<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter from the President</td>
<td>1</td>
</tr>
<tr>
<td>Chimera News</td>
<td>3</td>
</tr>
<tr>
<td>ASTS Committee Updates</td>
<td></td>
</tr>
<tr>
<td>Report from Washington</td>
<td>6</td>
</tr>
<tr>
<td>ASTS Testimony</td>
<td>10</td>
</tr>
<tr>
<td>Medicare Coverage for Transplants</td>
<td>14</td>
</tr>
<tr>
<td>New Extramural HRSA Grant Program</td>
<td>19</td>
</tr>
<tr>
<td>ASTS 2002 Awards</td>
<td>20</td>
</tr>
<tr>
<td>American Transplant Congress</td>
<td>23</td>
</tr>
<tr>
<td>ASTS 2003 Winter Symposium</td>
<td></td>
</tr>
<tr>
<td>”Tumors and Transplantation”</td>
<td>24</td>
</tr>
<tr>
<td>Clinical Trials Corner</td>
<td>26</td>
</tr>
<tr>
<td>Job Board</td>
<td>27</td>
</tr>
<tr>
<td>ASTS New Members</td>
<td>28</td>
</tr>
<tr>
<td>Calendar</td>
<td>28</td>
</tr>
<tr>
<td>ASTS Committees</td>
<td>29</td>
</tr>
</tbody>
</table>
ASTS Board of Directors May 2002 - May 2003

PRESIDENT
James A. Schulak, MD (2003)
Case Western Reserve University
Dept. of Surgery
11100 Euclid Ave.
Cleveland, OH 44106
Phone: 216-844-3020
Fax: 216-844-5398
Email: james.schulak@uhhs.com

PRESIDENT-ELECT
Abraham Shaked, MD PhD
University of Pennsylvania
Dept. of Surgery-4 Silverstein
3400 Spruce St.
Philadelphia, PA 19104
Phone: 215-662-6723
Fax: 215-662-2244
Email: shaked@mail.med.upenn.edu

IMMEDIATE PAST PRESIDENT
Marc I. Lorber, MD
Yale Univ. School of Medicine
PO Box 208062
333 Cedar St.
New Haven, CT 06520-8062
Phone: 203-785-2565
Fax: 203-785-7162
Email: marc.lorber@yale.edu

PAST PRESIDENT
Nancy L. Ascher, MD PhD
Univ. of California-San Francisco
Dept. of Surgery
513 Parnassus Ave., S-320
San Francisco, CA 94143
Phone: 415-476-1236
Fax: 415-476-1734
Email: ascher@med.surgery.ucsf.edu

SECRETARY
Arthur J. Matas, MD (2005)
University of Minnesota
Dept. of Surgery, Box 328 UMHC
420 Delaware St., SE
Minneapolis, MN 55455
Phone: 612-625-6460
Fax: 612-624-7168
Email: matas001@tc.umn.edu

TREASURER
Richard J. Howard, MD PhD (2003)
University of Florida
Dept. of Surgery, Rm. 6142
1600-6142 SW Archer Rd.
PO Box 100286
Gainesville, FL 32610-0286
Phone: 352-265-0606
Fax: 352-265-0678
Email: howard@mail.surgery.ufl.edu

COUNCILORS-AT-LARGE
David M. Follette, MD (2003)
Univ. of California Davis Medical Ctr.
Div. of Cardiothoracic Surgery
2221 Stockton Blvd., 2nd Fl., Rm. 2112
Sacramento, CA 95817
Phone: 916-734-7255
Fax: 916-734-3066
Email: david.follette@ucdmc.ucdavis.edu

Goran B. G. Klintmalm, MD PhD (2003)
Baylor Univ. Medical Center
Transplantation Services
3500 Gaston Ave.
Dallas, TX 75246
Phone: 214-820-2050
Fax: 214-820-4527
Email: gb.klintmalm@baylorhealth.edu

A. Benedict Cosimi, MD (2004)
Massachusetts General Hospital
Dept. of Surgery
55 Fruit Street
Boston, MA 02114
Phone: 617-726-8256
Fax: 617-726-8137
Email: cpadyk@partners.org

A. Osama Gaber, MD (2004)
UT Medical Group
Dept. of Surgery
956 Court Ave., A202
Memphis, TN 38163
Phone: 901-448-5924
Fax: 901-448-7208
Email: agaber@utmem.edu

Robert M. Merion, MD (2005)
University of Michigan Health Systems
2926 Taubman Center, Box 0331
1500 East Medical Center Drive
Ann Arbor, MI 48109-0331
Phone: 734-936-7336
Fax: 734-763-3187
Email: merionb@umich.edu

Francis L. Delmonico, MD (2005)
Massachusetts General Hospital
Renal Transplant-White Bldg., 505
55 Fruit Street
Boston, MA 02114-2696
Phone: 617-726-2825
Fax: 617-726-9229
Email: delmonico.francis@mgh.harvard.edu

NATIONAL OFFICE
Gail D. Durant
Executive Director
1020 North Fairfax Street., #200
Alexandria, VA 22314
Phone: 703-684-5990
Fax: 703-684-6303
Email: gaildurant@earthlink.net
Dear Colleagues:

It is with a great appreciation that I write my first president’s letter to you, the membership of the ASTS. I feel most honored to have this opportunity because, of all the professional societies to which I belong, the ASTS is the one that means the most to me. I hope and trust it does to you as well.

As transplant surgeons and scientists we have very much to be proud of, having given birth to one of the most exciting and successful fields in all of medicine. Our dedication to this discipline, particularly in the early years when our senior colleagues were often scorned rather than praised, is unquestioned and the fruits of our labors, to this day, are most noteworthy.

Needless to say, our medical colleagues also have contributed significantly to the field and our continued cooperation and collaboration with them on joint projects is of paramount importance. Our efforts in this regard were most recently manifest by the highly successful American Transplant Congress (ATC) meeting in Washington D.C., where the ASTS and AST worked hand-in-hand to make the meeting the best transplant scientific forum in the world. Additionally, our two societies are the proud parents of the American Journal of Transplantation (AJT), which is one of the most successful new medical journals ever launched anywhere in the world. The ATC and the AJT are true joint ventures that should bring both pride and a sense of accomplishment to the ASTS and the AST. We can and do work together for the betterment of our patients and for the advancement of our field, and we must continue to do so.

I believe letters such as this should have a message, so here it is. I urge you to contribute to the field of transplantation through the auspices of your society, the American Society of Transplant Surgeons. In the past several years, the ASTS has gained new energy and a sense of purpose. It has attracted the membership of many energetic and talented young surgeons, and has reawakened the enthusiasm of its senior members as well. The ASTS is trying very hard to be responsive to your professional needs. As you know, we are embarking on new relationships with both the American Board of Surgery and the American College of Surgeons. Moreover, Marc Lorber, our past president, has just established three new ad hoc committees, the Committee on Professional Reimbursement, the Committee on Living Donation, and the Committee on the Workplace to address important areas of concern to all of us. In addition, he has appointed scores of ASTS members to serve on and lead our many standing committees. I wish to be the first to welcome all of you new committee members to the service of your society.

Participation is the best way to show your support for the ASTS. Get involved. When appointed to ASTS committees, participate and contribute. Make attendance at ASTS sponsored events an important part of your professional agenda. Plan on attending the Winter Meeting this coming January, where you can meet your colleagues and make new friends in a relaxed and collegial, surgeon friendly environment.

As your president, I pledge to put forth my best efforts on your behalf, and to work diligently to make the ASTS a meaningful and important part of your professional life. I need your help. Jump in, the water’s fine!

Jim Schulak, MD
President
ASTS President James Schulak presents gavel and plaque to outgoing President, Marc Lorber.
ASTS Committee Updates

The following reports were made at the April 30, 2002 ASTS Membership Business Meeting at the Marriott Wardman Park Hotel in Washington, DC:

Awards Committee

Thomas Peters, ASTS Awards Committee Chairman, presented the results of a study the Awards Committee undertook this year to survey ASTS award recipients for a ten year period. This included information on the current position of the award recipient, their current institution, current activity and the ASTS award results which showed that the recipients had gone on for further research and received grants ranging from $50,000 to 1.7 million dollars. All had very favorable comments about the value of their ASTS fellowship and the conclusions reached by the survey was that the ASTS research fellowship awards influence young professionals at several academic levels to perform important and sustained research and to remain in careers in clinical and research transplantation. Dr. Peters next noted that there had been no applications for the Roche Presidential Travel Awards this year and encouraged any of the Members who have individuals on their staff 42 years of age or younger to apply for this award in 2003. He also thanked the 40 reviewers of the applications submitted this year.

