

House Committee on Energy and Commerce

Subcommittee on Health

A Permanent Solution to the SGR: The Time is Now

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Alan Speir, MD, Testimony on behalf of The Society of Thoracic Surgeons

Chairman Pitts, Ranking Member Green, and distinguished members of the Committee, thank you for the opportunity to present testimony today on behalf of The Society of Thoracic Surgeons (STS). My name is Alan Speir. I am a practicing cardiothoracic surgeon and Medical Director of Cardiac Surgical Services, Inova Health System. I am also the Chair of the Workforce on Health Policy, Reform, and Advocacy for The Society of Thoracic Surgeons and Chair of Board of Directors for the Virginia Cardiac Surgery Quality Initiative.

Founded in 1964, STS is an international, not-for-profit organization representing more than 6,800 surgeons, researchers, and allied health care professionals in 90 countries 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.

On behalf of the Society, I would like to applaud this Committee for holding a hearing on Medicare physician payment reform just eleven days into the new Congress. With only a handful of weeks before the current SGR patch expires, we are grateful for your sense of urgency and are eager to work with you to ensure that permanent SGR repeal and Medicare payment reform are enacted this year. I also would like to thank many of the current members of this Committee for their considerable work to introduce The SGR Repeal and Medicare Provider Payment

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Modernization Act in the last Congress. STS endorsed this bipartisan, bicameral agreement, which won support across the physician community. I implore you not to leave this major policy achievement to languish beyond the March expiration of the current SGR patch. I hope that my testimony today helps to demonstrate that, the cost of continuing to do nothing would be far more devastating to Medicare patients and providers than the expense of implementing meaningful payment reform policy.

The STS National Database

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart Surgery. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case combined with robust risk-adjustment based on pooled national data, and feedback of the risk-adjusted data provided to the individual practice and the institution, will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients. In fact, published studies indicate that the quality of care has improved as a result of research and feedback from the STS National Database.

For example, ElBardissi and colleagues studied 1,497,254 patients who underwent isolated primary Coronary Artery Bypass Graft (CABG) surgery at STS National Database participating institutions from 2000 to 2009. They found that:

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- Patients received more indicated care processes in recent years, including a 7.8% increase in the use of angiotension-converting enzyme inhibitors preoperatively and a significant increase in the use of the internal thoracic artery (88% in 2000 vs. 95% in 2009).
- The observed mortality rate over this period declined from 2.4% in 2000 to 1.9% in 2009, representing a relative risk reduction of 24.4% despite the predicted mortality rates (2.3%) remaining consistent between 2000 and 2009.
- The incidence of postoperative stroke decreased significantly from 1.6% to 1.2%, representing a relative risk reduction of 26.4%.
- There was also a 9.2% relative reduction in the risk of reoperation for bleeding and a 32.9% relative risk reduction in the incidence of sternal wound infection despite the acuity of patients increasing during this period of examination.

The Database has facilitated advancements in many aspects of health care policy including public reporting of health care quality measures, facilitating medical technology approval and coverage decisions, and even saving money by helping cardiothoracic surgeons to find the most efficient and effective way to treat patients. Our ability to link clinical data with administrative data through the STS National Database has opened up important new ways to assess the effectiveness of treatment options and offered new avenues for medical research. Clinical data yield sophisticated risk-adjustment assessments, while administrative data provide information on long-term outcomes such as mortality rate, readmission diagnoses, follow-up procedures, medication use, and costs. In addition, linking clinical registries to the Social Security Death Master File (SSDMF) once allowed for the verification of “life status” of patients who otherwise would be lost for follow up after their treatment. The outcomes information

derived from these data sources helps physicians educate today's patients and families so that they can play an active and informed role in the shared decision-making process. Valid and reliable outcomes data give patients confidence in their medical interventions and demonstrate to patients and their families the durability and long-term risks and benefits of medical procedures based on real-life, quantified experience rather than abstract concepts.

Unfortunately, in November 2011, the Social Security Administration rescinded its policy of sharing state-reported death data as a part of the SSDMF so as to protect those listed in the file from identity theft. Balanced against these legitimate privacy concerns are the many advantages of linked administrative and outcomes data when placed in the right hands, with adequate protections in place. It is important to note that STS, through its contracts with the Duke Clinical Research Institute, maintains the patient identifier data separately from the actual clinical and other demographic data, and the only patient level identified information that ever leaves the database is simply that the patient has a record in the database. When combining records with outside sources, patient identification information is matched against other records, such as those in the SSDMF. The follow-up information is returned from external entities and linked back to the records in the de-identified database. The externally derived data are used to supplement the data in the individual record, but these clinical, patient-level data never leave the database except in de-identified form.

