100+years

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality: Highest Standards, Better Outcomes

Statement of the
American College of Surgeons

Presented by

Frank Opelka, MD, FACS

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

MACRA and MIPS: An Update on the Merit-based Incentive Payment System

July 26, 2018

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee, on behalf of the more than 80,000 members of the American College of Surgeons (ACS), I wish to thank you for inviting our participation in this hearing. ACS has a long-standing commitment to improving the quality of care for the surgical patient. This commitment extends to ensuring that the ongoing implementation of the *Medicare Access and CHIP Reauthorization Act* (*MACRA*) is accomplished in a way that improves the delivery of medicine for patients and removes administrative burdens on physicians. This is a critical time in the process of implementing the law and CMS would benefit not only from additional guidance from the physician community, but also from the committees in Congress who conceived the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways to restate the vision of that bill and refocus on Congress' original intent. We welcome this opportunity to share our experience, our impressions of the MIPS program thus far, and suggestions on how to make the program more meaningful for patients and physicians through implementation.

ACS' understanding at the time of passage of *MACRA* was that surgeons and other physician specialties would be evaluated based on measures related to the care they provide and would have access to APM options suitable to their practice. If these were unavailable at the time of passage, opportunities were built in by Congress to allow specialties to develop them. However, these new models and measures have not materialized, and not for lack of effort on the part of the physician community. ACS has, for years, sought to be a partner in developing solutions to the most complex challenges facing Medicare. This includes efforts to develop

innovative payment strategies as part of a replacement for the sustainable growth rate (SGR) as well as more recent work to create APM options for surgeons and other providers and new tools for participants to improve care for Medicare patients.

I would like to thank Congress for eliminating the Sustainable Growth Rate (SGR) and designing a program intended to tie payment more closely to quality and value. It is easy to forget the challenges faced prior to *MACRA* in the face of ongoing implementation efforts. There are a number of positive concepts to be noted in *MACRA* beyond the elimination of the much-maligned SGR cost control formula that were aimed at addressing these challenges. These include:

- Overall reduction of maximum penalties associated with PQRS, VM and EHR-MU from 10+ percent in 2016 to five percent this year and growing to a maximum of nine percent over time.

- Incorporation of a meaningful potential for positive updates. Prior to *MACRA*, penalties from PQRS and EHR-MU were lost from the physician reimbursement pool. Under *MACRA* these funds stay in the pool and are used to provide positive payment adjustments for high achievers. While we strongly believe there is a need for realistic updates to the physician fee schedule, we welcome the much greater upside potential. Surgeons, like all humans, are risk averse and reward focused. As such, we believe an asymmetrical risk profile with greater upside potential is more likely to incentivize behavioral change.

- Goal of combining and simplifying existing programs into a single streamlined program. We also recognize the focus on quality as witnessed by the weight

ascribed to both Quality and Improvement Activities. Continued physician input is essential to merge quality measurement and improvement activities seamlessly into the clinical care model.

- Goal of moving from fee-for-service to APMs as well as a pathway to develop new models. While we greatly appreciate this provision and have taken advantage of the Physician-focused Payment Model Technical Advisory Committee or (PTAC) pathway to propose a new model, we feel that more could be done to expedite testing of models once they have been recommended. To date, none of the models recommended by the PTAC have been implemented or even tested by the Center for Medicare and Medicaid Innovation (CMMI).

- Inclusion of additional incentivizes for the highest performers in MIPS as well as early APM adopters.

Congress showed foresight in providing a period of stability in the original *MACRA* legislation, and we commend Congress for extending this flexibility in the *Bipartisan Budget Act of 2018* (H.R. 1892) in recognition of the difficult task faced by CMS in implementing this program, and by physicians in educating themselves and changing their practices as necessary to meet the new requirements. To be clear, ACS plans to make good use of this opportunity to advise CMS on how best to measure quality for surgeons. If we are putting providers at risk based on these metrics, we must ensure that the appropriate physicians are being rewarded or penalized. We see this new discretion being used by CMS in the recently proposed rule to implement the QPP for 2019 in several areas including the cost portion of MIPS and the setting of the

threshold for the Final Score payment adjustment determinations.

