June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
U. S. Senate
Washington, DC 20510

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

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the more than 90,000 members of the American College of Surgeons (ACS), thank you for the ongoing attention to the need to reform Medicare physician payments. It is clear from reading through the whitepaper and request for information "**Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"** (the white paper) that the Committee shares the ACS' commitment to improving the care of and long-term outcomes of our nation's seniors.

While much of the focus of the document appears to be on the importance of primary care in managing the care of patients with multiple chronic conditions, we would point out that the complex care needs of these patients require the participation of a cohesive team of providers, frequently including surgeons and other specialists. We therefore welcomed the inclusion of the surgeon's perspective at the recent Finance Committee hearing on the subject in April. The ACS response to the white paper refers to and expands upon my testimony from that hearing. It is also notable, as pointed out in the white paper, that nearly 95% of seniors live with at least one chronic condition and two-thirds have two or more. For this reason, the ACS has built standards related to optimizing chronic conditions prior to surgery into many of our quality programs. Since a large majority of seniors (and nearly half of all Americans) have one or more chronic conditions, the ACS believes strongly that any efforts intended to improve the quality of care must recognize and reflect this fact.

In addition, we urge consideration of the following principles which were included in a RFI response letter from ACS and other organizations representing key stakeholders in the surgical care of Medicare beneficiaries:

- **Any reforms to the system must include additional funds to support appropriate and sustainable payments for physician services, including an annual inflation update based on the Medicare Economic Index.** A Congressional commitment to better fund Medicare physician payments is essential to meaningful, sustainable reform. Reallocating an already insufficiently funded Medicare payment system will not solve our enduring problem.
- **The punitive budget neutrality system must be reformed.** Mandating deep cuts to certain physician services for no reason other than to increase payments for other

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physician services is an unfair and outdated policy. Congress must modernize this dangerous mechanism that pits physician against physician and deters team-based care.

- **All components of Part B spending must be reviewed.** Pressures negatively impacting the fee schedule are multi-fold, including the shift of services from inpatient and outpatient settings to physician offices, as well as higher-cost supplies and services. Their impact on physician payments must be given consideration.
- **Recognition of the value of surgical care.** We commend the committee for their efforts to address primary care payments. Surgical services should also be recognized for their value to Medicare beneficiaries with appropriate and sustainable payment rates. All patients — including our nation's seniors — deserve access to the full range of medical care, so the system must be equitable and support surgical and other specialty care as well as primary care.
- **Efforts must be redoubled to develop workable voluntary surgical-based value-based payment models.** The lack of meaningful opportunities available through the QPP program must be remedied as part of any new payment system. The Centers for Medicare & Medicaid Services' failure to leverage clinical data registries and other alternative payment models developed by our members is but one of the shortcomings of the QPP, and the committee should take a fresh look at ways to improve these quality improvement tools.
- **Any changes to the physician payment system should consider ways to reduce administrative burden to focus resources on patient care.** The committee's reform efforts offer a unique opportunity to address the costly and burdensome administrative challenges faced by all physicians. This includes the proliferation of meaningless quality and cost measures that do little to improve quality and decrease costs. Efforts to streamline the Merit-based Incentive Payment System with its siloed approach to measuring value are long overdue.

Background

The practice of medicine has evolved greatly since the foundations of our current Fee-For-Service (FFS) physician payment system were laid decades ago. The resource based relative value scale (RBRVS), which was developed in the 1980s and implemented in the 1990s, is an effective method for determining prices for individual encounters, procedures and services but appears insufficient on its own to support team-based, patient-centered care.

Periodic refinements to the Medicare physician payment system have attempted to keep pace with the rapidly evolving practice of medicine and the needs of a growing senior population while simultaneously slowing growth in medical spending but have largely been unsuccessful on all fronts. This has left us with a cumbersome and confusing system, which largely ignores inflation, is irreflective of life saving or life changing innovations, creates adverse incentives for efficiency and fails to support the type of complex, coordinated care needed by patients with multiple chronic conditions.

