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AMERICAN COLLEGE
OF SURGEONS

Inspiring Quality:
Highest Standards,
Better Outcomes

Statement of the
American College of Surgeons

Presented by Frank Opelka, MD, FACS

United States Senate
Committee on Finance

Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead

May 8, 2019

The American College of Surgeons (ACS) thanks the Senate Finance Committee for convening a hearing on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). ACS has a longstanding commitment to improving the quality of surgical care and we are grateful to Congress for making quality a focus of the MACRA law. However, ACS has concerns that this focus may have been obscured as the priorities and ideas of Congress and the broader stakeholder community who partnered in developing MACRA met the constraints of a hurried implementation. We welcome the opportunity to continue partnering with Congress and the Administration to ensure that the goal of improving the value of care to the surgical patient stays at the forefront.

ACS Supports the Congressional Intent of MACRA but Implementation Misses the Mark

MACRA was intended to replace the failed cost containment strategy of the Sustainable Growth Rate formula (SGR) by implementing payment incentives that rewarded physicians for improving quality and keeping down cost. In other words, the idea was to tie payment more closely to the value of care provided to the patient. Achieving this congressional intent in the area of surgery requires the establishment of a strategy for expressing what constitutes value in surgical care. This is not achievable using legacy Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM) measures. The Centers for Medicare & Medicaid Services (CMS) relied on their skills as a payer to retrofit their payment models with sporadic, disaggregated quality metrics. The end result has been disruption of the care teams and a disconnect from real quality of care. For many physicians, the Merit-based Incentive Payment System (MIPS) has not, and given its current trajectory will not, serve as a driver of improvement in quality or reduction of cost.

In addition to these implementation issues, we also have great concerns about the structure of payments under MACRA in the years ahead. The modest statutory updates included in the law are now finished, and we will soon enter a six-year period with no updates. This will likely result in real reductions to payments due to inflation and budget neutrality requirements. Additional incentives for high performers and qualified alternative payment model (APM) participants also disappear during this time, which will be experienced as reductions by many of the highest performing physicians in Medicare. While the focus of the testimony today is improving incentives for quality and value, the ACS urges Congress to consider these factors as well. The ACS would welcome the opportunity to further describe the physician payment landscape from our perspective and how this might affect access to care in the future.

Quality Measurement in MIPS and APMs

ACS Vision for Meaningful Measurement Models

ACS continues to welcome and celebrate the congressional focus on quality and value built into MACRA, including the concept of rewarding those who provide high quality surgical care while holding down costs. However, CMS as a payer does not have the resources or knowledge to generate the master plan for quality for a surgical team working toward a patient outcome in a particular episode of surgical care and therefore must first fully collaborate with the surgical community. This collaboration would include 1.) defining the patient-centered care model, 2.) identifying the structure

and processes required to deliver quality in surgical care, and 3.) assigning quality metrics and attaching an incentive payment program to achieve care goals.

Expressing value in surgical care requires appreciation of the specific condition and its care model, consideration for clinicians and their unique roles as team members in providing surgical care to the patient, and the ultimate outcome of that care. With this understanding, it is possible to define the critical data and measurement elements across the care model for the team, which is essential in driving improvement. What follows then is agnostic to the payment system; it is possible for CMS to use the various tools of MACRA to design a payment model either within Medicare fee-for-service (FFS) or within some form of APM.

