# Transplant Reimbursement Hot Topics

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Methodist Health System, Dallas location

# Agenda

- Organ Donation Changes and Costs
- Covid-19 Operational and Financial Impact
- Executive Order on Advancing American Kidney Health

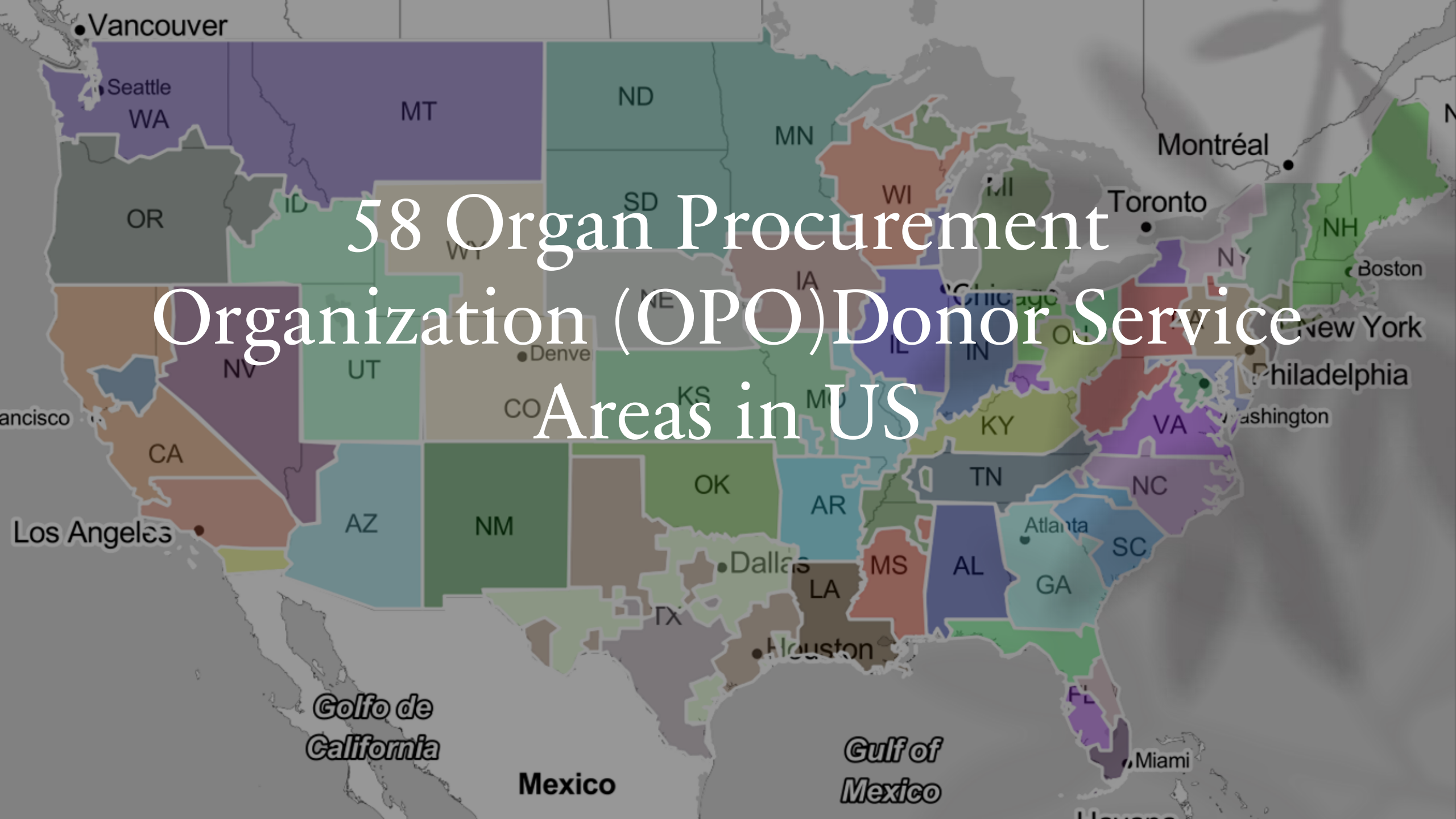
# Organ Donation Changes Impacting Cost

## Allocation in Concentric Circles Distance from Organ Donor Hospital

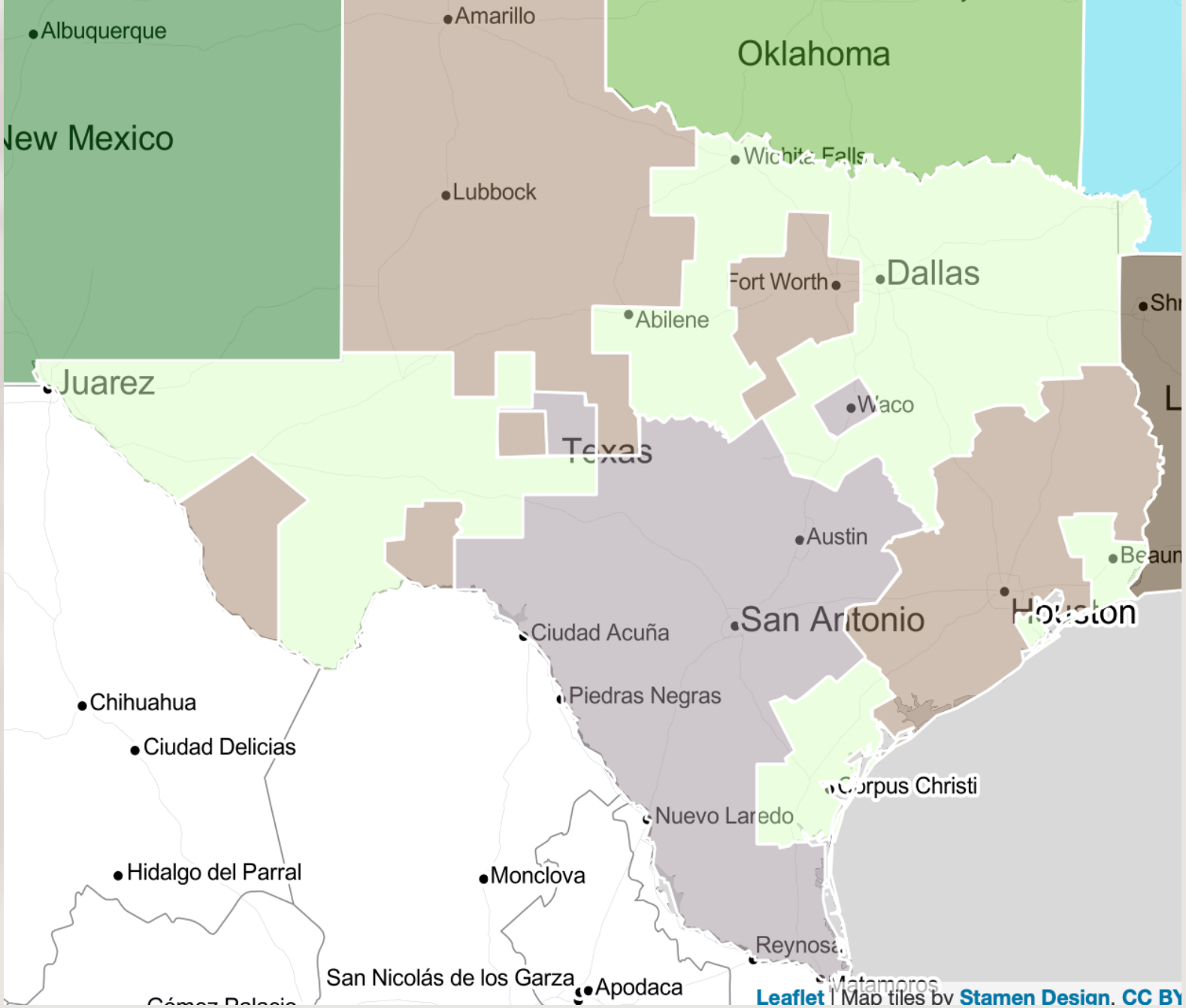
- Increased Sharing of organs over long distances and many different Organ Procurement Service Areas
- Import fees for coordination between OPOs
- Air transportation Costs

## Riverbend Intermediary for OPOs Changing Definitions of Procured Organ Count

- OPO involvement in imports defined as anything more than initial phone contact
- Intended recipient is defined as the recipient the organ procurement is intended for even if no organ is procured



