Statement of the
American College of Surgeons

Presented by

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before the
Senate Finance Committee
United States Senate

RE: Medicare Physician Payments: Perspectives from Physicians

July 11, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, on behalf of the more than 78,000 members of the American College of Surgeons (ACS or the College), I wish to thank you for inviting the College to participate in today's roundtable. The ACS appreciates your recognition that the current Medicare physician payment system and its sustainable growth rate (SGR) formula are fundamentally flawed and we wish to be a partner in the effort to develop a long-term solution that improves the quality of care while helping to reduce costs. The testimony today will focus on the new ACS Medicare physician payment proposal called the Value Based Update (VBU)[1] and the College's leading efforts in the areas of quality improvement.

I am Frank Opelka, and I am a Fellow of the ACS and 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. Within the ACS, I serve as Assistant Medical Director, and am also the 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.

The College recognizes that developing a long-term solution to the Medicare physician payment system is a challenging, yet essential undertaking, especially given the need to limit the growth in health related spending. The College understands that the current fee-for-service model as the predominant form of physician payment is unsustainable. The ACS asserts that any new payment system should focus on individual patients and populations and rely upon physician leadership to achieve improved outcomes, quality, safety, efficiency, effectiveness, and patient involvement. Improving outcomes and care processes holds promise to reduce the growth in health care spending, complementary objectives that are too often addressed separately.

The ACS has a rich history of quality improvement efforts and our belief is 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. We continue to assert that quality improvement and cost reduction are directly related objectives, and over the past year we have developed our quality improvement principles into the VBU, our Medicare physician payment reform proposal. Our proposal is predicated upon Congress finally addressing the flawed sustainable growth rate (SGR) formula and fully offsetting a permanent repeal. I will caution you that this is still very much a draft proposal, and we look forward to working with Congress and other stakeholders to continue to develop this option.

The Value Based Update Proposal

[1] See attachment for visual depiction of the Value-Based Update (VBU) proposal.

The Value Based Update (VBU) proposal is built upon a few key concepts. The proposal must be patient-centric, flexible, responsive to the changing needs of the health care system, inspired by quality, and be politically viable for all key stakeholders. Specifically, the proposal should:

1. Complement the quality-related payment incentives ***in current law and regulation*** while making necessary adjustments in the current incentive programs to facilitate participation by specialists. This includes the Physician Quality Reporting System (PQRS), e-Prescribing (eRx), and meaningful use requirements for electronic health records (EHR).

2. Incorporate the ***improvement of quality and the promotion of appropriate utilization of care*** into the annual payment updates, first by utilizing existing quality measures but also by developing practice-specific quality priorities and measures in the future.

3. Account for the ***varying contribution of different practices*** to the ability to improve care and reduce costs. To do this we have shifted the focus to the patient and created the concept of Clinical Affinity Groups (CAG), each with its own evidence-based quality measures.

4. And finally, create a mechanism to incentivize the provision of appropriate services that ***primary care*** can bring to the management of an increasingly more complex medical population.[2]

The VBU accomplishes these goals by allowing physicians who successfully participate in CMS quality programs to choose quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU bases performance on carefully designed measures. It also makes sustained investments in primary care in the early phases of implementation.

Implementation of the VBU can be accomplished in four steps: The first is to immediately and permanently repeal the SGR formula, which must be done independent of the VBU. While we are confident in the ability of quality improvement to save funds moving forward, the VBU does not seek to address paying down the accrued debt of the SGR, and therefore the ACS continues to advocate the use of savings in the Overseas Contingency Operations (OCO) account to offset this cost and allow a new system to be implemented.

