Statement of the American College of Surgeons
to the Committee on Energy and Commerce
Oversight and Investigations Subcommittee
United States House of Representatives
RE: MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors
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facs.org

CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

The American College of Surgeons (ACS) appreciates the committee's focus on the implementation challenges of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The ACS remains committed to improving the care for all surgical patients and has done significant work to ensure Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken in the area of improving surgical quality and value and provide some steps Congress can take to improve the current system.

It was the understanding of the ACS that MACRA was intended to solve the problem of the failed Sustainable Growth Rate formula by eliminating annual mandated cuts not tied to the value of care provided, while simultaneously creating incentives for the delivery of higher value care. The legislation included funding for new quality measure development and created a pathway for the proposal and development of new physician-focused alternative payment models (APMs).

In practice however, MACRA has fallen short of effectively achieving either of these goals and as a result many physicians remain locked into a budget-neutral fee-for-service (FFS) system that results in frequent steep cuts and still fails to incentivize quality or value.

Since the enactment of MACRA, ACS has made significant investments to translate what we have learned about improving quality of care and outcomes into proposals to increase value for surgical patients. Our efforts have included:

- The submission of one of the first Advanced APM proposals to the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, which is the "first stop" for adoption of a stakeholder-developed APM;
- Ongoing work to increase transparency in pricing through standardization of episode definitions;
- Development of the ACS-THRIVE (Transforming Healthcare Resources to Increase Value and Efficiency) initiative in collaboration with Harvard Business School which yielded important insights into how to help hospitals and practices move toward value-based care; and
- Proposing novel quality measures that incentivize team-based care organized around the geriatric hospital patient.

Yet eight years after the passage of MACRA the situation appears grim:

- Surgeons are again facing a Medicare physician fee schedule (PFS) conversion factor for 2024 that remains below the 2015 level;
- The combination of inflation and a physician fee schedule lacking updates that account for increased practice expenses means that it costs more to deliver care while payments are declining;
- Most physicians in FFS are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvements or for patients to make care choices; and
- Surgeons wishing to move beyond FFS will find that not a single physician-focused alternative payment model is available since none of the models submitted have been tested.

Clearly this was not the intent of Congress in passing this legislation. Knowledge about how to measure and improve quality and safety in healthcare has evolved steadily as lessons have been learned and the delivery of medical care has advanced. However, Centers for Medicare & Medicaid Services (CMS) and most other payers and delivery systems have struggled to adapt to this evolution in a way that increases value and creates a meaningful pathway for patients and surgeons to benefit broadly from this new knowledge.

Payers have traditionally focused on the cost side of the quality-over-cost value equation, seeking to reduce the price paid for care while maintaining quality. This has most often been accomplished through efforts to reduce overall spending coupled with individual quality measures designed as though care were a series of discrete encounters or services. This has not been particularly effective as the cost of care has continued to grow faster than inflation in most years. Conversely, focusing on creating a collaborative and patient-focused environment for quality improvement may succeed and indeed would enhance quality and potentially reduce cost.

The current volume-over-value paradigm is at least in part a byproduct of physician payment policies that are entirely unrelated to healthcare and are the result of blunt fiscal tools, such as sequestration and budget neutrality. These payment policies lack the proper incentives to maintain quality or increase value. In a budget neutral payment environment that lacks the data and tools necessary to deliver higher quality care, and without clearly defined incentives for achieving better outcomes, the most obvious path for success can be through increased productivity.

To overcome the volume-over-value paradigm, Congress must create true long-term stability in the physician payment system. This should be coupled with coordinated efforts to help surgeons and care teams transform into value-based payment models in which they can succeed financially by improving outcomes and value for their patients.

We cannot build this house on quicksand and therefore a crucial step is to immediately stop additional cuts to the Medicare physician fee schedule planned for 2024 and beyond and to implement positive annual updates reflecting the inflation in practice costs. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the PFS conversion factor to return to the same amount it was in the year 2000. Over that same period, inflation will have significantly eroded the value of payments. Clearly this is not tenable.