Ethics Committee

Dr. Francis Delmonico reported that the ASTS Ethics Committee work on financial incentives would appear in the form of a paper in the Transplantation Journal forum section. He next noted that the Ethics Committee had been asked by the ASTS President to review the Society’s position paper on adult to adult living liver donors and to see if it was pertinent and current. The Ethics Committee reviewed the document and held a meeting via conference call and agreed that it is current and relevant. The Committee is going to work further on the ASTS document to ensure that it remains current. The ASTS, by vote at the April 30, 2002 Business meeting formally adopted the recommendation of the Ethics Committee on financial incentives.

Bylaws Committee

Dr. John Roberts reported that there were three bylaws changes that the Members needed to vote upon at the April 30, 2002 meeting. The first was the formation of permanent Committee on Cellular Transplantation. The second bylaws change to be voted upon would grant permanent status as a committee to the Vanguard Committee. Finally, a vote was taken on reducing the dues from 50% for Candidate Members to no dues. All three of these bylaws changes were approved.

Informatics and Data Management Committee

First Dr. Robert Merion reported on the activity of the ASTS and Centerspan listserv. It was reported that they have approximately 444 subscribers at this time. Dr. Merion also reviewed the current ASTS website home page noting the information and links on it. The Informatics Committee discussed and approved the idea of online dues notification and secure online payment for ASTS Members. Dr. Merion reviewed the 2002 Winter Symposium
CME program now available on the ASTS website at www.astsonline.org. Dr. Merion also reported that the ASTS Council voted and approved online email voting for the quarterly new members ballots. Finally, he reviewed a request by the ASTS Scientific Studies Committee to have a clinical trials bulletin board on the ASTS website. It will include offers to centers to participate but there will be no solicitation of patients to the primary center. The ASTS Scientific Studies Committee would review all the potential postings. In addition to appearing on the ASTS website they will also appear in the Chimera.

Membership Committee

Dr. Douglas Farmer, ASTS Membership Committee Chairman, reported that there were 64 new Members in the Society this past year giving ASTS a total of 877 Members. Many of the new Members include thoracic surgeons and Candidate Members. The new list of Members appears on a regular basis on the ASTS website as well as in the Chimera. This year, ASTS hosted a new Members reception following the business meeting to welcome new Members from the past two years into the Society.

Programs, Publications and Post Graduate Course Committee

Dr. Jonathan Bromberg, Chairman of this Committee, presented information regarding the 2002 American Transplant Congress. There were 2,016 abstracts submitted and 4,006 registrants. 489 of those registrants were ASTS Members. He reported that the ATC Planning Committee is very interested in ideas from Members and registrants about what could be included in the 2003 program and noted that there will be a link on the ASTS website for them to submit their ideas.

Standards on Organ Procurement

The Committee had been working on and held a conference call to discuss qualifications of individuals who procure organs. A report will be appearing on the ASTS website in the future regarding the work of this Committee.

Thoracic Transplant Organ Committee

Dr. David Follette, Chairman of this Committee reported that the ASTS and the Society of Thoracic Surgeons held a joint meeting this past January in Ft. Lauderdale which was very successful. There were 140 registrants, which is twice as many as the previous year and that the ratings were very high for the program content. The Thoracic Committee will also be advertising the ASTS Thoracic Fellowship award in several thoracic journals this year to encourage more applications. The Committee is also addressing reimbursement issues that thoracic surgeons are facing in hopes to expand the ASTS cardiothoracic activity.

Vanguard Committee Report

Dr. Sandy Feng, Chairwoman of the Vanguard Committee, reported that there were 210 registrants at the ASTS 2002 Winter Symposium. Fifty-four abstracts were submitted and poster sessions included oral presentations.
There was also a new initiatives luncheon at this meeting as well as presenting CME credit via webcast. With respect to the 2003 meeting, the Committee hopes that there will be selected poster submissions reported in the *American Journal of Transplantation*.

Dr. Feng announced that the ASTS Awards Committee would be giving out a Vanguard Prize. There will be four each year for the four best published papers by a junior Member of the Society. The recipients will receive $1,000 plus coach travel to and registration at the next year’s Winter Symposium.

**Nominating Committee Report**

Marc Lorber reported that the Nominating Committee met on April 26, 2002. After much discussion over the large number of nominations, the nominations presented by the Committee are as follows: President Elect, Abraham Shaked; Secretary, Arthur Matas; Council Members, Robert Merion and Francis Delmonico. There were no nominations from the floor at the April 30, 2002 Business Meeting and the motion was approved to accept the report of the Nominating Committee and the candidates.

**Formation of ASTS Foundation**

The American Society of Transplant Surgeons’ (ASTS) Membership voted upon and approved the formation of an ASTS Foundation. The purpose of the Foundation will be to expand the Society’s ability to provide awards and fellowships, conduct more studies and projects and other endeavors to enhance the education and efforts of transplant surgery for the benefit of patients, surgeons, physicians, scientist and the transplantation community.

The Foundation will be a non-profit organization separate from the ASTS. The Foundation will seek funding to support its activities. A copy of the Foundation Bylaws can be found at the ASTS website at [www.asts.org](http://www.asts.org).


**ASTS** continues to play an active role in organ transplantation issues as the summer legislative session heats up in Congress and the Bush Administration presses forward with new initiatives. The Department of Health and Human Services (HHS) is continuing to advance its organ donor initiative as the Senate is poised to consider organ donor legislation. Congress is wrestling with Medicare prescription drug coverage and other changes to the Medicare program, the main piece of legislation to be watching this summer. In addition to the drug benefit, other provisions likely to be included are increases in physician payments and coverage for immunosuppressive drugs. ASTS will remain an active participant in these debates as Congress continues to grapple with an array of difficult issues as it moves towards adjourning this fall before the mid-term elections.

**ASTS President Testifies Before House Appropriations Subcommittee**

ASTS President James Schulak, MD, testified before the House Appropriations Subcommittee on Labor, Health and Human Services, and Education on May 7, 2002. The hearing gave ASTS an opportunity to present its views on future funding for the Health Resources and Services Administration’s (HRSA) Division of Transplantation (DoT) and the National Institutes of Health (NIH). The current fiscal year 2003 budget for DoT calls for an increase of $5,000,000 above the 2002 level, for a total appropriation of $25 million. While ASTS expressed its gratitude to the administration for its continued commitment to the DoT and its responsibilities, Dr. Schulak encouraged the subcommittee to increase the FY 2003 funding level to $30 million. This increase would be commensurate with the enormity of the challenge that DoT faces in meaningfully increasing organ donor rates.

Dr. Schulak spoke of ASTS’s support of the Bush administration’s commitment to the five-year effort to double the NIH budget. “These additional funds,” he stated, “should be used by the appropriate institutes to aggressively pursue research on organ transplantation to maximize success rates and explore new and emerging science in the transplant field, particularly in the area of transplant surgery.”

Dr. Schulak also explained to the subcommittee how ASTS has taken a leadership role in assessing the emerging practice of living donor liver transplantation. ASTS has joined with several transplant-related organizations to participate in the Live Organ Donor Consensus Group in 2000 and has issued its own guidelines regarding this type of transplantation. The 2000 group was tasked with recommending practice guidelines for transplant physicians, primary care providers, health care planners, and others who are concerned about the well being of live organ donors.

Providing this testimony also gave ASTS an opportunity to inform Congress of its proposed collaboration with the National Institute of Diabetes, Digestive and Kidney...
Diseases on an upcoming study of living donor liver transplantation. ASTS has proposed to contribute up to $300,000 per year for the duration of the study, which should amount to between $1.5 and 2.1 million over the five to seven year period. The funds will be used to recruit additional research centers to assist in answering a host of scientific and clinical transplantation questions.

Organ Donation Legislative Action Coming Soon in the Senate

On February 14, 2002, Senator William Frist (R-TN) introduced the Organ Donation and Recovery Improvement Act, S. 1949. This legislation follows legislation introduced last year by Senator Dick Durbin (D-IL), the Donor Outreach, Network, and Timely Exchange Act, or DONATE Act, and the Motor Donor Act, which was introduced by Senator Charles Schumer (D-NY).

The Frist legislation would establish an interagency task force on organ donation and research, award grants to carry out studies and demonstration projects to increase organ donation and recovery rates, establish a public education program, and support model curricula to train health care and other professionals in issues surrounding organ donation.

