Documents for the Record

E&C Oversight Hearing 6.22.23

1. Burgess – (A) DOC Caucus statement for the record and (B) AMA 6.21.23 Letter to E&C
2. Joyce – (A) Surgical Coalition Statement and (B) ACS Statement for the Record

1. Burgess – (A) DOC Caucus statement for the record

GOP Doctors Caucus
Co-Chair Brad Wenstrup, D.P.M.
Co-Chair Michael Burgess, M.D.
Co-Chair Greg Murphy, M.D.

June 22, 2023

The Honorable Cathy McMorris Rodgers
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chairman
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2202 Rayburn House Office Building
Washington, DC 10515

Dear Chairmen McMorris Rodgers and Griffith,

The House GOP Doctors Caucus would like to commend the Energy and Commerce Committee Subcommittee on Oversight and Investigations for holding a hearing on the Medicare Access and CHIP Reauthorization Act (MACRA) or "MACRA Checkup: Assessing Implementation and the

Challenges that remain for Patients and Doctors." The passage of MACRA reflected years of bipartisan, multi-committee and bicameral negotiations, bringing diverse outside stakeholders to join around a policy to help doctors, Medicare providers, and patients get out from the threat of payment cuts under the Sustainable Growth Rate.

The SGR formula was a cap on aggregate spending on physicians' services. The formula was passed into law in the Balanced Budget Act of 1997 to control physician spending and was proven to be a significant failure. Since 2003, Congress had spent nearly $170 billion in short-term patches to avoid unsustainable cuts imposed by the flawed SGR.

In 2015, the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law to repeal the sustainable growth rate (SGR) formula and introduce a new merit-based incentive payment system and processes to adopt alternative payment models (APMs). This new approach was designed to shift our physician payment system with the intent of paying providers based on quality, value, and results of the care delivered rather than the number of services provided.

It has been 4 years since Congress has had a hearing on the implementation of the MACRA. The past few years have highlighted the need to support our health care payments system and continue to examine the outcomes of the law. We have made significant progress since the transition to value in 2015. However, there are several areas where further improvements can be made to lower costs, increase value, and further beneficiary access to higher quality health care.

In an effort to accelerate Medicare's transition from fee-for-service payment, as MACRA intended, the GOP Doctors Caucus would like to highlight the need to provide a stable payment structure for the health care system to operate on while we work to identify shortcomings and highlight new ways towards a value-based care system.

The GOP Doctor Caucus is committed to working towards solutions for financial stability, making it easier for providers to practice in the system, and ultimately allowing physicians to focus on providing the best care to patients across America.

Sincerely,

Michael C. Burgess, M.D.
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Gregory F. Murphy, M.D.
Member of Congress

(B) AMA 6.21.23 Letter to E&C

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

June 21, 2023

The Honorable Cathy McMorris Rodgers
Chair
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chair
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigation
2202 Longworth House Office Building
Washington, DC 20515

The Honorable Kathy Castor
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chair McMorris Rodgers, Chair Griffith, Ranking Member Pallone, and Ranking Member Castor:

On behalf of the physician and medical student members of the American Medical Association (AMA), I commend the Committee on Energy and Commerce Subcommittee on Oversight and Investigations for holding a hearing on the Medicare Access and CHIP Reauthorization Act (MACRA) entitled, "MACRA Checkup: Assessing Implementation and the Challenges that Remain for Patients and Doctors." The AMA recognizes the importance of evaluating the implementation of MACRA and understanding the challenges faced by patients and physicians. Reforming the Medicare Physician Payment System (MPS) continues to be one of the AMA's top advocacy priorities as physicians from every state and specialty have expressed intense frustration with the current MPS and its lack of positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs. Without systemic reforms, the current physician payment system will continue to drive private practices out of business.

The AMA is deeply alarmed about the growing financial instability of the MPS due to a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, lack of inflationary updates, the ongoing negative impact of the pandemic, and significant administrative barriers. The MPS is on an unsustainable path that is jeopardizing Medicare patient access to physicians.

The AMA is working with our national specialty and state medical association Federation partners to determine the best path forward to lead the MPS to a more sustainable track. The AMA, along with our Federation partners, also developed the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 state medical and national specialty societies, including those representing primary care, surgical care, and other medical specialties. This core set of principles serves as the basis for reforming the broken physician payment system.

From these principles, the AMA has implemented a comprehensive strategy to address the challenges in Medicare physician payment. This strategy involves a series of key recommendations aimed at improving

the system and reflects the AMA's commitment to improving Medicare physician payment and ensuring sustainable, high-quality health care delivery for our patients.

The AMA's specific recommendations for Medicare physician payment reform are as follows:

- End the MACRA mandated six-year freeze on physician payment updates and pass H.R. 2474 to establish a stable, annual Medicare physician payment update that keeps pace with inflation and the cost of practicing medicine.
- Modify statutory budget neutrality requirements by establishing a look-back period to remedy overestimates and underestimates of spending based on actual claims data, refining which services are subject to budget neutrality, and increasing the trigger for budget neutrality adjustments;
- Improve Merit-based Incentive Payment System (MIPS) by allowing greater flexibility to set MIPS criteria, ensuring physicians have access to actionable data, and streamlining and fine-tuning measures and methodologies; and
- Extend the five percent APM participation incentive payments for at least two years, as well as halt the revenue threshold increase, which will have a chilling effect on participation, to encourage more physicians to transition into APMs.

We address each of these in greater detail below in the following order: 1) Need for Medicare Physician Payment Reform; 2) Status of MIPS: statutory refinements are necessary; and 3) How to increase provider participation in value-based payment models.

Need for Medicare Physician Payment Reform

1. **Establish a permanent, annual inflationary based update to physician payment**

MACRA repealed the Sustainable Growth Rate (SGR) and instituted significant reforms to Medicare by shifting the program's approach to physician payment—paying physicians and other health professionals based on quality and value. Unfortunately, MACRA froze physician payment rates for six years, from 2019 through 2025, at which point updates resume at a rate of only 0.25 percent a year indefinitely, a rate well below the medical or consumer price index and the rising costs facing physician practices.

