



## AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
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May 22, 2017

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee  
United States Senate  
104 Hart Office Building  
Washington, D.C. 20510

Dear Chairman Hatch:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we thank you for this opportunity to provide stakeholder input on efforts to reform the health care system. The ACS remains committed to working in a bipartisan manner with Congress and the new administration to improve the current health care system ensuring that all patients have coverage and access to high-quality surgical care. As the Senate considers making changes to the health care landscape, the ACS stands by our four key principles on health care reform (see attached document) and feels strongly that any health care reform legislation should include provisions that provide for:

- Quality and Safety
- Patient Access to Surgical Care
- Reduction of Health Care Costs
- Medical Liability Reform

### Quality and Safety

The ACS has a multi-faceted approach to enhancing quality and safety in health care worldwide. The cornerstone of the College's work focuses on our model of setting standards, building the delivery infrastructure to enable implementation of these standards, using clinical registries to measure performance and guide improvement, and assuring patients and the public at large with peer-reviewed verification programs. Scientific evidence shows that providing safe and effective quality surgical care helps to reduce the cost of health care delivery.

Our educational efforts drive quality improvement and safety and support the surgeon's lifelong learning needs to optimally serve their patients. Toward the

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satisfaction of this principle, the ACS supports and urges Congress to ensure that any effort directed at health care include provisions for:

- Well-designed clinical comparative effectiveness research
- Collection of meaningful, quality data with appropriate public reporting
- Adoption and utilization of truly interoperable health information technology (HIT)

### **Patient Access to Surgical Care**

The ACS has a long-standing policy supporting universal access to affordable, high-quality surgical care delivered in a timely and appropriate manner. It is the impact upon this principle that has caused the majority of our concern in the current health care reform debate. Our concerns are encapsulated in the following:

- Medicaid expansion has served to provide coverage for millions of previously uninsured Americans. Therefore, the ACS believes any efforts directed at health care reform must ensure these Americans maintain their coverage and the safety net upon which they depend.
- The ACS believes strongly that legislation should not facilitate a reduction in the number of Americans currently insured.
- The ACS support the essential health benefits included in the Affordable Care Act and therefore, has concerns with any efforts to reduce or eliminate these requirements as that may impede access to surgical care.
- The ACS also strongly supports the preservation of coverage for individuals with pre-existing conditions and the prohibition of the imposition of lifetime or annual maximums on coverage policies.

### **Reduction of Health Care Costs**

Through a process of continuous improvement, the ACS quality programs improve surgical care and cut costs by assisting in efforts to both reduce inefficiencies and prevent complications. The ACS is also a strong advocate for and an active participant in the numerous efforts toward quality-based payment reform. The most current, compelling example of such is the significant effort the ACS has undertaken in the development and testing of advanced alternative payment models (APMs). Going forward, the ACS believes that health care reform should take into account the following:

- Implementation of new alternative payment models should be accomplished in a manner that preserves a viable surgical workforce by

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providing fair and appropriate reimbursement, makes participation voluntary on the part of the provider, ensures that potential rewards for providing high quality, high value care are fair and achievable, and that the potential downside risks are not unreasonably great.

- While possibly not amenable to remedy under the budget reconciliation process, the ACS strongly supports the repeal of the Independent Payment Advisory Board (IPAB). The ACS firmly believes that it is the responsibility of Congress to establish Medicare payment policy and that such should not be delegated to an unelected and therefore, unaccountable body. Further, any binding mandates promulgated relative to Medicare reimbursement should be fairly constructed and applicable to the entire spectrum of health care providers.
- Acknowledging that addressing the following are also not likely permitted under budget reconciliation procedures, the ACS nonetheless points out that amending the Stark physician self-referral laws and the federal antitrust laws and/or regulations would facilitate provider collaboration and enhance innovation in the development of APMs.

### **Medical Liability Reform**

The mission of the ACS is to improve the care of the surgical patient, safeguard standards of care, and create an ethical practice environment. In addition, the ACS believes our nation's medical liability system is broken and fails both patients and physicians. Because medical liability reform helps to reduce costs to the health care system and improves access to care, the College continues to advocate for traditional reforms where appropriate and feasible and actively supports any reform based on safety, quality, and accountability. Accordingly, the ACS advocates that the ongoing health care reform effort should:

- Incorporate substantive medical liability reform and that even limited reforms, such as protections for physicians volunteering services across state lines in a disaster or a local or national emergency situation or the provision of federal tort claims act protections to those providing EMTALA mandated care would help to provide much needed relief.

