



AMERICAN COLLEGE OF SURGEONS

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Highest Standards, Better Outcomes

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Statement for the Record

American College of Surgeons

Hearing before the House Ways and Means Health Subcommittee

U.S. House of Representatives

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

Thank you Mr. Chairman, Ranking Member McDermott, and members of the committee. I am David Hoyt, executive director of the American College of Surgeons. On behalf of the more than 79,000 members of the College, I am pleased to be here today to discuss the reform of the Medicare physician payment system and to highlight some challenges moving forward that are described in greater detail in the College's February and April response letters to the joint Ways and Means and Energy and Commerce Committees' SGR Proposal, which I would like to submit for the record.

The College appreciates the committees' continued commitment to address the complex problems facing Medicare's physician payment system and applauds your work and inclusiveness.

In our February letter, the College outlined our Value Based Update (VBU) proposal to reform the physician payment system. We believe that any new payment system must be based on the complementary objectives of improving outcomes, quality, safety and efficiency while simultaneously reducing the growth in health care spending. The VBU proposal is based on the College's 100 years of experience in creating programs to improve surgical quality and patient safety, such as the National Surgical Quality Improvement Program (NSQIP). We have learned measuring quality improves patient care, increases the value of health care services, and reduces costs. The savings gained are the direct result of improving quality outcomes.

I will go into greater detail on the Joint Proposal below, however I would like to initially highlight some key points. We agree with the Joint Proposal that a full repeal of the SGR and a period of payment stability are prudent first steps in reforming the system while longer term reforms are developed, tested, and phased in over several years.

The College believes that the Phase One period of payment stability should be five years. If we are to move to a value-based system, it is imperative that we make sure the payment models and quality measures, which will serve as the backbone of the new system, are properly aligned and that will take some time.

The College urges Congress to provide statutory payment rates tied to inflation during the period of stability. Such stability will allow physicians to make the necessary capital investments in their practices to move to a value-based system.

In Phase Two of the Joint Proposal, the College believes that the most critical component to successfully establishing a base payment rate tied with a variable rate is that it incentivizes high quality care and does not just function through a withhold. Providers willingly take on risk based on performance - associated with the variable rate - must first see a starting base rate at an appropriate level to cover the work and expenses required to provide necessary care. We believe that the base payment rate should be based upon its market value at the end of five years of

stability. The College further believes that once the starting base rate is appropriately determined, subsequent base rates should account for the increased cost of providing care by increasing with inflation.

It is crucial that the variable rate not only require a level of risk by physicians that may result in reduced payment, but that it also contains a level of reward, with increased payment, for those physicians who achieve the highest quality care. The cost savings we have seen through our quality programs are in the money saved by improved outcomes.

In our experience, the College has found that offsetting higher variable payments to those physicians who perform well with lower variable payments to those who do not perform well does not serve the value-based proposition. We believe the variable rate should be determined as to whether a physician meets a specific performance threshold. For the new system to flourish, we must encourage those high performers to share their techniques with those who do not meet the performance threshold. Whether a physician experiences an increase or decrease from the base rate should be determined by performance compared to standards or thresholds known in advance, not on changing and unknown performance relative to peers or any scheme that by its design would guarantee that a set of physicians would lose. The standards and thresholds could be set considering the most recent past performance, including performance compared to peers. We would like to emphasize that a zero-sum, budget neutral scoring methodology for the variable rate could significantly hamper collaborative care, the sharing of best practices among providers, and hinder our ability to recognize all possible savings.

In our century of experience, the College has learned that real cost savings are best realized from coordinated care. Numerous elements of the committees' proposal related to performance measurement are strictly specialty or service-based. In contrast, our VBU proposal, which centers on clinical affinity groups (CAGs), breaks down the silos of physician care. The CAGs, which will have collective quality and performance measurement goals, are designed to be inclusive of multiple specialties working in concert to treat a patient.

In developing quality and performance measures, the College believes that we must be able to provide sufficient measures representing all specialties. The committees' proposal on measure development could lead to potential conflict between measures that go through the NQF process and those that use the proposal's suggested non-NQF process. The College recognizes that there are challenges with the NQF approval process that have led to frustration among specialties and physicians. However, with the possibility of multiple entities approving measures, there exists the real possibility that physicians could be compared to each other while not pursuing the same measure set. Alternative measure sets need clear evidence of effectiveness if they are to be used.