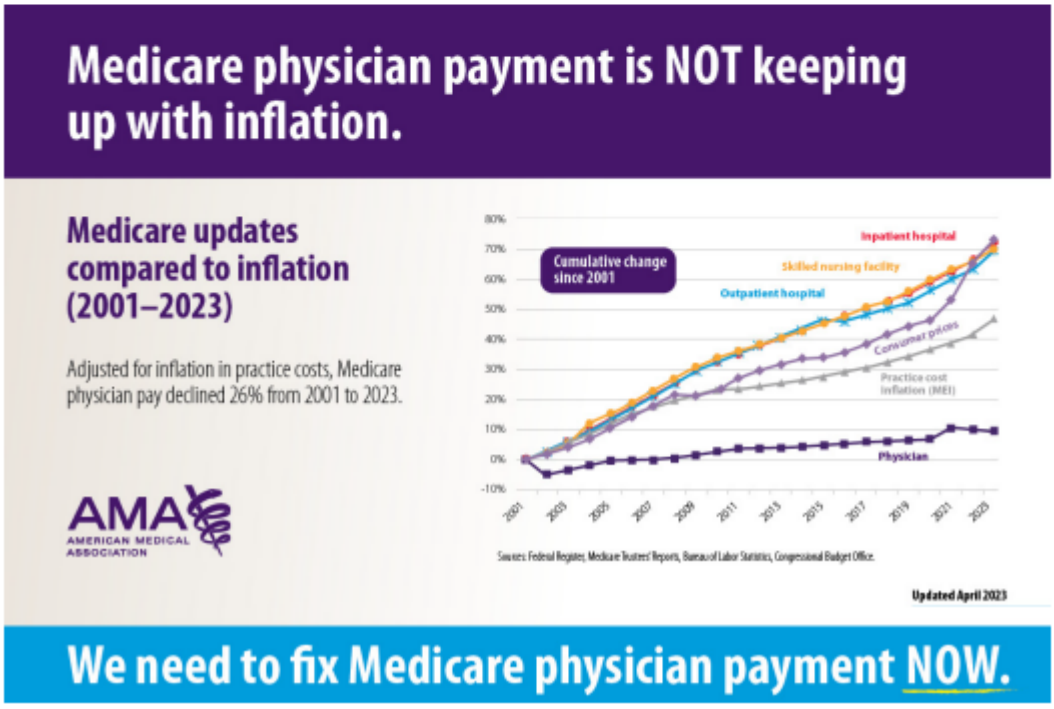
The physician community stands ready to work with Congress to develop long-term solutions to the systemic problems with the MPS in order to preserve patient access to care. The AMA commends Representatives Ruiz, Bucshon, Bera and Miller-Meeks for introducing H.R. 2474, the Strengthening Medicare for Patients and Providers Act. The legislation applies a permanent inflation-based update to the MPS conversion factor, which will provide much-needed stability to the Medicare payment system as our members contend with an increasingly challenging environment providing Medicare beneficiaries with access to timely and quality care. Passing H.R. 2474 is essential to enable physician practices to better absorb payment distributions triggered by budget neutrality rules and periods of high inflation.

We also appreciate that Congress, in the Consolidated Appropriations Act, 2023, mitigated a 4.5 percent cut to Medicare physician payment in 2023, but physicians still faced a two percent pay cut in 2023 and at

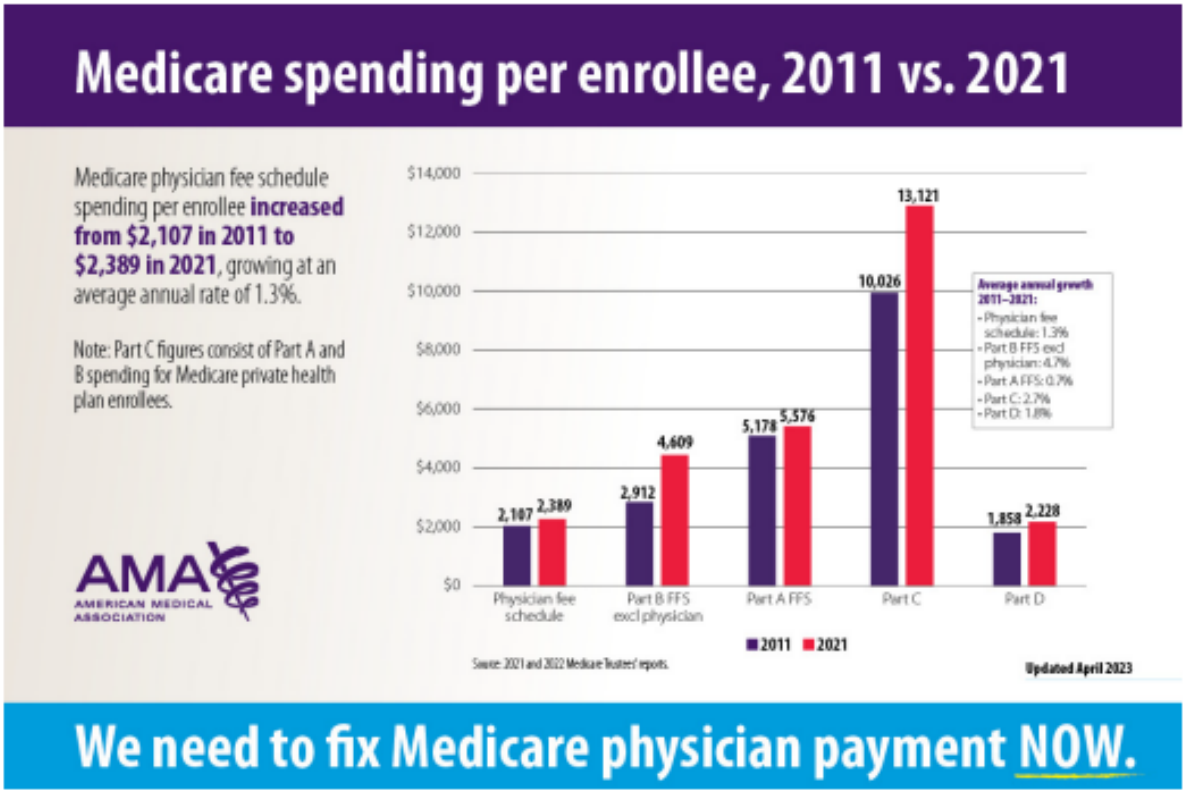
least 1.25 percent in 2024. Although Congress has taken action to mitigate some of the recent MPS cuts on a temporary basis, payment rates will continue to decline.

In the 2023 Medicare Trustees Report, the trustees warned that they expect access to Medicare-participating physicians to become a significant issue in the "long term" unless Congress takes steps to bolster the payment system. "In addition, the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases," the report said. The Medicare Trustees report followed a Medicare Payment Advisory Commission (MedPAC) recommendation that Congress increase 2024 Medicare physician payments above current law by linking the payment update to the MEI, something the AMA has long supported.

