Statement of the American College of Surgeons

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Committee on Finance

Bolstering Chronic Care through Medicare Physician Payment

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The American College of Surgeons (ACS) thanks the Senate Finance Committee for convening a hearing on the challenges of the Medicare physician payment system. The ACS remains committed to improving the care for all surgical patients, including those living with chronic conditions, and to ensuring that Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken in improving surgical quality and value. We hope to continue partnering with Congress on potential reforms to the current system to ensure that improving care and access for the surgical patient stays at the forefront.

The ACS and our more than 90,000 members recognize the impact that chronic conditions can have on surgical patient outcomes. These conditions have a distinct impact on the finances of Federal health programs and create additional challenges for providing high quality care. In the United States, more than 130 million adults suffer from at least one chronic condition.[1] These patients often require additional preparations or more intensive post-acute care after surgery is performed. ACS is focused on improving the quality of care provided and achieving the optimal outcome for all our patients.

Our surgeon members have first-hand experience with the challenges posed by the lack of an inflationary update and more recently the continued reductions to fee-for-service Medicare payments. Centers for Medicare & Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts. These reductions are often the unintended consequence of statutory budget neutrality requirements for the physician fee schedule. One aspect of budget neutrality falls on the Medicare Physician Fee Schedule conversion factor. These conversion factor reductions create a strain on physicians working towards value-based care and fail to incentivize quality or care coordination. This results in the Medicare program taking resources away from certain physician specialties in order to finance priorities in other areas. A payment model designed in such a way that different specialties are pitted against one another is counterproductive, since all specialties are doing their best to provide quality care to their patients with ever-scarcer resources. Since 2001, physicians have seen their Medicare physician payments decrease by 13 percent in real terms between 2001 and 2024 before indexing for inflation. In addition to these cuts, the impact of inflation has raised the overall cost to provide care as costs for rent, equipment, staffing and utilities have increased. Surgeons and other physicians have also seen an increase in financial pressures to meet new bureaucratic barriers such as increased use of prior authorization in Medicare Advantage.

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (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 and approval of one of the first Advanced Alternative Payment Model (APM) proposals to the MACRA-enacted 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; and
- Proposing novel quality measures that incentivize evidence-based, team-based care organized around the geriatric hospital patient.

Yet today, many physicians still struggle with the same barriers to improving outcomes and transitioning to modern payment systems that they did a decade ago:

- Surgeons are faced with a Medicare physician fee schedule (PFS) conversion factor for 2024 that

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/

remains below the 1998 level[2];

- The combination of inflation and a lack of physician fee schedule updates to account for the increasing cost of providing care means that it costs more to deliver care while payments are declining;
- Most physicians in fee-for-service (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 improvement efforts or for patients and referring physicians to make care choices; and
- Surgeons wishing to move beyond FFS will find few physician-focused alternative payment models are available for them, since none of the models submitted to the PTAC have been tested as proposed.

To create stability in the Medicare physician payment system, Congress should immediately address cuts already expected in 2025. A foundational step necessary to maintain access and improve quality for patients is the implementation of 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.

Stabilizing Medicare Physician Payment

The ACS is committed to working together with Congress to ensure the stability of the Medicare PFS through both short and long-term policy improvements. The Medicare PFS suffers from multiple shortcomings that have negatively impacted the care provided to our patients. It is unique in its lack of a meaningful mechanism to account for inflation and is currently in a multi-year window until 2026 where any positive updates to physician payment must be legislated. Once the positive updates begin in 2026, current law only provides a 0.25 percent conversion factor update for non-APM participants and a 0.75 percent update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without Congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an annual update for the PFS, it is unlikely that future payments will keep pace with medical cost inflation. This concerning combination of high inflation and a lack of any update for expenses results in a need to deliver expected high-quality care while payments are rapidly declining.

While Congress has taken action to address some of these fiscal challenges by mitigating part of the recent PFS cuts, Medicare payment continues to decline year after year. The recent 1.68 percent positive adjustment only partially offsets the 3.37 percent cut that went into effect in early 2024, and further cuts are expected in 2025. These yearly compounding cuts, combined with a broad lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken and falling short of the goals of MACRA. **As a starting point to create a more stable foundation for value-based care initiatives, ACS supports building an update into the Medicare Physician Fee Schedule, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors**. This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives.

The impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget neutrality trigger. The budget neutrality requirement in a system with no inflationary updates results in across-the-board cuts for any changes to the PFS expected to increase expenditure by as little as $20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger

[2] https://www.ama-assn.org/system/files/cf-history.pdf

for budget neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. **Congress, at a minimum, should amend 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current $20 million budget neutrality adjustment trigger and index it for inflation going forward**.

