

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1784-P; Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

The Society for Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seeks to advance excellence and innovation in vascular health through education, advocacy, research, and public awareness. The SVS, on behalf of its approximately 6,300 members, offers comments on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (MFS) and provisions relating to the Medicare Shared Savings Program and the Quality Payment Program for calendar year (CY) 2024, published in the August 7, 2023, *Federal Register* (Vol. 88, No. 150 FR, pages 52262-53197).

SVS Comments re: CY2024 revisions to payment policies under the Medicare Physician Fee Schedule (MPFS)

Stabilizing Payment for Physicians

For more than twenty years, Medicare payments have been under pressure from the Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a very modest portion of the overall growth in spending, they are perennial targets for cuts when policymakers seek to control spending. Although Congress repeatedly intervened to prevent reimbursement cuts to surgeons, anesthesiologists, and other physicians due to the sustainable growth rate (SGR) system — which was enacted in 1997 and repealed in 2015 — Medicare physician payments have remained constrained due to a budget-neutral financing system, and updates to the

conversion factor (CF), a critical factor for calculating Medicare payment, have failed to keep up with inflation.

For CY 2024, the conversion factor proposed by CMS is \$32.75, a decrease of \$1.14, or 3.34%, from CY 2023. Overall proposed payment amounts under the PFS would be reduced by 1.25% compared to CY 2023, in accordance with factors specified by law. Preliminary SVS analysis, in addition to the impact charts provided in the proposed rule by CMS indicate that vascular surgeons face an additional 3% cut to vascular surgery, variable to practice setting/type (-4% in the non-facility setting and -2% in the facility setting). In addition, payment reductions for many vascular surgeons are compounded by the third year of the phased in implementation of the CMS clinical labor pricing update, which was finalized in the CY2022 MPFS Final Rule. SVS has concerns that these ongoing and repeated cuts by CMS will measurably reduce the ability for vascular surgeons to provide critical services to vulnerable populations. Vascular surgeons are left asking themselves “Where, how, and when will I be able to care for my patients?” Burnout is real. CMS continues to ask our surgeons and their staff to do more with less.

Table 104: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

Vascular Surgery -3% combined impact

TABLE 105: CY 2024 PFS Estimated Impact on Total Allowed Charges by Setting

Vascular Surgery NF Setting -4%, F Setting -2%

As a result, vascular surgeons must *again* rely on Congressional action to further mitigate scheduled reductions. This year-over-year cycle of payment cuts (despite soaring inflation) is a clear indicator that the Medicare physician payment system is broken. Systemic issues such as the negative impact of the Medicare physician fee schedule’s budget neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for health care clinicians moving forward, threatening beneficiary access to essential health care services. Our policy makers, both within the Administration and in Congress, have a duty to ensure a Medicare system that provides financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for appropriate changes in spending growth. The ongoing inadequacies associated with physician payment shine the spotlight on our flawed payment system.

SVS Recommendation: CMS must work with Congress and applicable stakeholders to identify and advance Medicare physician payment reform policies that will provide long-term stability for physicians serving patients within the Medicare program.

Clinical Labor Pricing Update

CY2024 marks the third year of a four-year transition to the new clinical labor cost data that will be completed in CY2025. This CMS policy increases the source clinical labor pricing and then disproportionately cuts physician services with high-cost supplies and equipment to account for the budget neutrality requirements in place to offset the clinical labor rate increases. This update continues to apply a huge and unfair burden on specialties that require expensive supplies and/or

equipment to care for their patients. While the increase in clinical labor is appropriate, it is not appropriate that physicians, notably from a few small specialties, are negatively impacted by the change. These dramatic cuts will also further exacerbate disparities in access to care and health outcomes among rural and minority populations by constraining and in some cases preventing physicians in community-based office settings from providing critical patient care to underserved populations.

SVS Recommendation: The SVS urges CMS to signal its official support for H.R. 3674 , the “Providing Relief and Stability for Medicare Patients Act of 2023. This critical piece of legislation would mitigate cuts to office-based specialists for a targeted group of services for two years, avoiding significant disruptions in patient access to care while overall concerns regarding the future of Medicare physician payments are addressed. This targeted relief would occur by providing an increase to the non-facility practice expense relative value units (PE RVU’s) for those procedures performed in an office-based setting that need an expensive medical device or piece of medical equipment and thus were most negatively impacted in the 2022 Medicare Physician Fee Schedule (PFS) with the updating of the clinical labor costs in the budget neutral practice expense methodology.