Adjusted for inflation in practice costs, Medicare physician payment declined 26 percent from 2001 to 2023. This is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Additionally, Medicare payment rates for nearly all Medicare services except those on the physician payment schedule, such as inpatient and outpatient hospital services and skilled nursing facility services, have updates tied to inflation. Physician payment rates have been further eroded by the manner in which rates are adjusted to meet budget neutrality requirements, as well as Medicare sequestration.

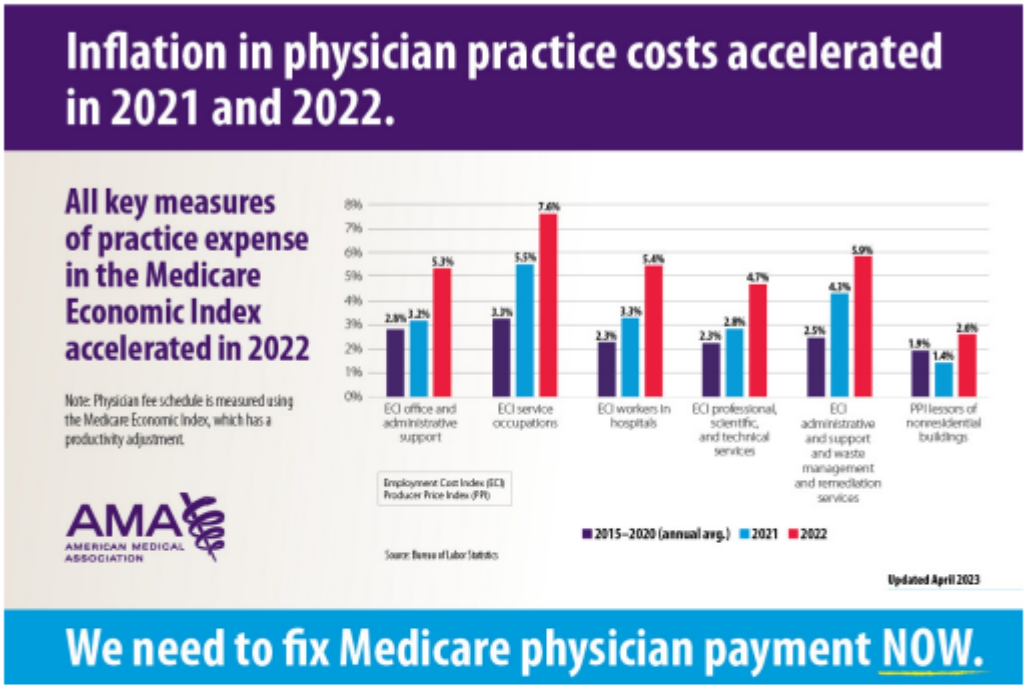


In addition, Medicare spending per enrollee has been nearly flat for a decade for physician payment schedule services even as it has risen steeply for other Medicare benefits.



Current government data on key elements of the MEI make it clear that, without an inflation-based update, the gap between frozen physician payment rates and rising inflation in medical practice costs will widen considerably.

Employment Cost Index (ECI) and Producer Price Index (PPI) data from the U.S. Bureau of Labor Statistics indicate that growth in key contributors to the MEI is much higher now than in previous years, which threatens to significantly widen this gap.



Recommendation: Congress must pass H.R. 2474 to establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to physician practice-based care. We look forward to working with Congress to ensure passage of H.R. 2474 and continue conversations around further payment reform to ensure America's seniors continue to receive access to the high-quality care they deserve.

2. Address Budget Neutrality

CMS actuaries have on occasion grossly overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule, resulting in permanent removal of billions of dollars from the payment pool. For example, a previous administration based the 2013 budget neutrality offset for Transitional Care Management (TCM) on a significantly greater estimate of initial utilization of the service than what actually occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after three years of implementation. Unfortunately, the damage was already done. For 2013, CMS reduced Medicare physician fee schedule spending by more than $700 million based on its overestimate of TCM utilization, and by 2021, Medicare physician payments had been reduced by $5.2 billion more than they should have been as a direct result of overestimation of this code alone. Similarly, CMS overestimated Chronic Care Management (CCM) utilization when adopting that code one year later (4.7 million estimated claims versus 954,000 in the first year). The overestimates of the utilization for TCM and CCM and the budget neutrality adjustments resulted in permanent reductions in MPS payments, disadvantaging physicians.

Recommendation: Congress should require a look-back period (as has been implemented in other payment systems) that would allow CMS to correct for overestimates and return inappropriately reduced funding back to the payment pool.

Importantly, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was also established in 1989—three years before the MPS took effect. Since then, there have been no adjustments for inflation.

Recommendation: Congress should increase the budget neutrality threshold to $100 million to better account for past and future inflation.

Finally, the physician community is concerned that budget neutrality adjustments could be applied based on changes in the MPS that directly result from changes in law or regulations or updates to elements of direct practice costs used in the determination of relative values and practice expense components. These categories of potential changes to spending under the MPS should be exempt from future budget neutrality adjustments:

- Newly covered Medicare services (e.g., A&B scores from the United States Preventive Services Task Force related to preventive services, new types of facilities or health professional services added to the MPS);
- Services that are being incentivized (e.g., physician bonuses, or no patient copay to encourage uptake of preventive services);
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures;
- Benefit or access expansions;
- New technology; and
- Updates to direct practice costs used in the determination of relative values and practice expense components.

Many of these benefit categories are high value services designed to improve patient care but adding them to the fee schedule negatively impacts payment for all Medicare services due to current budget neutrality requirements.

Recommendation: Congress should exempt from budget neutrality requirements certain high-value benefits or services for which utilization is expected to increase due to direct changes in law or regulations, including (but not limited to) those listed above.

Status of the Merit-based Incentive Payment System (MIPS): Statutory Refinements are Necessary

Since the enactment of MACRA, the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, eight years after passage of MACRA, there is a growing body of literature finding that MIPS has resulted in adverse outcomes, including harming small, rural, independent practices and exacerbating health inequities. Worse, a new study found MIPS is no better than chance at distinguishing between high- and low-quality care. We have serious concerns that this flawed program will increasingly

penalize physicians up to -9 percent of Medicare payments, particularly on the heels of the COVID-19 pandemic and when physicians must absorb the highest costs in recent history despite the lack of an inflationary update. For these reasons, statutory refinements to MACRA are urgently needed to achieve the goals of MIPS to improve quality care, reduce costs, and harness health information technology to these aims, while reducing undue administrative burden that contributes to physician burnout and waste in the health care ecosystem.