The bill would also award grants to qualified organ procurement organizations to establish programs to coordinate their efforts with hospitals and for reimbursement of travel and subsistence expenses incurred by individuals toward making living organ donations. It also directs the Secretary of HHS to contract with the Institute of Medicine to evaluate existing organ donation practices and living donation practices and procedures. The Secretary would also appoint an advisory committee to study and report to Congress on existing organ donor registries and maintain a registry of living organ donors.

Senator Edward Kennedy (D-MA), Chairman of the Health, Education, Labor, and Pensions Committee (HELP), is expected to markup bipartisan organ donor legislation based on the Frist, Durbin, and Schumer bills, perhaps as early as June 26, 2002. The committee is now in the process of finalizing draft legislation for review by members of the Committee and interest groups, including ASTS. ASTS will be coordinating with the HELP Committee and the sponsors of the legislation during the legislative process.

HHS Organ Donation Initiative

ASTS is very encouraged by the Bush administration’s continuing support for increased organ donation activities. In April 2001, Secretary of Health and Human Services Tommy Thompson announced a five-point initiative to encourage organ, tissue, marrow, and blood donations. In May 2002, one year after the HHS initiative began, Secretary Thompson announced very encouraging statistics on the increase in organ donation rates. In 2001, 12,522 people were organ donors, compared to 11,711 in the year 2000, a 7% increase. Even more encouraging is the living organ donor program, which increased by 12.5% over the 2000 numbers.

Medicare Reform/Prescription Drugs

The House of Representatives is scheduled to consider a Medicare reform and prescription drug package by the end of June. Although the legislation may have been considered in the House prior to publication, many of the details in the legislation will remain the same based on already published information. Also, it is important to keep in mind that any legislation regarding physician payments or so-called “give-backs” to other providers will be attached to this legislation.

House Ways and Means Committee Chairman Bill Thomas (R-CA), the architect of the drug benefit package, has stated that his goal is for the government to split overall program costs with beneficiaries 80-20 percent, although the federal share could be as low as 70 percent. The plan will include a monthly premium
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ASTS has been working with members of Congress and other physician groups in an attempt to change the formula that determines the annual update to the Medicare physician fee schedule, the same formula that resulted in a 5.4% decrease in 2002 Medicare physician fees. Further cuts, which could reach an additional total of 17% by 2005, are set to take effect if Congress does not act. Although Members of Congress, the American Medical Association, and 40 other interest groups released a legal analysis arguing that the administration has the authority to fix physician payments without Congressional action, the administration continues to contend that only Congress can fix the problem.

In response, House leaders tried to pass separate legislation giving the administration explicit authority to address the issue on its own. The theory was that this approach would have freed up funds to devote to a prescription drug benefit for seniors. Additionally, having the administration fix the physician fee schedule problem would eliminate the need for cuts to other providers in the current Republican Medicare proposal. However, the road to administratively fixing the physician fee schedule became noticeably more difficult when the Congressional Budget Office (CBO) scored the separate legislation at $43 billion over 10 years, well above what House Republicans had hoped and a number far in excess of what the

Democratic proposal, Graham moved forward now in an effort to capitalize on Miller’s clout with conservatives, and to keep in step with House GOP leaders.

The latest estimated cost of the Graham bill is $425 billion through 2010. It will include a $25 monthly premium to entice seniors to participate, down significantly from the Graham’s last bill that was estimated to be as high as $67 per month. The government would also pick up 50 percent of the cost of coinsurance on prescription drugs up to $4,000 annually. Under the plan, the government would pick up the entire tab for Medicare recipients with out-of-pocket expenditures that reach over $4,000 in drug costs in a given year.

While the respective proposals of each party take shape, how and when the next step in the process will occur is still to be decided. With both Democrats and Republicans in control of one chamber, and with relatively wide differences between the two most recent proposals, it is not likely that agreement can be reached on a compromise measure before the election. Additionally, it is still not clear that either party has the votes to pass a comprehensive Medicare bill.

Medicare Physician Payments

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ASTS will continue to monitor these important issues and seek every opportunity to take action to represent its members.

Bush Administration is likely to act on. This development rekindled interest in an interim solution proposed by the House Ways and Means Committee. Republicans are all but certain to include language changing the physician payment update in the Medicare reform package along with the drug benefit. The outline of the proposal was released in late May. This proposed legislation would override the current physician update formula for three years, providing Medicare fee updates of between 2% and 2.5% annually from 2003-2005. The current formula would be reinstated at that time, assuming Congress did not act during the 3-year period.

CBO has estimated the budget cost of the plan at $21 billion over five years. ASTS intends to support this interim approach and will work toward its passage.

Extended Immunosuppressive Drug Coverage Likely to be Included in Medicare Package

According to an early draft of the Medicare reform/prescription drug legislation, H.R. 2057, the Medicare Fairness for Organ Transplant Recipients Act of 2001, introduced by Steven LaTourette (R-OH), will be included in the package. The provision would require coverage of immunosuppressive drugs for Medicare beneficiaries who receive an organ transplant regardless of when that transplant was received. Currently Medicare only will cover immunosuppressive drug therapy if the transplant was covered by Medicare.

ASTS and other groups signed onto a letter sent by the National Kidney Foundation to Chairman Bill Thomas (R-CA) of the Ways and Means Committee and to Chairman Billy Tauzin (R-LA) of the Energy and Commerce Committee requesting that the LaTourette immunosuppressive drug coverage extension provision remain in the bill.

Patients’ Bill of Rights Update

Senate Majority Leader Tom Daschle (D-SD) is expected soon to appoint Senators to a conference committee to negotiate an agreement with the House on federal patients’ rights legislation. This action, while appearing to be a positive step forward, is likely the latest in a series of partisan gestures that should increase as the election approaches.

The legislation has been stalled for nearly one year since the Senate and House each passed patients’ rights bills. In January 2002, Senator Daschle delayed the appointment of conferees to allow sponsors of the Senate version of the bill — Sens. Edward Kennedy (D-MA), John Edwards (D-NC) and John McCain (R-AZ) — to negotiate an agreement with the White House out of the spotlight of a conference committee. The White House supports the House bill. White House officials and aides to Senator Kennedy have met several times to discuss a compromise over the rival bills, but talks seem to have broken down.

The Senate bill would allow patients to sue HMOs in state courts — which often award larger damages than federal courts — for denial of benefits or quality of care issues. Patients would also be able to sue in federal court for non-quality of care issues. It would cap damages awarded in federal court at $5 million but would allow state courts to award as much in damages as states allow. The House bill would allow patients to sue health plans in state court only for non-economic damages up to $1.5 million. In addition, the legislation would allow courts to award patients up to $1.5 million in punitive damages, but only in cases where patients won complaints against health plans before an outside appeals panel and an HMO still refused to provide care.

ASTS will continue to monitor these important issues and seek every opportunity to take action to represent its members.

Prepared by:
Peter W. Thomas, Esq.
Legislative Counsel to ASTS
Dustin W.C. May, Legislative Director
Powers, Pyles, Sutter, and Verville, P.C.
On May 7, 2002, ASTS President James Schulak testified before House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies. The following is the testimony presented by ASTS.

Introduction

Chairman Regula, Ranking Member Obey, and distinguished members of the subcommittee, thank you for the opportunity to testify on behalf of the American Society of Transplant Surgeons (ASTS).

My name is James A. Schulak, MD. I am Chief of Transplant Surgery at the University Hospitals of Cleveland as well as the Chairman of the Department of Surgery. I also serve as President of the American Society of Transplant Surgeons, an organization comprised primarily of transplant surgeons dedicated to promoting and encouraging education and research with respect to organ and tissue transplantation so as to save lives and enhance the quality of life of patients with end stage organ failure.

With respect to FY 2003 appropriations, our Society has two primary goals. The first is to support and enhance funding for the Division of Transplantation (DoT) within the Health Resources and Services Administration (HRSA) in order to increase the number of organ donors in this country through public information campaigns and other methods. Every individual who needs an organ transplant should be able to receive one in a timely manner and, as a nation, we are not close to achieving this goal. Second, we support a robust funding increase for the National Institutes of Health in order to improve the success of transplantation through medical techniques and technologies.

