

# **Comments**

of the

**American Academy of Facial Plastic and Reconstructive Surgery**  
**American Academy of Ophthalmology**  
**American Academy of Otolaryngology-Head and Neck Surgery**  
**American Association of Neurological Surgeons**  
**American Association of Orthopaedic Surgeons**  
**American College of Obstetricians and Gynecologists**  
**American College of Osteopathic Surgeons**  
**American College of Surgeons**  
**American Osteopathic Academy of Orthopedics**  
**American Society of Breast Surgeons**  
**American Society of Cataract and Refractive Surgery**  
**American Society of Colon and Rectal Surgeons**  
**American Society for Metabolic & Bariatric Surgery**  
**American Society of Plastic Surgeons**  
**American Urological Association**  
**Congress of Neurological Surgeons**  
**Society for Vascular Surgery**  
**Society of American Gastrointestinal and Endoscopic Surgeons**  
**Society of Gynecologic Oncologists**  
**Society of Surgical Oncology**  
**The Society of Thoracic Surgeons**

on the

**House Tri-Committee Draft Health Care Reform**

**June 30, 2009**

**Contact:** Kristen V. Hedstrom, MPH  
Assistant Director, Legislative Affairs  
American College of Surgeons  
1640 Wisconsin Ave, NW  
Washington, DC 20007  
202-672-1503  
khedstrom@facs.org

# Executive Summary

## **Public Health Care Option (Sec. 223, 225)**

- Surgery does not support tying the public plan option to Medicare rates. Health reform legislation that includes a public plan option must expressly state that physicians are not mandated to participate in such a plan.
- Any public plan must be self-sustaining and be truly competitive with private health care.

## **Health Benefits Advisory Committee (Sec. 123)**

- The surgical community strongly supports explicit language that guarantees that a minimum of three physicians representing different specialties, including surgical specialties, be appointed to the Health Benefits Advisory Committee.

## **Sustainable Growth Rate (Sec. 1121)**

- To reform Medicare's payment system and find more innovative models of Medicare physician payment, Congress must first immediately eliminate the SGR.
  - Surgery does not support another short-term "patch" that only temporarily prevents Medicare payment cuts but that does not directly address the problems with the SGR.
  - Congress must incorporate a realistic budget baseline that provides physicians with positive updates.
  - Surgery supports removing physician-administered drugs and clinical laboratory tests – both retroactively and prospectively – from the SGR.
  - During the transition period to a new payment system, Congress should replace the SGR with a system of separate service category growth rates (SCGR). The SCGR categories would recognize the differences among the various types of services (all evaluation and management services; major surgery; and all other physician services) that physicians provide to their patients, while providing additional dollars for primary care.
- Surgery applauds the Committees for its proposal to reform the SGR, which is generally in line with the above principles. However, we urge the Committee to amend the legislation to:
  - Modify the proposal to establish a third category of reimbursement for major surgical procedures.
  - Ensure that physician-administered drugs and clinical laboratory tests are expressly eliminated from the payment formula.
  - Remove gross domestic product (GDP) from the new target growth rate formula and base each category's target on the previous year's spending, rather than on a cumulative basis.

## **Misvalued Codes under the Physician Fee Schedule (Sec. 1122)**

- Surgery supports maintaining the role of the AMA/Specialty Society Relative Value Update Committee (RUC) as the entity through which medical services are valued. The RUC continues to be a dynamic process, which makes recommended increases *and decreases* in the value of codes reimbursed under the Medicare Physician Fee Schedule. We therefore urge the Committees to delete this section of the bill, as it is unnecessary.

### **Payment for Efficient Areas (Sec. 1123)**

- Surgery is concerned about arbitrary adjustments of payments based on geographic differences in utilization of medical services, particularly since such adjustments are not appropriately risk-adjusted. We support addressing any geographic disparities by extending the geographic floor for work.

### **Physician Quality Reporting Initiative (PQRI) Improvement and Requirements (Sec. 1124)**

- Surgery supports the recommended improvements to the PQRI program including the establishment of an appeals process and more timely feedback reports.
- Quality reporting for physicians should remain voluntary and not be mandatory and surgery therefore supports the provisions in the proposal that would extend the PQRI bonus payments through 2012.
- Surgery is concerned about the current HIT timelines for bonuses and penalties established in the *American Recovery and Reinvestment Act* (ARRA). Given continued problems with interoperability and lack of certified HIT systems, we urge Congress to amend the current bonus and penalty timelines so the entire surgical community can participate fully.

### **Payment for Imaging Services (Sec. 1147)**

- Surgery opposes subjecting ultrasound and less expensive imaging modalities to the 75 percent equipment use rate. We therefore urge the Committees to specifically exclude ultrasound from the definition of imaging services to which the equipment use rate formula is applied or any other reimbursement reductions directed at imaging services.

### **Reducing Potentially Preventable Hospital Readmissions and Post-Acute Care Services Payment Reform Plan (Sec. 1151, 1152)**

- Surgery is concerned with the unintended consequences that a hospital readmission and post-acute bundling policy may carry, particularly the potential avoidance of patients with complex medical conditions. The surgical community therefore applauds the Committees' recognition of the need for risk adjustment when calculating the readmission benchmark.
- When the readmission policy is phased out and the bundled payment policy is implemented, a workable and reasonable readmission policy must remain an essential piece of the initiative.
- Congress must also develop a coherent risk adjustment policy as the primary method for preventing the practice of deselection of patients, addressing the readmission issue, and ultimately providing the highest quality and most appropriate level of patient care with these methods of payment.
- Congress should exclude readmissions for a different diagnosis than the original admission in either the hospital readmission or post-acute bundling policy.

### **Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals to Hospitals (Sec. 1156)**

- Surgery believes that physician owned hospitals are an important component of our health care delivery system and Congress should not prohibit their development and further expansion.

### **Accountable Care Organization Pilot Program (Sec. 1301)**

- Surgery supports the development and testing of shared savings payment models for physician, hospital and other provider services. The Secretary or GAO should fully evaluate any shared savings program and report back to Congress within five years of enactment before a more expanded, permanent share savings program is implemented.
- If implemented, participation in shared savings programs should be voluntary, non-punitive and not restrict patient choice.
- Congress should amend the Stark physician self-referral and antitrust laws and/or regulations to allow provider collaboration and flexibility in the development of shared savings programs.

### **Medical Home Pilot Program (Sec. 1302)**

- Surgery supports allowing specialists who act as the principal-care physician to qualify for the Medical Home Pilot Program.

### **Increased Payments for Primary Care (Sec. 1303)**

- Surgery supports increased payments for primary care physicians; however we oppose any measure that would finance increased payments for primary care by an across-the board reduction in payments for all other physician services.

### **Comparative Effectiveness Research (Sec. 1401)**

- The surgical community embraces the need for well-designed clinical comparative effective research and supports the *Comparative Effectiveness Research Act of 2009* (H.R. 2502), sponsored by Rep. Kurt Schrader, and the *Patient-Centered Outcomes Research Act of 2009* (S. 1213), sponsored by Senators Max Baucus and Kent Conrad. We, therefore, urge the Committees to build off the framework of these bills, replacing the CER provision that is in the current draft legislation with a section based on the Schrader or Baucus/Conrad model.

### **Physician Payment Sunshine (Sec. 1451)**

- Surgery strongly supports disclosure and transparency of physician and industry relationships through a single, federal reporting system that preempts state law. We are opposed, however, to applying such requirements to the reporting of industry funding for continuing medical education and professional organizations.
- Physicians should have the opportunity to review and correct information about their financial relationships before those disclosures are made publically available.

### **Distribution of Unused Residency Positions (Sec. 1501)**

- Simply reallocating unused residency training slots has the potential to exacerbate already apparent and emerging workforce shortages in some surgical specialties unless an option to lift residency caps is included.

### **Improving Accountability for Approved Medical Residency Training (Sec. 1505)**

- Surgery believes very strongly that medical education should remain in the purview of medical educators, including the Accreditation Council for Graduate Medical Education (ACGME).
- The ACGME and surgical specialties are constantly evaluating and reevaluating graduate medical education curricula to ensure that it is appropriately achieving the goals of medical residency training and education. Surgery therefore opposes the provisions of the draft proposal that would (1) set forth in law the goals of medical education and (2) require a GAO study to evaluate training programs.

