

Official Testimony of

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On

Medicare Physician Payment: How to Build a Payment System that
Provides Quality, Efficient Care for Medicare Beneficiaries

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Health Subcommittee

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Good morning Chairman Deal, Ranking Member Brown, and members of the Subcommittee. Thank you for inviting the Society of Thoracic Surgeons (STS) to discuss Medicare physician payment and explore new ways to provide quality and efficient care for Medicare beneficiaries. My name is Jeffrey Rich and I am a practicing cardiothoracic surgeon at Sentara Healthcare in Norfolk, Virginia. I am testifying on behalf of the STS where I serve on the Board of Directors and Chair the Taskforce on Pay for Performance. I also serve on the Board of Directors and Steering Committees of multiple other national and regional quality improvement organizations and alliances including the National Quality Forum (NQF), the AQA, the Hospital Quality Alliance (HQA), and the Virginia chapter of the STS, also known as the Virginia Cardiac Surgery Quality Initiative (VCSQI).

As many of you know, the members of The Society of Thoracic Surgeons have been systematically measuring and improving patient outcomes in cardiac surgery – both nationally and in local collaborative efforts – for nearly two decades. We are currently involved in several pay for performance initiatives with private health plans and believe it is time for the government, i.e. Medicare, to undertake similar initiatives which have been shown can reduce costs while saving lives.

Over the past 18 years, we have gained significant experience in what has been proven effective in quality measurement and improvement, and have also encountered several serious pitfalls to avoid. We have found that improved quality can save money and that significant cost reductions are within our reach – but how these are implemented may determine success or failure.

The key messages we hope to impart to you today are:

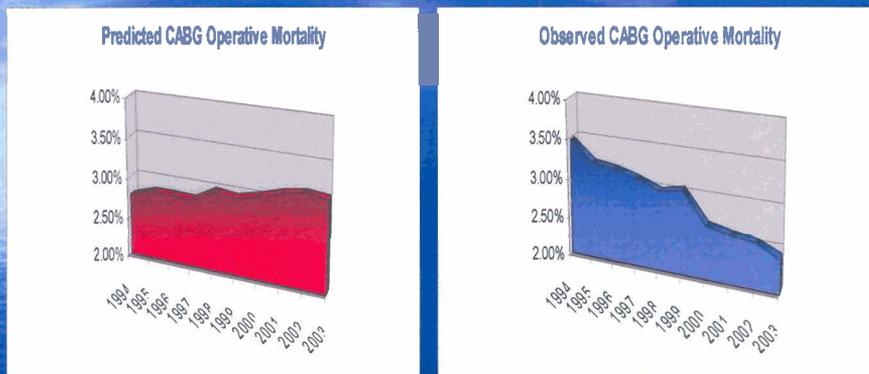
1. Data source is critical – Claims data are not sufficient to measure outcomes and are incapable of allowing the significant risk adjustment that can prevent patient access disparities – usually for the sickest patients.
2. All measures are not created equal – To best determine “value” in health care, patient outcomes over the episode of care are the best measurement.
3. The incentives must encourage continuous quality improvement – paying bonuses for compliance with generally expected processes of care or basic safety procedures will yield little and drive up costs.
4. The best use of quality data is to improve the quality of all providers – Use of data for simply profiling providers and steering patients will further exacerbate gaps in quality. We have shown that we can improve quality while eliminating variation among providers. This will yield the most savings for the program.

