THE SOCIETY OF THORACIC SURGEONS

20 F STREET NW, SUITE 310 C
WASHINGTON, DC 20001-6704
Phone: 202.787.1230
Fax: 202.480.1227
E-mail: sts@sts.org
Web: http://www.sts.org

May 2, 2011

Honorable Fred Upton, Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Upton:

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 in response to the House Committee on Energy and Commerce request for input on the Medicare physician payment system. Founded in 1964, STS is a not-for-profit organization representing more than 6,100 surgeons, researchers, and allied health care professionals 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. Thank you for the opportunity to share our comments with the Committee as it focuses on this most important issue.

SGR Reform

The volatility of the Medicare payment system is threatening Medicare beneficiaries' access to surgical care. Continued payment cuts, rising practice costs, and ongoing uncertainties about the Medicare payment system make treating Medicare patients more difficult for both community-based and academic surgical practices. Over the past decade, STS has repeatedly advocated for the reform and redesign of the unstable and unsustainable Medicare physician payment formula. Congress' reluctance to reform a flawed payment system has caused instability and uncertainty that undermine surgeons' abilities to plan for the future and has created a substantial impediment to continuing efforts toward improvements in the quality and efficiency of patient care.

STS believes it is the professional responsibility of all physicians to use health care resources effectively and efficiently so that the quality and value of health care are maximized. Existing payment systems reward providers only for delivering more care and more complex care rather than better care. Moving to a quality-based payment system must start with redesign of the Medicare physician payment formula. The current Sustainable Growth Rate (SGR) formula is fatally flawed and must be replaced.

In conceptual terms, the current SGR formula places overall responsibility for physician expenditures on the medical profession as a whole; but in practice, SGR experience has clearly demonstrated that setting a reduced growth rate target for Medicare Part B services is ineffective and unrealistic. A major shortcoming of the SGR formula is that there are no organizational mechanisms by which the profession can influence the growth rate of physician services and payments; there is actually a disincentive to self-regulate. Any modernization of the physician payment system should address this shortcoming of the

SGR formula with increased responsibility at the medical specialty level, where organizational infrastructures already exist. Professional responsibility for physician expenditures can then occur based on real data concerning what is most effective and most appropriate for the patient. The system should focus on methods that reward improved outcomes and efficiency rather than volume.

Different sectors of medicine grow at different rates; therefore a more realistic payment system would include multiple growth targets for different service categories based on rate of growth analysis. Unlike other areas in medicine, cardiothoracic surgery and other surgical specialties have *not* seen a substantial increase in the volume of specialty procedures, yet the volume target for increased utilization applies to all physicians. STS has analyzed this further, and data show that Medicare expenditures between 2000 and 2009 exceeded the growth rate of the Medicare beneficiary population in 41 specialties. In that same time period, expenditures were less than the growth rate of the Medicare beneficiary population in 10 specialties, including cardiothoracic surgery and other surgical specialties. Because most physicians in the U.S. belong to specialty and subspecialty organizations with their professional peers, and because such organizations increasingly are developing clinical registries to help physician members improve their practices, this organizational infrastructure could serve as a more realistic basis for control of physician expenditures.

Recommendations
STS recommends repealing the current SGR formula in favor of a system that aligns payment with quality and value.

STS recommends a system of multiple conversion factors that rewards professional accountability and encourages physicians to assess the effectiveness of treatments and services. At a minimum, STS supports a separate conversion factor for major surgical procedures and believes that separate conversion factors for each specialty should be strongly considered. Such a system would be administratively simple to implement and would provide a disincentive to "over spend" and exceed established targets. This approach would also allow quality incentive programs to be more targeted, requiring specialty-level self-regulation. Combining specialty conversion factors based on disease management could easily be adopted (cardiovascular disease, for example) and could rely on common outcomes databases. As the STS National Database and registries of other specialties have demonstrated, sharing outcomes data effectively motivates physicians to change their practice patterns, which can result in more efficient care delivery and increased patient value.

Investing in Proven Quality Improvement Initiatives
STS also believes that there is a need to improve the *value* of health care. In order to achieve this goal, there must be a reimbursement system in place that recognizes and rewards physicians who improve the quality and value of care. Such a system should reinforce meaningful quality improvement initiatives, including the acquisition and use of risk-adjusted reliable outcomes and clinical effectiveness data, and reward physicians for improved outcomes. STS has been the leader in developing physician-led quality improvement initiatives – initiatives that have resulted in improved outcomes and lower costs. Those initiatives have been possible because STS maintains a robust, externally audited, and world-renowned National Database of more than 4 million patient records, each detailed with clinical information. Such

experience emphasizes that physicians, in collaboration with their respective professional societies, are best and most appropriately positioned to define what constitutes high-quality care.

