value for CPT code 4X019 based on intra-service time and total time alone. **We disagree that this is an appropriate reference.** CPT code 69970 was valued 30 years ago, and it is not clear how the value for this low volume service was established at that time. CMS also references CPT code 47140 (*Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)*) to support its proposed value for CPT code 4X018. **We agree that this is an appropriate reference, as it supports a median work RVU of 55.00 for CPT code 4X019.** However, both reference codes involve just one organ and tissue type in single anatomical location in contrast to CPT code 4X019, which involves multiple organs and tissue types—we wish to emphasize that the technical difficulty of a procedure increases as the tumor size or bulk of tumor burden increases.

As shown in the table below, the data for all codes reviewed in the past 15 years with a 90-day global surgical period, an intra-time of 360 minutes, and total time above 900 minutes further indicate that the median work RVU of 55.00 is an accurate relative value for CPT code 4X019 when compared to other codes that describe significantly complex and intense work.

**Table 4: Comparison of 4X019 to Other 90-Day Global Codes**

RUC Year	CPT Code	Long Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	IM-POST	HV	OV
	4X019	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm	55.00 (median)	0.089	1,046	90	360	40	9	4
2016	43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy or tri-incisional esophagectomy)	62.00	0.093	1,097	105	360	45	11	4
2016	43287	Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle	63.00	0.097	1,097	110	360	60	10	4

RUC Year	CPT Code	Long Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	IM-POST	HV	OV
		and upper mediastinal esophagus and thoracic esophagogastrectomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)								
2009	<b>33783</b>	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	<b>65.08</b>	0.119	<b>926</b>	63	<b>360</b>	60	8	1
2010	<b>33916</b>	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass	<b>78.00</b>	0.112	<b>1,259</b>	63	<b>360</b>	60	15	2

As tumor size increases, the clinical judgement and medical decision making regarding the surrounding anatomy and relative fluid shift contribute to the complexity and length of the surgery—these also impact the postoperative period and potential for adverse events. For example:

- During the procedure described by CPT code 4X018, the operating surgeon resects a tumor of 28 centimeters in size from the retroperitoneum and additionally inspects the entire abdomen for all macroscopic peritoneal, mesenteric, and/or retroperitoneal primary or secondary tumor(s) and/or cyst(s). Every surface requires inspection when performing cytoreduction surgery. There is a significantly heightened risk of injury to all structures that are assessed or dissected during removal of a large retroperitoneal mass, thereby increasing the intensity of the patient’s hospital stay and postoperative clinic visits to evaluate and manage possible postoperative sequelae.
- During the procedure described by CPT code 4X019, the operating surgeon performs retroperitoneal exploration followed by the cytoreduction of all macroscopic tumor deposits on parietal, omental, and peritoneal surfaces. Resection of multiple surface nodules of the omentum, visceral, and mesenteric surfaces will typically be required. Mobilization of the surrounding organ(s) may occur, and peritoneum is resected from both diaphragms. Additionally, resection of the small lesions and multiple surface nodules of the omentum, visceral, and peritoneal surfaces will typically be required. Multiple organs and tissue types are taken into consideration during the dissection of these tumors—this includes monitoring for complications related to each tissue type along with fluid shifts from the tissue manipulation and length of the procedure. Such work increases postoperative management intensity, length of stay, and multiple outpatient visits to monitor healing.

**Given the change in work, complexity, and intensity of these procedures, the ACS opposes CMS’ proposed values for CPT codes 4X018 and 4X019. We urge the Agency to consider the information presented above and finalize the median work RVUs of 45.00 for CPT code 4X018 and 55.00 for 4X019 to maintain relativity within this family of codes and within the MPFS at large.**

***Hyperthermic Intraperitoneal Chemotherapy (CPT codes 96547 and 96548)***

In September 2022, the CPT Editorial Panel created two time-based add-on Category I codes—CPT code 96547 (*Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)*) and CPT code 96548 (*Intraoperative hyperthermic intraperitoneal*

*chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)*—to report HIPEC procedures for 2024. At the January 2023 RUC meeting, the RUC concluded that the survey data was flawed due to a lack of work definition and guidelines, and therefore recommended contractor pricing for CPT codes 96547 and 96548, which CMS finalized for CY 2024.

At the May 2023 CPT Editorial Panel meeting, new guidelines and descriptions of work activities were approved and the codes were resurveyed for the September 2023 RUC meeting with recommendations for national pricing. Based on this information, CMS proposes the RUC-recommended work RVUs of 6.53 for CPT code 96547 and 3.00 for CPT code 96548. **We agree with CMS’ decision to accept the RUC work RVU recommendations for these two codes.**

### **Enhanced Care Management**

#### ***Advanced Primary Care Management (APCM) Services (Healthcare Common Procedure Coding System [HCPCS] Codes GPCM1, GPCM2, and GPCM3)***

CMS proposes to establish and pay for three new G-codes that describe a set of care management services and communication technology-based services (CTBS) furnished under a broader application of advanced primary care that aim to encompass a greater range of services and simplify the billing and documentation requirements as compared to existing care management and CTBS codes.

**Given the lack of strict guidelines for billing GPCM1-GPCM3, which CMS believes a practitioner will bill “for all or nearly all the patients for whom they intend to assume responsibility for primary care,” we are extremely concerned that these codes are not evidence-based and may result in unnecessary out-of-pocket costs for patients for services that do not improve their care and that they are unaware are being furnished.** We request that CMS provide data proving that the current chronic care management codes have led to any significant change in healthcare quality and patient outcomes. In the absence of such data in addition to the ambiguity of the goals of this proposal, we urge the Agency to develop specific metrics to evaluate the perceived benefits of APCM services—we note that while there are 10 service elements associated with GPCM1-GPCM3 (a number of which overlap with existing chronic care management (CCM) and principal care management (PCM) services), none of these elements are required to be furnished during the provision of these G-codes.

Furthermore, we believe that complexity of care is the equivalent across all disciplines of medicine, yet, while the Agency continues to establish new—and often duplicative—HCPCS Level 1 and 2 codes for certain specialties (e.g., primary care) to pay for various care management services (e.g., PCM, CCM, transitional care management, psychiatric collaborative care management, behavioral health care management, general care management), CMS does not apply this same logic for proceduralists. **We remain disconcerted both by the Agency’s ongoing efforts to establish service-based payment outside of the impartial CPT/RUC process and by its failure to similarly create additional coding and reimbursement mechanisms to account for the extra intraoperative and postoperative complexity, intensity, and work related to the same patients prior to, during, and after an operation.**

#### ***Strategies for Improving Global Surgery Payment Accuracy***

CMS continues to express concern about whether the valuation of global surgical packages is consistent with the number and level of postoperative visits that are actually provided. To gather additional data on

postoperative visits, CMS (1) proposes changes to the existing policies for reporting transfer of care modifiers, and (2) proposes the addition of an add-on code for resources involved if practitioners who do not furnish the surgical procedure provide postoperative care during a 90-day global period. The Agency believes that these proposed reporting changes would make meaningful progress toward more accurate payment for global codes and improve relative valuation for MPFS services overall. CMS states that part of the rationale for these changes is that it seeks data on visits provided to a patient after having a procedure that is billed within a global period. We understand that collecting large quantities of data on postoperative visits that surgeons provide is difficult because practices do not bill for postoperative visits delivered during the global period. We also recognize that other reliable data sources have been elusive to both CMS and specialty societies.

