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*Inspiring Quality:  
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**Statement of the  
American College of Surgeons**

**Presented by**

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

**RE: MACRA and Alternative Payment Models:  
Developing Options for Value-Based Care**

**November 8, 2017**

Chairman Burgess, Ranking Member Green, and Members of the Committee, on behalf of the more than 80,000 members of the American College of Surgeons (ACS), I wish to thank you for inviting the ACS to participate in this hearing. We have been very active in working to improve the value of care, both through our longstanding commitment to continuous quality improvement as well as our more recent endeavor to develop the ACS-Brandeis Advanced Alternative Payment Model (A-APM) proposal.

### **MACRA and the Decision to Develop an APM**

In the weeks following the enactment of the *Medicare Access and CHIP Reauthorization Act* (MACRA), our advocacy and policy team began the work of reviewing our analysis of the bill with implementation in mind. As part of this, the ACS took stock of the existing alternative payment models that were available for surgeons, and decided that part of our MACRA implementation strategy would need to involve the development of new options for participation for surgeons consistent with modern surgical practice in team-based episodes of care. The payment structure and incentives in the law make it clear that over time the surest way to succeed will be to transition into new payment models designed to provide additional flexibility in care design to those willing to take on financial risk.

While opportunities to meaningfully participate in such models were limited for surgeons (due to geography, specialty, practice style, etc.) the law also created a

new pathway for creation of APMs, the Physician-focused Payment Model Technical Advisory Committee, or PTAC.

The ACS takes its responsibility in contributing to improved health care quality seriously. As some of you may remember, a little more than five years ago our Executive Director, Dr. David Hoyt testified before this panel on our efforts at that time to develop innovative payment strategies as part of a replacement for the sustainable growth rate (SGR). With the passage of MACRA and the creation of the PTAC we saw an opportunity to refocus our efforts toward creation of an APM that would meet the requirements under MACRA, meet the needs of surgeons, and provide new tools for participants to improve care for our patients.

In developing a new payment model, there are at least five important elements which need to be considered. These include:

**Clinical care model:** What changes can be made to the way we do things to improve the quality of care to the patient and clinical outcomes?

**Quality measurement:** What processes, outcomes and patient reported experiences are worth keeping track of and how do you use that information to adjust payments?

**Payment model:** How should we change the way we pay for health care to incentivize appropriate, high quality, efficient team-based care? For example, we intend to seek payment models tied to increased quality and reduced utilization through a novel shared savings framework.

**Business model:** How do you structure participation so that the necessary team of physicians would join together with APM entities, or form them, in order to create shared accountability for the patients for whom the team provides care? And how could the models attract private payers? What is the value proposition for the involved stakeholders?

**Risk structure:** Transferring risks from insurers to providers requires careful consideration. There is a difference between clinical risks that providers can reasonably assume and insurance risks that providers should avoid. How are risks structured within the constraints of behavioral economics to offer enough upside risk to attract participants and adequate downside risks to protect patients and the goals for optimal care? What limitations do you place on downside risk for cost overruns or not maintaining quality so that you meet MACRA advanced APM requirements while limiting potentially catastrophic losses?

For physicians and those deeply engaged in patient care, it is a natural tendency to begin from the clinical care model and subsequently add the other elements of quality, risk, and alternative payment models folded into new business operations. Starting by building multiple clinical models, each with its own underlying payment model would, however, be administratively difficult for participants and payers to implement and scale across the nation.

In contrast, we chose to partner with a team at Brandeis University who had in-depth knowledge of Medicare cost measurement and analysis. Our partners at Brandeis had developed software known as the CMS Episode Grouper for Medicare or EGM.

This software represents years of work and provides an in-depth, objective view of how care is currently provided. A combination of painstakingly developed clinical episode definitions and complex algorithms allow the software to automatically assign relevant charges to a team-based episode and assign providers to clinical roles in the episode based on which services they provide to the patient.

The EGM also looks at the patient's other current and historical episodes, both to provide risk adjustment and to ensure that each dollar spent is counted only once. This allows our model to produce risk adjusted, patient specific target prices for each episode. It also allows us to show extremely granular information on the causes of variation. And, this model allows for all physicians and all payers to share a common operational model in order to assist in a national scale for implementation.

## **Quality**

The ACS has over a century of experience in defining, measuring and improving quality. The ACS has long believed that the current approach to quality measurement is narrow, complex, costly and slow to adapt to changing care patterns. We see MACRA, and particularly APMs, as an opportunity to propose and implement new measurement strategies. Currently available measures are frequently irrelevant to surgical care and in fact in some reporting options providers may be scored for quality based on care they played no role in providing.

Our recently-published "Optimal Resources for Surgical Quality and Safety" is designed to be a valuable resource for surgeons as they work to improve the quality of care they provide and to improve patient safety. While our knowledge is primarily

in surgical care, the lessons learned have helped us to create an environment of continuous quality improvement and patient-centered care that can be easily adapted to a wide range of health care with the participation and clinical expertise of the wider physician community.