Recent federal efforts to break out of the FFS construct through alternative payment models (APMs) have shown promise but have been limited by a reluctance to be truly innovative.

Innovation requires firsthand knowledge of the problems and challenges to be overcome as well as the inspiration and the development of novel strategies to overcome these challenges. Additionally, a willingness to iterate is needed. This will require the testing of multiple ideas and keeping and improving upon what works while discarding what is ineffective. The driving factor for current Centers for Medicare & Medicaid Services (CMS) APM efforts has understandably been cost containment, given their mandate to run a healthcare system for millions of seniors under significant budget constraints. CMS looks at things through a largely financial lens and seeks to shoehorn clinical care, safety assurance, and quality improvement into a payment construct.

The result has been a stubbornly hard to escape FFS system, resistant to innovation in the business model for care despite major changes in clinical care. The ACS believes that the CMS perspective of starting with a payment construct and layering quality and efficiency programs on top is a root cause of many of the problems apparent in the current system. It would be logical and preferable to instead start with the quality program and then build payment incentives tailor made to support physicians who adopt best practice and reward care teams who center the patient and provide the highest quality care in the most efficient manner.

The ACS applauds ongoing efforts to redesign primary care to better support prevention and care-coordination for complex patients such as those with multiple chronic conditions. It is notable that in many cases these efforts seem to recognize the need for additional resources to support the transformation from FFS to value-based primary care. The same level of support and acknowledgement are justified to recognize the value of patient-centered specialty care. Just as with primary care, there are significant costs associated with the reorganization of clinical care pathways and business models to move from FFS to a coordinated health system that is necessary to center the patient.

If one attempts to envision care from the perspective of the patient (and their primary care physician), the lack of actionable information on how to choose the best surgical care team quickly becomes apparent. This is because current MIPS measures provide no data to indicate whether or not the care team has the right structures, processes, and personnel in place to safely treat patients of different complexities. A healthy patient with a straightforward diagnosis will require different resources from a highly comorbid and complex patient.

Producing such actionable data will require more than measuring the surgeon, the anesthesiologist, the facility, and other contributors to a surgical episode of care individually. This will miss the mark for informing patients about the outcomes they are seeking because high quality care requires coordinated, high-functioning teams. Also, when an individual physician is the unit of analysis, the sample sizes are often too small to be actionable for differentiation.

The ACS Quality model, in contrast, assesses the structural readiness and processes for optimal care of an entire care team for a specified patient population. This can be demonstrated through a detailed verification process that ensures the standards are being met and the degree to which those standards are met. The ACS has developed several such verification programs in a range of care areas such as geriatric surgery, trauma, bariatrics, or cancer care. These programs include a number of standards that relate directly to the care of patients with chronic conditions.

For example, the Surgical Quality Verification Program (or QVP) includes a standard on "Disease-Based Management Programs and Integrated Practice Units" that ensures 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, glycemic controls, and processes to ensure continuity of care postoperatively once the patient has been discharged back to the care of their primary care physician (PCP) or managing specialist. ACS standards also look specifically at the unique needs of geriatric patients, including management of prescriptions for multiple chronic conditions frequently found in this population.

Addressing Payment Update Adequacy and Sustainability

- **As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?**

Under MACRA, the physician fee schedule is currently in a six-year period of 0% updates. When factors such as budget neutrality, PayGo, and sequestration are taken into effect, the result has been reductions that Congress has had to act on an annual basis to partially or fully delay. Starting in 2026, updates are set statutorily at 0.25% for those in FFS and 0.75% for qualified Advanced-Alternative Payment Model (A-APM) participants. These update levels were essentially a placeholder in the MACRA legislation, are not in any way reflective of inflation in general or medical inflation specifically, and are set at such a low level that they are likely to be completely erased by budget neutrality requirements in most years. This lack of a mechanism to account for inflation in the cost of physician services is unique among Medicare payment systems, with other areas such as hospital in-patient and outpatient, home health, or Skilled Nursing Facilities (SNFs) updated annually to offset increased costs of labor, rent, and other inputs.