Background

Mr. Chairman, as you well know, one of the most pressing problems in the field of organ transplantation is the lack of available organ donors which creates long waiting lists of potential candidates for organ transplants. The Bush Administration is providing strong leadership in this area and we are very grateful to this subcommittee for including $20 million for the DoT in FY 2002, a 33% increase over what was appropriated for Fiscal Year 2001. Along with a concerted effort in the transplant community and with the private sector, we are starting to turn the corner on this national problem, but there is much more progress to be made.

ASTS is very encouraged by the Bush administration’s support for increased organ donation activities. In April 2001, Secretary of Health and Human Services Tommy Thompson announced a five-point initiative to encourage organ, tissue, marrow, and blood donations. As the Secretary eloquently described his passion for increased organ donation, he stated, “The good Lord doesn’t want your organs in heaven; he wants your soul.”

The five initiatives include the Workplace Partnership for Life, which has formed partnerships with over 1,100 employers to raise organ donation awareness among their employees. The Model Donor Card is a new model organ and tissue donor card that includes provisions for indicating whether all of designated organs and tissues may be donated. A National Forum on Donor Registries was held last November to create guidelines to assist in development and ongoing operation of donor registries. The creation of a National Gift of Life Medal is supported by Secretary Thompson to acknowledge America’s donors. And, in February, experts from HHS convened to review existing organ and tissue donation curricula in driver’s education and appropriate secondary school classes to make recommendations for the development of a model organ and tissue donation curriculum.
for high school students. Also part of HHS’s initiative is to allow all HHS employees to specify on their ID cards an option to be an organ donor. Secretary Thompson has said he plans to work with the Office of Personnel Management to encourage other Federal agencies to take HHS’s lead in this area.

Mr. Chairman, one year after the HHS initiative began, Secretary Thompson announced last week very encouraging statistics on the increase in organ donations. In 2001, 12,522 people were organ donors, compared to 11,711 in the year 2000. This is a 7% increase, a major improvement that demonstrates how effective a concerted effort can be to address an intractable problem. Even more encouraging is the living organ donor program where persons can donate a kidney or a portion of their liver or lungs. There were 6,445 live organ donors in 2001, a 12.5% increase over this number in 2000.

These are encouraging statistics and it is ASTS’s belief that because of the subcommittee’s FY 2002 appropriation and Secretary Thompson’s commitment to organ donation, much progress has been made in the access to and the advancement of transplantation. But these statistics belie the fact that more than 6,000 people die unnecessarily each year because they did not receive the organ they needed. Currently, sixteen people die every day waiting for a donated organ—that is one death every 91 minutes. In 2001, 24,017 organ transplants were performed, yet 79,585 people were registered on the waiting list to receive an organ. Unfortunately, this gap has been widening. In the past ten years, the number of registrations on the waiting list quadrupled. In 1990, the difference between the number of organs donated and the number of patients waiting for organs was 9,000. Today it is over 55,000.

Mr. Chairman, there are many strategies to combat this problem, some more controversial than others. More often than not, simple awareness of patients and their families about the facts of organ donation can make the difference between life and death. Studies have shown that over 95% of families would consent to organ donation if they knew it was the wish of their loved one. As the increase in organ donation over the past year has shown, education and awareness can be an effective tool in saving the lives of patients needing transplants. Consequently, the ASTS strongly favors initiatives that foster education efforts particularly for the young.

We must also make live organ donation easier for potential donors by eliminating financial disincentives to donate. We must also study ways to provide incentives for cadaveric donation that do not conflict with ethical norms or legal restrictions. Greater progress can be made in organ donor coordination and we encourage additional funding in this area to not only study the most effective strategies but also to assist in implementing coordination activities. Of course, there is tremendous potential in the area of medical research to maximize live organ donation as well as to increase the successful transplantation of organs from sub-optimal donors that are now being discarded.

The commitment of federal resources to address the nationwide shortage of donated organs is essential to both increase the success rate in organ transplantation and increase the number of organ donors available. I would now like to discuss several major initiatives that ASTS believes will bring us closer to achieving these goals.

Health Resources and Services Administration

HRSA administers the Division of Transplantation, which is the locus of federal programmatic activity affecting the field of transplantation. The DoT’s primary function is to provide federal oversight of the nation’s organ procurement, allocation, and trans-
ASTS would like to stress to the subcommittee the importance of continued funding for clinically-relevant surgical research.

plantation system, known as the Organ Procurement and Transplantation Network (OPTN). Since 1986, DoT has administered a contract with the United Network for Organ Sharing (UNOS) to operate the OPTN.

DoT also administers a contract with the University Renal Research and Education Association (URREA) to maintain the Scientific Registry of Transplant Recipients (SRTR). The SRTR contractor analyzes information collected by the OPTN and publishes the results to guide development and revision of organ procurement, allocation, and transplantation policies. Finally, DoT administers the National Marrow Donor Program (NMDP), a nonprofit organization headquartered in Minneapolis, Minnesota, which operates the National Bone Marrow Registry.

In addition to providing federal oversight of these organ and tissue allocation programs, DoT also supports public education to increase the rate of organ and tissue donation and manages a grant program to evaluate donation-enhancing activities. ASTS believes that these programs are of critical importance and strongly supports increased initiatives in this direction. After all, the decision to donate is a personal one that clearly can be influenced by one’s knowledge and perception of transplantation.

DoT currently conducts public and professional education initiatives to improve awareness of organ and tissue transplantation in order to take the mystery out of organ donation, and thereby increase the rate of donation in the United States. DoT also conducts a variety of activities such as workshops, national conferences, exhibits, seminars, and special events to inform the public at large about the critical need for organ and tissue donors. Endeavors such as these must be expanded and fully supported, particularly as they pertain to young Americans. DoT further plays an important role by working with private organizations such as ASTS and other national transplant-related societies and associations to maximize a wide range of private efforts on organ transplantation and donation issues.

Mr. Chairman, DoT will need additional funding in order to have the maximum impact on increasing organ donation in this country. The president’s current FY 2003 budget proposal calls for an increase of $5,000,000 above the FY 2002 level, for a total appropriation of $25 million. While we are grateful to the administration for its continued commitment to the DoT and its responsibilities, ASTS encourages the subcommittee to increase the FY 2003 funding level to $30 million. This increase is commensurate with the enormity of the challenge that DoT faces in meaningfully increasing organ donor rates and represents money very well spent. As Secretary Thompson’s recent announcement demonstrates, additional dollars spent on efforts to increase organ donor rates translates into additional lives saved.

While additional spending on public awareness, grants for organ coordinators, grants for studies to eliminate disincentives to organ donation, and other programs is critical, ASTS also supports changes in public policies to encourage donation. Last year, ASTS worked with a number of transplant-related organizations to craft a set of organ donation proposals for Secretary Thompson’s consideration, and ultimately for the consideration of Congress.

These proposals range from payment of travel and subsistence expenses for living organ donors and making leave time available to private-sector employees to become a live organ donor, to the enactment of a federal law to honor a donor’s consent to donate his or her organs based on the existence of an organ donor card or other credible evidence of intent to
donate one’s organs, regardless of familial objections. With these policy proposals and the programs funded by Congress through the DoT, we, as a nation, have it within our grasp to significantly reduce organ donor waiting lists within the next several years.

**National Institutes of Health**

ASTS supports this subcommittee’s as well as the Bush administration’s commitment to the five-year effort to double the National Institutes of Health (NIH) budget. We, therefore, recommend a 16% increase for NIH for FY 2003, bringing the total NIH budget to $27.3 billion. These additional funds should be used by the appropriate institutes to aggressively pursue research on organ transplantation to maximize success rates and explore new and emerging science in the transplant field, particularly in the area of transplant surgery.

The NIH is comprised of several institutes that conduct research on organ transplantation and related surgical research issues. The National Heart, Lung, and Blood Institute (NHLBI) conducts research on heart and lung transplants. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) funds research on pancreas, liver, and kidney transplantation.

The National Institute of Allergy and Infectious Diseases (NIAID) also conducts research designed to increase the success rates of organ transplantation. NIAID focuses on preventing graft rejection, developing more effective treatment interventions to treat graft rejection once it occurs, identifying and developing ways to overcome the biological barriers to transplantation that place certain groups of patients at a disadvantage, and supporting clinical trials and studies that evaluate new therapies. The additional resources proposed for the NIH in the administration’s budget will continue to build the scientific knowledge base of organ transplantation and related surgical research and we encourage the subcommittee to fund NIH at the President’s request.