Even without this important information, we have proven that the Database can serve as the foundation for appropriate use criteria and even medical liability reform. Perhaps most importantly, we have shown that allowing surgeons to receive feedback on their performance and

compare themselves to their peers elevates the practice of cardiothoracic surgery. Other innovations pioneered using the STS National Database include:

- Public Reporting: STS launched a Public Reporting Initiative in January 2011 in collaboration with Consumer Reports. As of December 2014, 42% of Database participants voluntarily report their results for Coronary Artery Bypass Graft (CABG) and/or aortic valve replacement on the Consumer Reports or STS websites. STS is universally regarded as the medical professional society leader in these activities.
- Medical Technology Approval and Coverage Decisions: The TVT Registry™ is a benchmarking tool developed to track patient safety and real-world outcomes related to the transcatheter aortic valve replacement (TAVR) procedure. Created by STS and the American College of Cardiology, the TVT Registry is designed to monitor the safety and efficacy of this new procedure for the treatment of aortic stenosis. The TVT Registry was instrumental in facilitating the approval and coverage with evidence development of new medical technology, helping to bring this technology to the marketplace safely and efficiently.
- Comparative Effectiveness Research: The Patient Centered Outcomes Research Institute has recognized the value of “observational research” using clinical registries to fulfill its mission. Furthermore, registries such as the TVT Registry can be developed and augmented to collect real time data to measure outcomes in different patient populations in real time. We believe that comparative effectiveness research can help physicians, in collaboration with patients and families, to provide the right care at the right time, every time.

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- Determining Value of Physician Services: STS has used the time data from the STS National Database as the basis for relative value recommendations to the AMA Relative Value Update Committee. Unfortunately, the use of this type of real data has been resisted by CMS with the rationale that other specialties are not able to provide comparable data. Congress should encourage CMS to use real, clinical data on procedural time and hospital lengths of stay collected via a clinical registry rather than time estimates which distort the relativity of the fee schedule.
- Appropriate Use Criteria and Medical Liability Reform: STS believes that setting standards aligned with best practices identified by specialty societies is the best way to institute meaningful medical liability reform. Quality measurement and data on clinical risk can be used to reduce lawsuits and the cost of liability insurance, and to restore balance to the justice system.

One of the most successful examples of innovation founded in the STS National Database is the Virginia Cardiac Surgery Quality Initiative (VCSQI). The VCSQI, a voluntary regional collaborative in the Commonwealth of Virginia comprised of 12 cardiac surgical practices in 18 hospitals, was founded in 1994. The purpose of this organization has been to improve the results of cardiac surgical care and reduce costs by sharing clinical data, outcomes analysis, and process improvement. VCSQI helps implement protocols to reduce post-operative complications, was involved in the adoption of quality measures in cardiac surgery for the National Quality Forum, and has formulated policies on pay for performance programs. All of the VCSQI programs participate in the STS National Database and uniformly follow the definitions and measures in this landmark clinical registry. This Initiative has constructed a

database of over 90,000 patients who have undergone cardiac surgery, matching the patients' STS clinical record with outcomes information and discharge financial data for each episode of care.

VCSQI has attempted to test a global pricing model and has implemented a pay-for-performance program whereby physicians and hospitals are aligned with common objectives. Although this collaborative approach is a work in progress, collaborators point out that a road map of short-term next steps is needed to create an adaptive payment system tied to the national agenda for reforming the delivery system. Using evidence-based protocols, VCSQI has demonstrated that improving quality will reduce cost. For example, the VCSQI generated more than \$43 million dollars in savings through blood product conservation efforts and more than \$20 million dollars in savings by providing the best treatment to patients with atrial fibrillation.

Medicare Physician Payment Reform

STS has been a strong proponent of leveraging the unique power of clinical registries, combined with administrative claims and patient outcomes data, to improve quality and efficiency in the healthcare system. In fact, we firmly believe that, without a national infrastructure for collecting, aggregating, and evaluating clinical information against valid, risk-adjusted quality measures, any effort towards true payment reform would be difficult if not impossible. Through its focus on clinical registries, we believe that the policy outlined in the SGR legislation introduced in the last Congress would make incredible strides towards developing such an infrastructure. The STS recognizes that claims information is critical to the effort to improve patient outcomes and care efficiency, and we were particularly grateful that the

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proposed SGR legislation would have allowed qualified clinical data registries to access Medicare administrative claims data. We hope that similar access to the SSDMF can also be restored. I would also like to underscore STS's support of the following provisions included in that legislation:

- A threshold model of physician performance measurement under the Merit-based Incentive Payment System that allows all providers to be rewarded for exceptional care quality and efficiency rather than one that promotes competition and discourages providers from sharing best practices.
- Clear guidelines that to promote the application of appropriate use criteria and legal protections for providers who engage in quality improvement efforts.
- A period of predictable payment for physicians, without the threat of SGR-related cuts to allow physicians to develop and transition to alternative payment models that truly recognize the value and appropriateness of care rather than only compensating for the volume of delivered care.

