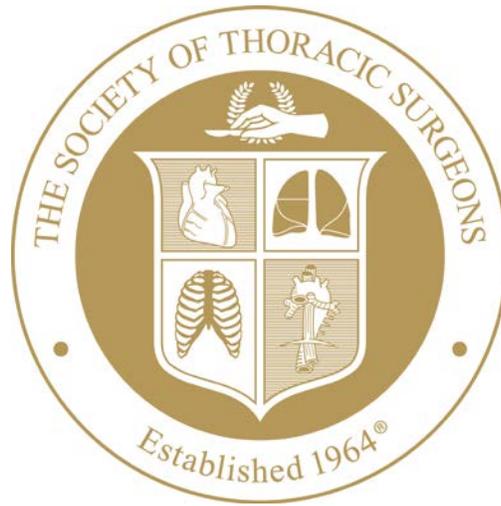


The Society of Thoracic Surgeons Alternative Payment Model Proposal



The Society of Thoracic Surgeons
STS-Alternative Payment Model Proposal

Heart/Lung Cancer Care Models

The current Medicare payment system supports fragmented care delivery and encourages overutilization of health care services, neither of which is in the best interest of the beneficiary. Thus, STS recommends Medicare adopt a physician-focused alternative payment model (PF-APM) that fosters collaboration among a multi-disciplinary team of providers. Such a model could use the STS National Database to combine clinical and cost data to develop evidence-based protocols with the goal of improving clinical performance in targeted aspects of care, such as atrial fibrillation prophylaxis, transfusion reduction, early extubation, perioperative glucose management, and postoperative wound management among others.¹ The additive cost of complications in cardiac surgery is well described by the Virginia Cardiac Surgery Quality Initiative (VCSQI)² and their impact on health care spending is substantial³. For example, when VCSQI members noted high rates of blood transfusions, best practice protocols were identified and reproduced in the region. Transfusion rates fell by 40% with \$49M in savings over a two-year period. Similarly, reductions in the incidence of atrial fibrillation were associated with \$21M in savings. A combined clinical/financial database tool has been an essential cornerstone of the Virginia project and has been critical to its success^{4,5,6,7}.

Creating payment models, especially those involving hospital and multiple physician payments requires time and a large amount of work. In addition, physician practices, hospitals and other entities are likely to be at various levels of readiness to participate in APMs. Therefore, STS proposes an incremental approach to APM development for cardiothoracic care representing different levels of complexity. The models described below can be layered over the current Fee-for-Service Medicare payment structure or could become the quality incentive component of the American College of Surgeons' bundled payment proposal. Future iterations of this model could

¹ Alan M. Speir, MD, Jeffrey B. Rich, MD, Ivan Crosby, MD, and Edwin Fonner, Jr, DrPH., Regional Collaboration as a Model for Fostering Accountability and Transforming Health Care, *Semin Thorac Cardiovasc Surg* 21:12-19

² VCSQI is a voluntary consortium of 18 hospitals and 14 cardiac surgical practices providing open-heart surgery in the Commonwealth of Virginia. VCSQI's members perform over 99 percent of Virginia's open-heart procedures. The group has convened since 1996, comparing data and exchanging information to improve the quality of surgical care and contain costs. VCSQI helps implement protocols to reduce post-operative complications, was involved in the adoption of quality measures in cardiac surgery for the National Quality Forum, and has formulated policies on pay for performance programs.

³ Damien J. LaPar, MD, MS, Alan M. Speir, MD, Ivan K. Crosby, MD, Edwin Fonner, Jr, DrPH, Michael Brown, PA-C, Jeffrey B. Rich, MD, Mohammed Quader, MD, John A. Kern, MD, Irving L. Kron, MD, and Gorav Ailawadi, MD,, Postoperative Atrial Fibrillation Significantly Increases Mortality, Hospital Readmission, and Hospital Costs, *Ann Thorac Surg* 2014;98:527-33

⁴ Osnabrugge, MSc, Ruben L, et al. "Cost, quality, and value in coronary artery bypass grafting." *The Journal of Thoracic and Cardiovascular Surgery*, 2014: 2729-2735.e1.

