Statement of the

American College of Surgeons

To the Subcommittee on Health

Committee on Ways and Means

United States House of Representatives

RE: The Implementation of

MACRA's Physician Payment Policies

March 27, 2018

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we thank you for convening a hearing to examine the implementation of the physician payment policies within the Medicare Access and CHIP Reauthorization Act (MACRA). Since MACRA was signed into law, there have been multiple opportunities for input from the physician community, and ACS would like to thank the Committee again for its continued effort in making sure the implementation of both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (A-APM) tracks of MACRA are successful.

Merit-based Incentive Payment System (MIPS)

The underlying concept of MIPS is to simplify several Centers for Medicare and Medicaid Services (CMS) quality programs and combine them into a single program. MIPS compares the value of care provided by participants, evaluating them on activities such as the use of electronic health records, clinical improvement activities, and importantly, the quality and efficiency of care provided. Payment is then adjusted up or down based on a comparison of all providers' performance on these metrics.

While Congress' goals in enacting MACRA were laudable, CMS' resources are limited, and the implementation of MIPS is taking longer than anticipated in some areas, such as in the development of new cost and quality measures. For example, money allocated in MACRA for the development of new quality measures has only recently been made available to prospective grantees. Similarly, the development of accurate episodic cost measures is proving both difficult and time consuming. We welcome this hearing as well as the extended flexibility granted by the recently passed Bipartisan Budget Act as an opportunity to propose solutions and improvements to these and other challenges.

Measuring Quality in Surgery

Surgeons are not opposed to being held accountable for the quality of care received by their patients. It is essential however, that quality measurement meets two key goals:

- Measures must accurately represent the quality of care being provided by the surgeon, providing information that facilitates improvement.

- Measurement must be accomplished in a way that minimizes unnecessary administrative burden, maintaining the focus on patient care.

As currently implemented, quality measurement in MIPS does not meet these goals when it comes to surgical care. If CMS is putting providers' compensation at risk based on metrics, the metrics used must ensure the appropriate physicians are being rewarded or penalized. However, measures currently reported by large groups are typically related to primary care or are population-based measures that are not related to the care surgeons provide. These measures can be complex, burdensome and frustrating as it takes time and resources away from other efforts that could have a greater impact for patients.

Unfortunately, this means that what affects payment is not directly related to what affects quality, as Congress intended. Surgeons and surgical patients are best positioned to understand what elements of care are important to measure in order to evaluate the quality of care and provide the information needed for improvement. To more accurately measure surgical quality, ACS proposes a combination of three elements: standards-based facility-level verification programs, patient reported experience and outcome measures, and traditional quality measures such as those currently in MIPS, including registry and claims-based measures. Combining these three elements will provide a much clearer picture of the quality of care provided to the patient, including not just the surgeon but the entire care team involved. ACS-created verification programs have a long history of success, including the current trauma, bariatric, and cancer accreditation programs, as well as the now independent Joint Commission, which began as an ACS initiative.

The importance of setting standards at the facility level to achieve quality outcomes cannot be overstated. Our experience tells us that if you put a surgeon with the highest technical skill level into an underperforming environment where the resources needed are not available and systems are not in place to protect the patient, that surgeon's outcomes are likely to be substandard. ACS recently published *Optimal Resources for Surgical Quality and Safety*, a manual that describes key concepts for developing standards in quality, safety, and reliability and explores the essential elements that all hospitals should have in place to ensure patient-centered care. We look forward to continued collaboration with Congress and CMS as we further develop our proposal to accurately measure surgical quality in MIPS.

Advancing Care Information

For many providers, the Advancing Care Information (ACI) component of MIPS which is designed to measure the meaningful use of electronic health records (EHRs) remains the most frustrating aspect of the program. The program unnecessarily maintains the focus on EHRs, rather than on truly advancing the availability and use of patient digital health information as the updated name implies.

When the Health Information Technology for Economic and Clinical Health (HITECH) Act was originally enacted, meaningful use was intended to be a means to validate that Congress' investment on EHRs was spent wisely. The resulting program therefore focused on the meaningful use of specific, Certified EHR technology (CEHRT) required by the program. However, the federal government is no longer subsidizing adoption of this technology. ACS believes that we should take this opportunity to refocus on the original goals of using technology to improve care. Specifically, more focus should be placed on the digital health information at the patient level, lessening the focus on EHRs alone. ACI should focus on who is using digital health information to build a more complete patient record that is available to patients and physicians at the point of care, and how they are using this information to improve the quality and efficiency of care.

