



## AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
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June 22, 2015

The Honorable Orrin Hatch,  
Chairman  
Senate Finance Committee  
United States Senate  
Washington, D.C. 20510

The Honorable Ron Wyden,  
Ranking Member  
Senate Finance Committee  
United States Senate  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
Washington, D.C. 20510

The Honorable Mark Warner  
United States Senate  
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Johnny Isakson,  
and Senator Mark Warner:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I would like to thank you for the opportunity to provide feedback on how best to improve outcomes for Medicare patients with chronic conditions. We appreciate the Senate Finance Committee's leadership in recognizing the need to analyze current law, discuss alternative policy options, and develop bipartisan legislative solutions.

The College recognizes that formulating a long-term solution to improving care for Medicare patients with chronic conditions is a challenging, yet essential undertaking, especially given the need to limit the growth in health related spending, coupled with the increase in members of the "Baby Boom" generation soon aging into the Medicare program. The ACS has a rich history of quality improvement efforts and our belief is that many surgical patients are affected by these conditions. Any efforts toward reforming chronic care must include surgical input when surgical care and chronic care management are needed for a particular patient. Thus, we applaud these efforts and ask that consideration is given beyond primary care and patient centered medical homes, and is inclusive of crucial components such as surgical care. Treatment of the chronically ill involves complex, cross specialty relationships. The reforms for the surgical patient with chronic illnesses that we ask you to consider should also include optimizing chronic conditions prior to surgical care and post-operative care coordination with the chronic care teams. The ultimate goals are to increase quality for the patient and efficiently use the health care resources, which when

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combined, will reduce growth in health care spending. We continue to assert that quality improvement and cost reduction are directly related objectives.

Over the last several years, the College developed our quality improvement principles into a draft Medicare physician payment reform proposal called the Value Based Update (VBU). Initially intended as a replacement for the Sustainable Growth Rate (SGR), our proposal seeks to define clinical affinity groups (CAGs) as disease or condition specific, patient-centric service lines of care which extend over a given period of time. This same principle of clinical affinity groups must incorporate chronic care teams into condition specific services when patients need more complex, coordinated care plans. By building teams of care around the patient, we believe quality and cost can be combined into incentive programs such as the alternative payment models as envisioned now in the Medicare Access and CHIP Reauthorization Act (MACRA).

MACRA and the long awaited repeal of the SGR brought closure to the need for a VBU. Now, we believe the same Clinical Affinity Group (CAG) concept previously built into the VBU proposal can be applied using clinical and cost data along with chronic conditions to improve care, drive coordination through aligned incentives and stimulate innovation in cost efficiency. Development of our proposal is ongoing but we believe the CAG model contains all the necessary factors to become a qualified APM under MACRA and may also provide solutions to a number of the problems posed in your letter. We look forward to working with Congress and other stakeholders to continue to develop this option.

In concept, a CAG describes a service line for a population of patients with specific conditions or diseases cared for by a team of various specialties of physicians and providers over a period of time, all sharing the common goal of optimal care for the patient with that condition. In fact, we believe this sort of thinking is more closely aligned with how successful delivery systems provide care – as teams of care. We believe CAGs might include categories such as cancer care, select or specific surgical procedures, and cardiac care as examples. Other concepts of CAGs include groups of patients considered as the elderly, end of life care, digestive diseases, women's health, rural health, primary care, and chronic care. Each CAG will have its own quality targets such as risk adjusted, outcomes-based, safe practices and patient experience of care measures. The measures selected would be designed to foster continuous improvement and help lower costs. These measures will be crafted in close

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consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own. The central theme of the CAG is to align incentive programs into the basic coordinated team-based care patients should receive in their care environment, and to avoid incentives that exist in silos of care for given federal payment programs for each specialty area. In other words, the incentives are aligned more with patient needs than with physician payment schemes.

As part of a voluntary APM, providers could self-select their CAG, providing they meet certain eligibility requirements based on the patients they see and conditions they treat. Payment adjustments could be applied based on performance in a set of measures specific to each CAG. Any alternative payment system tied to quality and cost relies heavily on accurate clinical and cost data. To develop appropriate measures, available data must be transparent and readily available for analysis. Success in tracking the cost drivers and controlling waste depends on available information. This understanding, based on a strong data and analytics infrastructure, would provide physicians with a clear picture of the quality/cost curve and allow them to target warranted and unwarranted variation, inefficiencies and suboptimal care. Physicians will have the opportunity to select the CAGs and the elements within that CAG for their APMs. We would suggest these choices may need to be identified annually in order to build team based solutions and proper metrics and incentives. CAGs are not specialty specific, and in fact are designed to accommodate participation by a variety of specialties, incentivizing care coordination for patients suffering from the related conditions or diseases. Payments to all members of the APM for that CAG can be adjusted up or down annually for participants in a given CAG based on aggregate performance of the group on the measures and how they work together to coordinate care and improve the quality/cost curve.

### **1. Improvements to Medicare Advantage for patients living with multiple chronic conditions.**

ACS believes the solution presented above- with its focus on using robust quality metrics and data infrastructure to target cost drivers across specialties- translates well to a wide variety of payment models and could be extended into Medicare Advantage plans.

### **2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current**

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**Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.**

As discussed above, ACS believes that the CAG based APM structure represents a patient-centric, flexible solution, which is responsive to the changing needs of the health care system. The CAG model could be built into current bundles and ACO programs as well.

In addition, the American College of Surgeons Commission on Cancer has developed an accreditation program specific to the delivery of cancer care by physician-run community oncology practices. The accreditation program addresses practices transforming themselves into patient-centric Oncology Medical Homes (OMHs), where the delivery of quality, cost-effective cancer care is a priority. This involves a high degree of care coordination and attention to reducing the costs of cancer treatment, both within the context of measurable quality outcomes. As more chronic disease is cancer related, the COC OMH accreditation program touches on the three policy goals of the Senate Finance Committee.