⁵ LaPar, MD, MSc., Damien J., et al. "Preoperative renal function predicts hospital costs and length of stay in coronary artery bypass grafting." *The Annals of Thoracic Surgery*, 2016: 606-612.

⁶ LaPar, MD, MS, Damien J., et al. "Postoperative atrial fibrillation significantly increases mortality, hospital readmission, and hospital costs." *The Annals of Thoracic Surgery*, 2014: 527-533

⁷ Holmes, Jr. MD, David R., Jeffrey B. Rich, MD, William A. Zoghbi, MD, and Michael J. Mack, MD. "The Heart Team of Cardiovascular Care." *The Journal of the American College of Cardiology*, 2013: 903-907.

focus on longitudinal disease management with the addition of clinical and financial information from other sources.

Fee-for-Service / Bundled Payment Shared Savings

The Society's recommendations rely on recognition of high cost complications and over-utilization of resources for certain procedures (CABG, valve replacement, and surgical procedures used to treat lung cancer) with targeted application of best practices to improve care quality and efficiency and reduce complications. Although we believe this quality-based payment proposal could be implemented almost immediately in the current fee-for-service environment, we are submitting it as a part of the ACS proposal for bundled surgical payments.

Data: STS-APM aims to blend the STS National Database and claims information from Medicare and other payers to create a clinical/financial tool to track patient outcomes relative to costs, while identifying high frequency and/or costly complications. The blended database would be used to develop best practice protocols aimed at reducing health care costs by minimizing complications and/or cutting excess resource utilization while maintaining quality. VCSQI has already created such a tool with demonstrated success. Although the Virginia model has had success accessing cost data from the Virginia Health and Hospital Association, a direct linkage to payer data is preferred. Adding UDIs and mortality data from the SSDMF or NDI to claims information would also yield important information on long-term efficacy of medical devices. Future iterations of this tool could potentially be linked with other clinical data registries to facilitate a longitudinal, population management payment model.

The linked data will serve as a feedback mechanism for participants. When the STS National Database dashboard feature is developed, STS members will be able to evaluate their respective performances relative to their peers and make adjustments as necessary. This information could include quality reporting and resource use measures. STS will continue to monitor MACRA implementation and what would be required to incorporate this functionality into the new dashboard feature.

Quality/Cost Metrics: Regardless of the exact payment methodology used, either the Merit-Based Incentive Payment System (MIPS) or APMs, MACRA requires providers to report on certain quality measures before they can benefit from any financial incentives established under the statute. Because STS believes that the best measures of physician performance are generated by physicians, using robust clinical information, the Society will continue to develop quality measures which, if endorsed by the NQF or approved through an alternate quality measure approval pathway, could be used in this APM. STS has sponsored more NQF-endorsed quality measures (34) than any other professional organization and which include risk-adjusted morbidity and mortality measures that have already driven change and improvements in care for Medicare beneficiaries. The STS National Database will maintain its status as a qualified clinical data registry (QCDR) and could report to CMS on quality measures on behalf of all database participants, regardless of whether those STS members are participating in MIPS or the STS-APM, should they elect to have STS report on their behalf. In addition, future measures will include both patient reported outcome measures and patient functional status when those measures are vetted and meaningful.

Payment Methodology: The framework for payments to providers would rely on retrospective reconciliation of the payment bundles proposed by ACS. Tracking of spending, outcomes, and savings would occur through the database by calculating the ratio of observed to expected costs attributed to a patient's care. Risk adjustment, an essential component of the model, will be accomplished using the STS National Database and the STS Risk Calculator. Cost benchmarks (or the "expected" cost) would be established for "typical" global episode periods by using historical data.