### **Physicians who order durable medical equipment (DME) or home health services required to be Medicare participating physicians (Sec. 1637)**

- All physicians – whether or not they participate in Medicare – must be able to order durable medical equipment or home health services.
- Surgery recommends that negative pressure wound therapy be removed from its current classification as DME.

### **Loan Repayment Programs (Sec. 2211)**

- The surgical community supports special medical education loan repayment programs for providers that are on the “frontline” of care. We encourage the Committees to use the Access to Frontline Health Care Providers Act (H.R. 2891), sponsored by Reps. Braley and Space, as a basis for this section of the legislation.
- Surgery also recommends that the Committees make loan forgiveness programs available to surgical specialties with documented current or potential workforce shortages, especially those specialties with longer training programs.

### **Prevention and Screening**

- Surgery supports coverage for a comprehensive treatment approach for obesity in any health care reform legislation. Such a system would provide coverage for the continuum of care for the overweight or obese patient – including behavioral, pharmaceutical and surgical treatment.

### **Access to Emergency and Trauma Care**

- The surgical community supports the establishment of a competitive grant program to support projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. We urge the Committees to incorporate in your proposal language related to emergency medical services that is contained in the Senate Health, Education, Labor and Pension Committee’s draft health care reform bill.

### **Medical Liability Reform**

- Congress should incorporate certain medical liability reforms in comprehensive health care reform, including: (1) alternatives to civil litigation, such as health courts and early disclosure and compensation offers; (2) protections for physicians who follow established

evidence-based practice guidelines; (3) protections for physicians volunteering services in a disaster or local or national emergency situation; and (4) provisions modeled after the laws in California or Texas, which include reasonable limits on non-economic damages.

June 30, 2009

The Honorable Charles Rangel  
Chairman, Ways and Means Committee  
1102 Longworth House Office Building  
Washington, DC 20515

The Honorable Henry Waxman  
Chairman, Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable George Miller  
Chairman, Education and Labor Committee  
2181 Rayburn House Office Building  
Washington, DC 20515

Dear Chairmen Rangel, Waxman and Miller,

We, the undersigned surgical organizations, write in response to the discussion draft recently released by the Ways and Means, Energy and Commerce and Education and Labor Committees. We appreciate the leadership that you and your colleagues in the House have dedicated to enacting comprehensive reform of our nation's health care system and we look forward to working collaboratively with you as more substantive details of the proposal are developed.

Much attention has been paid to the need to provide more Americans with access to health care coverage, to increase Americans' access to care, and to improve the value of care delivered in our health care system. Expanding coverage to more Americans and improving the quality of care will mean little if Americans are not able to access the care they need—particularly in potentially life-threatening situations. At the same time, we must be certain that coverage reforms are accompanied by system reforms that improve the delivery of health care. Without real reform of our Medicare physician payment system, the reform that our health care delivery system needs cannot be achieved. To that end, the surgical community stands united in the effort to bring fundamental and long-term change to the Medicare physician payment system and overall comprehensive reform.

### **Division A – Affordable Health Care Choices**

#### ***Public Health Insurance Option (Subtitle B)***

The surgical community supports the commitment to extending health insurance coverage to more Americans. If done appropriately, extending this coverage would help ensure that every American will be able to access the care they depend on America's physicians to provide in a timely manner without compromising their own financial well-being. Unfortunately, if done incorrectly, extending insurance coverage to more Americans will mean little if they are forced

to wait in lines and are not able to access a physician when one is needed. This scenario becomes particularly troubling when considering the life-saving and impairment-preventing acute care that surgeons provide to their patients every day. Whether or not a surgeon is available can be a life or death issue for a patient facing an emergency or trauma care situation.

Given the history of physician reimbursement under government-sponsored health plans where Medicare reimbursement rates have repeatedly failed to keep pace with the rising cost of practicing medicine, and where Medicaid and TRICARE reimbursements have been even lower, the surgical community is concerned whether such a plan will appropriately reimburse surgeons and other physicians for the care they provide to patients.

As described in Sec. 223 of the draft, it appears the plan would be based on Medicare's payment system. While the Medicare payment system proposed under the draft legislation would be an improvement from current law, it remains to be seen whether or not the Medicare physician payment reforms proposed in the draft will keep pace with rising costs of medical practice. To create another federal health insurance plan in which reimbursement rates are set for physicians, as opposed to allowing physicians some ability to negotiate rates, could impede patients' access to care; a problem that can already be attributed to the lower reimbursements provided under government-administered health care plans.

In addition, we are concerned about the considerable authority given to the Secretary to establish conditions of participation under the public option (Sec. 225). While we appreciate that the draft does not explicitly link physician participation in the public health insurance option to Medicare or any other public health plan, we are concerned that the authority granted to the Secretary could grant her this option of building a provider network based on Medicare participation. In order to protect the ability of physicians to make basic decisions that can affect the financial viability of their practices, it is important to preserve physicians' choice about whether or not they will participate in a particular health plan—private or public. For this reason, we advocate for language explicitly stating that the Secretary cannot base participation in the public option on providers' participation in all other public health care plans, including Medicare.

We also oppose provisions included in Sec. 225 forbidding balance billing under the public health insurance option. To forbid balance billing would disallow a business practice that is available to physicians in the private market, in which this public plan would presumably be competing. Likewise, such a prohibition could well undermine patients' ability to choose their doctor or keep their doctor, as the President has promised, if they are not afforded the opportunity to pay the additional dollars to see an out-of-network provider if they so desire.

While we do appreciate the desire to eventually move away from a payment system based on Medicare, the surgical community is also greatly concerned about the uncertainty over how reimbursement might be set beyond the first three years of the program. The Secretary is given considerable authority in year four and future years of the public plan, and we are concerned that there will be little input or opportunity for negotiation on the part of physicians (Sec. 223). It is our hope that the Committees will give greater consideration to developing a deliberative process that not only includes physician input, but one that also recognizes the rising cost of practicing

medicine and running a small business, as so many of our surgeons do. We stand willing to working with the Committees toward this end.

The surgical community applauds the Committees for their efforts to expand coverage. We agree that the one of the reasons for the lack of coverage for many Americans has been because of a lack of competition. Health plans, because of their large presence in particular areas, can often afford to set coverage costs high for patients and reimbursements low for providers, but physicians are still afforded the right to not participate in these plans if they so desire. We believe the same must be true for the public health insurance option. If true competition is to occur, the public plan, just as private plans, must be required to compete not only for the patients whom it will cover but for the physicians that will be participating under its plan.

### ***Health Benefits Advisory Committee***

The surgical community has concerns with the proposed composition of the Health Benefits Advisory Committee (HBAC) as outlined in Subtitle C, Section 123 of the draft health care reform legislation. The language stipulates "at least one practicing physician or other health professional" shall serve on the Committee. While non-physician health professionals serve an important role in the delivery of care, the surgical community strongly supports explicit language that guarantees that a minimum of three physicians representing different specialties, including surgical specialties, will serve on the Committee along with other health professionals. As the language is currently drafted, a situation could arise where physicians are not adequately represented on an advisory committee tasked with recommending necessary benefit standards for their patients. The medical expertise that can only be provided by a physician representative would help to advance Congress' goal of incorporating recent health care innovation in determining essential health care benefits and avoid the unethical practice of rationing care to America's patient population.

### **Division B**

#### ***Sustainable Growth Rate Reform (Sec. 1121)***

The surgical community appreciates the Committees' efforts to address many of the systematic problems in the Medicare physician payment system. For full-scale health reform to be successful, and given the role that Medicare plays in our nation's health care system, Medicare's physician reimbursement system must be set on a path toward full-scale and permanent reform.

#### **Payment Increase in 2010**

In the short-term, the surgical community appreciates your inclusion of a measure to replace the scheduled 22 percent cut in Medicare physician reimbursement in 2010 with a Medicare payment increase based on the Medicare Economic Index. After two years of payment freezes, this provision would ensure a third straight year of modest Medicare physician payment increases. This provision will aid surgeons and surgical practices to better plan for the costs of the coming year, especially in an uncertain economy. This increase will not only aid surgeons in their ability to provide care to their patients but it will also aid surgeons in addressing the rising

costs of running a small business, including covering employee salaries and benefits such as health coverage.