Office Visits Included in Codes with a Surgical Global Period

The SVS continues to strongly reject the establishment by CMS of a two-tiered system for evaluation and management services. The increased 2021 valuation of the office E/M visits should be incorporated in the surgical global packages and SVS disagrees with the CMS decision to not apply the office E/M visit increases to the visits bundled into global surgery payment. The increases in the hospital visits and discharge day management services should be applied to the surgical global period.

The SVS is insulted by CMS’ ongoing argument that they do not believe physicians are performing follow-up care with their patients. Stakeholders have articulated in great detail the fatal flaws with the RAND study, which CMS uses to defend their position that physicians are not seeing patients for follow-up care. We urge the agency to follow the established process to identify individual codes as potentially misvalued if there is concern with the post operative visits assigned to a particular service. A blanket approach to address all 010-day and 090-day inappropriately impacts physicians performing surgical procedures.

SVS Recommendation: The SVS continues to strongly recommend that CMS apply the office E/M visit increases to the office visits included in surgical global payment, as it has done historically. SVS urges CMS to account for the E/M payment increases for follow up visits within global periods.

Separate Payment for High-Cost Medical Supplies

The SVS continues to urge CMS to separately identify and pay for high-cost disposable supplies using distinct HCPCS Level II codes, rather than bundle into the service described by CPT, so that these expenses may be monitored closely and paid appropriately. There are approximately 30 disposable supply items with prices in excess of \$1,000 and bundled into the practice expense RVU for various CPT codes.

SVS Recommendation: SVS urges CMS to establish HCPCS codes for high-cost supplies. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated similar to drug pricing.

Refinement Process/Appeals Process

In 2016, CMS permanently eliminated its Refinement Panel process by making the nomination requirements so specific that no services could be eligible going forward. For two decades, the CMS Refinement Panel Process was considered by specialties like SVS to be an appeals process. The complete elimination of the Refinement Panel discontinued CMS' reliance on outside stakeholders to provide accountability through a transparent appeals process.

SV Recommendation: SVS recommends that CMS create an objective, transparent and consistently applied formal appeals process that can act as a peer-review to the work / time changes the Agency proposes.

Determination of Practice Expense Relative Value Units (PE RVUs) [FR section II.B.]
Medicare Economic Index (MEI) and the Physician Practice Information (PPI) Survey

In the CY 2024 proposed rule, CMS announced that they will continue to postpone implementation of the updated MEI weights, referencing the AMA's national study to collect representative data on physician practice expenses, the AMA Physician Practice Information (PPI) Survey. The MEI weights that are the basis for current CMS rate setting were based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data.

The MEI measures changes in the prices of resources used in medical practices including, for example, labor (both physician and non-physician), office space and medical supplies. These resources are grouped into cost categories and each 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.

The SVS has concerns that CMS' data sets used to propose new MEI weights were incomplete. In the PR CMS states, "*for physicians who are employed in other healthcare settings directly, such as hospitals, we do not believe that including costs for physicians that do not incur any operating expenses associated with running a practice would be technically appropriate.*" Physician practices have indirect practice expense costs even for providers who are solely facility-based (coding, billing, scheduling, etc.). SVS also questions the physician compensation and professional liability insurance data used in the new weights.

SVS Recommendation: CMS should postpone implementation of updated MEI weights until after the AMA completes its national study to collect representative data on physician practice expenses. SVS urges CMS to further analyze their proposed MEI methodology and data sets prior to implementation.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection Methodology
CMS is soliciting feedback from stakeholders and noting its desire for continued engagement regarding how to best review or update their current practice expense (PE) methodology. CMS acknowledges the AMA PPIS data collection effort but is asking for comment on whether contingencies or alternatives may need to be considered if there was data lacking during the collection effort. Specifically, CMS asked:

- Whether they should consider aggregating data for certain specialties, and if so what thresholds or methodologies should be employed to establish such aggregations?
- Whether aggregations of services, for the purposes of assigning PE inputs, represent a fair, stable, and accurate means to account for indirect PEs across various specialties or practice types?
- If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
- What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any highlighted considerations above?
- Whether specific types of outliers or non-respond bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

AMA PPI Survey Data

SVS supports the AMA's PPI effort and urges CMS to delay implementing contingency plans for potentially poor and inadequate data until the PPI survey data are in and analyzed. If potential deficiencies are identified within the Mathematic/AMA PPI survey, SVS supports the use of specialty specific supplemental survey data to address the deficiencies.