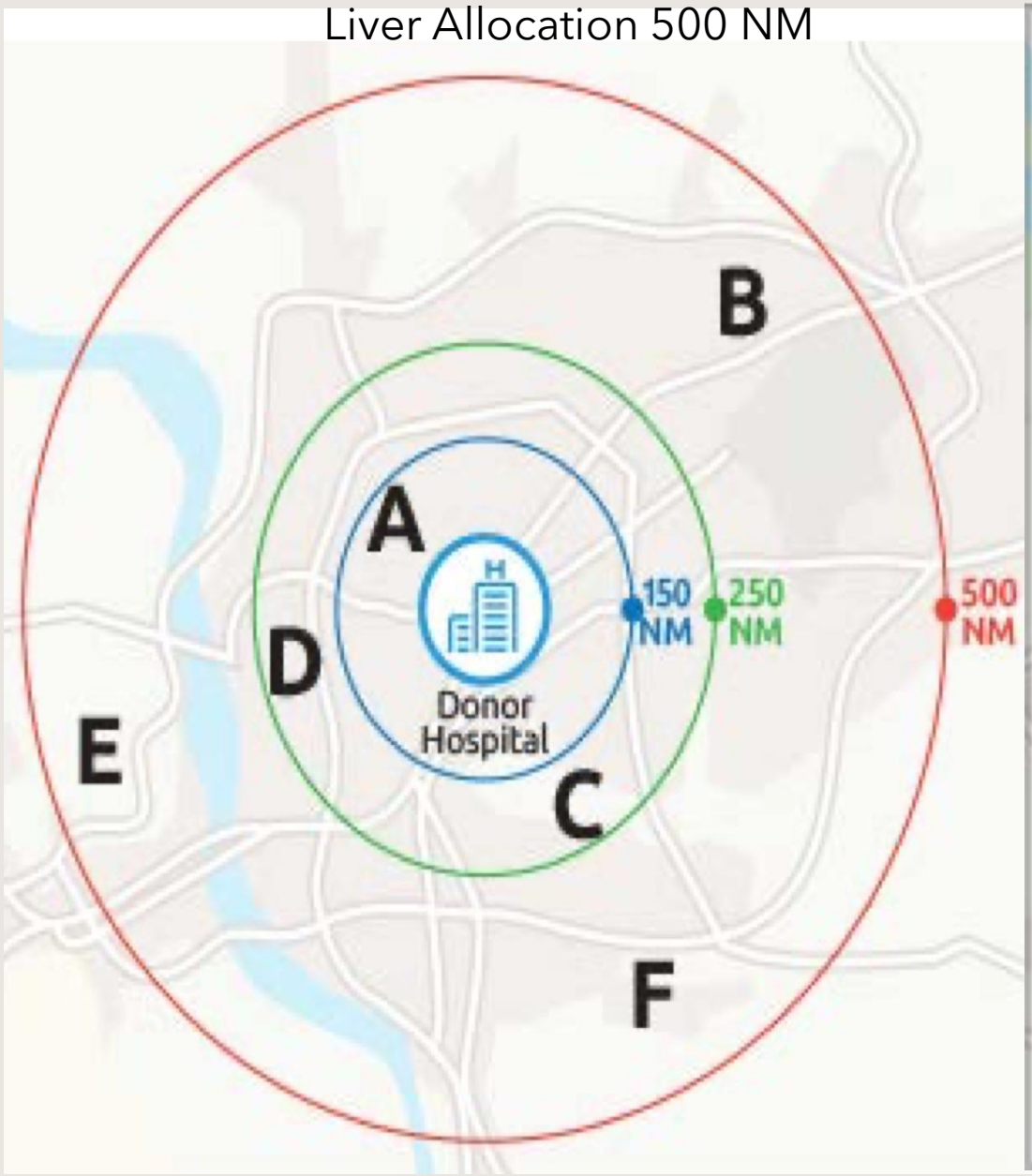

# 58 Organ Procurement Organization (OPO)Donor Service Areas in US

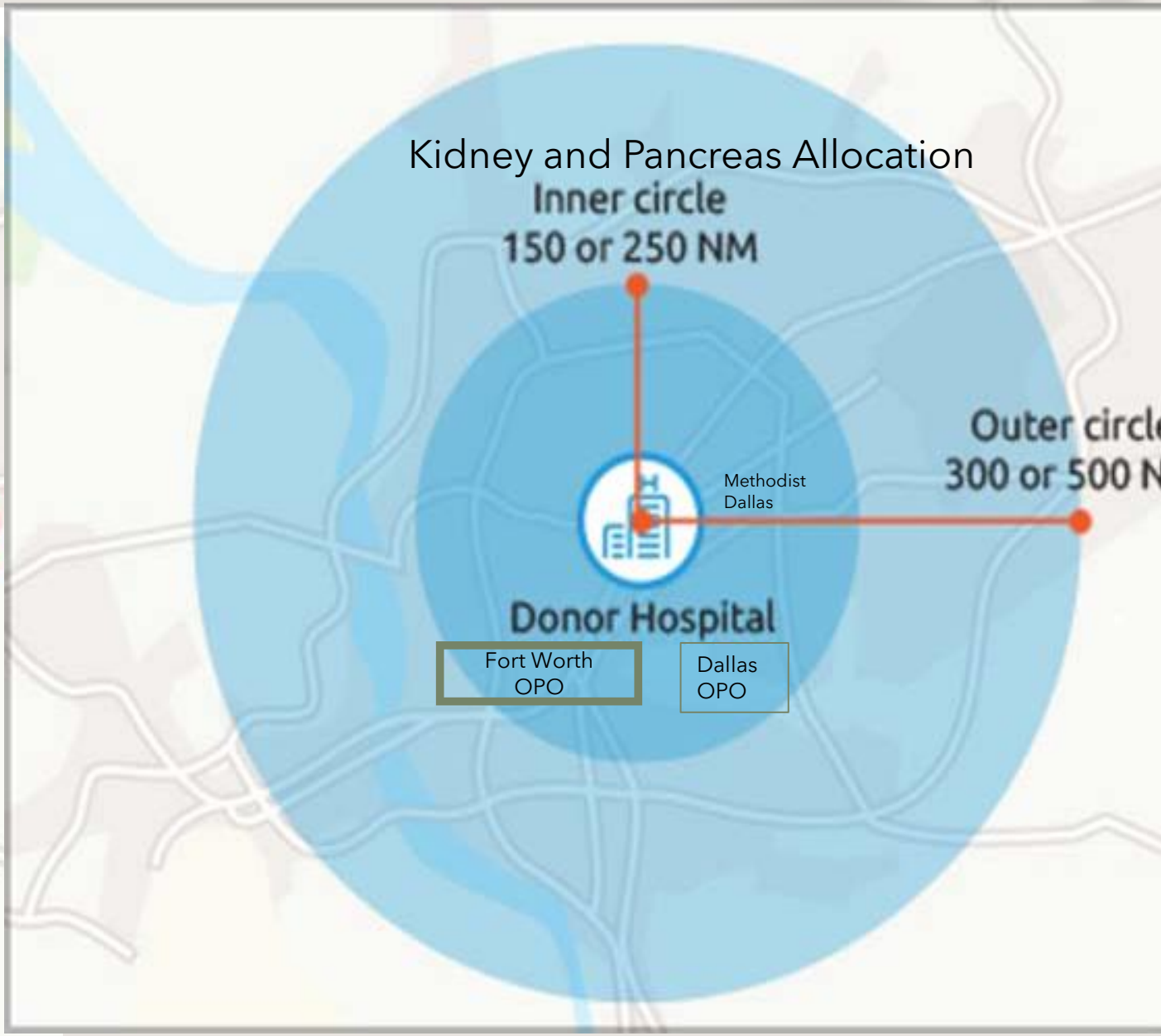



# Texas 3 OPOs

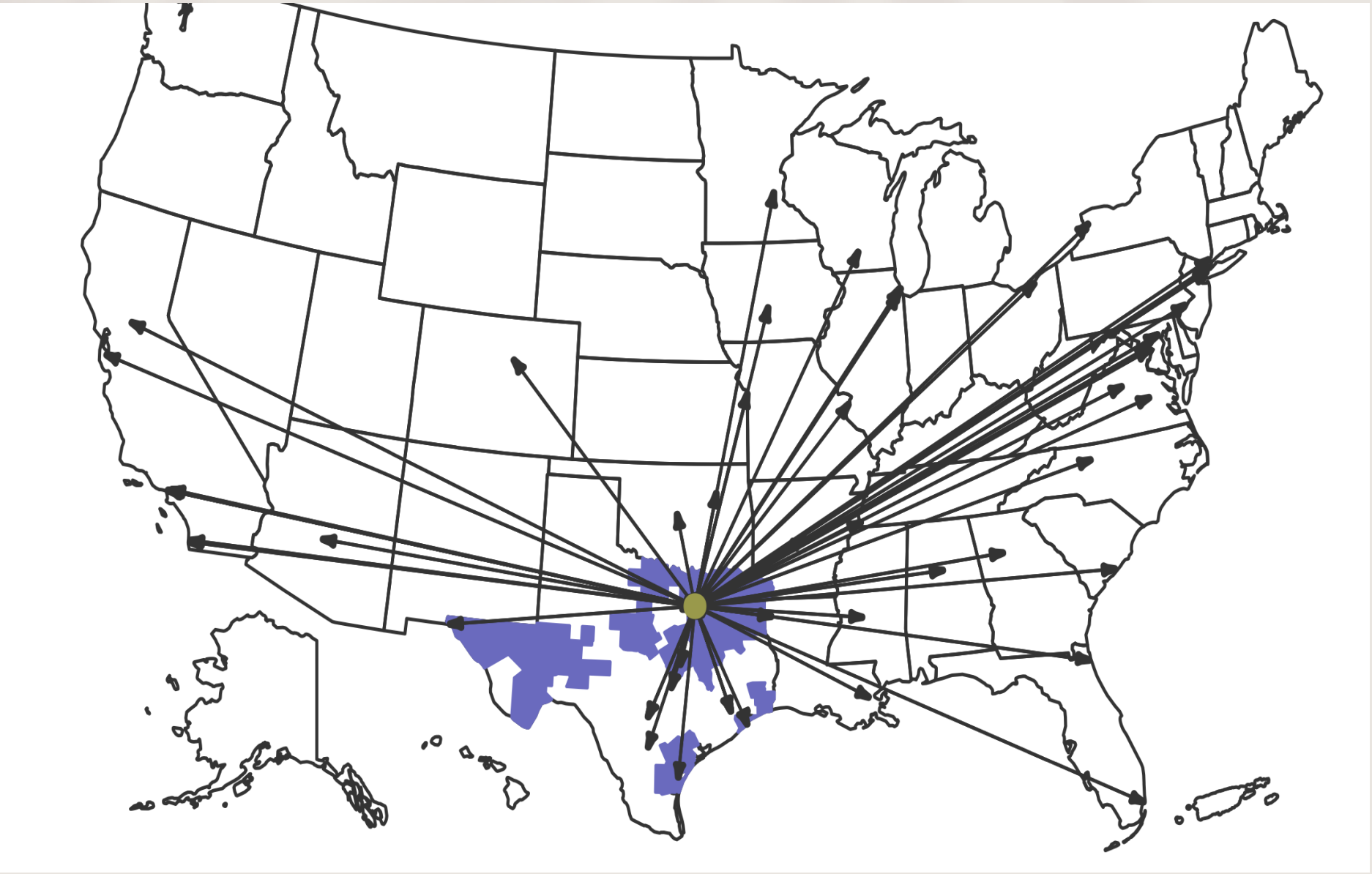
- Dallas in pale yellow
- Houston in tan
- San Antonio in Purple
- Each OPO has import fees
- Example Our OPO is Dallas so if we go to Fort Worth covered by Houston OPO, we pay Dallas OPO an import fee and pay Houston their procurement and transportation fees