CMS previously contracted with RAND to develop a process for data collection and to analyze the data; however, the RAND process was poorly structured, difficult for practices to operationalize, and the analyses relied on flawed and incomplete data that were not validated. These analyses showed less than expected follow up care but were flawed because claims for the nonpayment code (CPT 99024) were likely scrubbed by coders or claims processing services without the surgeon's knowledge. CMS did not audit providers' medical records to determine if postoperative visits actually occurred. **We strongly oppose the recommendations in the RAND reports that suggest the Agency should make across-the-board changes to global code payments based on incomplete and unvalidated data. Any changes to the values of global codes should be criteria-based and procedure-specific.**

Instead of concentrating on the postoperative visits provided by the surgeon, CMS is seeking data on visits provided by practitioners other than the practitioner who performed the surgery by expanding the transfer of care modifiers and by introducing a new add-on code, GPOC1, to be reported with an evaluation and management service (E/M) for postoperative follow up care. While theoretically these policies could generate some data about practitioners if they are providing E/M services to patients who are in a global period after a surgery, they will not result in data on the number of postoperative visits provided by the operating surgeon, nor confirm that the other practitioner was providing care related to the surgery. **Because these proposed policies will not produce data on the visits that surgeons provide postoperatively, they will not result in complete and actionable postoperative visit data and will therefore not be a step toward improving the accuracy of global code values.**

**We assert that surgeons are most often providing postoperative care to surgical patients.** Even in cases where the postoperative care is transferred, it is most often transferred to another surgeon. For example, if a surgeon in a small rural hospital with no intensive care unit (ICU) were to care for a trauma patient or a patient with a perforated colon, the patient could be stabilized and then transferred to a higher-level facility. In this example, the care would be transferred from one surgeon to another.

We reiterate our statements from our prior comment letters that we believe RUC-reviewed postoperative work for global surgical services has been appropriately surveyed, vetted, and valued using magnitude estimation of total work. **We support the RUC's deliberative process for evaluating codes based on the Harvard study protocol to establish work RVUs.** As a peer review group, all medical and surgical specialties participate and judge the data as presented. Those data are subjected to inspection, review, and deliberation before the RUC makes recommendations for valuation. To the extent CMS has a concern with the valuation of a particular service, the RUC's deliberative process exists to address that just as it does when there are concerns about the valuation of other services.



**The proposed expansion of the use of the transfer of care modifiers and the proposed add-on code GPOC1 will not result in any meaningful information about the care that surgeons are providing in the postoperative portion of the global period, and therefore will not generate accurate, complete, and actionable data for improving the accuracy of global code values.**

### Transfer of Care Modifiers

Under CMS' current transfer of care policy, the surgeon and one or more practitioners (who are not in the same group practice as the surgeon) formally document their agreement to provide distinct portions of the global package. Transfer of care modifiers must be appended to the global code(s) by both the operating surgeon and the provider taking over some or all the postoperative work within the scope of the global package. Postoperative work that is unrelated to the surgery does not apply to the transfer of care policy. The following Category I CPT modifiers for transfer of care describe different portions of the global surgical package that could be provided by a different practitioner(s):

- Modifier -54 Surgical Care Only
- Modifier -55 Postoperative Management Only
- Modifier -56 Pre-operative Management Only

CMS proposes to require the use of appropriate CPT modifiers for transfer of care for all 90-day global surgical codes when a practitioner plans to furnish only a portion of the global package (including but not limited to when there is a formal, documented transfer of care as under current policy, or an *informal, non-documented but expected*, transfer of care). CMS states that this policy would prevent duplicative Medicare payment for postoperative care because the global surgical package payment would be adjusted based on the appended modifier, and payment for postoperative care would not be made both as part of a global surgical package and through separately billed E/M codes.

### *The focus should be on true transfers*

CMS proposes to expand the use of transfer of care modifiers from a formal transfer to any perceived transfer, including transfers that are “non-documented but expected.” We request clarification on the kinds of transfers that fall into this category—specifically, those that are *expected* yet not *formalized*. We do not consider data related to any type of transfer other than a formal transfer to be valid for the purposes of adjusting payments and, eventually, as CMS suggests, the revaluation of global codes. In instances where a surgeon knows they will only provide surgical care and not provide postoperative care, these patients should be formally transferred to another surgeon. If a transfer is expected, but the surgeon does not know which surgeon the care will be transferred to, modifier -54 should be appended. While CMS could consider audit activities if corresponding modifiers -54 and -55 are not reported, the claims data itself provides CMS with no general information about the values or the postoperative visits of the codes to which the modifiers were appended. **These** modifiers only tell CMS what happened in **that** single case. Cases where surgeons report modifier -54s with no corresponding modifier -55s, and vice versa, are not relevant for data collection nor as a source of information for general revaluation of services in the fee schedule.

CMS should also stress that modifier -55 may only be reported if another practitioner (typically a surgeon) is truly taking over postoperative care. It should not be reported if, for example, a primary care provider sees a patient in the postoperative period for diabetes and incidentally examines the surgical site simply because the patient is already in their office. This would not count as a transfer, let alone a

surgery-related visit, since the visit was for diabetes management. Further, we are also concerned there could be circumstances where a practitioner other than the surgeon reports modifier -55, yet the surgeon is in fact providing the postoperative visits. Without a formal transfer and accompanying communication, this policy could create tension between the surgeon and the other practitioner if there is no agreement about whether a transfer has occurred or to whom the care is being transferred. Because surgeons are not required to report postoperative visits, there would be no way to know whether the surgeons are providing postoperative visits, and it should not be assumed that surgeons are *not* doing this work simply because another practitioner reports a modifier -55. Absent a formal transfer of care and clear communication, there could also be circumstances where more than one practitioner reports modifier -55. If one of CMS' goals with this policy is to prevent duplicative payment, CMS should be certain that the care has in fact been transferred and that the care is related to the surgery. **To avoid this confusion, CMS should only consider data on formal transfers, not cases where more than one practitioner (either the surgeon and another practitioner, or multiple other practitioners) consider themselves to be performing the postoperative care.**

CMS also fails to address that this proposed policy could create scenarios that could **increase** the utilization of modifier -55 with no corresponding increase in the utilization of modifier -54 because the “informal, undocumented transfer of care” was not “expected” at the time of the surgery when the claim was submitted. The current policy is a closed loop through which the surgeon performing the procedure knows that they have transferred the care to another provider and the physician accepting the transfer has all the necessary information to care for the patient (and to appropriately bill modifier -55). CMS is instead introducing a policy that will result in even less informative claims data than already exists.

### *Components of global codes*

As CMS further develops its payment policies for global packages, the Agency requested comments on how best to determine the appropriate payment proportions for the three portions of the global package (pre-operative services, the surgical procedure itself, and postoperative care). These policies impact payment to the different practitioners who furnish the different portions of the service. CMS seeks to identify a procedure-specific, data-driven method for assigning shares to portions of the global package payment to more appropriately reflect the resources involved in each portion. CMS anticipates revising the payment allocations through future rulemaking.

The ACS has always shared CMS' goal of ensuring that services paid under the MPFS are appropriately valued. This extends to the allocations for global packages. However, it is completely inappropriate for CMS to request addressing the allocation of values to the pre-procedure, the procedure, and post-procedure work when it broke with its own precedent and failed to provide the commensurate update to the global surgical packages for the revised office and outpatient E/Ms in CY 2021 and further, the changes to the inpatient/observation E/Ms and discharge management codes in CY 2023. **If CMS is interested in payment accuracy and ensuring the relativity of services in the fee schedule, the first step it should take is to finalize the updated global surgical package values based on the E/M code increases that the Agency approved to account for the increased intensity and complexity of patients that all providers serve.**

In addition, although CMS seeks to identify a procedure-specific, data-driven method for assigning shares to portions of the global package payment to more appropriately reflect the resources involved in each portion, this cannot be performed in a formulaic fashion. The current component percentages published in the MPFS were developed using magnitude estimation and cross specialty scaling. **We do**

**not believe that any reverse engineering of work and time can be performed to develop a better percentage of pre-, intra- and postoperative work than what is currently published in the MPFS.**

**The proposed expansion of the use of the transfer of care modifiers to report informal, non-documented but expected transfers of care is poorly defined, making its value uncertain and, to the extent it drives changes in claims data if finalized, will not result in accurate, complete, and actionable data.**

#### Postoperative Care Services Add-on Code

CMS believes there are instances where postoperative care is not furnished by the surgeon or other practitioner in the same group practice as the surgeon, or even by a practitioner who is in the same specialty as the surgeon, despite there being no formal transfer of care. For example, CMS states in this rule that the surgeon could direct the patient to follow up with other practitioners as needed, such as with the patient’s primary care provider, instead of providing postoperative care themselves. In addition, CMS states that the patient could also independently choose to follow up with their primary care provider or another practitioner based on other considerations such as convenience of the practice location or ease of scheduling. CMS acknowledged that the patient could choose to see another practitioner without the knowledge of the surgeon who performed the procedure. CMS believes there is an extra level of complexity involved when a practitioner sees a patient for postoperative follow-up after a surgical procedure performed by another practitioner. As such, CMS believes there are comparatively more resource costs incurred when a practitioner who did not furnish the surgical procedure in a global package provides follow-up care.