We are here today to discuss how physician payment can be changed to promote quality and efficiency. Quality measurement and improvement have not proceeded at the pace or scope proposed in the Institute of Medicine's "Crossing the Quality Chasm" report in 2001. In addition, we are facing exhaustion of the Medicare Trust Fund in 2018, threatening the program that elderly Americans cannot do without at a time when baby boomers will begin to need it the most. Multiple reasons exist for the financial insolvency of Medicare including the expanding elderly population, healthcare costs rising at a pace faster than inflation, and an expansion of physician services exceeding all expectations. It is this last point and the lack of quality improvement perceived to exist in the healthcare system that brings us here today. Current reimbursement models, in particular the Sustainable Growth Rate formula (SGR) have failed to engage providers in addressing these issues, and it is the feeling of policy makers and legislators that rewarding quality and efficiency measurement and reporting will provide solutions. The STS believes that there may be validity to this argument, but also strongly feels that any reimbursement system developed to reward performance in quality and efficiency must be designed properly to achieve these goals.

Today I would like to talk about the experience that the STS has in this area and the lessons learned along the way.

The STS has nearly 18 years of experience in quality measurement, monitoring and improvement through the use of our national cardiac database (NCD). With nearly 80% of hospitals and surgeons who deliver cardiac surgical care participating, the NCD now has over 3 million patient records on which to analyze and report the major morbidities and, most importantly, the risk-adjusted mortality associated with these procedures. By providing feedback through the use of the NCD the STS participants have managed to achieve a 30% reduction in risk-adjusted mortality in the face of rising patient acuity. Our patients are older and sicker and have, as the chart below shows, an expected mortality rate that has increased by 35%.

CABG MORTALITY TRENDS



In short, many more patients are surviving these difficult operations in an uncomplicated way. This has been achieved through the collection of accurate clinical data and feedback to providers of their performance based on regional and national benchmarks. In addition, the STS has promoted the development of regional collaboratives, true hospital/physician quality alliances that have worked to share data and identify best practices in order to improve quality. Examples of such are found in the states of Virginia, Michigan, Iowa, Washington and the northern New England region. Because of the strength and credibility of the database and in an effort to promote accountability the STS has vetted 15 of its measures related to the morbidities and mortality associated with cardiac surgery through the NQF consensus development process and is currently working with the HQA and CMS to adopt these measures for inclusion in the Hospital Compare website.