A patient's longitudinal care profile rarely exists in a single EHR. Therefore, it is imperative that we create a digital health information system, which represents the patient with enabling information from EHRs, smartphones, iPads, tablets and other available sources. The ACS appreciates recent congressional action to remove the counterproductive requirement that meaningful use standards grow more stringent over time, creating an opportunity to reimagine what constitutes meaningful use. The ACS looks forward to working with Congress, CMS, and ONC to help create a digital health information environment that achieves these goals.

Alternative Payment Models

The ACS has also been active in the area of alternative payment model development and would like to take this opportunity to update you on our progress. MACRA provides a separate pathway for those paid under certain arrangements known as Advanced Alternative Payment Models (A-APMs). These models are distinguished from other APMs because they must meet three requirements. They must include risk of financial losses, they must adjust payments based on performance on quality measures, and they must require the use of CEHRT. Part of our MACRA strategy has included the development of new options for A-APM participation for surgeons, consistent with modern surgical practice in team-based episodes of care. The payment structure and incentives in the law make it clear that over time the surest way to succeed will be to transition into new payment models designed to provide additional flexibility in care design to those willing to take on financial risk.

While opportunities to meaningfully participate in APMs are currently limited for surgeons (due to geography, specialty, practice style, etc.), the law creates a new pathway for the development of A-APMs, through the Physician-focused Payment Model Technical Advisory Committee (PTAC).

The ACS takes its responsibility in contributing to improved health care quality seriously. Roughly five years ago, ACS Executive Director, Dr. David Hoyt, testified before the Ways and Means Committee on our efforts at that time to develop innovative payment strategies as part of a replacement for the SGR. With the passage of

MACRA, and the creation of the PTAC, we saw an opportunity to refocus our efforts toward creation of an APM that would meet the requirements under MACRA, meet the needs of surgeons, and finally provide new tools for participants to improve care for our patients.

When we stated working the development of an A-APM, we considered the following five important elements:

- **Clinical care model:** What changes can be made to the way we do things to improve the quality of care to the patient and clinical outcomes?
- **Quality measurement:** What processes, outcomes, and patient reported experiences are worth keeping track of and how do you use that information to adjust payments?
- **Payment model:** How should we change the way we pay for health care to incentivize appropriate, high quality, efficient team-based care? For example, we intend to seek payment models tied to increased quality and reduced utilization through a novel shared savings framework.
- **Business model:** How do you structure participation so that the necessary team of physicians would join together with A-APM entities, or form them, in order to create shared accountability for the patients for whom the team provides care? And how could the models attract private payers? What is the value proposition for the involved stakeholders?
- **Risk structure:** Transferring risks from insurers to providers requires careful consideration. There is a difference between clinical risks that providers can reasonably assume and insurance risks that providers should avoid. How are risks structured within the constraints of behavioral economics to offer enough upside risk to attract participants and adequate downside risks to protect patients and the goals for optimal care? What limitations do you place on downside risk for cost overruns or not maintaining quality so that you meet MACRA advanced A-APM requirements while limiting potentially catastrophic losses?

For physicians and those deeply engaged in patient care, it is a natural tendency to begin from the clinical care model and subsequently add the other elements of quality, risk, and alternative payment models folded into

new business operations. Building multiple clinical models, each with its own underlying payment model, would be administratively difficult for participants and payers to implement and scale across the nation.

In contrast, we chose to partner with a team at Brandeis University who had in-depth knowledge of Medicare cost measurement and analysis. Our partners at Brandeis had developed software known as the CMS Episode Grouper for Medicare or EGM. This software represents years of work and provides an in-depth, objective view of how care is currently provided. A combination of painstakingly developed clinical episode definitions and complex algorithms allow the software to automatically assign relevant charges to a team-based episode and assign providers to clinical roles in the episode based on which services they provide to the patient.

The EGM also looks at the patient's other current and historical episodes, both to provide risk adjustment and to ensure that each dollar spent is counted only once. This allows our model to produce risk adjusted, patient specific target prices for each episode. It also allows us to show extremely granular information on the causes of variation. This model allows for all physicians and all payers to share a common operational model in order to assist in a national scale for implementation.

