The Society of Thoracic Surgeons

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Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

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

Dear Chairmen Camp and Upton:

On behalf of The Society of Thoracic Surgeons (STS), the largest organization representing cardiothoracic surgeons in the United States and the world, I write to provide comments to the Ways and Means and Energy and Commerce Committees on the second draft of the committees' joint Sustainable Growth Rate Formula (SGR) Repeal and Reform Proposal. Founded in 1964, The Society of Thoracic Surgeons is an international, not-for-profit organization representing more than 6,600 surgeons, researchers, and allied health care professionals in 85 countries who are dedicated to providing patient-centered high quality care to patients with chest and cardiovascular disease, including heart, lung, esophagus, transplantation, and critical care. 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.

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The STS National Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart Surgery. The STS Adult Cardiac Surgery Database is the world's premier clinical registry for cardiac surgery. The fundamental principle underlying the STS database initiative has been that engagement in the process of collecting information on every case, robust risk-adjustment based on pooled national data, and feedback of this risk-adjusted data to the individual practice and institution will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients and the public. Published studies indicate that the quality of care is improving. We wish to point out an example of the power of the STS database effort. ElBardissi and colleagues studied 1,497,254 patients who underwent isolated primary Coronary Artery Bypass Graft (CABG) at The Society of Thoracic Surgeons participating institutions from 2000 to 2009. They found that:

- Patients in 2009 had more preoperative diseases: compared with the year 2000, patients undergoing isolated primary CABG in 2009 were more likely to have diabetes mellitus (33% vs 40%) and hypertension (71% vs 85%).

- 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).
- Although predicted mortality rates of 2.3% were consistent between 2000 and 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%.
- The incidence of postoperative stroke decreased significantly from 1.6% to 1.2%, representing a 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.

With the recent publication of the Congressional Budget Office's Budget and Economic projections for 2013-2023, it is clear that Congress must act now while the cost of SGR repeal is significantly lower. Although expected growth in Medicare spending has slowed, there is no guarantee that the trend will continue. Congress has the opportunity to take SGR off the books at a significantly reduced cost and we cannot afford to let this opportunity slip by. We urge Congress to act and support the current effort by the committees to draft legislation for that purpose that recognizes and attempts to leverage the power of clinical registries.

General Comments

On behalf of STS, I would like to thank you for this, more detailed draft of a very thoughtful proposal. STS appreciates the work that the committees are doing and sees considerable promise in the revised proposal. The Society is particularly grateful that our endorsement of specialty-specific processes for determining quality and efficiency that rely on risk-adjusted outcomes (using registry data and associated quality measures) has resonated with the committees and has a prominent role in the proposal. Since survival and resource utilization information is such an important part of the outcomes for cardiothoracic surgery quality improvement efforts, we urge that steps be taken to insure these registries have access to claims data from CMS (and, hopefully, other payors) and outcomes (death) data from the Social Security Administration or another, accessible source. It is imperative that the committees' bill address this foundational issue.

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. STS has successfully linked its clinical data with CMS MEDPAR information, on a project-by-project basis, to obtain longitudinal outcomes data for a wide array of cardiothoracic surgery operations. Linked data are particularly useful in conducting comparative effectiveness research (CER) and establishing appropriateness of care.

In addition, linking clinical registries to the Social Security Death Master File (SSDMF) allows 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 to provide information to today's patients and families to help them with shared decision making. Valid and reliable outcomes data give patients confidence in their medical interventions and demonstrate to patients and their families the durability and long-term benefits of medical procedures. 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 the follow-up information is returned from external entities, such as the SSDMF, it is linked back to the records in the de-identified database, but the flow of information is only in this direction. The externally derived data are used to supplement the data in the individual record, but these clinical, patient level data never leaves the database except in de-identified form.

Unfortunately, in November 2011, the Social Security Administration rescinded its policy of sharing state-reported death data as a part of the SSDMF. There are continuing efforts to further restrict access to 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 SSDMF data.

