October 5, 2023

The Honorable Jason Smith
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
U.S. House of Representatives
371 Cannon House Office Building
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

On behalf of the more than 88,000 members of the American College of Surgeons (ACS), I appreciate the opportunity to respond to your request for information on improving access to health care in rural and underserved areas. The ACS appreciates the House Ways and Means Committee's attention to this critical issue and welcomes the opportunity to discuss some of our legislative priorities related to improving access to surgical care and other health care services.

Background

Increasing evidence indicates a maldistribution of surgeons in the United States, with significant shortages particularly in rural and underserved areas. A congressionally mandated 2020 report conducted by the Health Resources and Services Administration (HRSA) examined surgical shortage areas and showed a maldistribution of the surgical workforce, with widespread and critical shortages of general surgeons particularly in rural areas. Likewise, a 2021 report from the WWAMI Rural Health Research Center found that between 2001 and 2019, rural areas experienced a 29.1% decrease in the supply of general surgeons, and in 2019, 60.1% of non-metropolitan counties had no active general surgeon at all. This crisis extends beyond general surgeons as well. A 2021 report released by the American Association of Medical Colleges projects shortages of 15,800-30,200 in all surgical specialties by 2034. This is a critical component of the ongoing health care workforce shortage because surgeons are the only physicians uniquely trained and qualified to provide certain necessary, lifesaving procedures.

Better data is needed to fully understand why these shortages exist and inform policy solutions. However, several factors are apparent today. The U.S. population continues to grow and age, increasing demand for physicians across the country. At the same time, the health care system has grown more and more complex, subjecting physicians to an arduous and ever-changing landscape of regulation and administrative burden. The COVID-19 pandemic exacerbated already high rates of physician burnout, leading many practicing physicians to leave the workforce. Repeated cuts to Medicare reimbursement have forced some physicians to see fewer patients or shut their doors altogether. Finally, limited rural Graduate Medical Education (GME) positions and the financial burden of medical education pose barriers to recruiting new physicians and encouraging them to practice in underserved areas.

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Congress must act to address these critical issues. The ACS remains committed to working with policymakers to increase access to surgical care and other health care services across the country to ensure that all patients can receive the high-quality care they need.

Comment Topics

Geographic Payment Differences

Increasing evidence indicates there is a widespread maldistribution of surgeons resulting in many rural areas with growing shortages of surgeons available to serve their population. Currently, geographic practice cost indices are being calculated using inaccurate and outdated numbers that underestimate the cost of practicing in non-urban areas. **Congress should take steps to improve that calculation and establish a set minimum based on specific regions.** This will ensure physicians are appropriately reimbursed for the care they provide as well as help to incentivize new talent to practice in rural settings.

To target regional shortages, the ACS supports reauthorizing the Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP) for a period of five years. The HSIP, which expired in 2015, provided a payment incentive to surgeons who performed major operations—defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule (PFS)—in a geographic HPSA. A five-year reauthorization of the HSIP will provide current rural general surgeons with the additional support they need to continue serving rural communities and could provide incentives to attract additional surgeons to underserved areas. If targeted to general surgery workforce shortage areas (discussed below) this would be a potent tool in reducing geographic workforce maldistribution.

Sustainable Provider and Facility Financing

For more than 20 years, Medicare payments have been under pressure from Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a relatively modest portion of overall federal health care spending, they are perennial targets for cuts when policymakers seek to tackle affordability. The PFS is unique in its lack of a meaningful mechanism to account for inflation and remains constrained by a budget-neutral financing system. Updates to the Conversion Factor (CF) have failed to keep up with inflation and in recent years have been negative, with an approximately 3.5% cut to Medicare physician payments slated for 2024.

While Congress has taken action to address some of these fiscal challenges by mitigating part of the recent PFS cuts, Medicare payment continues to decline year after year. These yearly compounding cuts, combined with high inflation, a lack of updates to account for increased expenses, and a lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken. These systemic issues will continue to hinder surgeons' ability to undertake important quality improvement initiatives or make investments needed to move toward value-based care.

