Statement
of the
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Presented by

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Roundtable to Discuss
Reforming America's Health Care Delivery System

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Chairman Baucus, Ranking Member Grassley, and members of the Committee, on behalf of the American College of Surgeons (ACS) and the more than 74,000 ACS members, thank you for the opportunity to join you today in this roundtable discussion on "Reforming America's Health Care Delivery System."

I am Frank Opelka, and I am a colorectal surgeon from New Orleans, Louisiana. I am the Vice Chancellor of Clinical Affairs and Professor of Surgery at the Louisiana State University (LSU) Health Science Center. I am also the Chief Executive Officer, Chairman of the Board of Directors, and President of the LSU Healthcare Network. Within the ACS, I have served as Chair of the ACS Patient Safety and Quality Improvement Committee and am a member of the ACS Health Policy and Advocacy Committee. I also serve as Chair of the Surgical Quality Alliance, which is a collaborative effort of the ACS and 25 surgical specialty societies to promote and improve the quality of surgical care in the United States.

Today's roundtable covers one of the most important topics in the health reform discussion. Reform of our nation's health care system covers a range of important issues, from covering the uninsured to expanding patient access to care, from improving the quality of care to containing the growth of our nation's rising health care costs. A myriad of problems and challenges calls for not one but many steps and solutions to put us on the path to extending the possibility and promise of quality health care to all Americans. In addition, before adopting any proposed steps or solutions, we must carefully consider what unintended consequences may result. For example, a little over ten years ago, many were predicting a surplus of physicians, and as a result, Congress set limits on graduate medical education that have held the number of residencies static even as the American population continued to grow. Today, physician shortages are on the rise in both urban and rural areas, and surgery has not been immune from these trends. In fact, data from the Dartmouth Atlas show a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively. So while our present situation calls for change and health system reform, we must proceed deliberately and thoughtfully to ensure that the policy changes we make today do not lead to unintended consequences that could undermine Americans' access to quality care.

Improving Surgical Quality—System-Wide Approach

Much of the discussion around health reform has been on how our nation can improve the value of care that patients receive while either limiting the growth of or, in some cases, even reducing the volume of services used by patients. From our perspective, this discussion must start with a discussion of how we improve the quality of care, which from the ACS perspective means surgical care.

The concept of delivery system reform starts from an important and appropriate premise that patients receive their care in a large system of care rather than from one physician or health care provider. It is this same premise that has been the foundation for our

own successful surgical quality improvement (QI) efforts. For example, the ACS National Surgical Quality Improvement Program (NSQIP) started with a successful effort within the Department of Veterans Affairs, which produced marked reductions in VA post-operative mortality and complications of 27 and 45 percent, respectively, between 1991 and 2001. ACS NSQIP is a prospective peer-controlled, validated database that quantifies 30-day risk-adjusted surgical outcomes and allows for comparisons among all participating hospitals. ACS NSQIP does not merely examine the care the surgeon provides in the operating room, but rather it captures data regarding the range of pre-operative, intra-operative, and post-operative care that the surgical patient receives over the 30 days following the surgery. After a pilot to test NSQIP in three non-federal hospitals in 1999, the ACS applied for a grant from the Agency for Healthcare Research Quality (AHRQ) in 2001 to expand the program to 14 hospitals. Based on its successful application in these hospitals, the ACS has spearheaded the effort to implement ACS NSQIP in private hospitals across the country, with ACS NSQIP currently in place in 235 hospitals nationwide. The program has received wide recognition as a successful model for surgical quality improvement and the Joint Commission recognizes the value of participation in ACS NSQIP by including a Merit Badge next to the profile of all ACS NSQIP hospitals.

In the field of cancer care, the American College of Surgeons Commission on Cancer (CoC) is a pioneer in measuring performance. The more than 1,400 hospitals and free-standing cancer treatment facilities approved by the CoC report clinical data to the National Cancer Data Base (NCDB) and receive evidence-based benchmark comparison reports based on accepted standards of care for all types of cancer. Since 1995, the NCDB has captured over 21 million cancer cases and includes data on about 70% of all newly diagnosed malignant cases of cancer nationwide annually. To provide better "real-time" feedback, the CoC has also developed a new reporting system that could link into an interoperable, nationwide health information technology (HIT) system, which received significant support in the recently enacted American Recovery and Reinvestment Act of 2009 (H.R. 1). This prospective electronic reporting system, which is called the Rapid Quality Reporting System (RQRS), monitors evidence-based performance measures in real-time, alerting providers when standards of care for select cancers are not being met. The ACS believes RQRS could ultimately play an important part in any new, outcomes-based payment models.