Other individual physician-level payment adjustments for participation in quality programs including the PQRS, EHR and e-Rx adjustments are left in place and incorporated in further implementation of the VBU. While there is value in these programs, they are by no means perfect. In order for this proposal to proceed as

[2] There are significant physician workforce issues that must be addressed to ensure continued access to care across the country. The ACS believes that we must address these issues as a whole and not pit certain segments against one another.

efficiently as possible, we believe significant changes must be made to each of these programs. We believe there are four areas in which Congress can act swiftly to improve these programs:

1. The payment adjustment year and the performance period MUST be tied closer together to better align behavior changes with payment incentives;
2. Measures specific to specialists must be better incorporated into the programs or those specialists whose measures are not incorporated into the programs should receive exemptions from the payment penalties;
3. The quality measures currently used in the PQRS and EHR Incentive Program must be better aligned in order to prevent duplication and reduce unnecessary administrative burdens; and finally;
4. Incorporate clinical data registries into these programs since current claims data do not provide sufficient insight into the quality of care provided by a physician. Aligning clinical data with improvements to claims data is the most robust path forward toward true quality improvement.

The second phase of implementation approximates the "period of stability," which would grant physicians an opportunity to transition to the new system without the threat of unmanageably steep cuts. Simultaneously, the stability period would allow time for consultation with specialty societies and other stakeholders to properly make the adjustments listed above.

In this phase, the VBU adjustment is implemented based upon overall physician participation in PQRS, HER, *and* e-Rx programs.[3] Physicians who successfully participate in these three programs, in addition to avoiding any associated penalties, will be eligible for both an inflationary adjustment and the VBU adjustment, which, in this phase, will be based solely on the percent of physicians successfully completing the first step. For example, if 90 percent of physicians comply with the PQRS, EHR and e-Rx programs, the VBU adjustment might be 1.5 percent. If only 40 percent comply, that adjustment could be closer to 0.5 percent.[4]

During this phase, in the interest of addressing the unique need for improved patient access to primary care services and because of the availability of relevant quality measures, the primary care/chronic care Clinical Affinity Group will be introduced. Primary care physicians who successfully meet the above mentioned requirements would be eligible receive an additional adjustment of between 0.5 and 1.5 percent based upon quality measures specific to primary and chronic care.

The third phase is essentially a transition period, in which the Clinical Affinity Groups (CAGs) are introduced for all physicians. In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs are the core of this proposal, and might include categories such as cancer care, surgery, cardiac care, frail elderly/end of life, digestive diseases, women's health,

[3] The ACS is also exploring how surgical registries could be integrated in the VBU proposal.
[4] The percentages in our testimony are for illustrative purposes only.

rural and the previously mentioned primary care/chronic care group implemented in the second phase.

Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures will be crafted in close consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own.

Providers will self-select their CAG, providing they meet certain eligibility requirements based on the patients they see and conditions they treat. The Secretary of Health and Human Services will be tasked with creating CAGs and ensuring that there are a sufficient number and variety to accommodate all physicians.

During this phase, physicians will still need to reach the hurdle of successfully participating in the aforementioned CMS quality programs. Those who do will once again be eligible for both VBU and inflationary adjustments. However, the VBU adjustment will now be based upon the average performance of all CAGs, and if these measures were not met, this adjustment could be negative. In the case of a negative VBU adjustment, the MEI increase would also be eliminated.

In the fourth and final phase, physicians would continue to strive to meet both the individual and CAG quality measures, and application of the inflationary MEI update would still be based upon the overall performance in all CAGs. However, providers in each CAG would now have their VBU adjustment applied based on the performance of their specific CAG(s). Furthermore this update could be a blended number based half on national performance and half on the CAG's performance in the provider's Hospital Referral Region to emphasize the importance of local quality improvement efforts. This would allow regional variations in the provision of care to be captured and reflected in each physician's reimbursements.

Once fully implemented, physicians will have the opportunity to select their CAG(s) on an annual basis, and goals can be adjusted regularly to ensure that the quality of care provided to the patient is continuously improving.

Continuous Quality Improvement

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. We offer a caveat – cost reduction cannot be the driving force of change; change must be driven by quality measurement. 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 clinically meaningful data to measure and improve surgical quality, reduce costs, and thereby increase the value of health care services. 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 relevant, timely 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 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 Committee on Trauma 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 rate.

