Statement of the American College of Surgeons
to the Committee on Energy and Commerce
Health Subcommittee
United States House of Representatives
RE: What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors
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On behalf of the more than 88,000 members of the American College of Surgeons (ACS), we thank you for convening this hearing entitled "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." The topic of this hearing as well as the legislation under consideration are of the utmost importance for ensuring that our country's seniors have equitable access to timely, high-quality care. To achieve this, ACS holds that it will be necessary to shift from the current game of penalty avoidance across the multitude of reporting programs to a system built on quality programs for specific conditions, aligned with the team-based nature of care delivery. Such a shift will furthermore require measures to produce information that supports both patients and referring physicians when they must determine where to seek medical care. Unfortunately, the measures frequently used in the current environment do not achieve this. We thank Congress for their willingness to consider legislation that would improve Medicare patients' ability to find and access safe, affordable care that meets their individual goals by meeting the above objectives.

A number of the bills being considered at this hearing have the potential to make an impact on not only reducing the burden to physicians and access to care, but also on improving care coordination and the information available to patients seeking care that meets their needs. The ACS is especially pleased to see bills addressing prior authorization, shortcomings of current budget neutrality requirements in the physician fee schedule, assuring proper compensation to ensure access in rural areas and legislation to create flexibility in measurement that will foster greater care coordination in team-based, facility settings.

The ACS remains committed to improving the care for all surgical patients and has done significant work to ensure Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken to improve surgical quality and value and provide some steps Congress can take to improve the current system.

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 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.

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 remains below the 2015 level;
- 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 improvements 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 to meaningfully participate in since none of the models submitted to the PTAC have been tested as proposed.

A foundational step necessary to maintain access and improve quality for patients is immediate reversal of any additional cuts to the Medicare physician fee schedule planned for 2024 and beyond and 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

In order to maintain and improve access to care for Medicare patients it is important that we adequately and appropriately compensate all physicians and providers involved in their care. For more than 20 years, Medicare payments have been under pressure from Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a relatively modest portion of overall federal health care spending, they are perennial targets for cuts when policymakers seek to tackle affordability. The Medicare PFS is unique in its lack of a meaningful mechanism to account for inflation and remains constrained by a budget-neutral financing system. Updates to the Conversion Factor (CF) have failed to keep up with inflation and in recent years have been negative, with additional cuts to Medicare physician payments expected in 2024.

These yearly compounding cuts, combined with high inflation, a lack of updates to account for increased expenses, and a lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken. These systemic issues will continue to hinder surgeons' ability to undertake important quality improvement initiatives or make investments needed to move toward value-based care. There are several steps Congress can take to stabilize Medicare payment in the near term and reform the system in the long term.

<u>Stop Pending Payment Cuts for 2024</u>

We appreciate the action Congress took last year to mitigate part of the recent PFS cuts, however, Medicare payment continues to decline year after year. The Calendar Year (CY) 2024 Medicare PFS proposed rule includes a nearly 3.5% cut overall to surgeons, physicians, and other health care professionals and the G2211 add-on code accounts for more than half of this cut. ***Congress can stop the implementation of G2211 and eliminate a majority of the expected 2024 Medicare physician payment cut at no cost to the federal government.***

In 2020, Congress recognized the problems posed by the G2211 add-on code and delayed its implementation for three years. During that time, CMS did not address the flaws with G2211 and, unfortunately, there has been no congressional action on long-term reforms to fix the broken payment system. Under the coding structure for office visits [evaluation and management (E/M) coding], physicians and qualified healthcare professionals have the flexibility to bill a higher-level E/M code to account for increased medical decision-making or total time of the encounter. Because G2211 is already duplicative of work already represented by existing codes, there is no longer justification for implementation of the code. This add-on code will result in "double dipping" for those using it while at the same time penalizing all physicians due to a reduction in the Medicare conversion factor caused by budget neutrality requirements under the PFS.

Establish an Annual Inflationary Update

In order to ensure Medicare payments keep pace with the medical cost inflation, **Congress should pass legislation to provide an annual update to the Medicare physician fee schedule comparable to that in other payment programs starting with calendar year 2024**. The ACS supports the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide an annual inflationary update to the conversion factor based on the Medicare Economic Index. This legislation, introduced by Representatives Raul Ruiz, M.D. (D-CA-25), Larry Bucshon, M.D. (R-IN-08), Ami Bera, M.D. (D-CA-06), and Mariannette Miller-Meeks, M.D. (R-IA-01), would allow physician reimbursement to be adjusted for inflation in line with other Medicare providers such as hospitals, nursing homes, and home health providers.