With respect to the committees' expressed intent to remain open to the discussion of medical liability reform, we believe that the proposal helps to lay the groundwork for tort reform that can protect patients and providers alike. STS believes that setting standards aligned with best practices identified by specialty societies is the best way to institute meaningful medical liability reform. The Society of Thoracic Surgeons Workforce on Evidence Based Surgery has developed evidence-based guidelines to provide practical assistance to STS membership. Thorough research of each guideline topic is completed through an exhaustive review of clinical information. The conclusions and recommendations are based on a review of scientific evidence published in the medical literature. STS Clinical Practice Guidelines are intended to assist physicians and other health care providers in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. In addition, the STS Risk Calculator allows a user to calculate a patient's risk of mortality and other morbidities, such as long length of stay and renal failure. The Risk Calculator incorporates the STS risk models that are designed to serve as statistical tools to account for the impact of patient risk factors on operative mortality and morbidity. This information, when used in the context of multi-stakeholder collaboration, provides additional layers of patient protection.

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. However, tort-reform should not be implemented in a way that is overly burdensome on specialty societies in general. To that end, we realize that there is a right way and a wrong way to utilize clinical guidelines. Guidelines must be specific to ensure that poor clinical practices or judgments that meet minimum standards are not considered as justifiable, but guidelines cannot replace clinical judgment and experience. Practice guidelines should protect physicians who are following them, but guidelines should not be able to be construed in a way that would make a physician vulnerable for a malpractice suit because he/she has exercised clinical judgment on an individual case and departed from the published “standards.” A talented clinician is not one who blindly adheres to established guidelines but rather one who recognizes that patient care must be individualized, occasionally requiring deviation from guidelines that are effective in the overwhelming majority of patients.

Finally, as you might expect, it is difficult to comment on this proposal without additional information on the specifics of stable payments in Phase I and base payments in Phases II and III. Clearly the committees have to weigh the political value of a lower scoring bill against the consequences of deep cuts to physician payments. We believe that a system which incorporates positive incentives for the performance of higher quality and more efficient care will have far broader appeal than a penalty-driven system in Phases II and III.

In conversations with Committee staff, we have learned a bit more about the factors that might compose a physician’s “base pay” and “variable pay.” The following comments are predicated on the assumption that “base pay” in Phases II and III will be equal to Phase I payments *minus* a certain percentage of that total, providing an incentive for physicians to participate in Phases II and III of the program to earn back that income. In this model, high achievers would, ostensibly, be able to earn back all of their deferred income and even achieve higher payments than were available during Phase I. This variable pay would be capped at a certain percentage, meaning that providers could only earn 100% + X of their Phase I pay. The comments below are based in this understanding of the proposal.

While the creation of a reward/penalty system of physician reimbursement is not inherently wrong and may, in fact, be an effective method of improving health care quality and efficiency, it is the method of implementation that is logistically problematic. If such a system is designed to operate on the individual physician level, intra and inter-hospital cooperation and sharing of best practices will inevitably suffer. Additionally, from a purely statistical perspective, it is virtually impossible to distinguish different levels of performance between one clinician and another because the total number of patients / outcomes / events created by the individual practitioners is far too small to achieve any meaningful interpretation. For example: 95% of 25 patients equals 23.75 and 92% of 25 patients is 23 (essentially no difference). However, 95% of 10,000 patients equals 9500 and 92% of 10,000 is 9200 (a much more easily appreciated difference).

On the other hand, a national or perhaps regional construct will enhance cooperation and “cross-fertilization” of information. Cardiothoracic surgical examples of these structures include not only the STS National Database efforts, but also state and regional efforts such as the Virginia Cardiac Surgical Quality Initiative, the Michigan STS collaboration on adult cardiac surgery, and the Northern New England Cardiovascular Study Group. Placing incentives at a higher level can encourage collaborative learning and quality improvement that should be inherent aspects of professionalism and can avoid incentives to “game the system” or to refrain from sharing knowledge and clinical experience.

Finally, placing the focus on the individual practitioner detracts from the heart team approach to patient care that has become the hallmark of the advances in our specialty of late. In order for the heart team, which consists of the cardiothoracic surgeon, cardiologist, anesthesiologist, and advanced practice nurses and physician assistants (among others), to function at its highest level, there must be shared responsibility for patient care and patient outcomes. Assessing care quality at the institutional, regional, or national level allows the component parts of the heart team to share accountability, ensuring the patient receives the best care from the appropriate health care provider.

