March 1, 2019

The Honorable Lamar Alexander
U.S. Senate
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Alexander,

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I want to thank you for the opportunity to provide information on proposals to reduce health care costs by increasing price transparency and improving value.

What specific steps can Congress take to lower health care costs, incentivize care that improves the health and outcomes of patients, and increase the ability for patients to access information about their care to make informed decisions?

In order to meaningfully address the growing costs of medical care, we must first have a clear picture of how and where money is being spent and what impact this spending is having on the health of patients. In essence, this analysis of how much care costs along with the outcome of that care are the minimum requirements for making an assessment of the value of a given episode of care.

However, the current federal programs aimed at tying payment more closely to the value of care fail to accurately assess value, and therefore miss the mark on incentivizing the provision of high value care. The current measurement system, including the Quality Payment Program (QPP), fails to achieve an accurate assessment of value in three important ways:

- Cost measures are too narrow, focusing on the cost of individual services and not accounting for the true cost to the patient.
- Quality measures frequently fail to meaningfully and accurately assess care as experienced by the patient and provide the information necessary to make improvements.
- Quality and Cost are not measured for the same episode of care, resulting in a value disconnect.
The ACS has long been aware of these shortcomings, which not only hinder efforts to control costs, but also contribute to physician burnout as our Members and others spend a growing portion of their practice complying with data submission and other requirements that do not translate into improved patient care. Therefore, we are taking actions to address the lack of actionable cost and quality measures to provide a means of measuring both quality and cost, over the same episode of care. The goal is to create a value statement that is meaningful to patients, payers and physicians.

For all of the reasons noted in your letter, it is imperative that we develop tools to provide patients and other stakeholders with transparent information on both the cost and quality of care in a manner that is meaningful to the person consuming that information. ACS would like to take the opportunity to describe our efforts to accomplish this goal.

**Cost**

When a patient enters into an episode of care, they often wonder what their care journey will be, what lies ahead and how much it will cost. Unfortunately, in many cases this information is not readily available to the patient. Information that currently exists is of limited value. For example, some efforts have focused on providing access to hospital charge master files or aggregating survey and patient-reported prices for a given test, procedure or other service. While these may form part of the picture, the true cost of an episode of care will include the efforts of an entire care team and will be comprised of inputs from multiple providers, facilities and resources.

Providing patients with a comparison of how much a single service costs is only part of the picture and is often misleading. It is extremely rare that a patient has a significant health care problem which involves only a single, simple service. In fact, the fee-for-service world results in multiple services within the episode of care. Therefore, it is necessary to define the episode of care and represent the combined price for all the services within the limits of a particular episode.

Getting standard, average episode pricing is also not enough. Patients are not uniform widgets in an assembly line. Each patient is unique and has different attributes clinically, culturally, socioeconomically and geographically. A price transparency tool which provides patients and their physicians with a range of expected costs for an entire episode of care based on historical data from similar patients creates a much more realistic expectation of the true cost to treat a given condition. With this tool, the patient or their physician can see the mean price or an entire array of prices broken into deciles.
The PACES Center provides transparency and an opportunity to examine total cost of care

The ACS is an active participant in a coalition focused on the development of standard episode definitions and other tools that could be used across payers to create such estimates for other important purposes. This coalition will soon launch a non-profit organization, the PACES Center, dedicated to creating a clear and accurate picture of the total cost of care for a given patient for a defined episode of care across all payers.

PACES stands for the Patient-Centered Episode System, and its mission is to create, disseminate, and maintain a set of resources in the public domain that will facilitate efforts by stakeholders to improve the efficiency and value of the health care system and its components. The algorithms, analytics, and clinical episode definitions in PACES have been developed to allow the creation of a patient-specific expected price for a particular episode based on the average costs for patients with similar characteristics. The PACES Center plans to make available clinical specifications and supporting documents sufficient to organize or “group” administrative data (claims) into clinically meaningful episodes of care. A valid episode framework that describes the contexts in which clinicians and patients interact can yield actionable information for clinicians, payers, purchasers, consumers, and other stakeholders aiming to make sense of service patterns, cost, and efficiency.