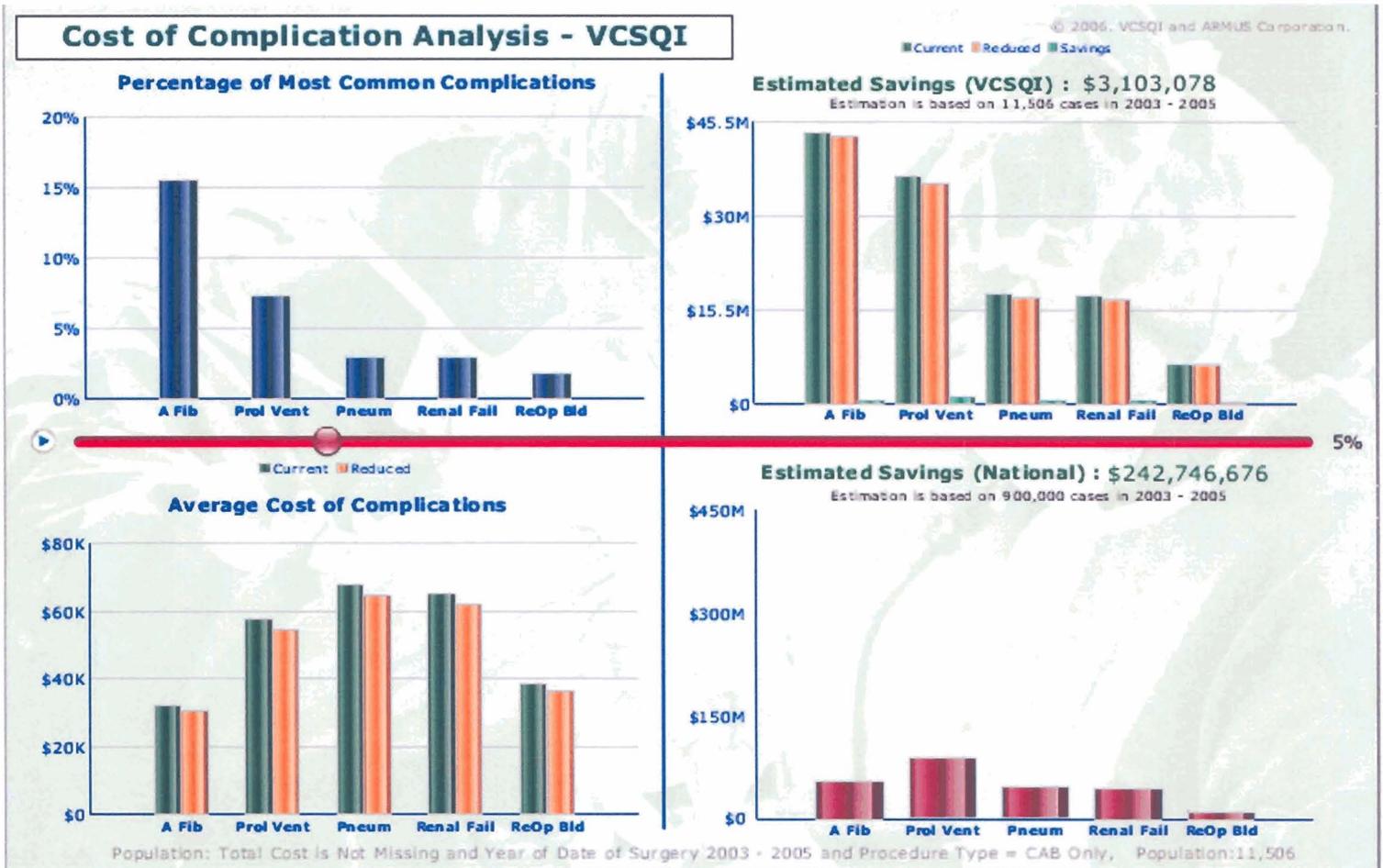
However, we have gone one step further. The STS participants in the state of Virginia formed the Virginia Cardiac Surgery Quality Initiative (VCSQI), a collaborative of 16 hospitals and 50 surgeons in order to improve quality and contain costs through the use of a unique database. This database is a blend of the STS **clinical** database and the CMS **financial** database creating a clinical/financial tool that enables providers in the state to monitor quality improvement and examine its impact on cost of care delivery. As seen in this chart, the incremental costs of the major complications associated with cardiac surgery have been identified.