It is this last point, the opportunity to develop alternative payment models during a so-called "period of stability," where I would like to focus my remaining comments. Inspired by this innovative proposal, STS convened our thought leaders and policy and registry experts to examine the procedures most frequently performed by STS members. Together we worked to craft team-based alternative payment models for the Heart Team and Lung Cancer Care Team in hopes that these models would provide a blue print for other care team models. For example, for the Heart Team Model, we considered an incremental approach to implementation that we believe will result in a longitudinal disease management bundled payment for Heart Team care.

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We are confident that we can use the STS National Database, combined with other sources of administrative claims and quality information, to promote patient-centered, team-based care that rewards all members of the patient's care team for putting the patient first. This approach can improve patient outcomes and patient satisfaction while also improving care efficiency and saving money by enabling the care team to identify and provide the right treatment at the right time.

While our APM concepts are not yet finalized, I wanted to demonstrate to this Committee that the physician community is ready and eager for this opportunity. Unfortunately, as we wait for payment reform to become a reality, the Centers for Medicare and Medicaid Services (CMS) is implementing policy that will decimate the promised period of stability, stifle innovation, limit our ability to transition to a new APM, and destroy the only example of bundled payment that currently exists in the Medicare program. Specifically, CMS proposes to convert more than 4,000 10 and 90-day global surgical CPT codes to 0-day global codes by 2017 and 2018 respectively. Currently, cardiothoracic surgeons receive a single, bundled payment from Medicare for the surgeries they perform. That payment includes pre-operative consultation, the surgical procedure itself, all post-operative care in the hospital setting including monitoring patients' recovery and coordinating any medical specialty consultations, and outpatient visits up to 90 days after the procedure.

Despite the fact that the policy will affect 10-day global codes in 2017 and 90-day global codes in 2018, CMS has not yet developed a methodology for making this transition. Indeed, the agency has stated that it does not know how best to proceed. However, in order to implement the change, CMS must begin to transition all these codes no later than February 2016. Although

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CMS will be gathering data on the number of post-operative services to more accurately value the individual services now included in the global, the Medicare Payment Advisory Commission estimates that data collection could take several years – well after the policy has already been implemented.

In addition to undermining the bipartisan, bicameral SGR legislation of the last Congress, the policy to transition 10- and 90-day global codes to 0-day has a number of potential consequences that should be well understood before implementation. Specifically, eliminating global surgical payments will:

- Detract from quality of care, impede patient access, and complicate patient copays
 - Under the 10- and 90-day global codes, patients typically pay one copay related to all the services covered under the 10- or 90-day global code. If 10- and 90-day global codes are transitioned to 0-day global codes, patients will pay copays on other services as well, including each of the follow-up visits. This could considerably increase the administrative burden on patients, or worse, discourage them from coming back for follow-up care.
 - By unilaterally requiring that surgeons must bill separately for each individual service they provide, CMS is hampering our ability to ensure patients receive the best possible care. In the hospital critical care setting, the global payment structure allows the surgeon to oversee and coordinate care related to the patient's recovery. Without the global, care will be fragmented and providers will likely be forced to compete for the opportunity to see patients and bill for the care they provide. This may well lead to confusion by the patients as to levels of

responsibility and accountability of care, appropriateness of procedures and processes of care, and attribution in the event of adverse events from delivered care. In addition, without global payments, patients will be subject to copays for each post-operative visit. This could considerably increase the administrative burden on patients, or worse, discourage them from coming back for follow-up care. Further, if surgeons are not seeing their patients after the surgery, they won't be able to capture data in clinical registries which will hamper many of the innovations I described earlier.

- Obstruct clinical registry data collection and quality improvement
 - If patients forgo follow-up treatment or seek it from other providers, this policy would have a deleterious effect on surgeons' ability to collect information on patient outcomes in clinical registries, undermining many of the most meaningful quality improvement initiatives
- Increase administrative burden
 - The administrative burden on surgical practices and CMS (and its contractors) will be significant. The American Medical Association estimates that eliminating the global package will result in 63 million additional claims per year to account for post-surgical evaluation and management services. Clearly, this will add unnecessary costs to the claims processing system.

Conclusion

It is clear that current Medicare payment policy is fatally flawed. Furthermore, with the uncertainty of the current SGR paradigm, compounded by the global payments issues, innovation

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and meaningful physician-led reform is nearly impossible. STS believes that the only way forward, for the benefit of patients and physicians alike, is a policy that allows for the development of alternative payment models. The STS is ready, willing, and able to take that next step, but first we need Congress to pass permanent Medicare physician payment reform. We urge Congress to act swiftly while the cost of SGR repeal is still relatively low, and to pass legislation that allows for the development of alternative payment models that will drive high quality health care and help Medicare beneficiaries to have access to the right care at the right time, every time.