The AMA is working closely with national specialty and state medical societies to finalize a short list of recommendations to remove statutory impediments to get closer to achieving the goals of MACRA to move toward value-based care while reducing administrative burden on physicians. Foremost among these changes must be greater flexibility for the Secretary to set MIPS requirements based on current data and circumstances, an enforcement mechanism to ensure implementation of MACRA's data sharing requirements, and technical refinements to improve MIPS measures and methodologies with a focus on improving patient outcomes while reducing burden.

1. **The COVID Impact**

To mitigate the impact of COVID-19, CMS has implemented significant flexibilities and hold harmless policies in MIPS from 2019 through 2023. The AMA strongly advocated for and supported policies to hold physician practices harmless from penalties as physicians cared for patients with COVID-19 during multiple surges, postponed non-essential procedures, and transitioned to telehealth when feasible. While we supported these much-needed flexibilities, it means that MIPS was disrupted for five years and there is currently no flexibility in statute to allow for a glide path to reengaging in the program as physicians recover from the pandemic, face staffing shortages, and try to absorb the rising costs of practicing medicine. These extraordinary headwinds could not have been foreseen when MACRA passed in 2015. The AMA greatly appreciates that CMS extended the hardship exception policy due to COVID-19 in 2023. However, during this five-year freeze, the statutory and regulatory requirements to comply with MIPS have continued to increase. As a result, the performance threshold to avoid a penalty has more than doubled and the MIPS penalty also increased from four percent to as much as -9 percent of total Medicare physician payment. When the MIPS requirements were originally set to resume in 2023, CMS estimated one-third of all MIPS eligible clinicians would receive a penalty. When the COVID-19 flexibilities end in 2024, we can expect an even greater number of MIPS eligible clinicians will be penalized because the performance thresholds, data completeness requirements, and measure benchmarks will be even higher. We know from the research that MIPS penalties are disproportionately likely to impact small, rural, independent, and safety net practices.

How will these practices continue to see Medicare beneficiaries and keep their lights on when they have only begun to recover from the financial hardships of COVID-19 and face rising costs, due to substantial staffing problems and higher supply costs while facing a nearly 10 percent cut to their Medicare payments?

Recommendation: Congress must afford the Secretary more flexibility to set MIPS performance thresholds based on current data and circumstances, rather than a rigid, preset formula.

2. **Lack of Timely, Meaningful Data**

Physicians and specialty societies need timely access to their claims data analysis to identify patterns or variations in quality outcomes and spending. Moreover, the MACRA statute requires CMS to provide physicians with timely feedback about their MIPS performance, as well as access to their raw claims data. Despite this, CMS currently provides physicians with a single annual MIPS Feedback Report that includes information about their performance on MIPS metrics from six to 18 months after they have provided a service to a Medicare patient. For example, the first MIPS Feedback Report that physicians received for services they provided anytime in 2021 was August 2022. CMS has also made no attempt to grant physicians access to their claims data.

Taking cost measures as another example, CMS calculates up to 25 cost measures for each physician using Medicare claims data. Physicians do not know either at the time they provide services or at any point during the performance year how they are performing on any of these measures that collectively account for 30 percent of their total MIPS score, including which cost measures they will be measured on, which patients are attributed to them, and for what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable.

Without this critical information, physicians have no way to monitor their performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs. This is not due to a lack of interest in the information. Physicians have repeatedly urged CMS to share more frequent and actionable data.

Physicians who do not receive timely information, which is used to improve care for their patients, identify and reduce avoidable costs, and monitor their performance in MIPS, should not be subject to a penalty of up to -9 percent of their Medicare payment. Congress in MACRA established a MIPS program in which data flows bi-directionally between physicians and CMS. Physicians would share their quality, cost, health IT, and practice improvement data with CMS, while CMS would share comparisons of their performance against benchmarks and claims data to inform physicians about the types of care that their patients receive outside of their practice, such as in emergency departments or other specialty practices. Yet, this is not how the program functions today. Physicians receive stale MIPS feedback that cannot be used to improve their performance and never receive claims data to better inform their quality and cost decision-making. Congress can solve this problem by enforcing the data sharing provisions in MACRA.

Recommendation: To improve the timeliness and usability of MIPS data, we urge Congress to exempt from MIPS penalties any physician who does not receive at least three quarterly MIPS feedback reports during the performance period.

3. MIPS Technical Refinements Needed

There is mounting evidence that the MIPS program, as implemented, is causing significant burden; raising costs for physician practices; further disadvantaging small, independent, and rural practices; and exacerbating health inequities. Worse, new research finds that MIPS may be totally divorced from clinical outcomes. Below is a summary of some of the key problems with the program that have been uncovered since MACRA's 2015 implementation:

- **MIPS is about as effective as chance at identifying high- and low-quality care.** A 2022 study in *JAMA* found that MIPS scores are inconsistently related to performance.

- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits.

- **MIPS disadvantages small and independent practices.** According to a study in *JAMA*, MIPS eligible clinicians affiliated with a health system were associated with significantly better 2019 MIPS performance scores.

- **MIPS exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians. Another 2022 *JAMA* study found that physicians caring for more medically and socially vulnerable patients were more likely to receive low scores despite providing high-quality care. These studies suggest that MIPS may penalize physicians for social factors outside of their control and, due to budget neutrality requirements, transfer resources from those caring for poorer patients to those caring for more affluent patients. This is called the reverse Robin Hood effect.

- **Rural and medically underserved practices participating in MIPS.** According to a Government Accountability Office (GAO) report, physicians in rural and medically underserved areas face several barriers to participating in MIPS, including lack of technology; lack of vendor support and high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of program requirements. According to another GAO report, similar challenges limit rural practices' ability to transition to APMs, meaning they are largely stuck in MIPS.

Since the passage of MACRA, the AMA has made numerous recommendations to CMS to make MIPS more clinically relevant and less burdensome, including in letters, town halls, and meetings with CMS staff. We have made progress where CMS has statutory authority and flexibility, such as increasing the low-volume threshold or reducing the total number of required measures in the forthcoming MIPS Value Pathways (MVPs), which aim to hold physicians accountable for the quality and cost during an episode of care, around a specific condition, or for a public health priority, once represented an opportunity for improvement. Unfortunately, due to statutory barriers, MVPs are repeating many of the same mistakes as the traditional MIPS program.