The ACS continues to urge Congress to bring the physician fee schedule in line with other areas of Medicare payment through implementation of an annual, automatic inflation adjustment to the conversion factor (CF). This change would account for increases in the cost of providing care to Medicare beneficiaries. The rampant inflationary pressure in recent years has jeopardized physicians' ability to continue to provide the high-quality care expected in a timely manner. The cost of staff, rent, technology upgrades, medical supplies, and other resources have continued to rise while the per-unit reimbursement to physicians has not kept pace, and in many cases has decreased. This problematic occurrence is compounded by how payments are set across the health care system. Facilities incur many of the same costs as physician practices with similar inflation dynamics, but facilities receive inflationary adjustments to account for this phenomenon. Due to this, it becomes a severely distorted employment market for the same staff and labor where facilities receive money from Medicare to hire staff in recognition of inflation while physician practices do not. This lack of assistance places a greater burden on physician practices than on all other providers. At a minimum, an annual inflationary index to mitigate these increases in costs should be adopted.

The ACS also believes that it is time to adjust the estimated change in spending that triggers a budget neutrality cut. Under current statute, when there is an increase annually of $20 million to the fee schedule it automatically requires CMS to implement across the board cuts for

physicians. This dollar amount is not indexed for inflation and has not been updated since implementation of the fee schedule in 1992. Increasing this amount to $100 million and indexing it for inflation moving forward would help to increase stability in Medicare physician payment by eliminating the need for cuts when necessary but minor changes are implemented to the fee schedule.

- **Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?**

The ACS strongly believes that to better center the patient in the delivery of care, payment systems must be moving steadily toward rewarding care teams for providing high-value care rather than just providing more care. Achieving this transformation will require structural changes within health systems, which are not without cost. The 5% incentive for APM participation under MACRA was an important investment in this transformation and its extension (although at lower rates) has been welcome. Starting with the 2026 performance year, MACRA also institutes differential payment updates of 0.25% for those in MIPS and 0.75% for qualified A-APM participants who meet the threshold for the percent of payments or patients seen through an APM. This payment differential serves to signal the importance of the move toward quality and value-based payment.

Unfortunately, efforts at developing, testing, and implementing Advanced APMs have been hindered by a breakdown of the process envisioned in MACRA. Along with dozens of other groups, the ACS developed and submitted proposals that were reviewed, revised, and evaluated by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). More than a dozen proposals have been recommended for testing or implementation by the PTAC, including several targeted at populations suffering from chronic conditions, but CMS has not tested a single model through the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) as envisioned. 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. No payment differential will succeed in moving physicians into A-APMs if meaningful models do not exist for them. While ACS supports differential payments for value-based care and extension of APM incentive payments, we also point out that it is vital that Congress and CMS invest in the development of physician-developed models. Such models will be more likely to succeed where CMMI models have struggled because they will have the clinical relevancy and actionable data necessary for physician buy-in.

- **What targeted policies should Congress consider pursuing to offset the costs associated with an alternative CF framework?**

The ACS does not have specific offsets but does strongly believe that moving away from FFS into more team-based, patient-centered care models will increase value both in terms of increasing quality and reducing spending on things such as duplicative services, or complications. Many of the models recommended by the PTAC and currently sitting idle were expected to reduce spending. In contrast, CBO estimates that models designed and tested to date by CMMI have ended up costing the federal government $5.4 billion. In the few cases where models did achieve savings over the cost of administration, the resulting amounts have been small, and in at least one case savings disappeared completely once the model was expanded.

Alternatively, research has continuously shown the value of physician-driven quality programs such as those developed by ACS in avoiding deaths, adverse events, and other costs. It is time to try a new pathway to achieve the goal of bending the cost curve.

Budget Neutrality Adjustments to the Conversion Factor

- **What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?**

Ideally, budget neutrality should not be an impediment to advances in technology, science, and the practice of medicine that meaningfully benefit patients. When overestimates of how much a policy change will cost inadvertently remove funds from the overall physician payment pool this harms all providers. Steps should be taken to ensure that cost and utilization estimates are as accurate as possible, and funding should be restored to support needed care for Medicare beneficiaries. While reversing cuts due to overestimates of utilization would be beneficial, the ACS also does not believe that it makes sense to penalize all providers through budget neutrality adjustments when small but meaningful changes are necessitated by advances in best practices or the science of medicine. Patients with competing care needs should not be required to sacrifice access or quality of care.

