The Society of Thoracic Surgeons

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The House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Re: January 22, 2015, Health Subcommittee Hearing: "A Permanent Solution to the SGR: The Time is Now"

Dear Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Green and Members of the Committee:

On behalf of The Society of Thoracic Surgeons, I would like to thank the Committee for the opportunity to testify at the January 22 hearing on the Medicare Sustainable Growth Rate (SGR) formula and would like to thank Representatives Engel and Lujan, in particular, for their thoughtful questions. I have provided my responses below.

The Honorable Eliot Engel

1. *I have been hearing from the physician community in New York for years about their growing frustration at the constant threat of significant reimbursement cuts. They frequently mention that the cost of running their practice is increasing each year and they are trying to properly treat patients with increasingly complicated medical conditions. All the while, facing double digit reimbursement cuts. It just isn't right.*
    a. *Can you elaborate on why it is urgent for physicians and patient access to care that Congress reform the Medicare reimbursement system <u>now</u> and how another patch would be detrimental to our Medicare Program*

The Society of Thoracic Surgeons agrees with Congressman Engel that Congress must act now to pass permanent Medicare payment reform. We firmly believe 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. This price tag can be assessed both in the billions of dollars Congress has already spent on temporary SGR patches as well as the opportunity cost of not helping the health care system transition away from the perverse incentives of the traditional fee-for-service model of physician payment. STS believes that, in addition to helping to develop a robust clinical data registry infrastructure, the most important policy in last year's SGR repeal proposal was the proposed period of predictable payment for physicians. Under that legislation, physicians would be guaranteed a "period of stability," free from the constant threat of SGR-related cuts, as well as incentives to help the development of, and transition to, Alternative Payment Models (APMs) that truly recognize the value and appropriateness of care rather than only compensating for the volume of delivered care.

STS was so inspired by this innovative proposal that we actually developed team-based APMs for the Heart Team and Lung Cancer Care Team. For example, we believe that our Heart Team APM, when implemented incrementally, can result in a longitudinal, disease management bundled payment for Heart Team care (which includes cardiothoracic surgeons, cardiologists, and other physicians and health care

providers). 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.

Of course, these APMs are made possible by the STS National Database, which 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. I hope you will consult my original testimony for more information on the Database and how it is already being used to improve health care quality and save health care dollars.

I want to further emphasize the point that, while permanent SGR repeal legislation has a price tag associated with it, we firmly believe that payment reform will result in cost savings. Moving away from the illogical incentive structure of fee-for-service is just the beginning. Improving health care quality and patient outcomes has the potential to help save billions.

As I mentioned in my testimony, 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. 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. It is our belief that such examples of quality improvement with cost savings, when implemented on a national level, help pay for the repeal of the SGR without cost shifting from other vital governmental programs, reducing benefits for our Medicare beneficiaries, or reducing hospital compensation for care delivery.

Moreover, the VCSQI implemented a pay-for-performance program whereby physicians and a major regional payor (Anthem) were financially aligned with common clinical objectives between 2009 and 2012. The VCSQI also attempted to test a global pricing alternative payment model for Cardiac Surgery. Although approved by Secretary of Health and Human Services Tommy Thompson in 2007, this Global Demonstration Project directed to patients undergoing heart valve replacement or coronary artery bypass surgery was subsequently forced by Office of Inspector General to be cancelled because of the inclusion of incentives to the providers for cost reduction. It was, however, the basis for the Medicare Acute Care Episode (ACE) Demonstration Project that was approved and implemented in 2009 and has recently been completed. 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.

The Honorable Ben Ray Lujan

1. *The current Sustainable Growth Rate (SOR) Medicare payment system is unsustainable and needs to be fixed. In New Mexico, I continue to hear from providers and seniors about their frustration with SGR and the uncertainty that it creates. We cannot continue to patch this broken system, and we've been talking about a permanent fix for years. We need to deal with this now, and I support the bipartisan/bicameral SGR structural reform that was crafted last Congress that is supported by both provider and beneficiary groups.*
    a. *In New Mexico there is a shortage of primary care physicians. Can you speak to how delivery system reform is connected to SGR repeal? How do you see the move away from fee-for-service impacting doctors' participation in Medicare?*
    b. *Given all we know about the impact of primary care on quality, patient satisfaction, and costs, what more do you believe we should do to promote and support our primary care physicians?*

I would like to thank Congressman Lujan for his support of the SGR reform legislation that was introduced in the last Congress. STS also endorsed this bill and would like to see Congress act swiftly to pass it before the current "SGR patch" expires on March 31, 2015. Although we understand the concerns of many physicians, particularly those who are near retirement and are struggling to meet the many new requirements of the current Medicare program, STS has always pushed for a path forward for early adopters. In fact, in his testimony before this Committee in June, 2013, STS Past President Jeffrey B. Rich said of the proposed SGR-repeal package:

> … in as much as those who currently participate in the STS National Database may already be able to meet the provisions in your proposal as outlined, we welcome the opportunity to get started. Understanding that others will need to develop the infrastructure to support such a program, it is our hope that specialties will be able to jump into the pay-for-quality world when they are ready, rather than waiting for all of medicine to get to the same place at once. To that end, STS has valuable experience in registry development that we are able to share with those specialties undertaking the task of building a registry now or in the future.

Put another way: "***We want to go first***!" The Society of Thoracic Surgeons is at the cutting edge of quality measurement, reporting, and performance improvement. We believe that we should be paid for providing the highest quality care for our patients and for helping them achieve their best possible outcomes. We are simply waiting for Congress to act so that we have a statutory foundation for our quality improvement and cost savings goals. Cardiovascular disease is one of the largest cost centers in the Medicare program, and is the leading cause of death in the United States with a mortality rate of over 375,000 Americans each year.[1] Congress could have an immediate impact on the rapid growth of Medicare costs by simply allowing us to transition to a pay-for-quality paradigm rather than waiting for the rest of medicine to catch up.

I would also note that, Medicare reimbursement for surgery is actually the one successful example of bundled payment in the Medicare program. Rather than using the traditional fee-for-service paradigm, at present, Medicare reimburses surgeons for the care provided in a 10-day or 90-day window of time including pre-operative, intra-operative, and post-operative care. Approximately 4,200 of the over 9,900 Current Procedural Terminology (CPT) codes are 10- or 90-day global codes. Unfortunately, CMS

[1] Heart Disease and Stroke Statistics – At-a-Glance. (2015, January 1). Retrieved February 27, 2015, from http://www.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_470704.pdf

recently finalized a policy that will transition all 10- and 90-day global codes to 0-day global codes by 2017 and 2018 respectively.

Eliminating global surgical payments detracts from quality of care, and patient access to care and may increase 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. This would disproportionally affect the sickest patients who require the most follow-up. 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 certain conditions most likely to be detected by a surgeon may go undiagnosed. Further, 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.

On behalf of STS, I implore Congress to put a stop to this policy, and instead, allow us to focus on transitioning to a more efficient and beneficial pay-for-quality APM as was envisioned in the SGR repeal legislation from the last Congress.

Thank you for the opportunity to present these ideas to the House Energy and Commerce Health Subcommittee. Please contact me or STS Director of Government Relations, Courtney Yohe (202-787-1222, cyohe@sts.org) if you have any additional questions.

Sincerely,

Alan M. Speir, MD
Chair, Workforce on Health Policy, Reform and Advocacy