However, we have run into statutory roadblocks when we have recommended more impactful improvements to MIPS. Several of these statutory constraints in MACRA stem from the statute's hyper specificity and lack of flexibility for CMS to respond to ongoing circumstances, such as the COVID-19 pandemic. Physicians agree that Congress must amend MIPS to allow a more flexible approach to achieve the program's original aim of incentivizing quality improvements and reducing unnecessary costs~~,~~ while addressing the clear inequities the program has created and reducing the unnecessary burden that has

evolved due to the siloed nature of the program's design. **The check-the-box requirements and zero-sum nature of the existing MIPS program doom it to failure.**

Accordingly, the AMA recommends the following statutory changes to give CMS greater flexibility to incentivize movement away from a check-the-box compliance program toward one that supports changes in care delivery to improve patient outcomes and reduce unnecessary costs and creates a more effective glidepath to widespread participation in APMs and to help MACRA fulfill its goal of increasing value in the U.S. health care system:

- **Recommendation: Alleviate the tournament model in MIPS by reducing penalties and using those funds to incentivize investments in value-based care.** MIPS' current design pits practices against one another, putting practices with fewer resources such as small, rural, independent, and safety net practices at a disadvantage, and limits CMS' ability to incentivize practices to test new measures or participation options that could help improve the program, such as a new payment pathway that could serve as a bridge to alternative payment model participation.

- **Recommendation: Remove overly prescriptive requirements in the Cost Performance Category,** including holding physicians accountable for costs outside of their control and requiring CMS to capture half of all Medicare Parts A and B costs, which results in measures that meet this requirement without regard to whether they result in adverse consequences, such as patient access problems, or align with high-quality care.

- **Recommendation: Recognize the value of clinical data registries and other promising new technologies** by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means.

- **Recommendation: Streamline and align the four performance categories together as appropriate and award cross-category credit for measures activities that are applicable to multiple categories** (e.g., participation in a clinical data registry), rather than requiring separate reporting and using separate scoring methods in four siloed components of MIPS, which adds burden and inhibits practices' abilities to achieve progress towards aligned value-based performance goals.

- **Recommendation: Create scoring flexibility for new or significantly refined measures, benchmarking approaches, or participation options**, such as MVPs, to facilitate continued improvement of the MIPS Program.

How to increase physician participation in value-based payment models

1. **Need for Expanded Opportunities for APM Participation**

CMS adoption of new nationwide voluntary alternative payment models to date has been slow. While the AMA is encouraged by the recent announcement of the Making Care Primary (MCP) Model, there are still limited details available, and a new model in eight states is not enough to solve the problem. This dearth of models to date means there are no APMs available for many of the conditions, episodes of care,

or patient populations that many physicians manage. There is also still no nationwide Medicare primary care medical home model.

Like the MIPS program, too often APMs are designed in ways that only allow practices that are part of large health systems to participate and succeed. Financial risk requirements are too steep and administrative requirements are difficult for small and medium size practices to fulfill. The AMA has long emphasized the importance of an onramp to risk and upfront payments to practices with fewer resources to support the up-front costs of transitioning to an APM, such as building out the necessary personnel infrastructure and investing in health information technology. We have also emphasized the importance of model payment structures that allow for greater flexibility in the way services are delivered by supporting hybrid models that blend in-person and virtual services. MCP, which takes effect in July 2024, will be a step in the right direction but there is still a long way to go.

Another specific void to date has been the lack of specialty-focused models. The AMA has developed a method for incorporating specialty care coordination within an Accountable Care Organization (ACO) model called the Payments for Accountable Specialty Care (PASC) Model. Under PASC, a specialist would receive an enhanced payment for delivering specific types of services to patients who are referred by primary care physicians participating in the ACO. Agreements between specialists and ACOs would describe how the specialist would use these enhanced payments to improve outcomes and/or reduce avoidable spending. Health equity would also be improved by providing higher payments to help support care for patients who have complex conditions or who are at higher risk for poor outcomes due to health-related social needs or other factors.

In addition, the APMs that have been implemented often do not really address the barriers in the current payment system. One of the most promising reasons for physicians to participate in an APM is because APMs can give them the ability to deliver higher-quality care to their patients than is possible under current payment systems by paying for the kinds of high-value services that improve outcomes and reduce unnecessary spending. Unfortunately, many existing models fail to fully recognize this potential because they are too narrowly focused on scope or timeframe. For example, certain episode-focused models begin after a patient has been admitted to the hospital or started chemotherapy but do not include support for physicians to prevent hospitalizations in the first place by better managing chronic conditions in outpatient settings. Medicare APMs should include payments for currently non-reimbursed care coordination and patient support services and funding for transitional care costs so that physicians can implement better approaches to care delivery. For example, many patients who come to an emergency department with symptoms, such as chest pain or syncope, could return home instead of being admitted to the hospital if the emergency physician could be sure the patient would receive the necessary assistance to return home safely, and that the patient would receive prompt follow-up care from a primary care physician. Medicare does not pay emergency physicians for the time needed to: locate the patient's primary care physician and develop a coordinated discharge plan; help identify community-based health and social services for the patient; or hire a nurse or community health worker to help the patient return home safely. As a result, the only safe option may be for the emergency physician to admit the patient to the hospital.

The American College of Emergency Physicians developed an APM proposal to fix this problem by paying for these discharge planning and transitional care services. Although the proposal was unanimously endorsed by the Physician-Focused Payment Model Technical Advisory Committee

(PTAC), which was created by MACRA, the model has not been implemented. As a result, patients continue to be admitted to the hospital who might otherwise have been safely discharged to their home. In addition to undermining efforts by physicians to be good stewards of scarce Medicare resources, failure to implement this policy proposal will likely disproportionately affect patients with health-related social needs and contributes to health inequities. This emergency medicine model is just one of 19 APM proposals that the PTAC recommended for further development, testing or implementation, which brings us to another important point. CMS, unfortunately, to date, has elected not to pursue a single APM proposal ultimately endorsed by the PTAC. Congress and the Administration should work together to develop a viable pathway for physician practices to voluntarily participate in pilot programs of APM proposals developed by stakeholders, such as those recommended by the PTAC.

Recommendation: Congress should work with the Administration to increase opportunities for physicians in all specialties and types of practice to voluntarily participate in well-designed, patient-centered APMs, including development of a pathway to permit people with Medicare to access health care through stakeholder-developed APMs such as those recommended by the PTAC.

