



**Statement of the
American College of Surgeons**

**To the Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives**

**RE: Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician
Efforts to Prepare for Medicare Payment Reforms**

April 19, 2016

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I would like to thank the Members of the Health Subcommittee for holding this important hearing on the work being done by physicians to prepare for new payment models and requirements in MACRA. We appreciate this opportunity to provide you with a summary of some of the efforts ACS has undertaken that we hope will improve the accuracy and efficiency of the Medicare payment system and ultimately improve care for surgical patients.

Since the passage of the *Medicare Access and CHIP Reauthorization Act* (MACRA) in April 2015, there has been a tremendous amount of activity in the area of physician payment. While it is common to read about the 5 year “period of stability” that commenced with the bill’s passage and which extends through 2019 when the Merit-based Incentive Payment System (MIPS) goes into effect, in reality physicians must be ready to meet the new program’s requirements as early as 2017.

In addition to repealing the Sustainable Growth Rate (SGR) formula that resulted in the need for annual legislative “fixes” to prevent cuts to providers, MACRA creates two paths for participation in the Medicare program. Those who wish to continue to primarily bill as fee for service providers can continue to do so. However, these fee-for-service payments will be increasingly impacted by the four components of the MIPS program, namely quality, resource use, meaningful use of the electronic health record, and clinical practice improvement activities. Providers may also have the option of participating in an Alternative Payment Model (APM) that provides greater flexibility in care delivery but which includes greater risk of financial losses if care costs exceed what is expected. Both routes have advantages and risks, but over time there will be growing financial pressure for physicians to move to APMs.

Fortunately, MACRA provides ample opportunities for input from physician societies and other stakeholders throughout the implementation process. In fact, in some areas, like development of APMs and quality measures, the physician specialty societies are responsible for ensuring the law works for their members. ACS has made MACRA implementation a top priority and is working diligently to shape the new MIPS payment structure and develop APMs that meet the requirements of the law in order to provide options for surgeons. Below are several specific areas of particular importance to surgeons.

MIPS Implementation

Developing New Quality Measures

One of the most important aspects of MACRA is the opportunity to streamline and improve existing CMS quality programs. The current measurement approach is narrow, complex, costly and sluggish. The measures available to surgeons in the Physician Quality Reporting System (PQRS) are often irrelevant to surgical care because a single set of measures is very difficult to translate to an individual general surgeon due to the diversity of procedures general surgeons perform. Procedures vary from surgeon to surgeon based on their patient

population, subspecialty, and geographical location. As a result, the current approach has likely slowed down the engagement of providers thereby hindering the ability to drive improvement.

In order to address the measurement of surgical care in the MACRA environment, ACS has developed a comprehensive approach to surgical measurement which follows the various phases of surgical care. ACS has a rich history in quality improvement. For more than 100 years, ACS has led national and international initiatives to improve quality in hospitals as well as the more specific fields of surgical quality, trauma, and cancer. All ACS quality initiatives are built on the following key principles: setting clinical standards, building the right infrastructure, using the right data, and verifying with outside experts. These principles led the development of the comprehensive framework spanning across the phases of care, including preoperative, perioperative, intraoperative, postoperative, and post discharge. This framework is comprehensive because all surgical patients experience these phases of surgical care during the course of their treatment. These phases involve key processes, shared decision making, critical care coordination with primary care physicians, anesthesia and other specialists as well as the technical components of surgical care relating to safety, outcomes and prevention of avoidable harms.

These metrics are different from measures in the current PQRS because they broadly apply to almost all surgeons, span across the various phases of surgical care, and when measured together they can have a real impact at the point of care. ACS has defined the below set of metrics for cross-cutting comparisons and they have been constructed to allow for more detailed, procedure-specific metrics to be added when necessary. The ACS strongly believes that when taken together, these measures represent an effective way to improve quality, and coordinate care and lower cost while increasing both patient and provider engagement.

Phases of surgical care measures:

1. Surgical Plan and Goals of Care
2. Identification of Major Co-Morbid Medical Conditions
3. Preventative Care and Screening: Tobacco Screening and Cessation Intervention
4. Preoperative Key Medications Review for Anticoagulation Medication
5. Patient-Centered Surgical Risk Assessment and Communication
6. Patient Frailty or Functional Index
7. Perioperative Composite
8. Postoperative Care Coordination and Follow-up
9. Unplanned Hospital Readmission within 30 Days of Principal Procedure
10. Participation in a National Risk-adjusted Outcomes Surgical Registry

Meaningful Use

Both MIPS and APMs will continue to require the use of certified electronic health record (EHR) technology in providing patient care. In a blog post earlier this year, Acting CMS Administrator Andy Slavitt indicated that major changes to the EHR Incentive Program, or Meaningful Use (MU), include “transitioning from measuring clicks to focusing on care.” ACS agrees that passage of MACRA should be seen as an opportunity to step away from the

current provider burden experienced with MU which detracts from patient care. MACRA provides an opportunity to improve interoperability by leveraging a data ecosystem (EHRs, registries, and multiple other data sources) to enable clinical decision support at the point of care and for meaningful discussions, including shared decision making. Common data standards are absolutely critical to achieve this vision of interoperability.