CMS proposes a new add-on code, GPOC1, to be reported with an office/outpatient E/M visit for postoperative follow up care during the 90-day postoperative period. The new code would be billed by a practitioner who furnishes the postoperative office/outpatient E/M visits when that practitioner is not the surgeon and is not in the same specialty or group practice as the surgeon. CMS states that documentation in the medical record must justify use of the add-on code and show that the E/M visit was related to a postoperative visit furnished during the 90-day postoperative period. CMS believes that instituting an add-on code to capture the time and intensity of postoperative work absent a formal transfer of care would be an essential step in recognizing how the services are currently furnished and make progress toward “right-sizing” the structure of global packages.

CMS proposes the following descriptor for this add-on code:

*GPOC1 (Postoperative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 090-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:*

- *Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient’s operation.*
- *Research the procedure to determine expected postoperative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).*

- *Evaluate and physically examine the patient to determine whether the postoperative course is progressing appropriately.*
- *Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established).*

#### *Lack of adequate billing instructions/guidance and additional payment*

We stress that, in most cases, surgeons provide postoperative care to their own patients. Surgeons do not abandon patients in the postoperative period and, if necessary, transfer the care to another surgeon. Patients are, however, often in the non-surgical care of non-surgeons, even while the patient is still in a global period. The vague description of GPOC1 fails to clearly distinguish between a *surgical postoperative visit* and a visit that is *unrelated* to the surgery. CMS does not define “post-operative follow-up visit” or “addressing [the] surgical procedure(s)” to inform whether the care that is provided by a practitioner other than the surgeon who performed the surgery is related to the surgery. For example, if a patient sees a primary care physician after an operation, the primary care physician should not report GPOC1 if they incidentally assess the surgical site wound. If a patient were to see their endocrinologist for labs and medication adjustment after a thyroidectomy, the endocrinologist should not report GPOC1. There are innumerable situations in which patients see other physicians for care after surgery but *not* for postoperative follow-up care. CMS also states that there are circumstances where a surgeon might not know that another practitioner is providing care in the postoperative period. If both the surgeon and another practitioner are providing postoperative care without a formal transfer of care, CMS is already paying for duplicative postoperative visits. **The lack of clarity for these and other situations demonstrates that this add-on code is poorly conceived and could result in duplicative payment.**

#### *Unreliable data*

We understand that CMS has proposed this policy to collect data on which practitioners are providing postoperative care in the global period. While it is possible that CMS could gather some information on visits provided by physicians other than the surgeon while a patient is in a postoperative global period, **we consider it impossible that CMS will gather complete, valid, reliable, and actionable data via this add-on code that could be appropriate for revaluing global codes.** Similar to our comments on the transfer of care modifiers above, we question the validity of data on visits provided by a practitioner other than the one performing the surgery without a formal transfer of care. If a surgeon instructs a patient to see another practitioner for postoperative care, that should be documented as a formal transfer.

#### *Liability*

CMS does not address the important issue of liability as it relates to reporting of GPOC1. We understand that CMS’ overarching goal is to gain a better understanding of which practitioners are providing postoperative care. However, by billing GPOC1, a practitioner who did not provide the surgery and who is, by definition, unfamiliar with the surgery and requires additional resources to learn about the procedure and all the possible postoperative complications to monitor and address, is also then taking on the liability for the postoperative care and post-surgical outcomes. A provider who performs a surgical procedure would likely provide postoperative care for their patients. **In cases where an uninformed practitioner in a different group were to claim to take over this care, at times without the knowledge of the surgeon, they must be held accountable for the risk as well.**

Therefore, given the ambiguity of add-on code GPOC1, the potential for misuse of the code, the issues related to liability that are unaccounted for, and the inability of the code to provide **any** meaningful information to CMS about the care that surgeons are providing to their patients in the postoperative portion of the global period at all (let alone for potentially valuing global periods), ***the ACS opposes the CMS implementation of GPOC1.***

### **REQUEST FOR INFORMATION (RFI): BUILDING UPON THE MIPS VALUE PATHWAYS (MVPS) FRAMEWORK TO IMPROVE AMBULATORY SPECIALTY CARE**

CMS is considering the development of an ambulatory payment model aimed at increasing the engagement of specialists in value-based payment with a focus on specialty care provider engagement with primary care providers and beneficiaries. The model would leverage the Merit-based Incentive Payment System (MIPS) Value Pathways, or MVP framework. As currently envisioned, participants under this model would not receive a MIPS payment adjustment. Instead, they would receive a payment adjustment based on (1) a set of clinically relevant MVP measures that they are required to report and (2) a comparison of the participant's final score against a limited pool of clinicians (model participants of their same specialty type and clinical profile, who are also required to report on those same clinically relevant MVP measures). The Agency describes various reasons it believes using MVPs will offer a more targeted approach to measurement. The Innovation Center is requesting feedback on the design of a future ambulatory specialty model, specifically on the following—

- Participant definition;
- MVP performance assessment;
- Payment methodology;
- Care delivery and incentives for partnerships with accountable care entities and integration with primary care;
- Health information and data sharing;
- Health equity; and
- Multi-payer alignment.

**The College strongly opposes MVPs or any MIPS measures for use in ambulatory settings.** We see this only as adding additional measurement burden in an environment that self declares for low-risk patients with low- to moderate-risk procedures. Measures focused on adverse events will be of limited use and uninformative, showing very little variation in the quality of care. Therefore, the MVP framework is the wrong tool for this setting. Instead, the measures needed are condition- or procedure-specific for patient goal attainment and patient experience.

#### **MVP Performance Assessment**

CMS outlines how a clinician's performance is assessed under the four performance categories in MVPs—Quality, Cost, Improvement Activities, and Promoting Interoperability. The Agency asks for feedback on what to prioritize when incorporating measures in an ambulatory specialty model.

The ACS does not support CMS' strategy to repurpose MVPs in an ambulatory specialty model. Instead, CMS should refocus care on the patient by using metrics that that will help patients and referring doctors determine the quality of care being provided by the physician and care team in a specific setting, such as shared decision making, patient goal attainment, and other patient-reported outcomes. To move physician payment incentives for quality and safety to a value-based program requires a change in measurement thinking.

For value-based care to exist, we must value the care delivered by all those who play a role in the care team, not only focusing on the individual roles in part. This means moving the unit of analysis from surgeons (physician measures) and facilities to become more patient-centric by using episodes of care measures for cost and quality. The traditional approach used by payors measures the surgeon, regardless of the procedures they perform. This does not help patients understand who delivers on their personal episode of interest. The payor’s approach depicts all procedures by a surgeon, as if the results of one operation are common to all their operations. This is simply not true. An alternative approach is to measure value at the episode level and assign surgeons and facilities—including ambulatory surgery centers—the episodes as care teams which results in shared accountability. This offers more descriptive information to patients and other stakeholders, depicting care across an episode similar to how a patient would think of their care, rather than applying broad quality metrics to the individual physician. The unit of analysis becomes the episode of care at a facility level for all surgeons performing their role on this care team. By combining all the surgeons for one episode in one facility, the volume of patients being measured achieves a threshold that will help to mitigate the statistical challenges of “small numbers” and add more precision to the determination of differences.

