SVS
SOCIETY FOR VASCULAR SURGERY

June 22, 2015

The Honorable Orrin Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
The Honorable Johnny Isakson, Co-chair, Chronic Care Working Group
The Honorable Mark Warner, Co-chair, Chronic Care Working Group
Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

The Society for Vascular Surgery (SVS), a professional medical society composed of over 5,000 specialty-trained vascular surgeons and other medical professionals who are dedicated to the prevention and cure of vascular disease, appreciates the opportunity to provide the following comments on Medicare Chronic Care Reform. Vascular surgeons provide care to those dealing with the next major disease epidemic, cardiovascular disease. It is important that efforts put forward by the Chronic Care Working Group be inclusive of all physician specialties that treat this disease.

SVS is working every day to bring education and clinical evidence forward, via quality measures, clinical practice guidelines and the Vascular Quality Initiative (VQI) to support our members in providing the highest quality patient care. The VQI is designed to improve the quality, safety, effectiveness and cost of vascular health by collecting and exchanging information. It consists of a distributed network of regional quality groups that function under an Agency for Healthcare Research and Quality-listed Patient Safety Organization.

Chronic Care Management Provided by Specialists

SVS supports development and implementation of initiatives designed to improve payment for and encourage long-term investment in care management services, particularly for optimizing health and quality of life for individuals with multiple chronic conditions. We know that chronic care management is a critical component of advanced primary care, which contributes to better health for individuals and reduced expenditure growth, but this is often a component of specialty care. Primary care physicians typically defer chronic care management to specialists when patients have acute conditions. Thus, in high morbidity situations, the specialists who are directing this care should receive appropriate reimbursement for it.

The following are two examples of acute conditions that require longitudinal care by vascular surgeons:

- Endovascular grafts require careful surveillance due to risks of potential endoleaks. The proper surveillance is not commonly part of chronic care management by primary care physicians;
- Interventions to save limbs (prevent amputations) require very specific surveillance and proper medical management to allow long-term patency and thereby long-term salvage of the legs.

Vascular surgery is also an excellent example of specialists taking on a longitudinal role in patient care that 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. The vascular surgery community has acknowledged and embraces this responsibility. Patients with these conditions are often a population with complex health care needs without convenient access to specialists, such as vascular surgeons, who have the ability to care for vascular diseases and know when to make referrals for tests and other ancillary services.

In developing the VQI, SVS proactively incorporates as quality measures a broad range of interventions related not only to short term or procedural outcomes, but also to long term survival, function and cardiovascular health of patients. These include appropriate lipid management, antiplatelet therapy and noninvasive screening and surveillance. Where specialists occupy an integral part in the longitudinal care of patients, including preventive health, care coordination and risk factor modification, care management models must appropriately value this care.

While SVS supports the Medicare policy to pay separately for care management services furnished to beneficiaries with two or more chronic conditions beginning this year, these services need to be covered using new funding. Care management included in many evaluation/management services does not describe non-face-to-face management work involved for beneficiaries who have two or more chronic conditions that are expected to last at least 12 months or until death. Because complex chronic care management services are budget neutral, one of our concerns is that funding for this would result in further dilution of payments for high resource intensity specialty services, such as vascular surgery, if only primary care practitioners are eligible for this payment.

In addition, we 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 and long-term outcomes. And, we would propose a split payment if more than one professional or group provided these services for the same patient.

Finally, we believe that chronic care management and follow-up should be furnished with the use of electronic health records (EHR), other health IT or health information exchange platforms that include electronic care plans that are accessible to all providers within and outside of a practice who are furnishing care to patients. For example, IT could be used for some of the follow-up work that can be done with minimal nurse assistance, especially if there is an accredited lab in the area. It is important that any efforts put forward by the Chronic Care Working Group be inclusive of all physician specialties that treat these diseases. However, we know this network will take time to develop and have recently sent comments to the Centers for Medicare and Medicaid Services (CMS) on our concerns with the EHR Incentive Program.

Alternative Payment Models (APMs) for Specialists

Presently, it is difficult for specialists to participate in the Medicare Shared Savings Accountable Care Organization (ACO) Program; SVS has provided comments to CMS on this obstacle for participation. However, with the release this month of the CMS Final Rule updating the Medicare Shared Saving Program, the addition of Track 3 that is similar to the Pioneer ACO Model is encouraging. This Model supports organizations with experience offering coordinated, patient-centered care that includes both primary care providers and specialists.

Surgeons already support APMs such as bundling, gain-sharing and global payments that are more appropriate for them. Congress and 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.

Also, surgeons are familiar with global payments and appreciate that Congress prohibited the elimination of the 10- and 90-day global surgical packages in the Medicare Access and CHIP Reauthorization Act of 2015; 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 health care 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 a collaborative agreement between the patient, primary care practitioner 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 benchmarks based on specialty society-sponsored clinical data registries, 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.

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