### **Resetting the Baseline Year; Removing Physician-Administered Drugs and Clinical Laboratory Tests**

The surgical community applauds the Committees for taking the critical step of addressing the long-term problems posed by the Medicare payment system and resetting the Sustainable Growth Rate (SGR) baseline year from 1996 to 2009 (Sec. 1121). In addition, while not included in the draft released on June 19, 2009, we appreciate your stated commitment to remove, both retroactively and prospectively, physician-administered drugs and clinical laboratory tests from the calculation of the SGR—should the Administration not remove these items from the SGR.

### **Replacing the SGR with Two Categories of Reimbursement**

While the surgical community appreciates that the draft does take measures to address some of the problems of the current system, many in the surgical community are concerned about the Committees' proposal to reform the SGR and replace the current SGR with a payment structure of only two service categories: 1) One category for evaluation and management (E & M) services—which would include new and established patient office services, primary care services, emergency department services, consultations, and home services—and preventive care services; and 2) Another category for all other physician services. Given trends in physician resource use and utilization of particular services, we are concerned that this approach would, for the purposes of calculating reimbursement, unfairly associate many lower growth services with services that have demonstrated exponentially higher growth in utilization in recent years. As a result, we propose replacing the proposed structure with a more fair and equitable system that does not directly link reimbursement for lower growth services to those other services that have continued to experience exponentially higher growth in volume and spending.

### **Treatment of Major Surgical Procedures**

By replacing the SGR with these two service categories, the surgical community is concerned that the proposal would not only maintain the blunt instrument of the SGR but that surgical reimbursement would see minimal increases and, in some cases, actually be cut starting in 2011. Such cuts would result from the fact that major surgical procedures would be included under the same spending target along with higher growth services, such as imaging and office-based procedures. This would mean that low growth services would be punished for the exponential utilization growth seen in others. As a result, major surgical procedures, the service category that the Medicare Payment Advisory Commission (MedPAC) in its March 2009 report cited as having the lowest volume growth (1.6 percent between 2006 and 2007) among all other physician services including E & M, would continue to be subject to penalties resulting from the higher growth services such as imaging and minor procedures (3.8 and 5.0 percent volume growth respectively between 2006 and 2007). While those who provide these high growth services contend that these services are largely provided on referral, it should be noted that surgical care is largely provided on a referral basis as well. Further, whereas these high growth services are billed on a discrete, per unit basis, Medicare payments for major procedures are

bundled over global periods of 10 and 90 days. As a result, the surgeon receives one payment that covers not only the surgery but the pre-operative and post-operative care as well. Given the low growth of surgical care and its unique reimbursement structure, we request that a third service category for major procedures, defined as all surgical care billed over 90-day and 10-day global periods, and the associated anesthesia services be established. A separate category for major procedures would not only recognize surgery's different payment structure, but it would also ensure that the lowest-volume growth service would not be unfairly required to bear the burden of lower payments resulting from other high-growth services.

### **Clarification Regarding Surgical E & M Services and Surgical Consults**

The surgical community appreciates language included in Sec. 1121 to include “new and established patient office services” and “consultations” within the category with primary and preventive care and other E & M services. While primary care physicians do provide the largest share of E & M services, the surgical community appreciates your recognition that they are not alone among physician specialties in providing these important services. When faced with acute and potentially life-threatening situations, patients and their families rely on consultations with physician specialists, including surgeons, who are most familiar with the patient's particular condition, disease or injury to discuss treatment options. At these critical times, patients need to be able speak with not just any physician but with one qualified to speak to their particular situation. Including E & M services and consultations provided by surgeons in the category with all other E & M services, which are among the second lowest growth service category among all physician services, will help ensure appropriate reimbursement for these services.

While we believe the language included in the legislative draft is fairly clear about the intent to include all E & M services and consultations in the first service category, we would request greater clarity in the legislation to ensure that all E & M services, including surgical patient visits and consultations, are included in this category with primary and preventive care. One manner by which this clarity could be achieved would be to remove the phrase “as determined by the Secretary” (p. 183, line 15). This clarification or some similar modification of this language would help ensure that these low volume growth services would be appropriately reimbursed under Medicare and not have their reimbursement subject to their inclusion in a category with higher growth, higher cost services.

### **Gross Domestic Product Provisions**

In addition, the surgical community appreciates your recognition that per capita growth in the gross domestic product (GDP) on its own is not an appropriate measure of the growth in the utilization of physician services. While it would be the surgical community's preference that the GDP be removed entirely from the calculation of Medicare physician reimbursement and replaced with a reasonable statutory amount above the ten-year rolling average of per capita GDP growth that is presently included in the formula, the surgical community does appreciate the inclusion of a growth rates of GDP+2 percent for the E & M category and GDP+1 percent for the other service category. We are concerned that the resulting target for spending growth may still not recognize the realities of practicing medicine and, in particular, surgical practice. As a result, surgery's inclusion in a category with higher growth services would continue to base

surgical reimbursement on the higher utilization of services provided by other physician specialties.

### **Cumulative Approach**

The surgical community also is concerned that the Medicare payment system under your proposal would not only continue to base payments on GDP but also that the resulting targets for spending growth would continue to be cumulative and could potentially require significant cuts in future years if spending amounts should exceed the targets set under this new system – placing physicians in the same position that we now face due to the cumulative nature of the current SGR system. While the bill’s proposal to move toward a five-year rolling cumulative target is an improvement over current law, it could likewise continue to complicate the reimbursement structure for low-growth services like major surgical care. Not only would surgical reimbursement be required to bear the burden of lower reimbursement because of higher utilization and spending in other services, there is the real possibility that this penalty could be borne by surgeons for many years into the future. As your Committees deliberate over this legislation, we would request that you modify and improve the legislation by amending the language to base each category’s target on the previous year’s spending.

### ***Misvalued Codes under the Physician Fee Schedule (Sec. 1122)***

The surgical community is concerned about the impact that provisions included under Sec. 1122 could have on surgical reimbursement and on patient access to surgical care. We are particularly concerned that these provisions would cede authority to the Secretary and limit the traditional role that has been reserved for the medical community at large through the work of the AMA/Specialty Society Relative Value Update Committee (RUC). The Secretary already at present has authority to accept, modify or reject certain recommendations of the RUC, and we question the need for the ceding of further authority to the Secretary in making determinations regarding reimbursement policy. While the RUC is not perfect and the surgical community has its share of differences with the RUC’s recommendations, the RUC has provided a mechanism for physicians to make their case regarding work valuations to other physicians, familiar with clinical practice, who are tasked with deliberating and making decisions regarding the energy and work required in caring for patients.

In recent years, the RUC has often drawn criticism because of a purported bias to non-primary care specialties, but the evidence simply has not borne this out. As Medicare payments for surgical care have steadily declined in recent years, significant steps have been taken through the RUC to improve reimbursement for primary care. In fact, the most recent five-year review by the RUC, approved by the Centers for Medicare & Medicaid Services (CMS), resulted in more than \$4 billion in the fee schedule being shifted to E & M codes from other services, including surgical care, in 2007. In addition, the most recent review resulted in a 37 percent increase in the work values associated with an intermediate office visit (CPT 99213), the most frequently billed physician service in Medicare. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009, which can be attributed largely to the work of the physician community through its work on the RUC.

### ***Payments for Efficient Areas (Sec. 1123)***

While the surgical community believes that Medicare should value and promote the efficient delivery of care, we are concerned about provisions that would provide 5 percent incentive payments for those areas determined to be efficient areas. Our greatest concern is that an efficient area under Sec. 1123 (pg. 199, lines 3-12) would be defined as “those counties or equivalent areas...in the lowest fifth percentile of utilization based on per capita spending for services provided in the most recent year for which data is available...” Further, it is stated that these payments are “to eliminate the effect of geographic adjustments in payment rates.” While we can appreciate goals of promoting efficiency or of addressing geographic discrepancies in reimbursement, we are concerned that these provisions would draw an inappropriate correlation between efficiency and cost without any accounting for the quality of care or any accounting of risk-adjustment for variations in population. Without accounting for quality of care or appropriate risk-adjustment, we are concerned that defining efficiency in such a way would create a dangerous precedent and perverse incentives that could impact practice patterns in such a way that patients’ ability to access care could be compromised. If Congress desires to address geographic payment disparities, it should build on efforts, such as those included in Sec. 1194, which would extend the geographic floor for work (Sec. 1194, pg. 314-315).