Practice Expense Methodology

CMS' practice expense methodology is complex and often yields unpredictable results when steps are updated. Future changes to CMS' overall practice expense methodology should avoid wild shifts in specialty reimbursements. Future changes should also reflect actual practice costs incurred by physician practices. All changes that impact physician practices should be phased in.

SVS Recommendation: The SVS urges CMS to delay any practice expense methodology changes until after the completion of the AMA’s PPI project. Should the Agency wish to update the PE methodology, stakeholders including PE experts should be engaged through meaningful exchanges (i.e. Town Hall discussions, AMA RUC workgroups, etc).

Split (or Shared) Evaluation and Management (E/M) Visits

For CY 2024, CMS is proposing to delay the implementation of its definition of the “substantive portion” as more than half of the total time through at least December 31, 2024. In the interim, CMS intends to maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

SVS Recommendation: The SVS appreciates the delay until January 1, 2025, as the policy (to report only on time) would disrupt team-based care. SVS urges CMS to allow physicians to bill split or shared visits based on time or medical decision-making.

Payment for Skin Substitutes

CMS is soliciting comments, for consideration for future rulemaking, on the best manner to incorporate skin substitutes as a supply within the PFS rate setting methodology. Currently, CMS reimburses skin substitutes through separately identifiable HCPCS Q-codes. If CMS transitions to reimbursing skin substitutes as direct practice expenses within CPT codes (i.e. incident to), under the current methodology, a significant number of PE RVUs would be introduced into the fee schedule, which would need to be offset due to budget neutrality requirements. If CMS were to transition to reimbursing skin substitutes as incident to services, CMS should include additional Part B funding to account for the change in methodology. The SVS is also concerned about patient access to wound care if these services are no longer provided in the non-facility setting due to CMS transitioning away from separately reportable HCPCS codes for skin substitutes.

SVS Recommendation: The SVS encourages the Agency to maintain skin substitute products as separately reportable HPCPS codes and to work with the AMA CPT Editorial Panel/RVS Update Committee to address potential changes in reporting structure.

Exploring Alternatives to the RUC

CMS is seeking public comment about the potential range of approaches CMS could take to improve the accuracy of valuing services. CMS also notes its interest in whether commenters believe that the current AMARUC is the entity that is best positioned to provide - recommendations to CMS on resource inputs for work and PE valuations.

The AMA’s RUC is a collaborative process within the house of medicine. The “RUC” is comprised of volunteer physicians from national medical specialty societies and other health care professional organizations. The volunteers provide expertise to the RUC regarding time, intensity, and relativity

for services that they are familiar with in our respective fields. They also provide data regarding clinical staff time, medical supplies and medical equipment. The clinical input and expertise of these individuals is imperative to ensure a fair, consistent, and resource-based payment system.

The relative value units within the physician fee schedule cannot be made in an automated way nor can they be established through independent chart reviews. There is no other entity positioned to perform the duties of the RUC volunteers. CMS should recommend process improvements to the AMA RUC if there are concerns with the existing protocols.

SVS Recommendation: The SVS urges CMS to continue to work with the AMA's RUC to establish relative value units for the Medicare physician fee schedule.

CMS Data

CMS should improve access to Medicare and Medicaid data. The first quarter of Medicare claims data should be available by July 1st of each year. A full year of claims data should be available by April each year (example, 2023 data should be publicly available by April 2024). Availability of timely Medicaid and Medicare Advantage data is also critical.

Data Anomalies

While engaging in the AMA RUC process, anomalies in the CMS data are often identified. For example, it might uncover that the rise in utilization for a particular code is the result of one provider or a very small number of outliers. Those data anomalies are then forwarded to the Agency. The SVS encourages CMS to address issues that involve a limited number of providers directly with those providers and to avoid creating far-reaching policy changes that impact an entire specialty or group of related specialties.

