



**Statement of the
American College of Surgeons**

Presented by

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

RE: "The Need to Move Beyond the SGR"

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Executive Summary

The American College of Surgeons (the College) recognizes that developing a long-term solution to the failing sustainable growth rate (SGR) formula for Medicare physician payment is an enormous undertaking. The College maintains that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality for the patient and reducing growth in health care spending, which we assert are directly related objectives. To move beyond the SGR, repeal must be followed by a period of stability in which bundled payments and other models can be tested and implemented, all the while keeping the focus on quality to improve value and lower cost.

The College has a century of experience in creating programs to improve surgical quality and patient safety. Based on the results of these programs, such as the National Surgical Quality Improvement Program, we have learned that four key principles are required to measurably improve the quality of care. They are:

- Setting appropriate standards
- Building the right infrastructure
- Using the right data to measure performance
- Verifying the processes with external peer review

Quality initiatives based on these principles have the potential to reduce complications and save lives, which translates into lower costs, better outcomes, and greater access. That's good for providers and payers, government officials and taxpayers. Most of all, that's good for patients.

Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee, I am David Hoyt, a trauma surgeon and the Executive Director of the American College of Surgeons. On behalf of the more than 75,000 members of the College, I wish to thank you for inviting the College to testify today. We appreciate the Subcommittee's recognition that the sustainable growth rate (SGR) is a failed system for calculating Medicare reimbursement for physician services and strongly support the effort to replace the SGR with more innovative models of physician payment.

The College recognizes that developing a long-term solution to the Medicare physician payment system is an enormous undertaking, especially given the need to limit the growth in health related spending. In addition to the SGR, the College is concerned about the impact of the Independent Payment Advisory Board (IPAB), which is scheduled to make recommendations on overall Medicare spending in 2014. The College strongly believes that, should the SGR remain in place when the IPAB takes effect, physicians will be subject not only to the SGR but also to further reductions in Medicare reimbursement based on IPAB's authority, which would endanger seniors' access to high quality care in the Medicare program. The College understands that the current fee-for-service model is unsustainable and maintains that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality and safety for the patient and reducing growth in health care spending, which we assert are directly related objectives. We therefore feel that to move beyond the SGR, repeal must be followed by a period of stability in which bundled payments and other models can be

tested and implemented, all the while keeping the focus on quality to improve value and lower cost.

Stable Transition Period

The first step toward reforming the Medicare payment formula is to immediately eliminate the SGR and set a realistic budget baseline for future Medicare payment updates. This baseline should allow for updates that fairly reflect the costs of providing quality health care and are sufficient to preserve the patient-physician relationship and ensure patients have continued access to the physician of their choice. Following the elimination of the SGR, we believe it is essential to provide a transition period of up to five years that would allow for the testing, development and future implementation of a wide range of alternative payment models aimed at improving quality and increasing the integration of care.

During the transition period, we propose that Congress replace the SGR with a system of separate service category growth rates (SCGR) that recognizes the unique nature of the various types of services that physicians provide to their patients, while allowing for increased payments for areas experiencing workforce shortages such as primary care. Unlike the SGR, which bases reimbursement on the overall spending on all physician services, the SCGR would establish a system that determines reimbursement based on the spending and volume growth among like services. The College believes that the SCGR would have distinct advantages as a transition model to more innovative reforms. First of all, it recognizes that all

physician services are not alike, and lower growth services, such as primary care and surgery, would no longer simply be subject to the blunt cuts of the SGR. Second, under the SCGR, efforts to promote specific services would be greatly simplified. Under the proposal for example, payments for primary care could be increased without requiring corresponding Medicare cuts for other services. Most importantly, the SCGR would support efforts to promote improved quality and safety leading to better value by recognizing that these goals will look different and will be achieved in different ways for different services. Also, as Medicare studies various payment models, the SCGR could enable Congress and CMS to study and better understand how these physician quality improvement efforts affect spending for hospitals, skilled nursing, home health and other service areas in the Medicare program. In addition, the SCGR could also provide a mechanism to study alternative payment mechanisms.

Testing and Implementation of New Models

The College strongly believes that a new delivery system must focus on promoting safe, high quality care and improving patient access while reducing cost. A partnership among patients, physicians, hospitals, and payers is essential to developing a successful delivery system. The testing, development, and future implementation of a wide-range of alternative payment models such as accountable care organizations (ACOs) and the bundling of payments for care received from various providers for a particular condition over a set period of time is critical to

reaching these goals. We believe that in order for any alternative payment model to be successful it must:

- Ensure that quality and safety are the highest priorities for patient care
- Require that specific quality metrics are achieved before any savings can be shared among payers or providers
- Structure payment models to work in concert with and align incentives with proven quality improvement programs
- Appropriately adjust for risk factors and variability that may impact cost of care or treatment, including age, health status, and other factors
- Maintain primacy of physician-leadership within a highly qualified team of health care professionals to work with patients in determining evidence-based courses of clinical care
- Acknowledge that surgical care is delivered in a variety of geographical locations and facilities and that innovative responses may be required to address patient needs in urgent or unique situations
- Preserve the ability of a surgeon to recommend the surgical treatment plan that best meets the patient's needs as guided by best practices and evidence-based medicine
- Ensure clearly-defined mechanisms for appropriate distribution of shared risk and savings among patients, physicians, and health care team members

One area that the College is currently analyzing is the role of surgery in bundled payments. The primary goal of a bundled payment model is to improve the

quality and coordination of patient care through the alignment of financial incentives of surgeons and hospitals. One approach to bundled payment combines the payments of surgeons and hospitals for a defined episode of inpatient surgery into one single fee. Instead of being paid for each visit or service, surgeons and hospitals would be paid for all services provided to a patient related to a particular procedure or condition, depending on how the episode is structured.

The College believes that a bundled payment model could foster greater coordination and improvement in quality of care, which could lead to greater efficiency and a reduction in cost. Accordingly, we are studying the process and the feasibility for creating bundles around surgical episodes of care. The criteria for choosing ideal surgical procedures to bundle include, but are not limited to, procedures that are elective, high volume, and/or high expenditure, and that can be risk-adjusted, and for which relevant evidence-based or appropriateness criteria exist. In order to maximize the opportunity for a bundle to improve quality and reduce cost, the bundle would likely combine both the payment to the hospital and the payment to all physicians who provide care to the patient for the chosen bundled procedure. Although the National Pilot Program on Payment Bundling, as set forth in the *Patient Protection and Affordable Care Act*, defines an episode as beginning three days prior to and ending 30 days post-discharge, it is unclear whether this timeframe would be appropriate for all potential surgical bundles. In addition, for a bundled payment model to be successful, certain safeguards must be included, such as ensuring quality patient care and physician-led decision making about how and to who bundled payments are distributed.

The College is examining these and other issues related to the creation of surgical bundles of care. We support efforts to coordinate patient care, improve quality, reduce adverse events, and thereby reduce costs, and we view bundled payment as a potential opportunity to further this goal.

Continuous Quality Improvement

Finally and most importantly, the College strongly believes that improving quality and safety offers the best chance of transforming our health care system in a way that expands access and improves outcomes while slowing the accelerating cost curve. Quite simply, improving quality leads to fewer complications, and that translates into lower costs, better outcomes and greater access. With the right approaches, we *can* both improve the quality of patient care and, at the same time, reduce health care costs.

The College has proven physician-led models of care that have allowed us to use strong data to measure and improve surgical quality, increase the value of health care services and reduce costs. For nearly 100 years, the American College of Surgeons has led national and international initiatives to improve quality in hospitals overall, as well as the more specific fields of trauma, bariatric surgery, cancer and surgical quality. These initiatives have been shown to significantly reduce complications and save lives.

Complex, multi-disciplinary care – such as surgical care – requires a commitment to continuous quality improvement. Surgeons have a long history of developing standards and holding themselves accountable to those standards. Four years after ACS was founded in 1913, leaders such as pioneering surgeon Earnest Codman of Boston helped to form the Hospital Standardization Program in 1917, which became The Joint Commission in 1951. Dr. Codman believed it was important to track patient “end results” and use those results to measure care, learn how to improve care and set standards based on what was learned.

Since then, the College has helped establish a number of key quality programs, including the Commission on Cancer in 1922, the Committee on Trauma in 1950, the American College of Surgeons Oncology Group in 1998, the National Surgical Quality Improvement Program or “ACS NSQIP” in 2004, and the National Accreditation Program for Breast Centers and the Bariatric Surgery Center Network Accreditation Program, both in 2005.

Based on the results of our own quality programs, we have learned that there are four key principles required for any successful quality program to measurably improve the quality of care and increase value. They are:

- Setting appropriate standards
- Building the right infrastructure
- Using the right data to measure performance

- Verifying the processes with external peer review

Establishing, following and continuously improving **standards** and best practices is the core for any quality improvement program. Standards must be set based on scientific evidence so that surgeons and other care providers can choose the right care at the right time given the patient's condition. It could be as fundamental as ensuring that surgeons and nurses wash their hands before an operation; as urgent as assessing and triaging a critically injured patient in the field; or as complex as guiding a cancer patient through treatment and rehabilitation.