Another important area of health care delivery comes through the emergency and trauma care delivered in our nation's hospitals. Traumatic injury is the leading cause of death for Americans aged 1 through 44, and studies of conventional trauma care show that as many as 25 percent of trauma patient deaths could have been prevented if optimal acute care had been available. In addition to saving lives, restoring function, and preventing disabilities, ensuring appropriate trauma care also can serve an important role in the larger goal to contain the growth of health care costs. According to an AHRQ report, trauma injuries were the second most expensive health care condition in 2005, costing approximately $72 billion. This includes money spent for doctor visits, clinics, emergency room visits, hospital room stays, home health care, and prescription drugs. The cost of trauma-related emergency room visits alone was $7.8 billion. The

National Safety Council's 2005-2006 edition of *Injury Facts* found that the total cost of unintentional injuries for 2004 was $574.8 billion, with $298.4 billion in wage and productivity losses and $98.9 billion in medical expenses alone.

Trauma systems provide for effective and efficient use of scarce and costly community resources. Yet, only one in four Americans lives in an area served by a trauma care system. Both the Institute of Medicine (IOM) and the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group have documented significant gaps in our trauma and emergency healthcare delivery systems, showing that hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialties are often unavailable to provide emergency and trauma care. The IOM has found that a coordinated, regionalized, accountable system based on the current trauma care system model should be created. Unfortunately, the most consistent element among the states is the lack of uniformity regarding system development. As a result, the quality of care a trauma patient receives largely depends on the quality of the regional and local system in place to respond emergency and trauma situations.

Since 1976, the ACS Committee on Trauma (COT) has developed criteria to categorize hospitals based on the level of trauma care available. These guidelines are now used by states to certify some hospitals as trauma centers and many hospitals seek certification to become a trauma center from the ACS COT. In addition, in 1989, the ACS COT collaborated with emergency medical organizations, governmental agencies, trauma registry vendors, and other interested parties to develop the National Trauma Data Bank (NTDB), which contains over 2 million cases from over 600 U.S. trauma centers and is the largest aggregation of trauma registry data ever assembled. The goal of the NTDB is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. The information contained in the data bank has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation. Finally, the ACS COT plans to develop a trauma QI program, paralleling the efforts with ACS NSQIP.

Through these efforts, the ACS has demonstrated a commitment to delivery reform that both includes and extends beyond the care that the surgeon provides to his or her patients. In addition, these efforts are based not simply on doing more for the patient but on doing what is most clinically appropriate for the patient. The ACS recognizes that surgical care is provided through a surgical team in the operating room and through a team of health care professionals, including the surgeon, who care for and monitor a patient's progress before and after an operation.

Achieving Better Quality and Better Value—A Collaborative Effort

The Physician Quality Reporting Initiative (PQRI) has sought to change the culture among physicians regarding QI efforts, and while this effort has not been without some value, the PQRI has also been limited in its effectiveness because it is focuses almost

solely on the physician's role in caring for a patient and because it is structured in such a way that supports a Medicare culture that bases how much a physician gets paid with how many services a physician provides. If we are to truly improve the value of care that patients are receiving, incentives need to be better aligned to ensure that the better value is what is being rewarded. Senator Baucus's and Senator Grassley's inclusion of provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) to allow physicians to meet the requirements of the PQRI through participating in an approved registry was a step in the right direction because registries focus not on providing more care but on clinically appropriate care. By building on such measures that reward participation in proven QI initiatives, incentives can be better aligned within Medicare to promote better quality and better value through collaboration and information sharing. It is this understanding of the importance of collaboration and information sharing between the surgeon and others caring for the surgical patient—a truly system-based approach—that has been the foundation of success for ACS's QI efforts.