The ACS thanks the Committee for the opportunity to provide input as the Senate develops health reform legislation. As acknowledged above, we recognize that some of the proposed steps may need to be undertaken outside of the budget reconciliation process, but we are hopeful that all will be part of continuing efforts. The ACS looks forward to continuing to work with Congress as it considers health reform legislation to protect timely and

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appropriate access to high-quality health care, including surgery. If you have any questions, please contact Mark Lukaszewski in the ACS Division of Advocacy and Health Policy at [mlukaszewski@facs.org](mailto:mlukaszewski@facs.org) or 202-337-2701.

Sincerely,

Courtney M. Townsend, Jr., MD, FACS  
ACS President

Michael J. Zinner, MD, FACS  
ACS Chair, Board of Regents

David B. Hoyt, MD, FACS  
ACS Executive Director

Marshall Z. Schwartz, MD, FACS  
Chair, Health Policy Advocacy Group

*Attachment*

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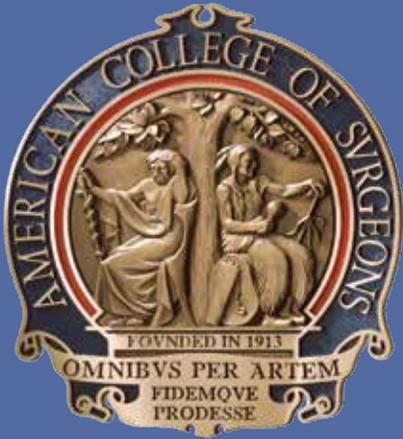
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## American College of Surgeons 2017 statement on health care reform

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.

—ACS Mission Statement

The American College of Surgeons (ACS) is the largest surgical organization in the U.S., representing more than 80,000 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 U.S. Although the ACS appreciates the challenges facing the U.S. health care system, the organization also emphasizes that many aspects of surgical health care in the U.S., including surgical education and training, are the best in the world.

The ACS 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 health care.

To this end, in any health care reform bill, the ACS strongly supports four core principles:

- Quality and safety
- Patient access to surgical care
- Reduction of health care costs
- Medical liability reform

Achieving these goals and building a better health care delivery system will require all stakeholders to work together.

## Quality and safety

The ACS has a multifaceted approach to enhancing quality and safety in health care worldwide. The cornerstone of this effort focuses on our clinical registries and our educational efforts to drive quality improvement 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 registries are built with scientific rigor, using standards and critical audit functions to ensure that surgeons and patients have valid, reliable information upon which to base health care decisions and drive improvement. College registries include the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and clinical databases focused on pediatrics, bariatrics, breast disease, cancer, trauma, as well as the Surgeon Specific Registry.™ The ACS education, improvement, and verification programs are broadly applied using the registries for their supporting infrastructure.

ACS NSQIP, for example, represents a nationwide effort to use risk-adjusted tools to improve surgical care and cut costs. This program helps to prevent thousands of surgical complications each year, which, in turn, reduces costs. These achievements have been recognized by the National Academy of Medicine, the National Quality Forum, and The Joint Commission.

### Physician quality data

The Centers for Medicare & Medicaid Services (CMS) quality programs have evolved under the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) into two major programs: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The ACS maintains that performance measurement is important in establishing value-based care for patients in both payment programs. Performance

measurement should focus more on patient safety than on surgeons adequately attaining participation thresholds in CMS payment programs. The ACS supports CMS and all payors in their efforts to align their quality programs with individual patient needs and goals of care. The ACS sent a cautionary message to CMS with regard to the use of outcome measures. Outcome measures are an invaluable tool in driving improvement, but they lack the statistical capabilities for discerning differences among individual surgeons for the purposes of payment differentiation or public reporting. Outcome measures, when used, should be risk adjusted and stratified and used to assist in developing quality improvement initiatives.

The ACS supports defining performance measurement within episodes of care using phases of care to define the foci for measurement. For example, the surgical phases of care are as follows: surgical preoperative evaluation and preparation, immediate preoperative readiness, perioperative, intraoperative, postoperative, and post-discharge. The ACS recommends use of high-value process measures and directed patient-reported outcome measures that are consistent with the goals of surgeons and their patients for each specific episode of care.

The ACS supports quality, safety, and related performance measurement that meets the following standards:

- Is actionable, reliable, and voluntary
- Seeks to reduce the administrative burden of data collection from physicians
- Provides positive incentives for participation
- Provides access to data in a timely manner
- Has a reasonable appeals process

Furthermore, the ACS believes that Congress should:

- Publicly release quality reports only after further evaluation and improvements occur to ensure that the reports are valid
- Provide additional federal funding to assist in the development of clinical data registries and other quality improvement tools

### Patient access to surgical care

The ACS has a longstanding policy of supporting universal access to affordable, high-quality, safe surgical care delivered in a timely and appropriate manner. Achieving universal access to such care requires that our nation maintain a well-trained and available surgical workforce to meet the needs of all surgical patients. The shortage of surgeons in several surgical specialties in many areas of the country jeopardizes patient access to timely, high-quality surgical care.