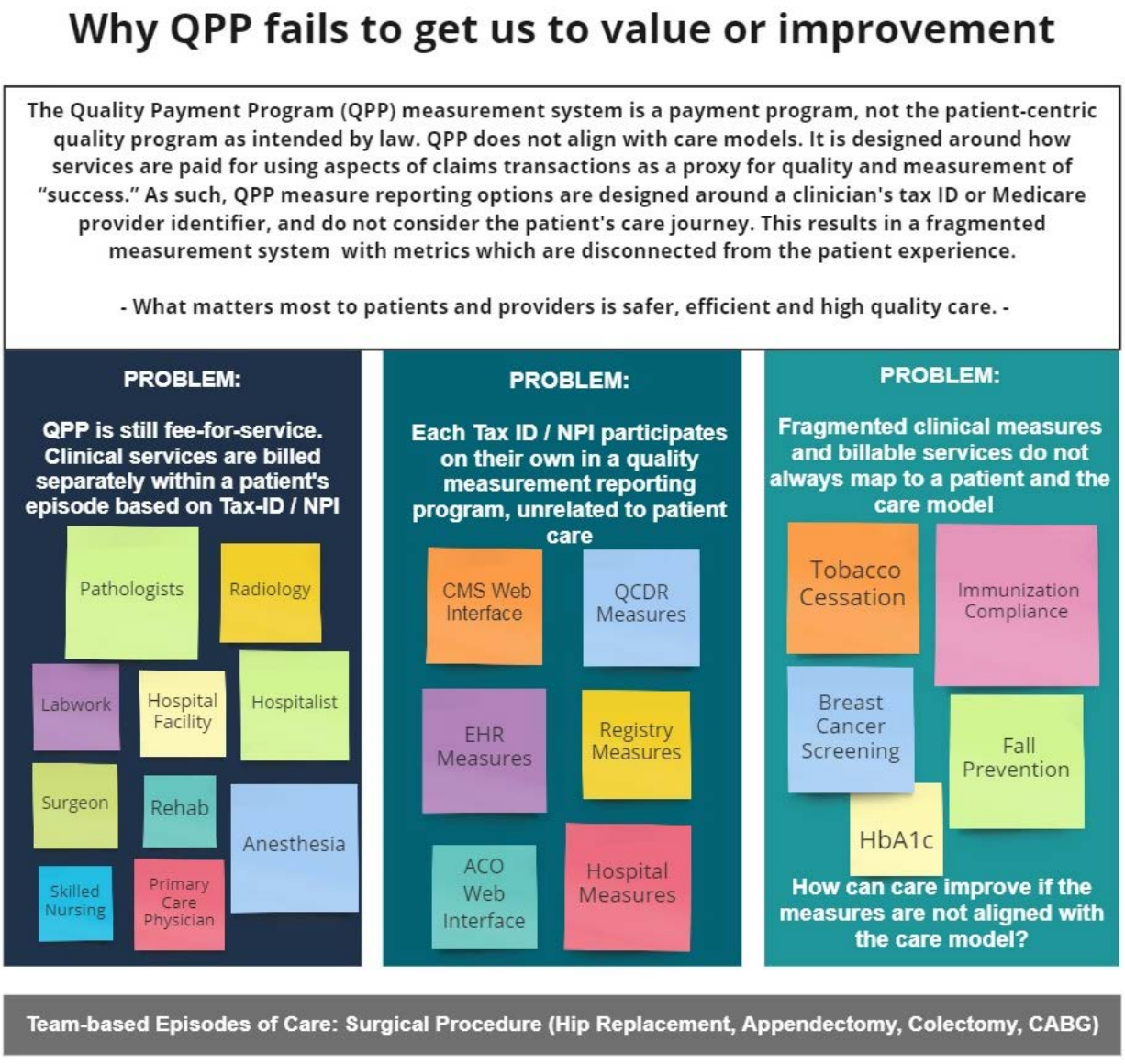
More specifically, by designing a master quality care plan for surgical care as the first step, these value-based models can be tailored to a broad range of payment models such as FFS in MIPS, Accountable Care Organizations (ACOs), bundled payments such as the Bundled Payment for Care Improvement-Advanced (BPCI-A) model, or other APMs. This master quality care plan would be used to measure quality across all payment programs so that the care team has one valid and meaningful quality target to define value for surgical care. Such an effort will also greatly reduce burden.

The ACS developed a model formula that could serve as the foundation for quality in surgical care. The ACS model formula for expressing value in care does not differ from those found in other industries. ACS believes that quality of care begins by setting evidence-based standards for care, ensuring that the right infrastructure and systems are in place through measurement and verification, and incorporating data at the point of care to inform surgeons' and patients' decisions. The patient should have a voice to determine whether the treatment met his/her goals. We define the episodes for a given domain such as trauma care, cancer care, or complex gastrointestinal care as examples and assign a surgeon champion. Within each of these domains, evidence-based, common standards are applied for areas that affect all surgical patients. Specific standards can also be applied for each individual surgical episode or condition. With the proper standards, infrastructure, data, and verification we can greatly improve outcomes and patient safety while simultaneously reducing complications and other unnecessary costs. If implemented correctly, the data generated helps to feed research into which interventions and care are most effective, creating a beneficial cycle of quality improvement. This marriage of quality and cost for a given treatment, condition, or episode of care is a true representation of value.