We will offer comments on the specific points of the current proposal with the understanding that we have significant concerns about the general approach of creating the option to place rewards/penalties at the individual physician or practice level.

Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

In general, STS endorses the proposal to assign providers a "quality score" based on clinical quality measures that are defined by the physician's specialty and assessed via a clinical registry. We hope to have the opportunity to work with the committees on how a "quality score" might be calculated and used for the purposes described in the proposal. We appreciate that the proposal recognizes registry-based reporting as a way to reduce the burden imposed on physicians. We would emphasize that clinical registry access to Medicare claims data (for resource utilization analysis) and longitudinal outcomes data (for clinical effectiveness analysis) are essential in this phase of the program.

While we endorse the concept of a quality score tool, we feel it is essential that any performance-based payment rate be based on a composite of all recommended variables rather than allowing a provider to choose the variable(s) on which he/she would be evaluated. In addition, we believe that component variables should be weighted. Aggregating these variables and giving them relative weights will help to negate any unintended externalities.

<u>Score on quality measures relative to peers</u>:

This variable presents a significant risk to the knowledge-sharing and collaboration that is inherent to membership in a profession. Tiering among like providers could have a number of unintended consequences. First, unless patient outcomes are carefully risk-adjusted, providers may have a disincentive to treat the sickest patients – those who are more likely to have an adverse outcome – and lower a provider's relative ranking. Second, per above, encouraging competition among providers may provide a disincentive to share best practices and improve the overall standard of care within a given specialty.

To address these concerns, we suggest that policymakers consider a positive incentive/reward for those groups with high quality scores and to do so without reductions for other groups. Some have termed this a "target approach", which is preferable to a "tournament approach" with obligatory winners and losers.

The committees may also consider employing this variable only when a group of providers has already achieved a quality score (based on the other weighted, composite variables) that would make them eligible for 100% of Phase I payments (in real dollars). This would effectively create a tiering structure among only those providers who are scheduled to earn payments between 100% of Phase I payments and 100% + X (or the performance-based, variable pay rate cap). At a minimum, this variable should be weighted to have the minimum possible effect on a provider group's quality score.

Significant improvement in their own quality score from the previous year

STS appreciates that the goal of this measure is to create a system that is constantly refreshing itself so that providers have continuous incentives to improve. However, employing a structure that relies on annual assessment based on only one year's worth of data makes providers extremely vulnerable to performance outliers. STS would recommend aggregating a provider group's quality score over a three year period to accommodate this concern. Because continued improvement on a given measure, without reaching a point of diminishing returns is impossible, this variable also assumes that the quality measures used by providers will change over time. It will also be important to set the bar of "significant" improvement at the right level so that quality improvement under this program is both attainable and meaningful. Finally, this variable amplifies the need to ensure appropriate risk-adjustment of patient outcomes so providers are not unfairly penalized when they treat sicker patients.

Alternatively, the committees might consider penalties for providers who fail to achieve certain benchmarks on a given quality measure.

If these modifications are added, STS believes that this variable should receive the highest weight among the variables.

Executing clinical improvement activities

Clearly, encouraging providers to engage in certain clinical practice improvement activities will help to set a level playing field among providers and specialties. This variable will be an important component of the program at its inception and provides a mechanism for policy-makers to signal recognition of innovations in health care delivery that they deem to be useful for future quality improvement. Like the quality measures, the list of clinical practice improvement activities can be updated regularly to promote growth and improvement. We support the proposal that physicians have the ability to choose from a menu of clinical practice improvement activities. Further, because some activities may not be immediately achievable, we believe that providers should be able to work towards these goals while receiving credit for completing other clinical practice improvement activities. Providers may also be given credit for working towards these goals (in anticipation of eventually completing them). For example, while STS has robust clinical guidelines already in place, we have not developed decision support tools, outside of the STS Risk Calculator. Disseminating and implementing proficient use of these tools could take a considerable amount of time.

STS recommends weighting successful completion of these activities, lower, relative to the variable above, "Significant Improvement in their own quality score from the previous year."

<u>Questions for Phase II</u>

- How should the Secretary address specialties that have not established sufficient quality measures?

