The U.S. 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 that benefit Medicare patients, or transition to alternative payment models when appropriate. Importantly, the Medicare Physician Fee Schedule (MPFS) is often the benchmark for determining payment rates for Medicaid and other payers. Thus, Medicare payment cuts have a cascading effect across payers, challenging physician practices' abilitÙ to coÖer 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/health 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, higher-quality care.

Surgeons and anesthesiologists are expecting another 2.8% cut due to temporary congressional relief set to expire at the end of the year. Previously, relief was provided to mitigate reductions resulti

violation of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which prohibits Medicare from paying physicians differently for the same work. The absence of equitable adjustments is negatively impacting the relativity and integrity of the MPFS, and Congress should urge CMS to apply the increased values to the E/M portion of global surgical codes.

Most recently, CMS proposed two policies intending to gather data on which practitioners are providing post-operative visits:

1. : Currently, transfer of care modifiers must be used when the surgeon and another practitioner formally agree to provide different portions of the global package (for example, if the surgeon performs the surgery and a primary care physician takes over the post-operative care). The proposal expands the use of the transfer of care modifiers to informal, undocumented, but expected transfers of care with the goal of gaining more data about who is providing post-operative care absent a formal transfer.
2. - : This code is intended to be appended to an E/M when a practitioner who did not perform the surgery provides post-operative care without the benefit of a formal transfer. In this instance, CMS believes there is additional work involved in learning about the procedure and complications.

The Surgical Coalition remains committed to working with CMS to ensure global surgical codes are valued appropriately, but it is unlikely that CMS will gather actionable data based on these policies, and CMS should not revalue global codes based on flawed or inaccurate data on post-operative visits.

In addition to stabilizing the payment system for the near term, Congress must build on the intent of

In addition to policies directly affecting Medicare physician payment, other CMS policies will have indirect but important effects on how surgeons care for their patients. One area of specific concern is the recently finalized Transforming Episode Accountability Model (TEAM). TEAM is a five-year mandatory model designed to test an episode-based approach for acute care hospitals. Selected facilities receive a target price for Medicare Parts A and B spending for a set of five initial surgical episodes. Participants will be held accountable for providing care within the target price while maintaining or improving the quality of care.

While episode-based payment models offer great promise, the TEAM approach is inherently flawed. The model is based on existing models that are still ongoing and have yielded variable to no net savings over time. CMS also did not actively consult impacted specialties during the development of this model, which has resulted in questionable quality metrics, insufficient risk adjustments, a lack of clearly defined roles for physician leaders, and other design concerns, which could detract from the overall effectiveness of the model. Importantly, the surgical community takes issue with the mandatory nature of this untested model. Mandatory participation fails to allow hospitals and surgeons to tailor innovative payment reforms to their specific patient populations, practice settings, administrative capabilities, and resources. It also forces certain providers that have already adopted their own innovative ways to provide high-value care to alter their care processes in ways that might reverse progress made in terms of patient outcomes and efficiencies.

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