Physicians Are United behind Stabilizing Medicare while Improving MACRA

The ACS, along with 19 other organizations representing surgeons and anesthesiologists, signed a statement calling for critical policy changes to bring stability to the Medicare PFS. Among the key points in this document are action items calling on Congress to stop the pending cuts scheduled for 2024, implement a baseline positive annual update reflecting inflation, and revise budget neutrality requirements to allow for appropriate changes in spending. These are only short-term measures that must be enacted by the current Congress and Administration, as we work together in the next few years toward a more sensible system of physician payment that accounts for quality and value. ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing health disparities and ensuring the availability of high-quality care across all settings are imperative, and medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may not be relevant to the

patients treated. **Congress and CMS should encourage innovation in value-based payment models that provide and utilize timely, actionable data to allow physicians to improve care.**

Additionally, there are temporary provisions of MACRA that could support the transition to value-based care, particularly given the delayed implementation of physician-focused payment models and the current lack of meaningful participation options. **Last year, Congress provided a temporary extension of the additional incentive payment at a reduced rate for the highest performing physicians in the Merit-based Incentive Payment System (MIPS) program. This incentive payment could support practices who are making investments to succeed in the current program.** Absent the additional incentive, physicians in the MIPS program with the highest scores would have seen payment updates that were a mere fraction of a percent, hardly commensurate with the work it takes to meet the requirements of the payment program. This is a disincentive to making investments that set a practice up to succeed in value-based payment arrangements.

Similarly, the sunsetting of incentives and increasing of thresholds to become a qualified participant (QP) in an advanced alternative payment model (APM) is premature given the lack of meaningful participation options for physicians in many specialties. The APM incentive was intended to attract early participants to models developed under MACRA's new pathway. However, as discussed below, none of the many models reviewed and recommended for testing and implementation have been acted upon by CMS. **Along with the extended incentive payment, Congress should consider taking additional steps to ensure that MACRA's vision of physician-developed models is realized. Flexibility in participation thresholds should similarly be granted to encourage participation.**

ACS Efforts to Drive Quality within the Confines of MACRA

Once a stable payment foundation is achieved, we can begin the task of moving beyond the transactional, siloed measures currently used to differentiate between individual physicians for payment purposes. As discussed, the current measures fail to recognize that care for all but the simplest ailments requires an integrated team of skilled individuals with the appropriate resources and structures to deliver optimal care. This failure is especially evident in the way that we currently measure quality for surgery throughout the Medicare Quality Payment Program (QPP) including both in MIPS and in the design of many of the CMS APMs.

Little actionable information is available in either option to inform surgeons for care improvement, or patients for making decisions about their care. Even when measures for surgeons and their patients are in place, surgeons are typically measured separately from the hospital or facility in which the care was provided and separately from the other members of the care team: using different goalposts for the surgeon, anesthesiologist, pathologist, the hospital, and others critical to successful patient care. In fact, a large portion of surgeons are not individually assessed in the MIPS at all because their institutions (employers) select primary care measures to report through the CMS MIPS Web Interface reporting option. These measures apply to all eligible clinicians who fall under the employer's tax identification number (TIN). Current measures therefore do not create incentives for care coordination or value-improvement because they fail to look at care as experienced by the patient, including their goals of care, safety during care, and the ultimate experience and outcomes of that care as a comprehensive whole.