There are several steps Congress can take to stabilize Medicare payment in the near term and reform the system in the long term. **First, Congress must address the additional cuts**

to Medicare payment planned for 2024, in large part by stopping the proposed implementation of Healthcare Common Procedure Coding Systems add-on code G2211 as set forth in the CMS calendar year 2024 PFS proposed rule. The G2211 add-on code was introduced in 2020 as an effort by CMS to pay more for certain office visits. However, Congress recognized the problems posed by G2211 and delayed its implementation for three years. Unfortunately, nothing has been done over the last three years to fix flaws in the G2211 code or the larger problems with the PFS.

There is no longer a valid justification for G2211. Under the new coding rules for office visits, physicians and qualified health care professionals have the flexibility to bill a higher-level code to account for increased medical decision-making or total time of the encounter. The numerous codes currently available for documenting work and time across various levels of care make G2211 redundant and, therefore, unnecessary. Finally, G2211 would inappropriately result in overpayments to those using it and at the same time penalize all physicians due to a reduction in the CF that will be required to maintain budget neutrality under the 2024 PFS proposed rule. **Congress can stop implementation of G2211 and eliminate a majority of the expected 2024 Medicare physician payment cut at no cost to the federal government.**

In addition to stopping the immediate cuts, Congress should pass the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) to provide a positive annual update to the PFS based on inflation. This will bring physician reimbursement in line with other Medicare providers such as hospitals, nursing homes, and home health providers. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take more than 40 years for the CF to return to the same amount it was in the year 2000. Over that same period, inflation will have eroded the value of payments by more than 60%. Clearly this is not tenable.

Finally, the ACS believes that medicine should be moving steadily toward a system that truly rewards the value of care provided. Alternative payment models (APMs) can not only facilitate better care but could also be used to incentivize physicians to practice in rural or underserved areas. Unfortunately, CMS has not tested a single model recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), meaning that there are simply no APMs available for most physicians to participate in. While it is our impression that Congress has provided the resources to CMS and the Innovation Center that are necessary to stand up and test PTAC recommended APMs, there is nothing within the law to compel CMS to try out new programs. This creates further barriers to those seeking to move to value-based care. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing APMs recommended by the PTAC.**

Health Care Workforce

The ACS is committed to working with Congress to increase access to surgical care across the country and support the surgical workforce across the surgeon's career to ensure that all patients can receive the high-quality care they need. Ensuring an adequate and diverse surgical workforce that is representative of the population is a critical first step in

guaranteeing access to high quality surgical care and reducing disparities in health outcomes for patients across the country. The ACS has long supported legislative efforts to increase the number of GME positions available in underserved areas in order to get more qualified medical students into the field of surgery. **However, we also assert that increasing the number of positions alone is not enough. We must ensure that the right type of physician is at the right place, at the right time, to optimally meet the needs of a particular population.** Recruiting diverse physicians who are representative of the population to the surgical workforce leads to improvements including better access to care for the underserved, better quality of care, increased patient trust in their health care providers, novel questions in research, and more inclusive and broad reaching solutions to policy challenges.

The high cost of medical education is one barrier to individuals wishing to pursue a career in surgery. Physicians often accumulate immense student debt during their education, and then must undertake several years of residency training with low pay, during which time their student loans accrue significant interest. This financial burden may deter students from pursuing certain specialties, practicing in underserved areas, or even entering the health care profession at all. **The ACS supports legislative efforts to reduce the burden of student loan debt on physicians, including the *Resident Education Deferred Interest Act* (S. 704/H.R. 1202), which would allow borrowers in medical or dental internships or residency programs to defer student loan payments without interest until the completion of their programs, and the *Specialty Physicians Advancing Rural Care Act* (S. 705/H.R. 2761), which would establish a new loan repayment program for specialty physicians practicing in rural areas.**

Incentives like loan repayment programs can encourage surgeons to practice in underserved areas and help address the maldistribution that currently exists in the workforce. However, better data is critical to accurately identify shortage areas. **The ACS believes the periodic, repetitive collection and analysis of workforce data on both a regional and national basis, undertaken in consultation with relevant stakeholders, should be a top priority.** One step Congress can take to strengthen health care workforce data collection is to fully fund the National Health Care Workforce Commission. The Commission was established more than a decade ago as a multi-stakeholder body charged with developing a national health care workforce strategy, including reviewing current and projected health care workforce supply and demand and analyzing and recommending federal policies affecting the workforce. Unfortunately, this body was never funded and therefore has not been able to begin this important work. **The ACS supports funding the Commission at $3 million for fiscal year 2024.** Doing so will direct needed resources to address the nation's workforce challenges and provide a new opportunity for direct stakeholder engagement.