Liver Allocation 500 NM



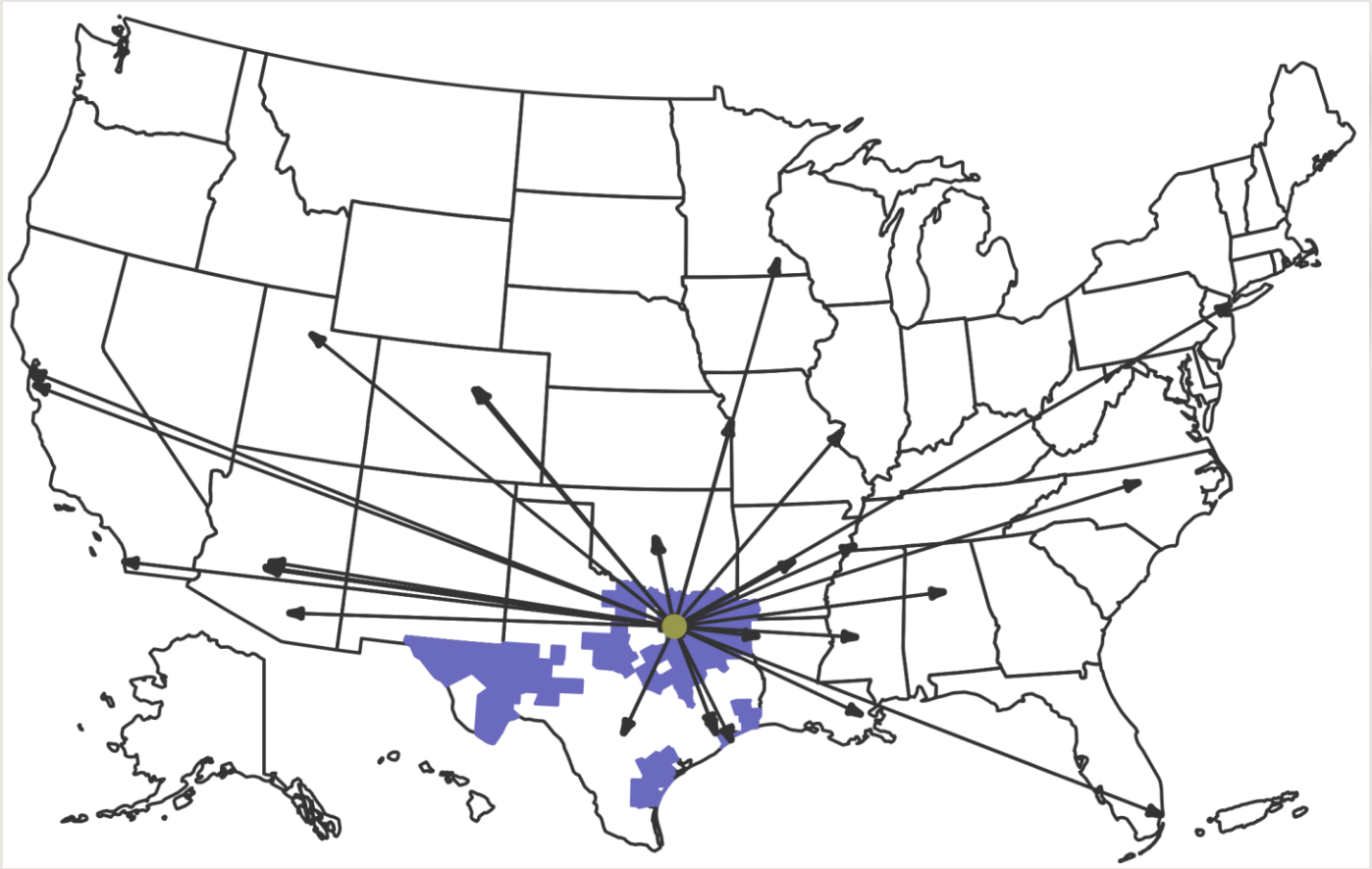




Concentric Circles around Donor Hospital

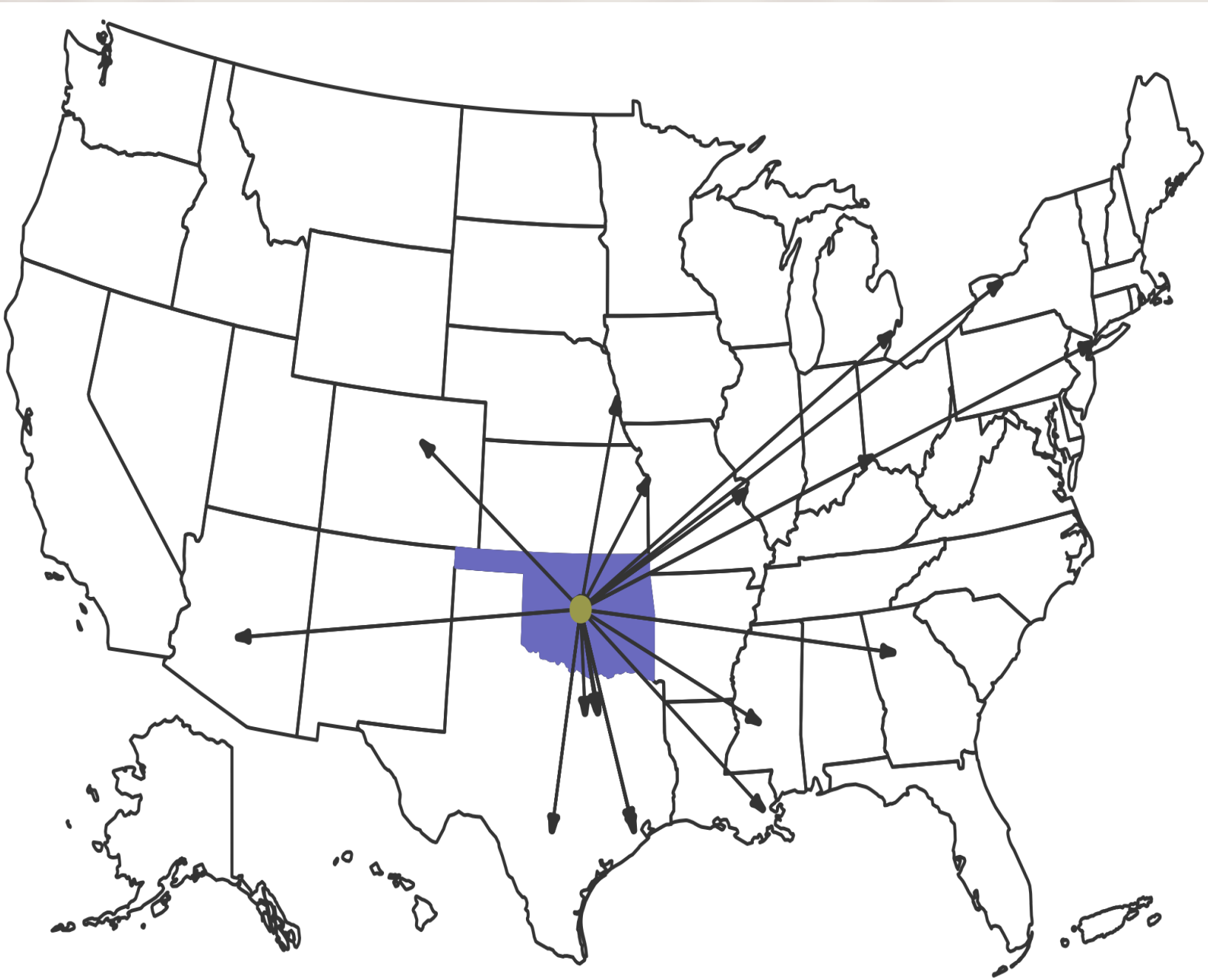


# 2020 Kidneys Transplanted from Dallas Donor Hospitals

# 2020 Livers Transplanted from Dallas Donor Hospitals



# 2020 Kidneys Transplanted from Oklahoma Donor Hospitals



# 2020 Livers Transplanted from Oklahoma Donor Hospitals

# Organ Donation Changes Impacting Cost: IPPS

IPPS Transplant Changes Under Review/Discussion/Proposed:

- Counting only organs recovered from donors at the transplant hospital that are ultimately transplanted into Medicare recipients as “Medicare Usable Organs”
- Excludes claiming costs of transportation of deceased donors to recovery centers
- OPO must pay donor hospital when organs are not ultimately transplanted and have no mechanism for cost reimbursement of these donors

# Operationally Managing Organ Donation Cost

- Establish Standards for when air transportation is deployed
- Educate Surgeons and transplant team on definition of intended recipient
- Can’t travel and visually inspect organ so need to use more videos and pictures
- Work with OPO on development of SAC annual letter detailing expenses for imports and intended recipients
- Effective Engagement in  Transplant Policy Development (IPPS decision delayed)

# Fiscal Implications of Organ Donation

- OPOs Standard Organ Acquisition Charges exclude Transportation expenses  which range between $5k to $8k per organ for air transport in state and $15k out of state
- Imported Organ Costs – fees charged by the OPO for coordination, evaluation or recovery of organs outside of their donor service area and costs $13,000 to $16,000 if organ procured and half that price if organ is not recovered.
- Transportation costs and Import organ costs increased with new allocation circles.