Services Addressing Health-Related Social Needs

CMS believes that medical practice has evolved to increasingly recognize the importance of addressing health-related social needs; however, this work is not explicitly identified in current coding. CMS is proposing to create new coding to identify and value these services for MPFS payment and distinguish them from current care management services. CMS expects that its proposed new codes would also support the CMS pillars for equity, inclusion, and access to care for the Medicare population and improve patient outcomes, including for underserved and low-income populations where there is a disparity in access to quality care. They would also support the White House's National Strategy on Hunger, Nutrition and Health, and the White House's Cancer Moonshot Initiative.

CMS is proposing five new codes recognizing services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services, and under the billing practitioner's supervision, when reasonable and necessary to diagnose and treat the patient.

CMS stated in the proposed rule concern about potential fragmentation when addressing health related social needs. One potential solution is to limit reporting of the G codes to one practitioner

per beneficiary per calendar month. Operationalizing the ‘one practitioner limitation’ will be challenging, with a real potential of discovering another practitioner has reported an instance of the G Code only after receiving a denial for their submission.

SVS Recommendation: The SVS supports the Agency’s initiative to address health-related social needs. However, we believe further work needs to be done prior to the implementation of new G codes for community health integration services, SDOH risk assessment, and principal illness navigation (PIN) services. The SVS recommends that any new G codes created to address social health needs be exempt from budget neutrality requirements. The physician services in the Medicare Fee schedule should not be reduced to pay for these new (non-medical) services.

Valuation of Specific Codes [FR section II.E.]

Proposed Valuation of Specific Codes for CY 2024

(14) Ultrasound Guidance for Vascular Access (CPT code 76937)

In September 2017, the CPT Editorial Panel revised CPT codes 36568, 36569 and 36584 and created two new codes 36572 and 36573 to specify the insertion of a peripherally inserted central venous catheter (PICC), without a subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion. This coding revision created a new bundled code and incorporated a bimodal clinical scenario, wherein a clinical staff member performs the procedure without imaging, or a radiologist performs the procedure with imaging guidance. In January 2018 when this code family was surveyed, CPT code 76937 was identified as part of this family of services. CPT code 76937 is used by a variety of specialties for a variety of similar endovascular procedures, and the utilization was expected to decrease once the PICC procedures were bundled with the imaging modalities. At the January 2018 RUC meeting, the specialty societies that perform this service proposed to review CPT code 76937 when two years of Medicare data (post-PICC bundling) became available. This would allow the specialty societies to develop a typical vignette and determine which specialties would need to be involved in the survey and valuation process. CPT Code 76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting* was surveyed for the September 2022 RUC meeting for inclusion in the 2024 cycle. **SVS appreciates CMS proposal to accept the RUC-recommended work RVU of 0.30 for CPT 76937 and the RUC-recommended direct PE inputs.**

Evaluation and Management (E/M) Visits [FR section II.F.]

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation

For CY 2021, CMS established HCPCS Code G2211 “*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*” (which replaced temporary code GPC1X) as an add-on code that may be billed for visits that are part of ongoing healthcare

services and/or visits that are part of ongoing care related to a patient's single, serious condition, or a complex condition.

As a result of these code changes, MPFS expenditures were estimated to increase by over \$11 billion, requiring CMS to reduce the CY 2021 conversion factor (CF) to comply with Medicare's budget neutrality requirements. While primary care and other office-based specialties were slated to realize significant payment increases resulting from these code changes (irrespective of the reductions to the CF), many specialties — including those physician and non-physician clinicians who rarely, if ever, bill E/M — were slated for steep payment cuts if the G2211 code was implemented. Furthermore, even without the G2211 code, primary care and office-based specialties received payment increases (in the CY2021 Rule cycle), while the others continued to face cuts. Congress intervened and instructed CMS to delay implementation of G2211 for three years.

The SVS continues to believe that code G2211 is not a separately identifiable service given the extensive changes to the office/outpatient E/M codes. Overall, there is a lack of clarity on the purpose, use and reporting of this code. Specifically, CMS stated in the CY 2019 final rule that the code was created “to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient levels 2 through level 5 visits.” That rationale no longer holds true under the finalized policy of retaining the multiple levels, because physicians may bill a higher-level E/M code for such visits, based on the level of MDM or time.