Incremental Cost of Complications: VCSQI, 2003 to 2005, CABG only

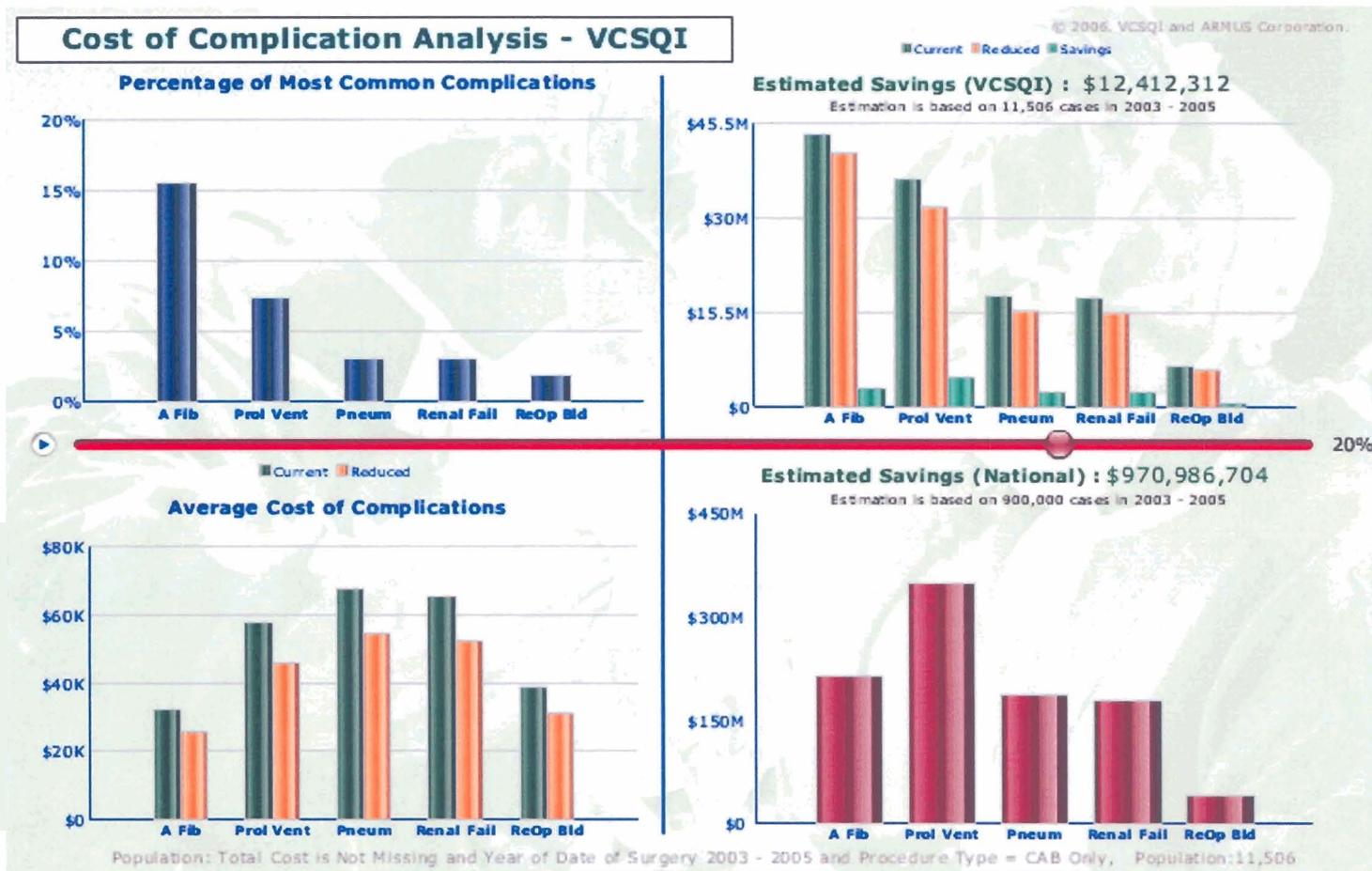
Complication	Average Cost	Incremental Cost
All CABGs	\$25,973	NA
No Complications	\$21,994	\$0
Atrial Fibrillation only	\$25,331	\$3,337
Atrial Fibrillation + Other Complications	\$32,247	\$10,253
Re-operation for Bleeding	\$38,470	\$16,476
Permanent Stroke	\$49,419	\$27,424
Prolonged Vent.	\$57,516	\$35,522
Mediastinitis	\$61,459	\$39,465
Renal Failure	\$65,234	\$43,239
Pneumonia	\$67,785	\$45,791

This represents data from a 3-year period and over 30,000 patients. Armed with this data, the VCSQI has identified best practices and implemented statewide protocols to reduce complications, such as atrial fibrillation, a common heart arrhythmia following surgery. In a single institution, this complication has fallen from an incidence of 21% to 5% and within six months of statewide implementation the rate has already declined by 5% in Virginia. As seen in this interactive slide and charts provided in the written statement, we could now show the real cost savings achieved for the state of Virginia and can also extrapolate those nationally.

With the initial 5% reduction in atrial fibrillation we have already achieved a savings of \$3,103,078 in the state and if we had implemented this protocol nationally would have achieved a \$242,746,676 savings nationally.