### Surgical workforce and access to surgical care

- Existing legislation should be modified to allow for growth of surgical and other specialties as demand for service dictates. For more detailed recommendations, see the January 2017 ACS Policy and Position Paper on Graduate Medical Education Reform.\*
- Deliberate efforts should be undertaken to increase the number of women and minorities training in graduate medical education programs.
- Nonphysician providers may serve as extenders to augment and facilitate the efforts of surgeons but cannot and should not replace them.
- Congress should include those surgical specialties with documented workforce shortages, such as

\*American College of Surgeons. ACS Policy and Position Paper on GME Reform. January 2017. Available at: [facs.org/~media/files/advocacy/workforce/2017\\_ahp\\_gmepaperappendixprimer.ashx](https://www.facs.org/~media/files/advocacy/workforce/2017_ahp_gmepaperappendixprimer.ashx). Accessed April 4, 2017.

general surgery, in the loan forgiveness programs of the National Health Service Corps.

### Medicaid

- The expansion of Medicaid provides coverage for millions of previously uninsured Americans. Any further efforts directed at health care reform must ensure that these Americans keep their coverage and that the safety net upon which they depend is preserved.
- Medicaid is the single largest children's health insurance program, covering more than one in four children. It must continue to support these vulnerable children.
- Medicaid should reimburse physicians at levels equal to those of Medicare.

### Ensuring equal access to quality surgical care for children

- Funding for the Children's Health Insurance Program expires in September of 2017. The reauthorization and appropriation of funds for this program is vital to ensuring that eligible children have coverage and access to surgical care.

### Insurance reform

- The ACS supports preserving coverage for those individuals with pre-existing conditions.
- The ACS supports continuing to preclude lifetime maximums on coverage policies.
- Reforms must address issues of reducing costs, improving coverage, and relieving administrative burdens.

### Ensuring responsible physician ownership

- 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 remove the restriction on physicians owning and expanding 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.

### Reduction of health care costs

- 38 | Provision of appropriate, high-quality, safe, and cost-effective patient care should begin with defining unwarranted, unnecessary, high-cost care. Surgeons should reduce unwarranted variation in order to preserve quality while optimizing resource use. Efforts to promote value-based risk models linking quality and optimal cost should encourage rewards and limit penalties. Further, optimal care should encourage patient engagement in shared decision making. Patients require education and support in fulfilling their individual role in the maintenance of health and well-being. These efforts should promote access to appropriate and compassionate care for all.

### Advanced APMs

- The ACS supports efforts (including MACRA provisions) aimed at allowing more physicians to voluntarily participate in APMs such as shared savings programs, bundled payments, accountable care organizations, and episode-based payments where containment of cost is linked to improvements in care.
- The ACS has expended significant time and resources to ensure that surgeons have viable opportunities to participate in these models, including the development of the ACS-Brandeis Advanced APM, which was

recently submitted to the Physician-Focused Payment Model Technical Advisory Committee.

- All payment programs should ensure sustainable business models to preserve a viable surgical workforce by providing fair and appropriate reimbursement for surgeons.
- If implemented, participation in value-based payment programs should be tied to quality, involve voluntary participation, possess fair and attainable upside risks and limits on downside risks, and not unduly restrict patient choice.
- Congress must amend the Stark physician self-referral laws and the federal antitrust laws and/or regulations to allow for provider collaboration and flexibility in the development of APMs.

### Commitment to evidence-based guidelines for surgical care

- Clinical practice guidelines (CPGs) based on the best available evidence and recommendations from clinical experts are valuable resources to assist surgeons in implementing evidence-based practice.
- Surgeons need CPGs so that patients can be assured that the best possible outcomes of care will be achieved.
- Well-developed CPGs can be used to eliminate waste and inefficiency wherever possible, including overuse, underuse, and misuse of services.
- Development of CPGs is an expensive and a labor-intensive process that requires periodic revision to ensure accuracy and dependability.
- The ACS is committed to the assessment, development, and promulgation of guidelines that will lead to the best outcomes and the most cost-effective care for patients with surgical disease, so that the full spectrum of care is optimized and coordinated.

### Independent Payment Advisory Board

The ACS supports the repeal of the Independent Payment Advisory Board. The ACS maintains that Medicare payment policy should remain the primary purview of Congress rather than delegated to an unelected, unaccountable governmental body that may minimize input from stakeholders and citizens. Any binding mandates promulgated from such a body that affect reimbursement should be fairly constructed, spread across the spectrum of all health care interests, and not directed at any one sector, such as surgery.