### ***Modifications to the Physician Quality Reporting Initiative (PQRI) (Sec. 1124)***

We appreciate your recognition of the surgical community’s concerns with respect to shortcomings in the Centers for Medicare & Medicaid Services’ (CMS) Physician Quality Reporting Initiative (PQRI). The provisions included in your health care reform draft under Section 1124 have the potential to increase provider confidence in the PQRI program and improve participation, as well as increase patient confidence in the validity and reliability of publicly-reported PQRI data.

In addition, the surgical community supports the provision that maintains the PQRI as a voluntary, non-punitive program, particularly as the PQRI continues to evolve, and would extend the positive incentives through 2012. We also support the current regulation, which allows physicians participating in clinical databases and registries to be recognized under PQRI. The surgical community appreciates the inclusion of a mechanism to provide PQRI-participating providers with timely feedback that includes recommendations on how to correct reporting inconsistencies. Timely feedback reports are essential for providers in determining whether their quality improvement efforts are being appropriately captured by CMS.

Finally, we support the inclusion of an appeals process in the PQRI. Despite the fact that approximately half of participating providers received a bonus payment under the 2007 PQRI, the remaining half did not for reasons that include errors made by Medicare Carriers and Medicare Administrative Contractors (MAC).

### **Electronic Health Records**

Health information technology (HIT) has the potential to increase efficiency and quality of care, and to lower health care costs significantly. The surgical community strongly supports the

development of an electronic health information network that is reliable, interoperable, secure, and protects patient privacy. Congress made significant strides towards the implementation of HIT with the passage of the *American Recovery and Reinvestment Act of 2009* (ARRA) (PL11-5), and we are appreciative for the opportunities available for physicians to receive enhanced Medicare payments to support the adoption and effective utilization of HIT.

As HIT moves forward within comprehensive health care reform, the surgical community is concerned, however, about the current HIT timelines for bonuses and penalties established in ARRA. Smaller physician practices, which include the majority of the physicians practicing medicine in this country, continue to face barriers to purchasing HIT systems. The financial incentives and penalties are based on the adoption and “meaningful use” of **certified** HIT systems. However, current, certified HIT systems have only been fully developed for primary care settings, and have not yet been fully adapted for specialty/surgical care. Physicians are hesitant to make the considerable investment until the systems are certified and meet their unique needs and appropriate interoperability standards have been developed.

Some surgical specialties are taking steps toward achieving interoperable HIT solutions for their members and have been placed on the Certification Commission for Health Information Technology (CCHIT) roadmap for HIT certification. CCHIT is the only recognized certification body. However, the majority of surgical specialties are not on the roadmap because of the significant obstacles that must be overcome to be identified by CCHIT as one of the planned expansion areas and the lack of CCHIT financing and staff. Furthermore, due to the time it takes to move through the CCHIT process, even those specialties currently on the roadmap will face significant challenges meeting the HIT timelines.

Because of the existing HIT challenges and limitations, it will be very difficult for the majority of specialty/surgical physicians to purchase certified systems designed for their specialty, become meaningful users, and qualify for the majority of the vitally necessary financial incentives under the currently established timelines. We recognize that HIT will play an important role in achieving and maintaining high quality care and performance and, therefore, urge you to amend the current HIT bonus and penalty timelines included in the ARRA so the entire surgical community can participate fully.

#### ***Payment for Imaging Services (Sec. 1147)***

The surgical community is very concerned and urges the Committees to exclude ultrasound and other less expensive imaging modalities from the definition of imaging services that would be subjected to an equipment use rate change of 75 percent versus the current rate of 50 percent.

Ultrasound, more than other imaging modalities, is integrated into the clinical care provided by specialties whose primary occupation is direct patient care services, such as evaluation and management (e.g., office visits) and surgical procedures. Therefore, the use rate of ultrasound equipment is significantly lower than that of other imaging modalities which are used typically by physicians whose principal focus is providing imaging services. In fact, a survey conducted by American College of Obstetricians and Gynecologists in 2007 found that ultrasound is used by its members, on average, approximately 23.79 hours per 50 hour work week, verifying that

the current equipment use rate of 50 percent used by Medicare to calculate practice expense relative value units for ultrasound procedures is accurate and should not be changed.

Also, because of the relatively low reimbursement rates for ultrasound procedures, ultrasound is one of the most cost-effective diagnostic imaging modalities currently available to physicians. Yet, recent analyses have shown that lower cost imaging modalities such as ultrasound have declined in use relative to more expensive imaging modalities. For patients this is a troubling statistic and one that directly impacts the quality and cost of their health care. For example, ultrasound imaging in clinical practice enables faster diagnosis of breast cancer within as little as two days, whereas previously a surgeon had to do a more expensive open biopsy procedure and the patient and her family had to wait as long as 10 days to learn the result. Ultrasound is also used to diagnose a wide variety of ophthalmic diseases. In particular, the migration of ultrasound from the hospital into less expensive health care settings has advanced treatment of age-related macular degeneration (AMD) and diabetic retinopathy.

Reductions in ultrasound and other less expensive imaging modalities' reimbursement threatens access to prevention and early detection services for obstetrical complications, cancer, and cardiovascular disease, all conditions that we as surgeons have faced.

- For example, the ultrasound procedures performed as part of an ultrasound-guided breast biopsy procedure would be reduced under the House Health Care Reform Discussion Draft by as much as 22 percent.
- Ultrasound procedures used to monitor the progress during pregnancy, would have their reimbursement cut by 19 – 21 percent under the House Discussion Draft, depending on what week during pregnancy the ultrasound study was performed.
- Ultrasound screening for abdominal aortic aneurysms would be reduced by almost 22 percent, at a time when this life-saving screening procedure is already greatly underutilized: currently fewer than 10,000 Medicare beneficiaries receive this preventive service because of other barriers, such as a Welcome to Medicare Referral Requirement.

Ultrasound's clinical appropriateness is well established and its growth rate is moderate. There is no evidence that ultrasound services are currently overvalued. In fact, GAO found in its September 2008 report to Congress that after the implementation of *Deficit Reduction Act* caps, the disparity in utilization between ultrasound and advanced imaging modalities continued to grow. Acknowledgement of this fact is reflected by the Congressional Budget Office's (CBO) December 2008 recommendations to Congress as well as MedPAC's recommendations on this issue – both of which exclude ultrasound and other inexpensive imaging modalities in their call for a change in the equipment use rate for only the advanced or over \$1 million imaging equipment.

Therefore, in recognition of these differences, we again urge the Committees to exclude ultrasound from the definition of imaging services to which an increase in the equipment use rate formula is applied or any other reimbursement reductions directed at imaging services.

***Reducing Potentially Preventable Hospital Readmissions and Post-Acute Care Services Payment Reform Plan (Sec. 1151 and Sec. 1152)***

The surgical community understands that current methods of reimbursement by government programs and private insurance offer little incentive to help control the cost of delivering care and supports efforts of all stakeholders to develop and evaluate payment methodologies that will incentivize coordination of care among providers and help curb health care inflation. However, the surgical community is concerned with the unintended consequences that a hospital readmission and post-acute bundling policy may carry.

The patient must be the focal point of any initiative and therefore the system must not create incentives to treat healthier patients and limit access to sicker patients. One possible consequence is deliberate deselecting of complex or risky patients. As is already occurring, we are concerned that physicians may find it even more difficult to treat their most complex, vulnerable patients. We are also concerned that physicians may be subjected to facility pressure to discharge a patient earlier or later than medically necessary and/or to an inappropriate post-acute setting. We encourage the Committees to ensure that the payment policy facilitates a provider's ability to decide the most appropriate facility in which the patient should receive care.

Additionally, when the readmission policy is phased out and the bundled payment policy is implemented, a workable and reasonable readmission policy must remain an essential piece of the initiative. Unavoidable, planned, scheduled, or extreme cases of high risk readmissions will still need to be addressed in the development of a bundled payment methodology between the hospital and post-acute provider. Developing a coherent risk adjustment policy is the primary method for preventing the practice of deselecting patients, addressing the readmission issue, and ultimately providing the highest quality and most appropriate level of patient care with these methods of payment.