  Although some specialties have not yet established their own quality measures, STS believes that all physicians should be working to improve patient outcomes through quality assessment. The program can be designed to accommodate such specialties while they develop the databases and registries that should serve as the basis for credible and statistically valid measures necessary to fulfill the promise of this policy. While we do not know the duration of Phase I, medical specialties may be able to commence with some data collection and analysis during that time. A short grace period may be necessary but we would encourage policy-makers not to delay implementation for those who are able to fulfill many of these requirements today. We wish to again point out there are advantages to placing rewards and penalties at a different organizational level than the individual physician or practice.

- Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

  Yes, per above, while both may be valuable, over-weighting quality compared to one's peers may have unintended consequences.

- Are there sufficient clinical practice improvement activities relevant to your specialty?

  Yes, STS excels at many of these. However, some of the identified clinical practice improvement activities are more accessible to STS than others. For example, STS has been at the leading edge of developing clinical practice guidelines based on outcomes data derived from the STS National Database. However, we do not currently provide decision support tools to our members, outside of the STS Risk Calculator.

- Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

  Yes, we believe small practices should have the ability to aggregate measurement data and we would encourage this.

<u>Phase III: Reward for Efficient Use</u>

Based on our experience with measuring both care efficiency and comparative effectiveness, STS wishes to emphasize that access to claims data from CMS (and other payors) and outcomes data (from the SSDMF) is essential for this phase as well. Funded by the National Heart Lung and Blood Institute (NHLBI) at the National Institutes of Health (NIH), the ASCERT (American College of Cardiology Foundation-The Society of Thoracic Surgeons Collaboration on the Comparative Effectiveness of Revascularization STrategies) study was designed to examine the comparative long-term effectiveness of Coronary Artery Bypass Graft (CABG) and percutaneous coronary intervention (PCI) revascularization strategies in real world populations, including specific subgroups of patients such as those with diabetes, severely impaired heart function (low ejection fractions), chronic lung disease, and kidney dysfunction. The study uses data from STS Database and ACC registry along with CMS Medicare Provider Analysis and Review (MEDPAR) data. STS views the ASCERT study as a paradigm for a comparative effectiveness research enterprise based on linked clinical and administrative data. Clinically robust, broadly generalizable data from thousands of patients, linked with longitudinal outcomes from claims data, could quickly and cost-effectively answer a broad range of questions. The results of these studies will be a unique and innovative source of information for patients, providers and various third party payers concerning the potential long-term results of different treatments in specific subgroups.

The STS National Database has also been used to support regional health care quality and efficiency improvement programs. For example the Virginia Cardiac Surgery Quality Initiative (VCSQI) was formed in 1994, with the express purpose of improving clinical quality across an entire state in cardiac surgical programs of all sizes through data sharing, outcomes analysis, and process improvements. It is founded on the principle that a focus on quality will contain costs by lowering complications, improving efficiency, and reducing resource utilization.

All of the VCSQI programs participate in the STS National Database and uniformly follow the definitions and measures in this landmark clinical registry. This regional quality initiative has constructed a database of over 80,000 patients who have undergone cardiac surgical procedures. The database is unique in that it matches the patient’s clinical outcome data with each patient’s discharge financial data. Each record includes clinical outcome tied to costs for each episode of care. On a quarterly basis, each program’s clinical and financial outcomes are reviewed and used to develop new evidenced-based methodologies to improve care in cardiac surgery. VCSQI has served as a test bed for the STS’s evidenced-based guidelines to be implemented.

VCSQI has attempted to test a global pricing model and has implemented a pay-for-performance program where 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.

Questions for Phase III

- How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

  By the time we enter into Phase III of this program, specialties should be able to identify a few targets for efficiency improvements. The process will need to be refined over time and will depend on the program requirements.

- Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

  Yes, setting a baseline of high quality care before assessing efficiency sets the right priority for providers and gives beneficiaries confidence in their care.

Additional Provisions

Questions for APM Adoption

- What do you believe will be necessary to support provider participation in new payment models?

  Certain changes will be required to promote bundled payment initiatives and allow for gainsharing to take place. STS proposes removing restrictions on gainsharing arrangements (Sections 1128A(b)(1)-(2) of the Social Security Act regarding civil monetary penalties and Section 1128B(b) of the Social Security Act regarding antikickback provisions) provided that necessary patient protections are in place. This is consistent with actions taken by regulators in developing the Accountable Care Organization model and other shared savings programs.