The right **infrastructure** is absolutely vital in order to provide the highest quality care. Surgical facilities must have in place appropriate and adequate infrastructures, such as staffing, specialists and equipment. For example, in emergency care, we know hospitals need to have the proper level of staffing, equipment such as CT scanners, and infection prevention measures such as disinfectants and soap dispensers in the right quantity and in the right locations in their emergency departments. If the appropriate structures are not in place, the risk for the patient increases. Our nation's trauma system is an example of the importance of having the right infrastructure in place. The College has established trauma center standards for staffing levels and expertise, processes, and facilities and equipment needed to treat seriously injured patients. Trauma centers are independently verified by the COT and receive a Level I, II, III or IV designation, based on the care they are able to provide. Ideally, the most challenging cases are immediately rushed to the nearest Level I or Level II center. There is good scientific

reason for this: Patients who receive care at a Level I trauma center have been shown to have an approximately 25 percent reduced mortality rateⁱ.

We all want to improve the quality of care we provide to our patients, but hospitals cannot improve quality if they cannot measure quality, and they cannot measure quality without valid, robust **data**. The College has learned that surgeons and hospitals need data strong enough to yield a complete and accurate understanding of the quality of surgical care. This data must also be comparable with that provided by similar hospitals for similar patients. Therefore, it is critical that quality programs collect information about patients before, during and after their hospital visit in order to assess the risks of their condition, the processes of care and the outcome of that care. Patients' clinical charts – not insurance or Medicare claims – are the best source for this type of data.

The fourth principle is to **verify**. Hospitals and providers must allow an external authority to periodically verify that the right processes and facilities are in place, that outcomes are being measured and benchmarked, and that hospitals and providers are doing something in response to what they find out. The best quality programs have long required that the processes, structures and outcomes of care are verified by an outside body. The College has a number of accreditation programs that, among other things, offer a verification of standards that help ensure that care is performed at the highest levels. Whether it is a trauma center maintaining its verification as Level I status or a hospital's cancer center maintaining its accreditation from CoC, the College has long stressed the importance of review

by outside authorities. Undoubtedly, increased emphasis on such external audits will accompany efforts to tie pay to performance and to rank the quality of care provided.

Together, these principles form a continuous loop of practice-based learning and improvement in which we identify areas for improvement, engage in learning, apply new knowledge and skills to our practice and then check for improvement.ⁱⁱ In this way, surgeons and hospitals become learning organisms that consistently improve their quality – and, we hope, inspire other medical disciplines to do so as well.

ACS NSQIP is built on these principles. The NSQIP program, which has its history in the Veterans Health Administration, is now in more than 400 private sector hospitals around the country. NSQIP uses a trained clinical staff member to collect clinical, 30-day outcomes data for randomly selected cases. Data is risk adjusted and nationally benchmarked, so that hospitals can compare their results to hospitals of all types, in all regions of the country. The data is fed back to participating sites through a variety of reports, and guidelines, case studies and collaborative meetings help hospitals learn from their data and implement steps to improve care.

ACS NSQIP hospitals have seen significant improvements in care; a 2009 *Annals of Surgery* study found 82 percent of participating hospitals decreased complications and 66 percent decreased mortality rates. Each participating hospital prevented, on average, from 250 to 500 complications a year.ⁱⁱⁱ Given that major

surgical complications have been shown in a University of Michigan study to generate more than \$11,000 in extra costs on average, such a reduction in complications would not only improve outcomes and save lives, but greatly reduce costs.

If ACS NSQIP can be expanded to the nation's more than 4,000 hospitals that perform surgery we could prevent millions of complications, and save thousands of lives and billions of dollars each year. ACS NSQIP's success will require collaboration from the broader surgical community; other providers, including hospitals; healthcare policy experts; and government officials and elected representatives. We need to get ACS quality programs into more hospitals, more clinics and more communities.

Implementation of the *Patient Protection and Affordable Care Act* is intensifying the focus on quality by requiring hospitals and providers to be increasingly accountable for improving care through measurement, public reporting and pay-for-performance programs. By taking an outcomes-based approach that relies on setting and following standards, establishing the right infrastructure, collecting the right data and outside verification, we have shown that complications and costs can be reduced and care and outcomes improved on a continual basis.

The College welcomes the focus on quality and believes it offers an extraordinary opportunity to expand the reach of our programs and, most importantly, puts the country's health care system on a path towards continuous

quality improvement. The evidence is strong: We *can* improve quality, prevent complications and reduce costs. That's good for providers and payers, government officials and taxpayers. Most of all, that's good for patients.

Thank you once again, Mr. Chairman, for the opportunity to offer the College's comments and views. It is the College's position that controlling health care costs in Medicare should be achieved not through methods that would endanger patients' access to care, but through improving quality and value. I would be pleased to answer any questions.

ⁱ The National Study on Costs and Outcomes of Trauma, published in the Journal of Trauma; Injury, Infection and Critical Care, by Ellen Mackenzie, et al. December 2007

ⁱⁱ Sachdeva AK, Blair PG. Educating surgery resident in patient safety. Surgical Clinics of North America 84 (2004) 1669-1698.

ⁱⁱⁱ Hall BL, et al. "Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program." Ann Surg. 2009; 250:363-376.