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Committee on Ways and Means
Subcommittee on Health

Hearing on

Options to Improve Quality and Efficiency Among Medicare Physicians

May 10, 2007
Chairman Stark, Ranking Member Camp, members of the Subcommittee, thank you for inviting me to testify before you today regarding methods to improve both quality and efficiency among physicians treating Medicare beneficiaries. I am a heart surgeon at Children’s Hospital in Boston and Professor of Surgery at Harvard Medical School, and I currently serve as the President of the Society of Thoracic Surgeons.

I’d like to make four main points for you here today which have a unifying theme of engaging medicine as a profession in addressing our healthcare cost and quality problems:

1. **Measurement and Feedback of performance to physicians is the most effective way of improving physician performance, and we have many examples.**

2. **Feedback and profiling are two very different concepts, with differing goals which must be understood to achieve desired results.**

3. **Bundling of payments is a critical step toward aligning incentives for better quality and more appropriate care.**

4. **The ultimate goal is to measure both patient outcomes and cost of care, which will rapidly improve quality while simultaneously reducing cost.**

**Feedback as the most effective way to change how physicians make decisions**

Cardiothoracic surgeons have an extensive history and culture of focusing on and improving the clinical outcomes of our patients, and based on our 3 million patient cardiac surgical database, we believe that we can legitimately claim to have prolonged millions of lives. We have done this because we believe that this is part of our professional responsibility without resorting to profiling, public reporting, or monetary incentives. We also have data indicating that improvements in clinical outcomes, such as reducing complications, result in cost reductions as well. However, as I will outline for you in a moment, physicians are now being pulled in opposite directions by our professional responsibilities to our patients and to society on the one hand and by the perverse incentives in the current reimbursement system in the other. We believe that the two main mechanisms you are investigating today - information feedback to physicians and bundling to align payment incentives with patient need, can help to address these conflicts. These two changes, if implemented correctly and executed carefully, can realign the incentives to enlist the medical profession in a rapid and continuous quality improvement cycle that can drive down costs while treating patients better. We believe our experience can serve as a guide for the Medicare program and physicians to get there.

To date, physician payment in Medicare has been set based on budget targets. Whether it is the “Sustainable” Growth Rate (SGR), or the Volume Performance Standards (VPS) before it, budget targets can look good to CBO or on a balance sheet. But budgetary targets don’t help patient care. What’s worse, the looming SGR-mandated payment reductions do not affect individual physician decision-making. And perhaps most tragic, budget driven reductions put off the more important work of replacing poor care with high quality care, avoiding unnecessary treatments, and preventing expensive complications.
What does help patients is clinical expertise, technical skill, and physician responsibility – and these are the province of the Profession of Medicine. The incentives in the Medicare program today are perverse, and are contrary to our professional responsibility as doctors. Medicare currently pays more if you perform more services, order more images, schedule more office visits. Hospitals are paid more if patients have more complications, and more ER visits. The primary care physician who does the best at keeping his or her patients healthy struggles because prevention is not rewarded at all. So in a sense, the Medicare reimbursement system encourages worse outcomes for patients. Our professional responsibility to society as physicians dictates otherwise.

We believe the changes in policy you are examining have been successful because they align with one very powerful motivator for all physicians: their responsibility as a profession to provide societal benefit in treating patients and responsibly shepherding scarce resources. I strongly believe changes in policy must be made to re-engage medicine as a profession in helping to solve some of the major quality and financial issues facing healthcare in the US, in general, and the Medicare program, in particular.

You may be thinking that we are simply saying “Trust us, leave it to the professional responsibility of physicians and all will be well,” but what we are really suggesting is a “trust, but verify” scenario. Collection of data on quality of care – patient outcomes – is what should drive the healthcare system. We believe that a system of bundled payments coupled to feedback of outcomes information to physicians will help to do so. So trust physicians, but we also need to collect the data.

In surgery, we have historically focused primarily on quality improvement because our professional responsibility is foremost to improve patient care. However, we now recognize that this focus on quality can also reduce costs and that our professional responsibility to society requires that we wisely use societal resources.

The impact of feedback to physicians – of both the quality of their outcomes and their resource use – will be helpful. It has been said that, “You will improve that which you measure.” We have found this to be true. If we measure process compliance, process compliance improves. If we measure patient results – or outcomes – that is what will improve. We should avoid measuring only cost, for the cheapest care is no care, and the least costly outcome may be death. Though feedback of data on resource utilization is likely to improve those utilization rates, we must be very careful in doing so. We believe that cost is most appropriately measured only in conjunction with outcomes so that we can provide care that is of value to the patient.

The STS experience with 18 years of quality measurement in cardiac surgery shows that feedback to physicians on both quality and efficiency may well be the most effective means of changing physician behavior to improve patient care and increase efficiency.

