STATEMENT SUBMITTED BY THE

AMERICAN SOCIETY OF TRANSPLANT SURGEONS

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

REGARDING THE MAY 7, 2013 HEARING ON

"DEVELOPING A VIABLE MEDICARE PHYSICIAN PAYMENT POLICY"

May 6, 2013

Dear Congressman Brady:

On behalf of the American Society of Transplant Surgeons (ASTS), we appreciate the opportunity to submit this statement for the Committee's consideration regarding options for repealing the Sustainable Growth Rate (SGR) formula and developing a viable Medicare physician payment system that rewards quality and value. The ASTS is a medical specialty society comprising more than 2,000 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 lives of patients with end stage organ failure.

Please note that in this submission we focus on two aspects of our detailed feedback of April 15, 2013, to Congressmen Upton, Camp, Pitts and you on your Second Draft of the Sustainable Growth Rate Repeal and Reform Proposal. First, we believe that transplant surgery and transplant healthcare delivery can serve as an ideal model for healthcare and payment reform, based on quality and value. Second, current proposals for SGR repeal pose certain specific challenges for transplant surgery and we hope you will consider our suggested solutions and incorporate them into reform plans.

Transplant Surgery as a Model

ASTS respectfully submits that transplantation should serve as a model for healthcare and payment reform, based on quality and value. Some relevant characteristics of our specialty include:

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- Coordinated delivery of lifelong, complex, multi-disciplinary care;
- System of bundled payments to the hospital and physicians who provide care to the patient;
- Established healthcare improvement initiatives that focus on the entire episode of care, incorporating data driven quality assessment and performance improvement;
- Use of the scientific registry of transplant Recipients (SRTR), as described below. SRTR reporting mechanisms focus on what transplant patients focus on: patient and organ survival – what health economists call "ultimate" health outcomes, rather than a multiplicity of "process" and intermediate outcomes measures that are of little or no meaning to patients and that are incomplete measures of quality.

The SRTR is a comprehensive national database of transplantation statistics. The SRTR operates under contract with the Health Resources and Services Administration (HRSA), a sister agency to CMS within HHS. Participation in the SRTR is mandatory. The SRTR is an electronic, secure registry. SRTR reporting is audited by the Organ Procurement and Transplantation Network (OPTN), which operates under a separate HRSA contract. Accuracy is audited and missing data is flagged. Non-compliance can lead to a transplant center being classified as not in good standing by OPTN. Additionally, CMS can decertify a program that is non-compliant with SRTR reporting. Third party payers utilize SRTR data to make contracting decisions such as selection of transplant programs into Center of Excellence networks. The SRTR provides:

- A well-established and publicly available website;
- Reliable transplant information for patients, families and medical professionals;
- A complete list of U.S. transplant centers;
- Waiting time and organ availability data;
- Survival statistics and other relevant outcomes data for waitlisted and for transplanted patients, lifelong;
- Risk adjusted outcomes data; and
- Publicly available, Program Specific Reports (PSRs).

The SRTR provides comprehensive outcomes data on patient and organ survival, broken down by transplant center and specific to the type of organ involved. It shares detailed patient and organ survival and other outcome information for every transplant for each transplant center and 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. Hospitals can compare their results to hospitals of all types, in all regions of the country. The data is fed back to sites through a variety of reports, and guidelines, case studies and collaborative meetings help hospitals learn from their data and implement steps to improve care. CMS CoPs related to transplant program quality improvement mandate programs to continually review center specific data to identify opportunities for

process and outcome improvements. The SRTR has enabled health outcomes and transplantation research leading to publications in peer-reviewed journals covering such topics as renal patient mortality, morbidity, and quality of life, organ allocation, organ transplant wait lists, organ procurement, and outcomes after transplantation. We invite you to explore the SRTR website at greater length at www.srtr.org/local_stats.aspx.

RECOMMENDATION: Use the SRTR as a viable, tested, and effective model to create or support existing mechanisms to measure health care outcomes and quality.

Specific Concerns and Solutions

Your joint letter with the Energy and Commerce committee on SGR reform send to the Provider community on April 3, 2013, conveyed details about the three phase plan for payment reform. ASTS applauds the Committee's intention to provide a multi-year period of time to develop meaningful quality measures with adequate risk adjustment, and to decrease the administrative burdens of reporting on performance.