The College is dedicated to the use of clinical data with common data standards to improve outcomes and the quality of patient care—EHRs, clinical data registries and other data sources are all critical pieces which form the clinical data ecosystem. ACS has taken many steps to demonstrate our commitment. We have been a national leader in innovative quality improvement by building our initiatives on the key principles mentioned above. Guided by these principals, we have recently embarked on a project to develop the “registry of the future” by building a comprehensive and integrated clinical registry platform that combines data from more than 1,800 hospitals across the United States, international medical contributors, and individual surgeons to improve surgical outcomes for millions of patients.

Additionally, last year ACS convened stakeholders from various branches of the government, the physician community, academia, think tanks and the private sector in our first Clinical Data Ecosystem Summit with the goal of freeing the data in EHRs, through the use of standardized data points for use in an open architecture system. Last week ACS took The Office of the National Coordinator for Health Information Technology’s (ONC) Pledge to Improve Interoperability.

Alternative Payment Model Development

Perhaps the most impactful portions of MACRA on the future of physician payment are the provisions on developing APMs and the multiple incentives aimed at introducing more physicians to these payment structures. MACRA encourages physician led development of new models and created a new Physician-Focused Payment Model Technical Advisory Committee (PTAC) tasked with providing feedback on APMs developed and submitted by Stakeholders. Incentives to participate in new models include credit in the CPIA portion of MIPS, exemption from certain MIPS reporting requirements, a temporary 5 percent incentive payment to reward successful early APM participants, and partially offset the costs of transitioning to new models and higher payment updates for successful APM participants starting in 2026.

ACS received the message on the importance of APMs in MACRA and is investing significant resources in developing APMs to allow surgeons the opportunity of transitioning to new models that qualify them for these benefits while improving care. Our partners in the process include Brandeis and the Center for Surgery and Public Health at the Brigham and Women’s Hospital, & their Harvard faculty. The ACS APM project is ambitious and is designed to be inclusive and scalable, coalescing as many of the surgical disciplines as possible into a single framework of options and providing solutions suitable in an all-payer model. It is our intention to present a proposal to CMS and CMMI for approval and implementation as a demonstration by the end of 2016. While many of the details of our proposal are still developing and rules have yet to be issued by CMS as to what the

requirements of a qualified APM will be, we have moved forward with the project to meet MACRAs demanding timeline.

More than a dozen surgical disciplines and other specialties directly involved in surgical care are currently participating at various levels of engagement. The idea started as bundles built around defined episodes of care triggered by a diagnosis or procedure which could then be built into APMs (not dissimilar from those in the Bundled Payments for Care Improvement Initiative or BPCI) but has evolved rapidly. We are now exploring multiple options including APMs built around episodes, chapters of care including multiple episodes or Clinical Affinity Groups or CAGs which incorporate multiple chapters of care. This structure has the potential to grow beyond surgery and include other specialties and primary care into integrated care models.

To better fit the needs of the patient, we began our process by defining the clinical construct of an APM based on the providers a patient with a given diagnosis is most likely to see and the services they are most likely to require in the course of their treatment, around an episode of care. We soon realized that building APMs using the Brandeis method and episode grouper software could open the door to combining multiple episodes into chapters of care, thereby coordinating multiple clinical disciplines and other parts of the delivery system working together in the course of a patient's treatment. Examples include cancer care, trauma care, cardiac care, musculoskeletal care, or common chronic condition chapters.

By further expanding the model to incorporate multiple treatment options (chapters or episodes) for a given condition or patient population as well as prevention efforts, a Clinical Affinity Group (CAG) can be created. Each CAG comprises a number of clinical chapters or smaller service lines. For example the cancer CAG may consist of three separate sub-service lines; 1) Prevention and detection, 2) Surgical treatment, and 3) Chemotherapy and radiation therapy care. Each of these chapters in turn could contain one or more episodes of care. The APM could be designed and built at any level by adding or removing component parts such as quality measurement and payment and risk structure.