Perhaps the earliest example of feedback improving quality and reducing variation was the Northern New England Cardiovascular Study Group project in the late 1980’s - using
variation in outcomes as a tool for improvement, not as a means to profile. The surgeons in those states met to discuss results and implement the best practices. The mortality rate in cardiac surgery became the lowest in the country in those states, and variation among institutions disappeared. This is the goal of feedback.

In the VA system, cardiothoracic surgeons have been using an outcomes measurement/feedback system and have evaluated the observed-to-expected mortality rates in open heart surgery for two decades. While patients have been arriving older and much more ill, the results have steadily improved. Thus the ratio of the observed mortality rate to the expected mortality rate has declined continuously. The American College of Surgeons has adopted the VA methodology for their National Surgical Quality Improvement Program (NSQIP). These exemplify the type of Continuous Quality Improvement we could expect in Medicare if all of medicine could measure results and feed the data back to physicians.

![System-Wide O/E Ratio Time Trend](image)

It was an STS leader who performed the landmark clinical trial based upon the STS database with a grant from AHRQ. This was the largest Continuous Quality Improvement (CQI) trial in medicine where Dr. Bruce Ferguson was able to document that intervention in the form of education and formal CQI led to changes in physician practice that produced rapid improvements in care. Within 18 months of receiving feedback and education on two practices that improved outcomes in heart surgery patients, we saw a dramatic improvement.
The recently completed second part of this study focused on how surgeons can prevent further heart disease following bypass surgery (CABG). The study answered the question: “Can the STS influence our surgeons to use the "teachable moment" of hospitalization to get patients on correct medications following CABG?” And once again, there were no incentives other than the knowledge that it is the right thing to do.

This was a huge trial with 234 Control Sites, and 224 Treatment sites across the country. They measured the rates at which four separate medications were prescribed at discharge after coronary surgery. Every treatment site showed a significant increase in the rate these medicines were prescribed vs control groups in 18 months. They even created a patient web site created with "steerage" of patients at discharge to the Web site for additional information. This is an example of physicians taking responsibility for managing patient care beyond the treatment period.

This national RCT demonstrated that a professional society CQI program could speed adoption of these prevention therapies. Patients as well as physicians were successfully engaged in the CQI process and the results will improve the long-term patient outcomes following contemporary CABG.

**Feedback and Profiling are two distinct concepts and will achieve vastly different results**

This distinction is one that will be critical for all to understand. Feedback is the use of data to improve physician behavior, while profiling is use of data to discriminate among physicians and steer patients – without affecting the behavior of the provider. Physicians who may have had patients steered away from them by managed care, but have not improved their performance through feedback will continue to treat patients in the same way, and that benefits neither patients nor Medicare. The quality improvement driven by data collection and feedback promotes system-wide quality improvement and is not focused at the care of a single patient.

To take it one step further, and achieve large costs savings, we must bring costs of care into the equation with quality, and determine the “value” of care provided. In Virginia, cardiothoracic surgeons matched their STS quality data with Medicare’s cost data, and calculated the value that each hospital and practice was delivering. But rather than using this information for profiling and competition, they shared the data, shared the methods for improving complication rates, and saved millions of dollars each year by producing better outcomes for patients statewide. This is the best way to save money in Medicare – through higher quality results. The most recent results here show that doctors in Virginia reduced the incidence of sternal wound infections by 67% below the historically expected rates. Each prevented infection of this type saves $73,000.00. Rates of heart arrhythmia (each occurrence costing over $3,000) have been reduced statewide by 5%. Together these two improvements save millions of dollars each year, not to mention saving hundreds of lives.
In Michigan, all cardiothoracic surgeons in the state and all 31 hospitals (that perform cardiac surgery) voluntarily submit data to the STS database for analysis. Blue Cross/Blue Shield of Michigan has agreed to fund this data collection for not only their covered patients, but for all Medicare, Medicaid, and uninsured patients. The data are audited and fed back to the surgeons. The surgeons have shared results, and discuss with the top performers how they achieved their results. This Michigan QI project has reduced variation between sites in the most critical outcomes including mortality, atrial fibrillation, and kidney failure. Participants know that it has improved quality of care for the patients, and are confident that it will also save money. Moreover, focus on outcomes accelerates improvement well beyond what you would achieve from rewarding static process measures. In fact, the focus on measurement and improvement in outcomes has caused them to seek out and find new innovative processes worldwide that improve quality and reduce complications. By focusing on outcomes, they found discrete new methods in use in Australia that they are now implementing in Michigan. If they had focused solely on compliance with static process measures, these innovations may not have been sought nor found.