The ACS experience in quality has taught us that it cannot be sufficiently assessed or incentivized by simply tracking specific transactions or adverse events such as mortality, surgical site infection, or reoperation. These are important indicators of failures in the system and are critical metrics for driving quality improvement, but we believe the surgical team must ensure more than just avoiding adverse events to achieve value that matters to patients. One must evaluate the entire course of care and assure that each of the necessary processes, structures, and personnel are in place to achieve the desired outcomes. ACS Trauma Verification, ACS Bariatric Surgery Accreditation, and ACS Geriatric Surgery Verification are examples of some of our efforts at ensuring that patients have access to the expertise, personnel and resources needed to attain high quality care. **Building this type of effort into a shared programmatic measure would provide shared incentives for coordinated teams engaged in patient-centered care.**

The ACS knows that value-based health care is about putting patients at the center, with teams of coordinated clinicians working to produce the best outcomes for those patients. The concept of value in health care must be defined in terms of results that matter to the patient for the condition they have. Patients on a care journey need patient-centric measures across their clinical pathway that appreciate the achievement of their care goals. These measures should inform patients about where to get affordable, and equitable care from provider teams with a track record of achieving the desired outcomes and avoiding preventable harms. CMS appears to recognize this but seems hampered by statutory requirements carried over from early quality programs and may require legislative changes from Congress providing more direction and greater flexibility to lean on expertise from the physician community to facilitate the value transition.

From the ACS' perspective, the mindset needs to be changed from the current game of penalty avoidance to one that: (1) encourages implementation of quality programs built around care for specific conditions; (2) aligns with the team-based nature of care delivery; and (3) provides useful information that supports patients when they must determine where to seek medical care. We encourage Congress to develop legislation that would improve the QPP and foster the value transformation by meeting the above objectives.

Barriers to Achieving Value-based Care

Unfortunately, our efforts have encountered challenges that have slowed progress. Our efforts to improve geriatric surgery quality measurement and our Advanced APM proposal are prime examples. Our geriatric hospital and geriatric surgery measures are "programmatic measures" that include the full spectrum of elements needed for optimal geriatric care such as a focus on patient goal identification and shared decision making, medication and pain management strategies, and post-discharge care plans. Additionally, the measures promote health equity by accounting for social determinants of health. The concept behind the programmatic measure is based on several decades of history implementing programs that demonstrably improve patient care provided by the clinical team along with the facility. Given the patient population, these measures would of course be applicable to Medicare, but another benefit is that this type of measure could be widely applied across CMS and other payer programs. Surgeons in the MIPS or a MIPS Value Pathway (MVP) could benefit from such measurement but unfortunately, it is not an option to design an MVP proposal that would recognize the hospital geriatric programmatic measures due to CMS' perceived lack of authority to align efforts with facilities—instead proposing we use the concept as a MIPS Improvement Activity. At a minimum, the level of effort and comprehensiveness of this proposal would merit using it to derive both the Quality and Improvement Activity category scores.

Congress should improve MIPS by providing CMS with explicit authority to use measures developed through alternative evidence-based pathways such as those described above.

Since these measures differ from those in use by CMS in physician payment, it has proven difficult to fit into the current regulatory framework despite a strong evidentiary base of its potential benefits and broad support across organizations who care for older adults.[1] The ACS approach to comprehensive quality accounts for the entire care team, including clinicians and facilities, but CMS finds that it most resembles structural hospital measures. Last year, at CMS' request, we submitted the two programmatic quality measures for consideration in the Hospital Inpatient Quality Reporting Program (IQR). The Geriatric Hospital Measure incorporates elements of the Institute of Healthcare Improvement's (IHI) Age Friendly Health Systems program, standards from the Geriatric Emergency Department Accreditation (GEDA) framework developed by the American College of Emergency Physicians (ACEP), and ACS Geriatric Surgical Verification (GSV) standards; the Geriatric Surgery Measure focuses on surgical care. Both measures were reviewed by the Measures Application Partnership (MAP) for consideration in the Hospital IQR program. The MAP was supportive of both measures but had concerns with reporting burden. In response, ACS resubmitted a single more streamlined Age Friendly Hospital Measure. Now, due to the pre-rulemaking requirements, this measure must go through the lengthy, resource intensive measure review process again this year. Even if such a measure were implemented in the IQR, its use across other programs, such as in MIPS, would be dependent upon it being later adopted into the Hospital Value-Based Payment program and would still be limited to a subset of physicians providing a substantial portion of care in the in-patient setting. **Congress should expand facility-based scoring in MIPS to accommodate the type of collaborative measure proposed by ACS, such as the Age Friendly Hospital Measure, to incentivize care delivery that has a patient-centric approach. This type of measure will help build a better, safer environment for the geriatric patient and will help patients and caregivers know where to find good care. This should include expanding the program to additional settings such as hospital outpatient departments and ambulatory surgical centers in cases where the facilities are reporting this or similar measures.**