Previously, CMS based budget neutrality assumptions on primary care physicians and specific specialties reporting the add-on with 100% of their E/M office visits. In this proposed rule, CMS clarifies that the code may not be reported when a modifier -25 is reported with an E/M service, providing limited coding clarity. CMS reiterates that this service may be appended to any E/M level. CMS has not published or shared the exact methodology utilized to derive the new utilization assumptions. CMS projected utilization estimates that 38% of all office visits will append the G2211 add-on code in the first year of implementation and then several years later, 54% of all office visits will append G2211. The CMS method to predict these precise estimates was not published.

CMS proposes to mitigate some of the anticipated cuts due to the budget neutrality impact of adding the new evaluation and management (E/M) add-on code, G2211, which was finalized in 2021 but then delayed for three years by Congress with revised actuarial assumptions. Although the utilization assumptions have been greatly reduced, from 90% to 38% in 2024 and then to 54% when it is fully adopted, the add-on code will still lead to an additional across-the-board cut to the conversion factor due to budget neutrality requirements. The SVS, along with other specialty societies, has continued to highlight several likely barriers to implementing this code, including ambiguity about when to use it and how to document it, as well as concerns about patient cost-sharing obligations. CMS has not addressed these operational issues/concerns in this proposed rule.

Unfortunately, the proposed implementation of G2211 will still have a significant impact on the MPFS and CMS estimates G2211 is responsible for roughly 90% of the proposed budget neutrality reduction to the CF for 2024. G2211 remains duplicative of work already accounted for by existing

codes and, if implemented, will inappropriately result in overpayments to those using it. The code is poorly defined, lacks detail regarding appropriate use, and is not resource-based.

SVS Recommendation: G2211 is unnecessary and duplicative of previously completed code revaluation(s) designed to recognize complexity. The SVS urges CMS to delete HCPCS Code G2211 prior to the scheduled 1/1/2024 implementation. Allowing implementation of G2211 will cause further erosion of the already fragile Medicare Fee Schedule.

**SVS Comments re: CY2024 Updates to the Medicare Shared Savings Program
and the Quality Payment Program**

**Merit-based Incentive Payment System (MIPS)
MIPS Final Scoring – Performance Threshold**

Proposed Rule: CMS is proposing to use the mean of final scores from the 2017 – 2019 MIPS performance periods/2019 – 2021 MIPS payment years to set the MIPS performance threshold. This proposal would increase the performance threshold from the current 75 points in the 2023 MIPS performance period/2025 MIPS payment year to 82 points for the 2024 MIPS performance period/2026 MIPS payment year.

The SVS does not believe this is the time for CMS to propose a greater than 9% increase in the QPP performance threshold for 2024 to avoid a payment penalty in 2026. The current score of 82 points is already recognized as difficult for physicians, particularly in smaller, private practices to reach. With a higher ceiling and the clustering of scores at the upper end of the spectrum, very small differences in performance will mean many providers and groups will be subjected to a negative payment adjustment in 2026. Given the clustering of scores, which do not follow a normal distribution, we request that CMS provides additional information as to why the mean was chosen over the median. In addition, it would be informative to understand related parameters including the standard deviation, the actual distribution of scores, and the median value.

SVS Recommendation: The SVS strongly recommends that CMS take steps to alleviate the burden on MIPS eligible physicians during the 2024 performance period as we continue to deal with the after effects of COVID 19 on practices and at a minimum, CMS should maintain the current performance threshold at 75 points for 2024 performance to prevent undue penalties.

Quality Performance Category

Proposed Rule: CMS proposes to maintain the data completeness criteria threshold for the quality performance category at 75% for the 2024, 2025 and 2026 MIPS performance years and increase the data completeness criteria threshold to 80% for the 2027 MIPS performance year.

The SVS agrees that maximizing data completeness to the greatest degree possible is beneficial, both in terms of data integrity and meeting participation thresholds. However, maintaining the data completeness criteria threshold at 75% is appropriate. Raising the data completeness criteria

threshold to 80% for the 2027 MIPS performance year will be a challenge, placing a greater reporting burden on clinicians. Increasing the data completeness thresholds should not occur until there is more availability of electronic and claims-based measures that require no additional efforts from clinicians and their staffs that would detract from their practice activities.

SVS Recommendation: CMS should maintain the data completeness criteria threshold at 75 percent for the foreseeable future.