2. Advanced APM Incentive Payments Need to Be Continued

The five percent incentive payments for participants in Advanced APMs have been a key factor in physicians' interest and even in their ability to participate in APMs. Without these incentive payments, many physicians could not otherwise cover the costs of APM participation, cover the costs of providing services that are necessary for APMs to meet their care improvement goals, handle the downside financial risk, or deal with the revenue reductions that can occur from reducing avoidable services.

Physicians also face significant transition costs participating in APMs. For example, even if an APM pays for delivery of enhanced services to patients that the payment schedule alone does not adequately support, the physician practice will still have to recruit, hire, and train staff to perform those functions, which requires incurring significant costs before services and payments can begin. APM participants also make investments in data analytics, technology, and other improvements that allow them to effectively participate in the APM that the incentive payments help to offset.

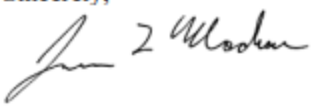
The AMA has significant concerns with regards to the negative consequence of allowing the APM incentive payments created under MACRA to expire at the end of the year. It is important for Congress to pass the soon-to-be-reintroduced Value in Health Care Act, which would extend the incentives for an additional two years.

The Value in Health Care Act would also authorize CMS more flexibility to set the APM revenue percentages that participants in Advanced APMs must meet to be eligible for the incentive payments. The most recent report from CMS on these thresholds shows that the MACRA mandate to generate at least 75 percent of their revenue from their APM, which takes effect in 2024 under current law, would be unattainable for many Advanced APM participants. Even participants in the largest Advanced APM model, Medicare Shared Savings Program accountable care organizations (ACOs), had an average revenue score of 63 percent. For the Bundled Payments for Care Initiative Advanced model, the average score was just five percent, and for the Comprehensive Care for Joint Replacement Model, just three percent.

Recommendation: Congress should pass the Value in Health Care Act of 2023, which would extend the Advanced APM incentive payments created under MACRA and authorize the Secretary increased flexibility to set the revenue threshold for physicians to be eligible for these incentive payments. Absent Congressional intervention, 2023 marks the last year physicians are eligible to qualify for an APM incentive payment and the associated revenue thresholds jump from 50 percent to 75 percent on January 1, 2024.

Reforming the MPS is an urgent matter for the AMA, our physician members, and their patients, and we are ready to work with Congress to achieve a sustainable solution for this vital issue. Without needed reforms, we are on a collision course with a payment system that threatens to destabilize the Medicare program and patient access to care. We thank you for considering our recommendations.

Sincerely,



James L. Madara, MD

2. Joyce – (A) Surgical Coalition Statement

Surgical Coalition's Plan for Reforming the Medicare Physician Payment System

The Centers for Medicare & Medicaid Services (CMS) continues to put forth annual regulations that exacerbate the underlying problems within the broken Medicare physician payment system. Furthermore, these policies negatively impact the ability of physician practices to invest in quality improvement efforts to benefit Medicare patients or transition to alternative payment models when appropriate. And importantly, the Medicare Physician Fee Schedule is often the benchmark for determining payment rates for Medicaid and other payers. Thus, Medicare payment cuts have a cascading effect across all payers, challenging physician practices' ability to cover the cost of taking care of their patients.

While Congress considers long-term reforms to physician payment, it must exercise its oversight authority over Medicare payment policy to ensure a stable environment that allows multiple physician practice models — independent private practice or hospital/hospital system employment — to thrive. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, high-quality care.

Current legislative and regulatory policies impede efforts to improve the quality and value of care provided in all practice settings and geographic areas, and they create adverse incentives for volume. For example, focusing on payment program requirements that may have little to do with direct patient care takes time and resources from activities that could have a more meaningful impact. Similarly, artificially holding reimbursements below the rate of inflation may mean that a practice needs to squeeze in more patients and charges to keep their practice afloat and their staff employed. A shift in policy direction is necessary to provide Medicare patients with high-quality, patient-centered, value-based care, which is the ultimate goal.

To do this, Congress and the Administration must:

1. **Stop all Medicare physician payment cuts scheduled for calendar year 2024**. Ongoing cuts to the Medicare physician fee schedule make it difficult for physicians to invest resources in value-based care initiatives.

2. **Establish an annual Medicare Economic Index (MEI) update**. An annual update to the Medicare physician fee schedule comparable to that in other payment programs (e.g., hospitals) starting with calendar year 2024 will help ensure that payments keep pace with medical cost inflation.

Updates for Selected Medicare Payment Programs

	2022	2023
Physician Fee Schedule	-3.7%	-2%
Hospital Inpatient (IPPS)	2.5%	4.3%
Hospital Outpatient (OPPS/ASC)	2.0%	3.8%
Skilled Nursing Facility	1.2%	2.7%
Home Health	3.2%	0.7%

3. **Eliminate certain budget neutrality requirements.** Medicare's budget neutrality requirement — unique to the physician payment program — has been a key driver of the broken payment system. It requires CMS to implement across-the-board cuts 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. At a minimum, 42 USC 1395w-4 (c)(2)(B)(ii) should be amended to increase the current $20 million budget neutrality adjustment trigger to $100 million and indexed to adjust for inflation moving forward.

4. **Halt implementation of the G2211 add-on code.** This new CMS-created payment code was proposed as a budget-neutral way to increase payments to primary care and other office-based physician specialties to account for CMS' proposal at the time to collapse the higher level complexity of primary care visits. The rationale for creating the G2211 add-on code is no longer valid because CMS ultimately implemented changes in 2021 to the office visit codes that incorporated complex visits, thus substantially increasing payment for office visit codes. Primary care and other physicians can now bill a higher-level evaluation and management (E/M) office visit code, obviating the need for the G2211 code — which, if implemented, will result in a 3% across-the-board cut to the conversion factor.

5. **Appropriately value the global codes**. 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. Global surgery payments must be modified to include the current stand-alone E/M payment levels as adjusted in 2021. Furthermore, CMS should refrain from making any other changes to the 10- and 90-day global codes that would have a negative effect on patient access to surgical care and/or are not based on reliable and accurate data collection.

6. **Avoid payment cuts due to MEI rebasing**. Rebasing the MEI cost weights may lead to steep Medicare payment cuts for some surgical care. Any rebasing should not rely on flawed data and should appropriately represent the cost share of physician work, practice expense and professional liability insurance.

7. **Keep Medicare savings in the Medicare program.** Invest savings generated by any new Medicare payment policy (e.g., site neutrality) to offset the cost of improving the Medicare physician payment system.