Congress has now made the transition from its legislative role to one of oversight to ensure that the *MACRA* law is being implemented in the best interest of Medicare patients, as you all intended. This is important because unfortunately, we have reason to be concerned that actions taken by CMS since the passage of *MACRA* may not be sufficient to take us to our shared end goals. While some of these actions may have been well intentioned and taken in the name of reducing reporting requirements or reducing overall burdens of participation, others seem counter to the very spirit of the law, such as the failure to move forward on any of the APMs reviewed by the PTAC. We need Congress' help to ensure the law is implemented correctly so that physicians who are providing high quality, high value care to their patients are able to succeed. We believe CMS needs additional guidance from Congress at this point to ensure the intent of moving the physician payment system toward quality and value is upheld.

Implementation of the MIPS program needs to be refocused to better achieve some of these intended goals. ACS would like to lend our century of experience in setting standards for surgical quality to that end. This history includes founding what is now referred to as the Joint Commission and creation of accreditation programs such as that used to verify trauma centers and quality improvement efforts such as the National Surgical Quality Improvement Program (NSQIP). We believe this experience may assist CMS with creating novel ways to improve the accuracy and validity of quality measurement while continuing to tackle unnecessary burdens on physicians.

Achieving the Goals of MIPS

To reiterate, the underlying concept of MIPS was to simplify the existing CMS quality programs, combine them into a single program that compares the value of care provided by participants (as judged based upon quality and cost metrics, use of electronic health records and improvement activities) and adjusts payments up or down based on that comparison.

As originally envisioned, the idea was to provide physicians with a period of stability after repeal of the SGR and its threatened reimbursement cuts, during which time CMS would develop the regulations to implement the new payment system and physicians could adapt their practice to meet the new requirements. The new program would then be gradually phased in over several years with certain additional incentives (such as an additional pool of money for bonus payments to early APM adopters) available in the early years of the program. The amount of money at risk for providers would gradually grow to nine percent, which was comparable to (but slightly less than) the maximum combined penalties associated with the Physician Quality Reporting System (PQRS), Value Based Modifier (VM), and Electronic Health Record Incentive Program (EHR-MU) programs. Unlike the prior programs however, MIPS has the potential for equivalent positive payment adjustments. Since payment adjustments are largely budget neutral and few physicians were penalized during the first transition year, we have not seen the positive updates of four percent for 2019 equivalent to the maximum four percent penalty for that year. This is due to low volume exclusions and favorable "pick-your-pace" policies which made it relatively straightforward to avoid penalties during the transition period.

Given the complexity of the underlying PQRS, VM, and EHR-MU, and the extremely diverse and broad range of physicians to be evaluated and compared, simplification has proven to be

a daunting task. Providing physicians with credit for their efforts to improve their clinical practice, while worthwhile, further adds to this challenge.

While Congress' goals surrounding the aforementioned policies were laudable, and while we acknowledge that CMS' resources are limited, the implementation of this new payment system is taking longer than anticipated in some areas, especially in the crucial development of new quality and cost measures. The first funding opportunity for measure development was delayed until this year and funds allocated in *MACRA* for the development of new quality measures have still not been awarded for this purpose. Similarly, the development of accurate, episodic cost measures is proving both difficult and time consuming. Currently cost measurement is based solely on legacy total cost of care measures.

Surgeons support being held accountable for the quality of care received by their patients. It is, however, essential that efforts to do so are accurately measuring quality in a way that can lead to improvement and which does not overburden providers, inadvertently taking their focus away from the patient. To accomplish this, CMS needs measures that accurately and meaningfully target the episode of care being assessed, providing useful information to physicians and patients. This is not currently the case. For example, surgeons are frequently being evaluated based on a patient's immunizations. This is not relevant to the care surgeons provide, and therefore is seen as unnecessary and burdensome. This in turn reflects poorly on MIPS and its intention, causing a lack of buy-in on the part of many surgeons. This buy-in on the part of all physicians will be necessary if MIPS is to be successful in its goal of improving quality and value in health care; otherwise it will simply be seen as a new set of burdensome boxes to check as part of a payment program. Unfortunately, this focus on check-the-box

measures to maximize reimbursement will have the unintended consequence of crowding out quality programs that truly improve care to the patient. This is most certainly not aligned with the Congress' intent when *MACRA* was passed and the ACS is committed to working with Congress to ensure CMS prioritizes meaningful measure development for all specialties moving forward.

