A New Medicare Physician Payment System: Principles for Replacement of the SGR Formula for Surgeons

1. Early intervention from specialists will create cost-effectiveness by decreasing unnecessary diagnostic testing, allowing preventive measures to thwart disease progression and allowing early intervention to prevent end-stage conditions.

2. Complement the quality-related payment incentives in current law and regulation by using risk-adjusted patient-centric outcomes measures and national standards and making necessary adjustments to facilitate participation by specialists and physicians in rural and underserved areas. Methods and various models for risk adjustment need additional study before this type of measurement can be adopted.

3. Support incremental changes with positive incentives and rewards during a transition period of five years and investment in infrastructure that provides the platform for care delivery and payment reform.

4. Develop a model that is immune from the political process, particularly during the transition period; stable payment during this period using a market basket update approach that would align hospital and physician payment is critical.

5. Make data available to medical societies that show progress with developing and testing of new systems. An open process will allow for identification of models that are most beneficial to patients.

6. Incorporate rewards into annual payment updates for quality improvement, identification of appropriate resource utilization and development of medically innovative treatments.

7. Reflect the diversity of physician practices by providing physicians a choice of payment models that work for their patients and practices.

8. Create a mechanism with input from surgeons to help maximize cost-effectiveness and quality of care that is measurable to incentivize the provision of appropriate services that primary care, including nurse practitioners and physician assistants, bring to the management of an increasingly more complex medical population.

9. Provide exemptions and alternative pathways for physicians in practice situations where care delivery reform would constitute a hardship.

10. Make the administration of the new system more streamlined, with as many common measures, data elements and reporting requirements as possible – the majority of a physician’s time should be focused on patient care.

11. Focus on prevention and wellness, not just treatment of disease. Also, practice guidelines should be followed
to avoid unnecessary/inappropriate surgery and testing.
12. To reduce the cost to practice and the overall cost of health care, include meaningful medical liability reform in any plan regarding new models for physician payment reform.
13. Use penalties collected for non-compliance with PQRS, e-Prescribing and the Meaningful Use of Electronic Health Records to help fund the total cost of health care.
14. Additional resources to pay for new payment systems will be created by efficiencies such as timely referral to specialists, halting duplicative tests and using evidence-based care. These savings should be captured by legislation that would direct funds to physician payments and total cost of health care.

Elements of a More Cost-effective Physician Payment System

A new physician payment system does not need to be entirely “new”: it can be based on refinements of models that have already been proposed by other medical societies, healthcare providers and/or CMS. These can broadly be categorized as quality initiatives for specialty care and for primary care, development and implementation of electronic health record and refinements to fee-for-service:

1. Quality Initiatives for Specialty Care – surgeons place a major emphasis on delivering the highest quality of care to patients. Many surgical specialties are developing outcomes measures that will eventually replace process measures in the PQRS and other national programs along with registries to report them. An example is the VQI mentioned above. Along with vascular surgeons, cardiologists, radiologists and other specialties that perform vascular procedures are able to join this quality initiative.

2. Quality Initiatives for Primary Care – working in cooperation with specialists such as vascular surgeons, primary care can be the means by which the largest gains in control of healthcare costs can be achieved. This can be done through quality incentives for preventive care, appropriate screening and appropriate use of referrals. Primary care physicians should be incentivized to provide the highest quality of first-line care for patients with acute conditions in partnership with surgeons. Reimbursement models that prioritize primary care working as a team with their surgical colleagues could lower costs and maintain safety and adequate access for Medicare beneficiaries. In order to do this, performance metrics that set and measure goals must be established for the new transitional care management codes, such as fewer hospital readmissions and correct medications on discharge.

3. Electronic Health Records (EHR) – surgeons support the adoption of EHR, but are concerned with the Meaningful Use criteria, which are burdensome for them to comply with, particularly for those in small practices. Surgeons are in various stages of incorporating well-developed EHRs into their practices to improve quality in care delivery and are trying to comply with the program, but barriers remain. These include financial and administrative burdens and the lack of an integrated system on a widespread basis. For example, Epic and Veterans’ Administration EHRs in a geographic radius are unable to communicate with each other at the present time.

4. Fee-for-service Refinements – many surgeons are reimbursed by a fee-for-service model particularly for Medicare patients, which is likely to change. An alternative to this model has the potential to bend the cost curve while maintaining incentives to provide high quality patient care especially for more acute cases. Recommendations for changes include adding an indication value to Correct Procedural Terminology (CPT) codes for urgency and diagnostic severity; both of these deserve higher reimbursement than elective procedures and milder diseases. Specialty societies that use these codes would be tasked with determining if indications’ incentives could make fee-for-service more cost-effective. Another recommendation is creation of a correct diagnosis bonus. The objective would be to incentivize good clinical decision-making and avoidance of excessive testing without penalizing the ordering of needed tests. Physician societies would identify target diagnoses that could be made with a lower number of tests than are usually performed. For this to be implemented, legal protections including medical liability reform would need to accompany these algorithms. If this is not done, such incentives would be eclipsed with additional testing as part of defensive medicine.

