

American College of Surgeons 2009 Statement on Health Care Reform

Introduction

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

--Mission statement of the American College of Surgeons

The American College of Surgeons (ACS) is the largest surgical organization in the United States, representing 77,000 members from all states and surgical specialties. The ACS was founded in 1913 and is dedicated to high-quality, safe surgical care delivered in a compassionate, ethical manner. Surgeons perform approximately 30 million operations annually in the United States. While the ACS appreciates the challenges facing the U.S. health care system, and believes that health care reform is necessary, we also emphasize that many aspects of surgical health care in the United States, including the education and training of our surgeons, are the best in the world.

The American College of Surgeons strongly supports efforts to ensure that individuals have universal access to patient-centered, timely, affordable, and appropriate health care while maintaining that surgeons are an integral and irreplaceable component of quality treatment.

To this end, in any health care reform bill, the ACS strongly ***supports:***

- 1. Quality and Safety***
- 2. Patient Access to Surgical Care***
- 3. Medical Liability Reform***
- 4. Reduction of Health Care Costs***

The College believes that achieving these goals will require all stakeholders to work together in order to build a better U.S. health care delivery system.

QUALITY and SAFETY

Scientific evidence shows that providing safe and effective quality surgical care will help to reduce the cost of health care delivery; cost reductions must be linked to quality improvement efforts.

The ACS National Surgical Quality Improvement Program - a national effort to improve surgical care and cut costs operated and directed by the American College of Surgeons - is helping to prevent thousands of surgical complications each year, according to a just-released study of 118 hospitals.

- The hospitals experienced a reduction of 262-524 complications per hospital, per year. This study shows that we can improve both the quality of patient care and, at the same time, reduce and even eliminate some health care costs.
- If Congress were to fund NSQIP in every hospital in the nation, health care costs would be reduced by \$175 to \$347 billion over 10 years, and help literally millions of patients avoid preventable complications.

The ACS supports:

Well-designed clinical comparative effectiveness research

- Comparative effectiveness research (CER) has value when:
 - Used as a tool to improve care on a per-patient basis by providing information on clinical value of varying treatments and interventions.
 - Used to enhance research on surgical innovation and technology
 - Used to inform and promote patient shared decision making
- CER should not be:
 - Used to determine medical necessity or make coverage and payment decisions.

Physician Quality Data

Health care payors, providers and consumers find great value in the collection and analysis of physician quality data. It is important to provide patients, the public, and physicians with accurate information on physician quality. One method of reporting is the CMS Physician Quality Reporting Initiative (PQRI).

The ACS believes that the Physician Quality Reporting Initiative (PQRI) should:

- Be actionable, reliable, and voluntary
- Provide positive incentives for participation
- Provide access to data in a timely manner, and
- Have a reasonable appeals process.

Further, the ACS believes that Congress should:

- Publicly release PQRI reports only when further evaluation and improvements occur to assure that the reports are valid;
- Provide additional Federal funding to develop clinical data registries and other quality improvement tools.

Public Reporting

The driving force for public reporting of surgeons is to promote quality improvement and assist patients in their health care decisions. Currently, health insurance payors, purchaser groups and other private entities offer variable reports on surgeons for health care quality or patient experience that do not always support these goals. Public reporting should be a trusted source of guidance for patients.

- Public reporting programs should:
 - Be risk-adjusted and peer-reviewed
 - Standardize and rely on national measures which have undergone a proper endorsement process for scientific validity and reliability.
 - Develop in collaboration with surgeons.
 - Have internal program audits to evaluate the effectiveness of the program for quality improvement and for meeting patient needs.
 - Provide surgeons with adequate access and time to review and provide comments on or corrections to the data before final reports are published.
 - Have methodologies which are transparent, available to the public and externally validated for fairness, reliability, meaningful and actionable reports.
 - Disclose limitations of the data and provide appropriate caveats for interpreting the reports.