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 must have sufficient relevant data 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. Today, patients' clinical charts – not the current insurance or Medicare claims – are the best source for this type of data. Eventually, capturing the relevant data from electronic health records should enhance accuracy and timeliness.

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 responding appropriately to the findings. 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 the Commission on Cancer, 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. 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 ACS NSQIP program, which has its history in the Veterans Health Administration, is now in more than 400 private sector hospitals around the country. ACS NSQIP uses a trained clinical staff member to collect clinical, 30-day outcomes data for randomly selected cases. Data are 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 are fed back to participating sites through a variety of reports. 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. 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, save thousands of lives, and recoup 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.

Again, while we acknowledge the need to further develop the VBU proposal, we strongly believe in the concept of tying physician Medicare reimbursements to the quality of the care provided as reflected in quality measures that are meaningful and directed specifically at the type of care that a physician provides to his or her patients. We believe that controlling health care costs in Medicare should be achieved not through methods that would endanger patients' access to care[5], but

[5]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 remains vitally concerned 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. In tandem, we

through improving quality and value, and we are confident that the ACS's Value Based Update proposal is a step in that direction. The ACS appreciates the opportunity offered by the Chairman and the committee to share the College's draft proposal and comments about its quality programs.

believe the IPAB and SGR hinder the ability to transition to a new physician payment system; acting as blunt and flawed budgetary axes, and endangering seniors' access to high quality care in the Medicare program.

AMERICAN COLLEGE OF SURGEONS

VALUE BASED UPDATE (VBU) DRAFT PROPOSAL

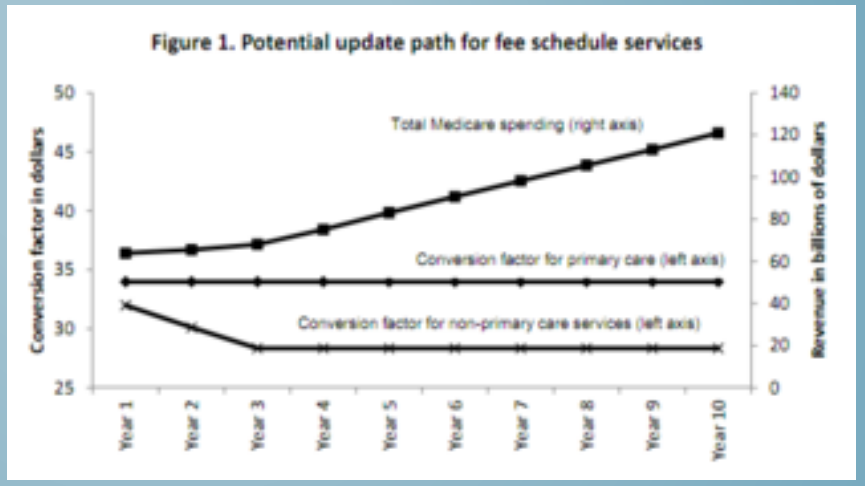
Draft

THE NEED FOR A PROACTIVE ACS PAYMENT REFORM PROPOSAL

Over the last year the ACS has succeeded in promoting the *Inspiring Quality* campaign to illustrate our ability to improve quality and engage patients through ACS initiatives.

The Value Based Update proposal expands this effort to show how we can incorporate quality improvement into payment reform.

THE NEED FOR A PROACTIVE ACS PAYMENT REFORM PROPOSAL



The few concrete proposals to replace the SGR that exist utilize blunt across-the-board cuts to physicians. Most notably, the MedPAC proposal would cut payments to non-primary care physicians by 5.9% each year for three years and then freeze payments at the reduced rate for 7 more years.