Unfortunately, current available data are not able to indicate if the supply of surgeons in a given geographic area is adequate to provide access to the services demanded by the population. This is largely because there is no agreed upon definition of what constitutes a shortage of surgeons for a given population, and unlike other key providers of the community-based health care system, HRSA does not maintain a geographic shortage area designation for surgery. **The ACS believes there is an urgent need to establish a surgical**

shortage designation. The *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781) would direct HRSA to study and define general surgery workforce shortage areas and collect data on the adequacy of access to surgical services, as well as specifically grant the agency authority to designate general surgery shortage areas. Determining what constitutes a surgical shortage and designating areas where patients lack access to surgical services will provide HRSA with a valuable new tool for increasing access to the full spectrum of high-quality health care services and could be used to target additional recourses, such as the HSIP discussed above.

Identifying where health care shortages exist and incentivizing surgeons to practice in those areas is critical. It is equally critical to support surgeons in their roles and prevent skilled practitioners from leaving the workforce due to burnout, administrative burden, safety concerns, or other factors. **The ACS is grateful for passage of the *Dr. Lorna Breen Health Care Provider Protection Act,* which aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among healthcare professionals, and looks forward to continuing to work with Congress on the issue of physician health and wellbeing**.

Likewise, the ACS supports legislative actions to eliminate unnecessary requirements that overburden surgeons and their practices and may hinder timely access to surgical care. **One such bill is the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 8487 in the 117th Congress) which will help alleviate administrative burden for physicians by improving the transparency and efficiency of prior authorization under Medicare Advantage.** The ACS also maintains that surgeons should be free to practice where they choose. Unfortunately, many employed surgeons are subject to non-compete agreements, which prohibit individuals from joining a competing firm or starting a new venture in the same field after leaving their employer, at times preventing them from starting a private practice or moving to practice in an underserved area. **The *Workforce Mobility Act* (S. 220/H.R. 731) would free physicians from non-competes, providing them with an option to work for a competitor, rather than be forced to move hundreds of miles or forgo a professional opportunity.**

Finally, the ACS supports the directive that surgery should be performed by surgeons. Decades of efforts by non-physician health care providers to expand their scope of practice further into medicine continue to be considered in many state legislatures. **The ACS remains committed to working with our partners in the surgical community and with Congress to ensure that patients receive surgical care by surgeons.**

Innovative Models and Technology

The ACS believes that surgical patients deserve to have the right structures, processes, and personnel in place to provide optimal care regardless of where they live or are treated. For this reason, many of the ACS quality verification and accreditation programs are tailored to meet the needs of facilities of a wide range of sizes and with varying resources. For example, the first group of 25 hospitals verified last summer through our new Quality Verification Program (QVP) included a variety of hospital types and sizes, such as community, large and mid-size academic, public safety-net, military, and small/rural, among others. These

hospitals were selected to help ensure that ACS QVP can adapt to unique hospital circumstances and provide customized, actionable feedback to a diverse group of hospitals. **Verification programs like the QVP or the Geriatric Surgery Verification program (GSV) could be used as the basis of programmatic measures that more accurately assess the ability of a system to provide high quality care to patients.** Programmatic quality measures do the following:

- Align multiple structure, process, and outcome measures;
- Target condition or population specific care;
- Apply to multiple quality domains;
- Address the continuum of care; and
- Are informative to and actionable for care teams and patients.

