



**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: Using Innovation to Reform Medicare Physician Payment.

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Executive Summary

For nearly 100 years, the American College of Surgeons has led national and international initiatives to improve surgical quality. 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 simultaneously slowing the growth in spending.

Over the past year the College has developed our quality improvement principles into a draft Medicare physician payment reform proposal called the Value Based Update (VBU). The VBU proposal is built upon a few key concepts. It is designed to be patient-centric, flexible, responsive to the changing needs of the health care system, inspired by quality and politically viable for all key stakeholders.

Under the VBU, physicians who successfully participate in existing individual-level quality programs would choose a set of quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU adjusts compensation based on attainment of carefully chosen and properly designed quality goals.

The core of the VBU is the concept of the Clinical Affinity Group or CAG. A CAG is a group of physicians and providers who care for a specific condition, disease or patient population. Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs.

Based upon our rich history of quality improvement, the ACS strongly believes that Improving outcomes and care processes, and slowing growth in health spending are *complementary* objectives that are too often addressed separately.

Chairman Pitts, Ranking Member Pallone, 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 hearing. My name is David Hoyt, I am a trauma surgeon and the Executive Director of the American College of Surgeons. 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) and the College's leading efforts in the areas of quality improvement.

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

The Value Based Update 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.¹

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 beginning in the early phases of implementation.

Implementation of the VBU will be a multi-step process, but must be preceded by immediate and permanent repeal of the SGR formula. While we are confident in the ability of quality improvement to save funds moving forward, the VBU does not

¹ 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.

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.

The core of the VBU is the Clinical Affinity Group (CAG). In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs might include categories such as cancer care, surgery, primary care/chronic care, cardiac care, frail elderly/end of life, digestive diseases, women's health and rural. 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 should 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.

A sufficient number and variety of CAGs must be created to accommodate all physicians. Physician compensation would be reflective of the quality of care provided at multiple levels, including through application of existing individual-level modifiers, performance of their specific CAG(s), and overall attainment of quality goals by all CAGs. Once fully implemented, 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 care², but

²The 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

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.

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 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.