The current lack of an open source resource for defining episodes and grouping costs results in immense complexity. With growing pressure to reduce costs, stakeholders throughout the health care system have taken it upon themselves to create and implement proprietary episode groupers (the clinical content and logic used to group charges into episodes of care), each with their own unique definitions and requirements. With the logic and specifications for episodes available in the public domain, there will be a standard framework that interested parties can use to measure cost, set benchmarks, align quality metrics, and optimize value within and across systems and regions. There will also be full transparency and opportunities to provide input. Agencies, organizations, and individuals can benefit from and contribute to these common resources.

The PACES Center will seek to increase price transparency along three critical dimensions: the patient’s view of out-of-pocket costs, the payer’s perspective of total cost of care, and the clinician’s view of the costs under their control. Patients want and deserve to know their specific out-of-pocket costs and the total cost of care, although given the nature of health care this can often be difficult to determine at the outset. Purchasers need to understand the impact of out-of-pocket costs on their employees and the total cost of care for their corporate budget as an expenditure. Insurers need to understand the impact of benefit design on patients and how they seek care, as well as the total impact on the cost of care. And, finally, the clinicians need to understand the impact of out-of-pocket costs, as well as
the total cost and the specific costs under their control, if they are to affect quality and optimal resource use.

For health systems and payers, this information can be aggregated to draw inferences about relative costs of care for a full episode rather than for a given procedure. Since the PACES grouper is designed to account for every dollar spent, it allows for insights into health care costs and spending that would otherwise not be available. To demonstrate examples of these insights we have included the following two examples. Figure 1, illustrates the range of costs experienced for the care of 200 patients undergoing a single procedure across the entire episode of care. The chart excludes imaging and laboratory services for the sake of simplicity in this example but includes the cost of hospital, home health, skilled nursing facilities, and physician services. The blue arrow indicates an average price. One can appreciate the enormous variability and why simply providing an average is minimally useful to most patients. The variation accounts for patient differences, complications and other variables.

**Figure 1**

![Episode Pricing Chart](chart.png)

- **physician**
- **hospital**
- **Home Health**
- **SNF**

Episode Pricing

- $<50,000
- $50,000 to $100,000
- $100,000 to $150,000
- $150,000 to $200,000
- $200,000 to $250,000
- $250,000 to $300,000
- $300,000 to $350,000
- $350,000 to $400,000
- $400,000 to $450,000
- $450,000 to $500,000
- $500,000 to $550,000
- $550,000 to $600,000
- $600,000 to $650,000
- $650,000 to $700,000
- $700,000 to $750,000
- $750,000 to $800,000
- $800,000 to $850,000
- $850,000 to $900,000
- $900,000 to $950,000
- $950,000 to $1,000,000
- $1,000,000 to $1,050,000
- $1,050,000 to $1,100,000
- $1,100,000 to $1,150,000
- $1,150,000 to $1,200,000
- $1,200,000 to $1,250,000
- $1,250,000 to $1,300,000
- $1,300,000 to $1,350,000
- $1,350,000 to $1,400,000
- $1,400,000 to $1,450,000
- $1,450,000 to $1,500,000
- $1,500,000 to $1,550,000
- $1,550,000 to $1,600,000
- $1,600,000 to $1,650,000
- $1,650,000 to $1,700,000
- $1,700,000 to $1,750,000
- $1,750,000 to $1,800,000
- $1,800,000 to $1,850,000
- $1,850,000 to $1,900,000
- $1,900,000 to $1,950,000
- $1,950,000 to $2,000,000
or payers who lack precise tools, this average price might be used, either alone or with blunt risk adjustment, as the payment rate in a bundled payment program. However, using PACES could provide payers with the ability to create patient-specific target prices based on each individual patient’s characteristics—this is represented by the red line. As you can see, such a system would more accurately capture savings created by reducing unwarranted variation while not punishing providers for accepting higher risk patients.

PACES is also capable of inferring a physician or other provider’s role in caring for a patient based on the claims they have submitted. These roles are based closely on Centers for Medicare and Medicaid Services (CMS) defined categories. Physicians can provide the key services as the episodic physician (a surgeon in this case), have a supporting role (anesthesia), or can step in briefly for a more limited ancillary role (pathologist or radiologist). Primary care physicians who care longitudinally for the overall health of the patient or specialists who monitor and care for patients for a specific chronic condition are also captured. To a patient, all of these services contribute to their overall care experience, but also to the overall cost. If we think of price transparency from the patient’s perspective, all of these charges should be factored into the price, not just a single service.