QPP Incentivizes Check-the-Box Compliance Instead of Striving for Quality Improvement

An increasing number of surgeons recognize that CMS efforts are not contributing to higher quality surgical care. The rational response is for surgeons and/or health care administrators to simplify their engagement in MIPS by taking the necessary steps to assure payment rather than to focus on quality. The figure below illustrates that the Quality Payment Program (QPP) is designed around how services are paid for, using aspects of claims transaction as a proxy for quality and measurement of "success," at the level of the tax identification number (TIN). The current measurement system does

not consider the patient's care journey and does not represent a patient's experience. For example, an ever-greater percent of surgeons are participating in quality reporting through the CMS Web Interface group reporting option. This translates into reports based on large groups of physicians (frequently providing care for very different patients and conditions) gathered under one TIN. It does not translate down to the care a surgical patient receives. In other words, surgeons receive credit for how well their group immunizes a population instead of assuring patients have safe surgical care.



Currently, much QPP reporting takes place in the CMS Web Interface option, which allows groups of at least 25 eligible clinicians with the same TIN or participants in certain ACOs to submit data together and be measured as a single unit. The Web Interface is a stable, known program to administrators. They know what their scores are likely to be, and it is built into the workflow for their organization. While easy for physicians to comply with, the ten measures available in the Web

Interface are focused on screening, preventive care, and diabetes control. These measures are important to a patient's overall health but provide absolutely no information on the quality of surgical care received by patients of surgeons in these groups and therefore are not relevant to efforts to improve surgical quality.

MIPS participants can choose to report both as part of a group and as an individual, but the majority of surgeons are unlikely or unable to do so due to financial implications. Administrators and the C-Suite often decide the most cost-effective way for the TIN to report in MIPS, and specialty specific reporting may result in a lower MIPS score. In fact, performance data from the first year of MIPS shows that the median score of groups was more than 50 percent higher than that of those who participated as individuals. For clinicians who still choose to report specialty-specific measures, those available are not patient focused, frequently dating back to the PQRS program, and are designed for an exclusively FFS world. Furthermore, new measures without a benchmark can only receive the lowest amount of points. These problems stem from how CMS has set up reporting incentives, favoring large group reporting on primary care.

Many believed that Qualified Clinical Data Registries (QCDRs) which are referenced more than 20 times in MACRA, would be a key pathway for stakeholders to influence quality measures. However, roadblocks emerged that impeded the ability of specialty societies to measure quality based on what matters most to their patients. There is a huge disincentive to use QCDRs for many specialties, such as the constant annual removal of measures, and very low opportunities for earning points. New measures without a benchmark receive the lowest point value. This has greatly limited the value and uptake of these registries.

Data rigor and aggregation standards are also crucial to registry success. As a payer, CMS has little ability and expertise to utilize these registry elements and value these tools within their current measurement systems, resulting in a cacophony of reports that are meaningless to the end user. Only when registries have standardized data, aggregation, normalization, and reporting from a single source of truth are they of value. This is evident in registries maintained by ACS. Registries and the information they provide are best implemented within an overall care plan where a team of experts use the knowledge imparted to inform the patients and the team members about clinical care based on rigorous data. The ACS continues to work to demonstrate how to structure data models for care improvement.

In sum, CMS' implementation of MACRA has fostered a payment model rather than first focusing on quality. As a result, surgeons currently lack confidence in CMS as a source of quality reporting. Thus, we expect more surgeons will be reporting through the group reporting options, which constitutes the path of least resistance. This is unfortunate since it may have the additional consequence of crowding out other efforts aimed at improving quality in surgical care and areas that are not incentivized. It also seems counter to the intent of MACRA which encouraged CMS to seek comprehensive measurement of groups. The statute notes that to the extent practicable, group

measurement should reflect the range of items and services furnished by the eligible clinicians in the group. This is not currently the reality in the CMS Web Interface.

