



Statement
of the
American College of Surgeons

Presented by

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before the
Committee on Small Business
United States House of Representatives

**“The President’s FY 2010 Budget and Medicare:
How Will Small Providers be Impacted?”**

March 18, 2009

Chairwoman Velazquez, Ranking Member Graves and Members of the Committee, thank you for holding this important hearing on Medicare policy proposals included in the President's Budget and their impact on small business providers and the patients they serve. My name is Dr. John Preskitt, and I am a general surgeon in private practice at Baylor University Medical Center in Dallas, Texas. As a Fellow of the American College of Surgeons (ACS) and a member of the ACS Board of Regents, I am honored to testify on behalf of the more than 74,000 ACS members regarding the President's budget and its impact on surgical practices and the patients our members serve.

I have been in private practice in general surgery and surgical oncology at Baylor since 1981. Seventy-eight percent of our members also practice in an office-based private practice. The average practice has five surgeons and 15 employees.¹ We must purchase health insurance and other benefits for our employees. We too are small businesses, and we struggle to maintain viable employment opportunities for our employees. And in all fairness, we are a very blessed profession.

Before turning to Medicare, I do want to express the ACS's appreciation for the President's commitment to healthcare reform in his budget. While there are many details to be sorted out along the way, the ACS applauds the overarching goals of President Obama's health care reform effort to expand access, improve quality, and reduce the growth of spending. These are goals that we share, and the ACS looks forward to working with the Administration and the members of this Committee on this important effort as the process moves forward. The ACS shares the belief that attention should be paid to initiatives that reward care that improves quality and reduces cost, and we are hopeful that these efforts will build on many of the successful initiatives undertaken by the ACS and our colleagues in medicine. Many of these efforts from the government's perspective have already started within the Medicare program, and it is widely expected that Medicare physician payment reform will be included in this effort. So it is appropriate that our conversation start with Medicare reimbursement.

Medicare Physician Reimbursement

Our member surgeons, on average derive 38 percent of their revenue from Medicare.¹ These surgeons feel the effects of Medicare's policy changes most directly because it is Medicare policy, particularly regarding reimbursement, that in large part determines the viability of their practices and their ability to continue to serve their patients.

Medicare's physician payment system is broken and needs to be replaced with a more reasonable structure that keeps pace with rising practice and liability costs and yet still provides healthcare value for our patients. If this system is not fixed, the people who stand to lose the most are the patients who depend on these physicians for care. Because of the sustainable growth rate (SGR), the Medicare method of calculating physician reimbursement, Medicare payments to physicians will be cut 21.5 percent on

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

January 1, 2010, if Congress fails to act. In fact, since the SGR first required a 5.4 percent reduction in payments in 2002, only congressional action has prevented additional cuts in each of the following years. On a couple of occasions, including last July, Congress has had to retroactively reverse cuts that had previously taken effect.

The ACS is grateful for the overwhelming bipartisan support that members on this Committee and the House of Representatives offered last July in passing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which reversed the 10.6 percent cut in Medicare physician payments that had taken effect earlier that month. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's—before adjusting for inflation.

The College appreciates the President's recognition that the current Medicare payment system is not sustainable or realistic if our nation is to have enough physicians to meet the health care needs of Medicare beneficiaries and our population as a whole. It is widely believed by members of both parties that the SGR is broken and should be reformed. The President's budget would provide \$147.1 billion over the next 5 years and \$329.6 billion over the next 10 years to initiate important and essential reforms to Medicare's physician payment system. Through this funding, the President's budget would reset the budget baseline for the SGR and would ensure that Medicare payments to physicians would not fall below current levels. According to some estimates this dollar amount could provide payment increases of up to one percent per year. With such a demonstrated commitment, the ACS believes reform that recognizes rising practice costs, provides the right incentives for quality care, and ensures that patients can access the care that surgeons and our colleagues in medicine provide can be achieved.

While Medicare physician reimbursement will have the most immediate and obvious impact on surgeons, surgical practices, and surgical patients, the President's budget includes other proposals that could also impact surgical practices and patient access to surgical care. Given that the Budget Outline was a broad document, it is our hope that the Administration and Congress will keep an eye to patient access to quality surgical care as it considers how and whether or not to ultimately pursue these policy proposals.

