May 23, 2012

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC  20515-6348

Re: Request for Comments on Medicare Physician Payments, the Sustainable Growth Rate and Alternative Payment Models

Dear Chairman Camp:

On behalf of The Society of Thoracic Surgeons (STS), the largest organization representing cardiothoracic surgeons in the United States and the world, I am writing to provide comments responding to the request from the U.S. House of Representatives Committee on Ways and Means regarding the Medicare physician payments system, Sustainable Growth Rate (SGR) formula and alternative payment models. STS represents more than 6,400 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. We appreciate the opportunity to provide comments on this important issue. STS has carefully reviewed the specific questions in the request and offers the following comments regarding our current positions as well as our previous and ongoing experiences.

I wish to frame our responses to the questions that you raised in your letter with some fundamental observations. First, we believe 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. Second, 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. Third, we 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.

Rewarding Quality and Efficiency

STS believes that the SGR formula must be repealed and any new payment model should reward providers for patient outcomes based on risk-adjusted quality outcomes data and the efficient use of limited resources.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.
1. How does your organization think quality, efficiency, and patient outcomes should be incorporated into the Medicare physician payment system? (Please include details on experiences with non-Medicare payers that could be instructive.)

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, 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 federal and state privacy regulations;
- 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 registries and other resources to generate comparative effectiveness research.

2. To what extent has your organization developed and/or facilitated the use of:

a. Quality and outcome measures?

STS has an extensive quality program that includes development of National Quality Forum (NQF) endorsed quality measures and inclusion in CMS’s Physician Quality Reporting System (PQRS). STS has developed composite, outcome, process and structure measures focused in the three subspecialty areas of Adult Cardiac Surgery, Congenital Heart Surgery and General Thoracic Surgery. STS National Database participants can voluntarily elect to have STS send their data from the Adult Cardiac Surgery Database directly to CMS’s PQRS. The STS Adult Cardiac Database has been successfully used as the platform for statewide quality improvement initiatives in Michigan and Virginia, and to increase the use of arterial grafts and beta-blockers in a multi-state initiative.

In the interests of transparency, the Society has also established STS Public Reporting Online: the publishing of Coronary Artery Bypass Graft (CABG) composite quality ratings from STS Adult Cardiac Surgery Database participants who have volunteered to participate. Launched in January 2011, STS initially received consent from 226 database participants to report their information through STS Public Reporting Online. Today, overall composite star ratings as well as their component ratings are listed on the STS website for 386 Database participants. These ratings were recently published in Consumer Reports as a consumers’ guide on how heart surgeons “perform.”

b. Evidence-based guidelines?

The Society of Thoracic Surgeons Workforce on Evidence Based Surgery has developed evidence-based guidelines to provide practical assistance to STS membership. Thorough research of each guideline topic is completed through an exhaustive review of clinical information. The conclusions and recommendations are based on a review of scientific evidence published in the medical literature.

STS Clinical Practice Guidelines are intended to assist physicians and other health care providers in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. STS has developed clinical guidelines on areas such as pre- and post-surgical antibiotic management, blood conservation, managing atrial fibrillation and surgical management of endocarditis.

c. Patient registries?

The STS National Database was established in 1989 as an initiative for quality improvement and patient safety among cardiothoracic surgeons. The three subspecialty areas of cardiothoracic surgery (Adult Cardiac, General Thoracic, and Congenital Heart Surgery) each have their own component database, with the availability of anesthesiology participation within the Congenital Heart Surgery Database. The Database has grown exponentially over the years, both in terms of participation and stature. There are currently over 1,000 participants in the Adult Cardiac Database and over 100 participants in the Congenital Heart Surgery Database. The Database is randomly audited and continues to expand with new initiatives. The Adult Cardiac Surgery Database, now containing more than 4.75 million patient records, represents an estimated 94 percent of all adult cardiac surgery centers across the U.S. With the success of participation nationally, STS launched an initiative in 2011 to accommodate Database participation worldwide by including international participants in the Adult Cardiac Surgery Database.

In addition, in 2012, STS joined with the American College of Cardiology (ACC) to develop the transformational TVT Registry™ under the guidance of the FDA and CMS. The TVT Registry is a new benchmarking tool developed to track patient safety and real-world outcomes related to the newly introduced transcatheter aortic valve replacement (TAVR) procedure. It is designed to monitor the safety and efficacy of this new procedure for the treatment of aortic stenosis.

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Employing a first-of-its-kind transcatheter heart valve technology, TAVR provides a new treatment option for patients who are considered to be inoperable for conventional aortic valve replacement surgery. Through the capture and reporting of patient demographics, procedure details, and facility and physician information, the TVT Registry provides a data repository capable of delivering insight into clinical practice patterns and patient outcomes. According to a recent National Coverage Determination, the TVT Registry will likely play a pivotal role in CMS’ coverage with evidence development of TAVR.

Many of the quality measures developed by STS have been directly attributed to data collected from the STS National Database. By collecting outcomes data for submission to the STS National Database, surgeons are committing to improving the quality of care that their cardiothoracic surgery patients receive.

The Database has the corollary potential to be a powerful tool for clinical research. Since its inception, more than 100 publications have been written using evidence from Database outcomes. These studies have been published in a variety of professional journals and textbooks and have significantly advanced knowledge in cardiothoracic surgery.

d. Continuous quality improvement programs or strategies?

STS is committed and continues to support new avenues to improve quality through our work with the STS National Database and the development of NQF-endorsed quality measures. STS databases are used as the data infrastructure for quality improvement efforts in several states and for several multi-state initiatives.

e. Electronic health records?

STS believes the use of electronic health records (EHRs) is a linchpin to improving the quality, safety and efficiency of patient care, as well as care coordination among providers. STS continues to work with stakeholders to refine use of EHRs to enhance patient care while addressing our mutual concerns with the implementation of programs incentivizing broader use of EHR. In May, STS signed a joint letter with other specialties providing feedback on CMS’s proposed rule on Stage 2 of the EHR incentive program.

3. What clinical improvement activities have been developed and are supported by your organization or have otherwise been used effectively by your members?

STS believes that the collection of clinical outcomes-based data is the best pathway to true quality improvement. As such, the best way to improve patient outcomes is through measurement, feedback, and focused system efforts at improvement. Tools such as the STS National Database can be utilized to track, monitor, and assess clinical improvement by physicians. To this end, the STS National Database plays an essential role in several initiatives aimed at improving health care quality.

In early 2012, CMS contracted with STS to develop measures that reflect quality of care for patients undergoing CABG. Specifically, STS will use its robust database to develop a hospital-level all-cause risk-adjusted readmission measure for CABG.
Additionally, the STS National Database plays a valuable role in many regional quality improvement programs. In the Virginia Cardiac Surgery Quality Initiative (VCSQI) Unsolicited Demonstration Project, which is a voluntary consortium of 17 hospitals and 13 cardiac surgical practices providing open-heart surgery in the Commonwealth of Virginia, participants utilize the STS National Database to identify quality improvement opportunities and patient outcomes. The work of the VCSQI has gone beyond quality improvement to include cost containment in cardiac surgery and its work has been highlighted in numerous Congressional testimonies over the past several years.

As described previously, the STS National Database is the information platform for the Michigan STS initiative which involves all institutions and surgeons in Michigan and has led to the adoption of higher quality surgical practices such as the use of arterial bypass conduits during coronary artery bypass operations. The Northern New England Cardiovascular Study Group has used similar methods over many years to improve the mortality rates for patients undergoing coronary artery bypass surgery and to completely eliminate the inter-institutional variation in outcomes that was present initially.

