

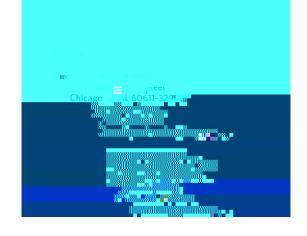
Statement of the American College of Surgeons

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United States Senate Committee on Finance

Bolstering Chronic Care through Medicare Physician Payment

April 11, 2024



The American College of Surgeons (ACS) thanks the Senate Finance Committee for convening a hearing on the challenges of the Medicare physician payment system. The ACS remains committed to improving the care for all surgical patients, including those living with chronic conditions, and to ensuring that Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken in improving surgical quality and value. We hope to continue partnering with Congress on potential reforms to the current system to ensure that improving care and access for the surgical patient stays at the forefront.

The ACS and our more than 90,000 members recognize the impact that chronic conditions can have on surgical patient outcomes. These conditions have a distinct impact on the finances of Federal health programs and create additional challenges for providing high quality care. In the United States, more than 130 million adults suffer from at least one chronic condition. These patients often require additional preparations or more intensive post-acute care after surgery is performed. ACS is focused on improving the quality of care provided and achieving the optimal outcome for all our patients.

Our surgeon members have first-hand experience with the challenges posed by the lack of an inflationary update and more recently the continued reductions to fee-for-service Medicare payments. Centers for Medicare & Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts. These reductions are often the unintended consequence of statutory budget neutrality requirements for the physician fee schedule. One aspect of budget neutrality falls on the Medicare Physician Fee Schedule conversion factor. These conversion factor reductions create a strain on physicians working towards value-based care and fail to incentivize quality or care coordination. This results in the Medicare program taking resources away from certain physician specialties in order to finance priorities in other areas. A payment model designed in such a way that different specialties are pitted against one another is counterproductive, since all specialties are doing their best to provide quality care to their patients with ever-scarcer resources. Since 2001, physicians have seen their Medicare physician payments decrease by 13 percent in real terms between 2001 and 2024 before indexing for inflation. In addition to these cuts, the impact of inflation has raised the overall cost to provide care as costs for rent, equipment,

remains below the 1998 level2;

The combination of inflation and a lack of physician fee schedule updates to account for the increasing cost of providing care means that it costs more to deliver care while payments are declining; Most physicians in fee-for-service (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 improvement efforts or for patients and referring physicians to make care choices; and Surgeons wishing to move beyond FFS will find few physician-focused alternative payment models are available for them, since none of the models submitted to the PTAC have been tested as proposed.

To create stability in the Medicare physician payment system, Congress should immediately address cuts already expected in 2025. A foundational step necessary to maintain access and improve quality for patients is the implementation of 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.

Stabilizing Medicare Physician Payment

The ACS is committed to working together with Congress to ensure the stability of the Medicare PFS through both short and long-term policy improvements. The Medicare PFS suffers from multiple shortcomings that have negatively impacted the care provided to our patients. It is unique in its lack of a meaningful mechanism to account for inflation and is currently in a multi-year window until 2026 where any positive updates to physician payment must be legislated. Once the positive updates begin in 2026, current law only provides a 0.25 percent conversion factor update for non-APM participants and a 0.75 percent update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without Congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an annual update for the PFS, it is unlikely that future payments will keep pace with medical cost inflation. This concerning combination of high inflation and a lack of any update for expenses results in a need to deliver expected high-quality care while payments are rapidly declining.

While Congress has taken action to address some of these fiscal challenges by mitigating part of the recent PFS cuts, Medicare payment continues to decline year after year. The recent 1.68 percent positive adjustment only partially offsets the 3.37 percent cut that went into effect in early 2024, and further cuts are expected in 2025. These yearly compounding cuts, combined with a broad lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken and falling short of the goals of MACRA. As a starting point to create a more stable foundation for value-based care initiatives, ACS supports building an update into the Medicare Physician Fee Schedule, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors.

for budget neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. Congress, at a minimum, should amend 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current \$20 million budget neutrality adjustment trigger and index it for inflation going forward.