## **Phases of Care**

Surgical care, and in fact all health care, occurs in phases. The ACS believes that registry-based quality measures that encompass the phases of care, along with care coordination and incorporation of patient reported outcome measures (PROs), will be meaningful and important to both surgeons and surgical patients. For example, measuring quality across the phases of surgical care (those being preoperative, perioperative, intraoperative, postoperative, and post-discharge) may include items such as documenting the surgical plan and patient's goals of care, screening the patient for things that could affect outcomes such as frailty and tobacco use and helping them to prepare for surgery, taking time out to review safety checklists, documenting a post-operative care plan and communicating that plan with the patient, his or her family and their primary care provider and measuring success in preventing infections, readmissions and reoperations. Adding in PROs provides a patient perspective and further validates the value and success of the process measures. The measures described are broadly applicable to many surgeries but can be customized for individual specialties or procedures to reflect the most pertinent processes and outcomes for a given episode.

Measuring quality in this way has the added benefit of lining up well with cost measurement to paint a much more detailed picture of the value of care provided. In the ACS-Brandeis model, performance in what we refer to as an episode-based measure framework is used to adjust payments, providing maximum incentives to those providing the highest value care.

### **Team-based Nature of Patient-centered Care**

The model that we have developed is broadly applicable to the full range of health care providers. As noted in the ACS' recently updated joint statement on physician-led team-based surgical care, "optimal care is best provided by a coordinated multidisciplinary team recognizing each member's expertise. Coordinated surgical care provides best outcomes, lowers costs, and increases patient satisfaction."<sup>1</sup> Our episode-based measurement framework coupled with the EGM allows for quality and cost measurement designed around the patient and the full team of providers who have influence over the patient's experience and outcomes.

Sometimes the highest value surgery for a patient is no surgery at all. The capabilities of the EGM allow the ACS-Brandeis model to incentivize the avoidance of unnecessary care through appropriate interventions. The model contains both treatment episodes and condition episodes. Related treatment episodes can be nested within condition episodes in a way that appropriately apportions costs and avoids double counting of Medicare dollars.

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<sup>1</sup> <http://bulletin.facs.org/2016/08/statement-on-physician-led-team-based-surgical-care/>

Ultimately with the further development of additional treatment and condition episodes and the analysis of participant data, this model could allow sophisticated health systems to take on global risk for a patient population or risk for the care of specific clinical chapters.

### **Recruiting Clinical Expertise**

Once it became apparent that our model was suitable for (and in fact hinged on) participation of the entire team involved in providing care to the patient, we began building a community. We first reached out to other surgical societies to fill them in on the early details of the model, but we soon expanded to other groups involved in caring for surgical patients and have welcomed participation and input from any interested groups whether they care for surgical patients or not. We leveraged this community to help further validate the clinical content and have leaned on them for their expertise in quality measurement around the care they provide.

Over the next several months, we held a series of in-person meetings and webinars to educate interested parties on the model and exchange ideas. The model has greatly benefited from this participation. Since our model does not mandate narrow clinical pathways, there are significant opportunities for innovation for the clinical experts. It is our intent that the ACS-Brandeis model will provide the tools, structure and incentives for these ideas to flourish.



## **The PTAC Experience**

Soon after the PTAC announced its process for accepting new models we submitted our letter of intent and began the work of organizing our materials into the mandated structure based on the ten required criteria. We were the first organization to submit a proposal in December of 2016. Given the newness of the PTAC and the broad scope of our proposal I think it is fair to say that it has been a learning experience on both sides, with many practical questions being addressed as they arose.

Between December 2016 and March 2017, ACS and Brandeis staff were kept busy with a series of questions and requests for clarification and additional information from the three-member preliminary review team assigned to our model. While we had intentionally designed the model to be flexible, these questions challenged us and helped us to refine various aspects of the model.

The ACS-Brandeis A-APM was one of the first three models considered by the PTAC at its April meeting and was one of two that were voted on favorably at that meeting, after much deliberation and with strong support from the community of organizations that had participated in the model's development or followed its progress.

This victory was followed by an eight-week period in which we recovered from the previous months' flurry of activity and waited patiently for the PTAC's formal report and recommendation which was transmitted to the Secretary in early June. We then experienced a slightly more nerve-racking period of anticipation while we waited for the Secretary's response. Since our model was again among the first to reach

this milestone, we had no idea of what to expect next or when to expect it. In fact, we were told that “there is no required timeline for the Secretary’s response to PTAC’s comments and recommendations.” In the interim, we spent a great deal of time working to educate interested organizations and potential partners and have been contacted by several other organizations interested both in our model, and in gleaned advice in navigating the PTAC process and developing physician focused models of their own.

It was another three months until we received the Secretary’s positive response and were contacted by representatives from CMS and CMMI to begin the next phase of refining and validating the model in preparation for testing. This is work that we are currently engaged in.

Overall, our experience in navigating the pathway for physician-focused payment models created by MACRA has been a time consuming and complex yet rewarding experience. We have taken the long view in development of our model, shooting for a model that will ultimately serve the needs of our patients and provide meaningful APM participation options for the broadest range of our members and other providers.

I, and the ACS appreciate the chance offered by the Chairman and the committee to share our story and experience in developing our APM proposal. While we are closely monitoring and regularly weighing in with CMS on all aspects of the implementation of MACRA, it is this opportunity for payment and care model design and development that we find most promising. This process is unprecedented in its

transparency, and leans heavily on the expertise of medical providers and it is for these reasons that we believe it will succeed. We look forward to keeping you informed of our continued progress as our model moves forward with refinement, testing, and hopefully implementation.