Medicare Payment Challenges Facing Surgical Care
September 2024

The U.S. Centers for Medicare & Medicaid Services (CMS) continues to put forth annual regulations that exacerbate the underlying problems within the broken Medicare physician payment system. Furthermore, these policies negatively impact the ability of physician practices to invest in quality improvement efforts that benefit Medicare patients, or transition to alternative payment models when appropriate. Importantly, the Medicare Physician Fee Schedule (MPFS) is often the benchmark for determining payment rates for Medicaid and other payers. Thus, Medicare payment cuts have a cascading effect across payers, challenging physician practices' ability to cover the cost of taking care of their patients.

While Congress considers long-term reforms to physician payment, it must exercise its oversight authority over Medicare payment policy to ensure a stable environment that allows multiple physician practice models — independent private practice or hospital/health system employment — to thrive. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, higher-quality care.

Budget Neutrality Constraints of the MPFS are Problematic

Surgeons and anesthesiologists are expecting another 2.8% cut due to temporary congressional relief set to expire at the end of the year. Previously, relief was provided to mitigate reductions resulting from long-term problems with the statutory budget neutrality requirement and its impact on the Medicare conversion factor. In recent years, budget neutrality rules have triggered steep payment cuts for most specialties providing surgical care. Mandating deep cuts to certain physician services for no reason other than to increase payments for other physician services is an unfair and outdated policy. Congress must modernize this dangerous mechanism that pits physicians against physicians and hinders team-based, coordinated care. The reform included in the **Provider Reimbursement Stability Act of 2023 (H.R. 6371) and the Physician Fee Stabilization Act (S. 4935) would represent a much-needed first step in addressing this punitive mechanism.** Budget neutrality — when coupled with a lack of inflation-based annual payment updates — will continue to lead to unstainable MPFS cuts.

Annual Inflation Adjustments Necessary for Reasonable Payments

Since 2001, physicians have seen their Medicare payments decrease by nearly 30% after adjusting for inflation. Congress should establish an annual update to the MFPS based on the Medicare Economic Index starting with calendar year 2025, which is comparable to updates in other payment programs (e.g., hospitals). This important adjustment will address the currently anticipated cut and help ensure that payments keep pace with medical cost inflation.

Globals Policy

Surgical services should be recognized for their value to Medicare beneficiaries with appropriate and sustainable payment rates. CMS continues to express concern about whether post-operative visits are performed as frequently as assumed in the valuation of global packages. The members of the Surgical Coalition have made good faith efforts to collaborate with CMS, providing the agency with thoughtful feedback and reasonable solutions on this matter for nearly a decade. Since payments for evaluation and management (E/M) visits increased substantially in 2021, the Surgical Coalition has urged CMS to apply those payment increases to the post-operative visits bundled into global surgical codes. Failure to do so is a

violation of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which prohibits Medicare from paying physicians differently for the same work. The absence of equitable adjustments is negatively impacting the relativity and integrity of the MPFS, and Congress should urge CMS to apply the increased values to the E/M portion of global surgical codes.

Most recently, CMS proposed two policies intending to gather data on which practitioners are providing post-operative visits:

1. **Expansion of transfer of care modifiers for global codes**: Currently, transfer of care modifiers must be used when the surgeon and another practitioner formally agree to provide different portions of the global package (for example, if the surgeon performs the surgery and a primary care physician takes over the post-operative care). The proposal expands the use of the transfer of care modifiers to informal, undocumented, but expected transfers of care with the goal of gaining more data about who is providing post-operative care absent a formal transfer.
2. **New add-on code for post-operative care**: This code is intended to be appended to an E/M when a practitioner who did not perform the surgery provides post-operative care without the benefit of a formal transfer. In this instance, CMS believes there is additional work involved in learning about the procedure and complications.

The Surgical Coalition remains committed to working with CMS to ensure global surgical codes are valued appropriately, but it is unlikely that CMS will gather actionable data based on these policies, and CMS should not revalue global codes based on flawed or inaccurate data on post-operative visits.

Long-Term MACRA Reforms are Needed

In addition to stabilizing the payment system for the near term, Congress must build on the intent of the Medicare Access and CHIP Reauthorization Act (MACRA) to better support physicians in transitioning to value-based payment. Today, nearly a decade after the passage of MACRA, many physicians wishing to move beyond fee-for-service will find a lack of viable alternative payment models (APMs). **"It is critical that specialty physicians be provided the opportunity to participate in workable, voluntary value-based payment models. Such models should reflect real-world medical practice and include appropriate physician input in their development. Models recommended by the Physician-Focused Payment Model Technical Advisory Committee may represent a starting point for some medical specialties."** CMS, including the Center for Medicare and Medicaid Innovation, has not tested or implemented a single APM recommended by the Physician-Focused Payment Model Technical Advisory Committee. These models have been developed by physician experts focused on the interests of their patients, and this lack of action on the part of CMS represents another unfortunate example of the many shortcomings of MACRA implementation.

Currently, our members face the unfulfilled promises of the MACRA Quality Payment Program (QPP), a program intended to give physicians the opportunity to receive payment bonuses for demonstrating improved quality of care. As implemented, the program remains unworkable for many in the surgical community. The opportunities to participate in the QPP program are minimal, and, in most cases, physician practices are obligated to meet burdensome and costly administrative requirements to earn negligible bonus payments.

Transforming Episode Accountability Model

In addition to policies directly affecting Medicare physician payment, other CMS policies will have indirect but important effects on how surgeons care for their patients. One area of specific concern is the recently finalized Transforming Episode Accountability Model (TEAM). TEAM is a five-year mandatory model designed to test an episode-based approach for acute care hospitals. Selected facilities receive a target price for Medicare Parts A and B spending for a set of five initial surgical episodes. Participants will be held accountable for providing care within the target price while maintaining or improving the quality of care.

While episode-based payment models offer great promise, the TEAM approach is inherently flawed. The model is based on existing models that are still ongoing and have yielded variable to no net savings over time. CMS also did not actively consult impacted specialties during the development of this model, which has resulted in questionable quality metrics, insufficient risk adjustments, a lack of clearly defined roles for physician leaders, and other design concerns, which could detract from the overall effectiveness of the model. Importantly, the surgical community takes issue with the mandatory nature of this untested model. Mandatory participation fails to allow hospitals and surgeons to tailor innovative payment reforms to their specific patient populations, practice settings, administrative capabilities, and resources. It also forces certain providers that have already adopted their own innovative ways to provide high-value care to alter their care processes in ways that might reverse progress made in terms of patient outcomes and efficiencies.

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