**3. Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions.**

The CAG model is designed to incentivize providers to coordinate care across specialties regardless of the actual payment mechanism used. As mentioned above, we feel that it would translate well to a wide variety of payment models, including fee-for-service. The underlying goal of a CAG is to incentivize physicians of different specialties to coordinate care for a specific condition or patient population. This can be promoted by using APMs based on the overall performance of all physicians of all specialties within a given CAG, thereby shifting the focus from individual procedures- like that found in the fee for service model- to the bundled payments of the entire group.

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#### **4. The effective use, coordination, and cost of prescription drugs;**

Medication errors are more easily detected when such information is shared among providers and pharmacies. E-prescribing often checks for drug-allergy interactions, drug-drug interactions and duplicate drugs. It often results in greater efficiencies because of the reduced number of clarifications required. As the utilization of E-prescription models increases, we must ensure that the systems are interoperable, and that the information can be translated into an understandable format.

The Cancer Drug Coverage Parity Act, H.R. 2739, would require health insurance plans that cover traditional intravenous or injectable chemotherapy to provide no less favorable coverage for prescribed, orally-administered anticancer medications. Insurance coverage for cancer treatments has been outpaced by promising oncology research. Even though oral chemotherapy is now commonly prescribed to treat cancer, health insurance coverage for different types of cancer treatments varies significantly between insurance plans. While intravenous treatments are usually covered under a plan's medical benefit component, orally-administered anti-cancer medications are covered under a plan's prescription drug component which often places a higher percentage of cost sharing on the patient. This disparity in coverage can force patients to decide what type of care they will receive or if they will forgo treatment altogether, as most orally-administered anticancer medications have no alternative intravenous or injectable equivalent. The College believes that a patient's treatment options should be based on the best, current medical recommendations of their doctor and not outdated health insurance policy guidelines. H.R. 2739 would ensure that cancer patients have access to all medically appropriate therapies by requiring equal coverage to orally-administered anti-cancer medications.

Another drug-related issue to consider is that post-acute surgical care often alters patient's medication needs from their baseline. Surgeons must coordinate with the chronic care team for care plans during this time and immediately after discharge. Medication errors often lead to readmissions. Post discharge coordination would greatly aid patients in the return to their former medication routines and prevent avoidable readmissions.

#### **5. Ideas to effectively use or improve the use of tele-health and remote monitoring technology;**

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Currently, Medicare pays for telehealth services which exist in Health Professional Shortage Areas (HPSAs) located outside of a Metropolitan Statistical Area (MSA), or are located in a county outside of a MSA. We would encourage Congress to examine the possibility of Medicare payment for telehealth without these restrictions. When the correct type of care is provided at the right time, patient outcomes may be improved, and there is potential for Medicare savings.

Also, as the usage of telehealth proliferates, policies must be developed with liability protections in mind. One such example of further liability parameters may be found in H.R. 2603, the "Saving Costs, Saving Lives" Act. Under this legislation, physicians who can demonstrate they followed recommended best practices will benefit from increased liability protection in the form of a legal safe harbor.

Licensure across state jurisdiction represents a potential barrier to the most efficient and effective use of telemedicine. While ACS does not at this time advocate for universal licensure, the creation and support of a central repository for the documents required of physicians to obtain licensure in the individual states would greatly enhance licensure of physicians and reduce the administrative burden on both individuals and state boards of medicine.

**6. Strategies to increase chronic care coordination in rural and frontier areas;**

Please see discussion above.

**7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers;**

A patient's health is largely dependent upon lifestyle choices. Many chronic conditions are developed due to diet, lack of exercise, and smoking. Providers should be encouraged to educate patients on the importance of prevention and provide them with the tools necessary to take charge of their health. Patients should also be undergoing routine screenings for common cancers such as those of the skin, breast, colon, or cervix. Additionally, allowing for an incentive program- such as lower Part C premiums- may further encourage patients to live a healthy life.

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Patients should continue to have access to their health data, whether it is in a portal or a "cloud based" format. Each data solution should be provided in a way that is easy for patients to digest, and offer the tools necessary for individuals to better assess their health and adhere to care plans.

We would also encourage the use of ACS' National Surgical Quality Improvement Program (NSQIP) Surgical Risk Calculator for patients. This is a revolutionary tool that quickly and easily estimates patient-specific postoperative complication risks for most operations. The Surgical Risk Calculator allows surgeons to enter a total of 22 preoperative patient risk factors about their patients. Next, the risk calculator estimates the potential risks of mortality and eight important postoperative complications, and displays these risks in comparison to an average patient's risks. This process allows for patient-centered care, shared decision making with patients, and true informed consent when it comes to surgery.

**8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

The goal of the CAGs is to create information readily available for the patient in a way that is easily absorbable and transparent. It is important to recognize that in some scenarios a patient's primary care provider may not serve as the patient's first point of contact. For example, during cancer treatment and into survivorship care, the patient's surgeon may play that role. In such circumstances it is vital to ensure that care transitions are handled effectively, including transitions from hospitals to other sites of service, for patients returning home, and for medication reconciliation as discussed in question three.

Attaining true interoperability and interoperation of EHRs will also ease this process. A complete patient record will mean that all of a patient's care providers (as well as the patient him or herself) will have a clear picture of their health status and care needs.

Your acknowledgement of the need to ensure public policy is in line with the best outcomes for Medicare patients with chronic conditions is greatly appreciated. We thank you again for your leadership and commitment, and look forward to working with you on this very important endeavor.

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Sincerely,

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Executive Director

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