



American Society of Transplant Surgeons

June 1, 2011

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1345-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Berwick:

The American Society of Transplant Surgeons (ASTS) is delighted to have the opportunity to comment on the proposed changes to the inpatient prospective payment system (IPPS) for 2012. The ASTS is comprised of over 1700 transplant surgeons, physicians, scientists, advanced transplant providers and allied health professionals dedicated to excellence in transplant surgery through education and research with respect to all aspects of organ donation and transplantation so as to save lives and enhance the quality of life of patients with end stage organ failure. ASTS has a number of questions and concerns about the IPPS changes proposed for Calendar Year 2012.

### **Comparing Transplant Centers to Other Hospitals**

Our primary concerns relate to implementation of a number of provisions of the Affordable Care Act (ACA). To provide hospitals with an incentive to improve care coordination, the ACA directs CMS to implement a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 to certain hospitals that have excess readmissions for certain selected conditions. CMS is proposing measures for rates of readmissions for three conditions -- acute myocardial infarction (or heart attack), heart failure and pneumonia. CMS also proposes a methodology that would be used to calculate excess readmission rates under the program.

We urge CMS to consider that the standard of care for post-transplant patients includes strong immunosuppressives, and that, as a result, infections (including pneumonia) are not unexpected in this patient population. We urge CMS to take this into account in finalizing the Hospital Readmission Reduction Program, to ensure that transplant centers are not unduly penalized by being compared with hospitals that do not serve this special patient population.

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Along related lines, and also in accordance with the ACA's mandate, CMS is proposing to add a new "claims based" reporting measure to the FY 2014 hospital Inpatient Quality Reporting (IQR) measure set--"Medicare spending per beneficiary." This measure also would be used as one component of the calculation made to determine a hospital's eligibility to receive an incentive payment under the hospital inpatient Value-Based Purchasing (VBP) Program in FY 2014.

For the purposes of both the FY 2014 IQR and the FY 2014 VBP programs, CMS would determine Medicare spending per beneficiary "episode" for each hospital. For these purposes, the "episode" would extend from three days prior to hospitalization through 90 days post discharge, and the expenditures included in the measure would include all Part A and Part B expenditures during this period (with certain relatively minor adjustments)—not just expenditures related to the admission.

For the purpose of the IQR measure set of the FY 2014 VBP programs, it would be inappropriate to compare spending per beneficiary for hospitals that operate transplant centers to spending per beneficiary for hospitals that do not. We urge CMS to exclude transplant patients from this measure or to otherwise adjust the formula such that hospitals that maintain transplant centers are not negatively impacted.

Comparing the readmission rates and post-discharge costs of transplant centers with hospitals that do not maintain transplant programs is especially inappropriate in light of current public policy, which strongly encourages the transplantation of organs from marginal donors. The quality of the organs transplanted contributes significantly to patient outcomes, and impacts both readmissions and post-discharge complications (and therefore post-discharge costs). If transplant surgeons are encouraged to transplant marginal organs, as under current policy, it is especially important to ensure that transplant centers are not penalized by the readmission reduction and VBP programs.

#### **VBP Program: 90-Day Post Discharge Period**

We also urge CMS to reconsider its proposal to include 90 days of post-discharge care in the "Medicare spending per beneficiary" measure, rather than 30 days of post-discharge care. Transplant patients often return to their communities post-discharge, and transplant centers have limited means to influence the care that they receive in distant locations from unaffiliated providers. While transplant centers generally assume responsibility for care for up to 30 days post-discharge, we do not believe that it is realistic to expect transplant centers to assume the responsibility for the cost or quality of care for 90 days post-discharge. It is significant in this regard that transplant centers' contracts with private payers generally provide for global payment for transplantation for up to 30 days post-discharge, not for the longer 90 days post-discharge period proposed by CMS.

#### **Other Concerns**

In addition, we have a number of other concerns. First, we note that the proposed DRG weight for "Heart Tx or Implant of Heart Assist System w/MCC" is almost 9% below the current DRG weight. It is possible that this decline is in some way attributable to CMS' proposal to discontinue the "pass through" for ventricular assist devices, which have been eligible for pass-through treatment as "new technology" under the IPPS; however, we are not in a position to determine whether in fact, this is the reason for the proposed reduction in Medicare payment for this DRG. We urge CMS to further investigate this issue

and to include the results of its analysis in the CY 2012 Final IPPS Rule. If, in fact, the DRG weight for heart transplants with MCC is affected by the inclusion of heart assist system implants in the same DRG, it may be appropriate to bifurcate this DRG in the future.

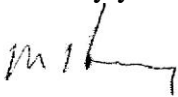
Second, we are concerned about CMS's discussion of services provided by physicians within the three day payment window prior to hospitalization of a Medicare patient. It is our understanding from this discussion that CMS considers both diagnostic and therapeutic services provided within the three day pre-admission window to be included in the DRG weight for the admission. CMS therefore believes that the DRG payment includes most of the practice expenses associated with physicians' services performed in hospital-based clinics during this three day payment window. Accordingly, CMS directs physicians in hospital-based clinics to report these services using the "facility" (i.e. hospital) place of service, which excludes payment for most practice expenses.

It is unclear to us whether the facility costs involved in the provision of services in off-campus hospital-owned clinics during the three day pre-admission window are, in fact, taken into account in determining DRG weights. Moreover, if physicians practicing in a hospital-owned clinic generally bill for their services using a "non-facility" place of service code, it is likely to result in substantial confusion to require them to use a "facility" place of service code for services rendered within the three day payment window-- especially since, for some patients, including transplant patients, hospitalization may be unexpected. This is especially the case for hospital-owned off campus facilities that are not "provider-based."

We urge CMS to enable hospital-owned facilities that are not provider-based to bill for services rendered during the pre-hospitalization "window" using the non-facility site of service codes and to exclude these services from consideration in determining the DRG weight for the hospitalizations involved. Such a methodology prevents double billing for the practice expenses associated with the services rendered during the three day "window" while simplifying billing for hospital-owned clinics that are not "provider-based."

We appreciate the opportunity to comment on the CY 2012 Proposed IPPS Rule. If you have any questions regarding these comments, please do not hesitate to contact ASTS' Washington counsel, Diane Millman at 202-872-6725 or [dmillman@ppsv.com](mailto:dmillman@ppsv.com).

Sincerely yours,

A handwritten signature in black ink, appearing to read "M L Henry".

Mitchell L. Henry, MD  
ASTS President