- **Should the Committee consider additional parameters to align the statute's budget neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?**

While the ACS would need to review any proposed changes or enhancements prior to taking a position, we do believe that a mix of budget neutrality updates, including raising the threshold from $20 million to $100 million and indexing it for inflation moving forward, could help to create a more stable payment system while maintaining fiscal responsibility.

Incentivizing Participation in Alternative Payment Models

General Comments on APM Participation

The ACS appreciates the Committee's recognition of the need to improve APM tracks to create more options to accommodate all specialties and attract more patients with chronic conditions into appropriate models. As noted, MACRA created a process for creation of physician-focused models, the Physician-focused Payment Model Technical Advisory Committee (PTAC), but while it was successful in spurring the development of new targeted models, it has become a dead-end for models once they have gone through the process and been recommended. Existing models such as Accountable Care Organizations (ACOs) may be too general, with a focus on population-based metrics that fail to value and meaningfully incorporate the work of surgeons and other specialists.

While the primary concern of physicians is the clinical care of patients, they are also a business and must maintain business models that are sustainable and allow them to invest in new technology, personnel and improvement efforts that benefit patients. The concept of shared risk and shared accountability for a cohort for measurement and payment is very different from traditional FFS. The risk bearing entity must meet certain standards to bear that risk, including risk-based capital, to enable it to cover the compensation of the various team members sharing the responsibility of caring for the patient. This entity should be flexible and could be a physician specialty group, a health system, or a hospital for example. It could also be an ACO with its own internal risk bearing groups. Any models proposed should support the care team in making the transition from FFS to value-based, risk bearing business models, and recognize additional investments needed to improve patient care to ensure that participating physicians and facilities remain financially viable.

ACS believes that for much of specialty care, especially for those seeing patients with complex care needs requiring a large team to support the patient in achieving their goals and desired outcomes, the most appropriate model is one based on episodes of care. Episodes naturally lend themselves to team-based measurement of both quality and cost specific to the patient and can be designed to achieve savings through efficiency rather than through cuts or other adverse incentives. Episode of care models incentivize the entire team by having them work toward shared goals, those being achieving the patients' desired outcomes in the most efficient and safe way possible. The ACS-Brandeis model, approved several years ago by the PTAC, is one such example of a model that the ACS believes would represent a significant step forward. Episode models can also be incorporated into larger population-based models such as ACOs to increase engagement and buy-in of specialists.

- **In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?**

As previously mentioned, the ACS-Brandeis Advanced APM (A-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. This proposal would allow for specialists and other providers to manage chronic conditions to improve the overall value for patients. 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.

- **What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs?**

The ACS maintains that CMS should work with stakeholders to develop measures that are more meaningful to providers, with the goal of improving the value of care. It is important to first develop a surgical care model, then define the standards to measure the team around that care model and track the clinical outcomes. CMS should work with relevant providers to develop a surgical quality measurement system that includes a combination of three elements: standards-based facility-level verification programs, patient-reported outcomes-performance measures, and traditional quality measures, such as registry and claims-based measures.

- **Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?**

The ACS supports relaxing participation thresholds as long as participation in the models is substantial and increases value to patients. The current thresholds ensure that physicians are seeing or billing many patients attributed to the model but do nothing to ensure that these encounters meaningfully impact the way physicians practice or the value of care patients receive. In the early years of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) implementation, surgeons were often surprised to learn that they were included on the participant list of an ACO and would be receiving an incentive, and the measures upon which they were being scored are still rarely related to the surgical care of patients in the model. If a surgeon is unaware that they are participating in a model, how can their participation meaningfully impact care? Conversely, many physician-developed proposals that have been rejected by CMS are more clinically relevant to physicians, particularly specialists, who feel that their quality improvement efforts are not recognized or valued by existing models. This has led to a lack of buy-in from the physician community and a complete reliance on the part of CMS on the use of the flawed statutory financial incentives and, in many cases, not substantial enough to merit taking on additional burdens. The ACS strongly believes that physicians are much more likely to participate in models which provide actionable information on how to continuously improve quality of care and lower cost for their specific patients. Models that fail to provide actionable information, or otherwise benefit their patients through improved quality, are more likely to be seen as burdensome, and therefore struggle to attract and retain participants.

