November 12, 2013

The Society for Vascular Surgery (SVS), a professional medical society composed of over 4,600 specialty-trained vascular surgeons and other medical professions who are dedicated to the prevention and cure of vascular disease, appreciates the opportunity to comment on the Sustainable Growth Rate (SGR) Repeal and Medicare Physician Payment Reform Discussion Draft. The following are comments on the sections:

1. **SGR Repeal and Annual Updates** – SVS strongly supports the repeal of SGR, but is very concerned about annual updates of zero percent through 2023. A freeze is essentially a yearly pay cut because it does not keep up with the cost of living. It is estimated that this could result in a cumulative gap of 45 percent between Medicare payments and the cost of treating patients. Vascular surgeons, like all other physicians, must maintain offices, buy/lease equipment, employ support staff, etc. No increases in 10 years will make it very difficult or impossible for many physicians to sustain their practices. In order to align payment for health care services, SVS recommends harmonizing physician payment updates with hospital updates, which are yearly market basket updates that factor in inflation and other economic considerations.

2. **Value-Based Performance (VBP) Payment Program**

   a. **Terminating Current Law Incentive Program Payment Reductions** – SVS supports making physician payment programs more streamlined by combining the Physician Quality Reporting System (PQRS), Value-Based Modifier (VBM) and EHR Meaningful Use programs. We firmly believe that any penalties which are assessed remain in a physician payment pool. However, SVS opposes including the VBM until the Centers for Medicare and Medicaid Services (CMS) has validated the methodology used in calculating this in order to better identify both high and low performers. Also, EHR Meaningful Use programs must add measures that have relevance to surgeons. Presently, the measures mainly apply to primary care physicians. Surgeons treat patients who require both continuity of care and episodic care; measures must reflect these in order for surgeons to become meaningful users.

As outlined in the Discussion Draft, the VBP would be the only alternative that specialists could use because there are presently no Alternative Payment Models (APMs) that include them. SVS has promising suggested models for vascular surgery that are outlined in the next section; but like CMS, ours are only conceptual at this point. Beginning this program in 2017 with a look-
back period of two years is unrealistic. SVS strongly believes that there needs to be at least a five year period of reimbursement stability (i.e. market basket updates) not only for physician payment, but also for those specialties that have established few or no quality measures. We support incremental changes during this transition period and investment in infrastructure that provides a platform for care delivery and payment reform. We also support development of a model that is immune from the political process to ensure stability.

It is especially challenging for small specialties to afford the time and expense to develop measures and measure groups using existing performance improvement methods. Measure endorsement through an entity such as the National Quality Forum (NQF) is long, burdensome, and for some specialties, financially prohibitive. Other entities such as CMS in conjunction with physician societies should also be able to develop quality measures. Additional costs must also be factored in for the gathering and reporting information, purchasing IT, etc.

Vascular surgery is one of the smallest surgical specialties, yet the SVS has made it a priority to conduct multiple quality improvement initiatives for its members. These initiatives include working with the NQF for evaluation and endorsement of quality measures through its consensus development process and establishment of a registry to report quality measures. Even with our progress on these measures, SVS needs support from CMS before quality is tied to payment. We appreciate that funding would be provided to develop additional measures and believe it could also be used as an incentive for participation in registries.

Quality programs not only depend on the existence of quality measures and sufficient reporting, but also on the appropriateness of measures, proper risk-adjustment and the existence of a system that provides ease of reporting. Thus, the administration of a new Medicare physician payment system should be 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. Also, measures must be critically examined for actual impact on improved clinical outcomes, although there are few outcomes measures presently available due to methodological challenges and lack of data.

b. **Assessment Categories** – SVS supports multiple ways to assess performance, including improvement over time and comparison to one’s peers. However, we do not support “tiering” in a budget neutral environment. SVS believes that all physicians should have an equal opportunity to achieve performance metrics in a way that is not budget neutral by specialty because enhanced performance reduces overall medical cost to the Medicare system (Parts A and B).
Although we believe that identification of resource utilization by physicians is appropriate in the creation of a performance benchmark as mentioned above, we are concerned about the attribution of resource use as described in the Discussion Draft. Practice patterns by referring physicians (typically primary care physicians) regarding the ordering of tests and when/how patients are referred to specialists, will have a significant impact on how vascular surgeons and other specialists will be judged. A solution to overutilization of resources is early intervention from specialists, which will create cost-effectiveness by decreasing unnecessary diagnostic testing, allowing preventive measures to thwart disease progression and help to prevent end-stage conditions. We support the concept of data accumulation by physicians, but tools must be provided by CMS that will alleviate administrative burden, allowing physicians to focus on patient care.

Vascular surgeons and other specialists would have difficulty meeting any of the five clinical practice improvement activities listed in the Discussion Draft because they are rarely part of medical homes. This means that only primary care would be able to receive high scores, resulting in bonuses just for them. Activities must be expanded so that specialties are able to be scored on appropriate activities such as: use of evidence-based intervention that creates cost-effectiveness and prevention of more acute conditions, care coordination in other settings and registry utilization.

c. **Performance Assessment/Performance Pool Funding** – SVS reiterates that we oppose a tiering system mandating “winners and losers”. We support assessment that is based on applicable composite categories and associated measures that are valid and based on appropriate care by diagnoses rather than specialty. The current problem with database use is that PQRS measures are not risk-adjusted and therefore not comparable across services or providers. However, risk adjustment needs additional study before this type of measurement can be adopted. We do support quality reporting credit for groups reporting to a qualified clinical data registry, but this should be expanded to include individual reporting.

d. **Assistance to Small Practices** – With such dramatic proposed changes to physician payment, SVS believes that any small practice should be able to get assistance from CMS, not just those in rural and underserved areas. We also believe that Quality Improvement Organizations would be the appropriate entity to provide assistance since the program’s mission is to improve the effectiveness, efficiency, economy and quality of services to be delivered to Medicare beneficiaries. However, the allocation of ten million dollars for 2014-2018 is not nearly enough funding to provide vital technical assistance.

e. **Feedback for Performance Improvement** – SVS supports quarterly “real-time” confidential feedback on performance to professionals on quality and resource use. We also support an appeals process that would allow physicians
the opportunity to correct any inaccuracies, particularly if this information is available to the public. In addition, feedback should be provided to physicians for at least a year prior to holding them accountable for performance.