# Sample OPO Organ Acquisition Charges Annual Letter- Excludes Transportation

| | |
|---|---|
| Kidney OAC | $37,500 |
| Pancreas OAC | $39,600, plus transportation costs where applicable |
| Liver OAC | $43,800, plus transportation costs where applicable |
| Split Liver OAC | $28,500, plus transportation costs where applicable |
| Kidney Pump Charge | $4,630 – supplies included<br>$1,700 – no supplies |
| Import Service Charge for non-renal organs* | $14,000, plus pass through costs as applicable (i.e, transportation fees and Host OPO OAC) |

No organ recovered →

Note: If a non-renal organ is planned for import and, if accepted, is with a waiver from the Host OPO, but the non-renal organ is not transplanted, the import service charge will instead be $7,000, plus pass through costs as applicable (i.e., transportation fees).

# Air Transportation Invoice Dallas to San Antonio and Back

| LEG | DATE | DEPARTURE | ARRIVAL |
|---|---|---|---|
| 1 | 07 Feb 2020 | DALLAS, TX (KDAL) | SAN ANTONIO, TX (KSAT) |
| 2 | 07 Feb 2020 | SAN ANTONIO, TX (KSAT) | DALLAS, TX (KDAL) |

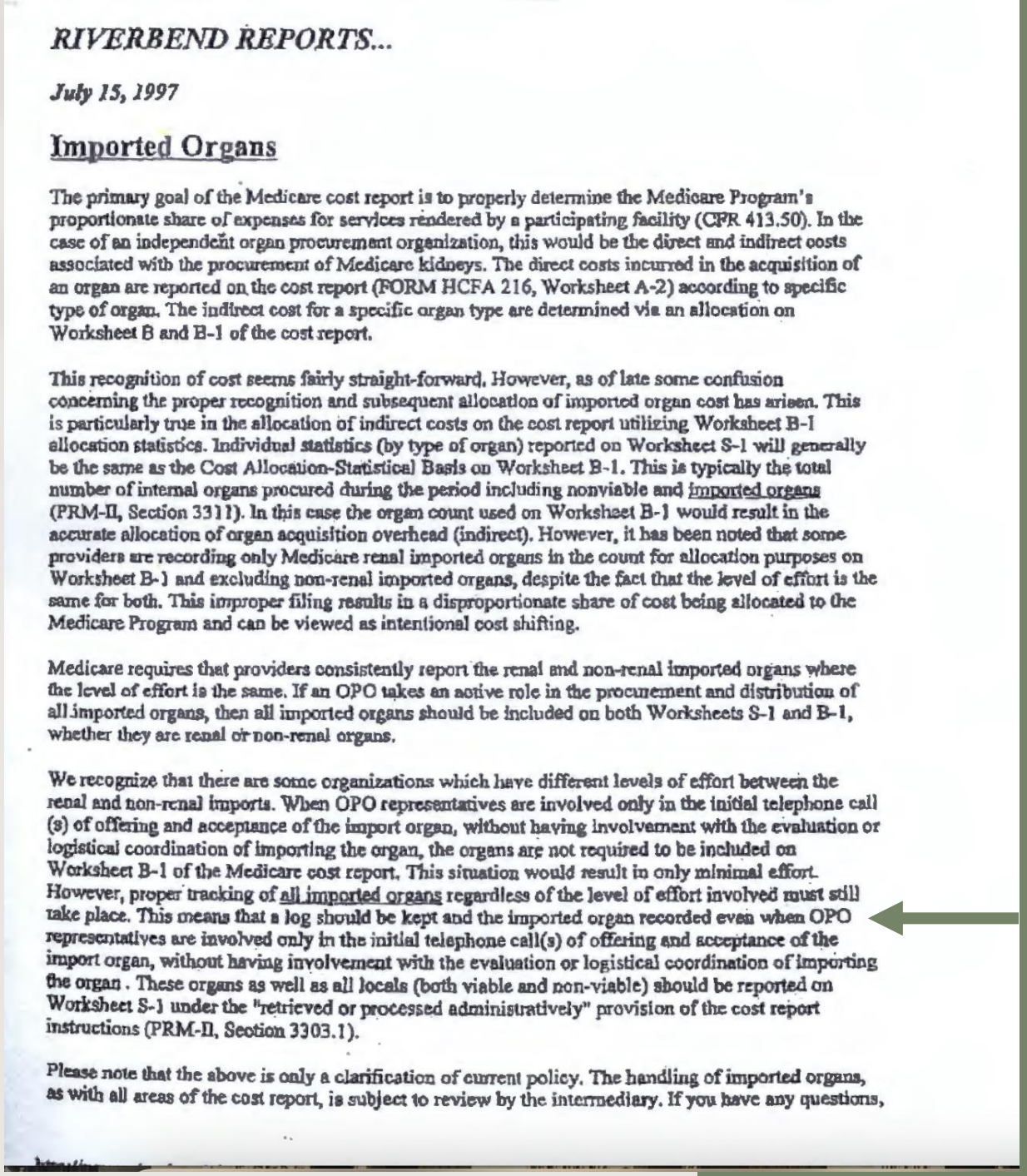
| DESCRIPTION | QUANTITY | RATE | AMOUNT |
|---|---|---|---|
| Aircraft Charter /Est. Block Time | 02:30 | 2,600.00 /hr | 6,500.00 |
| SUBTOTAL | | | 6,500.00 |
| Airport Fees | 2 | | 77.25 |
| Crew Charge | 1 | | 750.00 |
| SUBTOTAL | | | 7,327.25 |
| FET | | | 0.00 |
| GRAND TOTAL | | | 7,327.25 |

# Typical Acquisition and Transportation Fee paid when no organ is recovered but has an intended Liver Recipient

| | | |
|---|---|---|
| Acquisition Fee for Liver from Hot Springs,AR | | $6,500.00 |
| Transportation Fee * Air | | $7,842.60 |
| | Net Amount: | $14,342.60 |

| | | |
|---|---|---|
| Acquisition Fee for Liver from San Antonio,TX | | $6,500.00 |
| Transportation Fee * Air | | $8,727.60 |
| | Net Amount: | $15,227.60 |

Import fees by Dallas based OPO
extra $7000



*RIVERBEND REPORTS...*

*July 15, 1997*

## Imported Organs

The primary goal of the Medicare cost report is to properly determine the Medicare Program's proportionate share of expenses for services rendered by a participating facility (CFR 413.50). In the case of an independent organ procurement organization, this would be the direct and indirect costs associated with the procurement of Medicare kidneys. The direct costs incurred in the acquisition of an organ are reported on the cost report (FORM HCFA 216, Worksheet A-2) according to specific type of organ. The indirect cost for a specific organ type are determined via an allocation on Worksheet B and B-1 of the cost report.