The counterarguments that call for measuring a surgeon in broad measures across all the service lines in their clinical arena fail to inform patients, fail to drive team-based efforts, or reliably signal areas for improvement. By selecting an episode approach, the focus turns away from individual contributors to care and drills in directly on the patients.

### *Considerations for Ambulatory Surgery Center (ASC) Specialty Model Quality Targets*

As CMS considers assigning quality targets for an ambulatory specialty model, we want to highlight that while care delivered in an ASC is team-based, it differs from care in the hospital—ambulatory care is not a high-risk environment; episodes are shorter, and procedures have lower risk with less variation in outcomes. From a cost perspective, procedures in the ASC can be thought of as a commodity with minimal variation compared to the inpatient setting. In recent years, payors have pushed to move care from inpatient facilities to ASCs to appreciate a more affordable setting. This creates the potential to select patients or procedures that could be less safe in an ASC. It would be more meaningful to the Agency and patients using ASCs if CMS used measures as a proxy for assessing appropriateness in selecting ASCs as the optimal site of service. A proxy for measuring this could involve tracking how many high-risk patients underwent ASC procedures that resulted in post-discharge emergency department (ED) visits or hospital admissions. As an ASC facility measure, this should be a rare event. The same measure attributed to a surgeon would likely yield low volumes and require large sample sizes to show distinction.

**Measure frameworks that include patient experience, patient goal attainment, and patient-reported outcomes (PROs) can be better indicators for gaps in care in ambulatory settings than typical cost and quality outcome measures. These are essential elements of patient-centric quality programs, which should be the basis for defining quality in an ASC model.** As further discussed in the “Transforming the QPP” section, programs 1) align multiple structure, process, and outcome measures; 2) target condition- or population-specific care; 3) apply to multiple quality domains; 4) address the continuum of care; and 5) are informative to and actionable for care teams and patients. This framework can be applied across various care settings with limited burden on providers while demonstrating improvements in overall care.

To this end, the ACS recommends that CMS explore ways to leverage quality programs and patient-centric measures to identify performance and distinction across specialties working in ASCs. CMS may

wish to consider if this should occur by service line, subsets of service lines for particular episodes, or the ASC more widely.

### ***Health Information Technology (HIT) and Data Sharing***

The Agency asks various questions about how to align with, build upon, and leverage advances in federal interoperability policy. The ACS is supportive of efforts to align interoperability policy wherever possible. Major steps to reduce burden and improve data flow were taken with the creation and implementation of the United States Core Data for Interoperability (USCDI) and Fast Healthcare Interoperability Resources (FHIR) standards in electronic health record (EHR) technology. Continuing to advance these policies to keep pace with the rapidly moving HIT industry is critical and presents opportunities to leverage data to better understand patient risk factors, identify conformance to care pathways, inform care teams about performance, and more. **In an ideal state, standardized data would exist in a structured Health Insurance Portability and Accountability Act (HIPAA)-secure data environment where machine learning is applied to offer a multitude of meaningful data points about key performance indicators, patient risk, affordability, etc. and move past using data and data exchange that was designed for payment.**

**Beyond data sharing at the point of care, we challenge CMS to think about their next steps in evolving personalization of care with knowledge management that would benefit from USCDI and FHIR. Using artificial intelligence (AI) in this setting may help to define customized and personalized care, predict outcomes, aid with social needs, and so forth. The ideal environment for implementing these knowledge management tools may be at the EHR system level or a regional or community level health information exchange (HIE). Working with generative AI directly on EHR data works best if these data are filtered using logical rules that assure data integrity. It is possible to filter data using tools, such as FHIR, to pull filtered data into a data lake that sits within the HIPAA security boundary, then apply the generative AI functionality for a myriad of use cases and feed outputs back to the EHR or HIE environment.**

### ***Multi-Payer Alignment***

CMS seeks feedback on how to best promote multi-payer alignment between a potential ambulatory alternative payment model (APM), established models and programs, and payors. CMS believes that increased engagement in value-based care proposed in the model could support other payers like Medicare Advantage, Medicaid, and commercial plans in achieving their goals by providing an on-ramp for specialists inexperienced with value-based care. The implementation of a standard approach to capturing data in an all-payor claims database (APCD) would be helpful in aggregating data across payors. Today, there are many APCDs, but the data within them do not align, forcing users to adjust for variability and missing data. **If CMS moves to adopt a standard approach for all-payor data, it should incentivize the standardized approach for data fields and establish a standard pricing model.** Establishing a standard pricing model for all services would allow for service comparisons, patient risk profiles, and more without exposing individual contracted rates for various services. There are other means for all claims price transparency underway. If this is implemented, state Medicaid programs would be able to compare services in a population if a normalized standard price data warehouse were added to the all-payor claims data. It is also important to encourage commercial plans and Employee Retirement Income Security Act (ERISA) plans to participate. A standards-based APCD would give facilities, including ASCs, and clinical teams clearer understanding of their performance on condition-specific quality measures, the cost of care in their facility, and other relevant data points to better inform the various stakeholders and care teams within the market.

## OTHER PROVISIONS OF THE PROPOSED RULE

### Colorectal Cancer (CRC) Screening Coverage

CMS proposes to remove coverage for barium enema procedures from CRC screening in response to stakeholder feedback that such procedures no longer meet clinical standards and are no longer recommended in clinical guidelines. **In recognition of the extensive evidence indicating that barium enema is now an outdated and ineffective CRC screening modality relative to modern CRC screening technologies, the ACS supports this proposed change in coverage for barium enema procedures.**

The Agency also proposes to add coverage for CT colonography (CTC) as a method of CRC screening, in part citing the American Cancer Society's *2018 Colorectal Cancer Screening for Average-Risk Adults Guideline Update*, which includes the CTC procedure among the various recommended tests and procedures for CRC screening.<sup>1</sup> **We support CMS' proposal to add coverage for CTC as a CRC screening test and to expand the applicable regulatory definition of a complete CRC screening to include CTC.**

### Low Titer O+ Whole Blood Transfusion (WBT) Therapy During Ground Ambulance Transport

Under the Ambulance Fee Schedule (AFS), Medicare covers seven levels of life support or advanced life support (ALS) services for ground ambulance transports, which include:

1. Basic life support (emergency);
2. Basic life support (non-emergency);
3. Advanced life support, level 1 (ALS1) (emergency);
4. Advanced life support, level 1 (ALS1) (non-emergency);
5. Advanced life support, level 2 (ALS2)
  - Coverage Pathway 1: Transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or
  - Coverage Pathway 2: Transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures (performed by ALS personnel trained as an EMT-intermediate or paramedic):
    - Manual defibrillation/cardioversion
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line
6. Paramedic intercept; and
7. Specialty care transport.

<sup>1</sup> Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. *CA Cancer J Clin.* 2018;68(4): 250-281.



CMS conducted a review of the clinical benefits of the administration of low titer O+ WBT therapy during ambulance transport—which previously has only been available in the hospital setting—and found that WBT therapy significantly increases a patient’s chances of survival.

The Agency believes that ground ambulance transports providing WBT already qualify for ALS2 payment under Coverage Pathway 2 given that patients requiring such transfusions are generally critically injured or ill and often suffering from cardio-respiratory failure and/or shock, and therefore are likely to receive one or more of procedures currently listed as ALS procedures in the definition of ALS2. However, CMS does not believe that most patients who may require WBT would meet Coverage Pathway 1 criteria and notes that not all ground ambulance transports already qualify for ALS2 payment. The Agency also states that the administration of WBT should independently qualify for an ALS2 procedure because the administration of WBT and handling of low titer O+ whole blood require a complex level of care beyond ALS1. Therefore, CMS proposes to modify the definition of ALS2 to add the administration of low titer O+ whole blood transfusions to the list of ALS2 procedures.

**The ACS supports CMS’ proposal to establish coverage for low titer O+ whole blood WBT therapy and urges the Agency to expand coverage under the AFS to also include therapies for all other Food and Drug Administration (FDA)-approved blood and blood components.** We believe coverage and reimbursement for these services should be applicable to both ground *and* air ambulance transport.

