October 12, 2012

The Honorable Tom Price, MD  
403 Cannon House Office Building  
Washington, DC 20515-1807

The Honorable Charles Boustany, MD  
1431 Longworth House Office Building  
Washington, DC 20515

Dear Drs. Price and Boustany:

On behalf of the Society of Thoracic Surgeons (STS), I write to thank you for taking a very important step in drafting legislation that will help us to move toward a Medicare physician payment system that eliminates the flawed “Sustainable Growth Rate” (SGR) model. Physicians providing services under Medicare Part B have been plagued by this payment model for many years which repetitively introduces uncertainty into the practice of medicine and which only rewards provision of more and more complex patient care. We need real leadership in Congress to replace the SGR with a payment formula that rewards physicians for high-quality, cost effective care and does not penalize physicians for reducing unnecessary services. We believe that the draft legislation you provided is an important step in that direction.

As you know, STS is the largest organization representing cardiothoracic surgeons in the United States and the world, representing more than 6,600 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, as well as other surgical procedures within the chest. STS has long advocated that the most powerful and reliable method to affect physician practice is to engage physicians in the collection of outcomes data on the services that they provide, and to provide meaningful, risk-adjusted feedback that allows them to compare these outcomes to those of their peers. We believe that the reimbursement system should promote physician practices that exemplify the profession’s responsibilities to not only improve the quality of the care that is given to patients but also to wisely allocate societal healthcare resources. We also believe that responsible professional organizations provide important database and educational resources that can provide the infrastructure to support the needed improvements in physician practice and resource utilization.

STS believes that the SGR formula must be repealed and any new payment model should reward providers for patient outcomes based on risk-adjusted quality outcomes data and the efficient use of limited resources. The STS National Database has been collecting and reporting data on quality and patient outcomes for cardiac and cardiothoracic procedures since 1989. Any modernization of the physician payment system should ensure that individual medical specialties can—and have incentive to—control the growth rate of their services and payments by identifying the most effective and appropriate treatment for the patient. At the very least, specialties should not be penalized if their quality and value improvement activities result in a lower Medicare utilization and expenditures.

As the STS National Database and registries of other specialties have demonstrated, sharing outcomes data allows physicians to change their practice patterns to achieve better outcomes, more efficient care delivery and increased patient value. The following should be included in any Medicare physician payment reform initiatives:
Mandate and incentivize the development and utilization of clinical data registries;

Require the Centers for Medicare and Medicaid Services (CMS) and other payers to make administrative (cost and claims) data available to registries for use in their analyses so that resource utilization becomes an outcome variable to be assessed in the same manner as traditional clinical outcomes such as mortality or complication rates;

Address barriers imposed by overly proscriptive federal and state privacy regulations while still protecting patient privacy;

Allow physicians to share the savings generated by their quality improvement efforts and consider providing economic incentives and disincentives at higher level than the individual physician or practice; and

Utilize clinical registries and other administrative resources to generate comparative effectiveness research.

The proposal you have drafted provides an important first step for discussions about these important priorities in the future. STS has provided comments on each section of the proposed bill as drafted. We hope that these comments will act as the opening communication in an ongoing conversation about a real solution to Medicare physician payments going forward.

1. PROVIDE CERTAINTY FOR PROVIDERS AND BENEFICIARIES.

This section represents a reasonable and important step in the development of a sustainable Medicare payment solution. Although pegging payments to the Medicare Economic Index (MEI) without any adjustment for years of deferred payment increases is not ideal, the MEI can be considered the “cost of doing business” and is therefore a reasonable starting place for a proposal that will buy physicians five years of stability so that we can join policymakers in the important discussion about a future Medicare physician payment model.

We encourage Congress to consider using funds excess baseline projections for Overseas Contingency Operations (OCO) to pay for the ultimate repeal of SGR. Using the OCO baseline as an offset for the accumulated SGR bad debt amounts to “cleaning the books.” This eliminates one flawed budget device with another and allows for a more accurate accounting of future government expenditures without increasing the federal deficit.

2. PROPOSAL FOR FUTURE REFORM.

We appreciate that you have provided a clear timeline for reforming the Medicare payment system. We are concerned that this proposal falls to the wayside in a series of goals for a Congress that has had difficulty reaching consensus, even when there are consequences for inaction. We hope to work with you to ensure that Congress does live up to this promise to develop and implement a plan for payment reform within the time frame you propose. We believe that it is critical to consider multiple payment models and to recognize that a single methodology may not be appropriate for all physicians and specialties.