  We again wish to emphasize that for complex, hospital based procedural specialties, APMs should allow providers to engage a higher level than the individual physician and will recognize the importance of not only the surgeon, but also the other entities in the team delivering care to cardiothoracic surgical patients. As has been our experience with the heart team, we anticipate that gainsharing APMs will promote a much greater level of inter-specialty communication and cooperation, incentives to control resource utilization and an internal self-policing system to maximize efficiency and quality.

- What is a reasonable time frame for CMS to approve and adopt APMs?

  STS would hope that CMS (or the Center for Medicare and Medicaid Innovation) would be able to approve new payment models within one year. We strongly encourage CMS to engage clinical experts in each area of medicine to guide the design of these alternative payment models and to resist the temptation to try to create a “one size fits all” mechanism.

- Should providers be able to participate in more than one payment model?

  Yes – this is particularly important for medical and surgical specialists who are precluded from meaningful participation in ACOs and other shared savings programs that are primary-care centric.

Questions for Current Law Improvements

- What improvements upon current law do you believe will be required to support alternate payment model adoption?

  Require that CMS and other payers make administrative (cost and claims) data available to registries for use in their analyses so that resource utilization becomes an outcome variable to be assessed in the same manner as traditional clinical outcomes such as mortality or complication rates.

  It is only by linking administrative and clinical data that we can appropriately and accurately assess whether physicians are improving patient outcomes and providing better value. By using linked longitudinal registries, physicians can more broadly monitor patients for readmissions or care transitions and receive feedback that allows a rational basis for practice improvement. Similarly, longitudinal patient histories allow physicians to assess the success of cardiothoracic interventions. STS also requests that Congress endeavor to make outcomes (death) data available to clinical registries for outcomes analyses. The importance of access to the SSDMF cannot be overstated.

  Importantly, STS believes that meaningful quality measures and rewards for physician performance cannot be applied simply to administrative data reported by hospitals and physicians alone. While administrative data provide information on longitudinal medical treatment and resource utilization across settings of care and by various physicians, their clinical accuracy have been shown to be poor, and they exclude pertinent information on patient risk factors, disease severity, and clinical outcomes. This critical information is only found in clinical datasets where there is input of clinical data by clinicians.

  Address barriers imposed by federal and state privacy regulations

  Healthcare providers are now being required to produce objective evidence of the quality, safety and value of care to a variety of healthcare stakeholders. These quality related efforts necessitate the collection, analysis and reporting of clinical data. Meaningful data collection often relies on the ability to use individually identifying patient information (particularly in analyses related to the value or sustainability of treatment interventions) in a careful manner that protects patient privacy. Risk-adjusted data collected in this way reliably results in the generation of new knowledge. The current regulatory structure fails to recognize that data collection for quality improvement purposes (including the retention of Personal Health Information) and the generation of “new knowledge” pose no substantial risk to the patient. In the STS National Database environment, privacy risk is minimized since individual patient records exists in the clinical registry in a rigorously de-identified format. As the HIPAA Privacy Rule already addresses many of these patient privacy risks by imposing restrictions on how certain identifiable health information is collected by health plans, healthcare clearinghouses, and healthcare providers (‘‘covered entities’’ and their “business associates”) and how it may be used and disclosed, it would appear superfluous and counterproductive to impose Common Rule consent requirements since compliance with HIPAA patient protections are already in place.

STS requests that Congress instruct CMS to work with the Department of Health and Human Services Office for Human Research Protections (OHRP) and Office for Civil Rights (OCR) to establish appropriate standards for quality improvement (QI) activities that will both adequately protect patients without unnecessarily burdening QI efforts. Until that guidance is made available, it is inevitable that significant variability in interpreting and applying the Privacy and Common Rules will persist.

Specifically, we ask that OHRP issue guidance that the Common Rule does not apply to the collection and analysis of identifiable patient information for quality assessment and improvement purposes where the entities collecting and analyzing the data (such as clinicians and a corresponding clinical data registry) are engaged in standard patient care and are in compliance with all applicable HIPAA requirements. Moreover, we ask that definitive language be included in federal guidance to allow for a clear differentiation between "human subjects research" and the processes related to the essential prospective analyses directed at advancing our national quality care objectives. In particular, the generation of new knowledge should be recognized as an expected and desired outcome of healthcare quality improvement projects; the processes related to the generation of such knowledge should therefore be exempt from a requirement for informed consent (on the basis that all HIPAA related regulations are adhered to in the course of clinical data collection and analysis).