Just as the ACS has approached surgical quality improvement as an effort that extends beyond the surgeon, the ACS likewise believes that efforts to improve the care in our hospitals must support and recognize the role of surgeons in caring for patients. Even though our members are paid separately from hospitals, surgeons are the critical component of the care delivered in hospitals, and delivery reform should support the collaborative efforts of surgeons and hospitals to serve patients facing a major illness, disease or injury. If hospitals do not have surgeons, hospitals cannot survive and patients in the surrounding community are forced to travel great distances to seek surgical care. Likewise, our members cannot serve patients if there is not a hospital with whom to partner in caring for patients. In this context, it is important to consider how best to build upon the current hospital quality improvement program. Last year, Chairman Baucus and Grassley released draft legislation that would expand the existing hospital QI effort to include surgical care. If the expanded program is to be a success, it will be essential that the hospital program and the PQRI be in harmony to improve and not impede quality surgical care. As a result, if surgical care is included in this effort, it is critical that the perspective of surgeons and others who are caring for these patients be considered and weighed in measure development. In addition, if surgical care is included, risk-adjustment to account for the wide-range of patient acuity, as is included ACS NSQIP for example, will bring not only accountability but also added respectability that will yield the buy-in from hospitals, surgeons, and other stakeholders needed to ensure the program's success.

If surgical care is included in the hospital QI program, it will be of vital importance to ensure that the public reporting of performance data regarding specific hospitals be accurate. As you know, the Centers for Medicare & Medicaid Services (CMS) already publicly reports certain hospital measures, but the addition of surgical care would require an added complexity and should be approached with a degree of caution. If surgical care is included, ensuring appropriate risk-adjustment becomes all the more important to ensure that hospitals and surgeons are not penalized for caring for high-risk and severely ill patients. The ACS is concerned that at present there are

considerable limitations with the public reporting of hospital quality information. These limitations were chronicled in the November/December 2008 issue of *Health Affairs*. In the article, some hospitals listed as top performers in one survey were listed toward the bottom of another and vice versa. Before reporting this type of data to the public, it will be necessary to ensure that the measures being used are recognized by clinicians as true measures of quality and not simply proxies for what a payer, private or public, or a consumer may interpret as quality care. One such proposed proxy has been to define "high quality" providers as those, who, on a review of Medicare claims, perform the highest number of certain procedures. Such proposals could have particular impact on rural and other underserved areas where general surgeons care for a wide range of patients with a wide range of conditions, diseases, and injuries. Many rural, frontier and even some urban communities already face an emergency and surgical workforce crisis, and, if not done carefully and accurately, public reporting could serve to threaten patients' ability to access care in these smaller communities. The public reporting of data that has not been appropriately aggregated and risk-adjusted could lead to incentives that eventually drive surgeons and patients away from these rural communities to hospitals in larger cities. Such a result would not only bring added inconvenience to patients as they seek acute health care services, but it would also threaten the future of hospitals in these smaller, rural communities. These rural hospitals not only serve an important economic function in smaller communities, but they also serve as a safety net when patients are in need of emergency surgical care. The distance a patient travels before receiving the necessary care can often be the difference between life and death. As a result, it is of the utmost importance that appropriate safeguards be developed to ensure that public reporting does not threaten access to care in rural and underserved communities and that any reported data be based on sound clinical information with thorough testing before being released to the public.

In raising these cautions and concerns, I want to stress that the ACS also sees these QI efforts as an opportunity to build on successful efforts already underway, such as those in ACS NSQIP and the NCDB. In fact, the Baucus-Grassley legislative draft provides such an opportunity by including the Surgical Care Improvement Project (SCIP) as part of future hospital QI payment reforms. It is important to note that ACS NSQIP also gathers data under SCIP, which could help facilitate hospitals' ability to meet these requirements should they become a part of the larger hospital QI program. As Congress has appropriately set incentives for physician participation in registries that satisfy the requirements of PQRI, the ACS believes that ACS NSQIP, a database already in existence, could similarly support efforts to design a meaningful hospital QI program for patients.

