October 12, 2023

Representative Michael Burgess, M.D.
Chair
Health Care Task Force
House Budget Committee
U.S. House of Representatives

Dear Representative Burgess:

On behalf of the more than 88,000 members of the American College of Surgeons (ACS), I appreciate the opportunity to provide information and proposals to improve outcomes and reduce federal health care spending in the budget. The ACS appreciates the Health Care Task Force's focus on identifying innovative solutions to long existing challenges in the nation's health care system and hopes that we can be a partner in improving access, affordability and quality for surgical patients and all Americans.

The ACS sees an opportunity for reducing health care spending while improving quality through a transition to meaningful value-based alternative payment models (APMs). A meaningful value-based care or payment model is one that makes actionable information on both the quality and price of care available to patients and their physicians. This is necessary to create insights on how to improve outcomes and to help reduce unwarranted variation. Unfortunately, despite the long-held Centers for Medicare & Medicaid Services (CMS) goal of moving toward APMs, many physicians remain locked into a budget-neutral fee-for-service (FFS) system that results in frequent steep cuts and still fails to incentivize quality or value.

Since the enactment of 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 of one of the first Advanced APM proposals to the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, which is the "first stop" for adoption of a stakeholder-developed APM;
- Ongoing work to increase transparency in pricing through standardization of episode definitions; and
- Proposing novel quality measures that incentivize team-based care organized around the geriatric hospital patient.

Most physicians in FFS are currently evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. This means that no information is available for improvement or to help patients choose the best care for them. The ACS efforts above have all been designed to overcome barriers faced by surgeons (and other physicians) who currently must expend time and resources on meaningless, "check-the-box" measures. Based on these

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efforts and the more than 100-year history of the ACS working to improve the quality and value of care for surgical patients, we have proposed some specific solutions to your questions below.

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending

Specific legislative barriers that the ACS believes could ultimately reduce health care spending through improved care coordination and reduced surgical complications are current limitations on the types of quality measures available and on the facility-based scoring option. 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 have recently been notified that the measure will be included on the MUC list with further action expected in November. 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 from 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. 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:

1) Eliciting Patient Healthcare Goals;
2) Responsible Medication Management;
3) Frailty Screening and Intervention;
4) Social Vulnerability; and
5) Age Friendly Care Leadership

If adopted, the *Age Friendly Hospital Measure* could be further enhanced through an expansion of the facility-based scoring option of the Quality Payment Program. Facility-based scoring opportunities are currently limited to very specific circumstances. These opportunities should be expanded and enhanced 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, not just 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 sees quality as a comprehensive program. This program is 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 areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care. The ACS developed programs like GSV and QVP have demonstrated 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. This is why alignment with facility reporting is critical for care organized around a 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.**

In addition to increasing care coordination and reducing reporting burden, such a proposal could lead to a reduction in federal health care spending. The ACS experience with a programmatic approach to quality has demonstrated that such an investment can result in fewer costly complications and readmissions and ultimately in lives saved. The ACS has recently launched the Power of Quality Campaign and is partnering with hospitals to help them let patients know of their commitment to surgical quality. Hospitals who successfully participate in one of 13 ACS programs will now be able to display a Surgical Quality Partner diamond emblem to demonstrate their commitment to quality improvement and the best possible outcomes for surgical patients. This type of information is much more valuable and actionable to patients than what is typically provided by current measures used in federal programs as they make decisions about where to receive care. The ACS would welcome the opportunity to further discuss how these efforts could be amplified to help patients choose care more likely to achieve desired outcomes without costly complications or readmissions.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes:

Efforts at 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 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 the 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 has long 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. The ACS-Brandeis Advanced APM proposal included shared accountability for cost and quality for defined episodes of surgical care and allowed for the entire care team to work together toward shared goals. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are prerequisites for a valid depiction of the value of care. It is our strong belief that this proposal would have provided the data and incentives necessary to drive value improvement and reduce costs in specialty care.

While it is our impression that Congress has provided the resources to CMS and the Innovation Center 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. A Congressional Budget Office (CBO) analysis of CMMI's first decade published in September[1] estimates that the proposals developed and tested by CMMI resulted in a net *increase* of $5.4 billion in net Medicare spending. The document goes on to revise its projections for the second 10 years of CMMI. Instead of generating $77.5 billion in net savings as projected previously, they now estimate that there will be an additional net increase in spending of $1.3 billion. The report cites several factors for the revision including that "in its earlier analysis, CBO expected that CMMI would identify more models that reduced spending as it tested more models over time." Unfortunately, as witnessed by the lack of testing of PTAC models, this has not occurred.

Many physician-developed models would take novel approaches to improving care coordination, patient experience, and outcomes and could result in better care and reduced costs. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing APMs proposed by physicians and recommended by the PTAC.**

Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes

As witnessed by the recent massive revision to its projections for savings from CMMI (a $78.8 billion swing), CBO can have a difficult time modeling the effects of innovative policy proposals. This is especially true in areas such as health care where competing incentives and multiple outside factors can have unforeseen influences on the financial outcomes. For this reason, any such modeling or projections that will have an influence over policy adoption should include an opportunity for expert input. Such estimates should also be used as a guide and not as the sole deciding factor as to whether or not to pursue a legislative policy proposal.