- **Are there other A-APM programmatic designs that would make participation more attractive for providers?**

Surgeons along with other physicians and healthcare providers understand the importance of transitioning to value-based care models, such as A-APMs, but find the transition difficult due to the uncertainty in the current system, the lack of actionable data needed to succeed, and other factors. Some physicians may also be skeptical of models they feel are aimed more at reducing spending rather than improving patient care, as is the case with most CMS developed models. Many of the physician-developed models that are sitting on the shelves after receiving PTAC endorsement would address some of these concerns. For example, some models include explicit compensation for currently uncompensated services needed to improve the care of patients with a given chronic condition. All of these models have been developed with the leadership or active participation of physicians with direct clinical knowledge and experience in the care of the specific conditions and patient populations targeted, ensuring the level of clinical relevance needed for a model to be seen as beneficial to patients rather than burdensome.

The provision of actionable, real-time data at the point of care is also key to ensuring the success of a model and therefore is a prerequisite for physician buy-in. High quality clinical data is desirable for such purposes but in some cases important insights can be derived from timely access and analysis of claims data as well. For example, claims data can be used to show the delta between more and less efficient practices, essentially creating an opportunity analysis for participants to improve and succeed.

- **How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such**

options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?

The ACS strongly supports efforts to improve the clinical relevancy for specialists or subspecialties in A-APM options. As previously mentioned, the lack of incentives and any meaningful buy-in from specialists has stifled overall participation. One way Congress could address this would be by directing that a portion of the CMS Innovation Center's budget be devoted to testing APMs recommended by the PTAC. Beginning in 2016, there was a groundswell of support for value-based care in the form of physician-developed payment models submitted to the PTAC. These models were, in most cases, well thought out and based upon the lived experiences of physicians who cared for the patient populations and conditions targeted by the model. Information on the models submitted can be found here: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials.

Many of the models explicitly targeted chronic conditions and several were judged by the PTAC to be likely to either increase the quality of care without increasing spending, reduce spending without lowering quality, or both increase quality *and* reduce spending and were therefore recommended for testing or even in some cases immediate implementation. Unfortunately, the PTAC process, while beneficial, appears to have been a dead-end road. Not a single model recommended by the body has been tested as proposed. This has contributed to a lack of buy-in among providers who are more willing to stay put in FFS rather than take on the additional expenses and risk associated with participating with existing models which are seen as having limited clinical relevancy. Devoting a portion of the CMMI budget to limited scale, voluntary testing of PTAC recommended models would start to build data on what works and provide options for participation for specialties neglected by the current CMS administered models.

- **What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?**

One challenge that the ACS faced in working with CMS is the requirement that the model be scored as a savings by the CMS Actuary. Estimating the effects of complex changes to care models such as a novel APM is notoriously difficult, and the actuary is expected to be conservative in its assessments. Allowing models to move forward even when CMS has not previously implemented equivalent models would allow for the collection of vital data on what works and what does not. This is critical in the process of innovation. However, the Actuary should not throw caution to the wind and test all models, including those deemed likely to greatly increase cost with low likelihood for improved quality or patient outcomes. But, if a model has been recommended by the PTAC or an equivalent body and the Actuary cannot definitively demonstrate the model's impact on spending, then this should not be a roadblock to potentially transformational new care models. If the model can be implemented with little or no up-front cost to CMS, then testing such model should be seen as an investment in collecting data on what works.