The surgical community applauds the Committees' recognition of the need for risk adjustment to adequately account for a "patient's severity of illness and differences in case types" when calculating the readmission benchmark and the recognition of readmissions that are planned, scheduled, unavoidable, and/or related to extreme cases of high risk. We encourage the Committees to include provisions for both readmissions and bundled payments that require risk-adjustment for patient demographics, co-morbidities, severity of illness, and procedure-specific characteristics that account for the differences that contribute to outcome and costs of treatment. The surgical community understands that risk adjustment is a costly and complicated task and, therefore, proposes that the Committee require the federal agencies to work with the individual specialty societies when developing, implementing, and evaluating the metrics for risk adjustment, particularly those specialty societies with clinical databases and registries that provide statistically valid methodologies for risk adjustment. As is always the case, when stakeholders are involved in the decision making process, the support and participation follows.

The surgical community would like to highlight the importance of excluding readmissions for a different diagnosis than the original admission in either the hospital readmission or post-acute bundling policy. It is important to avoid the unintended consequences of restricting choice and/or encouraging denial of care based on a payment policy. We encourage the Committees to ensure that an all-cause approach to readmissions and bundled payments is not taken.

Ultimately, we must have safeguards to protect both the patient and the equity and role of providers. Policies should not create a system where each entity is imputing blame on the other. Before proceeding with hospital readmission and post-acute bundling policy, we urge the Committee to consider the necessary resources, structure, and cultural changes necessary to reasonably implement such a policy.

**Necessary Safeguards to Protect Patient Access to Quality Care:**

- The patient should be the primary focus of all initiatives.
- The patient should be empowered to be a fully participating stakeholder in their health care process.
- The patient's access to quality care should always be a priority over cost savings.
- No stakeholder should be incentivized to limit care or provide unnecessary care.
- The physician should be the patient's primary advocate for their unique medical needs.
- All stakeholders should disclose potential conflicts of interest when providing patient care.
- Patients should maintain access to a variety of necessary providers and facilities.

**Necessary Safeguards to Protect and Facilitate Provider Alignment:**

- One provider should not have control over another provider.
- The burden to improve quality and affect cost savings should be on all providers and stakeholders.
- The process should be transparent so that all financial incentives and any revisions are known by all stakeholders.
- The initiative should align providers to collaboratively work together.
- All stakeholders should be represented when developing initiatives to align payment and incentives.
- The payment should be agreed upon prior to delivering care.
- All stakeholders should be represented when creating a method of distribution for payment.
- The compensation for work should be fair and reasonable for all providers.
- Payment should be risk adjusted for patient and procedure specific characteristics.
- The implementation should be equitable for all patients and providers.
- Competition should be maintained in the health care system.
- A provider should have the autonomy to provide care that addresses each patient's unique medical needs.

***Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals to Hospitals (Sec. 1156)***

The surgical community believes that physician-owned hospitals are an important component of our health care delivery system. Physician owners in physician-owned hospitals have greater control over the facility and the quality and efficiency of care (e.g., scheduling of surgeries, surgical equipment, staffing, etc.) which lead to higher quality patient care. Furthermore, these facilities tend to have greater patient satisfaction, reduced costs, and lower infection rates.

While the surgical community appreciates provisions that would allow for the expansion of physician hospitals in limited circumstances, the House draft would allow less than 10 hospitals to apply for growth, and still have significant and harmful effects on the 218 existing physician-owned hospitals and the eighty-six projects under development. Significantly, it will prevent physicians from owning hospitals in this country in the future.

Currently, hospitals that have physician ownership are located in 31 states across the country and provide diversity of location, specialty, and ownership. Of the 218 hospitals that are currently active, 18 are general acute-care facilities, 150 are multispecialty (includes surgical, women's and children's hospitals), 18 are rehabilitation hospitals, 19 specialize in cardiac care and 13 focus on orthopaedics. More than half (117) are joint ventures with not-for-profit, general acute care hospitals and health systems. The remaining entities are a mixture of joint ventures with for-profit hospitals and corporate investors or are owned entirely by physicians. Although the debate over physician ownership may have started with specialized facilities in a few states, it now affects hospitals of all variations. Because of this wide geographic impact, the proposed legislation will disrupt access to medical care in many communities.

Resulting from a study of physician-owned hospitals required by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, the Federal government in 2005 reported that structural measures of quality, such as staff specialization, clinical staff per patient, and complication rates, all suggest good performance on the part of physician-owned hospitals and demonstrate very high quality of care. Mortality rates were also shown to be significantly lower in physician-owned hospitals than in other community hospitals. For all medical procedures analyzed by the U.S. Department of Health and Human Services (HHS), there was a measurable statistical significance. In addition, complication rates at physician-owned hospitals are measurably lower than at general hospitals. According to the HHS study, patients are 3 to 5 times more likely to experience complications at general hospitals than at physician-owned hospitals. All of the HHS results were adjusted for patient acuity.

In a survey conducted in 2008 by Lake Research Partners, an independent third party, it was determined that “The American public believes doctors would do a good job running hospitals in their community, and they want doctors to make decisions about patient care and how hospitals are run. They believe doctors should be allowed to own hospitals where they work and that Congress ought to vote to allow this practice to continue.” Two-thirds (67 percent) of the American public believes physicians would do an excellent or good job running a hospital in their community. Additionally, physicians are the American public’s first choice (over hospital administrators) of the person(s) they would prefer to see in charge of hospitals in their

communities (March 2008 telephone survey of 1,000 adults nationwide, conducted by Celinda Lake of Lake Research Partners).

Not only do physician-owned hospitals deliver high quality medical care to the patients they serve, they also provide much needed jobs, pay taxes, and generate significant economic activity for local businesses. In its 2005 study, HHS concluded that, considering uncompensated care and tax payments, physician-owned hospitals returned a net community benefit as a percent of total revenue almost 8 times higher than non-profit hospitals, averaging 7.23 percent in net benefit as compared to .87 percent for non-profit hospitals. Physician-owned hospitals have a huge economic impact at the national, state, and local levels.

While the surgical community opposes any limitation on physician ownership, the draft's exclusion of facilities that do not have a Medicare provider agreement as of January 1, 2009, would certainly lead to further job losses in what is one of the toughest economic times in our nation's history. Not even counting for physicians, these facilities employ over 55,000 nurses, other health professionals, and support staff, and provisions limiting the ability of the facilities to improve and expand would also certainly threaten jobs as these facilities age. In addition, the bill's provisions to exclude all facilities built after January 1, 2009 will not only threaten capital investments in communities around America but will threaten numerous associated jobs in construction and infrastructure required to build and prepare these facilities for delivery.

Finally, it should be noted that Sec. 1156 would place limits on surgeons' ability to practice unlike limits placed on any other physician specialty in America. Across America and across physician specialties, many physicians, from family physicians to radiologists, own their practices. Many surgeons own their own practices as well, but much of the care they provide takes place outside of the office-based setting and in a hospital or ambulatory surgery center. For over 30 years, surgeons and hospitals have partnered with each other as owners and investors in ambulatory surgery centers that deliver high quality surgical care for a fraction of the cost that the same care would command in a hospital. Likewise, it should follow that surgeons be afforded the same opportunity to own or invest in their place of practice, whether that place is an office, ambulatory surgery center, or hospital.

The surgical community believes legislation limiting physician ownership is bad for health care, bad for business, and bad for Medicare beneficiaries who receive care at the many physician-owned and operated hospitals throughout the country and urges the House to not include any legislative language that would discriminate against physician-owned hospitals.

#### ***Accountable Care Organization Pilot Program (Sec. 1301)***

The surgical community believes that a reformed health care delivery system should encourage providers to collaborate and provide patient-centered care with the goal of improving quality and creating cost savings and shared savings programs may appropriately align incentives between stakeholders to improve the quality of care for patients leading to reductions in costly complications, the creation of quality guided resource utilization, and the achievement of sustained savings. We support the development of incentive programs that allow physicians to participate in the sharing of savings generated by quality improvement efforts. Care must be

refocused around the needs of patients, and systems of delivery should allow and encourage – rather than discourage – collaboration and accountability among health care providers and across sites of care. The surgical community therefore recommends that Congress require the Secretary of HHS or the Government Accountability Office to fully evaluate the shared saving programs and report back to Congress within 5 years of enactment of this provision before a more expanded, permanent shared savings program is implemented.