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.

Signed:

American College of Surgeons

American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Ophthalmology

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Obstetricians and Gynecologists

American Orthopaedic Foot & Ankle Society

American Society for Metabolic and Bariatric Surgery

American Society for Surgery of the Hand Professional Organization

American Society of Anesthesiologists

American Society of Breast Surgeons

American Society of Cataract and Refractive Surgery

American Society of Colon & Rectal Surgeons

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urogynecologic Society

American Urological Association

Congress of Neurological Surgeons

Society for Vascular Surgery

The Society of Thoracic Surgeons

1. Joyce – (B) ACS Statement for the Record

Statement of the American College of Surgeons
to the Committee on Energy and Commerce
Oversight and Investigations Subcommittee
United States House of Representatives
RE: MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors
June 22, 2023

The American College of Surgeons (ACS) appreciates the committee's focus on the implementation challenges of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). 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 in the area of improving surgical quality and value and provide some steps Congress can take to improve the current system.

It was the understanding of the ACS that MACRA was intended to solve the problem of the failed Sustainable Growth Rate formula by eliminating annual mandated cuts not tied to the value of care provided, while simultaneously creating incentives for the delivery of higher value care. The legislation included funding for new quality measure development and created a pathway for the proposal and development of new physician-focused alternative payment models (APMs).

In practice however, MACRA has fallen short of effectively achieving either of these goals and as a result 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 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;
- Development of the ACS-THRIVE (Transforming Healthcare Resources to Increase Value and Efficiency) initiative in collaboration with Harvard Business School which yielded important insights into how to help hospitals and practices move toward value-based care; and
- Proposing novel quality measures that incentivize team-based care organized around the geriatric hospital patient.

Yet eight years after the passage of MACRA the situation appears grim:

- Surgeons are again facing a Medicare physician fee schedule (PFS) conversion factor for 2024 that remains below the 2015 level;
- The combination of inflation and a physician fee schedule lacking updates that account for increased practice expenses means that it costs more to deliver care while payments are declining;
- Most physicians in 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 to make care choices; and
- Surgeons wishing to move beyond FFS will find that not a single physician-focused alternative payment model is available since none of the models submitted have been tested.

Clearly this was not the intent of Congress in passing this legislation. Knowledge about how to measure and improve quality and safety in healthcare has evolved steadily as lessons have been learned and the delivery of medical care has advanced. However, Centers for Medicare & Medicaid Services (CMS) and most other payers and delivery systems have struggled to adapt to this evolution in a way that increases value and creates a meaningful pathway for patients and surgeons to benefit broadly from this new knowledge.

Payers have traditionally focused on the cost side of the quality-over-cost value equation, seeking to reduce the price paid for care while maintaining quality. This has most often been accomplished through efforts to reduce overall spending coupled with individual quality measures designed as though care were a series of discrete encounters or services. This has not been particularly effective as the cost of care has continued to grow faster than inflation in most years. Conversely, focusing on creating a collaborative and patient-focused environment for quality improvement may succeed and indeed would enhance quality and potentially reduce cost.

The current volume-over-value paradigm is at least in part a byproduct of physician payment policies that are entirely unrelated to healthcare and are the result of blunt fiscal tools, such as sequestration and budget neutrality. These payment policies lack the proper incentives to maintain quality or increase value. In a budget neutral payment environment that lacks the data and tools necessary to deliver higher quality care, and without clearly defined incentives for achieving better outcomes, the most obvious path for success can be through increased productivity.

To overcome the volume-over-value paradigm, Congress must create true long-term stability in the physician payment system. This should be coupled with coordinated efforts to help surgeons and care teams transform into value-based payment models in which they can succeed financially by improving outcomes and value for their patients.

We cannot build this house on quicksand and therefore a crucial step is to immediately stop additional cuts to the Medicare physician fee schedule planned for 2024 and beyond and to implement 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.

Physicians Are United behind Stabilizing Medicare while Improving MACRA

The ACS, along with 19 other organizations representing surgeons and anesthesiologists, signed a statement calling for critical policy changes to bring stability to the Medicare PFS. Among the key points in this document are action items calling on Congress to stop the pending cuts scheduled for 2024, implement a baseline positive annual update reflecting inflation, and revise budget neutrality requirements to allow for appropriate changes in spending. 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.**

Additionally, there are temporary provisions of MACRA that could support the transition to value-based care, particularly given the delayed implementation of physician-focused payment models and the current lack of meaningful participation options. **Last year, Congress provided a temporary extension of the additional incentive payment at a reduced rate for the highest performing physicians in the Merit-based Incentive Payment System (MIPS) program. This incentive payment could support practices who are making investments to succeed in the current program.** Absent the additional incentive, physicians in the MIPS program with the highest scores would have seen payment updates that were a mere fraction of a percent, hardly commensurate with the work it takes to meet the requirements of the payment program. This is a disincentive to making investments that set a practice up to succeed in value-based payment arrangements.

Similarly, the sunsetting of incentives and increasing of thresholds to become a qualified participant (QP) in an advanced alternative payment model (APM) is premature given the lack of meaningful participation options for physicians in many specialties. The APM incentive was intended to attract early participants to models developed under MACRA's new pathway. However, as discussed below, none of the many models reviewed and recommended for testing and implementation have been acted upon by CMS. **Along with the extended incentive payment, Congress should consider taking additional steps to ensure that MACRA's vision of physician-developed models is realized. Flexibility in participation thresholds should similarly be granted to encourage participation.**

ACS Efforts to Drive Quality within the Confines of MACRA

Once a stable payment foundation is achieved, we can begin the task of moving beyond the transactional, siloed measures currently used to differentiate between individual physicians for payment purposes. As discussed, the current measures fail to recognize that care for all but the simplest ailments requires an integrated team of skilled individuals with the appropriate resources and structures to deliver optimal care. This failure is especially evident in the way that we currently measure quality for surgery throughout the Medicare Quality Payment Program (QPP) including both in MIPS and in the design of many of the CMS APMs.

Little actionable information is available in either option to inform surgeons for care improvement, or patients for making decisions about their care. Even when measures for surgeons and their patients are in place, surgeons are typically measured separately from the hospital or facility in which the care was provided and separately from the other members of the care team: using different goalposts for the surgeon, anesthesiologist, pathologist, the hospital, and others critical to successful patient care. In fact, a large portion of surgeons are not individually assessed in the MIPS at all because their institutions (employers) select primary care measures to report through the CMS MIPS Web Interface reporting option. These measures apply to all eligible clinicians who fall under the employer's tax identification number (TIN). Current measures therefore do not create incentives for care coordination or value-improvement because they fail to look at care as experienced by the patient, including their goals of care, safety during care, and the ultimate experience and outcomes of that care as a comprehensive whole.