Our experience with programmatic measures demonstrates applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures. In early 2023, the ACS submitted a programmatic measure, the *Age Friendly Hospital Measure,* to the CMS Measures Under Consideration (MUC) list to demonstrate how programmatic measures could be implemented in CMS programs. We have recently been notified that the measure will be included on the MUC list with further action expected in November. This measure considers the full program of care needed for geriatric patients. It incentivizes hospitals to take a holistic approach to the provision of care for older adults by implementing multiple data-driven modifications to the entire clinical care pathway spanning from the emergency department, the operating room, the inpatient units, and beyond. The measure puts an emphasis on the importance of defining patient (and caregiver) goals, not only from the immediate treatment decision, but also for long-term health. The measure underscores the importance of aligning care with what the patient values. It acknowledges certain processes, outcomes, and structures that are necessary for providing high-quality, holistic care for older adults across five domains:

1) Eliciting Patient Healthcare Goals;
2) Responsible Medication Management;
3) Frailty Screening and Intervention;
4) Social Vulnerability; and
5) Age Friendly Care Leadership

If adopted, the *Age Friendly Hospital Measure* could be further enhanced through an expansion of the facility-based scoring option of the Quality Payment Program. Facility-based scoring opportunities are currently limited to very specific circumstances. These opportunities should be expanded and enhanced to cover more physicians, more facility settings and reporting programs, and to apply it to all four Merit-Based Incentive Payment System (MIPS) categories (to include Promoting Interoperability and Improvement Activities, not just Quality and Cost as currently in statute). In such a scenario, the score would be determined automatically unless physicians prefer to submit additional data and be scored through a different scoring option. Then, like in other cases, they would have the option of reporting data of their choice.

The ACS sees quality as a comprehensive program. This program is built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual, disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care. The ACS developed programs like GSV and QVP have demonstrated improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas all of which involve the clinical team and facilities coming together to improve the delivery of care. This is why alignment with facility reporting is critical for care organized around a patient. **We believe expanding facility-based scoring to additional sites of service and to all MIPS categories could greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the payment environment.**

In addition to increasing care coordination and reducing reporting burden, such a proposal could lead to a reduction in federal health care spending. The ACS experience with a programmatic approach to quality has demonstrated that such an investment can result in fewer costly complications and readmissions and ultimately in lives saved. The ACS has recently launched the Power of Quality Campaign and is partnering with hospitals to help them let patients know of their commitment to surgical quality. Hospitals who successfully participate in one of 13 ACS programs will now be able to display a Surgical Quality Partner diamond emblem to demonstrate their commitment to quality improvement and the best possible outcomes for surgical patients. This type of information is much more valuable and actionable to patients than what is typically provided by current measures used in federal programs as they make decisions about where to receive care. The ACS would welcome the opportunity to further discuss how these efforts could be amplified to benefit rural populations.

Concluding Remarks

The ACS is dedicated to working with Congress on improving access to health care in rural and underserved areas. Optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Identifying communities with workforce shortages, incentivizing surgeons to practice in those areas, and ensuring stable and sustainable payment for health care services, is critical to guarantee all patients have access to quality surgical care. **Stabilizing Medicare payment by stopping implementation of G2211 and updating the PFS to account for inflation and increased practice expenses, particularly in rural areas, is essential to maintain patient access to care. Congress should also direct CMS to make more APMs available to physicians to encourage them to practice in underserved areas and aid the transition to value-based care, including through interim steps such as adopting programmatic measures and expanding facility-based scoring options. Designating general surgery shortage areas will help to identify underserved communities with surgical workforce challenges. Additionally, Congress should consider enhancing funding for graduate surgical education, providing loan repayment programs to surgeons who choose to practice in**

areas of need, funding the National Health Care Workforce Commission, and continuing its focus on physician health, wellbeing, and administrative burden reduction.

The ACS thanks the Ways and Means Committee for its thoughtful attention to the nation's health care access challenges and looks forward to continuing to work with lawmakers on these important issues. For questions or additional information, please contact Amelia Suermann with the ACS Division of Advocacy and Health Policy at asuermann@facs.org.

Sincerely,

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Executive Director & CEO