Measuring Quality in Surgery

Surgeons and surgical patients are best positioned to understand what elements of care are important to measure in order to evaluate the quality of care and provide the information needed for improvement. As noted above, surgical quality measurement in MIPS is seen by many as poorly representing surgical care. Measures reported by large groups are typically related to primary care or are population-based measures that are not at all related to the care surgeons provide. These measures can be complex, burdensome, and frustrating as it takes time and resources away from other efforts that could have a greater impact for patients. Unfortunately, that means that what affects payment is not directly related to what affects quality, as Congress intended.

ACS has taken advantage of the additional flexibility granted recently by Congress to further develop our thoughts on how best to measure surgical quality in a way that is accurate. The right measures for quality and improvement, no matter how complex, are never burdensome. It is meaningless measures, such as many of those currently reported to CMS, which are burdening care teams.

We have proposed to CMS that surgical quality measurement should include a combination of three elements: standards-based facility-level verification programs, patient reported experience and outcomes measures, and traditional quality measures such as those currently in MIPS, including registry and claims-based measures. Combining these three elements will provide a much clearer picture of the quality of care provided to the patient, including not just the surgeon, but the entire care team involved. The verification programs used have a long history of success, including the Joint Commission and ACS' Trauma, Bariatric, and Cancer accreditation programs.

We wish to draw attention to ACS' Verification, Review, and Consultation (VRC) program for trauma verification as a model program. We have developed and offer trauma verification and review consultations to assist trauma centers in the evaluation and improvement of trauma care. Using the *Optimal Care of the Injured Patient* as a guide, the VRC validates resources at trauma centers with the goal of assisting a trauma center to attain a designated level of service – Level I, II, or III. To achieve the highest recognition, Level I, means the trauma facility must meet or exceed more than 200 clinical standards for optimal care. Who, if seriously injured, does not want to seek care at a Level I trauma unit? Thousands of lives have benefited from these trauma verification standards, with only limited recognition from CMS, the federal government, or commercial insurers.

These verification programs are proven to measure quality and to drive improvement. We are currently developing pediatric trauma care and geriatric trauma care verification programs as well. It is time the US Congress and the ACS come together to set expectations from CMS

and our commercial insurers which leverages standards in verification programs for all aspects of surgical care such as cancer, bariatrics, cardiac care, orthopedics, and so forth.

The importance of setting standards at the facility level to achieve quality outcomes cannot be overstated. Our experience tells us, if you put a surgeon with the highest technical skill level into an underperforming environment where the resources needed are not available and systems are not in place to protect the patient, that surgeon will struggle to provide the highest quality care. Conversely, if you put an average surgeon in a great system, their outcomes are likely to improve and patients will receive better, more coordinated care. ACS' recently published manual, entitled *Optimal Resources for Surgical Quality and Safety*, describes key concepts for developing standards in quality, safety, and reliability, and explores the essential elements that all hospitals should have in place to ensure patient-centered care. Publication of the *Optimal Resources for Surgical Quality and Safety* further reinforces ACS' commitment to high-quality and coordinated care.

To compliment the verification program, patient reported outcomes or PROs are important to validate, from the patient directly, that their personal goals for their surgical care were met. PROs represent the views and perceptions of patients and can be extremely useful in improving patient care. These measures are the mainstay in the promotion of patient-centered care.

Finally, our quality model includes traditional claims-based measures to be aggregated with limited burden, primarily as an additional check to verify that quality care is being delivered. If the correct measures are selected, they can be seen as informative and meaningful to physicians, not burdensome. It is important to ensure that collection of these data enhances

patient care rather than taking the focus away from what is important. Many existing measures, including outcome measures, are not sufficient on their own for measuring the quality of care provided.

Due to decades of continuous quality improvement efforts, there is little variation in outcomes for many surgical procedures as judged by existing outcome measures. In fact, there is so little variation that use of these measures is statistically not valid in many cases due to the large sample size that would be needed. Instead, attaining high quality care through a combination of ensuring that standards are being achieved and validating outcomes through measuring the patient's perspective on whether goals of care and other milestones are being achieved may be more reliable.