- **Are there other A-APM programmatic designs that would make A-APMs more attractive to beneficiaries to increase attribution and thus support A-APMs?**

One way in which to attract more beneficiaries to A-APMs is to create a central source of valid, reliable, and actionable information which patients and their PCPs can use to help select the care

that best meets their needs and goals. As mentioned previously, current CMS quality measures and programs offer little to no actionable information on where to get safe, equitable, high-value care for a given condition or diagnosis. We welcome you to confirm this yourself by searching the CMS care compare website (https://www.medicare.gov/care-compare/) and trying to find a general surgeon to perform a needed procedure.

In many cases, no quality or safety information will be available at all. In others, you may be able to find important information on whether the physician has electronic medical records, offers telehealth services or other similar information, or how they or their group practice does on several population or primary care focused measures. While important to know, no information is available on the readiness of the physician, care team and facility to safely perform a given service. The ACS concept of quality starts by ensuring that these structures, processes, personnel, and resources are in place to deliver safe, equitable, and efficient care. It is also necessary to track outcomes to confirm patient safety and determine to what extent patient goals of care are being met. Recently, the ACS has started to raise awareness of these critical components of quality through the ACS Surgical Quality Partner Program. This program provides hospitals that successfully participate in ACS quality programs with an emblem to display in their facility or office. These emblems help to assure patients that they can be confident that they will receive high quality care. Building this type of information into an APM, like what was included in the ACS-Brandeis Advanced-APM proposal, would go a long way toward attracting patients into value-based care.

Rethinking MIPS

- **What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?**

Recent proposals to reform the MIPS program through implementation of MIPS Value Pathways (MVPs) appear to be a reshuffling of the deck, simply moving around the existing pieces with little flexibility or capacity for meaningful improvement. Within the current MIPS framework, we would suggest encouraging the entire care team to demonstrate that they are centering the patient in everything they do through shared, team-based measurement. This would require the development of shared "programmatic" quality measures which could then be applied to all providers involved in the care of the patient, including both physicians and facilities through a voluntary expansion of the facility-based scoring mechanism already available in MIPS.

The ACS has a more than 110-year history of measuring and improving the quality of care for surgical patients. We have come to recognize the importance of shared goals and evaluation in spurring quality improvement. This knowledge has been used to develop numerous quality programs aimed at verifying that the people, resources, structures, and processes necessary for optimal outcomes are in place. The ACS envisions quality as a comprehensive program developed from the patient perspective and including all of those who contribute to ensuring the patient's goals of care for a given condition or diagnosis are met. Having all of these players working toward achieving the same standards rather than striving for payment incentives (or to avoid cuts) by checking the box on different, non-coordinated measures. Achieving coordinated care requires coordinated measures and this is simply not an option in MIPS as it currently exists.

The ACS, in collaboration with the American College of Emergency Physicians and the Institute for Healthcare Improvement, developed a programmatic measure that builds on the successes of the ACS Geriatric Surgery Verification Program. This improvement incentivizes hospitals to take a holistic approach to care delivery for older adults. The measure highlights the importance of implementing a clinical framework, using evidence-based best practices, which provides goal-centered, clinically effective care for older patients.

The Age Friendly Hospital Measure is a "focused-composite" metric that is comprised of a handful of structural metrics, process metrics, and outcomes focused on activities that are essential for effective care in this demographic. This measure was included in the Hospital Inpatient Prospective Payment System proposed rule for implementation in the 2025 performance period. If finalized, the measure would be a positive step toward incentivizing team-based care organized around the geriatric patient. And would be an example of the type of measure appropriate for shared, team-based attribution in a facility-based scoring construct.

The American Medical Association (AMA), working with ACS and a number of physician specialty societies has spent many months developing a proposal containing numerous reforms to the MIPS program, including the ACS proposed expansion of facility-based scoring to additional MIPS categories, facility settings and a broader range of physicians. This proposal is intended to be budget neutral and would represent a meaningful step forward toward reforming the program in a way that will make it more meaningful for patients and less burdensome for physicians. The ACS supports this proposal and would encourage the committee to include it when considering policies to improve physician payment in Medicare.