## UPDATES TO THE QUALITY PAYMENT PROGRAM (QPP)

### Transforming the QPP

CMS discusses its goal to have all traditional Medicare beneficiaries in an accountable care relationship with their health care provider by 2030. As part of those efforts, CMS continues to pursue higher-value care, supporting Advanced APM participation, increasing alignment to reduce burden, and promoting health equity. CMS envisions a full transition to MVP reporting and a sunset of traditional MIPS to support movement towards value-based payment, and the RFI seeks feedback on how to achieve this.

For many years, the ACS has worked with CMS to reshape and meet the vision and goals for the QPP set forth by the Agency. We realize that CMS hopes to eventually sunset traditional MIPS. **However, it will be important to maintain the traditional MIPS reporting pathway for MIPS-eligible clinicians for whom CMS has not designed an MVP until CMS has developed a strategy for linking quality efforts across facilities and physician programs, such as aligning quality around episodes, as we discussed earlier.** By doing so, care teams will be more incentivized to organize care around the patient and apply quality metrics across all clinicians who work as part of the team.

We appreciate CMS’ efforts to transition traditional MIPS toward measures organized by clinical domain or condition. However, at their root, MVPs have only reshuffled existing MIPS metrics and are still focused on single metrics for clinicians/specialties that do not map to the patient or the care team and will continue to perpetuate the silos created by fee-for-service (FFS). Metrics that only focus on the individual physician do not capture the whole picture of patient care or distinguish quality—there are many members of the care team, as well as the facility, that impact a patient’s experience, and the quality of care delivered.

Key MIPS and MVPs measure framework limitations include the following:

- Defining a surgeon in general terms—MVPs include broad measures that lump many different procedures into a measure or set of measures, such as the Surgical Care MVP;
- Often the measures selected for inclusion focus on rare events;
- Limited availability of PROs in surgical care;
- Limited utility for patient informed decision making; this extends to patient advocates, such as primary care provider (PCP), or purchaser with regard to the underlying condition and need for referral;
- Small case numbers are inadequate to demonstrate precision or meaningful confidence intervals; and
- Lack of information that leads to meaningful improvement activities in surgical care.

A major hurdle to overcome is the persistent payor/purchaser approach to using the FFS payment system to apply measures for individual clinicians or facilities, without considering a method that accounts for shared accountability. In a similar way, price and quality transparency have used the available information about a surgeon or a facility for single services, lacking information that would help inform patients about a specific condition. When a surgeon or a facility is the unit of analysis, the impact on referral decisions is limited since most of the information is not episode specific. It ends up being too general to be useful and PCPs or patients do not find it helpful enough in their referral considerations. A one-size-fits-all approach to measurement may seem prudent and easier to implement in a payment model, however, surgical services are too diverse for a one-size-fits-all approach if it is to be informative and meet the needs of the various stakeholders.

Care and the care environment are extremely nuanced, and therefore relying on measures in their current state to capture a care team’s ability to manage patients will not achieve the Agency’s goals of driving value. A high-performing care team works within a system that has the right structures and processes in place to deliver on the optimal care pathway AND manage patients when rescue strategies are identified and needed. It is more than doing the routine steps; rather, it is the little details together that take care from good to great. The current payor measurement systems do not have this capability. The ACS has years of experience developing and implementing quality programs in our ACS verification and accreditation programs. These programs are intended to complement the payor measures, while also assessing the interconnectedness of a team in a service line. They assess a care team’s capacity to identify problems, use clinical measures, formulate improvement plans, execute a work plan, and seek solutions, all as a learning health system. Most health systems do not harbor mature systems approaches to their service lines; therefore, it is important that CMS consider how to leverage programs, such as the ACS verification and accreditation programs that have proven success in implementing systems, to support the Agency’s efforts to help patients and care team.

Furthermore, we recommend that CMS consider whether moving all care into value-based arrangements is the right strategy or if some care is most efficient, safe, and affordable in FFS. Perhaps some aspects of care, such as simple, self-limited, and safe care, are most efficient if they remain in the traditional FFS payment system. Some chronic illnesses perform well in a population health Per Member Per Month (PMPM) model. Others seem well-suited for episodes of care within service lines. Setting forth the right business model allows for alignment with the right quality model. To date, we have tried to fit all business models into one quality model and vice versa, all quality models into one business model. The results make payment possible but have also been burdensome and chaotic with limited ability to provide patients and their referring physicians with the best possible information.

From our experience, the fix must start with the QPP refocusing on the patient. To do this, CMS must look to measure the patient with a certain condition within an episode attached to the facility, rather than the individual clinician. As we have stated in the past, when CMS thinks about defining episodes, the episode of care should be as inclusive as possible of the services, resources, and personnel necessary to achieve the patient’s desired outcome for their defined condition or diagnosis. An inclusive yet targeted episode definition also helps to build shared incentives and coordination across the delivery system in cases such as surgery where numerous providers may participate in care. MVPs do not do this—they do not incentivize team-based coordinated care for a condition. Instead, MVPs were built based on an FFS model where each clinical specialty (including primary care) individually receives payment for the services they provide and are incentivized from a business perspective to provide services in order to earn payment. This has led to physician-centered competition rather than patient-centered care. Furthermore, the budget neutral MPFS has contributed to a divide between primary and specialty care, putting physicians of all specialties in competition with each other not for improved quality or outcomes, but for scarce financial resources.

CMS and the Innovation Center have taken steps in its inpatient programs, through implementation of the Transforming Episode Accountability Model (TEAM) and other models, to define key service lines that bring care teams together. The ACS recommends CMS consider ways to carry over efforts from TEAM to the QPP, by for example designing a complex gastrointestinal (GI) or major bowel surgery MVP to align with the surgical episodes required under the TEAM. By aligning these programs, CMS would have episode-based information on the facility and the surgical team (including the surgeon) who performs the procedures. To align this work, **CMS should explore ways to overlay measures that account for structure, process, and resources within a facility and a core set of measures that account for adverse events and safety (readmissions, surgical site infections (SSI), surgical age friendly status, pneumonia, patient safety, etc.) that could be altered based on episode-specific variables (coronary artery bypass graft (CABG), surgical oncology, major bowel, etc.). We see this as an opportunity for CMS to think outside the box, create measure alignment across programs, and align performance metrics across the whole care team, thereby incentivizing team-based care.**

### *Programmatic Measures for Specialty Care*

The ACS has developed programmatic measures, most notably the Age Friendly Hospital measure which will be reported beginning with the CY 2025 reporting period/FY 2027 payment determination as part of the Hospital Inpatient Quality Reporting Program (IQR) to center quality around a patient and bring the care team together around patient goals. Measures that follow a quality program, referred to as “programmatic measures,” identify clinical frameworks based on evidence-based best practices to provide goal-centered, clinically effective care for patients.

The concept behind the programmatic measure is based on several decades of history implementing programs that demonstrably improve patient care provided by both the clinical team and the facility. Examples include ACS Trauma programs, Geriatric Surgery Verification, Bariatric Surgery Accreditation, the ACS Cancer program, and more. Programmatic quality measures 1) align multiple structure, process, and outcome measures; 2) target condition- or population-specific care; 3) apply to multiple quality domains; 4) address the continuum of care; and 5) are informative to and actionable for care teams and patients. The integration of structures, processes, and outcomes for common clinical purposes is fundamental to programmatic measures and follows the Donabedian framework.

Based on our experience, programmatic measures demonstrate applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures, such as MIPS/MVPs. Programmatic measures have benefits across stakeholders:

- Patients: Widespread implementation of these measures would benefit patients and caregivers by increasing transparency and empowering them to make effective decisions about where to receive care.
- Clinicians: The clinical team would benefit from integration into a commonly shared goal by defining and operationalizing a clinical unit-based system.
- Systems: Healthcare systems would benefit from resource and protocol standardization, evidence-based and data-driven processes, and pragmatically functional strategies to achieve improved care and outcomes.
- Payers: Payers would benefit by taking a programmatic quality approach because they can be confident that their beneficiaries will receive high-quality care with efficient cost savings.