The ASTS is concerned, however, that future NIH funding may not be directed toward transplant translational research, a field of investigation that was largely developed in surgical laboratories. Such clinically applicable research has impacted directly on the wellness of transplant recipients, leading to improved transplant outcomes and significant financial savings. As NIH contemplates a reorganization of its study sections, ASTS would like to stress to the subcommittee the importance of continued funding for clinically-relevant surgical research and we look forward to partnering with NIH to achieve this mission.

**ASTS and NIH Partnership**

One area of transplantation that holds significant promise is living donor liver transplantation. ASTS has taken a leadership role in assessing the emerging practice. The ASTS has joined with several transplant-related organizations to participate in the Live Organ Donor Consensus Group in 2000 and has issued its own guidelines regarding this type of transplantation. The 2000 group was tasked with recommending practice guidelines for transplant physicians, primary care providers, health care planners, and others who are concerned about the well being of live organ donors. For the subcommittee’s information, the group reached the following conclusion concerning live organ donation:

“The person who gives consent to be a live organ donor should be competent, willing to donate, free from coercion, medically and psychosocially suitable, fully informed of the risks and benefits as a donor, and fully informed of the risks, benefits, and alternative treatment available to the recipient. The benefits to both donor and recipient must outweigh the risks associated with the donation and transplantation of the living donor organ.”

Since a growing number of liver transplants are made possible by living donors who must contribute between 20% and 60% of their livers for a successful transplant, ASTS has proposed a collaboration with the NIDDK on an upcoming study of living donor liver transplantation. ASTS has proposed to contribute up to $300,000 per year for the duration of the study, which should amount to between $1.5 and 2.1 million over the five to seven year duration of the study. The funds will be used to recruit additional research centers to assist in answering a host of scientific and clinical transplantation questions, aimed at making this “gift of life” not only more successful but more importantly, safer for the donor.

**Conclusion**

Thank your, Mr. Chairman, for the opportunity to present the views of the ASTS before the subcommittee. Please do not hesitate to contact me in the future if I can be of any further assistance. Thank you.
On April 30, 2002, the Centers for Medicare and Medicaid Services (CMS) posted on its website a Decision Memorandum reconfirming its policy of denying coverage of liver transplantation for patients with malignancies other than hepatocellular carcinoma (HCC). The Decision Memorandum is the culmination of a process that began over a year ago, when CMS (then the Health Care Financing Administration) first determined that it did not possess sufficient internal expertise to fully or fairly review liver transplantation for malignancies other than HCC.

In its Decision Memorandum, CMS found that, generally, most of the available literature consists of individual case studies or very small case series and that there were no cohort studies comparing liver transplantation to other treatment options for any non-HCC malignancy. According to CMS, a search of the literature did not produce a significant volume of literature, or literature of sufficiently sound methodology, to permit a positive coverage determination. Based on the evidence that was available, CMS concluded that liver transplantation for non-HCC malignancy results in higher mortality than transplantation for other diagnoses; that the transplants do not appear to be curative in the majority of the cases since, in over half of recipients, the disease recurs; and that there has been a significant decline in the number of transplants performed for non-HCC malignant disease in the United States. Based primarily on these findings, coverage was denied.

The observation that the number of transplants performed for non-HCC malignant disease has declined is hardly surprising in light of Medicare’s prior decision not to extend coverage for these procedures; in fact, in light of the costs involved and the lack of insurance coverage, it would be quite startling if there had not been a decline in the number of transplants performed for non-HCC malignant disease. And therein lies the proverbial chicken-and-egg dilemma for those seeking coverage for new medical technologies and procedures: Without coverage, it is unlikely that costly procedures will be performed; and without strong evidence of clinical efficacy, coverage is denied.

This article will explore the process used by one extraordinarily influential third party payer—Medicare, in making coverage decisions. Since other payers often follow Medicare’s lead—Medicare coverage decisions often indirectly affect coverage for services provided to non-Medicare patients.

The Medicare Coverage Process

The statutory authority for the entire Medicare coverage process is a seemingly simple requirement that, in order to be covered, the expenses incurred for items or services must be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” From this ostensibly straightforward requirement, a complex, confusing and often achingly contrived bureaucratic process has emerged.

Incredibly, there are no regulations setting forth the criteria to be used by the Medicare Program in making coverage decisions. Efforts to publish such regulations have been complicated by controversy over whether, and to what extent, cost/benefit analysis should be used in determining whether a new technology or service is eligible for coverage. Due to the lack of national regulations, Medicare coverage determinations are most often made on the local level, by individual Medicare contractors, using informal and often indeterminable standards. The decisions made by the various contractors often are not consistent with one another, and various contractors may impose different conditions for coverage and provide different levels of payment for the same procedure.

But while the process of obtaining positive local coverage decisions can be frustrating, it does provide the opportunity to obtain coverage in the initial stages of the development of a new procedure or technology—when the clinical evidence is insufficient to support the issuance of a positive national coverage determination. In this regard, it is often crucial to avoid a national coverage determination before a new technology or procedure is ready for “prime time”: an adverse national determination can eliminate
the possibility of obtaining coverage at the local level.

CMS will initiate its review process for making a national coverage decision when it identifies issues internally that it wishes to consider for a national coverage decision or when it receives a formal request to review an issue and make a national coverage decision. For example, this may occur if:

- There are conflicting carrier or intermediary policies.
- The service represents a significant medical advance, and no similar service is currently covered under Medicare.
- The service is the subject of substantial controversy among medical experts as to its medical effectiveness.
- The service is currently covered, but is widely considered ineffective or obsolete.
- There are program integrity issues surrounding significant underutilization or overutilization of the service.

CMS also may issue a national coverage determination based on a formal written request, which must include supporting documentation specified by CMS.

Once CMS has determined that it would be appropriate to review the issue involved, it may take any one of a number of actions. Specifically, after conducting its own internal review, CMS may issue a national noncoverage decision (which precludes contractors from making Medicare payment); may decide not to issue a coverage decision, thus continuing to allow for local contractor discretion; or may issue a blanket or limited coverage decision. Increasingly, however, CMS is referring such issues to the Agency for Healthcare Research and Quality (AHRQ) or another contractor for an independent technology assessment or to the Medicare Coverage Advisory Committee (MCAC) for consideration.

Most national coverage issues do not get resolved quickly—in fact, the time for issuance of a national coverage decision is often over a year, and may be significantly longer, especially when an independent technology assessment is requested. This is particularly true if a decision is referred to the MCAC or for an independent assessment. A decision may be reviewed by the MCAC if it is the subject of significant scientific or medical controversy; if it has the potential to have a major impact on the Medicare program; or if it is subject to broad public controversy.

During CMS’s or the MCAC’s review of a request, it may find that it will require a technology assessment to complete a review. Generally, a technology assessment provides a systematic analysis of the safety, efficacy, and effectiveness of a health care technology. CMS may decide to request a technology assessment if there is sufficient medical and scientific literature available to provide a basis for an assessment, and the complexity of the subject and/or complexity of the issue exceed CMS staff’s expertise or capability, or if a key element of the assessment process is the need for the assessor to be impartial. (For example, this process was followed by CMS in making its coverage determination with respect to transplants performed for malignancies other than HCC.)

Before CMS issues a national coverage decision, it will announce its intention to do so, in the form of a Decision Memorandum. The Decision Memorandum will announce CMS’s intention to make a national coverage decision and may contain remarks regarding the level and content of evidence presented and reviewed. Moreover, if significant, CMS will include the conclusions and recommendations of any independent technology assessments or any MCAC recommendations received. The Decision Memorandum may set forth any other factors that had a major influence on CMS’s decision, and will contain the rationale for the decision made. If CMS announces its intention to not cover or to reduce coverage of a service, the Decision Memorandum will include the reasons for noncoverage and identify the information needed for a different coverage decision.

The Decision Memorandum will not be effective immediately, but will become effective on the date specified in a national coverage decision issued within 60 calendar days of forwarding the Decision Memorandum to the requestor and posting the Memorandum on the CMS Home Page. Generally, payment changes will
be effective within 180 calendar days of the first day of the next full calendar quarter that follows the date the national coverage decision is issued.

If CMS makes a decision to cover an item or service, numerous complex and related steps remain before a payment change is made. Determinations will be made on which codes the providers, suppliers, and contractors will use for submission and payment of claims consistent with the coverage decision and appropriate instructions will be issued. CMS must also determine the appropriate Medicare payment level. There have been cases in which the six month anniversary of a National Coverage Determination has passed without implementation of the necessary payment rules.