Once the infrastructure is in place, STS would appoint a panel or other working group to annually develop a menu of quality improvement initiatives (QII) for general thoracic and adult cardiac surgery APM participants to adopt. The group would be comprised of members of the STS Task Force on Quality Initiatives but could also have representation from other stakeholder groups including patients, payers (e.g., Medicare) and hospitals. Possible QII will be derived from peer-reviewed journals. The group will consider publications that utilize the STS National Database. However, other QII may be selected based on the evidence or consensus that they will improve patient outcomes and/or patient experience and may be associated with cost savings. Although CMS has stated that infrastructure costs, like cost associated with implementing new QII or even database participation in general do not count toward downside financial risk, it will be important to track the financial burden of QII implementation to participants.

APM Participants would be required to select a subset of QIIs from the proposed menu of activities and implement them over the course of the year.

Shared Savings: The main goal of the STS-APM is to drive quality improvement and reduce costs through the creation of standardized treatment protocols. If the resulting care transformations generate savings relative to agreed-upon pricing targets, cardiothoracic surgeons would be allowed to share in those savings.

Analysis of data extracted from the STS National Database will serve two purposes for APM participants. It will allow them to accurately assess patient risk and it will also be the primary method of clinical performance feedback. The importance of accurate risk adjustment and continuous member feedback cannot be overstated.

Third Party Administrator: Under the MACRA statute, Medicare payments will be made to the APM entity. In the proposed rule, CMS makes clear that it does not wish to interfere with the financial arrangements in which each APM Entity might wish to engage with those providers (including physicians and physician group practices) delivering services related to the APM.

Waivers: Current Medicare rules and regulations may prove a hindrance to these types of provider arrangements (waivers already exist for the Acute Care Episode demonstration project). However, in similar circumstances (e.g., the Medicare Shared Savings Program), Congress has provided a pathway for entities to seek a waiver from certain rules and regulations (e.g., gain-sharing regulations). Members of the heart or lung cancer team, as needed, could seek a waiver allowing them to provide financial incentives, which would encourage Medicare beneficiaries to accept referral to the heart and lung cancer team and treatment from those team members.

Other Surgical Bundled Payment Initiatives

In July, 2016, CMS published a proposed CABG Episode Payment Model (EPM), essentially a mandatory bundled payment for CABG that would potentially allow participants to earn Advanced APM bonus payments. STS provided extensive comments on the proposed rule. If the STS-APM is implemented, it would be our expectation that voluntary participation in the STS-APM would preclude mandatory participation in the mandatory CABG EPM.

Longitudinal Disease Management Bundled Payment

Future iterations of this model could replace the FFS infrastructure with a payment for a surgical episode. In order to effectively implement this model, the STS clinical/financial tool may need to be combined with the robust clinical information found in the American College of Cardiology's National Cardiovascular Data Registry (NCDR®) and/or other sources of clinical data reported by members of the care team.

In 2015, the Department of Health and Human Services established the Health Care Payment Learning and Action Network (HCP-LAN) with the goal of aligning private payers and CMS in moving payment from traditional FFS methods to FFS-linked to quality and APMs.⁸ STS has provided substantive comments on the HCP-LAN whitepaper on Accelerating and Aligning Clinical Episode Payment Models: Coronary Artery Disease. It is the Society's position that a population-based payment model will not be implemented successfully in the near term.. We think that incremental implementation of the quality-based care principles outlined in this document and the combination of clinical and claims data from across the spectrum of care are essential to the success of such a model. We will continue to engage actively in this space to ensure that those principles are upheld.

Summary

STS looks forward to taking a lead role in the creation of PF-APMs that reward providers based on the value, rather than the volume of care they provide to millions of Medicare beneficiaries. With a focus on high cost, high risk patients and high impact procedures, STS recommends APMs that incentivize and reward coordination and collaboration among providers. With adoption of the PF-APMs described above, the Medicare program would be creating a system through which all the involved providers are collectively responsible for the care provided. By advancing a model that helps ensure that the patient receives the most appropriate care in the right setting, at the right time, from the most appropriate provider, outcomes could be maximized while extraneous costs could be minimized – goals shared by patients, Congress, CMS, and STS alike.

⁸ <http://hcplan.wpengine.com/about-us/faqs/>