PRINCIPLES FOR THE CREATION OF A MEDICARE PAYMENT ALTERNATIVE

(1) Complement the current quality-related payment incentives *in current law and regulation* while making necessary adjustments in the current incentive programs to facilitate participation by specialists

- *PQRS, eRx, EHR, all of which are individual measures*

(2) Develop a model that is immune from the outcome of the Supreme Court case related to the *Affordable Care Act*

- *Payment reform will happen with or without the ACA*

(3) Incorporate the *improvement of quality and the reduction of overutilization* into the annual payment updates

- *1st Phase: utilize existing quality measures*
- *2nd Phase: practice-specific quality measures*

(4) Account for the *varying contribution of different practices* to the ability to improve care and reduce costs

- *Phase in the concept of Clinical Affinity Groups with appropriate quality measures*

(5) Create a mechanism to incentivize the provision of appropriate services that *primary care* can bring to the management of an increasingly more complex medical population

PRINCIPLES FOR THE CREATION OF A MEDICARE PAYMENT ALTERNATIVE

In short . . .

There is a demonstrated need for the ACS to develop an alternative to the SGR that is focused, patient-centric, politically viable, responsive to the changing needs of the health care system, and inspired by quality.

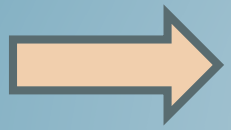
VALUE BASED UPDATE (VBU)
ACS PROPOSAL
DRAFT

STEP 1

- Continues the current individual measure programs under current law
- SGR Formula still exists under current law
- Utility of our proposed Value Based Update is predicated on the removal of the SGR Formula
- The Value Based Update does *not* propose to address paying down the debt of the SGR
- The ACS continues to advocate for paying down the SGR debt by the use of the Overseas Contingency Operations (OCO) funds available to Congress.

Current Law & Regulation

Physician Level Payment Adjustments



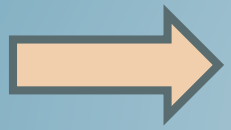
- PQRS
- EHR Meaningful Use
- e-Rx Incentive Program