We support data-driven approaches to quality measurement, improvement, and reporting. Building truly continuous quality improvement systems is dependent on the collection and analysis of risk-adjusted clinical outcomes and utilization data. Most importantly, it requires providing feedback on those data to physicians. Clinical data can then be linked with administrative data to track the cost of care over time and provide an assessment of clinical and cost effectiveness, including for issues related to new technologies and devices. Only a clinical database with a sufficient volume of clinical records can be credibly risk-adjusted for case mix to yield accurate and comparable findings.

STS has successfully linked its clinical data with Centers for Medicare and Medicaid Services (CMS) MEDPAR information to obtain longitudinal outcomes data for a wide array of cardiothoracic surgery operations. The ability to link clinical data with administrative data 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. Linked data are particularly useful in conducting comparative effectiveness research (CER) and establishing appropriateness of care.

The use of national clinical registries offers insight to a population of "real-world" patients and provides ready access to data that can yield analytic results quickly. Furthermore, these attributes of registry-based observational studies permit the analysis of patient populations far greater in size than that typically seen in randomized controlled trials and at a much lower cost. The use of clinical registries in this manner could well serve as an important national resource to compare long-term outcomes for a variety of medical devices and treatment options. By pinpointing appropriate care, the application of these registry-based studies should improve outcomes, minimize overuse of therapeutic options by reducing waste and ineffective diagnostic and therapeutic measures, and ultimately reduce health care costs.

Recommendations

STS strongly urges Congress to mandate that the Department of Health and Human Services (HHS) incentivize development of specialty and/or condition-specific, outcomes-focused clinical data registries and utilize funds available in the Center for Medicare and Medicaid Innovation for such purposes.

Additionally, we support well-designed comparative clinical CER to evaluate treatments and procedures, the long-term efficacy of drugs and devices, and appropriateness criteria for utilization -- all of which can best be addressed with valid clinical data. Therefore, Congress should fully fund the Patient Centered Outcomes Research Institute (PCORI). With its focus on clinical rather than cost data, PCORI would provide the appropriate avenue for conducting CER in a transparent manner. Congress also should direct AHRQ to utilize valid clinical registries whenever possible.

Alternative Payment Systems

Accountable care organizations (ACOs), bundled payments for defined episodes of care, and gainsharing are three mechanisms CMS is considering to encourage collaboration among physicians, hospitals, and other relevant providers by aligning incentives for improving the quality of care and lowering costs. STS takes the position that in order to ensure optimal health care delivery, these alternative payment systems must be physician led, patient centered, and quality driven.

We recognize that ACOs and other innovative payment models can help physicians deliver more efficient and more effective care, but not all physician practices will be able to change their organizational structure and processes in order to participate in these new payment models. Thus, ACOs must be completely voluntary, and those physicians who cannot or choose not to participate must not be penalized. Of equal importance, although ACOs may prove effective in improving the management of common conditions, payment systems must also recognize that, in reality, there are significant numbers of patients with uncommon conditions who require highly complex procedures or treatments. ACOs may not have the financial resources to develop expertise for these conditions, and therefore payment mechanisms must exist to compensate those who provide this type of tertiary/quaternary care.

Any payment model implemented should use an effective and rigorous risk-adjustment methodology so that ACOs are rewarded, not penalized, for accepting sicker patients and addressing their needs in the most effective way possible. But risk adjustment alone is not enough; some patients will have unique problems that require unusually expensive care not adequately captured by any risk-adjustment methodology. Even a single patient of this nature could be financially devastating for a specialized physician practice, whereas a large health system would be much less affected. Thus, in addition to appropriate risk-adjustment methodologies, limits should be established on an ACO's accountability for the total cost of services to any individual patient. Moreover, timely and detailed feedback to physician practices is needed if opportunities for cost and quality improvements are to be identified.

We believe that shared-savings arrangements encourage wise allocation of health care resources and provide a guide for sustained savings. Bundling Part A and Part B Medicare payments would also shift incentives from the current volume-based system to one that rewards physicians for using only the most appropriate procedures and reducing post-operative complications – efforts that ultimately can reduce expensive hospital readmissions. This bundled payment model could be applied to the care of beneficiaries with defined conditions over a distinct period of time, particularly for those with the most costly diseases and chronic conditions. A bundled payment system should also reward attainment of outcomes benchmarks, such that underutilization of services is not encouraged. The coupling of outcomes measures with bundled payment would align incentives to improve the quality of care for Medicare beneficiaries, leading to reductions in costly complications, the creation of quality-guided resource utilization, and the achievement of sustained savings, efficiency, and innovation.