Proposed Alternative Payment Demonstrations

Surgeons support alternative payment methods such as bundling, gain-sharing and global payments. CMS must work
with physicians to develop bundling models that would link payments for multiple services that patients receive during an episode of care. Bundling could also align hospital and physician incentives for optimal care and limitation of avoidable complications. Gain-sharing arrangements provide payments made by hospitals and other providers to physicians and other practitioners as a result of collaborative efforts to improve quality and efficiency. Both of these concepts should be thoroughly tested before being finalized. Surgeons are already familiar with global payments; surgical societies can provide the leadership to incorporate these into payment methods for more physicians.

Disease Specific Bundled Payment Systems

- **Vascular Access** – global payment models are already being developed for the management of dialysis access. These payment models are attempting to target the highest quality vascular access method for a given patient and then setting up a bundled/global payment that incorporates placement of the vascular access as well as maintenance of this access over some defined period of time. Under the current fee-for-service payment system, many procedures and services for maintaining vascular access for dialysis patients have an inherent incentive for the physician to treat only the immediate problem with an access catheter or graft. However, vascular surgeons are uniquely positioned to offer insights into fistula planning, using the results of vein mapping to determine the choice of access created and the most cost-effective and durable strategy for maintenance of an access. With this demonstration project, all of these individual services could be paid under a single, bundled payment, changing the current incentive in the physician payment system from volume to value for patients and the health care system over many years.

- **Carotid and Atherosclerotic Diseases** – the concept for this demonstration project would be to test various types of bundled payments, including physician only or a combined physician and hospital payment. It could compare which of these two types of bundles is most effective in creating value for the healthcare system. Also, it could test various types of severity-related add-on payments for patients with more severe conditions similar to the current Diagnosis-Related Group system where severity is graded based on the presence of co-morbidities such as diabetes mellitus, ESRD or carotid artery disease. These payment models could also test severity add-on payments for various risk scores, family history or other factors.

Applications for this demonstration could test whether to segment bundled payments by activity, such as non-operative activities at a certain amount per Medicare beneficiary per month or a single payment capped at a certain amount per year, with the use of established guidelines for patient follow-up. To receive the entire payment per patient, there could be mandatory documented communication with the patient’s primary care physician to ensure a team approach and patient compliance.

Finally, there could be a surgical management bundle that would cover the initial surgery and a reimbursement cap or maximum for any follow-up on a yearly basis as needed for the initial surgical intervention. This same model could also be tested for venous disease and other emergent and elective vascular traumas.

Evidence-Based Care/Shared-Savings Model for Peripheral Vascular Insufficiency

The goal of this alternative payment demonstration would be to maximize functional limb salvage in patients with critical limb ischemia and to also maximize patient-based functional outcomes in patients with intermittent claudication from sub-critical vascular insufficiency, while minimizing total health care expenditures for this patient population.

This shared savings payment model could be determined by using annual historical Medicare claims data for these two sets of patients. For critical limb ischemic patients, their annual costs would include all revascularizations, both open and percutaneous surgical procedures, wound care and amputations, rehabilitation and nursing home facilities costs. An analogous set of annual total costs could also be determined for claudicant patients.

As physicians accrue new patients, they would provide patients with what physicians consider to be evidence-based care. All decisions regarding medical, interventional and surgical care would be based on an agreement between the
patient and vascular surgeon. Two types of data would be initially collected: outcomes and quality data followed by total cost of care data, including physician costs and all facility costs.

In order for a physician to receive incentives for participating in this program, his or her quality data would need to meet or exceed published outcomes for critical limb ischemia and claudication. If, and only if the quality outcomes results met the threshold, the difference between actual costs and historical costs would be determined. If the actual costs for the year are less than historical costs, the physician would receive 75 percent of the difference, while the Medicare program would retain the remaining 25 percent.

Vascular Disease Specialist and Primary Care Physician Partnership (Specialist Managed Patient-Centered Medical Home)

The care of a patient with a suspected or diagnosed vascular disease would be coordinated by a single health care provider, the vascular surgeon, who is trained as an expert in the treatment of vascular disease. The vascular surgeon would direct a group of health care professionals, in concert with a primary care physician, who are all working together on behalf of the patient. There would be payment incentives to promote the targeting and appropriate referral of the most severe vascular disease to the vascular medical home.

Every patient would have a care plan created by the vascular surgeon and he/she would “coach” the primary care physician on care coordination and implementation of the patient’s care plan. The vascular surgeon would receive a monthly medical home payment to cover the non-procedure coordination costs of the patient’s needs. The medical home would provide for either a shared savings or capitated payment, both based on historical costs. This demonstration project would also measure the “value” of the involvement of the vascular surgeon regarding appropriate ordering of tests, prompt diagnosis of stenosis and planning of the surgical intervention(s) and follow-up care, including avoidance of hospital readmissions.

Summary

There is no one-size-fits-all solution to Medicare physician payment. Medicare beneficiaries with vascular disease are very complex; vascular surgeons offer a high level of expertise and education and using evidence-based guidelines, provide high quality, cost effective health care for these complex patients. Using elements of the present system along with a new payment model that is physician-led and tested for five years before it is adopted should provide timely, open access to sustainable, high quality health care.

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