The College believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. Physicians and other providers will need to work together to achieve cost savings and those savings cannot be constrained by the

current financing silos of the Medicare program. As physicians work to bring costs down, those savings should be accessible to those who are achieving the savings, whether in Parts A, B, C or D of Medicare.

Our more specific comments on the Joint Proposal are organized below according to the phased implementation presented in the committees' second draft and our full detailed comments can be found in our February and April response letters.

Phase One

As stated above, the ACS strongly supports immediate repeal of the SGR and elimination of the 24.4 percent across-the-board cut slated for 2014 as well as any future SGR cuts. Neither the current SGR formula nor any modified version of the SGR should be used to determine the physician payment update in any future year. The SGR methodology is fundamentally flawed and is no longer an effective approach to determine physician payment updates and encourage efficient, high quality care.

The ACS endorses the committees' proposal to establish stable, predictable fee schedule updates that are set in statute for a period of time sufficient to develop and implement the Phase Two measures and processes that will promote high quality, efficient care through a reformed payment system. We believe that this period of payment stability should be for five years during which physician specialties and other stakeholders will develop the quality and efficiency measures as well as clinical improvement activities that are the key to Phase Two and Phase Three of the proposal. This stable period also will enable providers to prepare for the future payment changes and to assess the applicability of private sector and Medicare alternative payment models as they make their individual decisions.

The ACS urges that the statutory payment rates during this period of stability provide for a very modest increase in payment rates, such as 1.0 percent a year. Continuation of a payment freeze would fail to recognize the fact that physician rates have increased only 4.1 percent cumulatively over the eight years 2005-2013 despite an increase of 12.8 percent in the cost of providing care as measured by the Medicare Economic Index (MEI).¹ Physicians cannot afford to see payment rates frozen while the cost of providing care escalates.

Phase Two

In Phase Two, the committees propose that payment rates be based in part on the quality of care provided to beneficiaries using an Update Incentive Program. Payment rates would be determined by a base rate and a variable rate tied to performance with providers having three alternative ways to receive credit that would determine their variable, performance-based rate:

¹ Source: Office of the Actuary, "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2014," dated 4-13-2013

- score on quality measures relative to their peers;
- significant improvement in their own quality score from the previous year; or
- executing clinical improvement activities.

Quality measures are to be risk-adjusted for severity of illness so that providers are not penalized for treating sicker or more complicated patients. Providers also would be allowed to choose whether the assessment of their quality occurs at the individual or group practice level.

The ACS generally supports the changes included in Phase Two and believes they will lead to a physician payment system that promotes the quality and efficiency sought by providers, payers and patients. We are pleased that in many respects, the approach complements ideas advanced by the ACS and other specialties. A critical element determining the acceptability of this approach for physicians, however, is the level of the base rate. The base rate must be set at an appropriate level to cover the work and expenses required to provide the service, with the variable rate applying adjustments, plus or minus, depending on performance. Thus, the base rate should be determined by a conversion factor that continues to provide for very modest annual increases similar to the Phase One period of stability; at the very least, the base rate in phase two should provide a zero percent increase to which upward or downward adjustments are applied by the performance-based variable rate.

The ACS strongly opposes a system in which rates are cut up front – perhaps significantly – for all physicians with any gains toward a zero update or rate increase based on performance. We believe that access, equity and performance incentives as well as physicians’ acceptance of the payment reforms all would be enhanced by establishing a reasonable base rate and adjusting that rate up or down based on performance. Importantly, we agree that poor performance should lead to lower payment rates and would support reductions from the base rate for inadequate performance.

The ACS strongly opposes a performance-based variable rate methodology in which physicians can earn additional payments only to the extent that other physicians lose. The performance-based rate should not be budget neutral but should be based on performance standards or thresholds established before the beginning of the period during which performance is to be assessed. Each physician or provider’s variable rate adjustment would be determined based on performance compared to the standard or threshold. Whether a physician experiences an increase or decrease from the base rate should be determined by performance compared to standards or thresholds known in advance, not on changing and unknown performance relative to peers or any scheme that by its design would guarantee that a set of physicians would lose. The standards and thresholds could be set considering the most recent past performance including performance compared to peers (for example median performance), perhaps with an increase assumed for improvement based on empirical trend data. The ACS notes that a zero-sum, budget neutral scoring methodology for the variable rate adjustment could significantly hamper collaboration, cooperation and the sharing of best practices among providers.