Program Level Payment Adjustments

Current SGR Formula

STEP 1: REPEAL THE SGR

Physician Level Payment Adjustments



PQRS

EHR Meaningful Use

e-Rx Incentive Program

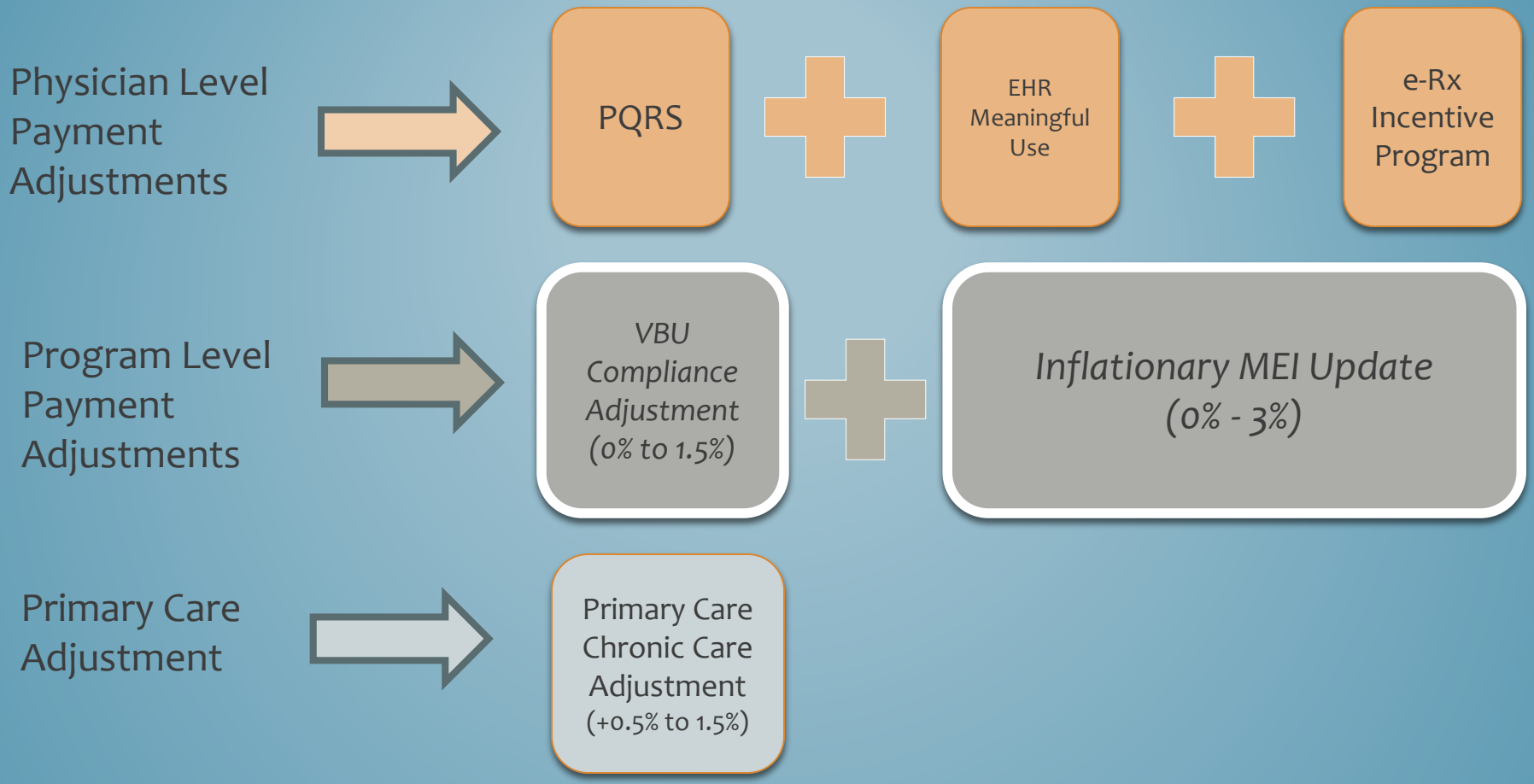
Program Level Payment Adjustments

~~*Current SGR Formula*~~

STEP 2

- Value Based Update linked to compliance with PQRS, EHR, and e-Rx programs
- If compliant, program-level inflationary adjustment of the Medicare Economic Index (MEI) plus VBU adjustment
- Introduces Primary Care Chronic Care Adjustment based on performance measures