A Way Forward in the QPP: Proposed ACS Measurement Framework for Value-Based Care
The ACS proposes alternate quality measurement structures for the QPP based on our more than a century of experience in surgical quality improvement. This focus on quality resulted in the publication in 2017 of *Optimal Resources for Surgical Quality and Safety*, referred to as the "Red Book." This comprehensive volume serves as a manual for those seeking to build a learning environment designed to provide patient-centered, high-quality care. Standards drawn from the Red Book are now being used for the verification and accreditation of hospitals on the basis of surgical quality and patient safety.

The ACS alternative framework for surgical quality measurement is comprised of three components:

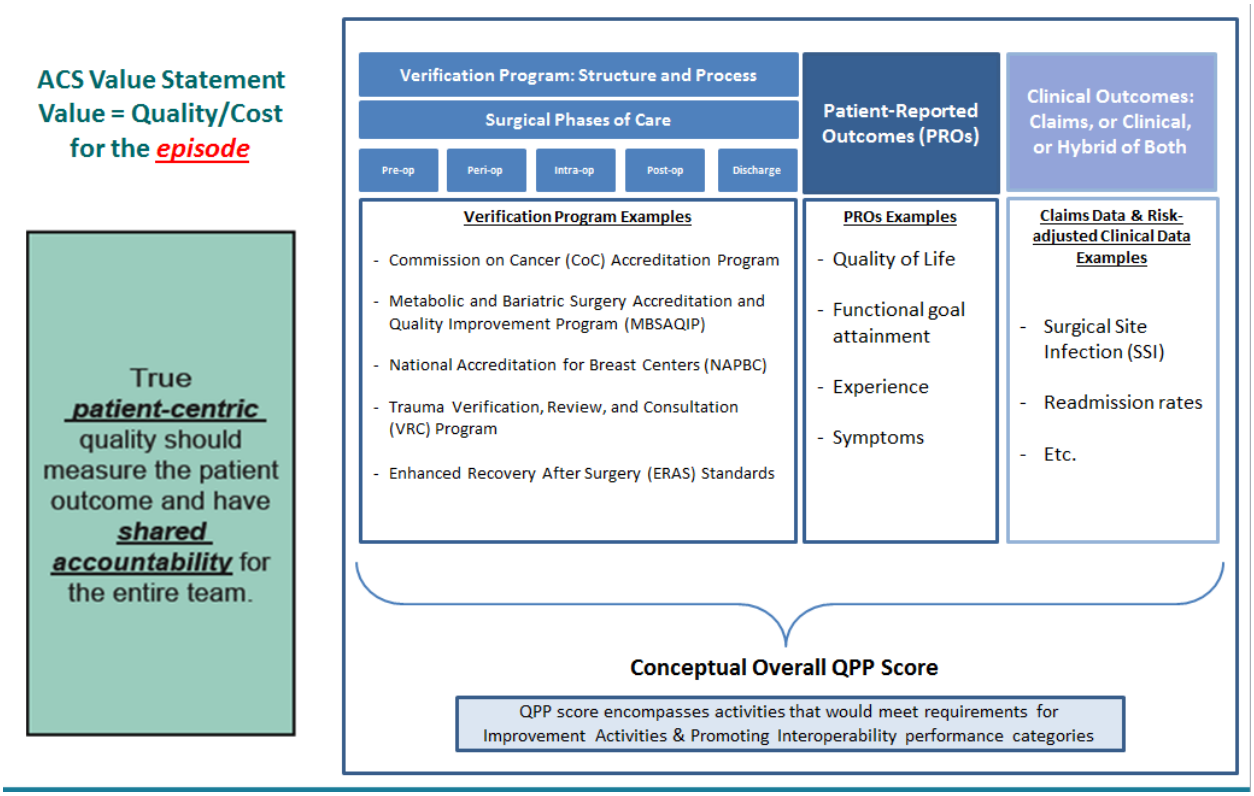
1.) **Verification of Key Standards of Care** Since the inception of the ACS, we have sought to build standards for clinical domains with the expectation to improve overall outcomes of surgical care. While implementing these standards, we have gained over a half-century of experience in building clinical verification programs in specific clinical domains to drive quality, improvement, and excellence in care. The success of verification programs are well-established in the peer-reviewed literature. Each of the major surgical domains contain a set of standards for inclusion in a renewable, triennial verification program. The long-term goal is to scale these verification programs initially through pilot testing, then as a foundational component to building a national quality system in surgical care.