STS believes that similar approaches in other specialties will work in most areas of medicine and will help improve the quality and appropriateness of care and thereby reduce costs. STS is now teaming up with the American College of Cardiology (ACC) who have built their own database of 5 million patients undergoing heart catheterization. By doing so, we will measure the quality of care in patients with cardiovascular disease over the patient’s entire history of the disease. We are beginning to work with health plans and payers, including United, Wellpoint, Blue Cross, and Aetna to combine the robust STS-ACC quality data with the plans’ cost data including treatments, drug costs, and hospital costs. **These efforts are not for the primary purpose of profiling, and steering patients, but to actually improve the care provided while reducing costs.** We are asking Medicare to work with us to combine Medicare’s claims data with our clinical data. If we can do this, we will have the total picture of what quality delivered at what cost in the treatment of heart disease – the number one killer of Americans, and by far the major cost center for Medicare.

All physicians believe they are giving the highest quality, most efficient care – until they are shown otherwise. The critical issues are high quality clinical data, a statistically valid method for risk-adjustment, and feedback of data to the local institution or practice level. We are all trained in science, and data doesn’t just talk, it speaks very loudly. Once professionals know the truth, behavior shifts easily.

**Bundling of payments is a critical step toward aligning incentives for better quality and more appropriate care.**

The second focus of this hearing is on how bundled payments in Medicare might realign incentives from rewarding “more care” to rewarding “more effective care”. To align payment with quality and efficiency, care delivery must be focused on patient need. Which is to say, payment should be organized around the disease or condition of the patient.
In my field of pediatric heart surgery, interdisciplinary teams of specialists come together for the benefit of children with congenital heart disease. This needs to be the norm in medicine, particularly in the high intensity, high risk areas of medical care.

Care delivery teams should be organized around major conditions, as well as around wellness and prevention. In the future, I believe we will have teams of providers who are expert in caring for specific conditions, as well as experts in keeping patients healthy. The question is, when will that future be realized?

Payment for treatment of Medicare beneficiaries ultimately should be made on the basis of a period or episode for treating each condition. Most in medicine are far from that point today, but there are areas of Medicare where it is working well to control spending growth and encourage only the most appropriate care. In cardiothoracic surgery, as well as nearly all major surgical procedures under Medicare, physicians are paid one fixed fee (in a bundle) for the care they provide. If I perform open heart surgery for a Medicare beneficiary, Medicare pays me one fee for the procedure, patient visits, intensive care, and recovery care for 90 days regardless of what additional needs arise. If the patient requires me to spend more time with them, if I need to speak with the family and meet with the patient, or if the procedure requires more time in the operating room or more time in the intensive care unit, and there are other costs involved in the treatment of that specified condition, so be it. Medicare only pays one fixed fee. This may well be the reason why, in 2003, office visits in Medicare accounted for 29% of increased physician spending, minor procedures that are not paid in a bundle accounted for 26% of growth, and imaging (also not paid in a bundle) accounted for 18% of spending growth. Major procedures, frequently paid under bundled (or global) payments, were the smallest contributor to growth, accounting for only 3% of Medicare physician spending growth.

A bundled payment for treatment of many medical conditions under Medicare would shift the incentives from the current system that pays “a la carte” for each service or test, thus encouraging ever more to be performed; to an incentive to keep the patient healthy while performing only the most appropriate and helpful tests or procedures. Medicare should seriously consider a bundled payment model for the care of beneficiaries with the most costly diseases – especially chronic conditions.

The current incentive under a la carte Medicare fee for service payment urges professionals to perform as many services on each patient as possible, when instead, we should have a system that enables professionals to regulate themselves based upon what is most effective and most appropriate for the patient.

Exercise caution however, as a bundled payment without a measure of patient outcomes (or results), could reward underutilization. The coupling of outcome measures with bundled payment would align incentives, prevent underutilization, and encourage efficiency and innovation.
Conclusion

If we are able to successfully implement a system of measurement of results, outcome data feedback loops to physicians, and aligned incentives through bundled payment, we will have made major strides toward a system that will improve care continuously, and drive dramatic costs reductions.

So, how can such a system be implemented? What can the Congress do now to allow and encourage the medical profession to help solve the current healthcare problems? We recommend four steps:

1. Recognize that the medical profession must be an integral part of any solution.

2. Provide Medicare support for the development of specialty or condition-based electronic clinical databases focused on patient outcomes, building on the efforts of groups such as the STS, the ACS, and the ACC.

3. Provide bonuses for the very difficult work of measuring the actual patient outcomes. This will become a critical check against underprovision of services in a bundled payment environment.

4. Realign the reimbursement system to focus on integrated care based on specific patient needs by bundling payment for treatment of conditions.

The options you are exploring today are important pieces of realigning incentives in Medicare. If they are implemented carefully, they could be a major step toward improving quality for patients while reducing costs in not only Medicare, but in our health care system nationwide.

Thank you for the opportunity to share my views and experience with you today.