- **Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?**

Separating improvement activities from quality is in many ways artificial. The ACS experience with quality has taught us the value of continuous quality improvement and therefore we strive to foster a culture of continuous quality improvement and excellence in our surgical programs. ACS quality programs explicitly include quality improvement cycles and research and our conferences present opportunities for participants to come together to share best practices. When improvement activities are built into a quality program by default and are being adhered to as witnessed by verification, it does not make sense to require the reporting of additional measures just to check a box in MIPS requirements. The AMA-led proposal mentioned above includes a provision allowing multiple category credit when a measure meets the goals and requirements of more than one MIPS category. The ACS supports this concept.

MACRA included a number of incentives for the use of registries, but the promise of the bill has yet to be achieved due to shortcomings in implementation. Registries can be good sources of data to help identify gaps in care and areas for improvement, especially when they are maintained with high-rigor and standards for the quality of data such as in the ACS National Surgical Quality Improvement Program (NSQIP). The ACS has urged CMS on multiple occasions to leverage the clinical data included in registries to support advanced digital tools that can inform care teams and improvement cycles in real time. The clinical data in registries represents an important but largely missed opportunity and should continue to be incentivized.

Improving Primary Care and Chronic Care

- **In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?**

In general, any item that cannot be reasonably foreseen, or which is not typically provided for the care of patients with the chronic condition or conditions in question, should continue to be paid on a fee for service basis. This will depend greatly on the breadth of services meant to be compensated through the PBPM payment and which capabilities are meant to be subsidized or incentivized. In addition, if a given chronic condition is typically managed or comanaged by a specialist such as a neurologist, cardiologist, rheumatologist, oncologist, or surgeon, such care should be excluded from the PBPM payment, and either be paid to the PCP on a FFS basis or bundled to the managing specialist as appropriate. Congress may wish to think of such a PBPM proposal in terms of the *program* needed to support the highest quality, patient-centered care, and design the PBPM compensation at a level sufficient to support these needs.

The ACS feels strongly that any such PBPM payment representing compensation for previously unbillable services should be excluded from budget neutrality requirements that would otherwise result in cuts to other physicians. Such cuts are both harmful and unnecessary. If PBPM chronic-care focused payments are successful, they will by definition reduce downstream spending through avoidance of complications and unnecessary or duplicative care.

- **Should a hybrid model design include a hybrid-specific risk adjustor for primary care?**

Accurate risk adjustment is a necessary component for successful risk-based payment models to both avoid adverse selection and to make sure that practices taking on more complex patients are not harmed by looking worse on outcome measures. Risk adjustment allows for both financial adjustment and measurement on more equal grounds. If such a model were built into a two-sided risk model with appropriate quality safeguards, then risk adjustment would become a more important consideration.

- **How can such a policy account for quality?**

The ACS perspective on quality has been discussed extensively in this document and the same lessons can be applied here. The PCP is an important component of the care team tasked with achieving the goals of the patient and plays a key role in longitudinal care-coordination. Quality measures for such a hybrid model should focus on the goals of the patient and to what extent those goals are being met. If additional up-front investment in primary care services is not shown to objectively improve care for chronic care patients than appropriate action should be taken to address shortcomings, or there should be consideration toward discontinuing the additional PBPM payments for these practices.

- **If Congress were to pursue such a hybrid model design, should policymakers also differentiate the CF, budget-neutrality adjustments, and other mechanisms to promote team-based care and appropriately account for distinctions in payment models across specialties and subspecialties?**

If Congress decides to structure such a model, it should be careful to ensure that they do not harm specialty care and treatment of the very patients for whom they are seeking to improve care coordination. Funding compensation for additional services at the expense of other equally necessary care simply shifts patient access problems from one area to another. This should be done through a new investment and exempt from budget neutrality requirements. If properly structured, a model that centers the patient with multiple chronic conditions could both invest more resources up front in care management and save money by reducing downstream costs such as acute exacerbation, surgical complications, or other costly and preventable interventions.