To do this, we first must define the service line and the episodes within that service line. For example, a cancer service line may include a specific cancer and its procedural episodes including surgical oncologic services for biopsy and excision, medical oncology, and/or radiation oncology. These services include ancillary services in imaging and pathology. It is only through the care team acting in concert that patients can discover the care they seek and the systems that can drive them to improve. Some of the key questions include:

- Who are the key members of the clinical team within the episodes?
- How do they define outcomes that are meaningful to patients?
- How do they generate knowledge to drive improvement cycles and continuously iterate on improvement?

One of the challenges of using episodes of care attributed to a facility arises when PCPs wish to make a referral for an episode of care, or patients are seeking care for their condition. In most cases referrals are made for the lead point on the care team—such as the surgeon for surgical episode—not the facility. If the episode of care is accounted for at the facility level, PCPs and patients need a mechanism that attributes the surgeon/care team to the procedures they deliver at the various facilities. In addition to the facility where they operate, information about payor mix, affordability, safety profiles, outcomes, and ability to care for high-risk patients would be helpful for those making referrals. Therefore, we encourage CMS to investigate how to best leverage these data captured with an episode-based model.

In summary, CMS must continue to explore ways to align programs that are built to bring care teams together around the patient—such as the CMMI TEAM, and programmatic measures like the Hospital IQR Program Age Friendly Hospital measure. These efforts are taking steps to move the system closer to value-based, team-based care that provides meaningful information to patients, physicians, and other stakeholders, while MVPs and traditional MIPS are splitting teams into individual members and distracting from CMS' goals.

## **Development of New MIPS Value Pathways**

### **Surgical Care MVP**

CMS proposes six new MVPs to be available for reporting beginning with the CY 2025 performance period:

- Complete Ophthalmologic Care,
- Dermatological Care,
- Gastroenterology Care,
- Optimal Care for Patients with Urologic Conditions,
- Pulmonology Care, and
- Surgical Care.

Our comments pertain to the proposed Surgical Care MVP. CMS states that the Surgical Care MVP will focus on the clinical theme of surgery and will be most applicable to clinicians who treat patients within the surgical settings of general surgery; neurosurgery; cardiothoracic surgery; anesthesiologists; and nonphysician practitioners (NPPs), such as certified registered nurse anesthetists (CRNAs), nurse practitioners, and physician assistants.

**The ACS thanks the Agency for prioritizing surgical care, but we do not support the implementation of the Surgical Care MVP as proposed.** When MVPs were first introduced in 2020, the ACS was hopeful that the pathway would be a step in the right direction. For many years, we received feedback from ACS Fellows that traditional MIPS is time consuming, distracting, and does not focus efforts on building a better program of care. However, the new MVP model used is not what we believe Congress intended. MVPs seem to technically meet legislative requirements, but the outcome appears to be a rearrangement of the traditional MIPS program focusing on the wrong targets for surgical value-based care. The current MVP framework will not result in value to patients for the price paid for care or drive surgeons to build teams that improve. Instead, the key elements for value begin with a clinical program focused on informing patients or their surrogates as to where to find care. Next, is assembling care teams around patients and giving them meaningful feedback necessary to drive improvements in care and providing payors with key information to reward care they value for elements of safety, good outcomes, affordability, and meeting patients’ goals. To the ACS, it appears that MVPs are focused on checking boxes in a legislative mandate, rather than realizing the intent of the law to create better value in surgical care.

Specifically, the ACS views the Surgical Care MVP as a repackaging of what is already in MIPS and results in the same problems as before. We outline various issues with the Surgical Care MVP below.

- The MVP includes an expansive set of measures; however, the MVP is still extremely limiting for many surgical specialties.
- The MVP does not align measures for quality with the cost associated with the care; in other words, quality and cost are disconnected.
- Focus is not on a condition for a patient; instead, the focus is on the “specialist.” This has potential to pit clinicians against each other and may distract them from organizing around the condition and patients’ goals. The result will not incentivize team-based care around a condition to increase value.
- There is a lack of clarity around how MVPs, specifically the Surgical Care MVP, address essential elements of quality programs, such as defining problems, failure points, and gaps in care to better serve patients. Measuring a single point of care for one patient with one condition, cost of care for a separate condition, and unrelated improvement activities does not give patients the confidence needed to trust the care is organized around their goals and interests.
- Most importantly, the Surgical Care MVP does not provide meaningful information to patients when seeking a surgeon for a condition or procedure. The information is vague and too general

and therefore not transparent. The ultimate goal should be to answer the question the ACS commonly hears from Accountable Care Organizations (ACOs) and other care seekers—how can a patient with a condition find care that is safe, affordable, good, and equitable? The Surgical Care MVP seems to fall short of answering this vital concern.

**As CMS continues to build out the MVP inventory, we recommend the development of a Geriatric Surgery MVP. A Geriatric Surgery MVP could align physician reporting with the Age Friendly Hospital measure that will be required for hospital reporting under the IQR in 2025. An MVP on this topic would focus on the unique needs of older adults as they move through the phases of surgical care. If aligned with the IQR measure, hospitals could show their commitment to improving care for older adults, while also aligning metrics to achieve attestations and track performance for multiple programs.**

### **MIPS Performance Category Measures and Activities**

#### ***Quality Performance Category Requests for Information (RFI)***

##### **Guiding Principles for Patient-Reported Outcome Measures in Federal Models, and Quality Reporting and Payment Programs RFI**

CMS states that part of its National Quality Strategy and the strategy of the Innovation Center is to incorporate more Patient-Reported Outcome Measures (PROMs) and Patient-Reported Outcome Performance Measures (PRO-PMs) in CMS quality reporting and payment programs and CMS Innovation Center Models. PROs and PROMs are important for the advancement and support of patient-centered care, and CMS discusses a potential path to provide more resources for the future development of PRO-PMs. The Agency seeks feedback on the development of a database of PROMs/PRO-PMs used in programs and payment systems in health care by federal, state-based, and commercial payors, and healthcare systems. It also asks for stakeholder feedback on guiding principles related to data infrastructure, selection, feasible implementation, and patient engagement of PROMs and PRO-PMs.

The ACS has been extremely supportive of the use of PROM and PRO-PMs in quality programs and thanks CMS for highlighting their importance through this RFI. These measures can offer meaningful insight from the patient’s perspective, which is foundational to determining the value of care based on what matters to the patient. PROMs also give insight on the performance of the care team that cannot be captured in traditional outcome or process measurement mechanisms. For example, when thinking about centering care around the patient, understanding their expectations or goals for an operation and then receiving direct feedback from the patient about their goal attainment, their experience, and/or their physical function following an operation is invaluable to the surgical team, the patient/patient’s caregivers, and referring doctors. These metrics give patients a voice while also giving providers useful insight on areas for improvement.

When considering the role of PROMs in the transition to value-based care or an episode-based model, key performance indicators typically focus on cost and quality, which should include mechanisms for patient experience and patient goal attainment. In some cases, because performance on current quality metrics is relatively high, what can really distinguish facilities and providers is the patient experience and if patients’ goals for their care were met.

However, just as quality metrics should vary and align with each episode, the same should be considered for PROMs. A one-size-fits-all PROM environment may not be suitable—for example, we have seen

this in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which provides limited meaningful information to the care team and patients/patient caregivers. **As CMS builds out its catalog of PROMs and PRO-PMs, it will be important to define the episodes and understand the specific needs of patients and care teams and design the measurement system around these needs to have a better understanding of the areas where PROMs will have the most impact. PROMs and other quality metrics should be designed with the intent to inform patients about where to seek the care they need, for PCPs to help refer care, and facilities where they need improvement.** Where few other measures help to inform referring physicians and patients, PROs fill a gap. They provide valuable insights into patients' perspectives on their health, quality of life, and functional status.

