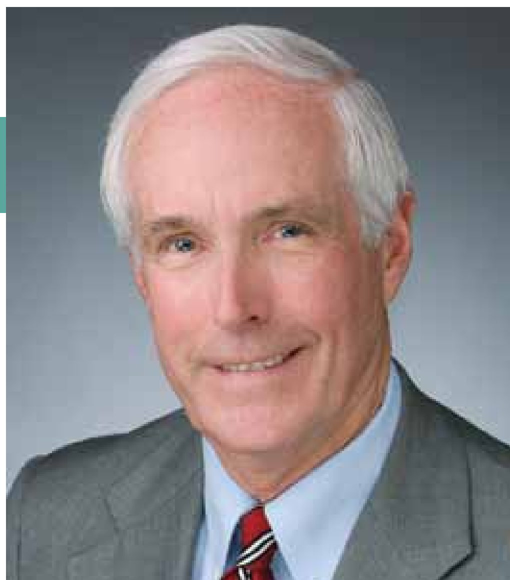
From my perspective



As anticipated, President Barack Obama has moved quickly regarding the development of plans to reform the U.S. health care delivery system. Related provisions in the American Recovery and Reinvestment Act (ARRA) of 2009 and in the President's budget proposal could significantly alter the way in which surgeons run their practices and are reimbursed for their services. Hence, the College has offered swift and proactive responses to these plans for change.

> **"The College promptly issued a press release responding to the budget plan, applauding efforts to address Medicare's broken physician payment system and the overarching goals of expanded access, improved quality, and reduced spending growth."**

Research and HIT

The ARRA, also known as the economic stimulus package, contains several provisions pertaining to health care, most of which are centered on advancements in research and technology. The American College of Surgeons' advocacy staff and consultants examined this bill before Congress passed it, and I submitted comments to House Speaker Nancy Pelosi (D-CA) and Senate Majority Leader Harry Reid (D-NV) outlining our position.

To begin, the ARRA contains considerable language pertaining to "comparative effectiveness research" (CER), which is defined as (1) comparative analysis of items, services, and procedures used to prevent, diagnose, and treat illness; and (2) work conducted through clinical registries, clinical data networks, and other electronic means for purposes of generating outcomes data. The Act states that a significant portion of the $1.1 billion in CER funding—$400 million—is to be used to "accelerate the development and dissemination of CER."

The College largely supports the law's allocation of funds to speed efforts to compare clinical outcomes in an unbiased manner. Furthermore, the ACS is pleased to note that the information gathered and examined through a newly established Federal Coordinating Council for CER will not be used, as stated in the Act, to "mandate coverage, reimbursement, or other policies for any public or private payer."

To further advance outcomes research as a means of promoting safer, higher-quality, better-coordinated care, the law invests $20 billion in the health information technology (HIT) infrastructure, including the expansion of existing clinical registries and quality improvement tools. The College has requested that some funds be allocated to the ACS National Surgical Quality Improvement Program—the only risk-adjusted, validated instrument for measuring surgical outcomes.

The legislation also provides financial assistance to physicians for the acquisition and implementation of HIT. The ACS supports Medicare and Medicaid bonus payments of $40,000 to $65,000 through 2016 to physicians who switch to interoperable electronic medical records (EMRs). Nonetheless, we have concerns about making the availability of these funds contingent on participation in a quality improvement program, and we have reminded lawmakers that the adoption of interoperable HIT may precede an individual's ability to participate in a reporting system.

Because surgeons who fail to comply with the new HIT requirements by 2015 will be penalized—a mandate that the ACS opposed—the College urges its members to put modernized record-keeping systems into place as soon as possible.

The ACS Committee on Informatics recommends consulting with the Certification Commission for Healthcare Information Technology (CCHIT), (*http://www.cchit.org*). CCHIT is an independent, not-for-profit organization that defines a set of functions for EMR systems and certifies products that meet those levels of functionality.

Insurance and payment reforms

Soon after the President signed the ARRA, his Administration released its fiscal year 2010 budget proposal, which seeks to create a $634 billion reserve fund over the next decade to finance expanded health insurance coverage and other health care investments. Approximately half of the reserves would be generated by increasing taxes on couples filing jointly who earn more than $250,000 annually and on individuals earning more than $200,000 per year. The remainder of the funding would be derived from Medicare and Medicaid savings.

Of particular relevance to physicians, the budget proposal includes $329.6 billion "to account for additional expected Medicare physician payments" over the next 10 years. If adopted by Congress, these funds would effectively eliminate the deficit in Medicare physician payments as well as scheduled payment cuts of 40 percent over the next seven years.

Furthermore, the budget package iterates the Administration's willingness to "support comprehensive, but fiscally responsible, reforms to the payment formula." Importantly, the proposal signals a willingness to modify the sustainable growth rate formula and to move toward a system in which physicians are rewarded for providing high-quality care.

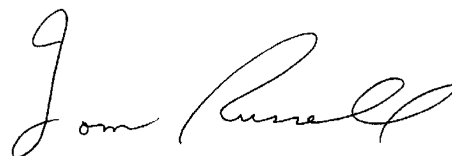
Included in the Medicare and Medicaid savings proposals are restrictions on physician-owned hospitals and requirements for the use of radiology benefits managers. Other provisions aimed at reducing Medicare spending are as follows: competitive bidding for Medicare Advantage plans, bundled payments for hospital and post-acute care services, reduced payment for hospital readmissions, reduced payment for home health services, increased Medicaid drug rebates, increased Part D drug premiums for higher income beneficiaries, and Medicare program integrity efforts.

The American College of Surgeons promptly issued a press release responding to the budget plan, applauding efforts to address Medicare's broken physician payment system and the overarching goals of expanded access, improved quality, and reduced spending growth. We affirmed our willingness to work with the Administration on meaningful adjustments to the current physician payment system. We also stated our belief that health care reform should encourage and reward surgeons for choosing the optimal treatment and should reduce spending by eliminating waste and inefficiencies.

A new era

At press time, Congress had just begun its review of President Obama's budget proposal, and the College has been at the table for key deliberations, including small stakeholder meetings with the Senate Committees on Finance and Health, Education, Labor, and Pensions. Most likely, lawmakers will markedly change the budget proposal before it passes as legislation. Nonetheless, we clearly are entering a new era in the delivery of health care services—one in which there will be considerable emphasis on outcomes reporting, the use of interoperable EMRs, bundled payments, and coordinated care.

Some surgeons have contacted me to voice their concerns about the proposed reforms and the means of financing these changes. Although their frustrations are understandable, this organization would be ill-served if we focused solely on areas of disagreement. To help the College advance its mission of providing optimal care to surgical patients, we intend to continue to offer proactive responses as new policies are developed and to be a constructive participant in efforts to create a more sustainable, high-quality health care system.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.