Finally, STS actively engages in the creation of quality performance measures many of which have been endorsed by the National Quality Forum. Some of the Society’s measures have also been approved for inclusion in the PQRS, allowing STS National Database participants who participate in PQRS to qualify for incentive payments by satisfactorily reporting on the approved quality measures under the existing program.

4. Have non-Medicare payers recognized or rewarded these clinical improvement activities? If so, how?

Non-Medicare payers have readily recognized that the utilization of quality performance measures generated from comprehensive clinical registries that offer alternatives to standard fee for service reimbursement. By linking overall payments, or supplemental payment to routine reimbursement, to clinical outcomes that have exceeded accepted benchmarks derived from recognized clinical databases, non-Medicare payers have established legal incentives to surgical providers who have achieved clinical improvement to cardiac surgical care at decreased cost by reduction of mortality and morbidity. This is exemplified by the pay for performance agreement with the cardiac surgery practices that were members of the VCSQI and Anthem that was in effect from 2006 to 2011. Clinical and process metrics were generated and mutually agreed upon, derived from STS performance measures, and endorsed by the National Quality Forum. Weighted scores were derived from such metrics and augmented payments to contracted rates, ranging between 3 percent and 8 percent, were then added to the payments of surgical care depending upon the extent to which these metrics were achieved. This resulted in an overall improvement in care with associated decrease in costs by those providers who exceeded established quality standards. Importantly, the Michigan initiative has also received major funding through a grant from Michigan Blue Cross.

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6 Rich, MD, Jeffrey; Measuring Physician Quality and Efficiency of Care for Medicare Beneficiaries; House Committee on Ways and Means, Health Subcommittee; March 15, 2005
7 Rich, MD, Jeffrey; Gainsharing; House Committee on Ways and Means, Health Subcommittee; October 7, 2005
8 Rich, MD, Jeffrey; Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries; House Committee on Energy and Commerce, Health Subcommittee; July 27, 2006
9 Mayer, MD, John; House Committee on Ways and Means, Health Subcommittee; Hearing on Options to Improve Quality and Efficiency Among Medicare Physicians; May 10, 2007
10 STS Comments for the Public Record, House Committee on Ways and Means Subcommittee on Health Hearing: Programs that Reward Physicians Who Deliver High Quality and Efficient Care; Submitted February 2, 2012
From 2006 to the present, STS has partnered with WellPoint, one of the largest private health plans, to provide performance information from hospitals and medical groups that agreed to share their data from the Society’s Adult Cardiac Surgery Database of nationally accepted outcomes measures for adult cardiothoracic surgical procedures. STS provides WellPoint with a series of reports on the quality performance of hospitals and cardiothoracic surgeon groups in certain states served by WellPoint health plans. The reports highlight participant performance on approximately 15 performance measures that have been endorsed by the National Quality Forum. These measures represent the first national voluntary consensus measures for cardiac surgical care, and include use of beta blockers before and after surgery, as well as infection and mortality rates.

WellPoint has incorporated performance on these quality measures into its pay-for-performance and quality improvement programs, including the Quality-In-Sights: Hospital Incentive Program. The Society also provides information on quality performance to United Healthcare, which incorporates STS’s quality metrics into their quality recognition program. Periodically, STS has provided quality performance information to Blue Cross Blue Shield related to its Blue Distinction Quality Recognition Program.

5. Is there anything else your organization would like to share with the Committee on how to reward physicians for high quality, efficiency, and patient outcomes?

STS believes that meaningful quality measures and rewards for physician performance cannot be applied simply to administrative data reported by hospitals and physicians. While administrative data provides information on longitudinal medical treatment and resource utilization across settings of care and by various physicians, its clinical accuracy has been shown to be sub-optimal, and it excludes pertinent information on patient risk factors, disease severity, or clinical outcomes. This critical information is only found in clinical datasets where there is input of clinical data by clinicians. It is only by linking administrative and clinical data that we can appropriately and accurately assess whether physicians are improving patient outcomes.