**For surgical patients, relevant categories of PROs/PROMs are outlined in Table 5. The specific PROs/PROMs are described in Table 6. Please note the list of PROs/PROMs tools are for illustrative purposes only.**

**Table 5: Use Cases for Patient-Reported Outcomes and Patient-Reported Outcome Measures**

Category	Use Cases
<b>Functional Outcomes</b>	<ul style="list-style-type: none"> <li>• Physical function (e.g., mobility, strength, range of motion)</li> <li>• Activities of Daily Living (ADLs)</li> <li>• Return to work or normal activities</li> <li>• Sports and exercise capacity (for relevant surgeries)</li> </ul>
<b>Pain and Discomfort</b>	<ul style="list-style-type: none"> <li>• Pain intensity scales (e.g., Numeric Rating Scale, Visual Analog Scale)</li> <li>• Pain interference with daily activities</li> <li>• Analgesic use</li> </ul>
<b>Quality of Life</b>	<ul style="list-style-type: none"> <li>• General health-related quality of life (e.g., SF-36, EQ-5D)</li> <li>• Disease-specific quality of life measures</li> </ul>
<b>Mental Health and Well-being</b>	<ul style="list-style-type: none"> <li>• Anxiety and depression scales (e.g., HADS, PHQ-9)</li> <li>• Emotional well-being</li> <li>• Social functioning</li> </ul>
<b>Symptom Burden</b>	<ul style="list-style-type: none"> <li>• Fatigue</li> <li>• Sleep disturbances</li> <li>• Gastrointestinal symptoms (for relevant surgeries)</li> </ul>
<b>Patient Satisfaction</b>	<ul style="list-style-type: none"> <li>• Satisfaction with surgical outcomes</li> <li>• Satisfaction with care process</li> <li>• Willingness to recommend the procedure/provider</li> </ul>
<b>Recovery and Rehabilitation</b>	<ul style="list-style-type: none"> <li>• Progress in rehabilitation</li> <li>• Adherence to postoperative instructions</li> <li>• Complications or adverse events from the patient's perspective</li> </ul>

**Table 6: PROs and PROMs Examples (for illustrative purposes)**

Full Name	Abbreviation	Category	Description
Numeric Rating Scale <sup>2</sup>	NRS	Pain and Discomfort	A scale used to measure pain intensity on a scale from 0 to 10, where the 2 respective endpoints are “no pain” and “worst possible pain.”
Visual Analog Scale <sup>4</sup>	VAS	Pain and Discomfort	A line to measure pain intensity with anchor statements on the left (no pain) and on the right (worst imaginable pain).
36-Item Short Form Survey <sup>3</sup>	SF-36	Quality of Life	A survey designed to capture adult patients’ perceptions of their own health and well-being.
EuroQol <sup>4</sup>	EQ-5D	Quality of Life	A measure of self-reported health which is accompanied by weights reflecting the relative importance of different types of health problems in the general medical population.
Hospital Anxiety and Depression Scale <sup>5</sup>	HADS	Mental Health and Well-being	A self-report rating scale of 14 items, each scored from 0-3, to measure anxiety and depression.
Patient Health Questionnaire-9 <sup>7</sup>	PHQ-9	Mental Health and Well-being	A self-report rating scale of 9 items, each scored from 0-3, to measure the severity of depression.

For a comprehensive approach to PROs/PROMs in surgery, consider the following categories:

1. Generic Health Status:

Use widely validated tools like SF-36 or EQ-5D to assess overall health status and quality of life. These allow for comparisons across different surgical procedures and patient populations.

2. Procedure-Specific Measures:

Implement measures tailored to specific surgical procedures. For example:

<sup>2</sup> Hawker GA, Mian S, Kendzerska T, French M. Measures of Adult Pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Chronic Osteoarthritis Pain (ICOAP). *Arthritis Care Res.* 2011;63(S11):S240-S252.

<sup>3</sup> Ware JE. SF-36 Health Survey Update. *Spine.* 2000;25(24):3130-3139.

<sup>4</sup> Devlin NJ, Brooks R. EQ-5D and the EuroQol Group: Past, Present and Future. *Appl Health Econ Health Policy.* 2017;15(2):127-137.

<sup>5</sup> Smarr KL, Keefer AL. Measures of Depression and Depressive Symptoms: Beck Depression Inventory-II (BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), and Patient Health Questionnaire-9 (PHQ-9). *Arthritis Care Res.* 2011; 63(S11):S454-S466.



- Oxford Hip Score for hip replacements
- BREAST-Q for breast surgery
- International Prostate Symptom Score (IPSS) for prostate surgery

3. Functional Status:

Assess physical function relevant to the specific surgery. This could include measures of mobility, strength, or specific functional indices like the Oswestry Disability Index for spine surgery.

4. Symptom Assessment:

Focus on symptoms most relevant to the surgical procedure, such as pain, fatigue, or procedure-specific symptoms.

5. Psychosocial Outcomes:

Include measures of mental health, social functioning, and overall well-being to capture the broader impact of surgery on patients' lives.

6. Recovery Trajectory:

Implement measures that track patients' recovery over time, assessing milestones like return to work or normal activities.

7. Patient Experience:

While not strictly a clinical outcome, patient experience measures can provide valuable insights into the care process and may influence overall outcomes.

8. Goal Attainment:

Consider using patient-specific goal attainment scaling to assess whether individual patient goals for surgery were met.

By incorporating a well-designed set of PROs/PROMs, surgical teams can gain a more comprehensive understanding of surgical outcomes from the patient's perspective, leading to improved patient-centered care and outcomes.

### **MIPS Final Score Methodology**

#### ***Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice***

Topped out measures are measures for which performance is so consistently high that improvement or meaningful distinctions in quality are limited. In the CY 2018 MPFS final rule, CMS capped the number of points a MIPS participant could receive for reporting a topped-out measure in its second consecutive year of being topped out at 7 points. Measures in their third consecutive year of being topped out could be considered for removal in future rulemaking. The Agency states that these topped out measure policies were first instituted in order to drive continuous quality improvement, but as the pace of measure development has not matched the rate at which measures are removed, the list of MIPS quality measures has decreased since 2018 from 271 to 198.

CMS notes that it has received feedback from numerous stakeholders that providers reporting specialty sets with a high number of topped out measures face both limited measure choice and limited scoring opportunities. The Agency acknowledges that as the performance threshold increases, specialists face rising difficulty in achieving a positive payment adjustment. To address these concerns, CMS proposes to remove the 7-point cap for certain topped-out measures, beginning with the CY 2025 performance period. Under this policy, measures would be scored on a scale of 1 to 10 measure achievement points based on a topped-out measure benchmarking methodology in which the 97<sup>th</sup> percentile corresponds to 7.5 measure achievement points. The Agency also proposes to maintain its policy of considering topped out measures in their third consecutive year for removal in future rulemaking. CMS proposes to determine which measures are eligible for the scoring cap exemption by conducting an annual analysis of the measure sets affected by limited measure choice. This analysis would include the number of capped topped-out measures, the number of measures without historical benchmarks, and the scoring potential to meet or exceed the performance threshold. The measures selected for the scoring cap exemption will be published each year in the *Federal Register*.

**The ACS supports this proposal to exempt certain quality measures from the topped-out scoring cap. However, we request that CMS remove the scoring cap from all topped out measures, not only those in specialty sets with limited measure choice.** In the past we have highlighted the flawed nature of the topped-out measure policy. From our perspective, clinicians should always be striving to achieve the highest possible performance on a measure, and if clinicians are consistently scoring well on a measure, it can be an indicator of higher quality care in that area, not of an unvaluable measure. In addition, when tying points to measures, the scoring caps disincentivize providers from reporting topped-out measures because they will face increased difficulty in reaching the performance threshold. However, many of the topped-out measures can still offer valuable insights into care delivery. If clinicians stop reporting topped-out measures, CMS will have no way of knowing whether performance regresses or how quality of care is impacted in the long term. Rather than removing these measures or limiting their scores, CMS should convert topped-out measures into program standards or roll them up into a composite, as it is critical that we continue to incentivize the long-term tracking of key processes and outcomes. Physicians should be incentivized, not disincentivized, to maintain high quality and ensure that performance does not change. But most importantly, CMS must invest in the development of new measures to drive improvements of care which better align with the transition to patient-centered value. As discussed above, the ACS strongly supports efforts to build out PROs and PROMs for episodes of care. Focusing on new and improved measures will also create a larger pool for MVP development.

