



American Society of Transplant Surgeons

Filed Electronically

August 31, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW - Room 445-G
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule; Proposed Rules (CMS-1590-P)

Dear Ms. Tavenner:

On behalf of the American Society of Transplant Surgeons (ASTS), I am pleased to submit these comments on the 2013 Physician Fee Schedule (PFS) Proposed Rule (the "Proposed Rule"). ASTS is comprised of over 2000 transplant surgeons, physicians, scientists, advanced transplant providers and allied health professionals dedicated to excellence in transplant surgery through education and research with respect to all aspects of organ donation and transplantation so as to save lives and enhance the quality of life of patients with end stage organ failure.

Impact of Proposed Rule on Transplant Procedures.

ASTS notes that Medicare payment for transplant procedures may be impacted by a number of the proposals set forth in the Proposed Rule. For example, kidney transplant code (CPT Code 50360) is to be revalued since, according to the CMS data base, the current valuation is based on a Harvard value rather than the RUC valuation process. In partnership with the American College of Surgeons (ACS) and the American Urological Association (AUA), ASTS looks forward to working with the RUC to survey this procedure at the February 2013 meeting.

In addition, transplant surgeons may be impacted significantly by any future modification of the global surgery package, since transplant recipients receive a wide array of post-transplant services during the 90 day global period. ASTS fully supports the comments of the ACS with regard to the appropriate approach to revaluation of the services included in the global surgery package for each code. Given the narrow scope of the data in the Office of the Inspector General (OIG) report, we maintain that the OIG is less reliable and the RUC survey and review remains the most reliable and accurate process for obtaining data.

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Physician Quality Reporting System (PQRS)

It is our understanding based on the Proposed Rule that physicians who do not participate in PQRS beginning in 2013 will be assessed a penalty of 1.5% in 2015. Physicians who are currently successfully participating in the PQRS will receive a 0.5 percent bonus on all Medicare payments for 2013. This bonus will continue the next two years.

For purposes of the 2015 and 2016 penalties, CMS is proposing, in an effort to increase participation in PQRS, that it would be sufficient for eligible professionals and group practices to report only one measure or measure group during 2013 and 2014. While this is significantly less stringent than the reporting criteria that must be met to obtain the incentive payment, we concur with CMS that this accommodation is necessary to facilitate participation for physicians and groups that have not previously participated in PQRS. ASTS also appreciates CMS' commitment to aligning PQRS with other incentive programs (including the Electronic Prescribing Incentive Program, Electronic Health Records Incentive Program, Medicare Shared Savings Program, etc.) wherever possible to decrease the burden of participation in these programs.

Value Based Payment Modifier (VBM)

CMS is required by law to begin implementation of the value-based payment modifier beginning in 2015 and to include all physicians by 2017. The agency is proposing to apply the modifier in 2015 only to physicians in groups of 25 or more. Physicians in smaller groups would not be affected until 2017. It is unclear to us whether an academic practice plan that bills under a single Tax Identification Number (TIN) would be considered a group practice for this purpose. Since many transplant surgeons are members of faculty practice plans for teaching hospitals, if faculty practice plans are subject to the VBM, it is possible that many transplant surgeons will be impacted by this new program. We request clarification on how group size will be determined. Additionally, we support the ACS comments that request to increase the threshold from 25 to at least 100 and preferable 200.

It is also unclear to us whether or how the VBP program may impact physicians who are individually employed by a hospital or hospital-affiliated entity. If a transplant surgeon is a direct employee of a hospital or hospital-affiliated entity, claims for the surgeon's services may be submitted by the hospital using the surgeon's identifying information, but without a group practice TIN. In these cases, it is unclear whether or not the VBM program requirements will apply.

For the initial 2015 implementation, physician groups can avoid all negative adjustments by participating successfully in PQRS. Thus, as we understand it, under the Proposed Rule, successful participation in PQRS in 2013 provides a "safe harbor" for physicians that will be subject to the VBM program in 2015.

We strongly urge CMS to establish a second "safe harbor" for physicians whose services are included in specified registries ("safe harbor registries"), and that the Scientific Registry of Transplant Recipients (SRTR) be approved as a safe harbor registry.

The Scientific Registry of Transplant Recipients (SRTR) is a comprehensive national database of transplantation statistics. The SRTR transplant program reports include:

- Reliable transplant information for patients, families and medical professionals;
- A complete list of U.S. transplant centers;
- Waiting time and organ availability data; and
- Survival statistics.

The SRTR provides detailed patient and organ survival and other outcome information for each transplant center and for each type of organ transplant (i.e. kidney, liver, heart, heart-lung, pancreas, intestine, kidney-pancreas). This is precisely the type of specific, accessible outcome information that patients and prospective patients want and need. Each center's performance is risk adjusted and reported against applicable benchmarks: Actual performance is compared to "expected" performance on key measures, taking into account sophisticated (albeit as-yet-imperfect) risk adjustment methodologies.

Under the SRTR methodology, individual surgeon performance is not reported separately. This is as it should be. Transplantation is a team activity and is dependent not only on individual surgeon performance but also on a myriad of other factors, including the quality of the services provided by the transplant center, organ procurement organization and other members of the transplant team, such as nurses, nutritionists, pharmacists, transplant coordinators, and administrators.

The SRTR can and should serve as a model of how outcomes data should be reported and, while this data is formally provided by transplant centers, transplant surgeons are integrally involved in its collection and accurate reporting. We strongly believe that transplant surgeons' integral involvement in the collection and reporting of this highly meaningful outcomes information should be considered sufficient to shield transplant surgeons from negative adjustments under the VBP program, just as participation in the PQRS program would shield them from such negative adjustments.

We invite you to explore the SRTR website at greater length (http://www.srtr.org/local_stats.aspx). We firmly believe that the SRTR data collection process and the Program Specific Reports that it makes publicly available should serve an important role in implementation of the VBM as a model for other surgical procedures. The establishment of similar registries for other procedures can be best encouraged by designating the SRTR as a safe harbor registry and establishing clear criteria for other surgical registries to obtain safe harbor status.

Sincerely yours,



Kim M. Olthoff, MD
President