3. **Encouraging Alternative Payment Model (APM) Participation** – SVS appreciates the opportunity to propose new APMs in order to make the bonus opportunity available for a greater number of professionals. Surgeons support alternative payment methods such as bundling, gain-sharing and global payments that are appropriate for them. CMS must work with physicians to develop bundling models that would link payments for multiple services that patients receive during an episode of care and make data available to medical societies that show progress with developing and testing of new systems. 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. The following are proposals for vascular-specific APMs:

**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 conditions.

**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.

In order to create these, SVS recommends the following assistance:

a. CMS should be directed to create a technical assistance program for medical societies that are trying to develop APMs, which would include sample contracts for physicians to use and templates for creating financial models from claims and other data and episodes of care maps for creation of bundled payment programs.

b. CMS should be directed to create a “data hub” where medical societies and individual groups of physicians could submit a request for claims data for use in modeling APMs.

c. CMS should offer technical assistance workshops that include tools, worksheets, Excel model templates, etc.

4. **Encouraging Care Coordination for Individuals with Complex Chronic Care Needs** – SVS agrees that care management is a critical component of both primary and specialty care that contributes to better health for individuals and reduced expenditure growth. Vascular surgeons routinely provide care for chronic conditions and lead patients’ care management when they have acute
conditions. In those instances, the primary care physician typically defers chronic care management to the specialist. Thus, in specific high morbidity situations, payments should be directed to physicians who are coordinating the care, which in many cases are specialists.

Vascular surgery is an excellent example of specialists taking on a longitudinal role in patient care that often involves large quantities of uncompensated time and effort devoted to coordinating with other providers, including endocrinologists, cardiologists, nephrologists, primary care, podiatrists and others to ensure that diabetes, hypertension, foot care needs, wounds and overall medical risk factor modification and preventive care needs of these patients are met. This is often a population without convenient access to primary care and with complex needs.

We also believe there needs to be an accountability mechanism for complex chronic care management services which goes beyond “standards”, such as quality measures that demonstrate improved outcomes and benefits for relevant patients. Otherwise, it will be impossible to determine whether these services actually produce any real return on investment as measured in improved patient care.

5. **Ensuring Accurate Valuation of Services Under the Physician Fee Schedule**

Physician involvement must be maintained in the continued determinations of valuation of services under the Physician Fee Schedule. The Relative Value Update Committee (RUC) plays an important role in ensuring that all services have an objectively determined value and RUC members have a high level of expertise. Alteration of these values without physician input and consideration of the true time and intensity of work will undermine the validity of the Resource-Based Relative Value Scale.

For several years, the RUC has been using screens to determine misvalued services, which include both over-valued and under-valued codes. SVS recommends adding an indication value to Current Procedural Terminology (CPT) codes for urgency and diagnostic severity and creating a correct diagnosis bonus to incentivize good clinical decision-making and promote avoidance of excessive testing without penalizing the ordering of needed tests. CPT Category II codes which facilitate data collection for the purpose of performance measurement could also be used to track improvement.

The steep ten percent penalty proposed in the Discussion Draft is unreasonable and places a significant administrative and finance burden on physician practices for the completion of “surveys”, which is time-consuming and challenging. This activity should be voluntary and never punitive.

SVS does not understand why the Discussion Draft directs the HHS Secretary to review global payments for surgical procedures and office visits in the global
period. Global period surgical codes are a starting point for condition-based payment bundles, allowing the surgeon to manage patient care resources in the 90 day period. The system uses relative magnitude estimation to create an overall payment for the 90 day period. Instead of breaking the bundles apart by visit, the Secretary should work with surgical societies on initiatives that begin with a 90-day global surgical procedure and expand to a condition-based, bundled payment APM for a longer period of time for the condition being addressed. A good example is the management of dialysis access that is presently being developed as discussed in the APM section. Thus, we should be **building** the packages, not breaking the packages apart.

6. **Expanding the use of Medicare Data for Performance Improvement** – Since this data is already available to the public and is widely used, the committees need to provide further explanation of why this is included in the Discussion Draft.

7. **Transparency of Physician Medical Data** – SVS continues to have concerns with the accuracy of the underlying database that is being used for the Physician Compare Website, particularly since CMS is proposing to expand public reporting for both group practices and individual eligible professionals beginning in 2015 based on 2014 data. Also, additional improvements are necessary to ensure that both the search function and underlying demographics are accurate. In addition, SVS members have reported that their information is not correct on the website. Most significant is the incorrect designation of their specialty; there are also errors in other information such as office addresses. To add utilization and payment data will require an explanation of methodology, including use of risk adjustment, in order for this to be accurate and useful for patients.

We are encouraged that there are processes in place for physicians whose information is publically reported to have a 30 day period to review the results before they are posted on the website. Physician input is critical to ensuring the site provides information that is accurate and useful for patients and physicians. It is also critical that all appeals are “flagged” and publically noted.

For additional information or any questions, please contact Pamela Phillips, SVS Washington Office Director at **pphillips@vascularsociety.org** or 202-787-1220.