The ACS recommends that each provider's performance score would equal the highest value earned among these three options, which are similar to the options identified in the committees' proposal:

- performance on quality measures relative to the standards and thresholds set by the Secretary and published in advance;
- significant improvement in their own quality performance from the previous year; or
- executing clinical improvement activities, as discussed below.

Similar to the hospital value-based purchasing system, a physician or other provider would receive a score under each of the three alternatives with the highest score being designated as the determinant performance score that is used to calculate the variable performance rate.

The ACS urges that the legislation direct the Secretary to phase in the standards and thresholds used to determine the variable rate portion of the update. For example, initially the standards could be set and performance measured for a category of physicians rather than requiring individual practices to satisfy specific standards. Numerous elements of the committees' proposal are specialty or service based in contrast with the ACS VBU proposal, which centers on clinical affinity groups (CAGs), as described in detail in our February 25 letter. We recommend that the committees include CAGs, at least as an additional option. We believe that clinical affinity groups have a great potential to improve outcomes and efficiency because they would encourage collaboration across specialties. Using the CAG concept, the portion of a physician practice's services included in the definition of the CAG would receive a quality score based on the score earned by the CAG, which in turn would be determined by the quality performance of all of the services falling within the CAG across all of the physicians in the CAG irrespective of specialty. Physicians would self-designate the CAGs in which they would participate and could participate in multiple CAGs representing the various portions of their patient mix or clinical services. The ACS also supports allowing providers the option to have their assessment of quality be based on individual or group practice level.

The ACS is concerned about accurately measuring quality performance for small practices and urges the committees' legislation to require the Secretary to study options for addressing the problem working closely with providers and to report to Congress on the options studied and the agency's recommendations.

The committees' proposal directs the Secretary to ensure that providers receive timely feedback to enable them to assess their quality score relative to their peers during the performance period, but it does not specify how this might happen or what the lag time will be between the performance period and application of the results to the payment rate. Timely feedback will give physicians the ability to optimize their incentive payments. The ACS believes that the lag between the performance and payment periods should be no longer than six months and that quarterly feedback should be provided. For example, for physician payments beginning in

January, the 12-month performance period could end the previous June 30. Feedback could be required to be given 60 days after the end of each calendar quarter for the accrued portion of the performance period. The ACS supports the committees' proposal to allow providers the opportunity to review their results before they are used to determine the update incentive payment (UIP) as well as to request reconsideration or to appeal the UIP determination.

With respect to risk-adjustment, the ACS believes that all outcomes measures must be risk adjusted to avoid incentives that could discourage physicians from treating high risk, sicker or more complex patients. It might also be necessary to risk adjust certain process measures to assure equity and access, or to carefully define the type of patients, with appropriate exclusions, to which a process measure would apply. As the committees' proposal envisions, these types of details will need to be developed over the next few years, during the period of stability, working closely with physicians and other stakeholders. We strongly support the approach that the Secretary will work with provider organizations to establish the quality measures and clinical improvement activities on which provider performance will be assessed in Phase Two.

Concerning measure development, the ACS is concerned that there be sufficient measures to represent all specialties and the scope of services that they provide. To help fill gaps in the currently available measures, we urge the committees to include in their legislation funding and other provisions, such as directing the Secretary to commission measure development from appropriate entities as necessary to ensure an adequate and equitable set of measures across specialties. We do not believe that the Secretary should be authorized to adopt unendorsed measures to fill gaps except in conjunction with the relevant specialties. We understand and support the need for flexibility as measures are developed for different clinical areas, but we are concerned about establishing and maintaining consistency across specialties and avoiding competing measures promoted by different specialties. The Secretary should be directed to work with providers and other stakeholders and with national consensus organizations to minimize these problems.

In addition to working with provider organizations and consensus organizations such as the National Quality Forum (NQF) in the development of the quality measures and clinical improvement activities, the Secretary should be required to establish all measures, improvement activities and performance standards through notice and comment rulemaking. Finally, measures and clinical practice improvement activities should be updated and improved on an ongoing basis, although we believe that an annual review of all measures could be burdensome and is not necessary. Instead, CMS (with input from providers and other stakeholders) should review the latest scientific evidence to consider adding new measures and refining or dropping existing ones as needed to enhance the value of the quality measurement system for providers, patients and payers.