Adjusting the budget neutrality trigger is an example of a small, but important, concrete step Congress could take to improve the functioning of the current system. Without meaningful adjustments to account for the increased cost of staff, office space, and other resources, surgeons will find it increasingly difficult to continue to improve care and outcomes. Beyond this, it will be necessary to counteract the effects of inflation to help provide stability while Congress and the Administration provide support to facilitate the transition to value-based payment models.

The ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing well-documented 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. This could partially be achieved through testing and expansion of alternative payment models developed by and for specialists. These models should complement primary care focused models, not compete with them, and could include primary care physicians and other specialists focused on chronic conditions in the fiscal attribution model and rewards to encourage care coordination. **Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.**

Facilitating the Transition Value-based Care

The ACS believes that medicine should be moving steadily toward a system that truly rewards the value of care provided. APMs can facilitate better care and could also be used to incentivize physicians to practice in rural or underserved areas. Unfortunately, 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 model through the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs, as witnessed by the lack of new proposals on the PTAC website since 2020.

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, including the primary care physician, 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 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 physician and specialist-developed APMs recommended by the PTAC.**

Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual, disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural and under-resourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are currently evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported data applies two years after the data has been reported. This means that no actionable, recent information is available for improvement or to help patients choose the best care for them. In contrast, ACS has designed quality programs to overcome barriers faced by surgeons and other physicians who want to work together to coordinate and improve care. Based on these efforts and the more than 100-year history of ACS working to improve the quality and value of care for surgical patients, the ACS believes addressing the shortcomings of traditional Medicare FFS payments will require new types of quality measures, facilitated by increased flexibility in the facility-based scoring option in MIPS. As described below, such a combination will improve care coordination and reduce surgical complications.

The ACS believes that surgical patients deserve to have the right structures, processes, and personnel in place to provide optimal care and that information should be available to allow them to find and access such care. **Verification programs like the Quality Verification Program (QVP) or the Geriatric Surgery Verification program (GSV) could be used as the basis of programmatic measures that more accurately assess the ability of a system to provide high quality care to patients.** Programmatic quality measures do the following:

- Align multiple structure, process, and outcome measures;
- Target condition or population specific care;
- Apply to multiple quality domains;
- Address the continuum of care; and
- Create actionable information for care teams and patients.

Our experience with programmatic measures exhibits 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.

In early 2023, the ACS submitted a programmatic measure, the Age Friendly Hospital Measure, to the CMS Measures Under Consideration (MUC) list to demonstrate how programmatic measures could be implemented in CMS programs. We are optimistic this measure will be included in the Fiscal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) proposed rule and will hopefully be available for hospital reporting in future years. This measure considers the full program of care needed for geriatric patients. It incentivizes hospitals to take a holistic approach to the provision of care for older adults by implementing multiple data-driven modifications to the entire clinical care pathway spanning the emergency department, the operating room, the inpatient units, and beyond. The measure puts an emphasis on the importance of defining patient (and caregiver) goals, not only from the immediate treatment decision, but also for long-term health and functional status. The measure underscores the importance of aligning care with what the patient values. It acknowledges certain processes, outcomes, and structures that are necessary for providing high-quality,

holistic care for older adults across five domains:

- **Domain 1: Eliciting Patient Healthcare Goals:** This domain focuses on obtaining patient's health related goals and treatment preferences to inform shared decision making and goal concordant care.
- **Domain 2: Responsible Medication Management:** This domain aims to optimize medication management through monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm.
- **Domain 3: Frailty Screening and Intervention (i.e. Mobility, Mentation, and Malnutrition):** This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition for the purpose of early detection and intervention where appropriate.
- **Domain 4: Social Vulnerability (social isolation, economic insecurity, ageism, limited access to healthcare, caregiver stress, elder abuse):** This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan.
- **Domain 5: Age Friendly Care Leadership:** This domain seeks to ensure consistent quality of care for older adults through the identification of an age friendly champion and/or interprofessional committee tasked with ensuring compliance with all components of the measure.

If adopted and implemented, the Age Friendly Hospital Measure could be further enhanced through an expansion of the facility-based scoring option of the Quality Payment Program to make the same measure directly applicable to physicians. Facility-based scoring opportunities are currently limited to very specific circumstances. This scoring method should be expanded to cover more physicians, more facility settings and reporting programs, and to apply it to all four Merit-Based Incentive Payment System (MIPS) categories (to include Promoting Interoperability and Improvement Activities, in addition to Quality and Cost as currently in statute). In such a scenario, the score would be determined automatically unless physicians prefer to submit additional data and be scored through a different scoring option. Then, like in other cases, they would have the option of reporting data of their choice.

The ACS developed programs like GSV and QVP have demonstrated marked improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas all of which involve the clinical team and facilities coming together to improve the delivery of care. Alignment with facility reporting is critical for care centering the patient. **We believe a voluntary expansion of facility-based scoring to additional physicians, sites of service, and to all MIPS categories could greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the payment environment.**

Surgical Quality and Impact on Chronic Care

The ACS recognizes the impact of chronic conditions on both surgical patient outcomes and the finances of federal health programs. Chronic conditions also have a huge impact on the quality of life of patients and in many cases, surgeons are best positioned to intervene to fix longstanding problems. Patients with chronic, comorbid conditions often face additional challenges in surgery and may need additional preparation or more intensive post-acute care after surgery. ACS's Strong for Surgery initiative provides checklists, tools and resources that can be used to ensure patients are controlling blood sugar, managing medications, and stopping tobacco use to reduce the risk of adverse events and improve outcomes from surgery. Additionally, surgical procedures often play a role in the prevention of chronic condition progression or can even serve as curative treatment of some chronic conditions. Surgical intervention to address chronic conditions comes in many forms and continues to grow with the introduction of innovative technologies and procedures, such as

groundbreaking work in the area of xenotransplantation, which will help save even more lives in the future and overcome shortages of viable donor organs for transplantation. Curative interventions include orthopaedic surgery for chronic joint pain, transplantation for organ failure, and bariatric surgery, which can be an effective treatment for obesity, diabetes, hypertension, and osteoarthritis. Reducing obesity can further treat or prevent other conditions such as cancer etc.[3]

Even the effects of a traumatic injury can be considered a chronic condition, and surgeons play a key role in helping those affected emerge from trauma and re-enter normal life, both through surgical skill to address the immediate injury, and by being part of a team-based approach to managing the injury from stabilization through rehabilitation. Simply put, surgery lets people get back to work and live fuller, more productive lives. ACS is focused on improving the quality of surgical care for all patients and avoiding or managing chronic conditions is an important aspect of this.

Quality has been the cornerstone of the American College of Surgeons (ACS) since its founding more than a century ago. Through the Power of Quality campaign, ACS is on a mission to improve surgical quality and patient care for every patient and in every setting across the country. This includes expanding the reach of ACS Quality Programs to more hospitals, enlisting more surgeons in quality improvement efforts, encouraging adoption of quality metrics into public policy, and expanding patient recognition of the important role these programs play in health care. At the ACS, we believe a strong, united voice for surgery is essential to effective advocacy in service of our patient and surgeon community. With thirteen ACS Quality Programs, the ACS has set the standard for high quality, evidence-based surgical care and is the definitive marking of quality patients should seek.

Achieving optimal outcomes for the surgical patient must include a highly qualified surgeon and must involve an entire well-functioning team. This focus on team-based care includes coordination with primary care physicians and other specialists to ensure that the patient's chronic conditions are managed to help patients achieve the best possible outcomes. This commitment to team-based care is witnessed by our verification programs, which include standards related to disease management. For example, the ACS Surgical Quality Verification Program or QVP includes a standard on "Disease-Based Management Programs and Integrated Practice Units." The purpose of this standard is to ensure that the surgical management of diseases, procedures, and patient populations requiring multispecialty care is integrated, organized, and standardized. Another standard on team-based processes in the five phases of surgical care requires facilities to document processes to optimize patients for surgery through review of medications and glycemic controls and processes to ensure continuity of care postoperatively. The standard also looks specifically at the unique needs of geriatric patients, including management of prescriptions for multiple chronic conditions frequently found in this population. ACS recognizes hospitals that successfully meet these standards through our Power of Quality campaign.

This focus is not new and was also demonstrated in the ACS-Brandeis Advanced APM, where the entire care team including primary care and other specialists managing chronic conditions could participate to improve value. Unfortunately, the model was never advanced by CMS. Team-based APMs with patient-focused measurement represent an opportunity to both improve patient outcomes and lower costs for Medicare through increased efficiency.

[3] https://asmbs.org/for-patients/explore-conditions-procedures/

Congressional Action is Needed to Reform Medicare Payment: In Summary

The value-transformation is underway but could greatly benefit and accelerate through a combination of improving the foundation of the physician fee schedule and efficient investments in the 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, and additional authority to help 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;**
- **Expressly direct that, at a minimum, a portion of the Innovation Center's budget be devoted to testing APMs recommended by the PTAC; and**
- **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.**

These are relatively modest reform ideas that would stabilize the physician fee schedule and build upon MACRA to squarely focus on providing high value care to our patients. Surgeons are devoted to being part of the solution and to continue to work with Congress to advance these critical and necessary reforms.
The ACS thanks you for convening this important hearing and for the committee's attention to improving quality and value, particularly for those with chronic conditions. We share this commitment and look forward to working collaboratively with the committee to achieve the goal of safe, affordable care for all Americans.