### ***Complex Organization Adjustment for Virtual Groups and APM Entities***

In the early years of the QPP, CMS provided a measure bonus point and bonus cap to incentivize MIPS participants to use certified EHR technology (CEHRT) for end-to-end reporting. The Agency revoked this policy in CY 2022, stating that it wished to simplify scoring by removing many of the transitional policies implemented at the start of the QPP. However, CMS acknowledges that currently, satisfying reporting requirements is not equally accessible for all MIPS participants. In particular, Virtual Groups and APM Entities may face additional barriers to reporting, such as difficulties aggregating patient data across multiple tax identification numbers (TINs), data deduplication, and interoperability between different EHR systems.

To address these concerns, CMS proposes to establish a Complex Organization Adjustment starting with the CY 2025 performance year in order to account for the various organizational complexities by Virtual

Groups and APM Entities. Under this policy, Virtual Groups and APM Entities would receive one measure achievement point for each submitted electronic clinical quality measure (eCQM) that meets the data completeness and case minimum requirements. Each reported eCQM could earn a maximum of 10 points and the total number of achieved points could not exceed the total number of available points in the quality performance category. Likewise, the Complex Organization Adjustment cannot exceed 10 percent of the total available measure achievement points in the quality performance category. This adjustment will then be added to each measure submitted at the individual measure level.

The Agency states that adding one point for each submitted eCQM would help Virtual Groups and APM Entities overcome their barriers to reporting while also not masking quality performance. CMS notes that it chose to only include Virtual Groups and APM Entities in this proposal in order to avoid score inflation and target interventions with those who need it most. The Agency also describes its intention to one day end the Complex Organization Adjustment when uptake of the FHIR application programming interface (API) increases, as that will reduce or eliminate the current barriers to eCQM submission. **The ACS thanks CMS for considering barriers to eCQM reporting across EHR systems; however, we ask CMS to consider expanding this policy for others, such as large groups.** It is common that large group practices work in multiple settings and would have similar barriers to aggregating data across EHR systems.

***Proposed Modification to Scoring Methodology for the Cost Performance Category Beginning with CY 2024 Performance Period/2026 MIPS Payment Year***

CMS proposes to modify its methodology for scoring the cost performance category, beginning with the CY 2024 performance year. The proposed updated methodology would be based on standard deviation, median, and an achievement point value derived from the performance threshold. A clinician whose average costs under a given measure are equal to the median would receive an achievement point value equal to 10 percent of the performance threshold; for CY 2024, since the performance threshold is 75 points, a clinician whose average costs are equal to the median would receive 7.5 points. The cut-offs for benchmark ranges would be determined by standard deviations, in dollars, from the median.

CMS states that this methodology will align the assignment of achievement points for cost measures so that clinicians with costs near the measure's 50<sup>th</sup> percentile would not receive a disproportionately low score. The Agency states that it believes the proposed policy will increase the mean cost performance category score from 59 to 71 out of a possible 100 points. It would increase the mean(s) for each cost measure score from between .04 to 2.52 points, and the mean final score for MIPS participants would increase by 3.89 points. CMS notes that their analysis did not find a negative impact for any participants whose average costs for a cost measure are around the median.

**The ACS is supportive of the proposed methodology for scoring the cost performance category. We thank CMS for its efforts in identifying the discrepancy in cost scores in previous reporting periods and taking steps to rectify these issues.** Since the flawed cost methodology was used for multiple years and has accounted for lower performance scores in 2022 and 2023, **CMS should consider applying adjustments to the cost scores for performance years 2022 and 2023 or at the very least zero out the cost category contribution and update associated payment adjustments for years where cost scores were negatively affected.**

## **MIPS Payment Adjustments**

### *Establishing the Performance Threshold*

CMS proposes to use the mean of the final scores from the CY 2017 performance year/CY 2019 MIPS payment year to determine the performance threshold for the CY 2025 performance period. The mean final score from the CY 2017 performance period is 75 points; thus, CMS proposes to set the performance threshold for the CY 2025 performance period at 75 points. This proposal would maintain the same performance threshold as CY 2024.

**The ACS is supportive of this proposal to maintain the performance threshold at 75 points. For many practices, meeting the requirements of MIPS reporting is already burdensome. Measure scoring policies, such as benchmarking and topped-out measures, make it extremely difficult for many specialists to meet the threshold.** The goalpost of MIPS should be set to ensure that patients are informed about the care they receive and know where to access safe, affordable, good, and equitable care. Chasing siloed metrics with the sole goal of meeting an ever-increasing point threshold becomes meaningless to patients and extremely burdensome for practices. **The ACS is concerned that if the performance threshold were to increase and more resources were required to meet it, providers may feel the program is no longer worth the effort and potentially be disincentivized from participating in Medicare.**

## **Alternative Payment Models**

### *Payment Amount and Patient Count Methods*

When CMS finalized the definition of “attribution-eligible beneficiary,” it aimed to adopt a definition that would allow it to be consistent across contemporaneous Advanced APMs. It chose to refer to E/M services as the primary basis for purposes of attribution-eligibility because many Advanced APMs used E/M claims to attribute beneficiaries to their APM Entity groups. Over time, CMS has updated the list of services that are considered to be E/M services for the purpose of identifying attribution-eligible beneficiaries. CMS states that in recent years it has developed concerns that the current policy to use E/M services as the default basis for attribution, and to use an alternative approach for Advanced APMs that use a different attribution basis, could result in a complex set of unique attribution approaches for various Advanced APMs. This also causes variability among the ways CMS defines “attribution-eligible” when making qualifying APM participant (QP) determinations, particularly as CMS anticipates that Advanced APMs will continue to evolve and use novel approaches to value-based care that may emphasize a broad range of covered professional services. In addition, CMS recognizes that PCPs generally furnish a higher proportion of E/M services than do specialists for the same beneficiary. The current reliance on E/M services for attribution in its Threshold Score calculations means that primary care practitioners may contribute more significantly to achieving QP status for an APM Entity group. As such, CMS’ current policy may have inadvertently encouraged APM Entities to prefer PCPs over specialists in their Participation Lists. As such, CMS proposes to modify the sixth criterion under the definition of “attribution-eligible beneficiary” to include any beneficiary who has received a covered professional service furnished by the eligible clinician (identified by their National Provider Identifier [NPI]) for whom CMS is making the QP determination, beginning with the 2025 QP performance period.

**The ACS is supportive of broadening the definition of “attribution-eligible beneficiary” as it will allow more specialists (including surgeons) opportunities to participate in APMs.** This is a step in

the right direction towards increasing specialty involvement; however, **the larger problem where there is a lack of APMs that are relevant to specialty care still exists. As we noted earlier, we do not believe that mandatory participation in MVPs is an appropriate solution to fill these gaps.** While this is a welcome update, with the APM incentive no longer available, many specialists may not see the benefit of participating in APMs at this time. **To incentivize surgeons to join APMs and to ensure they can invest in the infrastructure needed to support successful participation in an APM, we urge CMS to ask Congress to extend the APM incentive payment.**

The ACS appreciates the opportunity to provide feedback on this proposed rule and looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Mujumdar, Chief of Regulatory Affairs, at [vmujumdar@facs.org](mailto:vmujumdar@facs.org) or Jill Sage, Chief of Quality Affairs, at [jsage@facs.org](mailto:jsage@facs.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Turner', with a long horizontal flourish extending to the right.

Patricia L. Turner, MD, MBA, FACS  
Executive Director and CEO