Promoting Interoperability

For many providers, Promoting Interoperability (PI) remains the most frustrating aspect of the MIPS program. The category is focused too narrowly on the EHR and less on the advancement of broadly applied patient digital health information from all data sources as the original name of "Advancing Care Information" implies. In implementing MIPS, CMS should have a laser focus on making sure that a complete view of a patient's digital health information is available to physicians, in a useful, standardized form, when it matters most. A patient's longitudinal care profile rarely exists in a single EHR. Physicians need a digital health information environment which represents the patient with enabling information from EHRs, smartphones, iPads, tablets and other available sources. The passage of *MACRA*, along with the recent removal of the counterproductive requirement that EHR meaningful use standards grow ever

more stringent over time (a provision of the aforementioned *Bipartisan Budget Act*) have created an opportunity to reimagine what constitutes meaningful use.

When the *HITECH Act* was originally enacted, meaningful use was intended to be a means to validate that Congress' investment on EHRs was spent wisely. The resulting program therefore focused on the meaningful use of specific, Certified EHR technology or CEHRT required by the program. The federal government is no longer subsidizing adoption of this technology however, and ACS believes that we should take this opportunity refocus to the original goals of using technology, and more specifically digital health information at the patient level, to improve care and lessen the focus on EHRs alone. PI should focus on who is using digital health information to build a more complete patient record that is available to patients and physicians at the point of care, and how they are using this information to improve the quality and efficiency of care. The ACS looks forward to working with Congress, CMS, and the Office of the National Coordinator (ONC) to help create a digital health information environment that achieves these goals.

Development of Alternative Payment Models

One aspect of the law where ACS has seen both great promise and significant frustration is in the area of APMs and specifically the potential for new physician-focused models. The incentives included in *MACRA* made it clear to the ACS that an underlying goal of the legislation was to incentivize the creation of and move to APMs and Advanced APMs (A-APMs). These incentives include the five percent lump sum bonus for qualified A-APM participants for the first six years of the QPP, the reduced reporting requirements potentially associated with these models and higher updates to the conversion factor for APM participants

than those in MIPS in later years. *MACRA* also included a new pathway for APM development in the PTAC. ACS saw the value of creating such a model and was the first organization to submit a proposal to the PTAC. Our experience with the process was smooth and helped greatly in refining our model (known as the ACS-Brandeis Advanced Alternative Payment Model) and our thinking on APMs, as well as informing our positions on quality and cost measurement in team-based health care. However, there appears to be a disconnect with the PTAC recommendation process compared to the testing of new models by CMS.

To date, the PTAC has received more than 20 proposals and reviewed and made recommendations on 15 models. Of these, 10 were recommended to the Secretary of Health and Human Services for either limited scale testing or implementation. Yet despite all of this work on the part of the PTAC and the organizations who have developed these proposals, none of the recommended models have been tested or implemented by CMS. In fact, Secretary Azar recently declined to move forward on testing of eight of these PTAC-recommended models in a single letter. While we feel there is great merit in the move toward APMs, and plan to continue work on developing core concepts of the ACS-Brandeis A-APM, it is unfortunate that the input from the broader health care community is being largely ignored.

Given the challenges noted previously from the perspective of our specialty, as well as those noted by others, it may be invaluable to commission a study on these challenges, including CMS' ability to measure the true quality of care provided by physicians of all specialties, the availability of cost measures that are meaningful and actionable in concert with these quality measures, physicians' ability to access patient health information when they need it and in a standardized predictable format, and the availability of APMs that grant physicians of all

specialties the opportunity to be creative in using their expertise to increase quality and value of care to the patient.

I, and the ACS, appreciate the opportunity offered by the Chairman, Ranking Member, and the committee to testify at this hearing. *MACRA* and MIPS should be seen as an opportunity for ongoing and iterative improvement in how physicians are paid under Medicare, and more importantly, on how quality in medical care can be incentivized. This hearing represents an important example of congressional leadership and oversight to ensure that the promise of the new law and the new payment system are achieved. We look forward to continued partnership in improving the quality of care enjoyed by Medicare patients.