



Statement
of the
American College of Surgeons

Committee on Ways and Means
U.S. House of Representatives

**Health Reform in the 21st Century:
Reforming the Health Care Delivery System**

April 1, 2009

The American College of Surgeons (ACS) commends Chairman Rangel and the Committee on Ways and Means for holding this hearing on “Health Reform in the 21st Century: Reforming the Health Care Delivery System.” On behalf of its more than 74,000 members, the ACS appreciates the opportunity to present this statement for the record.

Today’s hearing 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 10 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.

This hearing today 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 the ACS’s successful surgical quality improvement efforts. For example, the ACS National Surgical Quality Improvement Program (NSQIP) started with a successful effort within the Department of Veterans Affairs, which decreased VA post-surgical mortality by 27 percent and post-operative complications by 45 percent over 10 years. 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 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 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 220 hospitals nationwide. The program has received wide recognition as a successful model for surgical quality improvement and the Joint Commission acknowledges the value of participation in ACS NSQIP and includes 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 breast and colorectal cancers. These measures are endorsed by the National Quality Forum. Since 1995, it 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. Medical evidence has shown that the care and treatments delivered within the first hour of a severe injury, known as the "golden hour," are likely to mean the difference between temporary and permanent disabilities, as well as between life and death. 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 the 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 a report published by the Agency for Healthcare Research & Quality (AHRQ), 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 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 quality improvement program, paralleling the efforts with ACS NSQIP.

Through these quality improvement 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. 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.

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). The hope for patients in these systems is that they will receive 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 health 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, public or private, to deny a patient access the best clinical care available—whether or not 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.

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 Rangel and Subcommittee Chairman Stark 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 the Relative Value Scale, 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 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.

The ACS looks forward to working with this Committee 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.