STS urges the Committee to consider quality incentive programs which encourage the coordination of Medicare claims data with existing registries to enhance patient monitoring and physician performance, and improve quality. Without linking the administrative data collected by health plans with the clinical information reported by clinicians, patients cannot be effectively monitored. By using linked longitudinal registries, physicians can more broadly monitor patients for readmissions or care transitions. Similarly, longitudinal patient histories allow physicians to assess the success of cardiothoracic interventions. The successful linking of the STS database with CMS administrative data in Virginia has led to a clinical/financial tool that brings quality improvement and cost containment to reality through a focus on reductions in costly complications and the redesign of care delivery models that promote high quality efficient care.

Alternative Payment Models


1. Are there quality-enhancing alternatives to fee-for-service, such as bundled payments and shared savings models that your members have experience with or are developing with private payers?

a. If so, what are the pros and cons of such approaches?

STS believes that quality improvement initiatives such as Accountable Care Organizations (ACOs) have the potential to improve the quality of patient care and patient outcomes. However, the final ACO rule released by CMS mandates that participating ACOs must comply with 33 quality measures, none of which are relevant to cardiothoracic (CT) surgery. Measures used in any payment delivery model must include items for specialists, such as CT surgeons, to encourage their participation. Moreover, the final ACO rule does not require registry-based reporting, such as that in the STS National Database.

STS supports the use of payment systems which align incentives not only between physicians and hospitals, but also among physicians of the same or related specialties. Bundled payment, such as the previously mentioned VCSQI and the CMS Acute Care Episode (ACE) demo, are appropriate alternatives to the current fee-for-service environment. Utilizing STS data, both programs were shown to be associated with improved quality and patient outcomes when physician payment is bundled with the hospital. By bundling payments, Medicare can align payment with quality and efficiency based on the patient’s disease or condition.

b. If not, are there alternatives to fee-for-service that are relevant and feasible for your members?

The existing fee-for-service payment system rewards providers for volume of services rather than for efficient delivery of quality-based care. We believe that the path toward rewarding physicians for improved patient outcomes begins with fixing the existing Medicare physician payment formula. We believe that it is important for the Committee to consider alternative payment methodologies that align incentives along specialty or disease process lines at the regional or national level. This type of payment system would foster and incentivize physicians to act as members of a profession and fulfill their professional responsibilities to collaborate and share knowledge and practices with their peers.13

Patient Involvement and Regulatory Relief

It is important that patients have access to high-quality, high-value healthcare services. Through STS Public Reporting Online and incorporation of STS quality measures in other ranking programs, STS has led the way towards increasing transparency and access to value-based care. STS encourages patients to utilize these tools in seeking out cardiothoracic surgery services.

1. How does your organization think physicians can encourage beneficiaries to seek appropriate, high-value health care services?

STS believes that patients will seek high-value healthcare services if they are provided with access to accurate, vetted physician and hospital performance measurements or ratings. The STS Public Reporting Online program allows patients to review provider scores based on a “star” system derived from quality measures reported to the STS National Database.\textsuperscript{14} The U.S. News and World Report utilized the STS Congenital Heart Surgery Database in their ranking calculations for the Best Children’s Hospitals of 2011–2012.\textsuperscript{15} Hospitals reporting congenital heart program data to the Database earned additional points for quality improvement activities. We believe that including endorsed measures and quality programs in these publicly available ranking programs is beneficial to both providers and patients. However, we strongly urge that any performance information must be appropriately risk-adjusted and weighted and we believe that clinical registries such as the STS Databases offer the most valid and reliable mechanisms for risk-adjustment. We also believe that there should be mechanisms in place to allow for physician appeal of the ratings prior to public release.

2. Are there administrative and regulatory burdens that your organization sees as barriers to fundamental delivery system reform? If so, please describe.