In addition to supporting the hospital QI expansion, the ACS NSQIP's use of 30-day risk-adjusted outcomes could also support the proposal, included in the President's budget, to bundle hospital payments to cover not just the hospitalization but to cover care from certain post-acute providers provided within 30 days after hospitalization. Just as a successful hospital QI expansion must have risk-adjustment so must any proposal that would penalize hospitals with higher readmission rates. To simply punish

hospitals with higher readmission rates, without accounting for the severity of patient's illness or other conditions that could lead to complications, could have adverse consequences for hospitals, surgeons and ultimately, the sickest of patients that they are seeking to serve.

Building a Foundation for Success—A New Approach to an Old Problem

As the Committee studies the important issue of delivery reform, it is important not to lose sight of the fact that no delivery system, no matter how ingenious, can survive if those who are caring for patients are not being appropriately reimbursed, and the most immediate challenge for patient access to surgical care is the precarious reimbursement situation confronting surgeons and surgical practices. As the Committee is well aware, Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The ACS calls on this Committee and Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The ACS greatly appreciated the leadership of Chairman Baucus and the bipartisan support from this Committee to enact the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how work was valued under Medicare fee schedule, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's.

In discussing delivery system reform, many often discuss the importance of measures to promote primary care to both prevent illness and disease as well as to manage the conditions that a patient may already have. To this end, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while seeking to promote efforts to help Americans better manage their care, would only exacerbate the workforce challenges described earlier and establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. The ACS wholeheartedly supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

A better alternative would be reforms that recognize the important roles that different specialties play in caring for the whole patient. Unfortunately, Medicare's payment

model is not constructed in such a way. At present, physicians and hospitals are paid under separate Medicare silos, and even though, I have described that ACS's QI efforts are in collaboration with hospitals, Medicare's physician and hospital QI efforts are essentially separate from each other. In the discussion of health reform and Medicare physician payment reform in particular, considerable attention is being paid to ideas that would base payment on organizational arrangements such as accountable care organizations (ACOs) or through regional constructs such as hospital referral regions (HRRs). ACS sees great promise in models that seek to better coordinate the range of care from primary to acute services, but also believes that these models can only be successful if these relationships are entered into voluntarily. Not forcing physician involvement in these organizations and arrangements will help ensure that these relationships will be based on collaboration and mutual respect in improving the quality and, ultimately, the value of patient care. Likewise, ensuring a voluntary arrangement will also protect against the imposition of "one-size-fits-all" or "top-down" efforts that fail to recognize that the unique health delivery situations facing different practices, hospitals, populations and regions.

The hope for patients in these systems of care is that they will receive integrated, high quality care in more efficient way, and indeed there are examples of systems that do that now. In addition, there is also the hope that these systems will contain costs. While the ACS supports the goal of containing cost, it is critical that the goal of cost containment not be used as tool by ACOs, HRRs or any other organization or arrangement, public or private, to deny a patient access the best clinical care available—whether that care is provided by a surgeon or any other physician or health care professional. Likewise, when measuring the quality and cost of care delivered in these systems, it will always be critical to risk-adjust to account for possible complications and outcomes. Finally, in order to determine the value and practicality of different models, ACS believes that appropriate demonstration and pilot projects should be conducted before widespread implementation. It is likely that a variety of models will be needed to meet the various situations and needs facing patients, physicians and health care delivery around the country.

As Congress, CMS, and other policymakers test and study various payment models and systems of care, the ACS supports a transitional step that would replace the blunt tool of the sustainable growth rate for all physician services under Medicare with a reimbursement structure of multiple expenditure targets. As policymakers find more desirable payment models and arrangements to promote better value in care, this model could be phased out over the next three to five years or as Congress determines appropriate as it evaluates a variety of different models of care. Until that time, the ACS proposes replacing the single expenditure target of the SGR with multiple expenditure targets based on sub-sets or categories of services such as major surgical procedures, primary care, and other physician services. Such a structure would no longer subject low-volume growth services, such as major surgical procedures and primary care, to the across-the-board cuts of the SGR, and it would also enable Congress to focus additional dollars toward particular services, such as primary care, without necessarily cutting other services.

Thank you again for the opportunity to participate in this important discussion today. The ACS looks forward to working with this Committee in the days and weeks to come to reform our nation’s health care system and to preserve and improve Americans’ ability to access high quality surgical care and health care services.