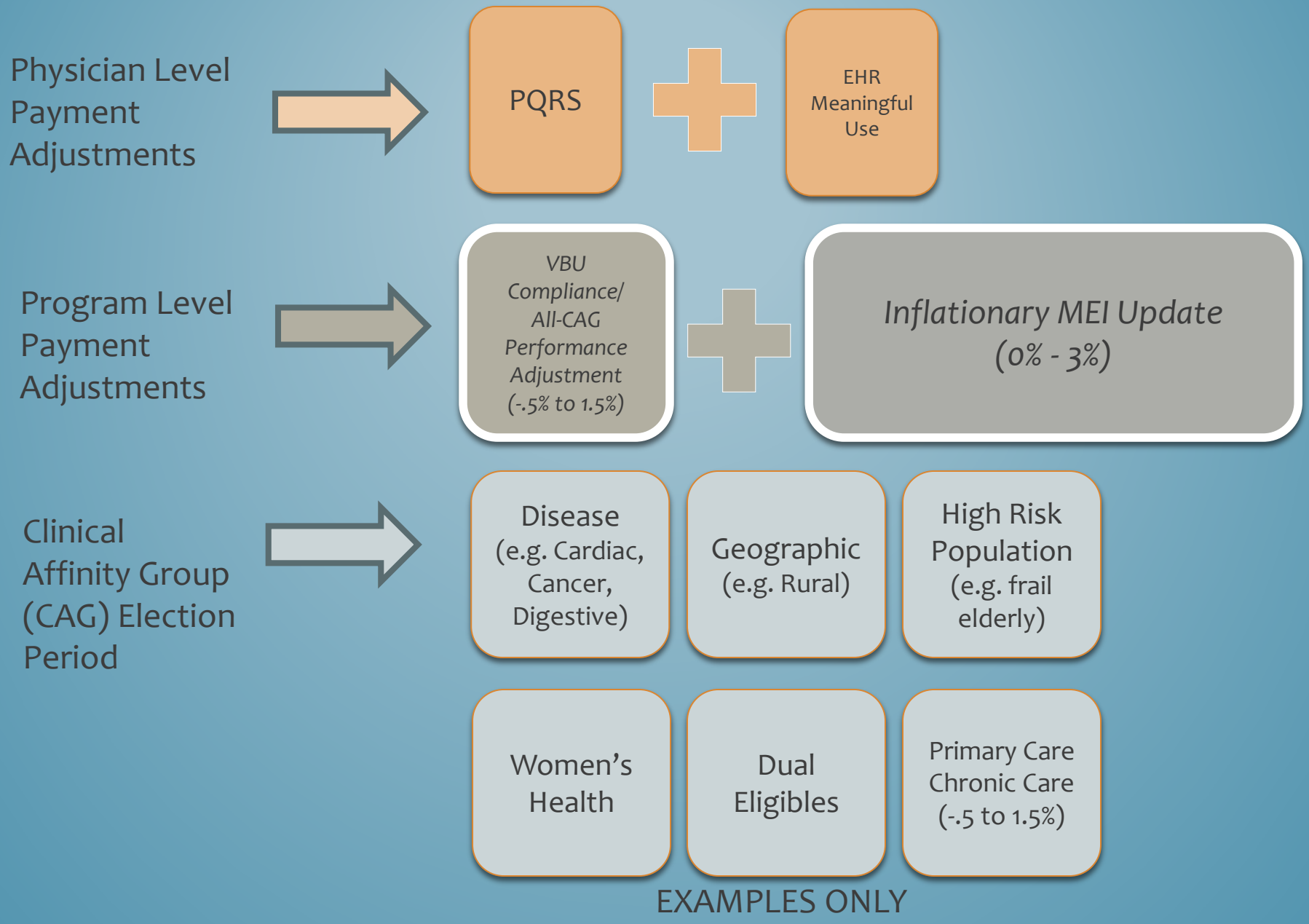
Value Based Update Proposal: STEP 2



STEP 3

- Individual physician level adjustments simplified
- Program level adjustment: continues the MEI update and introduces additional updates based on the concept of the "*Clinical Affinity Group*"
- "*Clinical Affinity Group*" measures can be based on disease, geographic designations, types of care (e.g. primary care or geriatrics), etc and will determine the program level adjustment provided in addition to the MEI update.
- "*Clinical Affinity Groups*" are yet to be determined but will be designed to incentivize physicians to work collectively toward a quality or utilization goal.

Value Based Update Proposal: STEP 3



STEP 4

- Individual physician level adjustments only determine eligibility, not amount of program level adjustment
- Program level adjustment: MEI update if minimum overall Clinical Affinity Group performance levels met
- Clinical Affinity Group categories and quality measures can be altered from year-to-year

Value Based Growth Rate Proposal: STEP 4

Physician Level Payment Adjustments

- PQRS
- \+
- EHR Meaningful Use

Program Level Payment Adjustments

- *Inflationary MEI Update (0% - 3%) (application determined by All-CAG Performance Score)*

Clinical Affinity Group (CAG) Payment Adjustment

- Disease (e.g. Cardiac, Cancer, Digestive) (-.5% To 1.5%)
- Geographic (e.g. Rural) (-.5% to 1.5%)
- High Risk Population (e.g. frail elderly) (-.5% to 1.5%)
- Women's Health (-.5% to 1.5%)
- Dual Eligibles (-.5% to 1.5%)
- Primary Care Chronic Care (-.5% To 1.5%)

EXAMPLES ONLY

UPDATE based on 50/50 National/Local blend. Local performance based on Hospital Referral Regions (HRRs)[39]