In addition, ACS is concerned that the committees' proposal on measure development could lead to potential conflict between measures that go through the NQF process and those that use the

proposal's suggested non-NQF process. ACS recognizes that there are challenges with the NQF approval process and it has led to frustration among specialties and physicians. However, with the possibility of multiple consensus groups approving measures, there exists the real possibility that physicians could be compared to each other while not pursuing the same measure set.

The committees' proposal directs the Secretary to solicit clinical practice improvement activities from providers and to determine a menu of activities from which providers can select. The menu is to include activities relevant to all providers and must at a minimum include several categories identified in the proposal. The ACS supports the recognition of clinical practice improvement activities for the purpose of earning credit for the variable rate portion of the payment update but is concerned that one of the suggested categories is too narrow as described. Specifically, the category of targeted utilization of patient registries for chronic conditions should be expanded to include other registries such as the ACS National Surgical Quality Improvement Program (ACS NSQIP). Also, "enhanced access to comprehensive and timely care that is delivered in the least intensive and most appropriate setting based on patient needs" requires that appropriate setting be clearly and carefully defined.

The ACS believes that the National Surgical Quality Improvement Program (NSQIP) should be recognized in the legislation as qualifying participants for quality incentive credits. NSQIP is a powerful tool for quality improvement and was named "Best in the Nation" by the Institute of Medicine (IOM). Advantages of ACS NSQIP include:

- Collects data from the patient's medical chart instead of insurance claims that are shown to have limited information for quality purposes;
- Is risk-adjusted, meaning the analysis accounts for the health of the patient and factors such as age, obesity, smoking habits, diabetes and other factors that increase the risk of complications;
- Is case-mix adjusted, meaning it accounts for the complexity of operations performed to show more accurate national benchmarking for hospitals; and
- Follows patients for 30 days after their operation. Since more than half of all complications occur after the patient leaves the hospital, ACS NSQIP uncovers more complications than many other quality programs.
- Includes National Quality Forum (NQF)-endorsed outcomes measures developed in partnership with the Centers for Medicaid and Medicare Services (CMS) with the goal of creating practical outcomes-based measures that will help hospitals achieve significant quality improvements. Further, it is in early exploration of how such measures might be captured directly within EHRs at the point of care.

A study in the September 2009 issue of the *Annals of Surgery* evaluated 118 hospitals that began participating in ACS NSQIP between 2005 and 2007. The study showed that for hospitals participating in ACS NSQIP, each:

- Prevented 250-500 complications annually;
- Saved 12-36 lives annually; and
- Reduced costs by millions of dollars annually.

If ACS NSQIP results were translated across all hospitals in the country that perform surgeries, hospitals would have the potential to prevent millions of complications a year, save billions of dollars, and demonstrate that higher quality care can cost less.²

The ACS also appreciates and strongly endorses the committees' intent and list of suggestions for minimizing providers' participation burden.

Phase Three

In Phase Three, provider efficiency would be added to the quality-based physician payment system implemented in Phase Two. As proposed, only providers meeting a minimum quality score threshold would be eligible to earn additional incentive payments based on efficient use of health care resources. The committees' proposal would assess provider efficiency using a risk-adjusted relative ranking system that also accounts for geographic differences. The Secretary is directed to consider both episode-based and per capita measurements of provider costs of care, but also is directed to solicit physician organization input on how to assess efficiency and to consult with physician organizations on an on-going basis. Providers could choose whether the assessment of their performance-on quality and efficiency-occurs at the individual or group practice level.

The ACS believes that incorporation of measures of efficient resource use in determining physicians' payment should employ only rewards, as the committees' draft seems to imply, and not also penalties. The ACS is concerned that measuring on a per capita basis could create a perverse incentive to withhold care. Addressing this concern will require not only effective risk adjustment but rigorous monitoring. As has been experienced with implementation of current law episode-based measurement and the value modifier, defining episodes of care and attributing services to physician practices are serious and complex issues that defy a "perfect" solution. The Secretary must engage in a process of continual evaluation and improvement in consultation with physician organizations.

The ACS supports the proposal that only physician practices meeting quality threshold should be eligible for efficiency-based incentives.

Provider Opt-Out for Alternate Payment Model (APM) Adoption

² ACS has other databases that could aid the transition to a new payment system based on quality, including the Trauma Quality Improvement Program (TQIP), the Commission on Cancer National Cancer Data Base, the Surgeon Specific Registry (SSR), and the Bariatric Surgical Centers (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)).