3. PATIENT-SHARED BILLING.

We appreciate that this section is responsive to the concerns of many of our colleagues that insufficient Medicare payments have led some providers to perform and bill Medicare for additional procedures in an attempt to offset what is perceived to be inadequate reimbursement for their other services. Despite the concerns of our colleagues in other specialties, many STS members have expressed reluctance to balance bill, and under the current law, contracting for services outside Medicare is associated with a “poison pill” prohibition on receiving Medicare payments for two years. As a Society, we are committed to the principle of ensuring that no patient who needs thoracic surgical intervention will go untreated, no matter their ability to pay. To the extent that any revisions to
Medicare physician payment become law, the STS believes that it is essential that our members continue to have the ability to individualize the approach to patient economic responsibility for services that is consistent with this principle.

4. **LAWSUIT ABUSE REFORM.**

Tort reform is essential for an optimally functional health care system. We agree that setting standards aligned with best practices identified by specialty societies is the best way to institute meaningful medical liability reform that will ensure that patients get the best care possible while protecting their rights to seek remuneration in the unfortunate and rare cases of provider negligence. However, we would encourage you to be sure that this policy cannot be implemented in a way that is overly burdensome on specialty societies in general. In addition, we would note a considerable drawback if guidelines are vague, where poor clinical practices or judgments could be considered as justifiable so long as the behavior stays within the letter of the written guidelines.

STS is well-equipped to develop specialty-specific benchmarks and best practices. However, we fear that other specialties may not be as prepared or as rigorous in their own self-evaluation. STS established the STS National Database 1989 as an initiative for quality improvement and patient safety among cardiothoracic surgeons.

The Society has developed quality performance measures in all three sub-specialities of surgery, (adult cardiac, general thoracic, and congenital) and these measures have either been endorsed or are in the process of being considered for endorsement by the National Quality Forum. By collecting outcomes data for submission to the STS National Database, surgeons are committing to improving the quality of care that their patients receive. Since its inception, more than 100 publications have been derived from Database outcomes. These studies have been published in a variety of professional journals and textbooks and have significantly advanced knowledge in cardiothoracic surgery.

The Database continues to expand with new initiatives. Launched in January 2011, STS Public Reporting Online enables Database participants to voluntarily report to the public their coronary bypass surgery performance. Overall composite star ratings as well as their component ratings are listed on www.sts.org for more than 250 Database participants. With the success of participation nationally, STS launched in 2011 an initiative to accommodate Database participation worldwide by including international participants in the Adult Cardiac Surgery Database.

We recognize that not all patients with the same condition are identical and that clinical judgment and experience are important components of good patient care. Therefore, we believe that practice guidelines should protect physicians who are following them, but that guidelines should not be able to be construed in a way that would make a physician vulnerable for a malpractice suit because he has exercised clinical judgment on an individual case and departed from the published “standards.” Although STS supports guideline development, there needs to be flexibility in the utilization of guidelines.

5. **ALIGNING INCENTIVES FOR BETTER PATIENT CARE.**

Even before the promise of a reformed health care system and the development of Accountable Care Organizations (ACOs) and other shared savings programs, STS members were working with their colleagues in other specialties and other settings to improve care, cut costs, and, to the extent possible within existing law, share in the savings they generated. Cardiothoracic surgeons have achieved improved patient outcomes and cost savings by defining, reviewing, and tracking appropriateness of surgical interventions. This is evident in the work done in Virginia Cardiothoracic Surgery Quality Initiative (VCSQI) where their use of STS clinical data and CMS financial data has led to cost savings and quality improvement. We believe that a payment model that rewards for
evidence-based medicine will achieve the health care savings necessary to implement a successful gainsharing program.

Unfortunately, recent shared savings initiatives have presented a number of problems. For example, the ACO model does not adequately acknowledge and account for the importance of specialists. The success of an ACO will depend, not only on the participation of qualified primary care physicians, but also on specialists, including cardiothoracic surgeons, who will be crucial to the improvement of quality of care. Lack of coordination between primary care physicians and specialists can result in duplication of efforts thereby reducing potential shared savings. As such, for any shared savings program, it will be necessary to promote better coordination with specialists.

We are well aware that any shared savings model cannot violate the "Prohibition on Hospital Payments to Physicians to Induce Reduction or Limitation of Services" and therefore incur Civil Monetary Penalties. However, in order for these programs to work, shared savings must eventually flow from participating hospitals to participating physicians. STS members have worked within the bounds of these provisions to institute meaningful shared savings programs. We are eager to work with you to identify practical and regulatory challenges to shared savings programs so that we can build national programs based on the experiences of cardiothoracic surgeons across the country who continue to innovate and share their successes with their patients and colleagues.

Thank you for allowing us the opportunity to comment on your draft legislation. We look forward to working together to finally repeal the flawed SGR payment policy and replace it with a Medicare payment policy that encourages health care quality and builds on the efficiencies pioneered by cardiothoracic surgeons.

Sincerely,

Jeffrey B. Rich, MD
President