



Statement
of the
American College of Surgeons

Presented by

Charles D. Mabry, MD, FACS

before the
Committee on Small Business
United States House of Representatives

RE: *Medicare Physician Fee Cuts:*

Can Small Practices Survive?

May 8, 2008

Madam Chairwoman, Ranking Member Chabot, and Members of the Committee, my name is Charles D. Mabry, MD, FACS, and I am a general surgeon from Pine Bluff, Arkansas. I am the Chairman of the American College of Surgeons Health Policy Steering Committee and am here representing the American College of Surgeons and its more than 74,000 members, the large majority of who work in and own small businesses. We are grateful to you for holding this hearing on the Medicare physician payment system and, specifically, how that system impacts the ability of the small business surgeon to provide high-quality and efficient care to Medicare beneficiaries and to their communities as a whole. Contrary to public perception, most surgeons are not employees of the hospitals in which they operate but rather are small business owners. I am a small business owner and one of seven general surgeons in my town of 60,000. I practice at Jefferson Regional Medical Center, a 300-bed hospital that serves as the regional referral center for southeast Arkansas.

Surgeons as Small Business Owners

Seventy-eight percent of the Fellows of the American College of Surgeons practice in an office-based private practice, and on average, they derive 38 percent of their revenue from Medicare.¹ Forty percent of our Fellows are general surgeons. The typical general surgery practice is composed of five surgeons and 15 employees. Each individual general surgeon employs three health care workers with a payroll of roughly \$130,000. These practices and

¹ Characteristics of Office- Based Physicians and Their Practices: United States, 2005–2006 Data From the National Health Care Survey, April 2008

their employees typically purchase services and supplies within their own communities, often from other small businesses. Thus, in addition to providing critical surgical care to their communities, surgical small businesses help support local economies and numerous local small businesses.

As small businesses, surgical practices, including my own, have seen costs rise year after year due to single- and double-digit increases in the costs of medical supplies, professional liability insurance, health insurance for our employees, and numerous other business expenses. Like any other business, surgical practices must budget and plan for the future. Medicare payments compose a major source of revenue for surgeons (25-40%)², and we have seen continued, inflation-adjusted decreases in Medicare payments for major surgical procedures—in some cases, as high as 70 percent—since 1989. Sound business planning for surgical practices has been further complicated by the annual possibility of cuts of 5 percent or more in Medicare payments, which are required under Medicare's current method for calculating physician reimbursement known as the sustainable growth rate (SGR).

The Crisis in Surgical Workforce in America

Cuts in Medicare reimbursement coupled with rising practice costs are a major reason that many surgeons are retiring early, moving their practices to a hospital-based location, or opting to sub-specialize. The decrease in the numbers of surgeons is being seen across the surgical specialties, including my specialty

² Data from Medical Group Management Association, Cost Survey 2006

of general surgery. Between 2000 and 2005, the number of general surgeons in full-time practice decreased by 4.4 percent; over the same period, the number of thoracic surgeons declined by 4.7 percent.³ Between 2005 and 2020, the number of practicing surgeons is expected to grow only 3%. If obstetrics and gynecology, which is often classified by policymakers as a primary care specialty, is not included in this calculation, the actual number of practicing surgeons in all surgical specialties is projected to decrease by 1.7 percent over this time period—with several specialties, including general surgery, thoracic surgery, and urology facing much larger projected declines in their total workforce.⁴

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. Unlike other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist when it comes to trauma care or surgical emergencies.⁵ A recent study by the Lewin Group has noted that trauma surgical specialties are in short supply for emergency department (ED) on-call panels, while the American College of Emergency Physicians notes that 75% of ED medical directors have inadequate on-call surgical coverage, an increase from two-thirds in 2004.^{6, 7}

³ Bureau of Health Professions. Health Resources and Services Administration. Physician Supply and Demand: Projections to 2020. October 2006

⁴ Bureau of Health Professions. October 2006

⁵ Zuckerman R. General surgery programs in small rural New York state hospitals: a pilot survey of hospital administrators. *J Rural Health*. 2006;22(4):339-342

⁶ Lewin Group Analysis of AHA ED Hospital Capacity, 2002
<http://www.aha.org/ahapolicyforum/resources/EDdiversionsurvey0404.html>

The compounding challenges facing surgeons are leading increasing numbers to choose a hospital-based practice over private practice. In fact, since 2001, there has been an 18 percent decrease in office-based surgical practices.⁸ If a surgeon is forced to move from private practice to a hospital-based practice, the effects on other individuals and businesses can be significant. In fact, it is often the small businesses that furnished services and supplies to that office-based surgical practice that suffer because hospital-based practices often purchase services through large, national suppliers as opposed to local small businesses. In addition, a shift from office-based to hospital-based practice may result in the laying off of some of the office employees, further impacting a community and its economy.

However, the worst case scenario is when a surgeon retires or moves thereby leaving the local hospital without the capability of providing surgical care to patients. This is a scenario that is becoming increasingly common in hospitals in rural communities. In such a situation, the hospital must replace the departed surgical specialty within 18 months or significantly curtail services. Often, those hospitals are subsequently forced to close.⁹ Such closures have a devastating impact on the health care of the community, the economy, and especially on the small businesses that support these communities.