This recognition of cost seems fairly straight-forward. However, as of late some confusion concerning the proper recognition and subsequent allocation of imported organ cost has arisen. This is particularly true in the allocation of indirect costs on the cost report utilizing Worksheet B-1 allocation statistics. Individual statistics (by type of organ) reported on Worksheet S-1 will generally be the same as the Cost Allocation-Statistical Basis on Worksheet B-1. This is typically the total number of internal organs procured during the period including nonviable and imported organs (PRM-II, Section 3311). In this case the organ count used on Worksheet B-1 would result in the accurate allocation of organ acquisition overhead (indirect). However, it has been noted that some providers are recording only Medicare renal imported organs in the count for allocation purposes on Worksheet B-1 and excluding non-renal imported organs, despite the fact that the level of effort is the same for both. This improper filing results in a disproportionate share of cost being allocated to the Medicare Program and can be viewed as intentional cost shifting.

Medicare requires that providers consistently report the renal and non-renal imported organs where the level of effort is the same. If an OPO takes an active role in the procurement and distribution of all imported organs, then all imported organs should be included on both Worksheets S-1 and B-1, whether they are renal or non-renal organs.

We recognize that there are some organizations which have different levels of effort between the renal and non-renal imports. When OPO representatives are involved only in the initial telephone call (s) of offering and acceptance of the import organ, without having involvement with the evaluation or logistical coordination of importing the organ, the organs are not required to be included on Worksheet B-1 of the Medicare cost report. This situation would result in only minimal effort. However, proper tracking of all imported organs regardless of the level of effort involved must still take place. This means that a log should be kept and the imported organ recorded even when OPO representatives are involved only in the initial telephone call(s) of offering and acceptance of the import organ, without having involvement with the evaluation or logistical coordination of importing the organ . These organs as well as all locals (both viable and non-viable) should be reported on Worksheet S-1 under the "retrieved or processed administratively" provision of the cost report instructions (PRM-II, Section 3303.1).

Please note that the above is only a clarification of current policy. The handling of imported organs, as with all areas of the cost report, is subject to review by the intermediary. If you have any questions,

# Riverbend OPO Medicare Intermediary

This means that a log should be kept, and an imported organ recorded even when OPO representatives are involved only in the initial telephone calls of offer and acceptance of the imported organ

# OPO Current Count of Imported Organs

- If the OPO is involved in the logistical coordination, evaluation, or recovery of the imported organ, the OPO is required to count the organ on their cost report, and they bill for the services to recoup costs that are allocated to the imported organ.
- Where the organ itself is not recovered, a typical import charge is one-half of our standard import coordination fee to cover costs, including the allocation of costs on our cost report due to the inclusion of the organ intended to be imported.

# IPPS Proposed Changes to Cost Report: Organ Pre-Transplant Acquisition

- Change to only reimburse proven Medicare FFS transplanted organs.
  - Reduces Medicare organ %
  - Further % reduction for exclusion of non-kidney Medicare Advantage organs
  - Results in lower coverage of pre-acquisition costs
  - Removes 30-year incentive to transplant hospitals to retrieve organs
  - Delays in retroactive Medicare Coverage for ESRD patients
  - Challenge in ascertaining whether organ is Medicare i.e. Donor transplant hospital > OPO > recipient transplant hospital – reporting interdependencies.
    - MSP payment validations

# Cost Report: Organ Pre-Acquisition Changes

- Average Decrease in Reimbursement for FY 2019 Filed Cost Reports would have been $1.7M per hospital *(per Alliance analysis of FY19 cost reports)*
- Impact on Medicaid Reimbursement –
  - Many states use Medicare data to calculate payment rates for Medicaid patients and lowering total Medicare Cost Report reimbursement decreases Medicaid reimbursement.
  - Specifically, Texas Medicaid Supplemental programs utilize Medicare cost report CCR which is negatively impacted by disallowance of costs.
- Change to allowable costs
  - Reduces cost base
    - Specifically excludes reporting costs of transportation of deceased donors

# Cost Report: Organ Pre-Acquisition Changes

*Historical Organ Treatment*

| | Cost | |
|---|---|---|
| | Part A | Part B |
| | 1.00 | 2.00 |
| **PART III - SUMMARY OF COSTS AND CHARGES** | | |
| Routine and Ancillary from Part I | 1,594,868 | |
| Interns and Residents (inpatient) | 0 | |
| Interns and Residents (outpatient) | 0 | |
| Direct Organ Acquisition (see instructions) | 9,068,244 | |
| Cost of physicians' services in a teaching hospital (see intructions) | 0 | |
| Total (sum of lines 56 thru 60) | 10,663,112 | |
| Total Usable Organs (see instructions) | | 202 |
| Medicare Usable Organs (see instructions) | | 130 |
| Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) | | 0.643564 |
| Medicare Cost/Charges (see instructions) | 6,862,395 | |
| Revenue for Organs Sold | 509,499 | |
| Subtotal (line 65 minus line 66) | 6,352,896 | |
| Organs Furnished Part B | 0 | 0 |
| Net Organ Acquisition Cost and Charges (see instructions) | 6,352,896 | 0 |

*Proposed Organ Treatment*

| | Cost | |
|---|---|---|
| | Part A | Part B |
| | 1.00 | 2.00 |
| **PART III - SUMMARY OF COSTS AND CHARGES** | | |
| Routine and Ancillary from Part I | 1,594,868 | |
| Interns and Residents (inpatient) | 0 | |
| Interns and Residents (outpatient) | 0 | |
| Direct Organ Acquisition (see instructions) | 9,068,244 | |
| Cost of physicians' services in a teaching hospital (see intructions) | 0 | |
| Total (sum of lines 56 thru 60) | 10,663,112 | |
| Total Usable Organs (see instructions) | | 202 |
| Medicare Usable Organs (see instructions) | | 70 |
| Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) | | 0.346535 |
| Medicare Cost/Charges (see instructions) | 3,695,142 | |
| Revenue for Organs Sold | 220,000 | |
| Subtotal (line 65 minus line 66) | 3,475,142 | |
| Organs Furnished Part B | 0 | 0 |
| Net Organ Acquisition Cost and Charges (see instructions) | 3,475,142 | 0 |

# Financially Managing Organ Donation Costs

- Increase Hospital Standard Organ Acquisition charges to reflect increased costs at least annually
- Notify managed care department of intended and import fees for analysis to be done on private payor reimbursement
- IPPS awareness of proposals: Why are we worried, after all it didn't get passed into law?