Adjusting the budget neutrality trigger is an example of a small, but important, concrete step Congress could take to improve the functioning of the current system. Without meaningful adjustments to account for the increased cost of staff, office space, and other resources, surgeons will find it increasingly difficult to continue to improve care and outcomes. Beyond this, it will be necessary to counteract the effects of inflation to help provide stability while Congress and the Administration provide support to facilitate the transition to value-based payment models.

The ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing well-documented 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. This could partially be achieved through testing and expansion of alternative payment models developed by and for specialists. These models should complement primary care focused models, not compete with them, and could include primary care physicians and other specialists focused on chronic conditions in the fiscal attribution model and rewards to encourage care coordination. Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.

Facilitating the Transition Value-based Care

The ACS believes that medicine should be moving steadily toward a system that truly rewards the value of care provided. APMs can facilitate better care and could also be used to incentivize physicians to practice in rural or underserved areas. Unfortunately, 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 model through the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs, as witnessed by the lack of new proposals on the PTAC website since 2020.

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, including the primary care physician, to work together toward shared goals. In hB6s-4(ateon o)n her 552.04 3(IbBennBd Tm0 g0 QBra)-5(ndeis Ad)-2(van)-6(ced APM)

Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual, disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural and under-resourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are currently evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported

holistic care for older adults across five domains:

Domain 1: Eliciting Patient Healthcare Goals:

related goals and treatment preferences to inform shared decision making and goal concordant care.

Domain 2: Responsible Medication Management:

groundbreaking work in the area of xenotransplantation, which will help save even more lives in the future and overcome shortages of viable donor organs for transplantation. Curative interventions include orthopaedic surgery for chronic joint pain, transplantation for organ failure, and bariatric surgery, which can be an effective treatment for obesity, diabetes, hypertension, and osteoarthritis. Reducing obesity can further treat or prevent other conditions such as cancer etc.³

Even the effects of a traumatic injury can be considered a chronic condition, and surgeons play a key role in helping those affected emerge from trauma and re-enter normal life, both through surgical skill to address the immediate injury, and by being part of a team-based approach to managing the injury from stabilization through rehabilitation. Simply put, surgery lets people get back to work and live fuller, more productive lives. ACS is focused on improving the quality of surgical care for all patients and avoiding or managing chronic conditions is an important aspect of this.

Quality has been the cornerstone of the American College of Surgeons (ACS) since its founding more than a century ago. Through the Power of Quality campaign, ACS is on a mission to improve surgical quality and patient care for every patient and in every setting across the country. This includes expanding the reach of ACS Quality Programs to more hospitals, enlisting more surgeons in quality improvement efforts, encouraging adoption of quality metrics into public policy, and expanding patient recognition of the important role these programs play in health care. At the ACS, we believe a strong, united voice for surgery is essential to effective advocacy in service of our patient and surgeon community. With thirteen ACS Quality Programs, the ACS has set the standard for high quality, evidence-based surgical care and is the definitive marking of quality patients should seek.

Achieving optimal outcomes for the surgical patient must include a highly qualified surgeon and must involve an entire well-functioning team. This focus on team-based care includes coordination with primary care managed to help patients

achieve the best possible outcomes. This commitment to team-based care is witnessed by our verification programs, which include standards related to disease management. For example, the ACS Surgical Quality Verificat

-Based Management Programs and Integrated

Practice Units. The purpose of this standard is to ensure that the surgical management of diseases, procedures, and patient populations requiring multispecialty care is integrated, organized, and standardized. Another standard on team-based processes in the five phases of surgical care requires facilities to document processes to optimize patients for surgery through review of medications and glycemic controls and processes to ensure continuity of care postoperatively. The standard also looks specifically at the unique needs of geriatric patients, including management of prescriptions for multiple chronic conditions frequently found in this population. ACS recognizes hospitals that successfully meet these standards through our Power of Quality campaign.

This focus is not new and was also demonstrated in the ACS-Brandeis Advanced APM, where the entire care team including primary care and other specialists managing chronic conditions could participate to improve value. Unfortunately, the model was never advanced by CMS. Team-based APMs with patient-focused measurement represent an opportunity to both improve patient outcomes and lower costs for Medicare through increased efficiency.

Congressional Action is Needed to Reform Medicare Payment: In Summary

The value-transformation is underway but could greatly benefit and accelerate through a combination of