Figure 2 illustrates PACES’ ability to illuminate the large variation in the number of clinicians submitting claims for providing services to the patient in a cancer-related colon resection—from as few as 1 or 2 physicians to as many as 63 different tax IDs billing for a single patient related to the procedure. This information is not widely available currently, and creates a huge opportunity for reducing unwarranted variation and cost.

<table>
<thead>
<tr>
<th>Patient Relationship Category</th>
<th>Average Number of Clinicians</th>
<th>Largest Observed Number of Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Supporting</td>
<td>10</td>
<td>46</td>
</tr>
<tr>
<td>Ancillary</td>
<td>10</td>
<td>40</td>
</tr>
</tbody>
</table>
CMS has recognized the importance of episode groupers. In fact, PACES is built upon the Episode Grouper for Medicare (EGM) which was originally developed by Brandeis University under contract to CMS. However, to date, CMS has failed to implement this tool due to logistical concerns and other factors. The PACES Center has been working to address logistical concerns such as the conversion to ICD 10 codes, expanding the groupers ability to private payers, and setting up a means for continuous updates of the clinical content of the episode definitions. **One step that Congress could take to provide health transparency to patients and payers in order to reduce the cost of health care would be to support the work of PACES and encourage CMS to partner with PACES.** This would help to build the critical mass necessary to set a standard for episode definition, reducing administrative complexity and allowing stakeholders to focus on driving down costs that do not contribute to improved patient experience and outcomes.

Efforts to increase transparency in the health care system and to reduce costs are also happening on the state level. For example, Tennessee, as part of their State Innovation Model (SIM) grant, developed a comprehensive episode program, drawing on concepts and logic closely related to PACES\(^1\). As part of their effort, Tennessee adopted the episode logic to work with their Medicaid data and hosted a series of state-wide clinical review groups. Their value-based payment framework ties resources use to episode level detail, rewarding providers who maintain or improve quality while reducing costs. The program has generated savings in perinatal care and joint replacement and continues to expand to include commercial payers. Now that Tennessee has developed a comprehensive episode strategy, the state faces the on-going challenge of keeping the episodes updated as clinical practice changes. State administrators are interested in (support) the PACES Center efforts to maintain and update a common set of definitions – they are simply not in a position to maintain clinical logic over time. It is also powerful for a state-based program to draw on the vast clinical resources represented by medical specialty societies, giving depth and breadth to the work\(^2\).

**Quality**

The other main component of the value prospect in health care is quality. ACS has developed an alternative solution to the current quality measurement framework in the Quality Payment Program, described below. This alternative could act as a paradigm for quality measurement across surgery, ensuring the resources and conditions are in place for surgeons

to provide high quality surgical care, collecting relevant information to ensure that quality care is being delivered, and creating data to drive improvement. This will lead to better outcomes and minimize the burden of data collection. We believe that this framework defines health care value in a patient-centric way aligned with episodes of care as experienced by the patient, and with the intent of shared accountability across a clinical domain.

Our alternative solution for quality measurement is comprised of three key components:

1. **Verification of Key Standards of Care.** Since the inception of the ACS, we have sought to build standards for clinical domains with the expectation to improved overall outcomes of surgical care. While implementing these standards, we have gained over a half-century of experience in building clinical verification programs in specific clinical domains to drive quality, improvement, and excellence in care. Each of the major surgical domains contain a set of standards for inclusion in a renewable, triennial verification program. The long-term goal is to scale these verification programs initially through pilot testing, then as foundational component to building a national quality system in surgical care.

2. **Clinical Outcome Measures.** We envision the use of administrative claims measures for low event rate care, and propose using programs such as the National Surgical Quality Improvement Program (NSQIP), to show risk adjusted, clinical outcomes for complex, high risk care. This would require pilot testing before large-scale implementation.

3. **Patient-Reported Outcomes.** In addition to standards-based verification programs and clinical outcome measures, we propose inclusion of patient-reported outcomes (PROs) based on an episode of care. Episode-based PROs are inclusive of the patient’s voice and can assess whether care achieves the patient’s expectations. We have begun early testing and development of enriched PROs, focused on surgical outcomes. This model is designed to recognize the complexity of modern medicine and demonstrate that it exceeds the ability of a single physician to provide all of the care.