Cost Performance Category

Proposed Rule: CMS proposes to calculate improvement scoring for the cost performance category at the category level without using statistical significance beginning with the CY 2023 MIPS performance period/2025 MIPS payment year. CMS is proposing that the maximum cost improvement score of 1 percentage point out of 100 percentage points will be available beginning with the CY 2023 MIPS performance period/2025 MIPS payment year. CMS is also proposing that the maximum cost improvement score available for the CY 2022 MIPS performance period/2024 MIPS payment year will be 0 percentage points.

SVS Recommendation: The SVS recognizes the importance of improvement on the cost performance category measures and supports CMS phasing in an improvement score to recognize physician efforts with specific percentage points being allocated to their cost improvement category score. This new improvement score needs to be transparent and understandable to physicians regarding how it is achieved.

Promoting Interoperability Performance Category

Proposed Rule: CMS is proposing to increase the performance period to a minimum of 180 continuous days within the calendar year to ensure the MIPS Promoting Interoperability performance category continues to align with the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals. CMS is also proposing to modify the definition of CEHRT to incorporate the Office of the National Coordinator for Health IT new definition of Base EHR and its certification criteria for Health information technology (health IT) as proposed in its recent HTI-1 regulation.

SVS Recommendation: While this proposal could allow for greater standardization throughout the healthcare system, the SVS supports retaining the current 90-day reporting period until practices are better equipped -i.e. able to retain and hire staff to comply with increased reporting requirements such as this CMS proposal to increase the performance period to a minimum of 180 days.

Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)

Medicare CQM Proposals – Data Collection

Proposed Rule: CMS is proposing to establish Medicare CQMs, a new data collection type specifically for ACOs, which can only be reported under the Alternative Payment Model Performance Pathway (APP). Under the Medicare CQM collection type proposal, an ACO that participates in the MSSP would be required to collect and report data on only the ACO's Medicare fee-for-service beneficiaries that meet the proposed definition of a beneficiary eligible for Medicare CQM, instead of its all payer/all patient population. If reporting quality for MSSP through the Medicare CQM collection tool, CMS will provide ACOs with the list of beneficiaries who are eligible for Medicare CQMs within the ACO, upon the ACO's request. CMS anticipates the list of beneficiaries eligible for Medicare CQMs to be shared once annually, at the beginning of the quality data submission period. CMS also proposes that ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance category score.

SVS Recommendation: The SVS supports the use of robust CQMs in quality programs if it does not increase the reporting burden on providers. Collecting data from a subpopulation of the covered beneficiary group will place an additional administrative burden on the ACOs, even with a supplied list of eligible beneficiaries provided upon request by CMS. Sharing the data for eligible beneficiaries once annually may also lead to many missing data points and compromise data completeness due to beneficiaries switching plans or mortality. The SVS recommends that such calculations be performed on the back end of the reporting trail by CMS, similar to the calculations performed for risk adjustment. In addition, if the performance period is 180 days, the list should be automatically furnished biannually, without the need for the ACO to request it, to ensure data completeness and reliability. The application of the health equity adjustment needs to be transparent and easily understandable to the provider.

Medicare CQM Proposals – Data Completeness

CMS proposes that ACOs meet the same data completeness standard established/proposed under MIPS (75% for the CY 2024, CY 2025, and CY 2026 MIPS performance periods, and 80% for the CY 2027 MIPS performance period) and that benchmarks for scoring ACOs on the Medicare CQMs be aligned with MIPS benchmarking policies. CMS is soliciting comments on scoring incentives for ACOs when their specialists report quality MVPs.

SVS Recommendation: The concerns around increasing the threshold criteria for data completeness have been discussed above. It may be worthwhile to consider offering an additional scoring increase (either through bonus points or a proportional increase in total score) for ACOs who submit specialty-specific quality MVPs.

Proposals to Align CEHRT Requirements with MIPS

Proposed Rule: CMS proposes to align CEHRT requirements for MSSP ACOs with MIPS. CMS proposes to remove the MSSP CEHRT threshold requirements beginning in performance year 2024, and to add a new requirement (for performance years beginning on or after January 1, 2024) that all MIPS eligible clinicians, QPs and partial QPs participating in the ACO, regardless of track, must report the MIPS Promoting Interoperability performance category measures and requirements to MIPS at the individual, group, virtual group or APM level, and earn a MIPS performance category score. CMS is also proposing to require ACOs publicly report the number of MIPS eligible clinicians, QPs, and Partial QPs participating in the ACO that earn a MIPS performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level.