ASTS' key concerns and solutions regarding current proposals for SGR repeal include:

1) Although transplant healthcare providers already must comply with extensive process regulations and attain robust outcome standards, ASTS remains concerned about the time, expertise and expense needed to develop and implement additional meaningful measures of quality and efficiency. The process of quality measure development is complex and ongoing. In order to complement quality outcome measures, ASTS currently seeks to develop additional transplant-specific, evidence based, performance measures. We have engaged with the AMA's Physician Consortium for Performance Improvement (PCPI) and with ACS's NSQIP to investigate possibilities to facilitate this complex process. Such measure development requires great resource of expertise, time, and expense. While the SRTR focuses on what patients focus on – patient and organ survival – transplantation as a specialty would need time and require assistance to develop clinical practice improvement activities.

   ASTS is pleased that you plan for a period of stable payments allowing providers enough time to prepare for change, to develop appropriate quality and efficiency measures, and to implement clinical practice improvement activities.

   RECOMMENDATION: We request that Congress also make increased funding and assistance readily available from agencies such as AHRQ, HRSA, PCPI, and NSQIP, to bolster current systems or assist in the development of any new measurement systems.

2) As you have proposed, quality and performance measures must contain appropriate risk adjustment so that incentives are fair and mitigate against risk aversion. Providers who treat sicker, more complicated patients should not be penalized. Appropriate risk adjustment will require significant

time and expertise. For example, the SRTR publishes observed and expected outcomes for transplant centers every six months using a thirty month rolling national cohort and Cox proportional hazards models to adjust for risk. These program specific reports (PSRs) are used by OPTN and CMS to scrutinize transplant center performance. Despite having a long-standing registry, transplantation continues to struggle with appropriate risk adjustment. Even after many years, the current model does not appear to take into account many risk factors that may have an adverse effect on transplant center outcomes, but provides the best model going forward to achieve this important result.

RECOMMENDATION: We propose that the Committee use the SRTR as an example of the complexities of appropriate risk adjustment, and again ask that you provide for ample time and resources required to develop meaningful risk adjustment.

3) The quality of healthcare is increasingly viewed as a collaborative endeavor and ASTS is concerned about problems that would result from attribution of transplant results to individual surgeons, including the potential untoward effect of risk aversion instead of necessary teamwork. Transplantation is dependent not only on individual surgeon performance but also on a myriad of other factors, including the quality of the infrastructure and services provided by the transplant center, the efficacy of the organ procurement organization, and the contributions of the other members of the transplant team, such as non-surgeon transplant physicians, medical consultants, nurses, nutritionists, pharmacists, transplant coordinators, and administrators. To attribute patient or organ outcomes solely to the lead transplant surgeon is to ignore the significant and often critical roles of the rest of the team. Such an approach would be inimical to the focus on care coordination that is the hallmark of quality assurance programs and that is increasingly recognized as critical by healthcare policymakers.

   We urge the Committees to facilitate considerable flexibility in determining the reporting entity for which quality performance is assessed for the purpose of variable payments. Transplantation is a "team endeavor," and it is most appropriate for performance data to be attributed to the transplant center as an entity.

   RECOMMENDATION: We suggest that the proposal require institutions that organize transplant teams to be responsible for the individual quality measures. This approach would allow for the "ultimate" health outcomes to be viewed from the team perspective and other, less than "ultimate" measures, viewed from the individual standpoint. We believe this model has application across other specialties – especially certain surgical specialties.

4) ASTS is concerned about the huge administrative burdens on transplant centers created by dual federal agency oversight. Transplant Centers are currently regulated by both the Centers for Medicare and Medicaid Services (CMS) through its certification requirements and by the Health

Resources and Services Administration (HRSA) through the Organ Procurement and Transplantation Network (OPTN).

RECOMMENDATION: We strongly believe that CMS and OPTN requirements pertaining to transplant center safety and quality should be consolidated to the extent practicable; that on-site surveys should be conducted only when substandard outcomes are detected and documented; that surveys should be conducted at the same time by both agencies to reduce the administrative burden on affected centers; that survey personnel should be coordinated to ensure that clinical review is conducted by those with substantive expertise in transplantation; and that reports of deficiencies by the two agencies should be consistent.

Thank you for this opportunity to provide ASTS's perspective on the SGR issue. We applaud you for efforts to repeal the SGR and to develop a new Medicare payment policy. Transplant surgery's quality measurements an ideal model for your efforts to develop a viable Medicare physician payment system.

In summary, we strongly urge you to allow adequate time, funding, and assistance to develop specialty-specific quality performance measures and improved risk adjustment methods, and that transplant quality be measured from the perspective of a team endeavor, so that incentives are fair and to mitigate against risk aversion. We also call for increased harmonization of transplant regulatory measures (CMS CoPs, UNOS policies and SRTR mandates) and substantially decreased reporting burdens.

ASTS looks forward to continued partnership with you in this important effort and we would be delighted to engage in further discussion as you move forward.

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