# COVID-19 Transplant Operational Impact

## Higher Mortality in the Immunocompromised

- Transplanting the unvaccinated
- Testing prior to transplantation
- Living donor program on hold during high community spread
- Vaccination less effective post transplantation but health systems not able to mandate pre-transplant

## Lack of Scientific Knowledge/Treatments

- Transplant non elective surgery
- Learning to adapt practices quickly as more knowledge is gained
- Reporting data for expedited review by transplant professional organizations

# COVID-19 Transplant Operations Impact: Access to Care

- ICUs full of COVID-19 patients prompting early discharge from ICUs or less access
- Telemedicine patient management even on inpatient
- Resources tied up providing COVID-19 patient care
- Patients not returning once discharged from hospital with transplant
- Delaying living donor cases during surge
- Market driving up personnel expenses
- Staff and Physicians out with COVID-19 or taking care of own family with COVID
- Testing delaying transplant process
- Organ donors with COVID-19 can't donate

# Operationally Managing COVID-19 Impact

- Validating the vaccination status on every patient on the waiting list and promote vaccination
- Add testing time into organ cold ischemic time (time the organ is outside the body for determining acceptance of organ)
- Double up on living donor operating room cases till backlog addressed once surge is over
- Consider policies for accepting COVID Positive donors into vaccinated recipients
- Interim policies for easy adaptation as new knowledge is gained

# Covid-19 Financial Impacts

- As donations and transplants are delayed, costs associated with recipient and donor monitoring escalate.
- High readmission rate
  - Nationally - 12% pre-COVID to 50% within 30 days
  - MDMC – over 40%
- Nursing costs increased

  By 30% during pandemic *(DFW Hospital Council Report)*
  - MDMC – *28%*
  - *Unsustainable without COVID Government Money*
- Costs of Covid-19 testing - increased LOS is approx. half a day or $1,800
- Payment models - Pre-acquisition costs are frontloaded, transplant delays cause revenue/payment to be delayed.

# Financially Managing COVID-19 Impact

- Capture expenses in COVID designated cost centers for isolating expenses, such as supplies, staff incentive payments and COVID screeners at entrances
- Include COVID waitlist management testing and vaccination as part of transplant evaluation protocol for allocation to cost report
- Eliminate additional staff financial incentive programs that are not sustainable as COVID community spread declines
- Close monitoring of CMS and insurance plan payment for Telemedicine changes as revert to pre-pandemic policies

# Executive Order on Advancing American Kidney Health

## Past President Order

- Issued July 10, 2019
- Declared "The State of Chronic Kidney Disease and End Stage Renal Disease Unacceptable"

## Principle Goals

- Reduce the number of Americans developing ESRD by 25% by 2030
- Double the number of organs available for transplant by 2030
- 80% of new ESRD patients in 2025 will either start treatment at home or are transplanted

# Executive Order on Advancing American Kidney Health: Impact

- Increased Awareness of Kidney Disease Burden and Legislative Kidney Focus
  - Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020
    - Starts Jan. 2023
    - Benefit will continue for life of allograft
  - Living Donor Protection Act of 2021
    - Prevents insurance carriers from discriminating against
- New Payment Models
  - Designed to increase home dialysis and transplantation
  - Patients on transplant waiting list or transplanted pre-dialysis are part of payment formulas
- Increased Payor and Consumer Awareness

# Operationally Managing Executive Order Impact

- Enhanced communication with nephrologists and dialysis facilities for patients to achieve living donor, pre-emptive transplant and wait listing
- Expedited work ups to achieve listing quickly
- Waitlisted patients on active status with accurate and up to date information
- Management of increase in referrals (good and bad)

# Executive Order Financial Impact

- Increased evaluation costs with increased referral rates
  - Nationally – Medicare beneficiaries, from 2006 – 2018, stage 3 485%, stage 2 306% and stage 4 98%.
  - MDMC - 25% increase in referrals for CY 21
- Increased wait list management costs with increased waitlist size
  - National trending vs Texas trending – prior to COVID, national increase at 6-9% whereas Texas was 14-16%
  - Nationally – Kidney accounts for 85% of organ waitlist, 90,266 waitlisted
  - Texas - Second highest nationally for waitlisted Kidneys at 18,164 or 9.2%
  - MDMC - Patients being waitlisted up 18% for CY 21
- Increased Technology expenses to support communication with dialysis centers. (TxConnect)
- Future payment model proposed to include pre transplant expenses and this would impact OAC and again contradicts other proposed methodology.  (global payments)

# Financially Managing Executive Order Impact

- Capture increasing evaluation and waitlist management expenses for all payors for inclusion in the cost report
- Bill for third party payor pre transplant services including HLA testing
- Account for new implementation operational expenses such at dialysis communication software in transplant cost centers for allocation to cost report instead of in capital budget as depreciation expense
- Awareness that taking a patient off the waitlist impacts Nephrologists and Dialysis facility metrics for payment
- Understand which new payment models will include pre transplant, inpatient or post services (currently excluded)

**More Important than Ever**

for Financial and Cost Accounting to work with their transplant administrative and clinical team to track down the mounting expenses for inclusion in the Cost Reporting and Insurance Billing Process.

Any Questions???