- What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?

  There is significant risk for the imposition of multiple data entry burdens. STS respectfully suggests that the committees consider delegating data collection to registries and databases that meet certain criteria, including external audits, comprehensiveness standards, ability to provide feedback of risk-adjusted outcomes, and protection of private patient information. We believe that the medical professionals who will design these databases and registries will be in the best position to determine the important data elements that should be collected and how the outcomes and risk-adjustment analyses should be undertaken.

- What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?

  As per above, STS believes that the most effective mechanisms to improve practice are the collection of data on every case, the submission to a central registry to allow risk-adjustment, and the feedback of this risk-adjusted data to the individual physician and practice. Removal of barriers to this process and provision of incentives to encourage participation in this process is essential, including addressing patient privacy issues. We also feel that the practice of defensive medicine is, perhaps, the biggest challenge physicians face when working with patients to identify the best plan for treatment. Having clinical data that support practice guidelines and clinical decision making gives both providers and patients confidence that the best care at the right time is being provided and received. Reforming the tort system to rely on these advances can only

> serve to promote provider buy-in to the provisions outlined above. The issue of over-utilization will never be fully addressed without a significant and meaningful level of tort reform.

STS remains hopeful that other Medicare initiatives, such as the Value Based Modifier (VBM), that attempt to improve, and even to pay for improved quality care, would be supplanted by the reformed fee for service (FFS) program outlined in this draft. Implementing a VBM, or a similar program, concurrently with the reformed FFS would be confusing and, potentially counterproductive. However, we support the committees' proposal to afford physicians' the option to enter into one, or more, approved alternative payment models (APMs). To that end, we hope the committees will continue to monitor the implementation of APMs, including Accountable Care Organizations (ACO) and others that might blur the lines between Medicare Parts A and B. In the ACO and other payment models, it remains to be seen who will receive the incentive payment for improved quality and/or reduced cost, and how that check will be divided among the providers. As STS represents surgical specialists who predominantly perform their services in a hospital setting, we remain skeptical, yet vigilant, to ensure that the process is equitable. Nevertheless, we strongly endorse the committees' openness to physician-hospital gainsharing programs and hope the final legislation will help to define some parameters for a gainshairing APM.

Conclusion

We believe that an outcomes-based/data driven approach to care should be encouraged and supported, and that specialty societies are the best entities capable of generating relevant and clinically meaningful measures that are widely accepted by all stakeholders, including providers, patients and third party payers. The ideal source for such data are clinical registries designed by content experts—the physicians and surgeons in a particular specialty. Sufficiently granular information should be collected to ensure robust risk-adjustment so that practices and hospitals caring for sicker patients are not penalized. Similarly, specialties will determine the most appropriate outcomes to measure, in most instances focusing on objective outcomes measures such as death and complications. A mechanism such as the STS National Database 1) takes advantage of an existing, nationally standardized, and validated data infrastructure, 2) minimizes duplication of quality reporting mechanisms, and 3) provides a method for reporting transparency among providers. It is, however, essential that any specialty-specific database be carefully audited by an external entity to maintain the integrity of the database and the process of quality improvement. In the case of STS, we contract with Telligen to randomly audit 8% of all STS participant programs annually, and we intend to increase the percentage of sites audited to 10% next year.

There must be a central review process, such as the process utilized by the National Quality Forum (NQF), to ensure the measures chosen by each specialty are valid and meaningful. The AMA Relative Value Update Committee and Physician Consortium for Performance Improvement are also examples of entities that utilize processes that are transparent and evidence-based.

Thank you for the opportunity to provide comments during this phase in your process. We appreciate the work the committees have undertaken to help resolve this important issue. If you need additional information, or if STS can be of any assistance, please contact Phil Bongiorno, STS Director of Government Relations, at pbongiorno@sts.org or 202-787-1221.

Sincerely,

Douglas E. Wood, MD
President