Supporting Chronic Care Benefits in FFS

- **Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?**

The ACS recognizes the impact of chronic conditions on both surgical patient outcomes and the finances for these patients. Primary care places a huge role in the prevention and early diagnosis of chronic conditions, which can be vitally important in reducing downstream spending. Once a chronic condition has been diagnosed however, in many cases the care of the patient for the chronic condition is either managed or comanaged by a specialist with expertise in that particular condition, such as oncology, neurology, rheumatology, cardiology or in some cases surgery.

Chronic conditions have a huge impact on the quality of life of patients and in many cases, surgeons are best positioned to intervene in these 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. The ACS' Strong for Surgery initiative provides checklists, tools and other 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 serve as curative treatments. Surgical intervention to address chronic conditions comes in many forms and continues to grow with the introduction of innovative technologies and procedures. These procedures and processes help to provide the best possible care for patients while preventing future downstream costs if able.

- **What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?**

In general, the ACS would support increasing screenings of chronic conditions, including for several types of cancer, for Medicare beneficiaries. While the ACS would require the ability to properly review legislation involving this concept, we are supportive of ways to improve access. Screenings are one of our best strategies for detecting cancers and other conditions early when the disease can still be cured or managed more properly. To address issues surrounding delayed

or missed screenings, particularly due to the pandemic, the ACS Cancer Programs collaborated with the American Cancer Society on a quality improvement initiative and clinical study to accelerate screening numbers in the US. By providing easy-to-adopt plans that leveraged existing guidelines, messaging, and interventions, ACS-accredited programs worked to increase access to, and participation in, crucial cancer screenings.

Additional Considerations: Ensuring Accuracy of Values within the PFS

- **What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?**

From the ACS perspective, RVUs were created to reflect the resources—time, effort, and expenses—required for a medical procedure or service. However, the RVU-based compensation model has failed to keep pace with the evolving resources that are required to provide modern care effectively and generally struggle to keep pace with improvements in medical science and clinical best practices. To improve the rate-setting processes a system would need to work to base compensation on both productivity and other value-adding activities with the appropriate balance tailored to the practice, hospital, and region. Examples of value generators not directly linked to revenue include research, teaching and training, administrative tasks and appointments, participation in quality improvement initiatives, clinical care coordination, and perioperative care. An ideal compensation model accounts for these essential contributions.

In contrast to comments made at the April Finance Committee Hearing, the Relative Value Scale Update Committee (RUC) is not a secretive rate setting body, rather it is a committee made up of physicians who volunteer their time and expertise to make recommendations to CMS on Medicare payment adjustments. This type of language unnecessarily pits primary care and other specialties against each other and is counter to the best interest of the patient. Centering the patient requires high quality primary care capable of keeping them healthy and catching problems early but also of playing a role in coordinating team-based specialty care. This will not work if primary care and specialists see each other as adversaries rather than teammates.

- **For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS's annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?**

The ACS would urge CMS to consider the restoration of the Refinement Panel process that was first implemented in 1994. This multispecialty panel of physicians served to assist CMS in reviewing comments from stakeholders who disagreed with work RVUs proposed by the Agency for a given code. The intent of the panel process was to capture each participant's independent judgment based on their clinical experience and the evidence presented. Following each discussion, panel participants rated the work for the procedure or service in question. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel's twenty members. The Agency's decision to convene multispecialty panels of physicians and to apply statistical tests to their ratings reflected the need to balance the interests of those who commented on proposed work RVUs against the redistributive effects that would occur in other specialties. In 2011, CMS modified this process and began to independently review every

Refinement Panel decision, resulting in the rejection of over sixty percent of the panel's recommendations. In the CY 2016 MPFS, the Agency permanently eliminated the Refinement Panel process. The AMA, the ACS, and over ninety other specialty societies opposed CMS' decision and requested the restoration of the Refinement Panel. We again urge CMS to reinstate the Refinement Panel, which would provide an opportunity for stakeholders to present all available data on services under review during rulemaking to a formal panel of objective experts.

Conclusion

Thank you for your efforts to address the growing concerns with the Medicare physician payment system. The ACS shares your commitment to improving outcomes for seniors with chronic conditions. We look forward to working collaboratively to achieve the goal of high-quality care for all Medicare patients.

Sincerely,

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