Similarly, our efforts at implementing an Advanced APM were hindered by a breakdown of the process envisioned in MACRA. Along with dozens of other groups, ACS developed and submitted proposals that were reviewed, revised, and evaluated by the PTAC. Fourteen proposals have been recommended for testing or implementation by the PTAC, but CMS has not tested a single one as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs. The ACS-Brandeis Advanced APM proposal included shared accountability for cost and quality for defined episodes of surgical care and allowed for the entire care team to work together toward shared goals. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are prerequisites for a valid depiction of the value of care. The ACS has supported the development of standardized episode definitions to foster alignment of both price and quality measurement and create shared accountability for the team of providers. Our proposal would provide the data and incentives necessary to drive value improvement in specialty care. While it is our impression that Congress has provided the resources to CMS and the Innovation Center that are necessary to stand up and test PTAC recommended APMs, there is nothing within the law to compel CMS to try out new programs. This creates further

[1] https://www.healthaffairs.org/content/forefront/need-geriatrics-measures

barriers to those seeking to move to value-based care. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing APMs recommended by the PTAC.**

Congressional Action is Needed to Improve MIPS and APM Participation: In Summary

The value-transformation is underway but could be greatly accelerated through a combination of shoring up the foundation of the physician fee schedule and partnership between CMS and stakeholders interested in improving the way quality is measured and incentivized. Congress has the power to provide CMS with direction, flexibility, or additional authority to help them achieve the goal of improving value. **ACS proposes the following specific action items for Congress to consider:**

- **First, prevent pending cuts and implement an update mechanism in the physician fee schedule to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;**
- **Eliminate the Medicare PFS budget neutrality requirement or increase the trigger threshold from $20 million to $100 million and index it annually to account for inflation;**
- **Grant CMS flexibility in MIPS to test and use novel measures developed and vetted through alternative, evidence-based pathways and to score multiple categories if deemed appropriate;**
- **Expand facility-based scoring in MIPS to accommodate the type of collaborative measure proposed by ACS. This should include expanding the program to additional settings such as hospital outpatient departments and ambulatory surgical centers in cases where the facilities are reporting this or similar measures; and**
- **Expressly direct that, at a minimum, a portion of the Innovation Center's budget be devoted to testing APMs recommended by the PTAC.**

These are relatively modest reform ideas that stabilize the physician fee schedule and build on MACRA to put the focus back on providing high value care to the patient. Surgeons are eager to be part of the solution and to work with Congress to advance critical reforms. In addition to improving quality through implementing a comprehensive quality program and shared accountability, more could be done to improve the cost or price side of the equation as well. As noted above, the ACS has participated in efforts to define standard episode definitions for better price and cost measurement. Current measures of price (what is ultimately paid for care by the patient or their insurers) for episodes of specialty care are frequently siloed and overly narrow, similar to what is seen in quality measurement. While price transparency is broader than value-based payment reform, in the context of MACRA more comprehensive price measures that correlate with quality measures would be a logical next step in improving the value equation.

The ACS thanks you for convening this important hearing on the implementation of MACRA and for the committee's attention to improving quality and value for Medicare patients. We share this commitment and look forward to working collaboratively with the committee to achieve the goal of safe, affordable care for all Americans. Please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org if you would like to learn more about our efforts to improve the quality of surgical care.