A CAG-based APM could be defined to bring together many specialties involved in all aspects of prevention and care of a specific condition in mature delivery systems, or scaled down to focus on specific individual service lines or episodes where the fewest number of distinct specialties and providers share risk when needed. These models of CAGs, chapters and episodes as APMs could further be incorporated into population health APMs or ACOs in the future.

The APM model's flexibility in design allows for specific aspects of care to be added or removed from the framework of the APM models to meet the needs of different specialties, practice models or settings without being overly burdensome on CMS to administer. This multi-level approach may also be necessary to meet MACRA requirements for greater than nominal financial risk. Areas of medicine with greater variability could more easily meet financial risk requirements at the episode level, while those who have low variation could band together to improve care for a population. This is just one type of risk and we will continue to advocate for CMS to consider the interaction of multiple types of risk (including actuarial, operational and financial risk) when defining the APM risk requirement.

Another vital consideration in making this project a success will be access to data. As in MIPS, data from multiple pertinent clinical data sources and registries will need to be made readily available to inform physician decisions. This data will be used in conjunction with advanced analytic tools and techniques that measure and drive accountability and improvement.

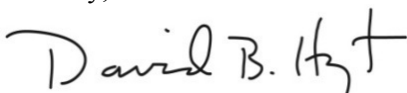
Recently we have also challenged our project team to combine the various episodes, chapters or CAGs engaged in by a single physician, and combine them into a “cluster” which is essentially the bundle of bundles for that provider. In this model a given physician would have their performance in each type of care measured against other similarly situated providers for each type of care provided. This could allow for more objective and meaningful measurement, and combined with the multiple levels of APM described above, could help providers to reach the percent of care thresholds required to be qualified APM participants.

There are a number of other concerns that will need to be addressed as our project matures such as designating the payment mechanism and entity and balancing actuarial, operational and financial risk in a way that meets MACRA requirements without overburdening potential participants. Risk based contracting and risk based capital needs are critical to cover unexpected losses and allow for business sustainability. For surgeons and other physicians, MACRA readiness will involve risk management, clinical operational readiness and fiscal readiness.

Due to the short timeframe for implementation, ACS and other societies have had to begin work on APMs prior to release of the rule implementing MACRA in order to have models available in time for their members to participate in early years. As our work continues, much uncertainty remains and many unanswered questions exist. For example, what regulations, if any will be promulgated on stop-loss and premium support for re-insurance? Also while Congress intended to create a clear pathway for development of physician focused APMs that would qualify under MACRA, CMS and CMMI are under no statutory obligation to move forward with any models recommended by the PTAC. Therefore, not only are models being developed with limited guidance, there are also no assurances that models approved by the PTAC will ultimately be adopted by CMS.

This project is still very much a work in progress but we are making steady headway with the team at Brandeis and the Center for Surgery and Public Health at the Brigham and Women’s Hospital and our partners in multiple surgical specialties. ACS is committed to making MACRA a success and is providing periodic updates to CMS and stakeholders as our project moves forward. We appreciate the Committee’s commitment to the reforms started with MACRA and we thank you for this opportunity to provide input as the process continues.

Sincerely,

A handwritten signature in black ink that reads "David B. Hoyt". The signature is written in a cursive, slightly stylized font.

David Hoyt, MD, FACS
Executive Director

1. Alignment of surgical treatment plan and **patient goals of care:** percent of patients who have been given the purpose for the recommended procedure AND goals of care have discussed and documented in the medical record

Purpose of the procedure:

1. Establish a diagnosis
2. Relieve symptoms
3. Treat underlying condition
4. Improve function and/or QoL

2. Identification of **major co-morbid medical conditions:** Percentage of patients undergoing a surgical procedure who received general or spinal anesthesia and who has documentation of significant co-morbid condition(s) in their medical record

3. **Modifiable risk factor, smoking cessation:** percentage of smoking patients who receive tobacco screening and are offered counseling of delaying procedure until smoking cessation is achieved

Two steps to the measure:

- 1) Identify that the patient is a smoker
- 2) Refer the patient to a cessation program



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4. Pre-op key medications review for anticoagulation medication:

percentage of patients undergoing anesthesia who are on anticoagulation medication(s) and who are given a perioperative management plan for anticoagulation medications

6. Patient frailty or functional index

: percentage of patients 65 years and older who underwent a non-emergency surgery and were evaluated using a frailty index score or a functional status score

(this can include multiple tools)