The ACS supports providing options for physician practices to participate in alternate payment models and the exemption of services provided through these models from the physician payment system, reimbursing them instead according to the payment arrangements of the model. Payment models would need to be assessed and approved by the Secretary, but the committees' proposal provides no details about requirements.

The ACS urges that providers be allowed to participate in more than one alternate payment model so that, for selected physicians or services, for example, a physician practice might be participating in an accountable care organization, bundling project and clinical affinity group. Such flexibility will enhance physician practices' participation in these alternate models, which we believe could bring significant improvement in both the quality and efficiency of care. The Secretary should give priority to alternative models that are physician developed, physician led, and that truly improve care.

The ACS believes that clinical affinity groups (CAGs) should be considered to be an alternate payment model that is recognized explicitly in the legislation. In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs might include categories such as primary care/chronic care, cancer care, surgery, cardiac care, frail elderly/end of life, digestive diseases, women's health, and rural healthcare. Each CAG would have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures will be crafted in close consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own. Providers would self-select their CAG, providing they meet certain eligibility requirements based on the patients they see and conditions they treat. The Secretary would be tasked with creating CAGs and ensuring that there are a sufficient number and variety to accommodate all physicians.

Improvements upon Current Law

The ACS believes that improvements are needed in the payment adjustments for participation in current quality programs including the PQRS, EHR and e-Rx adjustments. We believe there are four areas in which Congress can act swiftly to improve these programs³:

- The payment adjustment year and the performance period must be tied closer together to better align behavior changes with payment incentives;
- Measures specific to specialists must be better incorporated into the programs or those specialists whose measures are not incorporated into the programs should receive exemptions from the payment penalties;

³ The committees' proposal is unclear. It is possible that once the new system, as currently portrayed, has been fully implemented that these programs should be done away with completely as they would be repetitive of components of the new system.

- The quality measures currently used in the PQRS and EHR Incentive Program must be better aligned in order to prevent duplication and reduce unnecessary administrative burdens; and finally
- Incorporate clinical data registries into these programs since current claims data do not provide sufficient insight into the quality of care provided by a physician. Aligning clinical data with improvements to claims data is the most robust path forward toward true quality improvement. Congress began to address this issue, as related to PQRS, in the fiscal cliff legislation at the end of 2012; and CMS issued a Request for Information (RFI) seeking input on how it may deem certain clinical registries as sufficiently meeting the requirements of the PQRS program. This would allow physicians participating in approved clinical registries to be deemed to have met the PQRS requirements.

ACS NSQIP experience demonstrates that national patient registries can have a major impact in improving quality and reducing the cost of health care. Giving physicians full meaningful use credit for purposes of avoiding the meaningful use penalty is critical to investment in this mechanism. CMS has set a precedent through the e-prescribing and PQRS programs of allowing alternative methods for physicians to avoid penalties other than those required to achieve incentives. CMS should be urged to extend this practice to the meaningful use program by allowing physicians to demonstrate meaningful use in a way that requires fewer workflow changes than the CMS Stage 1 and Stage 2 objectives, such as participation in a private national clinical registry approved by CMS.

Clinical registries developed by specialty societies have the potential to collect better and more meaningful quality data than traditional claims reporting and even more importantly can provide regular and timely feedback to physicians for quality improvement purposes. By definition, true participation in a clinical registry requires that physicians (1) capture patient data, the goal of stage 1 meaningful use, (2) exchange patient data with the registry and across settings, the goal of stage 2 meaningful use, and (3) engage in quality improvement activities, the goal of stage 3 meaningful use. The decision support tools, professional improvement, longitudinal patient data and quality improvement promised by EHRs only occur with a registry overlay on the EHR. Promoting registry participation would achieve the broader goals of the meaningful use program because it more easily supports measurement in multiple domains and produces more meaningful and actionable data than the one-size fits all approach of the current meaningful use program.

We appreciate the opportunity to testify at today's hearing and look forward to continued discussions related to reforming the Medicare physician payment system. The challenges facing the overall Medicare program are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. ACS believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. We must find a balance between fiscal prudence, delivering high quality

care and preserving the trusted physician-patient relationship. We look forward to working, as partners, in forging a new, patient-centric, quality-based health care system.