⁷ ACEP On-call specialist coverage in US EDs, April 2006 <http://www.acep.org>

⁸ Characteristics of Office- Based Physicians and Their Practices: United States, 2005–2006 Data From the National Health Care Survey

⁹ Fischer, JE. The Impending Disappearance of the General Surgeon. JAMA 298(18) 2191-3, Nov 2007

For example, researchers at the Sheps Center at the University of North Carolina found that between 1995 and 2005, 47 counties in North Carolina suffered a decline in the numbers of general surgeons, and four counties lost all of their general surgeons.¹⁰ In my state of Arkansas, we have seen a similar, disturbing pattern. Between 1997 and 2004, 12 Arkansas counties saw a decline in the number of practicing general surgeons; seven counties lost all of their general surgeons. In those seven counties, five hospitals have significantly reduced their services and two have closed their doors. It is in situations such as these that we observe the far-reaching impact of the surgical workforce shortage. If current trends are not reversed, such situations are likely to become increasingly common in our rural communities.

Medicare: A Broken Payment System

The sustainable growth rate (SGR) was created to control the growth in Medicare spending for physician services by setting targets for allowable Medicare spending on physician services from one year to the next. Whenever the spending target is exceeded in a given year, the spending above the target must be recouped in future years, resulting in a reduction in the Medicare conversion factor, the key component in determining Medicare payments for physician services. As a result, this spending above the SGR results in payment cuts for all physician services, regardless of whether utilization of a particular service actually grew beyond the limits of the SGR. This means that services

¹⁰ NC Health Professions Data System, and the Southeast Regional Center For Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, UNC, Chapel Hill 2007

with relatively inelastic demand and lower rates of growth, such as surgery, are subject to the same payment cuts as rapidly growing services that exceed the limits of the SGR.

In 2002, the SGR resulted in a 5.4 percent reduction in the Medicare conversion factor, and congressional action has been needed to prevent further cuts every year since. Late last year, by replacing a scheduled 10.1 percent with a 0.5 percent increase, Congress approved the first increase to the conversion factor since 2005. Unfortunately, these provisions will expire on June 30, and without congressional action, payments are scheduled to be cut 10.6 percent on July 1, 2008. Without further congressional intervention or full-scale reform, payments are scheduled to be cut over 40 percent by 2016.

In the past five years, spending on Medicare physician services has increased between 7 and 14 percent per year. These increases are fueled by growth in the volume and intensity of evaluation and management (E/M) services, imaging, lab tests, physician-administered drugs, and minor procedures. However, volume for major surgical procedures has remained relatively low—growing by less than 3 percent a year. While other specialties can increase Medicare billings by increasing the volume of the services they provide, surgeons cannot. For example, while a patient may see a physician many times for a particular condition, a surgeon can only remove a patient's gall bladder once. As a result, it is much more difficult, if not impossible, for surgeons to compensate for payment reductions by providing additional services or by seeing an individual patient more often.

Further, surgical care is reimbursed differently than other physician services in Medicare, making the ability to bill for additional services much more difficult for surgeons than other specialties. This is because the bulk of care provided by surgeons, unlike other physician services, is not reimbursed as discrete units but rather is reimbursed in global payments over 10- or 90-day periods. Instead of being paid separately for the surgery and for each post-operative visit associated with the surgery, the surgeon is paid in one payment for all of the necessary care associated with a patient's surgery over that period. As a result, this reimbursement structure adds an implicit incentive for the surgeon to ensure that the surgical care he or she is providing is being delivered in the most efficient way possible.

The challenge facing surgical reimbursement in Medicare also extends beyond the SGR. This is because the SGR and the conversion factor, though significant, are not the only factors in determining reimbursement for a particular service. Every five years, the Relative Value Update Committee (RUC), which is convened by the American Medical Association and comprised of physicians from across the spectrum of physician specialties, meets to make recommendations regarding the value of the work included in physician services provided under Medicare. The RUC assigns a value for the work in each service relative to the value of the work in other physician services. The values assigned to the work in each service are measured in relative value units (RVUs). After the completion of the five-year review process, the RUC's recommendations are submitted to the Centers for Medicare and Medicaid Services (CMS), who

reviews the RUC's work and implements the final recommendations, sometimes with modification, in the Medicare physician fee schedule. The most recent five-year review was completed in 2006 and implemented on January 1, 2007.

Under the RUC's most recent five-year review, which CMS approved, more than \$4 billion in the fee schedule was shifted to E/M codes from codes for other services, including surgical care. For instance, the work values associated with an intermediate office visit, the most frequently billed physician service in Medicare, increased 37 percent. Because all changes to the fee schedule must be budget-neutral, these increases were offset by a 10.1 percent across-the-board reduction in work values for all physician services, known as the "work adjuster." As a result, in 2007, most surgical codes were cut between 3 and 7 percent, depending on how many E/M visits were factored into the service. In 2008, even with a 0.5 percent increase in the conversion factor, the calculation of new work values for other services, in particular anesthesia services, along with the phase-in of other changes relative to practice expenses, meant that Medicare payments for many surgical services were cut again. As a result, the minimal growth in overall Medicare physician payments has meant significant cuts for surgical reimbursement.