### Process for valuing codes under the physician fee schedule

- The ACS opposes the creation of a duplicative process for determining code values.
- The surgical community supports maintaining the role of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) as the entity through which medical services are valued.
- The RUC continues to be a dynamic body, which makes recommended increases and decreases in the value of codes reimbursed under the Medicare physician fee schedule.
- The RUC has maintained budget neutrality.
- The ACS opposes reassignment of 10-day and 90-day global codes to 0-day, where stakeholder specialties have not requested a change in global codes.
- The ACS opposes use of a reverse building block methodology to revalue codes, which would subtract work values for changes in postoperative visits, unless clear

documentation is available to show that the code value was created using the building block methodology.

- The ACS supports code valuation that uses magnitude estimation to appropriately align codes relative to one another.

### Medical liability reform

In accordance with the “Statement on medical liability reform” developed by the ACS Legislative Committee and approved by the Board of Regents in October 2014,<sup>†</sup> the ACS actively supports the following:

- Reforms based on safety, quality, and accountability
- Continued advocacy for traditional reforms where appropriate and feasible
- Legislation that eases structural barriers to implementation of patient-centered reforms, specifically with respect to National Practitioner Data Bank reporting requirements and apology laws
- Culture change among hospitals and providers to embrace swift adoption of alternative patient-centered reforms, including communication and resolution programs (CRPs)

Meaningful medical liability reform would reduce health care costs and improve patient access to care, as demonstrated by the following examples:

- Before taking legislative action in 2008, Texas ranked 48th out of 50 states in terms of physician workforce, averaging 152 physicians per 100,000 population in contrast to the national average of 196.
- After passing strong medical liability reforms in 2008, Texas received more than 4,000 physician licensure applications compared with 2,500 received in 2002.

<sup>†</sup>American College of Surgeons. Statement on medical liability reform. *Bull Am Coll Surg*. March 2015. Available at: [bulletin.facs.org/2015/03/statement-on-medical-liability-reform/](http://bulletin.facs.org/2015/03/statement-on-medical-liability-reform/). Accessed April 10, 2017.

Included were 162 orthopaedic surgeons and an additional 49 neurosurgeons.

- A report by the Congressional Budget Office concluded that a medical liability reform package, including a \$250,000 cap on noneconomic damages would reduce federal budget deficits by roughly \$57.1 billion over the next 10 years.
- The medical liability crisis has contributed to a maldistribution of physicians.

The ACS maintains that our nation's medical liability system is broken and that it fails both patients and physicians. Less than 3 percent of patients who sustain medical injury sue for monetary compensation. Furthermore, in 37 percent of all closed liability claims, no error was discovered. In addition, the present liability system costs an estimated \$100 billion annually. The system is costly, inefficient, and the process of compensating injuries related to medical errors is inaccurate.

The mission of the ACS is to improve the care of the surgical patient, safeguard standards of care, and create an ethical practice environment. The College is a proven leader in patient safety through initiatives such as ACS NSQIP. The failing medical liability process jeopardizes the public's trust in the health care system and threatens to undermine the successes that the ACS has achieved. Therefore, the ACS will continue to lead the way by advancing practical reforms that improve patient safety and provide quality health care.

Beyond traditional legislative remedies, the medical liability system is in need of transformative change that focuses less on monetary reparations and more on patient safety, quality care, and provider accountability. Adverse events should be approached with open communication and recognition that an unfortunate outcome is not synonymous with negligence. Compensation for injured patients, monetary or otherwise, should be fair and timely without the unnecessary delay commonly associated with the current tort process. Hospitals should pursue system-level changes that

assure patients of quality care and that prevent event recurrences. Ultimately, negligent providers should be held accountable.

Alternative, patient-centered solutions to liability reform have received varying degrees of attention. Health courts, enterprise liability, and alternative dispute resolution can be crafted around patient-centered principles and also provide excellent opportunities for reform. However, on balance, disclosure and offer programs, otherwise known as CRPs, show great promise for promoting a culture of safety, quality, and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation. Whereas any of these alternatives would represent an improvement over the status quo for both patients and providers, they should be explored through additional research and advocacy. In addition, structural barriers to implementation, such as obsolete reporting requirements to the National Practitioner Data Bank and inconsistent apology protections, must be addressed.

Thus, the ACS believes that incorporating medical liability reform is essential in any comprehensive health care reform effort and supports the following:

- Provisions modeled after the laws in California (specifically the Medical Injury Compensation Reform Act, also known as MICRA) or Texas, which include reasonable limits on noneconomic 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 a local or national emergency situation ♦