Encouraging Realistic Health Information Technology (HIT) Use and Adoption

- Expanded HIT is an important step for quality measurement and coordination of care; yet the full benefits cannot be achieved without interoperability.
- The ACS is concerned about the current HIT timelines for bonuses and penalties established in the *American Recovery and Reinvestment Act (ARRA)* with the continued lack of interoperability in and among certified HIT systems.
- The ACS urges Congress to:
 - Amend the current bonus and penalty timelines so the entire surgical community can participate fully.
 - Require interoperability in all efforts to expand HIT

Physician and Industry Relationships

- There are positive aspects to physicians' relationships with industry including clinical research, education, and technology development, but some conflict of interest safeguards are appropriate.
- Surgeons must have the opportunity to review and correct information about their financial relationships before those disclosures are made publicly available.
- ACS strongly supports disclosure and transparency of physician and industry relationships through a single, Federal reporting system that preempts state law.
- Congress should not include reporting of industry funding for continuing medical education (CME) and professional organizations, if national conflict of interest guidelines are followed and funding for educational purposes is unrestricted.

Patient Access to Surgical Care

The American College of Surgeons has a long-standing policy supporting universal access to affordable, high-quality, safe surgical care, delivered in a timely and appropriate manner. This effort requires that our nation have a well-trained and available surgical workforce to meet the needs of all surgical patients. At the present time, there is a shortage of surgeons in many surgical specialties and in many areas of the country.

To address surgical access and workforce issues, the ACS supports:

- Current law should be modified to allow for growth of surgical and other specialties as demand for service dictates and accredited training are developed.
- Efforts should be put forth to increase the number of women and minorities in physician training programs.
- Non-physician providers can extend and facilitate the efforts of surgeons but cannot replace them.
- Congress should make loan forgiveness programs and participation in the National Health Service Corps available to surgical specialties with documented current or potential workforce shortages such as General Surgery.
- Medical education should remain in the purview of professional medical educators, including the Accreditation Council for Graduate Medical Education (ACGME) and surgical societies.
- Surgery opposes any proposals that would (1) set forth in law the goals of medical education or (2) require a GAO study to evaluate training programs.

Repealing the current sustainable growth rate (SGR) and establishing a new baseline for the physician payment system

- The ACS cannot support another short-term “patch” that only temporarily prevents major Medicare payment cuts but does not directly address the long-term problems with the SGR.
- For health care reform to be successful, Medicare’s physician reimbursement system must be set on a path toward full-scale and permanent reform.
- Congress must incorporate a realistic budget baseline that provides physicians with positive updates that reflects rising costs of providing care.
- The ACS supports proposed measures that increase payments for primary care physicians and rural general surgeons, but the ACS is opposed to provisions that would fund these bonus payments by an across-the-board reduction in payments for all other physician services.
- During the transition period to a new payment system, Congress should replace the SGR with a system of separate service category growth rates (SCGR). The four SCGR categories (primary care; other evaluation and management services; major surgery; and all other physician services) would recognize the differences among the various types of services and account for their varied rates of growth, while providing additional dollars for primary care.
- Participation in any new insurance payment structure should not be mandated for physicians, nor should payment be tied to the Medicare physician fee schedule or participation.

Ensuring Children Have Equal Access to Quality Surgical Care

The ACS believes that:

- Medicaid providers, including surgeons, should be reimbursed at levels at least equal to Medicare. Medicaid insures more than 1 in 4 children, making it the single largest children's health insurance program. Medicaid payments for physicians pay 72 percent of what Medicare currently pays for the same service. Current Medicaid payment rates for pediatric surgical specialties could lead to severe access problems for children across the country.
- Children's hospitals, where many pediatric surgeons practice are major Medicaid providers. On average, children's hospitals' Medicaid payments are only 80 percent of what Medicaid pays for similar services outside of the hospital.

Insurance Reform

The ACS believes that:

- Health care reform must include substantial reform of the health insurance industry. These reforms must include addressing issues of reducing costs, improving coverage and reducing administrative overhead.

Ensuring responsible physician ownership

The ACS believes that:

- Physicians should have the right to responsibly own, either individually or through a joint venture (with hospitals and/or other physicians), facilities (including hospitals), equipment, and services that provide appropriate, high quality care for patients.
- Congress should not prohibit the development and further expansion of such ventures. Physicians should be obligated, however, to disclose this ownership information to the public.
- Physicians should be able to continue to own, operate and refer patients to in-office imaging services as provided in the Stark in-office ancillary exception.

Access to Imaging Services

- Use of imaging services should follow evidence based guidelines. The ACS is fundamentally opposed to the use of radiology benefit managers or other pre-certification requirements for imaging services.
- ACS supports a non-punitive approach to eliminate unnecessary imaging based on education and confidential feedback programs.