Hospital Payment and Quality Improvement

One of the significant areas of reform included in the Budget Outline is hospital payment reform. While our members are paid separately from hospitals, surgeons are the critical component of the care delivered in hospitals, and surgeons and hospitals work together to serve patients facing a major illness, disease or injury. If hospitals do not have surgeons, hospitals cannot survive and patients in the surrounding community are

forced to travel great distances to seek surgical care. Likewise, our members cannot serve patients if there is not a hospital with whom to partner in caring for patients.

An area of both promise and potential pitfalls is the proposed expansion of the current hospital quality improvement (QI) program. While the budget does not address this directly, some have proposed expanding hospital quality improvement efforts and hospital payments to include surgical care. In order to ensure the expanded program's success, it will be essential that the hospital program and the Physician Quality Reporting Initiative (PQRI) be in harmony to improve and not impede quality surgical care. As a result, if surgical care is included in this effort, it is critical that the perspective of surgeons and others who are caring for these patients be considered. In addition, if surgical care is included, risk-adjustment to account for the wide-range of patient acuity will bring not only accountability but also added respectability that will yield the buy-in from hospitals, surgeons, and other stakeholders needed to ensure the program's success.

If surgical care is included in these QI efforts, the public reporting of performance data regarding specific hospitals becomes vital. As you know, the Centers for Medicare & Medicaid Services (CMS) already publicly reports certain hospital measures, but the addition of surgical care would require an added complexity and degree of caution. If surgical care is included, ensuring appropriate risk-adjustment will be absolutely critical to ensure that hospitals and surgeons are not penalized for caring for high-risk and severely ill patients. The ACS is concerned that at present there are considerable limitations with the public reporting of hospital quality information. These limitations were recently chronicled in the November/December 2008 issue of *Health Affairs*.² In the article, some hospitals listed as top performers in one survey were listed toward the bottom of another and vice versa. Before reporting this type of data to the public, it will be necessary to ensure that the measures being used are recognized by clinicians as true measures of quality and not simply proxies for what a payer, private or public, or a consumer may interpret as quality care. One such proposed proxy has been to define "high quality" providers as those, who on a review of claims data, perform the highest number of certain procedures. Such proposals could have particular impact on rural and other underserved areas where general surgeons care for a wide range of patients with a wide range of conditions, diseases, and injuries. Many rural, frontier and even some urban communities already face an emergency and surgical workforce crisis, and, if not done carefully and accurately, public reporting could serve to threaten patients' ability to access care in these smaller communities. The public reporting of data that has not been appropriately aggregated and risk-adjusted could lead to incentives that eventually drive surgeons and patients away from these rural communities to hospitals in larger cities. Such a result would not only bring added inconvenience to patients as they seek acute health care services, but it would also threaten the future of hospitals in these smaller, rural communities. These rural hospitals not only serve an important economic function in smaller communities, but they also serve as a safety net when

² Michael B. Rothberg, Elizabeth Morsi, Evan M. Benjamin, Penelope S. Pekow, and Peter K. Lindenauer, "Choosing the Best Hospital: The Limitations of Public Quality Reporting," *Health Affairs* 27, no. 6 (2008): 1680-1687.

patients are in need of emergency surgical care. The distance a patient travels before receiving the necessary care can often be the difference between life and death. As a result, it is of the utmost importance that appropriate safeguards be developed to ensure that public reporting does not threaten access to care in rural and underserved communities and that any reported data be based on sound clinical information with thorough testing before being released to the public.

In raising these cautions and concerns, I want to stress that the ACS also sees these QI efforts as an opportunity to build on successful efforts already underway in hospital quality improvement. Based on a highly successful effort within the Department of Veterans Affairs, which decreased VA post-surgical mortality by 27 percent over 10 years, the College has spearheaded the ACS National Surgical Quality Improvement Program (ACS NSQIP) in private hospitals across the country. ACS NSQIP is a prospective peer-controlled, validated database that quantifies 30-day risk-adjusted surgical outcomes, allowing for comparisons among all participating hospitals. After a pilot to test NSQIP in three non-federal hospitals in 1999, the ACS applied for a grant from the Agency for Healthcare Research Quality in 2001 to expand the program to 14 hospitals. Based on its successful application in these hospitals, the ACS has since expanded the ACS NSQIP program to include 220 hospitals nationwide. The Joint Commission already acknowledges the value of participation in ACS NSQIP and includes a Merit Badge next to the profile of all ACS NSQIP hospitals. It is important to note that ACS NSQIP also gathers data under the Surgical Care Improvement Project (SCIP), which has been offered by some for possible inclusion in future hospital QI payment reforms. As Congress has appropriately set incentives for physician participation in registries that satisfy the requirements of PQRI, the ACS believes that ACS NSQIP, a database already in existence, could similarly support efforts to design a meaningful hospital QI program for patients.