In addition to CBO, other bodies play a role in modeling the financial effects of health policies that can have just as large of an impact as to whether or not they are implemented. For example, when deciding whether to expand CMMI models after testing, the chief actuary of CMS must certify that the model's expansion

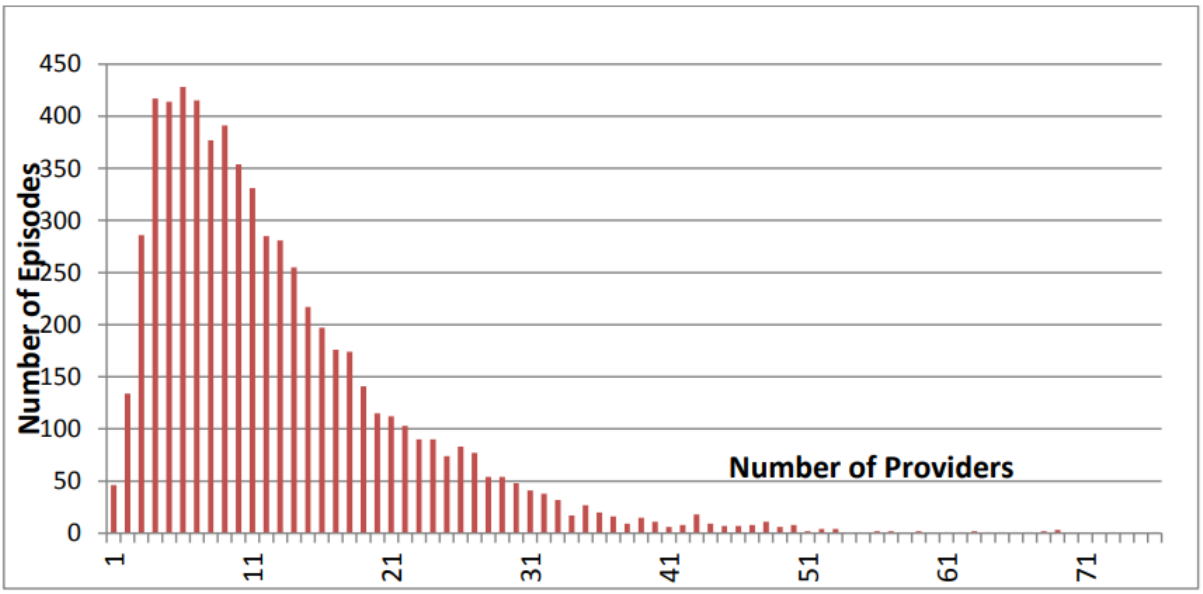
[1] Federal Budgetary Effects of the Activities of the Center for Medicare &Medicaid Innovation, https://www.cbo.gov/publication/59612

would reduce a program's spending or at least not result in additional spending. In practice however, the analysis of the actuary has been a limiting factor on which models are tested in the first place. With only six of the 49 CMMI initiated models that have been evaluated over the past ten years having demonstrated statistically significant savings, there is clearly room for improvement.

Recommendations to reduce improper payments in federal health care programs

One lesson the ACS has learned through analysis of surgical episodes of care (grouped charges for all items and services provided in the course of care for a given diagnosis or condition) is that there is great variation across delivery systems and among individual providers resulting in wide differences in cost. While this variation should not necessarily be classified as "improper payments," it does represent a roadmap of where to look for potential unwarranted variation, creating an opportunity for quality improvement and savings. For example, an analysis done on thousands of colectomy episodes as part of the ACS' APM submission showed that while the majority of patients were billed by 10 or fewer providers, many had charges from 20, 30, or more separate Tax Identification Numbers. Some of this variation is certainly due to surgical complications and varying complexity of underlying health conditions, but others may represent unwarranted variation that could be eliminated without negatively impacting quality.

Team Size Distribution in Colectomy Episodes



This type of information falls into the category of improved price transparency, but unfortunately current regulations and laws such as Hospital Price Transparency, Transparency in Coverage and the good faith estimate and advanced explanation of benefits provisions of the No Surprises Act lack sufficient depth and detail to create the comparable data necessary for this type of analysis. A study published in June in *Annals of Surgery* penned by researchers from the Heller School at Brandeis University and Boston Medical Center along with ACS staff took a more detailed look at variation in Medicare surgical episodes[2]. Specifically, the study looked at more than 1600 episodes of colectomy for cancer in the Boston area paid for by Medicare.

[2] https://journals.lww.com/annalsofsurgery/abstract/9900/surgical_episodes_of_care_for_price_transparency.519.aspx

The study found a mean Medicare allowed amount per case is $29,954 which varied from $26,605 to $36,850 as you move from low to high severity cases. The study also found that an average of 12 providers billed Medicare per patient case with significant variation of between three and 73 individual providers involved from pre-facility care to post discharge services.

The ACS has participated in efforts to define standard episode definitions for better price and cost measurement that could be used for analysis such as these as well as for improving patient price transparency and shoppable services. These efforts are currently maintained by the PACES Center for Value in Healthcare[3]. The catalog of episodes maintained by the not-for-profit PACES Center have been defined and independently vetted by clinical experts and already cover a majority of the care provided in terms of cost. Adopting episode definitions such as these as a standard could help improve clarity in price transparency efforts and could further be used to identify more targeted opportunities for reducing unwarranted variation in cost that would be applicable not just in Medicare but across payers. The ACS has written more extensively on the importance of standard episode definitions in our recent response to the CMS Request for Information on Episode Based Payment Models[4].

We thank the Health Care Task Force for its thoughtful attention to the nation's health care finance challenges and look forward to continuing to work with lawmakers on this and other important health issues affecting our country. For questions or additional information, please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org.

Sincerely,

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Executive Director & CEO

CC: House Budget Committee Health Care Task Force

[3] https://www.pacescenter.org/
[4] https://downloads.regulations.gov/CMS-2023-0127-0074/attachment_1.pdf