- Ultrasound is a less costly alternative to advanced imaging. We therefore urge Congress to specifically exclude ultrasound from the definition of imaging services to which increases in equipment utilization rate or any other imaging reimbursement reductions would occur.

Medical Liability Reform

Medical liability reform helps reduce costs to the health care system and improves patients access to care.

- At the height of the medical liability crisis, Texas ranked 48th out of 50 states in terms of physician manpower. Texas averaged just 152 doctors per 100,000 people, compared to a national average of 196.
- Texas passed strong medical liability reforms and in 2008, over 4,000 physician licensure applicants were received, compared with 2,500 in 2002, before liability reforms were enacted. Additionally, 162 orthopaedic surgeons began practicing since reform passed. Texas also added an additional 49 new neurosurgeons.
- A recent report by the Congressional Budget Office concluded that a medical liability reform package including a \$250,000 cap on non-economic damages would reduce federal budget deficits by roughly \$54 billion over the next 10 years.
- The medical liability crisis has created a misdistribution of physicians.

Thus the ACS believes that incorporating certain medical liability reforms is essential in any comprehensive health care reform. These include:

- Provisions modeled after the laws in California (MICRA) or Texas, which include reasonable limits on non-economic damages;
- Alternatives to civil litigation, such as health courts, arbitration, early disclosure and compensation offers;
- Protections for physicians who follow established evidence-based practice guidelines, such as safe harbors;
- Protections for physicians volunteering services in a disaster or local or national emergency situation.

REDUCTION OF HEALTH CARE COST

Provision of high-quality, cost-effective, safe, and appropriate patient care will require enhanced patient responsibility in maintenance of health, well being and decisions regarding treatment. It will also require the development of a payment mechanism that promotes quality and value. This effort should promote available, appropriate, and compassionate care for patients with life-limiting illnesses, including an understanding of all potential options.

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Funding for Evidence Based Guidelines for Surgical Care

- Surgeons should be guided to eliminate waste and inefficiency wherever possible, including overuse, underuse, and misuse of services.

The American College of Surgeons commits to assessing, developing, and promulgating guidelines for surgical disorders leading to cost-effective care of the patient with surgical disease, so that care is optimized and coordinated across the full spectrum of health care.

Denial of Hospital Payments for Readmission

- The ACS is concerned with the unintended consequences of a hospital readmission and post-acute bundling policy, particularly the potential for unwillingness to care for patients with complex medical conditions.
- The ACS therefore urges Congress to:
 - Require development of a coherent risk adjustment policy to prevent the practice of deselecting patients,
 - Address the readmission issue, and
 - Ultimately promote the highest quality and most appropriate level of patient care with these methods of payment.
 - Exclude readmissions for an unrelated diagnosis than the original admission in either the hospital readmission or post-acute bundling policy.
- When the readmission policy is phased out and the bundled payment policy is implemented, a workable and reasonable readmission policy must remain an essential piece of the initiative.

Innovative Payment Options

- The ACS supports the voluntary participation in the development and testing of alternative payment models, including shared savings programs, bundled payments, accountable care organizations, and episode grouping.
- All alternative payment models should ensure a sustainable surgical workforce, by providing fair and appropriate reimbursement for surgeons.
- Cost containment should be linked to improvements in care.
- If implemented, participation in shared savings programs should be voluntary, non-punitive and not unduly restrict patient choice.

- Congress should amend the Stark physician self-referral and antitrust laws and/or regulations to allow provider collaboration and flexibility in the development of alternative payment programs.

Independent Medicare Advisory Commission

- The ACS strongly believes that creation of Medicare payment policy should remain a primary responsibility of Congress rather than delegating it to the hands of an unelected, unaccountable governmental body with minimal input from stakeholders and citizens.

Valuation of Codes under the Physician Fee Schedule

- The ACS opposes the creation of a duplicative process for determining code values. Surgery supports maintaining the role of the AMA/Specialty Society Relative Value Update Committee (RUC) as the entity through which medical services are valued.
- The RUC continues to be a dynamic process, which makes recommended increases *and decreases* in the value of codes reimbursed under the Medicare Physician Fee Schedule.
- The RUC has maintained budget neutrality .

Payment for “Efficient Areas”

- The ACS opposes to arbitrary adjustments of payments based on geographic or physician level differences in utilization of medical services, where such adjustments are not appropriately risk-adjusted or explained simply by inefficiency.
- We support addressing any geographic disparities by extending the geographic floor for work.