2.) **Clinical Outcome Measures** We envision the use of administrative claims measures for surgical procedures that have a low event rate of care for poor outcomes (readmissions, mortality, reoperation, etc.), and propose using programs such as the National Surgical Quality Improvement Program (NSQIP), for complex, high risk care that have variation in outcomes and require risk adjusted, clinical outcome measurement with a high level of rigor. This would require pilot testing before large-scale implementation.

3.) **Patient-Reported Outcomes** In addition to standards-based verification programs and clinical outcome measures, we propose inclusion of patient-reported outcomes measures (PROMs) based on an episode of care. Episode-based PROMs are inclusive of the patient's voice and can assess whether care achieves the patient's goals, including functional outcomes and quality of life. We have begun early testing and development of enriched PROMs, focused on surgical outcomes. This model is designed to recognize the complexity of modern medicine and demonstrate that it exceeds the ability of a single physician to provide all of the care.

This framework, which is illustrated in the figure below, is based on decades of research and implementation of verification programs, which have proven successful in driving better outcomes in surgical care. It is applicable across various clinical domains, particularly in surgery where robust

verification programs exist in areas such as cancer care, trauma care, bariatric care, and care for frail geriatric patients. Such programs depend on triennial surveys, and already exist in thousands of delivery systems today with demonstrated success. As an example, measurement of cancer care spans the entire care journey experienced by patients and includes areas such as prevention, screening, early diagnosis, treatment, post treatment surveillance, and end-of-life care. A surgical resection for cancer may involve debulking and staging the disease, while also including a method for tracking quality through verification of key standards, PROMs, and clinical outcomes. Furthermore, if such a quality framework were combined with the ongoing cost measurement work that formed the core of the ACS-Brandeis Advanced APM described below, then this would constitute quality and cost measurement across standardized episodes of care representing true value to the patient.



PTAC Recommendations to Pilot APMs Not Actualized

In addition to MIPS, MACRA created a separate option for participation through APMs. Since quality measurement in APMs is required only to be "comparable" to that in MIPS, APMs were considered an attractive option to propose innovative measures and new concepts. The inclusion of the Physician-focused Payment Model Technical Advisory Committee (PTAC) in MACRA was seen by many in the physician community as a positive step. MACRA payment incentives and the establishment of PTAC encouraged the development of physician led models, creating a clear pathway for the transition from FFS to APMs.

ACS recognized the importance of the value transformation in healthcare through APMs and partnered with experts in episode-based cost measurement at Brandeis University to develop the first

proposal received, evaluated, and ultimately recommended by the PTAC in April 2017. The ACS-Brandeis Advanced APM proposal incorporated cutting edge cost and quality measurement beyond that currently required by CMS in the FFS world into a new value expression. The PTAC thoroughly vetted the model both through written requests for information and at an in-person meeting. PTAC ultimately agreed that the proposal satisfied their quality criteria. Unfortunately, the ACS model and many other models recommended for testing or implementation in the QPP have not been acted upon, closing another door for truly meaningful quality measurement.

Summary

MACRA promotes innovative quality and cost measures as well as the development of alternative payment models. We welcomed the legislative intent to improve care and have been hopeful the implementation of the law would promote meaningful surgical quality over the burdensome, insignificant measures used in many of the previous payment programs. Without real meaningful quality measurement, MACRA will fall short of achieving the aspirations of patient-centered quality care. The QPP as it currently stands fails to provide meaningful quality measurement and is in need of a course correction.

ACS holds that what matters most to patients and providers is safer, more efficient, and higher quality care. It is with these goals in mind that we designed our proposed measurement framework for value-based surgical care. Congress should encourage CMS to partner with clinical stakeholders to evaluate and test innovative, evidence-based proposals such as the one we have described. We believe CMS has the authority to accomplish this but may benefit from additional guidance from Congress. CMS may require additional resources to increase their ability to accept meaningful data and administer the QPP in a way that supplies participants with the tools and data they need to improve value, and patients with the information they need to make the best possible choices for their care. Creation of a formal process for partnerships with the physician community on efforts to improve value for patients could help improve the quality of care for Medicare patients and truly refocus the incentives in MIPS toward higher value care. This would go a long way toward ensuring the long-term viability and success of the QPP and MACRA.