5. Patient Centered Risk Calculator:

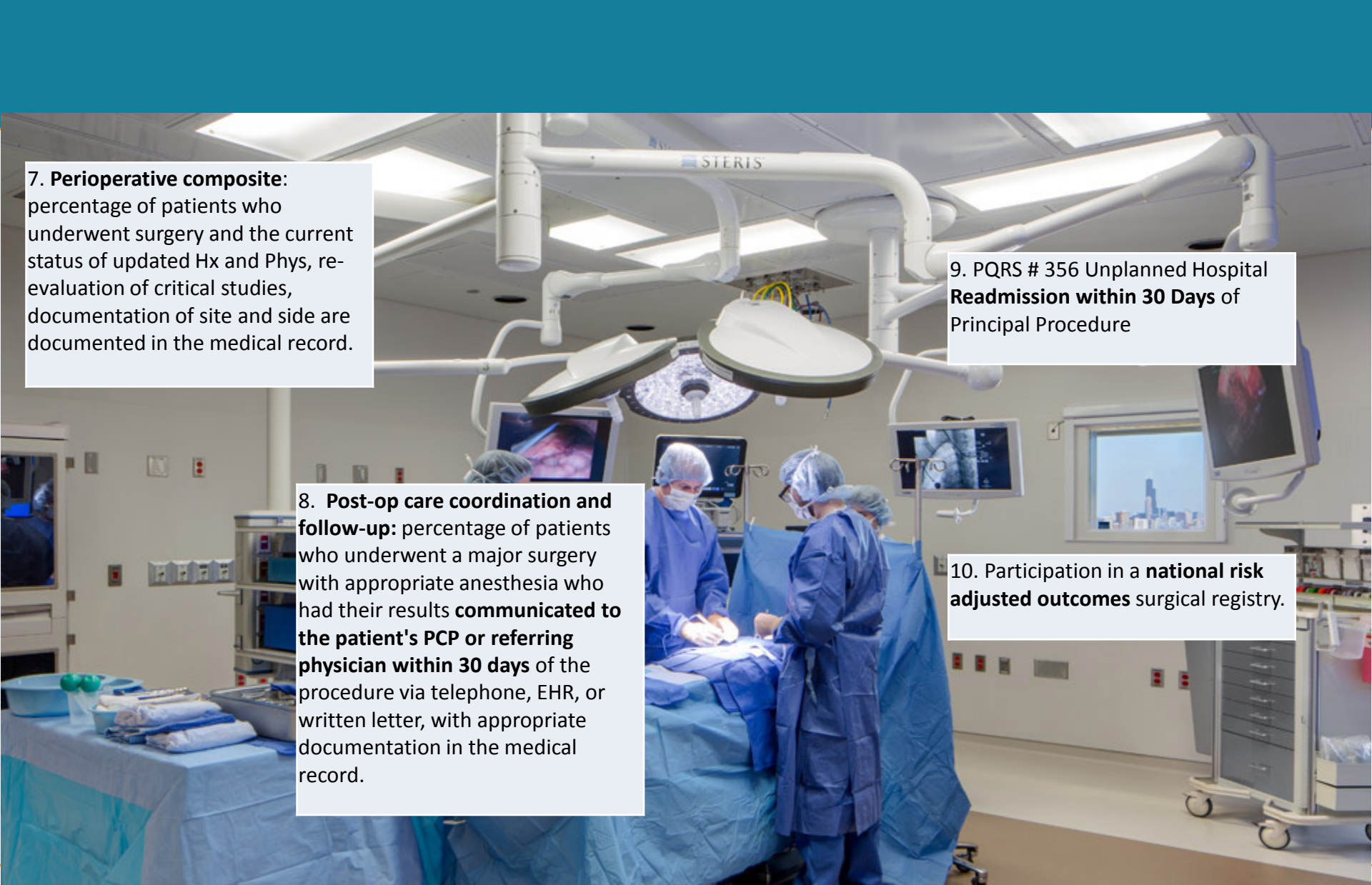
<http://riskcalculator.facs.org/>

As part of shared decision making, provide patient with preop risk calculator for expected outcomes.



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7. Perioperative composite: percentage of patients who underwent surgery and the current status of updated Hx and Phys, re-evaluation of critical studies, documentation of site and side are documented in the medical record.

8. Post-op care coordination and follow-up: percentage of patients who underwent a major surgery with appropriate anesthesia who had their results **communicated to the patient's PCP or referring physician within 30 days** of the procedure via telephone, EHR, or written letter, with appropriate documentation in the medical record.

9. PQRS # 356 Unplanned Hospital Readmission within 30 Days of Principal Procedure

10. Participation in a national risk adjusted outcomes surgical registry.



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