By reducing this and other complications even further to a very achievable 20% reduction below their current levels, \$12,412,312 will be saved in Virginia and \$970,986,704 nationally.



These results and the results of other STS regional and national efforts have led to a recently announced data sharing agreement between WellPoint/Anthem in the private sector in an effort to drive quality improvement. In addition, WellPoint/Anthem and the VCSQI members have developed a bimodal P4P in the state of Virginia with incentive payments for quality to both the hospitals and physicians. The Quality Hospital Incentive Program (QHIP) has completed two years of activity and the Virginia STS members (VCSQI) are about to launch the physician component of this P4P program, the Quality Physician Payment Program (QP3). Finally, the STS has written a proposal for a national pilot P4P program, "Quality Focused Cost Containment in Cardiac Surgery for Medicare Beneficiaries", which will apply the principles derived from the state of Virginia to achieve national savings in Medicare.

Much has been learned from these experiences and we wish to share those lessons with this Subcommittee in order to enable all providers to engage in quality improvement and to create efficiencies in care delivery allowing more widespread cost containment in the healthcare system.

LESSON ONE: Every effort must be made to encourage the development of accurate clinical databases. Reliance on administrative (or claims) data for performance measurement, particularly outcomes data, is inaccurate and may lead to payments to the wrong providers for the wrong reasons under P4P programs. On the other hand, clinical databases lack financial information and leave a gap when attempting to develop and implement measures of efficiency. The solution is to blend credible clinical databases with the financial database of CMS so that both goals can be achieved. This will require the development of an interoperable IT system that will allow a single common platform for data aggregation and a common pipeline for data reporting.

LESSON TWO: Not all measures are equal. Structural, process and outcomes measures have markedly different attributes and yield differing results under P4P programs, and the attributes of measures of efficiency have not yet been defined. **Structural** measures such as participation in a clinical database and adoption of electronic health records (EHR) have an upfront cost and it should not be the expectation that providers will bear this burden alone. Their use, however, will provide the necessary tools for quality improvement efforts and participation in a database will allow the creation of a culture of quality that will provide improvements beyond measurement in limited fashion. **Process** measures must be linked to quality improvement and care must be taken in choosing them. If process measures merely encourage expanded testing without feedback to and action by providers, then they will have the unintended consequence of expanding healthcare costs and the volume of physician services. **Outcome measures**, on the other hand, should be the ultimate goal of P4P. They must be risk-adjusted and the level of analysis (hospital, physician, physician group) must be set appropriately so that they promote **ownership** in the healthcare system.

A race to get individual physician data may neglect the most important aspect of care delivery, that of systems of care. Physicians working in hospitals are part of a team delivering complex care to individual patients. If we insist on measures that focus on the individual physician we will end up with simple process measures which they can control but which will provide much less benefit, both to the patient and in terms of savings to the system. If we measure both hospitals and physicians on the same measure then each will have ownership in the performance of the other and will encourage hospital physician collaboration. Only by focusing on systems of healthcare delivery will we be able to address quality in the continuum through transitional care models and most

importantly, efficiencies of care within and across care settings. I urge you as legislators to put in place the incentives to encourage providers to undertake the hard work of true quality improvement and move providers from structural, to process measures, and on to measure patient outcomes and value in patient care.

LESSON THREE: The use of quality data solely for profiling physicians and other providers will miss an opportunity to make broad improvements in quality and may have unintended consequences. The experience we have gained through public reporting programs in several states has shown that the unintended harmful effects on patient care can outweigh the perceived benefits of transparency if publicly reported data are not sufficiently risk adjusted. In fact, Dr. McClellan coauthored a paper on our experience with public reporting in New York state and Pennsylvania and found that risk aversion led to changes with serious ramifications for patients with heart disease. The authors found

“On net, these changes were particularly harmful. The less effective medical therapies that were substituted for CABG and PCTA, combined with delays in treatment, led sicker patients to have substantially higher frequencies of heart failure and repeated AMIs and ultimately higher total costs of care”