The ACS experience in quality has taught us that it cannot be sufficiently assessed or incentivized by simply tracking specific transactions or adverse events such as mortality, surgical site infection, or reoperation. These are important indicators of failures in the system and are critical metrics for driving quality improvement, but we believe the surgical team must ensure more than just avoiding adverse events to achieve value that matters to patients. One must evaluate the entire course of care and assure that each of the necessary processes, structures, and personnel are in place to achieve the desired outcomes. ACS Trauma Verification, ACS Bariatric Surgery Accreditation, and ACS Geriatric Surgery Verification are examples of some of our efforts at ensuring that patients have access to the expertise, personnel and resources needed to attain high quality care. **Building this type of effort into a shared programmatic measure would provide shared incentives for coordinated teams engaged in patient-centered care.**

The ACS knows that value-based health care is about putting patients at the center, with teams of coordinated clinicians working to produce the best outcomes for those patients. The concept of value in health care must be defined in terms of results that matter to the patient for the condition they have. Patients on a care journey need patient-centric measures across their clinical pathway that appreciate the achievement of their care goals. These measures should inform patients about where to get affordable, and equitable care from provider teams with a track record of achieving the desired outcomes and avoiding preventable harms. CMS appears to recognize this but seems hampered by statutory requirements carried over from early quality programs and may require legislative changes from Congress providing more direction and greater flexibility to lean on expertise from the physician community to facilitate the value transition.

From the ACS' perspective, the mindset needs to be changed from the current game of penalty avoidance to one that: (1) encourages implementation of quality programs built around care for specific conditions; (2) aligns with the team-based nature of care delivery; and (3) provides useful information that supports patients when they must determine where to seek medical care. We encourage Congress to develop legislation that would improve the QPP and foster the value transformation by meeting the above objectives.

Barriers to Achieving Value-based Care

Unfortunately, our efforts have encountered challenges that have slowed progress. Our efforts to improve geriatric surgery quality measurement and our Advanced APM proposal are prime examples. Our geriatric hospital and geriatric surgery measures are "programmatic measures" that include the full spectrum of elements needed for optimal geriatric care such as a focus on patient goal identification and shared decision making, medication and pain management strategies, and post-discharge care plans. Additionally, the measures promote health equity by accounting for social determinants of health. The concept behind the programmatic measure is based on several decades of history implementing programs that demonstrably improve patient care provided by the clinical team along with the facility. Given the patient population, these measures would of course be applicable to Medicare, but another benefit is that this type of measure could be widely applied across CMS and other payer programs. Surgeons in the MIPS or a MIPS Value Pathway (MVP) could benefit from such measurement but unfortunately, it is not an option to design an MVP proposal that would recognize the hospital geriatric programmatic measures due to CMS' perceived lack of authority to align efforts with facilities—instead proposing we use the concept as a MIPS Improvement Activity. At a minimum, the level of effort and comprehensiveness of this proposal would merit using it to derive both the Quality and Improvement Activity category scores.

Congress should improve MIPS by providing CMS with explicit authority to use measures developed through alternative evidence-based pathways such as those described above.

Since these measures differ from those in use by CMS in physician payment, it has proven difficult to fit into the current regulatory framework despite a strong evidentiary base of its potential benefits and broad support across organizations who care for older adults.[1] The ACS approach to comprehensive quality accounts for the entire care team, including clinicians and facilities, but CMS finds that it most resembles structural hospital measures. Last year, at CMS' request, we submitted the two programmatic quality measures for consideration in the Hospital Inpatient Quality Reporting Program (IQR). The Geriatric Hospital Measure incorporates elements of the Institute of Healthcare Improvement's (IHI) Age Friendly Health Systems program, standards from the Geriatric Emergency Department Accreditation (GEDA) framework developed by the American College of Emergency Physicians (ACEP), and ACS Geriatric Surgical Verification (GSV) standards; the Geriatric Surgery Measure focuses on surgical care. Both measures were reviewed by the Measures Application Partnership (MAP) for consideration in the Hospital IQR program. The MAP was supportive of both measures but had concerns with reporting burden. In response, ACS resubmitted a single more streamlined Age Friendly Hospital Measure. Now, due to the pre-rulemaking requirements, this measure must go through the lengthy, resource intensive measure review process again this year. Even if such a measure were implemented in the IQR, its use across other programs, such as in MIPS, would be dependent upon it being later adopted into the Hospital Value-Based Payment program and would still be limited to a subset of physicians providing a substantial portion of care in the in-patient setting. **Congress should expand facility-based scoring in MIPS to accommodate the type of collaborative measure proposed by ACS, such as the Age Friendly Hospital Measure, to incentivize care delivery that has a patient-centric approach. This type of measure will help build a better, safer environment for the geriatric patient and will help patients and caregivers know where to find good care. This should include expanding the program to additional settings such as hospital outpatient departments and ambulatory surgical centers in cases where the facilities are reporting this or similar measures.**

Similarly, our 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 one as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs. 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

[1] https://www.healthaffairs.org/content/forefront/need-geriatrics-measures

barriers to those seeking to move to value-based care. **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.**

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 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;**
- **Grant CMS flexibility in MIPS to test and use novel measures developed and vetted through alternative, evidence-based pathways and to score multiple categories if deemed appropriate;**
- **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 in cases where the facilities are reporting this or similar measures; and**
- **Expressly direct that, at a minimum, a portion of the Innovation Center's budget be devoted to testing APMs recommended by the PTAC.**

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. In addition to improving quality through implementing a comprehensive quality program and shared accountability, more could be done to improve the cost or price side of the equation as well. As noted above, the ACS has participated in efforts to define standard episode definitions for better price and cost measurement. Current measures of price (what is ultimately paid for care by the patient or their insurers) for episodes of specialty care are frequently siloed and overly narrow, similar to what is seen in quality measurement. While price transparency is broader than value-based payment reform, in the context of MACRA more comprehensive price measures that correlate with quality measures would be a logical next step in improving the value equation.

The ACS thanks you for convening this important hearing on the implementation of MACRA and for the committee's attention to improving quality and value for Medicare 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. Please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org if you would like to learn more about our efforts to improve the quality of surgical care.