Quality

As noted above, the American College of Surgeons has a century of experience in defining, measuring and improving quality. The College has long believed that the current approach to quality measurement is narrow, complex, costly, and slow to adapt to changing care patterns. We see MACRA, and particularly A-APMs, as an opportunity to propose and implement new measurement strategies. Our recently-published *Optimal Resources for Surgical Quality and Safety* is designed to be a valuable resource for surgeons as they work to improve the quality of care they provide and to improve patient safety. While our knowledge is primarily in surgical care, the lessons learned have helped us to create an environment of continuous quality improvement and patient- centered care that can be easily adapted to a wide range of health care with the participation and clinical expertise of the wider physician community.

One concept contained in our quality manual is the notion of **Phases of Care.** Surgical care, and in fact all health care, occurs in phases. The ACS believes that registry-based quality measures that encompass the phases of care, along with care coordination and incorporation of patient reported outcome measures (PROs), will be meaningful and important to both surgeons and surgical patients. When measurement is considered meaningful it is less likely to be seen as burdensome.

Measuring quality across the phases of surgical care (those being preoperative, perioperative, intraoperative, postoperative, and post-discharge) may include items such as documenting the surgical plan and the patient's goals of care, screening the patient for things that could affect outcomes such as frailty and tobacco use and helping them to prepare for surgery, taking time out to review safety checklists, documenting a post-operative care plan and communicating that plan with the patient, his or her family and their primary care provider, and measuring success in preventing infections, readmissions, and reoperations. Adding in PROs provides a patient perspective and further validates the value and success of the process measures. The measures described are broadly applicable to many surgeries but can be customized for individual specialties or procedures to reflect the most pertinent processes and outcomes for a given episode.

Measuring quality in this way has the added benefit of lining up well with cost measurement to paint a much more detailed picture of the value of care provided. In the ACS-Brandeis model, performance in what we refer to as an episode-based measure framework is used to adjust payments, providing maximum incentives to those providing the highest value care.

Team-based Nature of Patient-centered Care The model that we have developed is broadly applicable to the full range of health care providers. As noted in the College's recently updated joint statement on physician led team based surgical care, "optimal care is best provided by a coordinated multidisciplinary team recognizing each member's expertise. Coordinated surgical care provides best outcomes, lowers costs, and increases

patient satisfaction."[1] Our episode-based measurement framework, coupled with the EGM, allows for quality and cost measurement designed around the patient and the full team of providers who have influence over the patients experience and outcomes.

Sometimes the highest value surgery for a patient is no surgery at all. The capabilities of the EGM allow the ACS-Brandeis model to incentivize the avoidance of unnecessary care through appropriate interventions. The model contains both treatment episodes and condition episodes. Related treatment episodes can be nested within condition episodes in a way that appropriately apportions costs and avoids double counting of Medicare dollars.

Ultimately with the further development of additional treatment and condition episodes and the analysis of participant data, this model could allow sophisticated health systems to take on global risk for a patient population or risk for the care of specific clinical chapters.

Recruiting Clinical Expertise

Once it became apparent that our model was suitable for (and in fact hinged on) participation of the entire team involved in providing care to the patient, we began building a community. We first reached out to other surgical societies to fill them in on the early details of the model, but we soon expanded to other groups involved in caring for surgical patients and have welcomed participation and input from any interested groups whether they care for surgical patients or not. We leveraged this community to help further validate the clinical content and have leaned on them for their expertise in quality measurement around the care they provide.

Over the next several months, we held a series of in person meetings and webinars to educate interested parties on the model and exchange ideas. The model has greatly benefited from this participation. Since our model does not mandate narrow clinical pathways, there are significant opportunities for innovation for the clinical

[1] http://bulletin.facs.org/2016/08/statement-on-physician-led-team-based-surgical-care/

experts. It is our intent that the ACS-Brandeis model will provide the tools, structure, and incentives for these ideas to flourish.

The ACS-Brandeis A-APM was recommended by the PTAC for limited scale testing and received a positive response from the Department of Health and Human Services. ACS has had productive meetings with CMS to answer remaining questions and we look forward to continued work with the agency to move the model forward toward testing and implementation. If successful, we believe the model will provide innovative, meaningful opportunities for participation in A-APMs with a focus on quality improvement and cost reduction for CMS and an improved, more coordinated experience for patients.

Again, we would like to thank the Committee for its oversight work on the implementation of MACRA. We look forward to continuing to work with the Congress and the Administration in order to guarantee successful implementation of both the MIPS and A-APMs components of MACRA, and stand ready to assist the Committee in addressing any future challenges in physician payment policies. If you have any questions, please contact Carrie Zlatos in the ACS Division of Advocacy and Health Policy at 202-337-2701 or czlatos@facs.org.