**Medicare Coverage for Transplants**

Medicare covers at least five types of transplants under certain conditions: kidney, liver, heart, lung, and pancreas. The reimbursement scheme is essentially the same for all them, with the exception of kidney transplants, which are discussed separately below.

**Liver, Heart, Lung and Pancreas Transplants**

As discussed above, the Social Security Act prohibits Medicare reimbursement for items or services that are not “reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Based upon this provision, CMS refuses to cover medical and health care services unless they are proven safe and effective by clinical evidence. Not surprisingly, then, Medicare coverage policies for transplants and related services have evolved as medical technology has progressed—albeit at a significantly slower pace. In fact, the history of Medicare coverage for transplant services illustrates the uneven course followed by the Medicare Program when the Program is confronted with the need to make decisions regarding highly complex—and relatively costly—advances in medical technology.

Heart transplants were the first to gain Medicare coverage. In November 1979, CMS issued an interim decision announcing that Medicare would cover heart transplants performed at Stanford University Medical Center. CMS subsequently excluded heart transplants from Medicare coverage because it needed further data on safety and effectiveness. However, after engaging in a broad study of heart transplants in cooperation with the Public Health Service (PHS), CMS decided to rescind its earlier decision and to extend Medicare coverage to heart transplants.

CMS extended Medicare coverage to adult liver transplants in 1991. Although a 1983 study had found that such transplants were experimental in adults, the HHS Task Force on Organ Transplantation issued a 1986 report recommended coverage for adult liver transplants, and, as a result, CMS asked the PHS to review the scientific evidence regarding safety and effectiveness. The PHS ultimately found that orthotopic adult liver transplantation is safe and effective when performed in an approved facility for patients with certain conditions.

Four years later, CMS stated its national coverage policy regarding lung and heart-lung transplantation. The notice announcing the policy explained that, in the absence of a definitive decision from CMS, contractors that process Medicare claims had developed their own policies regarding coverage of lung transplants. While some contractors allowed such claims, other did not cover the procedure at all. After reviewing the results of a 1991 study conducted by the Public Health Service and additional data reported by the PHS in 1993, CMS decided to cover lung and heart-lung transplants under certain circumstances, if conducted in an approved facility.

Although the Medicare program historically excluded pancreas transplants from coverage because the procedure had not been proven safe and effective, CMS changed its position after reviewing the results of an assessment conducted by the Office of Health Technology Assessment in 1994. On April 1, 1999, CMS issued Transmittal No. 115, which announced limited coverage of pancreas transplants on or after July 1, 1999 in a licensed facility. Coverage extends only to whole organ transplantation if performed simultaneously with or after a kidney transplant. It is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. It occasionally is performed on patients with labile diabetes and hypoglycemic unawareness. Diabetic patients who have not experienced end-stage renal failure secondary to diabetes cannot qualify for coverage.

Medicare will cover heart, liver, and lung transplants only if performed in facilities that meet certain criteria specified by CMS. Put another way, CMS certifies facilities, rather than surgeons, to perform transplants, and, therefore, Medicare will reimburse a transplant surgeon for transplant services only if he or she practices in an approved facility.

The criteria take into account patient selection, patient management, commitment to the transplant program, facility plans, experience, survival rates, maintenance of required data, organ procurement activities, laboratory services, and billing practices. Until recently, CMS required a facility to perform transplants for two years before applying for Medicare approval, but the waiting period was recently reduced to only one year, if the facility meets a minimum volume.

One factor prompting CMS to make this change was the fact that transplant surgeons and physicians often change the facilities in which they practice. Transplant teams moving from approved to unapproved facilities complained that they should
Under these circumstances, unless the Medicare program undertakes serious regulatory reform in the near future, Congressional intervention may prove inevitable.

not have to sacrifice Medicare reimbursement, considering that they already had considerable experience performing transplants. Although CMS declined to support the concept of approving transplant teams, rather than facilities, it nevertheless decided that volume was a “more accurate predictor of successful outcomes than minimum experience” and reduced the waiting period, as explained above. CMS acknowledged that it will sacrifice some accuracy in survival rates but noted its intention to propose regulations providing for periodic reevaluation of transplant centers for Medicare approval and to remove approval for centers, pursuant to these regulations, if they fail to meet survival criteria.

Physician services related to heart, liver, and lung transplants, as well as nonhospital services and pre- and post-transplant care, are covered under Part B apart from the global surgical package. Those services are as follows:

- the initial consultation or evaluation by the surgeon to determine whether surgery is necessary;
- services of other physicians, in most circumstances;
- visits unrelated to the diagnosis for which the surgery is performed, unless due to complications;
- treatment for the underlying condition or an added course of treatment that is not part of routine recovery;
- diagnostic tests and procedures;
- clearly distinct surgical procedures after the surgery that are not reoperations or treatment for complications;
- treatment for postoperative complications that require a return to the operating room;
- a second, more extensive procedure, if the first procedure fails;
- a surgical tray, in some circumstances;
- immunosuppressive therapy for organ transplants; and
- some critical care services.

If a physician can provide sufficient documentation, he or she may bill separately for unrelated evaluation and management services provided during the postoperative period. The Medicare Carriers Manual specifically states that immunotherapy management furnished by a transplant surgeon after discharge may qualify as such an exception.

Kidney Transplants

CMS has created a completely separate scheme for reimbursing the costs related to kidney transplants covered by the Medicare program. Facilities that perform kidney transplants also must have CMS’s approval in order to seek Medicare reimbursement for such services, and the requirements for such facilities are set forth in the regulations. A “renal transplantation center” (RTC) is defined as a hospital unit approved to furnish directly transplantation and other medical and surgical specialty services required for the care of ESRD transplant patients. Among other things, a RTC must operate under the general supervision of a qualified transplantation surgeon or a qualified physician-director. A qualified transplant surgeon is one who is board eligible or board certified in general surgery or urology by a professional board and has at least 12 months training or experience in the performance of renal transplantation and the care of patients with renal transplants.

The regulations also set forth the procedures for payment of physician services related to renal transplantation. Transplant surgeons who assume primary responsibility for the patient’s postoperative surgical care for 60 days or both the postoperative surgical care and the related course of immunosuppressive therapy for 60 days are eligible for a comprehensive payment. The payment is subject to the deductible and coinsurance provisions and covers all surgical services furnished during a period of 60 days in connection with a renal transplant. The payment may include additional sums to cover other surgery performed concurrently with the transplant.

The comprehensive payment may not exceed the lower of actual charges or overall national payment levels.
established under the ESRD program and adjusted to give effect to nationwide variations (i.e., the maximum allowance in a carrier’s service area for renal transplantation surgery and related services by surgeons). The carrier adjusts payment amounts annually to account for inflation.

Coverage for Services Provided to Patients Enrolled in Clinical Trials

On September 19, 2000, CMS issued a final National Coverage Decision (NCD) clarifying Medicare coverage of the routine health care costs of beneficiaries in qualifying clinical trials. The NCD was issued in response to a June 7, 2000 Executive Memorandum that was intended to increase the participation of Medicare patients in clinical trials.

The NCD unfortunately has not produced uniform coverage rules for clinical trials; in fact, clinical trials involving new medical devices are not subject to the NCD. Even more importantly, however, the mechanism for implementing the process outlined in the NCD has not been finalized. The NCD, which applies to items and services furnished in qualifying trials on or after September 19, 2000, states that Medicare will cover the “routine costs” of “qualifying clinical trials” as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. A “Qualifying Clinical Trial” must have certain “desirable characteristics” or be “deemed” to have the required characteristics. However, the NCD contemplates that a multi-agency federal panel will develop qualifying criteria that will indicate a strong probability that a trial meets the required desirable characteristics, and clinical trials that meet the qualifying criteria will receive Medicare coverage of routine costs after the trial’s principal investigator certifies that the trial meets the criteria and enrolls the trial in a Medicare clinical trials registry which is currently under development. Thus there is currently no mechanism for certification, and items and services provided in trials that are not “deemed” to be qualified are eligible for coverage only if they would qualify under the pre-NCD rules for reimbursement or the existing regulations for reimbursement of investigational devices.

There are a number of other Medicare coverage rules that should be kept in mind with respect to research. Medicare coverage is not available if research sponsors or other parties have provided funding specifically for those items and services. Medicare Provider Reimbursement Manual, Section 504.1; Medicare Intermediary Manual, Section 3153.3; Medicare Carrier’s Manual, Section 2309.4. Unfortunately, sponsors often provide unspecified commercial support for research. In these cases, it is unclear whether the sponsor has paid for services otherwise covered by Medicare. To ensure appropriate insurance billing, the sponsor should specify any patient care costs that are intended to be covered by the grant or award.

