



January 26, 2016

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 further comments on Medicare Chronic Care Reform. Vascular surgeons provide care to those dealing with cardiovascular disease, which is escalating in the Medicare population. It is important that efforts put forward by the Chronic Care Working Group be inclusive of all physician specialties that treat this disease.

Chronic Care Management Provided by Specialists

As we stated in our June 2015 comments, 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 also 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. We are disappointed that the December 2015 document did not specifically mention specialty care.

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

- Today's advanced surgical therapies for aortic aneurysms require careful routine surveillance and management by specialists who understand the complexities of the therapy and potential long-term complications such as "endoleaks". Proper surveillance of this disease is not part of complex chronic management by primary care physicians.

- Following an intervention to restore circulation to a threatened limb and prevent amputation, patients require very specific surveillance and proper medical management to allow long-term function of the therapy, ensuring long-term salvage of the leg. Again, the complexities of the condition and the natural history of these complex therapies require specific knowledge that primary care physicians rely on their specialist colleagues to manage.

Vascular surgery is 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. Thus, SVS would like to emphasize that vascular surgeons not only perform procedures, but also focus on disease management that is highlighted in the Senate Finance Committee's December document.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

While SVS supports the Medicare policy to pay separately for care management services furnished to beneficiaries with two or more chronic conditions beginning on January 1, 2015, 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.

Also, 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 that result in savings. In addition, we would propose a split payment if more than one professional or group provided these services for the same patient.

SVS would strongly support a new permanent high-severity chronic care management code that specialists could bill under the Physician Fee Schedule and would reimburse them for coordinating care outside of face-to-face encounters for Medicare beneficiaries with multiple chronic conditions. We agree with the Medicare Payment Advisory Commission that these codes need to be carefully defined, with the result being improvement in the quality of care provided to a chronic care patient. As mentioned above, there needs to be quality measures developed that demonstrate improved outcomes and benefits for these patients.

SVS is working every day to bring 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, which consists of a network of regional quality groups, is designed to improve the quality, safety, effectiveness and cost of vascular health by collecting and exchanging information. Quality measures are incorporated on 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. The VQI has been designated a Qualified Clinical Data Registry by the Centers for Medicare and Medicaid Services (CMS) because it collects medical and clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. We believe this is an effective way to provide evidence on preventive health, care coordination and risk factor modification that will lead to improvement of care management. More information is available at www.vascularqualityinitiative.org.

In addition, SVS is pleased that the Committee included risk adjustment for chronically ill beneficiaries to take into account their demographics and health history. We agree that the severity of a beneficiary's illness and the accumulated effect of multiple diseases along with the interactive effects are factors in the accuracy of risk adjustment. However, methods and various models for risk adjustment need additional study before this type of measurement can be adopted.

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. This program has not adequately acknowledged and accounted for the importance of specialists who are crucial to the delivery of quality care, particularly since the quality measures that must be met for shared savings do not reflect a continuum of care for patients.

With the enactment of the Medicare Access and CHIP Reauthorization Act of 2015, SVS is already working on APMs that are appropriate for vascular surgeons. SVS provided comments to CMS in November on a Request for Information on APMs. The following are the comments that apply to chronic care:

Patient Approach

SVS continues to support a prospective approach to beneficiary assignment. This would allow active patient involvement and better coordination of their care as physicians would have real time data and the incentive to coordinate and collaborate on any changes needed in care delivery. Vascular surgeons provide longitudinal care that follows their patients for months or even years. To facilitate this, we support paying for the following services:

- Communications between primary care physicians and specialists to coordinate patient care, thus avoiding duplicative tests and conflicting medications.
- Time spent by a physician serving as a leader of a multi-physician care team for patients with complex conditions.
- Time spent in a shared decision-making process with patients and family members when there are multiple treatment options.

Many specialists, including vascular surgeons, manage certain proportions of patients with one of several different conditions. Assuming that episode- and condition-based payment models are approved as qualifying APMs, the models should be applicable to 25 percent of all Medicare payments that are attributable to a certain condition or a certain APM in 2019-2020. Thus, reporting on the patients who are being managed within an APM should be a patient-centered approach versus determining revenues from the services physicians provide.

Payment Incentives for APM Participation

SVS supports multiple ways to reward quality, including improvement over time and comparison to one's peers. However, we oppose "tiering" within a specialty where there would be winners and losers. SVS believes that all vascular surgeons should have the opportunity to be "winners" by starting with a baseline for all and then providing higher reimbursement for those surgeons who are deemed to be higher quality providers using the following: quality improvement, identification of appropriate resource utilization and development of medically innovative treatments, among others.

Baseline standards should be established that are predicated on input from physicians and other stakeholders and encourage a variety of quality measurement and improvement activities, while not setting the bar too high during initial years as to exclude providers and practices with an established record of achievement.

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-effective care.

Care coordination 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 care management of patients when they have acute conditions. In those instances, the primary care physician typically defers chronic care management to a specialist. Thus, in specific high mortality situations, payment should be directed to physicians who are coordinating the care, which in many cases are specialists.

Beginning in 2019, SVS supports incremental changes with positive incentives and rewards and investment in infrastructure that provides a platform for care delivery and payment reform. We also support confidential patient-specific feedback to physicians regarding quality and resource use, which should be provided to them for at least a year prior to holding them accountable for performance and financial risk.

The main financial risk to an APM entity is that revenue may not cover the cost of participating in it. The entity may be saving money for Medicare by reducing hospital admissions and expensive tests and on procedures, but still losing money, which will have a major impact on participating physicians.

SVS believes that physicians will be more willing to take accountability for costs that they can affect through their own performance versus taking on risk for the total cost of care for a large patient population. “More than nominal financial risk” should be defined in a way that allows physicians to take accountability for the services they can truly influence instead of requiring physicians to take responsibility for total Medicare spending on every health service their patients receive. It is also important for CMS to allow sufficient time to achieve savings’ goals and not expect them to be reached in the first year.

Thus, SVS does not support a requirement for reporting quality measures’ data based on a certain percentage or number of physician’s patients. We strongly discourage the development and implementation of one-size-fits-all data reporting system in any program that is created. The goal should be to provide physicians with greater flexibility to report on and get credit for quality improvement activities relevant to their practice and patients.

However, the administration of any new Medicare physician payment system should be streamlined, with as many common measures, data elements and reporting requirements as possible – the majority of the physician’s time should be focused on patient care. Also, measures must be critically examined for actual impact on improved clinical outcomes.

Vascular surgeons practice in a wide array of models, including small private practices. These practices, particularly in rural and underserved areas, should be eligible for hardship exemptions if they cannot meet an adequate number of patient events to reliably measure performance. APMs between hospitals and providers, such as bundling and gain-sharing arrangements, could provide a way to aggregate measurement development.

In addition, SVS strongly believes that all providers who treat vascular disease patients, including low volume providers, should be held accountable for their quality in some way, such as being board-certified and participating in Maintenance of Certification, which facilitates learning and assesses physician competence on a continual basis.

Proposed APMs for Vascular Surgeons

As previously mentioned, SVS is already beginning to create APMs that are appropriate for patients with vascular disease. We agree that the Center for Medicare and Medicaid Innovation should be much more transparent when it tests innovative payment and services delivery models and the public should be allowed to comment on these. Also, CMS needs to provide baseline data free-of-charge, original benchmarks of costs along with data runs and education on data sets, such as how they can be used and what their limitations are, to entities that are creating APMs.

Below are examples of APMs for vascular surgeons and other providers:

- **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.

SVS representatives would appreciate meeting with Finance Committee staff regarding our comments before legislation is introduced. 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.