Address the Problematic Budget Neutrality Requirements under the PFS

The statutory requirements for budget neutrality under Medicare is unique to the physician payment program and has been an underlying factor in why the payment system is broken. It requires CMS to implement across-the-board cuts to the conversion factor if changes to the Medicare physician fee schedule cause expenditures to exceed $20 million annually. This trigger amount has remained the same since its implementation in 1992. **The ACS strongly believes that at a minimum, 42 USC 1395w-4 (c)(2)(B)(ii) should be amended to increase the current $20 million budget neutrality adjustment trigger and index it for inflation going forward.**

Adjust the Global Surgical Code Values to Reflect Increased E/M Values

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor surgery such as back surgery, brain tumor removal, joint replacement, heart surgery, cataract surgery, colon resection, or provide maternity care. This single fee covers the costs of the surgery plus related care prior to surgery and follow-up care within a 10- or 90-day timeframe. CMS establishes these global payments, including payment for both the surgical procedure and payment for post-operative/follow up visits, which are a type of E/M visit. Post-operative services include follow-up visits in the hospital related to recovery from the surgery; post-surgical pain management; local incision care; removal of sutures and staples, lines, wires, tubes, drains, casts, and splints; and other services.

Since 1997, CMS increased the E/M portion of the global code values to reflect increases in the stand-alone E/M codes each time these office visit codes were adjusted. In 2021, CMS did not apply the adjusted values to the 10- and 90-day global surgical codes. This decision disrupted the relativity in the fee schedule mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239). Additionally, the Medicare statute prohibits CMS from paying physicians differently for the same work. Failing to adjust the global codes is equivalent to paying some physicians less for providing the same E/M services**. Global surgery payments must be modified to include the current stand-alone E/M payment levels as adjusted in 2021.**

These are only short-term measures that must be enacted by the current Congress and Administration, as we work together in the next few years toward a more sensible system of physician payment that accounts for quality and value. ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing health disparities and ensuring the availability of high-quality care across all settings are imperative, and medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may not be relevant to the patients treated. Congress and CMS should encourage innovation in value-based payment models that provide and utilize timely, actionable data to allow physicians to improve care**.**

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 not only facilitate better care but 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 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.

The ACS thanks Rep. Neal Dunn, M.D. (R-FL-02) for his leadership on developing legislation to extend the incentive payment for participation in eligible APMs. The APM incentive was intended to attract early participants to models developed under MACRA's new pathway. However, it is critical that the Innovation Center advance physician-developed models which have been reviewed and recommended for testing and implementation in order for this incentive to fully be effective. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing APMs recommended by the PTAC.**

Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

Most physicians in the current fee-for-service system 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. ACS's efforts have 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 efforts and the more than 100-year history of ACS working to improve the quality and value of care for surgical patient, the ACS believes addressing the current limitations on the types of quality measures available as well as the limitations on the facility-based scoring option 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 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. The ACS thanks Rep. Larry Bucshon, M.D. (R-IN-08) for sponsoring legislation on this issue and we thank the Subcommittee for considering these important improvements to MIPS.**

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.

Prior Authorization Reform Will Help Patients and Reduce Administrative Burden

Surgical patients are encountering barriers to timely access to care due to onerous and unnecessary prior authorization (PA) requests from Medicare Advantage (MA) plans. Utilization review tools such as PA can sometimes play a role in ensuring patients receive clinically appropriate treatment while controlling costs. However, ACS is concerned about the growing administrative burdens and the delays in medically necessary care associated with excessive PA requirements. A 2017 ACS questionnaire of nearly 300 surgeons and practice managers indicated that, on average, a medical practice receives approximately 37 PA requests per provider per week, taking physicians and staff 25 hours – the equivalent of three business days – to complete. Since then, Fellows have shared that this burden has grown significantly. Despite more automation since that time, payors are applying PA to an increasing number of services and use digital/AI tools to automatically deny PA and/or claims without any review of the medical record.[1] We appreciate the Energy and Commerce Committee's continued leadership in addressing the overutilization of prior authorization**. ACS strongly supports the Improving Seniors' Timely Access to Care Act. This legislation would improve continuity of care and reduce excessive administrative burden by facilitating electronic prior authorization, improving transparency, and increasing CMS oversight on how MA plans apply PA requirements.**

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

The value-transformation is underway but could be greatly accelerated through a combination of shoring up the foundation of the physician fee schedule and partnership between CMS and stakeholders interested

[1] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

in improving the way quality is measured and incentivized. Congress has the power to provide CMS with direction, flexibility, or additional authority to help them achieve the goal of improving value. **ACS proposes the following specific action items for Congress to consider:**

- **First, prevent pending cuts and implement an update mechanism in the physician fee schedule to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;**
- **Eliminate the Medicare PFS budget neutrality requirement or increase the trigger threshold from $20 million to $100 million and index it annually to account for inflation;**
- **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 as proposed in one of the bills being considered at the hearing.**

These are relatively modest reform ideas that stabilize the physician fee schedule and build on MACRA to put the focus back on providing high value care to the patient. Surgeons are eager to be part of the solution and to work with Congress to advance critical reforms. The ACS thanks you for convening this important hearing on improving the Medicare payment system and for the committee's consideration of policies that advance quality and value for patients. We share this commitment and look forward to working collaboratively with the committee to achieve the goal of safe, affordable care for all Americans.