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American Society of Transplant Surgeons®

June 21, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1716-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Hospital Inpatient Prospective Payment Systems for Acute Care and Long-Term Care Hospital Prospective Payment System (Proposed Rule); RIN: 0938-AT73; CMS-1716-P

Dear Administrator Verma:

The American Society of Transplant Surgeons (ASTS) appreciates this opportunity to comment on the CY 2020 proposed Inpatient Prospective Payment (IPPS) rule as published in the May 3, 2019 Federal Register. ASTS is a medical specialty society representing approximately 1,800 professionals dedicated to excellence in transplantation surgery. Our mission is to advance the art and science of transplant surgery through patient care, research, education, and advocacy.

Our comments relate to the MS-DRG assignment of kidney transplant cases. Most kidney transplant procedures (over 11,000 per year) currently are assigned to MS-DRG 652, which has a proposed weight of 3.384 and an average length of stay (LOS) of 5.3 days. For reasons that are unclear, the MS-DRG grouper algorithm currently assigns to other DRGs (MS DRG 981-MS-DRG 983) admissions for kidney transplants that involve recipients who have heart failure and certain other serious cardiac conditions. CMS is proposing to change the grouper algorithm to assign these more severe cases to DRG 264, which describes “other circulatory system OR procedures” and has a proposed weight of 3.2357.

CMS's proposal would reduce reimbursement for kidney transplantation of recipients with serious cardiac conditions to an amount that is an estimated 33% lower than current payment and less than the amount paid for kidney transplantation involving recipients that do not have serious cardiac conditions. It makes no sense that payment for the small number of kidney transplant cases in which the patient has heart failure should be less than all other kidney transplant cases.

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We believe a more reasonable and clinically appropriate solution is to assign these cases to MS-DRG 652, which is specifically for kidney transplants. We note that the length of stay (LOS) for the vast majority of kidney transplant cases involving patients with serious cardiac conditions approximates the LOS for kidney transplant cases generally. Moreover, assigning all kidney transplant cases to the same DRG would facilitate the collection of hospital and transplant center cost data which could then be used to evaluate whether new severity-based kidney transplant MS-DRGs are needed. When kidney transplants are split among different MS-DRG families, this unnecessarily complicates the analysis necessary to determine whether the creation of additional severity-based MS-DRGs would be appropriate. Finally, we believe that assigning kidney transplant cases to the kidney transplant MS-DRG would simplify the process of “backing -out “organ acquisition costs from other hospital charges.

In summary, we urge CMS to modify the grouper program to assign kidney transplant cases currently assigned to MS-DRGs 981 through MS-DRG 983 to MS-DRG 652. We also request that CMS review the grouper logic to ensure that it does not inappropriately assign other cases involving kidney transplantation to miscellaneous OR MS-DRGs, solely because of a transplant patient’s co-morbidities upon admission.

We appreciate the opportunity to comment on this issue. If you have any questions or if we can be of further assistance, please do not hesitate to contact ASTS’ Advocacy Manager, Jennifer Nelson-Dowdy, at Jennifer.Nelson-Dowdy@asts.org.

Sincerely yours,

A handwritten signature in blue ink, appearing to read "L. Ratner", is positioned above the typed name.

Lloyd E. Ratner, MD, MPH
ASTS President