In addition to supporting the hospital QI expansion, the ACS NSQIP's use of 30-day risk-adjusted outcomes could also support the President's proposal to bundle hospital payments to cover not just the hospitalization but to cover care from certain post-acute providers provided within 30 days after hospitalization. Just as a successful hospital QI expansion must have risk-adjustment so must any proposal that would penalize hospitals with higher readmission rates. To simply punish hospitals with higher readmission rates, without accounting for the severity of patient's illness or other conditions that could lead to complications, could have adverse consequences for hospitals, surgeons and ultimately, the sickest of patients that they are seeking to serve.

Physician Ownership and Specialty Hospitals

One area of significant concern for our members is the general reference in the outline's summary lines to "[a]ddress financial conflicts of interest in physician-owned specialty hospitals." Because the outline does not offer specifics and does not cite scored savings or cost, it is difficult to respond to a specific proposal. It is well known that there is a concerted effort to deny physicians the right to invest in hospitals and other facilities that offer patients alternative treatment settings. In my home state of Texas, hospitals

and healthcare systems have partnered with surgeons and medical specialists to develop hospitals. This is a similar model to that which has been followed by hospital-physician partnerships in forming ambulatory surgery centers. These have been shown to provide a high quality, cost-effective alternative to hospital outpatient departments.

Recent proposals considered by Congress would not immediately eliminate existing physician-owned hospitals but would limit capital investment in existing facilities while ending the prospect of building and developing specialty hospitals in the future. Benefits of these physician-owned hospitals can include more cost-effective care; lower infection, complication and mortality rates; shorter hospital stays; and increased patient satisfaction. These hospitals can complement our very fine community hospitals and academic medical centers. If our nation's health policy is to be consistent with efforts to promote better quality and value in patient care, it makes little sense to no longer allow patients the option to receive care at facilities, which in many cases have been shown in government-sponsored studies to produce very good outcomes and have high patient satisfaction.³

In addition to limiting patient choice in care, there would also be a significant impact on the people who work at these hospitals, their families, and the economy in the surrounding community. These facilities employ 55,000 people, including nurses, other health professionals, and support staff.⁴ Measures limiting the ability of the facilities to improve and expand would certainly threaten these jobs as these facilities age. In addition, proposals that would disallow the development of physician-owned hospitals will not only threaten capital investments in communities but will threaten numerous associated jobs in construction and infrastructure required to build and prepare these facilities for delivery. This is an economic time in which our communities cannot afford further job losses. Imposing new limits on physician-ownership and investment in these facilities would most certainly lead to job losses and economic hardship for these facilities' employees and families.

The ACS recognizes that legitimate concerns have been raised by the actions of a few physician-owned hospitals, but this does not mean that all physicians should be punished and denied professional opportunities. Instead, the ACS has consistently held that physician-owned hospitals and their physician-owners should operate under the following principles:

- Accept all patients for which they can provide appropriate care, without regard to source of payment.
- Patient selection should be based on medical criteria and facility capabilities. Patients with needs that extend beyond a facility's resources should be referred

³ Michael O. Leavitt, Secretary of Health and Human Services, *Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Centers for Medicare & Medicaid Services: 2005.

⁴ Physician Hospitals of America, "Congressional Action Could Harm Physician Hospitals, Economic Impact Could Be Severe," Press Release, 13 Jan. 2009. 16 Mar. 2009
<http://www.physicianhospitals.org/documents/PHArelease011309National.pdf>.

to a tertiary care center or other hospital that is appropriately equipped and staffed.

- Surgeons practicing in specialty hospitals should maintain their commitment to providing the emergency services needed in their communities and should take call in community hospital emergency departments, as necessary.
- The issue of whether specialty hospitals should have their own emergency rooms is, and should remain, a matter of state law and community need.
- Physician investors should disclose their financial interest to patients they propose to treat in a specialty hospital.

Across America and across physician specialties, many physicians, from family physicians to radiologists to surgeons, own their individual practices. However, much of the care surgeons provide takes place outside of the office-based setting and within a hospital or ambulatory surgery center (ASC). 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 less cost. 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.