SVS Recommendation: The SVS does not support MSSP ACOs also having to compile with MIPS requirements. This defeats one of the purposes for physicians to participate in an MSSP ACO. The concept of the ACO and APP pathways should incorporate movement away from reporting under the MIPS structure as a benefit of such participation and allowing a reduction in reporting burden.

MVP reporting for specialists in MSSP for ACOs

Proposed Rule: CMS is seeking feedback on the following aspects of MVP reporting for specialists in shared savings program ACOs:

- In order to highlight specialty clinical practice within ACOs, how should we encourage specialist reporting of MVPs?

SVS Recommendation: The most important piece will be the availability of MVPs that cover the full range of care provided within a given specialty. For Vascular Surgery and other specialties, this will necessitate the development of multiple MVPs. CMS will need to facilitate the development and approval of specialty-specific MVPs, including development and approval of new quality measures for those MVPs. Incentivization for specialty-specific reporting will be essential to engagement; there will need to be a robust opportunity to earn bonus points for both participation and meeting metrics.

- How should we encourage the reporting of MVPs to collect quality data that is comparable to data reported by other specialty providers in quality MVPs and to address clinician concerns over measure appropriateness?

SVS Recommendation: The benefits of improvement within the quality metrics of the MVP should be highlighted, with tangible benefits to the reporting clinicians and score transparency. The process of quality measure development for use within the MVP should be facilitated and streamlined such that new and meaningful measures are readily available. Measures relating to outcomes or processes that can be used in the development of quality improvement projects should be prioritized.

- How should we consider encouraging specialists to report the MVP that is most relevant to their clinical practice?

SVS Recommendation: The SVS believes specialists will look to report under the most relevant MVP, if one is available to them. Therefore, the pathway for societies and groups to develop these relevant MVPs must be smooth and free from burdensome and excessive requirements.

- How should we distinguish bonus points for ACOs that report on a larger volume of patients through MVPs?

SVS Recommendation: The SVS believes that currently, there is an insufficient number of MVPs to cover all specialties in a meaningful way and that it will be some time before an appropriate threshold is reached. Bonus points for MVP reporting should be calculated relative to the number of MVPs available for use. Will there be a minimum number of MVPs required for an ACO and if so, will that number be based on the size of the ACO?

- What concerns and considerations should we be aware of when assessing ACOs for quality performance based on reporting quality measures within MVPs?

SVS Recommendation: This will depend on the nature of the ACO. Large tertiary hospital systems will likely have a higher acuity regarding the care provided under their ACOs. They are less likely to report specialty specific MVPs due to lack of bandwidth to support multiple MVP submissions. In each case, there needs to be appropriate risk adjustment and a low administrative burden for subgroup reporting.

- Would incentivizing specialty MVPs create a disincentive for ACOs to report primary care focused APP and/or MVP measures?

SVS Recommendation: There would not be a disincentive for ACOs to report primary care focused APP and/or MVP measures, as specialty MVPs and primary care PVPs focus on different groups of physicians and different measures.

- As noted above, providing ACOs with bonus points to their health equity adjusted quality performance score when ACOs' specialty clinicians report MVPs serves to encourage reporting of MVPs. Therefore, we do not intend to establish bonus points as a permanent policy. We seek comment on how long we should have bonus points in place in order to incentivize.

SVS Recommendation: If CMS believes that such reporting in the MVP framework is beneficial as good practice, then bonus points would be a meaningful permanent policy. If not, then as discussed above a threshold number of MVPs should be available which would seem to be several years away.

Proposed Rule: CMS is proposing to end the use of APM Entity-level QP determinations and instead make all QP determinations at the individual eligible clinician level.

SVS Recommendation: The SVS supports this approach.

Continuous improvement for clinicians who consistently perform well in MIPS. Currently Net Positive

Proposed Rule: CMS seeks to address the challenge in that some MIPS eligible clinicians choose measures and activities on which that they are already performing well, rather than measures and activities where they would be required to implement changes in their workflow, clinical care, or practices in order to achieve a positive payment adjustment. This selection practice, to repeatedly choose the same measures and activities on which the clinician is confident they will perform well, can mean that the clinician has less incentive to transform the way that care is delivered and continuously improve quality of the care they provide.