As stated previously, the lack of access to Medicare cost and utilization data for physician claims is a roadblock in the path towards understanding care delivery and the impact of medical and surgical interventions. We believe that important first steps have been taken in opening the Medicare claims files to collaborating investigators from STS and the American College of Cardiology in the NIH funded ASCERT comparative effectiveness trial on coronary artery disease treatments recently reported in the New England Journal of Medicine and in the Annals of Thoracic Surgery.\textsuperscript{16,17} We urge the Committee to eliminate any barriers that prevent CMS from sharing this data with approved registries and databases. Physicians, hospitals, payers and patients could all benefit if registries could access and merge this data with administrative claims to study trends and ultimately improve the quality of interventions.\textsuperscript{18}

In addition, in November 2011, the Social Security Administration rescinded its policy of sharing state-reported death data as a part of the Social Security Death Master File (SSDMF). There are continuing efforts to restrict access to the SSDMF further so as to protect those listed in the file from identity theft. As expressed in a recent letter to Social Security Commissioner, “linking clinical registries to the SSDMF allows for the verification of ‘life status’ of patients who otherwise would be lost for follow up after their treatment. Research based on this information helps physicians to provide information to today’s patients and families to help them with decision making. Outcomes data gives patients confidence in their medical


interventions and demonstrates to patients and their families the durability and long-term benefits of medical procedures.\textsuperscript{19,20} We look forward to working with Congress to find a solution to this problem that protects those lists in the SSDMF and their families from fraud while allowing continued access to this important resource for legitimate uses.

We also encourage Congress to consider the effects of certain regulations that impose restrictions on potential gainsharing programs among providers. We ask the Committee to consider our comments to CMS on Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center; Notice with Comment Period.\textsuperscript{21}

In addition, we hope that Congress will take this opportunity to address the issue of medical liability reform. Our inability to protect physicians from frivolous law suits while maintaining patients’ rights to seek redress for legitimate grievances has had a deleterious effect on our ability to provide appropriate care. In addition to limiting physicians’ ability to provided needed health care services, our current system is affecting the cardiothoracic surgical workforce as increasing numbers of medical students choose careers in fields with lower liability insurance costs.

3. Are there unnecessary administrative and regulatory burdens that your organization sees as taking valuable time away from seeing patients and/or increasing costs to the Medicare program? If so, please describe.

The current and upcoming reporting programs will greatly impact the amount of time and attention physicians can dedicate to their patients. These programs include the value-based modifier, penalties under the electronic prescribing (e-prescribing) program, PQRS and EHR incentive program. We have recently joined over 90 other specialty and state medical societies to urge CMS to re-evaluate the penalty timelines associated with these programs and examine the administrative and financial burdens and intersection of these various federal regulatory programs. The combined implementation of these programs, along with preparations for transition to the ICD-10 coding system in 2014, may cause confusion and burden for physician practices.

While these programs are designed to improve quality, the design and implementation schedules place an administrative burden on physicians and their practices. Our hope is that these programs can be streamlined to work in concert with each other rather than creating repetitive work for physicians and their staff.

As the facility setting is the primary setting for care delivered by cardiothoracic surgeons, our members influence both physician and hospital reimbursements and revenues. Cardiothoracic surgeons need to be involved not only in discussions regarding Medicare physician payment systems, but also hospital payment


systems. While cardiothoracic surgeons are not primary care physicians and to this point in time have not been the lead physicians performing care coordination services and chronic condition management, our members do have a significant influence over costs and value in the healthcare system. Any changes to physician and hospital payment systems should be those that effectively and adequately value both primary care and specialty services.

Thank you for requesting the input of STS and for the work you are undertaking to find a permanent and equitable solution to the SGR. STS is looking forward to continuing to work with you to develop a strong and enduring physician payment system that will encourage broad access to cardiothoracic surgery services and, in conjunction with our cardiology colleagues, provide coordinated care for cardiovascular disease in Medicare beneficiaries. Please contact Phil Bongiorno, STS Director of Government Relations, at 202-787-1221 or pbongiorno@sts.org if you have any questions.

Sincerely,

Jeffrey B. Rich, MD
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