This framework is based on decades of research and implementation of verification programs, which have proven successful in driving better outcomes in surgical care. The benefits of the programs and methods ACS has used for the last quarter of a century to drive quality of care to new heights are well established in the peer reviewed literature. It is applicable across various clinical domains, particularly in surgery where robust verification programs exist in areas such as cancer care³, trauma care⁴, bariatric care⁵ and care for frail geriatric patients⁶. Such programs depend on triennial surveys, and already exist in

³ [https://www.facs.org/quality-programs/cancer](https://www.facs.org/quality-programs/cancer)
⁵ [https://www.facs.org/quality-programs/mbsaqip](https://www.facs.org/quality-programs/mbsaqip)
⁶ [https://www.facs.org/quality-programs/geriatric-coalition](https://www.facs.org/quality-programs/geriatric-coalition)
thousands of delivery systems today with demonstrated success. As an example, measurement of cancer care spans the entire care journey experienced by patients and includes areas such as prevention, screening, early diagnosis, treatment, post treatment surveillance, and end-of-life care. A surgical resection for cancer may involve debulking and staging the disease, while also including a method for tracking quality through verification of key standards, PROs, and clinical outcomes.

Congress should encourage CMS to test quality measurement based on this framework.

ACS holds that what matters most to patients and providers is safer, more efficient, and higher quality care. It is with these goals in mind that we designed this system. Furthermore, if combined with the work of the PACES Center described above, this framework could create complementary quality and cost measurement across standardized episodes of care representing true value to the patient. Congress should consider testing the described value statement for use in the QPP as part of the Merit-based Incentive Payment System (MIPS), potentially in the form of a MIPS alternative payment model (APM).

What does Congress or the administration need to do to implement those steps? Operationally, how would these recommendations work?

ACS believes that CMS may already have the authority to further develop and test these proposals, either through the Medicare Access and CHIP Reauthorization Act (MACRA) statute or Center for Medicare and Medicaid Innovation’s (CMMI) broad authority, and we have proposed this to them through the rule making process on several occasions. We have also developed and proposed an alternative payment model to the Physician-focused Payment Model Technical Advisory Committee (PTAC) which incorporated the episode construction methodology and clinical content utilized by the PACES Center. This model was considered and ultimately recommended for testing by the PTAC.

However, perhaps due to a perceived lack of statutory authority, or simply the massive requirements placed on CMS to implement the wide-ranging changes mandated by MACRA, they have thus far declined to test or implement innovative concepts that diverge too far from past programs. Instead, in implementing MACRA, CMS developed MIPS and APMs in a way that closely mirrors the legacy CMS quality programs.
In order to facilitate innovation and support adoption of patient-centered, value-driven care that makes sense to physicians, patients and health systems, additional guidance or support may be required from Congress. This could be operationalized in several ways. For example:

- CMS could implement a pilot of the quality measure framework including the three components mentioned above to demonstrate their validity.
- CMS could partner with the PACES Center in development of cost transparency tools for Medicare patients or development of a standard for episode definitions across payers.
- CMMI could combine the work of the PACES Center and the ACS quality measurement framework in an alternative payment model similar to the PTAC recommended ACS-Brandeis Advanced Alternative Payment Model proposal.

Once implemented, what are the potential shortcomings of those steps, and why are they worthy of consideration despite the shortcomings?

While there is strong evidence of the importance of the various components of a team-based patient-centered value framework, it has not yet been tested vigorously by CMS as a cohesive single framework. However, ACS feels that this method of describing and measuring the value of care will provide the best opportunity to reduce unwarranted variation and drive down costs, and we are not alone.

As noted, many health systems, payers, and other academic scholars have noted the benefit of episode-based payments, many with their own definition of “episode”. If a voluntary standard definition is not achieved, this proliferation threatens to increase complexity, confusion, and administrative burden rather than reduce it. For instance, CMS has developed and implemented episode-based payment models, but unfortunately, they are reliant on traditional overly broad quality measures such as “all-cause mortality”. These do not provide the knowledge necessary for improvement and fails to create shared accountability.

Instead, ACS strongly believes that creating a value statement based on patient-centered team-based quality measurement, with shared accountability and episode-based cost measurement, provides the best chance to both improve quality and reduce health spending.
We thank the Committee for its continued leadership on improving the value of health care for all Americans, and would be happy to provide additional information on any of the concepts or proposals outlined in this document with you or your staff. Please do not hesitate to contact Mark Lukaszewski in the ACS Washington office at mlukaszewski@facs.org or (202) 672-1509 with any questions or requests.

Sincerely,

David Hoyt, MD, FACS
Executive Director