Future Legislation

The lack of timely Medicare coverage for new technological innovations and the lack of any regulatory criteria setting forth the standards to be used in making such decisions have drawn—and continue to draw—Congressional ire. Most recently Senator Bob Graham (D-FL) introduced S.1135, the Medicare Reform Act of 2001, which would move the coverage determination process from within CMS to a presidentially appointed board subject to Senate confirmation. While the prospects for enactment of this legislation are relatively slim, its very introduction signals legislators’ growing frustration with the lack of predictability and reliability of the Medicare coverage process. Under these circumstances, unless the Medicare program undertakes serious regulatory reform in the near future, Congressional intervention may prove inevitable.

Prepared by:
Diane Millman, Esq.
Powers, Pyles, Sutter and Verville

1 The term “routine costs” includes items or services that are typically provided absent a clinical trial and well as those required solely for the provision of the investigational item or service, as well as clinically appropriate monitoring of the effects of the investigational item or service and those necessary for the diagnosis and treatment of complications. “Routine costs” specifically excludes the investigational item or service itself, items and services necessary for data collection; items and services provided by the research sponsor free of charge and those provided solely to determine trial eligibility.

2 Trials funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Department of Defense, the Department of Veterans Affairs, and CMS, trials conducted under an investigational new drug (IND) application reviewed by the FDA, and drug trials that are exempt from having an IND under FDA regulations are “deemed” to have the desirable characteristics.

3 Coverage for medically necessary services furnished in conjunction with clinical trials is determined by the local carriers. Such services may be covered only if the care being offered is generally accepted by the professional medical community for the patient’s condition and has not been expressly excluded by Medicare; the care is not performed for study purposes only; and the item of care is not related to a noncovered investigational procedure or treatment. Under existing rules, Medicare will not reimburse for services furnished in preparation for, at the same time as, or as necessary after for recovery from a non-covered treatment; however it will pay for services necessary to treat a complication. 42 C.F.R. Section 405.207.

4 Coverage for new medical devices depends in part on their categorization by the FDA. Unapproved medical devices on the FDA’s Category “A” list (“Experimental investigational” devices) are not covered, while unapproved medical devices on the FDA’s Category “B” list (“no-experimental/investigational” devices) may be covered.
New Extramural Grant Program
Clinical Interventions to Increase Organ Procurement

The Health Resources and Services Administration (HRSA), Office of Special Programs (OSP), Division of Transplantation (DoT) is pleased to provide notice of the introduction of a new extramural grant program, Clinical Interventions to Increase Organ Procurement, intended to assist organ procurement organizations (OPOs), transplant programs, and other private, non-profit entities to increase organ procurement. The goal of the grant program is to assist eligible entities in the evaluation of, or the implementation and evaluation of, highly promising strategies and approaches that can improve methods for identifying appropriate cadaveric heart beating and non-heart beating donation candidates, evaluating donated organs, maintaining donor stability, and optimizing methods to retrieve the maximum number of organs per donor. Rigorous evaluation protocols to assess outcomes of the intervention must be included as a key element of all proposed projects. Intervention outcomes must be defined as the effectiveness of the intervention in improving organ procurement as defined by an increase in one of the following parameters:

(1) number of organ donors; and,
(2) number of organs (heart, lung, liver, kidney, pancreas, small intestine) procured and transplanted.

Because it is recognized that interventions intended to optimize organ procurement also must be assessed in terms of post-transplant graft survival, a portion of proposed interventions may be dedicated to assessing the interventions' effectiveness in maintaining or improving short-term graft survival rates (e.g. less than 6 months). Projects intended solely to improve graft survival will not be accepted.

This grant program is focused solely on clinical interventions to increase heart-beating and non-heart-beating cadaveric donation. Funds will not be used for other types of projects. Examples of activities that will not be supported under this program are: living donation; clinical trials on drugs not approved by the FDA or off-label uses of FDA-approved drugs; long-term transplantation outcomes research; interventions to increase tissue donation alone; practices related to the pronouncement of death; and interventions inconsistent with Federal law or statute. Projects falling within the scope of DoT’s grant program, “Model Interventions to Increase Donation,” also are not eligible to receive funding under the clinical interventions program.

HRSA anticipates funding approximately 12-20 projects over a 1-3 year period. Funding for each project year is anticipated to be between $200,000 and $450,000. Project awards must be made by September 30, 2002.

A Federal Register notice was published on May 9, 2002 (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2002_register&docid=02-11580-filed.pdf) and a Request for Applications (RFA) has been posted on the federal government’s organ and tissue donation website, www.organdonor.gov. Questions regarding the Clinical Interventions grant program may directed to Laura St. Martin, MD MPH at lstmartin@hrsa.gov or Virginia McBride, RN BS CPTC at vmcbride@hrsa.gov or by calling 301-443-7577.
The following are the recipients of awards presented at the American Society of Transplant Surgeons Awards Presentation on April 30, 2002 at the American Transplant Congress in Washington, DC. Dr. Marc Lorber, President of ASTS and ASTS Awards Committee Chairman, Tom Peters, presented the awards to recipients along with corporate sponsors’ representatives. The awards presented were:

Anthony P. Monaco, MD is the 2002 recipient of the ASTS ROCHE PIONEER AWARD. Dr. Monaco (center) was presented the award by ASTS President Marc Lorber (left) and Robert Gordon of Roche (right).

ASTS ROCHE SURGICAL SCIENTIST AWARDS presented to Michael G. Hughes, Jr., MD (center left) of the University of Virginia who is working on a project regarding hepatitis C infection as it relates to liver transplantation and to Eric L. Marderstein, MD (center right) of the University of Pittsburgh who will study the AP-1 signaling pathway in liver ischemia/reperfusion injury. Dr. Robert Gordon of Roche (left) presented the award with Marc Lorber (right).

FOLKERT BELZER RESEARCH FELLOWSHIP OF THE ASTS AND NKF awarded to Theodore H. Welling, MD (left) of the University of Michigan School of Medicine who will be conducting research in his field of interest, chronic allograft rejection. Dolph Chianchiano (right) was presenter from the NKF with Dr. Lorber.
ASTS-FUJISAWA HEALTHCARE, INC. FACULTY DEVELOPMENT AWARD awarded to Juan L. Contreras, MD (center) of the University of Alabama at Birmingham. Dr. Contreras will conduct his research in pancreatic islet transplantation. Carl Kincaid (right) of Roche presented the award with Dr. Lorber.

ASTS NOVARTIS FELLOWSHIP IN TRANSPLANTATION AWARD was presented to Peter L. Abt, MD (center) of the University of Pennsylvania who will be conducting research in the immune response to tumor in the presence of costimulatory blockade. Jim Harold (right), Vice President, Novartis Transplant and Immunology Specialty Business Unit and Dr. Lorber presented the award.
ASTS 2002 Awards

ASTS COLLABORATIVE SCIENTIST RESEARCH AWARD presented to Charles G. Orosz, PhD (left) of Ohio State University who is doing research on new therapeutic approach for the treatment of experimental chronic allograft rejection. This ASTS award was presented by ASTS President Marc Lorber (right).

ASTS MID-LEVEL FACULTY RESEARCH AWARD presented by Marc Lorber (right) to James F. Markmann, MD, PhD (left) of the University of Pennsylvania who continues his research in pancreatic islet transplantation.

ASTS THORACIC SURGERY FELLOWSHIP presented by Marc Lorber (right) to Michael E. Bowdish, MD (left) of the University of Southern California who is studying mechanisms by which non-MHC alloantibodies induce chronic rejection.
Over 4,000 participants attended the American Transplant Congress held April 27-May 1, 2002 in Washington, DC. This is the joint meeting presented by the American Society of Transplant Surgeons and the American Society of Transplantation. In addition to the clinical and scientific sessions, Senator Bill Frist, a member of ASTS, addressed the general assembly on Tuesday, April 30.
The 3rd Annual ASTS Winter Symposium will be held January 24-26, 2003 at the Eden Roc Resort and Spa, Miami Beach, Florida. The topic for the symposium is “Tumors and Transplantation.”

Members of the organizing committee for the meeting are Sandy Feng, Douglas Hanto, J. Michael DiMaio, Joseph Buell and Ravi Chari.

The deadline for submission of abstracts is September 30, 2002.