The term “shared savings” has been used to describe a variety of potential payment models, including accountable care organizations (ACO). The success of the ACO concept will depend largely on how this entity is organized, as well as how the structure would effectively provide care for uncommon, yet costly diseases. The reality is that the incidence of various disease processes in the general population is quite variable, and therefore the “minimum population size” on which an ACO might take risk in an actuarially sound manner varies widely by the type of disease in question. An ACO would have to enroll millions of patients to develop significant expertise in the management of these disease entities, and the structure and financing of ACOs must not provide incentives to retain the care of these types of patients within care organizations without the experience and expertise to provide the best patient care. We recognize the need for improved coordination of care and reduction of resource utilization, but we suggest that improvements in health information technology, particularly interoperability and outcomes data feedback, are central to improved care coordination and more effective resource utilization.

We agree that if implemented, participation in shared savings programs should be voluntary, non-punitive and not restrict patient choice. We also agree with the inclusion in the criteria the requirements that the entity have in place both contracts with a core group of specialist physicians and processes to promote evidence-based medicine, report on quality and costs measures, and coordinate care.

As various shared savings programs models continue to be tested and explored, the surgical community urges the Committees to strongly consider policy changes that will allow for flexibility in the development these programs. Specifically, we support a new, targeted exception to the physician self-referral laws to permit provider arrangements, such as those between hospitals and physicians that foster high quality, cost-effective care through economic incentives. Another hurdle is the antitrust laws and/or the enforcement policies of the Department of Justice and Federal Trade Commission. Changes must be implemented to ensure that providers who wish to collaborate by forming an ACO do not run afoul of the antitrust laws. A number of attempts at shared savings programs involving cardiothoracic surgeons, including one sponsored by the Virginia Cardiac Surgery Quality Initiative, have been derailed due to concerns by the Office of the Inspector General and the Department of Justice regarding violations of physician self referral and civil monetary penalty laws. These programs have demonstrated the ability to generate improved outcomes through reductions in post-operative complications and thus to reduce costs. We believe that it is good public policy to enable these types of programs.

### ***Medical Home Pilot Program (Sec. 1302)***

We applaud you for recognizing in the Medical Home Pilot Program (Division B, Title III, Section 1302) that medical homes may be best led not just by primary care physicians, but also

medical subspecialists, who may act as the principal-care physician. As the legislation indicates, accessible health care in a medical home model can often best be provided by a physician who is a medical subspecialist, focused on addressing “the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist’s expertise, and for whom the subspecialist assumes care management.” For example, a 65-year-old male whose most significant medical condition is prostate cancer requires a urologist’s expertise and will best rely on that urologist for his personal health care needs and care management. Similarly a woman undergoing treatment for gynecological cancer would be best served by her gynecologic oncologist, who would provide for all her health care needs during this time and take responsibility for arranging care with other providers as appropriate.

### ***Increased Payments for Primary Care (Sec. 1303)***

The surgical community shares your concern regarding the need to ensure patient access to primary care services. While we support increased Medicare payments for our physician colleagues in primary care, we oppose any measure that would finance increased payments for primary care through an across-the-board reduction in payments for all other services. We appreciate that the 5 percent additional payment for primary care services included the draft legislation (Sec. 1303) would not be financed through decreased payments for other important physician services.

While the draft does not finance these additional payments through reductions in payments for other services, including surgical care, some have proposed financing these payment increases through such reductions. Such measures, while seeking to promote important physician services, would have a negative effect on patients’ ability to access other needed services, including surgical care. It should be noted that primary care physicians are not the only ones for whom Medicare reimbursement has failed to keep pace with the rising cost of practicing medicine. In fact, since 1989, Medicare reimbursement for many surgical procedures has been significantly reduced. For example, a three vein coronary artery bypass graft surgery (CPT 33512), for which Medicare paid an average of \$3,957 in 1989, is now reimbursed at an average of \$2,374—a cut of 40 percent in 20 years. Medicare payment reductions have affected a wide range of surgical care including cataract removal (CPT 66984), removal of spinal lamina (CPT 63047), and total hip replacement (CPT 27130), which have been cut 59.38 percent, 51.15 percent, and 43.96 percent, respectively.

We appreciate the Committees’ decision to not finance increased primary care payments through reductions in payments for other physician services. If the language included in the House bill were modified to finance these increased primary care payments in a budget-neutral manner that requires reductions in surgical payments, such an approach would be one that the surgical community would vigorously oppose.

### ***Comparative Effectiveness Research (Sec. 1401)***

The surgical community embraces the need for clinical comparative effectiveness research (CER) and we are pleased that the draft Tri-Committee health care reform bill includes CER provisions. We believe that well designed comparative effectiveness research can be a valuable

tool in meeting our health care challenges and supporting high quality clinical decision-making. Proposals to expand government-supported CER, if appropriately structured, can benefit patients by supporting health care decisions that best meet individual needs, improve overall quality of care and support continued medical progress.

At the same time, such research can be misapplied in ways that restrict patient access to optimal care, undermine physician/patient decision-making, and discourage continued medical progress. While surgeons are thrilled that the ARRA has provided significant “seed” money to begin conducting CER, we are also concerned that there is no appropriate independent structure or framework in place to oversee the CER enterprise and ensure that this research adheres to certain important principles. To that end, we ask that you consider the following principles and ensure that the legislation:

- Focuses on communicating research results to patients, providers and other decision makers, not making centralized coverage and payment decisions or recommendations;
- Provides information on clinical value and patient health outcomes, not cost-effectiveness assessments;
- Recognizes the diversity, including racial and ethnic diversity, of patient populations and subpopulations and communicates results in ways that reflect the differences in individual patient needs;
- Examines all aspects of health care including care management, medical interventions, benefit design, and processes of care for all patients;
- Establishes a governance structure that ensures appropriate experts are appointed to research advisory panels (e.g., physicians who are involved in treating the disease or disorder under consideration) and adequate physician representation on any CER Board;
- Ensures full transparency and adequate opportunity for surgeons to have input into the development of CER priority topics, research project methodology, and final CER findings;
- Provides physicians with certain medical liability protections (e.g., a rebuttable presumption or an affirmative defense that the doctor complied with the guidelines and therefore cannot be liable) when they follow clinical practice guidelines that are based on CER recommendations;
- Engages existing clinical registries and databases and their sponsoring societies in the CER process.

While we are pleased that the Tri-Committee draft bill meets some of the above criteria, we are concerned that the CER structure would be placed within the Agency for Healthcare Research and Quality rather than in an independent CER institute. Furthermore, we believe that the language could be strengthened to ensure that the focus of CER is on *clinical* not cost effectiveness research. The surgical community considers the *Comparative Effectiveness Research Act of 2009* (H.R. 2502), sponsored by Rep. Kurt Schrader, and the *Patient-Centered Outcomes Research Act of 2009* (S. 1213), sponsored by Senators Max Baucus and Kent Conrad, to represent a strong starting point that is consistent with organized surgery’s principles. We,

therefore, urge you to build off the framework of these bills, replacing the CER provision that is in the current draft legislation with a section based on the Schrader or Baucus/Conrad model.

***Physician Payments Sunshine Provision (Sec. 1451)***

The surgical community strongly supports disclosure and transparency of physician and industry relationships and believes that a reliable system of transparency will reinforce ethical standards that have long governed the practice of medicine. However, we are opposed to the language that includes reporting of industry funding for continuing medical education (CME) and professional organizations and strongly urge the Committees to remove sponsors of CME and professional organizations from the list of covered recipients. CME has long advanced the educational foundations and cutting edge science of our medical system, and issues relating to disclosure have not been thoroughly vetted. The complexity of this issue was evident during MedPAC's deliberations last year and we believe this issue must be thoughtfully considered and debated with all stakeholders participating in the process. Most, if not all, of the surgical specialty societies have specific provisions in their codes of ethics regarding industry funding of CME, and the ACGME has strict requirements on how industry funds can be accepted and applied if CME credit is to be awarded.

Furthermore, the surgical community opposes the five dollar threshold for reporting. Setting the threshold at such a nominal amount creates an onerous and burdensome requirement on the reporter and devalues the importance and true intent of the language.

In addition, the surgical community believes the language in the draft can be strengthened by including a provision that ensures the reporting and disclosure requirements would preempt state law. To reduce reporting errors and minimize public confusion, we believe that a national standard of reporting is preferable to the patchwork of state laws that would be created should the requirements allow states to go beyond what would be covered under federal law. Finally, the surgical community believes it is critically important that physicians have the opportunity to review and correct information about their financial relationships before those disclosures are made publically available.