Preserving a Surgical Workforce for the Future

While outside the scope of Medicare, the ACS also appreciates that President's recognition of the workforce challenges facing our health care delivery system by providing \$330 million for health care provider workforce shortages in certain areas, and to expand loan repayment programs for physicians, nurse, and dentists in medically underserved areas. The programs referred to in the President's budget do not include surgeons and focus largely on primary care. While many raise concerns about the adequacy of the nation's primary care workforce, it is important to note that the care these physicians provide is just one component of our nation's health delivery system, and primary care is not alone among physician specialties in facing a workforce shortage to meet the needs of patients. The ACS and others have continued to warn that the nation's health care workforce challenges extend beyond primary care, and we are already seeing signs of an emerging national crisis in patient access to surgical care.

One of the areas where the ACS has seen this crisis emerging most rapidly and most acutely is among our nation's general surgery workforce. General surgeons are specifically trained to provide comprehensive surgical care, and because their expertise is broad, they are qualified to manage a wide variety of medical conditions. These conditions range from cancer to gastrointestinal disease, from endocrine tumors to ruptured aneurysms, from hypertension to breast cancer, and for the care of the injured patient. 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.

Last April, the *Archives of Surgery* published an analysis of the trends of the general surgery workforce between 1981 and 2005.⁵ The analysis showed that the number of general surgeons as a proportion of the population declined by 26 percent during that 25 year period. While this decline was felt in both rural and urban areas, rural areas continued to have significantly fewer general surgeons per capita than their urban counterparts. In addition, whereas in 1981, only 39 percent of the general surgeons practicing in rural areas were between the ages of 50 and 62; now, over 50 percent are between the ages of 50 and 62. Further complicating the outlook for general surgical care, the *Archives* study showed that while the number of general surgical residents has remained fairly static at approximately 1,000 per year since 1980, increasing numbers of general surgical residents are specializing. Whereas in 1992, a little over half of all general surgery residents entered a fellowship, now over 70 percent of all general surgery residents choose to pursue a fellowship.

Other research shows that general surgery is not alone among surgical specialties facing both current and future workforce challenges. The Dartmouth Atlas compiled surgical workforce data showing a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively.⁶ Further, the Bureau of Health Professions (BHP) projects an increase of only 3 percent among practicing surgeons between 2005 and 2020—with projected declines in thoracic surgery (-15%), urology (-9%), general surgery (-7%), plastic surgery (-6%), and ophthalmology (-1%). Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.⁷

With trauma care and surgical emergencies, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist. Surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Surgical residencies require a minimum of five years and often several more years for specialties such as cardiothoracic surgery. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of litigation; a crippled workforce leading to more on-call time, higher caseloads, and less time for patient care; and an uncertain future for the U.S. health care system understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The ACS has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical

⁵ Dana Christian Lyngge, Eric H. Larson, Matthew J. Thompson, Roger A. Rosenblatt, and L. Gary Hart, "A Longitudinal Analysis of the General Surgery Workforce in the United States," *Archives of Surgery* 143, no. 4 (2008): 345-350.

⁶ Figures compiled through analysis of data available at the Dartmouth Atlas website at: <http://www.dartmouthatlas.org/atlas/98Atlas.pdf>, <http://www.dartmouthatlas.org/atlas/99Atlas.pdf> and http://cecsweb.dartmouth.edu/atlas08/datatools/datatb_s2.php?geotype=SPL_HRR&year=2006.

⁷ Bureau of Health Professions, Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020*. October 2006.

workforce in the future. First, it is important to support existing residency programs and to promote the development of additional residency programs, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career, while also, as much as possible, eliminating the disincentives that push medical students away from the surgical profession. To this end, the ACS would encourage the members of this Committee to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.
- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

The College also supports legislation that seeks to increase the number of residency training programs. At present, a majority of residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the ACS believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The ACS will continue to support this and other legislation that helps ensure patient access to surgical care.

In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed

increased Medicare reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. While not included in the budget, the ACS is concerned that some may want to include such measures in Medicare payment reform. Such proposals, while seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. The ACS supports efforts to prevent disease and to promote wellness not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans.

The ACS greatly appreciates the opportunity to testify before the Committee regarding the President's budget and its impact on surgical practices and patient access to surgical care. The prospect of meaningful and lasting health reform and Medicare payment reform offers much cause for hope but we should proceed with caution as well. Increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. That is why we must carefully consider what has worked and what has not. The ACS believes that the patient must be our guide on Medicare physician reimbursement, quality improvement, physician ownership, workforce or any other issue considered in the context of health reform. The American College of Surgeons stands ready to work with the members of this Committee, the Congress and the Administration on this important effort to reform our nation's health care system and to ensure that all Americans will continue to have access to quality surgical and medical care for years to come.