Transparency in the healthcare system for quality and pricing is currently a high priority for CMS and the administration. It is felt that this data will lead the charge for consumer driven healthcare choice and purchaser/payer preferred provider selection. The STS absolutely supports accountability. In fact, we have developed a risk calculator and placed it on our website which enables patients and doctors to go to the web and calculate the predicted risk for their procedure. However, quality information on providers must be used for more than profiling. Profiling falls short of the goals for healthcare with respect to quality improvement and efficiency. Importantly, claims data can not be sufficiently risk adjusted to make clinical judgments on provider quality. Only a clinical database with sufficient clinical variables can be risk adjusted enough to yield accurate findings. CMS and Congress should encourage the development of such clinical data either through EHR or through specialty society led efforts.

Broad gains in the improvement of patient care, and hence savings to the program will only be achieved through quality and efficiency measurement and feedback to providers to drive improvement in both areas. The STS through the use of the NCD has proven that continuous quality improvement can be achieved by the creation of information feedback loops and the development of refined processes of care that will impact outcomes. Support for the creation of regional and national collaboratives among providers will be

necessary. Finally, public reporting of quality information is a science and not simply done. The STS has appointed a taskforce to work with biostatisticians examining a variety of modeling techniques, including those found in educational testing, to create appropriate composite measures of quality. Medicare beneficiaries must be given credible but understandable data in order to make their healthcare choices.

LESSON FOUR: No single P4P program will fit all physicians or apply to all patients. The more cross-cutting the measures are, the less relevant to each patient's care they will be. The concept that "one size fits all" will not improve quality. Hospital based physicians will need different incentive structures than ambulatory care physicians. Regardless of the setting, payments should be additive to historic baselines and must be based on credible and achievable thresholds of performance. They must reward not only achievement of thresholds but quality improvement efforts. Encouragement to share and act upon data is essential. The STS has real experience in these areas. We have recently entered into a data sharing agreement with WellPoint/Anthem and as mentioned earlier the Virginia physicians have developed P4P programs that reward quality improvement efforts and recognize that QI will lead to cost containment. We are participating in a joint hospital/physician quality improvement effort with Blue Cross/ Blue Shield of Michigan that will improve patient care quality while saving that health plan millions. Measures in these programs are the same for hospitals and physicians to promote the concept of joint ownership for both clinical and financial outcomes. This subcommittee and others must look strongly at shared savings models where savings can be divided among CMS/physicians/hospitals as they are achieved. Only then will we create systems of care that can address quality and efficiency.

The STS proposes the following 10 step roadmap:

1. Begin with structural measures and pay for participation in clinical databases, creation of patient registries and adoption of EHR
2. Create an interoperable data repository that can accept data from specialty society credible clinical databases and that can match clinical data with financial data from CMS so that providers will have a clinical/financial tool to drive QI and develop cost savings models and efficiencies in care
3. Pay only for process measures that are linked to quality and do not promote unnecessary resource consumption or the expansion of the volume of physician services. Remove financial incentives for overuse of testing/diagnostics.
4. Identify and **reward preferentially** risk-adjusted outcome measures that have links to cost containment as demonstrated today and that promote ownership by providers in the healthcare system

5. Define efficiency measures as the costs associated with an acceptable quality of care and reward those who can deliver the highest quality of care at the lowest cost through shared savings models
6. Encourage healthcare setting specific alliances (hospital/physician, clinic/physician) that address both quality and efficiency at the system level of care delivery
7. Develop P4P programs unique to the setting of care delivery, and medical condition being treated. – “one size does not fit all”
8. Congress should enact national pilot programs to test P4P prior to implementation
9. Promote transparency but use quality information for more than profiling
10. Put “ownership” in the healthcare system back in the vocabulary of all providers by **rewarding** physicians for QI and efficient care delivery

Thank you for this opportunity to appear before you today.