- What potential policies in the MIPS program would provide opportunities for clinicians to continuously improve care?

SVS Recommendation: Since all measures should be reflective of, and possibly drivers for, good clinical practice there should be no significant difference between measures such that a constant rotation between measures to maintain a score supporting a bonus payment is warranted. If clinicians are asked to report on a new measure, there should be some amount of time – i.e. 2 – 4 years - where no penalty would be leveled to promote physician reporting of new quality measures. Following adoption of the new measure, clinicians should receive a preliminary report and subsequently submit an improvement plan to avoid any penalties. One improvement measure for the purpose of gaining a quality bonus could be to adopt a rotation of the measures reported over subsequent reporting periods, to ensure that different measures are addressed over time. This would require an evaluation to be sure that such a policy does not create an undue reporting burden. Another approach could be for CMS to offer incentives to physicians to report a certain percentage of new measures each reporting period.

- Should we consider, for example, increasing the reporting requirements or requiring that specific measures are reported once MVPs are mandatory?

SVS Recommendation: As in the above recommendation, the up-front development and endorsement of robust measures within specialty and sub-specialty specific MVPs will alleviate the need for such mandates. In the current state, the SVS believes these mandates would impose a weighty reporting burden on providers.

- Should we consider creating additional incentives to join APMs to foster continuous improvement, and if so, what should these incentives be?

SVS Recommendation: If adopting an APM structure is the desired outcome for all providers and it is felt that doing so will foster continuous improvement, then joining an APM should itself be considered a significant improvement activity and associated with a bonus over a several year period due to the investment and infrastructure costs associated with joining an APM.

- What changes to policies should CMS consider to assess continuous performance improvement and clinicians interested in transitioning from MIPS to APMs

SVS Recommendation: As noted above, recognizing the transition to an APM itself and a multiple year run in period would be meaningful to clinicians and facilitate the transition. CMS offering more specialty specific APMs would be helpful, as well.

- How should we balance consideration of reporting burden with creating continuous opportunities for performance improvement?

SVS Recommendation: The SVS believes that this will require an ongoing analysis and will depend on the availability of robust MVPs and MIPS measures available for use within APMs. In addition, we recommend no change in reporting policy over a 5-year period to allow clinicians to adjust.

- The proposed IA_MVP activity would require a clinician to complete a formal model for quality improvement action that is linked to a minimum of three of the measures within the specific MVP. We believe this activity would expand and formalize quality improvement (QI) activities across practices, ultimately leading to improvements in quality of care and fostering a culture of participation among staff. In addition, this activity would incentivize voluntary MVP adoption. It is important to note that a clinician who reports an MVP can attest to the MVP improvement activity.

SVS Recommendation: We support this new IA MVP as it supports the SVS's commitment to quality improvement for the vascular patient exemplified by the ACS/SVS Vascular Verification program. This program evaluates quality and safety during the five phases of care using a multidisciplinary approach. The SVS believes that the ACS/SVS Vascular Verification program is IA ready and can serve as a model for other specialties. It can also be readily adopted by vascular surgeons and programs thereby reducing development, implementation, and administrative costs.

The SVS appreciates the opportunity to provide comments and feedback regarding the policies included in the CY2024 Medicare Physician Fee Schedule Proposed Rule. However, and as is outlined in our comments, we remain deeply concerned with the inherent instability within the Fee Schedule and the residual impact that year-over-year payment reductions have on physician practices and the patients they serve. Absent systemic reform(s), the discrepancy between what it costs to run a physician practice and actual payment, combined with the administrative and financial burden of participating in Medicare, threatens the viability of many private and/or community-based practices,

incentivizes market consolidation, and is driving physicians out of rural and underserved areas. None of these things are good for patient care. Nonetheless, the SVS reiterates its commitment to work with all relevant stakeholders to identify and advance reforms that will ensure the Medicare physician payment system remains on a more sustainable and efficient path. We are continuing collaborative efforts across the House of Medicine to educate and build interest among Members of Congress regarding necessary reforms, and we look forward to additional engagement with the Agency to strengthen the Medicare physician payment system now, and for the future.

If you have questions regarding these comments, please contact Megan Marcinko, SVS Director of Advocacy (mmarcinko@vascularsociety.org).

Sincerely,

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