The Eden Roc Resort and Spa is located on prime oceanfront property overlooking world-renowned Miami Beach and the spectacular Intracoastal Waterway. The 349-room Eden Roc has been magnificently restored. Ranked one of the top spas in the country, the Eden Roc Spa is the perfect place to restore both body and soul. To visually enhance guests’ workout regime, a glass-enclosed weight complex, with the latest computerized equipment, has floor-to-ceiling windows overlooking the ocean. The private spa area offers a full array of massage therapies and body treatments and resort amenities include two oceanfront pools. You can view the Eden Roc by going to its website at www.edenrocreresort.com

More detailed information and registration materials will appear on the ASTS website at www.astso.org.
3rd ANNUAL WINTER SYMPOSIUM

January 24-26, 2003

TUMORS AND TRANSPLANTATION

Eden Roc Resort & Spa, Miami Beach, Florida

To register

Call 800-314-1921 or www.asts.org

Abstracts will be accepted. Deadline: September 30, 2002
Go to www.asts.org for details
The American Society of Transplant Surgery is establishing a Clinical Trials Bulletin Board for periodic distribution to the membership via Blast e-mail, the Chimera and the ASTS website. The purpose of this bulletin board is to allow investigators to solicit participation from other centers for their clinical trial. It is hoped that this bulletin board will attract enrollment of a sufficient number of patients to statistically power clinical trials.

Interested investigators should submit the following information to the head of the ASTS Scientific Studies Committee, Giacomo Basadonna at email address giacomo.basadonna@yale.edu

1. Title of study.
2. Hypothesis. Limited to 250 words.
3. Endpoints to be studied and length of followup.
4. Contact information for the principal investigator, including name, phone number, fax number, and e-mail address.
5. Period of enrollment.
6. Sponsorship, if any.

The ASTS Scientific Studies Committee will serve as the contact point for interested investigators. This information will then be posted on the ASTS website, and distributed via the Chimera and Blast e-mail. Other centers who are interested in participating in these clinical trials are encouraged to contact the principal investigator to obtain additional information.

It should be noted that posting of studies on the trials bulletin board does not in any way denote support or sponsorship of the principal investigator or clinical trial by the American Society of Transplant Surgeons. In addition, the American Society of Transplant Surgeons does not vouch for the scientific validity, clinical efficacy, and/or any safety issues related to conduct of these clinical trials.
The ASTS Job Board is enhanced further by the addition to the ASTS website, www.asts.org, of CV’s of ASTS Candidate Members. This is in an effort to facilitate the interactions between graduating fellows and transplant programs with junior position openings. To access the CVs go to the www.asts.org, log into the Members Only section and click on Upload/download files.

MULTI-ORGAN TRANSPLANT FELLOWSHIP:
The Beth Israel Deaconess Medical Center, Department of Surgery, Division of Transplantation, and Harvard Medical School are seeking highly motivated individuals for its ASTS-approved transplant fellowship beginning July 2002, 2003, and beyond. The fellowship is a two-year program with training in kidney, pancreas, and liver transplantation and multi-organ cadaver procurement. Training will be provided in laparoscopic living-donor nephrectomy, living-related adult liver transplantation, and dialysis access. Training in islet isolation and clinical islet transplantation is available, but optional for the fellow. Participation in ongoing clinical research projects or translational projects within the Division of Transplantation, Division of Immunology, and Immunobiology Research Center will be supported. Fellows should be board-eligible or board-certified in general surgery. Beth Israel Deaconess Medical Center and Harvard Medical School are Equal Opportunity Employers. Women and minorities are particularly encouraged to apply. Interested individuals should contact: Douglas W. Hanto, MD, PhD, Chief, Division of Transplantation, Department of Surgery, Beth Israel Deaconess Medical Center, 110 Francis Street, Suite 7, Boston, MA 02215 Fax: (617) 632-9820 Phone: (617) 632-9810 e-mail: dhanto@caregroup.harvard.edu

THE CENTER FOR SCIENTIFIC REVIEW (CSR)
At the NIH is expanding and reorganizing its scientific review structure into four Divisions, including a Division of Clinical and Population-based Studies. CSR is seeking a Director for this division with experience and knowledge in clinical research and/or behavioral and social science, who can serve as an effective liaison with these research communities. This is a senior executive level position. For more information, please see ad at http://www.csr.nih.gov/employment, or contact Ms. Pam Sullivan, SullivanP@csr.nih.gov

PROGRAM DIRECTOR OF RENAL TRANSPLANTATION
The University of South Alabama is seeking a Transplant Surgeon or Transplant Urologist to assume the reigns of a rapidly growing kidney transplant program in Mobile, AL. We are a fully staffed program with a dedicated transplant team and excellent inpatient and outpatient facilities. We have performed 75 transplants during our first 3 years of operation and have 200 patients on our waiting list. There are nearly 3000 dialysis patients in our area and the prospects for growth are obvious. Candidates must be able to qualify under UNOS guidelines as the primary transplant surgeon. Responsibilities will include performance of transplants, pre and post transplant care, teaching, and supervision of students and house staff. Interested candidates should send current CV to: Barry Browne, MD, 2451, Fillingim St, 10F, Mobile AL 36617, Phone: 251-471-7542, Fax: 251-471-7020, email: bbrowne@jaguar1.usouthal.edu USA is an affirmative and equal opportunity employer.

THREE POSITIONS AVAILABLE WITH A LARGE PHARMACEUTICAL COMPANY
In the NE area (USA). The Department is Molecular/Cellular Immunology. The positions require PhD, minimum of 3 years post doctoral experience in: T-Cell Immunology (regulation and signaling, human) for position #1; Immunoregulation (human/murine models) for position #2; cell based target validation in human primary immunocyte models for position #3. Contact: Shirley J. Casanas, Mankuta / Gallagher and Associates, 8333 W McNab Road, Suite 231, Ft. Lauderdale, FL 33321. 1-800-797-4276 x 1012 or 954-720-9645, Fax 954-720-5813 scasanasc@mankutagallagheimer.com website: www.mankutagallagher.com
ASTS NEW members

Abdelouahab Aitouche, PhD
University of Miami-Jackson Memorial Hospital

Cristobal G. Alvarado, MD
LifeLink Transplant Institute

Carl L. Backer, MD
Children’s Memorial Hospital

Thomas Bak, MD
University of Colorado
Health Sciences Center

Ramasamy Bakthavatsalam, MS FRCS
University of Washington Medical Center

William C. Chapman, MD
Vanderbilt University Medical Center

Jeffrey T. Cooper, MD
New England Medical Center

Elizabeth A. Davies, MD
The Ohio State University

Rebecca J. Dignan, MD
Vanderbilt University Medical Center

Bijan Eghtesad, MD
University of Pittsburgh School of Medicine

Martin Gasser, MD
University of Wuerzburg
Wuerzburg, Germany

Marshall I. Hertz, MD
University of Minnesota

Zakiyah Kadry, MD
University Hospital Zurich
Zurich, Switzerland

Tatsuo Kawai, MD
Massachusetts General

Keshavjee Shaf, MD
Toronto General Hospital
Toronto Ontario Canada

David M. Levi, MD
University of Miami School of Medicine

JUNE 2002

June 13-15, 2002
THE AMERICAN SOCIETY FOR ARTIFICIAL INTERNAL ORGANS
48TH ANNUAL CONFERENCE
New York, NY
Contact Phone: 561-391-8589
Contact Fax: 561-368-9153
Contact Email: info@asaio.com
Contact Website: www.asaio.com

AUGUST 2002

August 25-30, 2002
XIX INTERNATIONAL CONGRESS OF THE TRANSPLANTATION SOCIETY
Miami, FL
Contact Phone: 514-874-1998
Contact Fax: 514-874-1580
Contact Email: info@TxMiami2002.com
Contact Website: www.txmiami2002.com

JANUARY 2003

January 24-26, 2003
ASTS THIRD ANNUAL WINTER SYMPOSIUM
“Tumors and Transplantation”
Eden Roc Resort and Spa
Miami Beach, Florida
Contact Website: www.asts.org

MAY 2003

May 30 - June 4, 2003
AMERICAN TRANSPLANT CONGRESS
Washington, DC
Contact Phone: 856-439-0880
Contact Fax: 856-439-1972
American Transplant Congress web page
Contract Policy: Only the current President and Treasurer of the American Society of Transplant Surgeons is authorized to sign any contract or enter into any obligation of the Society including those with obligation of Society funds. All such contracts and other forms of obligation are to be submitted to the Society headquarters offices with recommendation from submitting person/committee for approval.