***Distribution of Unused Residency Positions (Sec. 1501)***

Workforce shortages affect nearly all surgical specialties and occur in both rural and urban areas. The *Archives of Surgery* published an analysis last April that showed a decline of more than 25 percent of general surgeons between 1981 and 2005 in proportion to the U.S. population. Looking to the future, between 2005 and 2020, the Bureau of Health Professions projects an increase of only 3 percent among practicing surgeons, with declines projected in cardiothoracic surgery (-15 percent), urology (-9 percent), general surgery (-7 percent), plastic surgery (-6 percent), and ophthalmology (-1 percent). Further, according to the Association of American Medical Colleges (AAMC) specialties like cardiothoracic surgery experienced an absolute decline in practitioners and a Government Accountability Office study released May 4, 2009 reports a 40 percent decline in applications for cardiothoracic surgery residency positions from 2004-2008. It should be noted that according to the AAMC October 2008 report, the anticipated physician workforce shortage in 2025 is nearly identical for primary care as surgery, with a projected shortage of 46,000 in primary care and 41,000 in surgery. Some experts believe that

had a cap not been imposed on graduate medical education (GME), the U.S. would not be faced with such severe surgical workforce shortages.

Addressing this problem presents a unique challenge for surgery. Physicians entering practice will not grow in spite of an increase in medical school graduates. Residency training is the limiting factor in the pipeline for the shortage. The training is rigorous and lengthy and it will take longer to fill the surgical pipeline than to increase the number of other specialists. In order for surgical residency programs to expand in response to increased patient demand, additional patient and educational resources will be necessary. Quality should be a major factor in determining which education and resident training programs should be funded and how additional residency slots will be allocated. Other factors, such as geographic need, current and future populations' needs, and minority participation, are also important considerations.

We agree that efforts to expand the number of insured Americans must be accompanied by proposals that will ensure an adequate health care workforce to meet the anticipated increase in demand for health care services. A redistribution of unused residency training positions will begin to address the workforce shortages in areas like primary care and general surgery. Consideration should also be given to redistributing residency training positions to other specialties experiencing anticipated workforce shortages, like cardiothoracic surgery, and subspecialties such as pediatric neurosurgery and pediatric orthopaedic surgery. Estimating future workforce shortages is not a perfect science and therefore reallocating unused slots - which those specialties may never regain - has the potential to exacerbate already apparent and emerging workforce shortages in some medical specialties unless an option to lift residency caps is included.

The surgical community encourages the Committees to examine other policy options that will create incentives for medical students to pursue training in specialty areas with demonstrated or anticipated workforce shortages, taking into account the severe workforce shortages in surgical specialties. Such solutions should ensure the quality of surgical training and a workforce that meets our nation's unique geographic and population needs.

#### ***Improving Accountability for Approved Medical Residency Training (Sec. 1505)***

The surgical community recognizes and appreciates the substantial investment that the Federal government makes in supporting graduate medical education (GME). Given that Medicare spends nearly \$9 billion annually on GME, we acknowledge that the medical education system needs to be accountable to ensure that Medicare is getting value for its contributions to training and educating our nation's doctors. However, we are extremely concerned about the sections in the draft that would (1) set forth in law the goals of medical education and (2) require a GAO study to evaluate training programs. Surgery believes very strongly that medical education should remain in the purview of medical educators. Furthermore, the Accreditation Council for Graduate Medical Education (ACGME), and its component Residency Review Committees, are the most appropriate bodies to oversee graduate medical education and they are already effectively addressing the issues raised in this section of the legislation. We therefore believe that Section 1505 of the draft legislation is simply unnecessary and urge you to delete this from the bill.

The ACGME is a non-profit council that evaluates and accredits medical residency programs in the U.S. Its member organizations are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies, which each appoint four members to the Board of Directors. The ACGME Board also includes two resident members, three public directors, the chair of the Council of Review Committee Chairs and a non-voting federal representative. The ACGME has 28 review committees (one for each of the 26 specialties, one for a special one-year transitional-year general clinical program, and one for institutional review). As stated by the ACGME, “the purpose of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's ethical, professional and personal development while ensuring safe and appropriate care for patients.” To further its mission of improving “health care by assessing and advancing the quality of resident physicians’ education,” the ACGME has established a set of common program requirements, or general competencies, that all residency training programs are required to integrate into their curriculum. These 6 core competencies include: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. These are defined as follows:

***Patient care*** - Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

***Medical knowledge*** - Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences as well as the application of this knowledge to patient care.

***Practice-based learning and improvement*** - Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one’s knowledge and expertise;
- set learning and improvement goals;
- identify and perform appropriate learning activities;
- systematically analyze practices using quality improvement methods, and implement changes with the goal of practice improvement;
- incorporate formative evaluation feedback into daily practice;
- locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
- use information technology to optimize learning; and
- participate in the education of patients, families, students, residents, and other health professionals.

***Interpersonal and communication skills*** - Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicate effectively with physicians, other health professionals, and health-related agencies;
- work effectively as a member or leader of a health care team or other professional group; and
- act in a consultative role to other physicians and health professionals maintain comprehensive, timely, and legible medical records, if applicable.

***Professionalism*** - Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession; and
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

***Systems-based practice*** - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinate patient care within the health care system relevant to their clinical specialty;
- incorporate considerations of cost awareness and risk-benefit analysis in patient or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in inter-professional teams to enhance patient safety and improve patient care quality; and
- participate in identifying system errors and implementing potential systems solutions.

This movement to a competency-based system of accreditation is part of the ACGME's Outcome Project, which started back in 1999, and reflects an increasing emphasis on educational outcome assessment in the accreditation process. The Outcome Project will be completely phased-in in a few years. In addition, it is our understanding that the ACGME is also moving toward an evaluation system for programs that would be annual rather than every five years.

The profession, through the individual medical and surgical specialties, is also constantly evaluating and reevaluating its graduate medical education curricula to ensure that it is appropriately achieving the goals of medical residency training and education. Neurosurgery, for example, established a special Task Force on Resident Education a number of years ago. Through this ongoing initiative, organized neurosurgery is fully evaluating its current residency training and education methods and curriculum to meet our nation's current and future health care needs related to neurological surgery. This is but one example of the commitment the profession has made to ensuring that the medical education and training system is dynamic and responsive to those who underwrite and support GME and to our country as a whole.

As you can see, medical education professionals, working through the ACGME and their specialties, are fully addressing the elements included in Section 1505 of the discussion draft. Given this fact, we are puzzled about what problem the Committees are trying to solve. Surgery is not aware of any data to support the notion that our graduate medical education system – which we have so carefully built over many years and are continually trying to improve as the health care system evolves - is not meeting its goals. We are confident that the ACGME stands ready to continue to take on these important tasks and so again, we urge you to delete section 1505 from the final legislation.

***Physicians who order durable medical equipment or home health services required to be Medicare participating physicians (Sec. 1637)***

The addition of the word “participating” to this section of the legislation is inappropriate. For a variety of reasons, many Medicare beneficiaries are treated by non-participating physicians, and the ordering of durable medical equipment (DME) is the standard of care for certain conditions. Restricting non-participating physicians from ordering DME will hinder patients' access to items that are essential to quality medical care. In addition, it is not clear whether or not any cost savings or quality improvement benefits will be realized by implementing this requirement.

Relevant to this subject, we also recommend that negative pressure wound therapy (NPWT) be removed from its current classification as DME, because it will likely be subject to competitive bidding in the future. Surgeons routinely provide NPWT following procedures such as skin grafting or debridement of open wounds to facilitate healing. Not all NPWT products are clinically equivalent. Therefore, selection of NPWT products should be based on clinical efficacy, not on price, as a competitive bidding program would dictate.

**Division C**

***Loan Repayment Programs (Sec. 2211)***

Our nation is facing a health care workforce shortage and is not meeting the needs of patients in underserved areas. The surgical community and others have continued to warn that the nation's health care shortages extend beyond primary care, and we are already seeing signs of an emerging national crisis in patient access to surgical care. The House draft legislation recognizes that need and attempts to provide these communities with the providers that are on the frontlines of care.

We applaud the committee for including “primary health services” and believe that there are many surgical providers that are essential to providing the necessary pediatric eye and ear screenings defined there, as well as providing acute emergency care. We suggest that the committees examine H.R. 2891, the *Access to Frontline Health Care Providers Act* offered by Representatives Braley and Space.

