



The Society of Thoracic Surgeons

Statement to the House Energy and Commerce Committee
Health Subcommittee Hearing
November 8, 2017

MACRA and Alternative Payment Models: Developing Options for Value-Based Care

The Society of Thoracic Surgeons (STS) appreciates the opportunity to submit a statement for the record for the House Energy and Commerce Health Subcommittee hearing on “MACRA and Alternative Payment Models: Developing Options for Value-Based Care.” Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,500 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. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

In passing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress sent a clear signal to the medical community that the health care system should transition from a fee-for-service, volume-based payment model to one that incentivizes care quality. STS was pleased with this development because we have been pioneers in quality measurement and improvement over the past quarter-century. As Congress is aware, many of the alternative payment models (APMs) introduced to date have focused on primary care. We hoped that MACRA would finally provide the pathway to help us to develop a specialty-specific APM that took advantage of the wealth of quality information being collected in the STS National Database. We remain excited at the opportunity to bring value-based payment into cardiothoracic surgery. Below we discuss the many ways in which The Society of Thoracic Surgeons is attempting to bring this to fruition.

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 Surgery, General Thoracic Surgery, 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. The Adult Cardiac Surgery Database has 90 to 95 percent penetration across all the cardiothoracic surgery practices in the country.

On December 10, 2013, STS held a policy planning meeting with members of STS leadership to discuss and identify key features to include in any cardiothoracic surgery APM model. Over the course of the past few years, STS has designed a quality-based payment program specifically related to cardiothoracic diseases (including coronary artery bypass grafting (CABG), valve repair and replacement procedures, and treatments for lung cancer) that relies on the robust data in the STS National Database as the foundation for quality measurement and improvement. The STS APM Whitepaper, included as an addendum to this statement, provides a high-level summary and framework for the heart team and lung cancer care team APM.

The STS APM Whitepaper presents CMS with an opportunity to identify and reward for value in healthcare. What the Whitepaper lacks is the infrastructure for that value-based payment. While we have had the opportunity to interact with 2 bundled/episode payment programs in the last year that offered acceptable infrastructure: the CABG Episode Payment Model (EPM) bundle and the ACS/Brandeis bundle, realistically for cardiothoracic episodes, both of these models failed to adequately incorporate the advanced quality measurement and improvement mechanisms developed by STS via the robust data available in our National Database. Basically, we have two puzzle pieces that fit together perfectly to make exactly the picture that CMS and Congress are looking for – a win on a specialty-specific APM in one of the largest cost centers in the Medicare program.

STS firmly believes that APMs should be developed in partnership with the clinical community and provide added incentives to clinicians to provide quality and cost-efficient care. However, in December 2016, the Center for Medicare and Medicaid Innovation (CMMI) and the Centers for Medicare and Medicaid Services (CMS) finalized plans to implement a Coronary Artery Bypass Graft (CABG) Model in the Advancing Care Coordination through Episode Payment Models (EPMs). Unfortunately, the CABG EPM was significantly flawed because it required that only two quality measures be used: all-cause mortality and a patient satisfaction survey. STS argued that CMS should use the STS CABG Composite Score, a five-part composite quality measure that has been endorsed by the National Quality Forum and includes all-cause mortality as a quality measure, specifically because the mortality rate for CABG is approximately 2%. This means that under the proposed CABG EPM, CMS would not have been able to differentiate among 98% of providers in the model. Using the STS CABG Composite, CMS would be using the same quality metrics that STS has used, alone and in partnership with Consumer Reports, to publicly report on hospitals' complete CABG performance. [See STS Public Reporting: <http://publicreporting.sts.org/>].

In late 2016, the American College of Surgeons and Brandeis University submitted a proposed physician-focused payment model (PFPM) to the PFPM Technical Advisory Committee (PTAC) for review. The model focused on procedure episodes and called for each qualified participant within an APM to assume risk in the episode(s) for which he/she provides care. Although PTAC approved the ACS/Brandeis model for limited testing by CMMI, the panel noted concerns with how the proposal fulfilled the "value over volume" criterion. It should be noted that where PTAC identified concerns with the ACS/Brandeis proposal, the STS APM Whitepaper offers solutions. The STS APM Whitepaper is a quality-based payment methodology that lacks a payment infrastructure. The ACS/Brandeis model is a payment infrastructure that can be enhanced by the quality-based measurement components provided by STS.

Policy-makers and thought leaders have largely indicated that bundled payments for episodes of care are a central tenet of alternative payment. At this stage, we feel the best opportunity for success is to identify a way to incorporate the STS quality data into the episode of care that CMS has already identified for the CABG EPM or the episodes of care being developed for limited testing through the ACS/Brandeis APM proposal. Rather than starting from scratch, we can build on gains made by CMMI with the EPM and by ACS/Brandeis with their PFPM proposal. Further, our quality-based payment methodology addresses critical gaps in all the models that have been proposed thus far – we have a validated and meaningful way to measure quality and we know how to tie it to payment.

Additionally, we believe that there is a role for other stakeholders in the APM-development process. For example, as we incentivize physicians to improve efficiency in the health care system, we run the risk of squeezing out innovations that, while costly at their inception, provide dividends over time. We are beginning to think about the concept of "risk" in a payment model to include the concept of medical innovation and the role that industry may play in support of evidence-based quality improvement.

We are actively pursuing all possible partnerships and look forward to working with Congress, CMS, and CMMI to bring to fruition a payment model that could provide quality incentives and efficiencies to one of the largest cost centers in the Medicare program. We hope to serve as an example for all of medicine. We are eager to be an active partner in the effort to drive medicine to value-based payment and we are more than willing to go first.