Solutions: Preserving Access Today and Tomorrow

While there are many facets to the broken Medicare payment system, it is critical that Congress act to protect patient access to surgical care and all physician services before July 1. It is hard to project what will happen if the 10.6

percent cut does go into effect, but it is scenario that none of us should want to explore. Therefore, the most important thing this Congress can do in the short-term is pass legislation to stop the scheduled 10.6 percent cut on July 1, 2008, and to replace a scheduled 5.4 percent cut in 2009 with a reasonable increase in Medicare physician payments. By stopping scheduled cuts through 2009, small business surgical practices will be better able to budget and plan for the next 18 months, and policymakers will be able to consider long-term reforms that will preserve patients' access to high-quality surgical care.

When the conversion factor was first cut in 2002, the physician community called on Congress to replace the SGR with payment updates based on a measure of practice cost inflation such as the Medicare Economic Index (MEI). From early on, budget policy complicated the prospects for this proposal, and the cost of this proposal has continued to escalate. According to the latest estimate from the Congressional Budget Office, this proposal would now cost as much as \$364.1 billion over the next ten years. As a result, the American College of Surgeons has developed an alternative for long-term reform.

The Service Category Growth Rate (SCGR)

As an alternative, positive solution, the College has proposed a reform of the Medicare physician payment system that recognizes the differences among the various types of services physicians provide to their patients. The College's reform proposal would establish a system of **six separate physician service categories** to use in calculating Medicare payment updates. The service

categories would include: 1) primary and preventive care; 2) other evaluation and management services; 3) major procedures; 4) anesthesia services; 5) imaging and diagnostic services; and 6) minor procedures and all other physician services.

In addition to the replacing the current SGR with separate service categories, the College's proposal would do the following:

- SCGR targets would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category.
- To accommodate already anticipated growth in chronic and preventive services, we estimate that primary and preventive care services would require a growth allowance about twice as large as the other service categories (between 4 and 5 percent as opposed to somewhere between 2 and 3 percent for other services).
- Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.
- As under the SGR, the annual update for a service category would be the Medicare Economic Index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or

less than 3 percentage points; nor could the update in any year be less than zero.

The benefit of separate physician service categories is that reimbursement for particular services would be based on the growth rates of similar services, allowing better analysis and understanding of the factors driving the rising costs of medical care and particular physician services. This stands in contrast to the current system of combining the utilization of dissimilar services to determine reimbursement rates. In addition:

- Low-volume growth services, such as major surgical care, would no longer be subject to the blunt payment cuts produced by the SGR.
- Different utilization trends would be easier to identify, providing the opportunity to study those differences so future payment policies can be developed to either allow higher growth rates or constrain spending, as appropriate, to meet beneficiary needs.
- Current and future efforts to identify and promote the use of specific services would be simplified.
- The SCGR would provide a framework for the development of quality improvement initiatives and value-based purchasing systems that are tailored to differences in the way various physician services are provided.

I am pleased to say that the College's proposal has already garnered significant bipartisan interest on Capitol Hill. The original version of the College's proposal was introduced as the "Medicare Physician Payment Reform Act of 2007," H.R. 3038, by Rep. Pete Sessions in July 2007. A modified version of the College's proposal was included in the "Children's Health and Medicare Protection Act of 2007," H.R. 3162, which was introduced by Rep. John Dingell and passed by the House on August 1, 2007. In addition, in a letter dated December 8, 2007, a bipartisan coalition of 140 members of the House of Representatives (90 Democrats and 50 Republicans), led by Rep. Lincoln Davis and Rep. Pete Sessions, sent a letter to Speaker of the House Nancy Pelosi and Republican Leader John Boehner expressing support for measures included in the House-passed CHAMP Act that would replace Medicare payment cuts in 2008 and 2009 with payment increases and would replace the Medicare payment system with a system that establishes six separate service category targets starting in 2010. By either voting for the CHAMP Act or signing the Davis-Sessions letter, 279 Members of the House have expressed support for separate service category targets.

Madam Chairwoman, thank you and your colleagues for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today, and to provide positive recommendations to help the small business medical practice survive. The College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the high-quality surgical care they need.

I appreciate this opportunity to testify before the committee and I would be happy to take any questions.

The American College of Surgeons is a voluntary, educational and scientific organization of 74,000 Fellows devoted to the ethical and competent practice of surgery and to enhancing the quality of care provided to surgical patients. Founded in 1913, the College was established to improve the care of surgical patients and the safety of the operating room environment. For over 90 years, the College has provided educational programs for its Fellows and for other surgeons in this country and throughout the world. In addition, the College establishes standards for the practice of surgical, trauma, and cancer care, as well as guidelines for office-based surgery facilities. It also provides information on surgical issues to the general public.

American College of Surgeons
Division of Advocacy and Health Policy
1640 Wisconsin Avenue, NW
Washington, DC 20007
(202) 337-2701