Included in this legislation are provisions for surgical specialists, such as ophthalmologists and otolaryngologists, that provide essential screenings for vision and hearing diseases to benefit from a loan repayment program, drawing them to serve in communities where their services are most in need. Devastating and costly diseases can often be easily detected through these early screenings – if the communities in need have access to the physicians that are necessary to provide them.

General surgeons are specifically trained to provide comprehensive general surgical care, and because their expertise is broad, they are qualified to manage a wide variety of medical conditions. When patients require complex, multi-system care, a general surgeon can fill the gap between other physician specialties. In the case of major trauma, general surgeons are frequently on the frontlines of emergency care, saving lives on a daily basis.

The *Archives of Surgery* recently published an analysis of the trends of the general surgery workforce between 1981 and 2005. Though the American population grew by more than 60 million people, the number of general surgeons actually declined by 4.2 percent over the same time span, with rural and underserved areas having significantly fewer general surgeons per capita than their urban counterparts. H.R. 2891 would assist general surgeons that wish to fill this need in these communities with the heavy debt burden they carry after medical school.

Additionally, the “Access to Frontline Health Care Act” would offer loan repayments to relieve some of the staggering debt burden faced by many health professionals that are in short supply but high demand in underserved areas. This assistance would allow these individuals who are motivated to care for underserved communities to enter and complete health professions training that might otherwise be unaffordable to them. The assistance would free them to take a career path that may be less lucrative, but more satisfying. Communities identified as “frontline shortage areas” will gain access to needed health care services that could continue after the minimum time commitment has ended. We encourage the committee to examine this legislation and provide for its inclusion in the package.

The Committees should also make loan forgiveness programs available to surgical specialties with documented current or potential workforce shortages, especially those specialties with longer training programs. As an example, cardiothoracic surgeons treat the two leading causes of death in the United States, heart disease and lung cancer, which are highly prevalent in the Medicare population. Yet, there has been a significant decline in the number of applications to fill cardiothoracic residency training positions. If financial incentives, such as loan forgiveness, are not available, this trend is forecast to continue and there will be a shortage of cardiothoracic surgeons to provide care for a rapidly expanding Medicare population. Another specialty in short supply is pediatric neurosurgery, where only 6 fellowship-trained pediatric neurosurgeons are certified by the American Board of Neurological Surgery annually. This is an insufficient supply when considering that 41.7 percent of the current pediatric neurosurgical workforce may retire in the next 10 years.

## **Additional Provisions for Consideration**

### ***Prevention and Screening***

The surgical community strongly supports the numerous provisions within the House discussion draft regarding prevention and screening. However, as noted below regarding trauma care, the House plan largely sidesteps another critical issue facing our country today - the growing obesity epidemic. How will this new delivery system help the patient who has a body mass index (BMI) that would classify them as overweight, obese or morbidly obese?

Multiple large epidemiologic studies have demonstrated that increasing BMI, particularly above 30 (defined as obesity), is associated with an increased risk of death or premature mortality. This relationship holds for various age groups, ethnic and minority populations and in different geographic locations. In addition, obesity is associated with multiple comorbidities, which are either caused or worsened by obesity. Furthermore, these comorbid conditions are expected to improve or resolve if effective weight loss is achieved.

More than 20 such conditions have been identified, some of which are known to be associated with premature mortality and play a role in mediating the premature mortality associated with obesity. Included are type 2 diabetes, hypertension, dyslipidemia, pulmonary disease (obstructive sleep apnea and restrictive lung disease), and multiple cancers. Additional comorbid conditions include renal and liver disease, musculoskeletal disease, gastroesophageal reflux disease, psedotumor cerebri and a variety of psychosocial conditions.

While health insurance plans generally provide coverage for a comprehensive treatment approach for many of the above-mentioned chronic diseases, the same is not true regarding obesity. A truly reformed health care system should provide coverage for the continuum of care for the overweight or obese patient – including behavioral, pharmaceutical and surgical treatment. Such an approach would be consistent with diagnosis and treatment coverage policy for other chronic diseases.

### ***Access to Emergency and Trauma Care***

Throughout the health care reform debate, Congress has focused primarily on increasing access to prevention services and “unclogging” our nation’s emergency rooms. However, this perspective largely ignores a critical aspect of patient health care - access to emergency and trauma care. The U.S. emergency care system is in crisis. According to the Centers for Disease Control and Prevention (CDC), traumatic injury is the leading cause of mortality for U.S. citizens younger than 44 years of age, and is the number one cause of mortality of children young than age 15. Medical evidence has shown that the care and treatment delivered within the first hour of a severe injury, known as the “golden hour,” are likely to mean the difference between temporary and permanent disability, 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, yet only one in four Americans lives in

an area with a trauma care system. Clearly, universal coverage does not equal access to emergency and trauma care.

In addition to saving lives, restoring functionality, and preventing disabilities, appropriate emergency trauma care also can serve an important role in achieving the larger goal of containing growing health care costs. The CDC estimates that approximately \$400 billion is lost each year due to medical costs and lost productivity. According to a report from the Agency for Healthcare Research & Quality (AHRQ), trauma injuries were the second most expensive health care condition in 2006, costing approximately \$68 billion. This total includes spending for physician visits, clinics, emergency room visits, hospital room stays, home health care, and prescription drugs. The cost of trauma-related emergency room visits 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.

Trauma systems allow for effective and efficient use of scarce and costly community resources. 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 health care delivery systems, showing that hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialists are often unavailable to take emergency call. The IOM found that a coordinated, regionalized, accountable system based on the current trauma care system model must 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 that a trauma patient receives largely depends on the quality of the regional and local system in place to respond to emergency situations.

To address these problems, the surgical community supports inclusion of the language included in the Emergency Medical Services section of the Senate Health, Education, Labor and Pension Committee's draft health care reform bill. The language is based on the IOM and EMTALA reports as included in the Improving Emergency Care and Response Act, the Trauma Care Systems and Development Act, and the National Trauma Center Stabilization Act, as well as new language on pediatric emergency care. Strengthening our nation's trauma systems, ensuring patient access to the critical care they need in trauma centers, and expanding trauma systems to encompass all emergency care by encouraging the regionalization of all emergency care in health care reform would be a step forward in addressing patient access to these services. By including these important provisions in health care reform, Congress will better ensure that patients will be able to access the right care, at the right time, when they need it.

### ***Liability System Reform***

As President Obama recently stated at the American Medical Association's Annual Meeting, we will not be able to make implement changes in our health care delivery system that reflect best practices, incentivize excellence and close cost disparities "if doctors feel like they are constantly looking over their shoulder for fear of lawsuits." And so while the surgical community is acutely aware of the current challenges in passing federal medical liability reform legislation, we

nevertheless believe that there are a number of approaches that would be worthwhile to pursue. To alleviate the medical liability crisis and ensure patient access to surgical services, we recommend that the House of Representatives bill should incorporate the following medical liability reform ideas in comprehensive health care reform legislation:

- Studying alternatives to civil litigation, including: early disclosure and compensation offers; the administrative determination of compensation model; and health courts;
- Providing medical liability protections for physicians who follow established evidence based practice guidelines;
- Protections for physicians volunteering services in a disaster or local or national emergency situation; and
- Provisions similar to those in place in California or Texas, which includes reasonable limits on noneconomic damages.

Again, thank you for your leadership and commitment to comprehensive health care reform. The surgical community appreciates the opportunity to provide comments on the discussion draft that will be considered by the Committees in the coming weeks. We look forward to continuing to work with you as the health care reform moves through the legislative process.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery  
American Academy of Ophthalmology  
American Academy of Otolaryngology-Head and Neck Surgery  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Obstetricians and Gynecologists  
American College of Osteopathic Surgeons  
American College of Surgeons  
American Osteopathic Academy of Orthopedics  
American Society of Breast Surgeons  
American Society of Cataract and Refractive Surgery  
American Society of Colon and Rectal Surgeons  
American Society for Metabolic & Bariatric Surgery  
American Society of Plastic Surgeons  
American Urological Association  
Congress of Neurological Surgeons  
Society for Vascular Surgery  
Society of American Gastrointestinal and Endoscopic Surgeons  
Society of Gynecologic Oncologists  
Society of Surgical Oncology  
The Society of Thoracic Surgeons