Recommendations

STS recommends that Congress support the development of incentive programs offering physicians the opportunity to share in savings generated by quality improvement efforts. Patient-centered systems of care should be encouraged to reform and reorganize the delivery of health care. Care must be refocused around the needs of patients, and systems of delivery should allow and encourage collaboration across

organizational boundaries and disciplines. Moreover, to lower cost and improve quality, payment must be restructured to create incentivized integrated delivery systems that focus on specific patient needs. While we support the concept of shared savings programs, we believe that incentives should not be based solely on cost savings (use of claims data exclusively), but should also include increases in value (quality divided by cost).

STS also recommends that Congress address legal concerns that might arise for physicians who provide patient care as part of an alternate payment system. We are concerned that a general waiver of the rules regarding discretionary decisions to not pursue enforcement actions will leave providers inadequately protected within the context of these types of arrangements. We urge Congress to ensure the Federal Trade Commission (FTC), Department of Justice (DOJ), CMS, and the HHS Office of the Inspector General (OIG) develop explicit protections from antitrust laws, the physician self-referral prohibition, the Federal anti-kickback statute, and the civil monetary penalty (CMP) laws for physicians providing care in alternative arrangements such as ACOs. These protections are absolutely imperative as attempts at shared savings programs involving cardiothoracic surgeons have been derailed, in part due to OIG and the DOJ concerns regarding physician self-referral and CMP laws.

Medical Liability Reform

Meaningful medical liability reform, a critical component of any payment reform, is necessary both to protect patients' access to quality care and slow the rising cost of health care. The inefficiencies of our current medical liability system, which contribute to escalating and unpredictable monetary awards, and the high cost of defending against malpractice lawsuits contribute to the increase in medical liability insurance premiums. As insurance becomes unaffordable or unavailable, physicians must make difficult decisions about whether to alter or limit their services because of liability concerns, an outcome that impedes patient access to care and increases costs. In addition, the cost of our liability system is borne by everyone as defensive medicine adds billions of dollars to the cost of health care each year, resulting in higher health insurance premiums for patients. The Congressional Budget Office has recognized the steep cost of our current medical liability system and has estimated approximately $40 billion in scored savings from comprehensive medical liability reform. The current system for compensating injured patients drives defensive medicine practices and so increases health care costs. Additionally, access to life-saving high-risk procedures is increasingly compromised by lawsuit abuse.

Recommendations

STS urges Congress to enact meaningful liability reform, such as that outlined in H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011.

Public Reporting

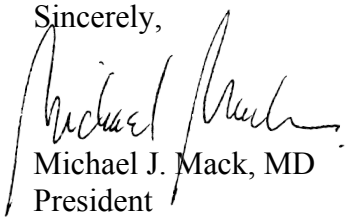
STS supports public reporting initiatives that are generated from credible, reliable and valid sources and utilize risk adjusted clinical outcomes data. Such initiatives should use clinical data that have been tested and found appropriate to drive improvement in care. It is important not to misinform patients, and to avoid the unintended consequences of delivering misleading or inaccurate guidance utilizing less sophisticated administrative data. STS feels strongly that consistency of formats in reporting on cardiac surgery outcomes is critical and believes that data are only as useful as they are understandable.

In that regard, STS has partnered with Consumers Union (CU), publisher of *Consumer Reports*, to make outcomes data – voluntarily submitted by U.S. cardiac surgery practices participating in the STS Adult Cardiac Surgery Database – available to the public. In September 2010, Consumers Union posted star ratings based on the STS composite quality measure on its website. STS has now launched its own public reporting initiative, STS Public Reporting Online, which provides the quality composite scores of more than 350 STS Adult Cardiac Surgery Database participants. While complementing the CU effort, STS Public Reporting Online provides more granular data and covers a more expansive timeframe.

Recommendations
STS urges Congress to temper those policies that expand public accountability of Medicare providers and set specific criteria and limits on the public release of raw administrative data reports in favor of alternative public reporting formats based on risk-adjusted clinical outcomes data similar to those currently used by STS and CU.

STS greatly appreciates the opportunity to offer these comments for the Committee's consideration as it addresses concerns related to the current Medicare physician payment system. We look forward to working with you toward repeal of the SGR and implementation of a more stable payment system that is patient-centered, physician-led, and quality-driven. We welcome the opportunity to serve on a witness panel to provide testimony during the upcoming Committee hearings. Please contact Phil Bongiorno, STS Director of Government Relations, at (202) 787-1221 or pbongiorno@sts.org if you have any questions.

Sincerely,



Michael J. Mack, MD
President

cc:
The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD