

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**ADDRESSING INCREASED ORGAN  
ACQUISITION COSTS**

**A MANAGEMENT ADVISORY REPORT**



**Richard P. Kusserow  
INSPECTOR GENERAL**

**OEI-01-88-01331**

# EXECUTIVE SUMMARY

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## PURPOSE

To identify opportunities for improving the efficiency of organ acquisition systems without adversely affecting the quality or quantity of organ transplantations.

## BACKGROUND

This brief report is a follow up to two prior Office of Inspector General reports urging that the Health Care Financing Administration (HCFA) address the increasing costs for organ acquisition. It presents the same basic recommendations presented in a November 1988 report. Those recommendations were supported by the Public Health Service and members of the professional community, but were opposed by HCFA.

We reintroduce the recommendations, cited below, because (1) the inefficiencies we described in the prior reports continue to exist, (2) fiscal oversight of organ procurement organizations is still limited and uneven, and (3) kidney acquisition expenditures per transplant appear to be much higher than previously assumed.

## RECOMMENDATIONS

*Support Demonstration Projects Incorporating Kidney Transplantation and Acquisition under a Diagnosis Related Group.*

*Conduct Priority Audits of Kidney Acquisition Expenditures of Renal Transplant Centers.*

*Establish Uniform Fiscal Oversight of the Organ Acquisition Costs of all Medicare-Certified Organ Procurement Organizations.*

*Establish, for Reimbursement Purposes, a Standardized Nomenclature of Pretransplant Laboratory Tests.*

*Allow for Only One Medicare-Certified Laboratory for Pretransplant Testing in Each Organ Procurement Organization Service Area.*

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# INTRODUCTION

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## PURPOSE

To identify opportunities for improving the efficiency of organ acquisition systems without adversely affecting the quality or quantity of organ transplantations.

## BACKGROUND

### *Prior OIG Report*

In September 1987, we issued a final inspection report entitled "Organ Acquisition Costs: An Overview," (OAI-01-86-00108). That report indicated that organ acquisition systems were operating without sufficient attention to costs. It called upon the Health Care Financing Administration (HCFA) to amend the Diagnosis Related Group (DRG) for kidney transplantation to include all costs associated with acquisition as well as transplantation.<sup>1</sup>

In November 1988 we issued a follow-up management advisory report entitled "Kidney Acquisition Costs," (OAI-01-88-01330). Taking account of widespread comments on the DRG recommendation, this brief report urged HCFA to conduct demonstration projects incorporating kidney transplantation and acquisition under a DRG. It also directed four other recommendations to HCFA, each intended to improve the efficiency of organ acquisition systems without adversely affecting the quality or quantity of organ transplantation.

The Public Health Service reacted positively to our recommendations as did members of the professional community. The HCFA, however, disagreed with the recommendations (see appendix A). We then initiated the conflict resolution process by holding a meeting with HCFA officials to discuss the recommendations. As stipulated in Departmental procedures concerning that process, it was incumbent upon HCFA to follow up that meeting by presenting a plan on how it intended to proceed. It did not do so.

### *Rationale for Repeating Prior Recommendations*

In this report, we present the same basic recommendations to HCFA. We repeat these recommendations for three major reasons. One is that the inefficiencies documented in our 1987 report continue to exist, with Medicare providing 100 percent reimbursement of covered costs. Fiscal oversight is still limited, most especially with respect to pretransplant laboratory costs, and uneven, with 50 independent organ procurement organizations (OPOs) being subjected to guidelines and procedures different from those of the 19 hospital OPOs. Also, there is still widespread variation

in pretransplant testing procedures, terminology, and costs and unnecessary duplication of pretransplant testing in various OPO service areas.<sup>2</sup>

A second major reason for reintroducing the prior recommendations is that Medicare organ acquisition costs continue to escalate. Although recent cost information is incomplete, we do know that total kidney acquisition expenditures of independent OPOs rose by about 30 percent from the end of 1988 to the end of 1990--from \$60.2 million to \$78.7 million.<sup>3</sup> These totals do not include the substantial kidney acquisition expenditures of hospital OPOs, pretransplant laboratories, or Medicare-certified renal transplant hospitals, of which there were 224 on July 15, 1991. It is also relevant to note that from December 31, 1988 to July 15, 1991, the kidney waiting list maintained by the United Network for Organ Sharing (UNOS) rose from 13,947 to 18,830. Nearly all of these individuals are incurring ongoing Medicare reimbursable costs for tests, whether or not they ever receive a transplant.

Finally, a third reason is that kidney acquisition expenditures per transplant appear to be much higher than perviously assumed. On the basis of information obtained from HCFA billing records as well as from cost reports, those expenditures appear to be closer to \$20,00 to \$30,000 than the \$10,000 estimated earlier.<sup>4</sup>

## RECOMMENDATIONS

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### *Support Demonstration Projects Incorporating Kidney Transplantation and Acquisition under a DRG.*

In response to our 1987 report, HCFA noted that it agreed in principle with the idea of a prospective payment approach to kidney acquisition, but expressed concerns about the operational details and the adequacy of the cost data available. We recognized the significance of those concerns and for that reason urged in our 1988 report that HCFA support demonstration projects. We reiterate that recommendation here and call for HCFA both to announce its readiness to fund such demonstrations and to state the specific questions it expects the demonstrations to address.<sup>5</sup>

In the interim, as the demonstrations are underway, we believe it is essential for HCFA to introduce a much greater sense of cost-consciousness in organ acquisition systems. Through the initiatives identified below it can make important progress in that direction. In the process, it can also contribute to the development of cost data that provide a much more appropriate basis for calculating a DRG than do existing data, which reflect the inefficiencies of the current system.

### *Conduct Priority Audits of Kidney Acquisition Expenditures of Renal Transplant Centers.*

The Medicare intermediaries serving these centers tend to give relatively little attention to organ acquisition costs. This is primarily because these costs tend to represent a small portion of the overall Medicare costs in the hospitals of which the transplant centers are a part. By specifying in an annual audit instruction that the intermediaries should give special attention to organ acquisition costs, HCFA could add an important measure of fiscal oversight and gain valuable information about current practices.

In carrying out this recommendation, HCFA should give priority attention to the 19 transplant centers that also serve as Medicare-certified organ procurement organizations (OPOs), since they account for a large share of overall Medicare expenditures for organ acquisition. However, because of escalating costs, we believe it is important to improve fiscal oversight of all transplant centers' expenditures for kidney acquisition.<sup>6</sup>

### *Establish Uniform Fiscal Oversight of the Organ Acquisition Costs of all Medicare-Certified Organ Procurement Organizations.*

It is vital that all 69 OPOs function under the same set of fiscal guidelines and the same degree of oversight. This is not now the case, as the 50 independent OPOs, which are serviced by a single intermediary, tend to be subject to different guidelines and greater scrutiny of their costs than the 19 hospital OPOs, which are serviced by whatever intermediary services their hospital.

We urge HCFA to introduce more consistent and rigorous oversight by using the services of a single intermediary for all OPOs. ~~It~~ should carry out this recommendation in the way it finds to be technically most feasible. For the 19 hospital OPOs, this could involve the single intermediary serving in an overseer capacity, making recommendations to the Medicare intermediary servicing the individual hospitals.

***Establish, for Reimbursement Purposes, a Standardized Nomenclature of Pretransplant Laboratory Tests.***

Pretransplant laboratory tests account for a significant proportion of organ acquisition costs.<sup>7</sup> And, they almost certainly account for a growing proportion, as the number of individuals on organ transplant waiting lists has soared--from 13,197 at the end of 1987 to 23,711 on July 15, 1991. Individuals on these lists, whether or not they ever receive a transplant, generate substantial ongoing costs for various tests as long as they remain on the list.

Because of widely varying terminology concerning these tests, HCFA's Medicare intermediaries essentially are unable to determine the reasonableness of the costs reported for these tests.<sup>8</sup> To address the situation, we urge HCFA to authorize the Medicare intermediary servicing the 50 independent OPOs to convene a group of experts to develop a standardized nomenclature for pretransplant laboratory tests that all laboratories would then have to use in reporting their costs for Medicare reimbursement.<sup>9</sup>

***Allow for Only One Medicare-Certified Laboratory for Pretransplant Testing in Each OPO Service Area.***

Enactment of this recommendation would avoid much unnecessary duplication of pretransplant laboratory work that now occurs in many metropolitan areas. This duplication, as we described previously, can add not only to the cost of organ acquisition, but to the time elapsed from the point of organ retrieval to transplantation.<sup>10</sup>

This recommendation, which may call for legislation, rests on much the same rationale that Congress relied upon to allow only one OPO in each service area. It would eliminate competition which serves to increase rather than reduce costs and would provide a central point of accountability for initial work-ups, on-going antibody screens, crossmatching tests involving sera from donated organs and potential recipients, and other appropriate tests.

## CONCLUSION

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Organ acquisition providers have remained by and large free from the cost pressures facing the rest of the health care industry. They continue to be reimbursed for all Medicare covered "reasonable costs," with little incentive to introduce efficiencies. The recommendations set forth in this report offer a way of improving this situation gradually and carefully, without adverse effects on organ transplantation. They have been refined over a number of years and have received considerable examination by and support from the professional community. We strongly urge that they be enacted.

# APPENDIX A

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COMMENTS ON NOVEMBER 1988

OIG MANAGEMENT ADVISORY REPORT ENTITLED

"KIDNEY ACQUISITION COSTS"

(OAI-01-88-01330)



MAR 10 1989

**Memorandum**

to: Terry Coleman *Terry Coleman*  
from: Acting Administrator

subject: OIG Management Advisory Report: "Kidney Acquisition Costs"  
OAI-01-88-01330

o The Inspector General  
Office of the Secretary

We have reviewed the management report on kidney acquisition costs. The results of this management advisory report will be useful to us as we continue to refine the Medicare program in the area of organ acquisition costs.

Our comments on the specific recommendations are attached for your consideration. Thank you for the opportunity to comment on this report.

Attachment

Comments of the Health Care Financing  
Administration on the OIG Management  
Advisory Report: "Kidney Acquisition Costs,"  
OAI-01-88-01330

OIG Recommendation

Support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis related group (DRG).

HCFA Comments

At the current time, we do not have plans to do a demonstration project on incorporating transplantation and acquisition costs into a DRG.

OIG Recommendation

Conduct priority audits of the kidney acquisition expenditures of those renal transplant centers that HCFA has designated as organ procurement organizations (OPOs).

HCFA Comments

HCFA instructions advise intermediaries to closely review pass-through costs. Kidney acquisition costs are relatively small in relation to other pass-through costs. Given the finite funding for audit activities, we believe it more prudent to focus on areas which are more susceptible to abuse involving significantly larger dollar amounts at issue.

OIG Recommendation

Establish more consistent and rigorous oversight of the HCFA certified OPOs.

HCFA Comments

HCFA is currently developing the recertifying standards package for OPOs. Included in the package are standards for accounting and fiscal procedures. We have no current plans for designating a single intermediary to oversee OPOs.

OIG Recommendation

Move toward the establishment of only one Medicare certified laboratory for pretransplant testing in each OPO service area.

HCFA Comments

It appears that this is not the time for such an initiative. There is no current regulatory authority in the Medicare Conditions of Participation for providers or suppliers to designate a single pretransplant laboratory for each OPO. Currently, histocompatibility testing is treated as a specialty in an independent laboratory with requirements for personnel, quality control, maintenance of records and participation in a cell exchange program. Histocompatibility laboratories in hospitals, whether hospital based or freestanding, must meet the same requirements. The conditions do not specify the methodology a histocompatibility laboratory must use in testing and surveyors have no means of identifying duplicative pretransplant testing.

OIG Recommendation

Establish, for reimbursement purposes, a standardized nomenclature of pretransplant laboratory tests.

HCFA Comments

This recommendation could be implemented if HCFA decides it wishes to take the lead and devote the resources necessary to force the industry to accept standardization. Preparation of such a list would require staff with scientific knowledge of laboratory testing as well as reimbursement specialists. We will consider seeking the assistance of the Public Health Service in establishing the standardized nomenclature of pretransplant laboratory tests.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date • FEB 2 1989

From Deputy Assistant Secretary for Health Operations and  
Director, Office of Management

Subject Comments on the OIG Management Advisory Report "Kidney Acquisition Costs,"  
OAI-01-88-01330, November 1988

To Inspector General, OS

Attached are the PHS comments on the subject report. Since the findings and recommendations contained in the report are directed to the Health Care Financing Administration, we have confined our response to general and technical comments.

  
Wilford J. Forbush

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF  
INSPECTOR GENERAL (OIG) MANAGEMENT ADVISORY REPORT,  
"KIDNEY ACQUISITION COSTS,"  
OAI-01-88-01330, NOVEMBER 1988

Even though there were no recommendations to PHS in this management advisory report, we support all of the OIG's recommendations on the organ acquisition costs issue. The following are our general comments on four of the recommendations directed to HCFA.

- o Support Demonstration Projects Incorporating Kidney Transplantation and Acquisition under a DRG

PHS supports, in principle, the idea of including standard kidney acquisition charges in a Diagnosis Related Group (DRG). We believe that the demonstration projects, as described, would be essential for implementing this policy in a way that would limit the potential for inadvertently creating disincentives for organ procurement.

- o Establish More Consistent and Rigorous Oversight of the HCFA Certified Organ Procurement Organizations

PHS supports the establishment of a reporting and monitoring system for renal transplant centers which parallels the oversight currently being performed on the independent organ procurement organizations (OPOs). OPOs are now reviewed on an annual basis by their Medicare intermediary, and acquisition fees are adjusted to reflect actual costs.

- o Move Towards the Establishment of Only One Medicare Certified Laboratory for Pretransplant Testing in Each OPO Service Area

PHS agrees that there appears to be overlap and duplication of testing in the histocompatibility laboratories. However, the laboratories might resist consolidation because it may require closure of some facilities. OIG could consider recommending that a demonstration project be conducted to determine the extent of the problem and the feasibility of consolidation.

- o Establish for Reimbursement Purposes, a Standardized Nomenclature of Pretransplant Laboratory Tests

PHS agrees that the lack of standardized vocabulary presents a problem in determining comparability and consistency of costs among histocompatibility laboratories. PHS, therefore, supports establishment of a standardized nomenclature.

Technical Comments

Page 3, last paragraph

OIG should clarify its statement that ". . . it is especially important to take into account the fact that nationally procured kidneys tend to be more expensive than locally procured ones."

We suggest that the sentence be changed to read:

"Kidneys that are obtained through the national sharing system, i.e., the National Organ Procurement and Transplantation Network, tend to cost more than kidneys that are obtained and used locally."

Page 4, first full paragraph

The wording and intent of the third sentence are unclear. OIG states "We are less certain, however, about whether living related and cadaver acquisition costs should be included in the DRG." The thrust of the recommendation is that cadaver acquisition costs should be included in the DRG, but the wording of the sentence contradicts this premise.

Page 6, fourth paragraph

The second sentence should be changed to read ". . . those on transplant waiting lists . . . ." instead of "waiting tests."

# New Inspector General study is remarkable

## They actually listened to our criticisms & suggestions



Roy R. Hull, MD, FACP  
Regional Coordinator

In September 1987, the Office of the Inspector General (OIG) published a report on organ procurement, which was excerpted and analyzed in *Nephrology News and Issues* in its November and December 1987 issues.

In October of 1987, I spent about two hours with Inspector General Richard Kusserow, pointing out errors in this report, and presenting what I believed was the transplant community's view.

I must emphasize that during this discussion, I was impressed with two things:

- The Inspector General, after looking at the transplant data, said "obviously we were wrong, we confused prevalence with incidence."
- He took the time to respond personally to the other criticisms and suggestions made by the transplant community in *Nephrology News & Issues*.

This was encouraging, but not much else was heard from the OIG, and I had presumed it was all forgotten—until I received a copy of an update on "Kidney Acquisition Costs" over Richard P. Kusserow's name, but edited by Mark Yessian, PhD, Regional Inspector General for the Northeast Region.

I would like to use this report as a means of commenting on where I believe the kidney transplant field stands in mid-1989.

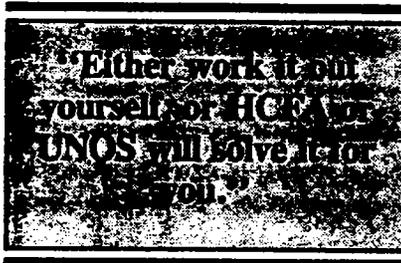
### REMARKABLE REPORT

The OIG's updated report is remarkable for two reasons: (1) They obviously listened to all the criticisms and sugges-

tions; and (2) They dropped inappropriate proposals and modified others.

The result is a short and readable report that challenges HCFA and the transplant field to respond to five points. After considering these proposals, I believe the transplant community is ready to move ahead on the challenges proposed in the new document.

Since the first report was issued in 1987, many significant changes have occurred: (1) UNOS is now established; (2) "Routine Inquiry" is in effect in a majority of states; and (3) single Organ Procurement Organizations (OPOs) for Standard Metropolitan Statistical Areas (SMSAs) are now in place nationwide.



Yet, despite these stabilizing moves, there has been no response from HCFA or anyone else on the issues raised by the OIG two years ago.

Let me review the five points Dr. Yessian now proposes, and try to see what will be involved.

### SUPPORT DEMONSTRATION PROJECTS INCORPORATING KIDNEY TRANSPLANTATION & ACQUISITION UNDER AN EXPANDED DRG 302

There were many comments and suggestions made in 1987, and what the OIG now proposes is not only reasonable, but it needs to be tested, in order to see what are the merits of the proposal. The OIG makes the following cogent points:

- Almost two years have passed, and no plan has been forthcoming from HCFA.
- The expense difference between locally procured and nationally shared kidneys must be ascertained, in order to determine if the alleged improved survival results in sharing are worth the cost.

I believe we should all encourage HCFA to establish such studies. If the kidney acquisition cost is to be included in an expanded DRG 302, it must allow for the following:

- Payment for workup and evaluation of the recipient at the transplant center prior to transplant. It does not make sense to expect the recipient's nephrologist to do this, when he or she is not directly associated with the transplant program.
  - Unused kidneys are included in the cost, a point the OIG has now agreed to.
  - Local problems will be considered. This can be problematic with a national DRG 302.
  - Inflation will be allowed for in the future in some manner (better than the present DRG update), which Congress is always trying to cut.
- These are not easy concepts to encompass, but they are necessary to develop a properly working reimbursement system.

### CONDUCT PRIORITY AUDITS OF THE KIDNEY ACQUISITION EXPENDITURES OF THOSE RTCs THAT HCFA HAS DESIGNATED AS OPOs

I am not sure what a priority audit is, but I assume it means an audit conducted within a certain time frame, ahead of other audits. This is the one area in the report that continues to depend on anecdotal claims (you may remember, this was a major problem in the 1987 report).

Thus, apparently "many people feel" that kidney acquisition costs are: (1) not accurate (read high); and (2) may not be fully eligible for Medicare reimbursement.

It is further alleged that this may be especially true in renal transplant centers (RTCs) that are their own OPOs. However, one cannot determine if this is true or not, because the "many people" are not identified, and no information is given.

It would appear, though, that these kinds of questions are going to remain until a study is completed, and quality data are generated.

The report does make a good point, in that hospital cost reports were modified

## Transplant Controversies

in 1985, and HCFA's excuse in 1987 was that they only had one year's data. Time has now passed, and at least three years of cost reports should now be available for review.

Since this information is apparently now available, the OIG editor, Dr. Yessian, suggests a priority study to see what the figures show. This would appear to be a sensible suggestion and should be done. In addition, when all RTC are studied, costs can be compared between those without their own OPO, and the 19 RTC with them.

### ESTABLISH MORE CONSISTENT & RIGOROUS OVERSIGHT OF THE HCFA-CERTIFIED OPOs

The aim here is to have all OPOs, independent and hospital-based, operate under the same fiscal guidelines and oversight. This is a point that has been raised before by the transplant community, and Dr. Yessian quotes Dr. Chris Blagg on this point.

This would probably, as the OIG suggests, require the hospital-based OPO to keep a separate set of books, but it would seem the information obtained would be well worth this extra effort.

The OIG's suggestion that HCFA conduct a pilot study with a number of RTCs, and individual intermediaries, is a very good way to try and work out these difficulties. We would agree with the OIG, that more rigorous and standard oversight is needed, and the proposal seems reasonable.

In points 4 and 5, the OIG moves to areas where there will be much more controversy and even resistance. In reviewing these two items, I will add some comments beyond those made by Dr. Yessian.

### MOVE TOWARD THE ESTABLISHMENT OF ONLY ONE MEDICARE-CERTIFIED LAB FOR PRETRANSPLANT TESTING IN EACH OPO SERVICE AREA

Quoting the OIG's report, "the time is right for movement in this direction." In its original 1987 report, the OIG claimed: (1) Wide variation in testing procedures and cost; (2) A sharp increase in lab cost for those on transplant waiting lists; and (3) Some unnecessary duplication of pre-transplant testing.

Naturally, these accusations raised an outcry from a number of tissue typing groups. One can understand this, since

unfortunately, some tissue typing labs may depend on these tests not only to exist, but also to undertake research. (My statement, not the OIG's.)

The one comment quoted by Dr. Yessian that I believe must be supported, is the American Society of Histocompatibility and Immunogenetics (ASHI) comment that the receiving center must repeat the crossmatch and the HLA typing. I do not believe this is the type of duplication the OIG was referring to, and it was certainly not what I discussed

in *Nephrology News & Issues* in 1987.

The other comments that were made, especially those about the OIG's statements affecting kidney sharing and perhaps discrediting HLA typing, I do not believe are valid.

If tissue typers want to validate typing to the disbelievers, they must present U.S. data. At this time, they have an unparalleled opportunity with the sharing of "zero mismatched" kidneys. However, there are two problems in my

*Continued on page 26*

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# Transplant Controversies

Continued from page 19  
mind.

- There is confusion about what the data show to date. Paul Terasaki, PhD, says it is good, and UNOS says it is not good. I say a "pox" on both of my friends' houses. The transplant community is made up of adults; show us the data and let us decide. Any deficiency is going to come forth sometime anyway. If it has problems, so be it, let's get them out in the open. An example of this problem is that we do not even know how many zero mismatched kidneys have been transplanted in the last 18 months—WHY NOT?
- The second problem is that even if the data show matching is better, the surgeons are going to claim that locally used kidneys do just as well. What has to be done is to also collect data on the paired kidneys that are used locally, presumably in a much shorter time. If over time (five years minimum), these kidneys do as well as zero mismatched shipped kidneys then matching is not worth the effort or the cost. While we must be patient, it would perhaps be easier if we were at least trusted with the early information as it emerges.

Before I suggest a possible solution, let's look at the OIG's last proposal.

## ESTABLISH, FOR REIMBURSEMENT PURPOSES, A STANDARDIZED NOMENCLATURE OF PRETRANSPLANT LABORATORY TESTS

The OIG again, presents compelling, albeit brief data that suggests there is wide variation in charges for tissue typing tests. Before one accepts this, we must be certain that we are comparing the same tests, i.e., apples to apples.

In addition, the OIG points out that the Medicare intermediaries are really in a poor position to determine what is reasonable.

Having been asked to help adjudicate in this arena by our local carrier, I can certainly agree that it is difficult to be certain how pertinent some tests are, and why there is not a common battery of tests. Apparently, ASHI has recognized this problem, and is trying to generate a list with standard nomenclature.

If these tests compose 20% of kidney acquisition costs, as is stated by the OIG's report, then these issues really

must be considered as we try to be fiscally responsible.

To solve the OIG's last two proposals, i.e., one tissue typing lab for each SMSA, and conducting a standard group of tests, I would suggest the following:

- The American Society of Transplant Physicians (ASTP) and the American Society of Transplant Surgeons (ASTS) each appoint two representatives who understand what is required in tissue typing, but are not necessarily immunologists by training. In addition, these representatives must not be biased in favor of either academia, or the private sector.

**"If the locally used paired kidneys do as well as zero mismatched shipped kidneys, then matching is not worth the effort or the cost."**

- UNOS would appoint four representatives, perhaps two from HCFA itself, and two scientists or economists who could help in this review.
- ASHI would select a group that would present to the advisory committee, as suggested in 1 and 2 above, a proposal that would entail the following:
  - A plan for combining tissue typing labs in major cities in much the same way OPOs were combined; i.e., either work it out yourself, or HCFA or UNOS will solve it for you.
  - A battery of tissue typing tests that are required to produce a satisfactory transplant.
  - Relative costs for such tests.

I believe this approach is reasonable and would be advantageous, since it comes from the transplant community itself. If we do not move in a responsible way to solve these issues (tissue typing), they will be solved for us by the government.

## CONCLUSION

In summary, the OIG's update on kidney acquisition costs proposed five ways to reduce costs and give more responsi-

ble oversight. The first three deal with areas where HCFA could now move to produce cost data and improve oversight.

These three proposals are now in HCFA's court, and we would encourage HCFA to move as rapidly as possible to implement these very reasonable suggestions. Suggestions, I might add, that have emanated from not just the OIG, but have been modified by interaction with the transplant community.

The last two recommendations deal with changes that are overdue in the tissue typing area. I would like to encourage the people involved to move forward in a responsible manner. This would show the government that we are willing to do our part in these times of fiscal restraint in an area that needs modifying.

I am almost certain that some of my criticisms will be challenged. However, let me close by saying that the OIG has done a first-rate job in listening to our criticisms and suggestions, and incorporating them in its latest report. Let us act in response to the OIG's challenge. □

*Editor's Note: Dr. Hull is a consultant for ESRD reimbursement and transplant issues; pres., Renal Phys. of TX; and member, Editorial Advisory Board, Nephrology News & Issues.*

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when it conceived the OPTN in the 1984 National Organ Transplant Act, and reaffirmed the OPTN's tasks in the 1988 Amendments to the National Organ Transplant Act.

Challenges will obviously continue in 1989, and formidable tasks do lie ahead. These include strengthening regional development to provide increased input into OPTN activities, broadening the scope of committee input to the board, and continuing to fulfill and improve service regarding OPTN contractual responsibilities. □

*Editor's Note: Barbara Estner received a BS from Medical Col. of Virg., MEd from Virg. Commonwealth U., and is pres. and chief consultant for Business & Education Associates. She was previously dir., ed. & PR, UNOS and SEOPF; has published several dozen medical articles and book chapters, and was previously managing editor of UNOS' newsletter.*

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# Inspector General's report encouraging



**Stephen D. Haid, CPTC**  
Executive Director  
Southwest Organ Bank  
Dallas, TX

**T**he Sept. 1987 report from the Office of the Inspector General (OIG), "Organ Acquisition Costs: An Overview," generated considerable attention and commentary, much of which appeared in *Nephrology News & Issues* (Nov. & Dec. 1987).

In response to the significant feedback on the final inspection report, the OIG has produced a new management advisory report, "Kidney Acquisition Costs," which was addressed in Dr. Alan Hull's *Transplant*

*Controversies* column (NN&I, May 1989 issue).

I applaud Richard Kusserow and his staff for the content of this document. It is refreshing to know that there is a system in place where members of the private sector can speak and be heard by the federal government.

The focus of the Sept. 1987 report, and the new management advisory report (Nov. 1988), is on promoting cost consciousness in kidney acquisition systems. The significant difference in the two documents is that the new report recognizes that some of the measures previously outlined might cause a reduction in kidney availability.

After taking that into consideration, the OIG developed five recommendations:

- Support demonstration projects which incorporate kidney transplantation and acquisition into one DRG. If, in fact, a DRG for acquisition is imminent, this seems like the most

sensible way to develop one. It would be based on sound data recovered over a period of time. I am certain that this approach would be much more palatable to organ procurement organizations (OPOs) than would be the immediate establishment of a DRG for kidney acquisition.

- Concurrently, I would recommend initiation of a systematic study to determine the efficacy of a DRG for kidney acquisition. While a DRG may weed out inefficient OPOs and reduce Medicare costs, it may also cause a decrease in organ availability in some areas. In other words, the medical impact must also be considered along with the cost savings.

- Conduct priority audits of kidney acquisition expenditures of renal transplant centers ( RTCs) that are designated as OPOs. These transplant center-based OPOs have typically been subject to only minimal oversight, and

(continued on page 46)

## Euro-Collins Multi Organ Perfusion Kits

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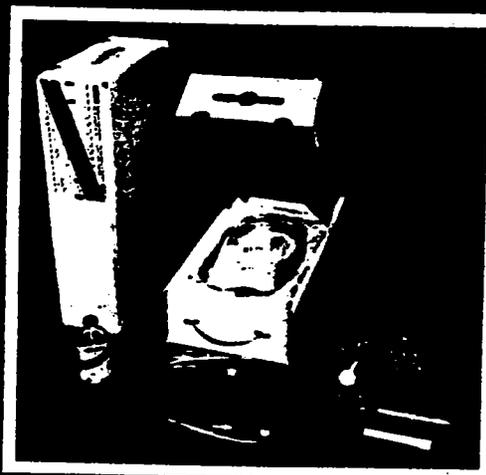
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# Renal Nutrition

## Teaching about nutrition in anemia

(continued from page 20)

### Exercise Program

Much research is being conducted on ways to improve the dilemma of anemia. Drs. Andrew Goldberg and Herschel Harter, both formerly of Barnes Hospital in St. Louis, MO, showed in 1978 that regularly scheduled exercise programs may improve anemia.<sup>5,16</sup>

For patients who tend to be a "couch potato," even walking 20 minutes a day could represent a noticeable improvement. Patients should ask their physicians to make sure they are a candidate for an exercise program. □

*Editor's Note: Ms. Harum is the new national manager for nutritional services at Home Intensive Care, Inc. She has published 20 articles on various aspects of renal nutrition, and she is a member of the Editorial Advisory Board of Nephrology News and Issues.*

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## HCFA: consider OIG proposal

(continued from page 43)

I believe the proposed audits are reasonable, in order to fully assess kidney acquisition expenditures.

- Establish more consistent and rigorous oversight of HCFA-certified OPOs. The OIG recommends a pilot test, using a single intermediary for independent and transplant center-based OPOs. I believe this is a good first step toward fiscal consistency, and I agree that it should be implemented.

- The least controversial (but probably the hardest to implement) recommendation is to move toward the establishment of only one Medicare-certified laboratory for pre-transplant testing in each OPO service area.

The problem of unnecessary duplication of services and associated costs have been long recognized by professionals in the field, as well as by Medicare, yet no substantive steps have been taken to reduce this unnecessary expenditure.

- Establish, for reimbursement purposes, a standardized nomenclature of

prelaboratory tests. The current system is extraordinarily costly and complex, with many different laboratories using varied tests and combinations of tests. Undoubtedly, Medicare and its intermediaries must find this process perplexing. I believe, therefore, that implementing this recommendation would be a reasonable and significant step to take in promoting cost consciousness.

I hope the new OIG recommendations will be seriously considered by the Health Care Financing Administration (HCFA). I would also encourage HCFA to carefully evaluate the impact on organ procurement of a DRG for kidney acquisition. □

*Editor's Note: Stephen D. Haid has served in various technical and administrative posts in the organ procurement and immunology fields since 1974. He received a BA in biology from the Univ. of Missouri, St. Louis, and has held a number of posts in professional associations, including pres. of the N. Amer. Transpl. Coord. Assoc. (NATCO) in 1986-87, and the board of the Amer. Council on Transpl. (ACT) in 1986-88.*



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Richard P. Kusserow  
Inspector General  
Department of Health & Human Services  
HHS North Building  
330 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Mr. Kusserow:

We are in receipt of a management advisory report entitled, "Kidney Acquisition Costs." Attached, please find our comments in response to the recommendations made in this report.

If you have any questions relative to our comments or if we can be of any assistance, please contact us.

Sincerely,

Chidghan J. Dave', Manager.  
Medicare Administration, M323  
Aetna Life Insurance Company

/jc

Attachment

c: B. Schumaker, Director, HCFA  
R.F. Weingartner, Director  
M. Yessian, Regional Inspector, OIG

## REPLY TO OIG REPORT

### 1. Recommendation:

Support demonstration projects incorporating kidney transplantation and acquisition under a DRG.

#### Commentary:

A demonstration project to determine the feasibility and impact both on procurement activity and on cost savings thorough implementation of a DRG for transplantation and acquisition, is a very supportable issue.

In this manner, both acquisition cost and procurement activities can be studied separately, yet combined with the transplant center activities to determine an overall DRG.

This project could avoid the confusion and sometime disastrous effects when large numbers of facilities are impacted before adequate information is available. As the control numbers within the universe sample can be maintained at a reasonable level, and as the area, size, and complexity of the facilities would be known up front, this project would appear to offer the greatest possibility of success.

It would appear from first blush that the independent OPO's would be the most complex towards determination of a fixed cap for costs. All the variables previously encountered in establishing DRG's in hospitals, plus several new ones, would have to be thoroughly researched and studied before effectuating a DRG. It may even be found that the establishment of a DRG in the RTC setting is appropriate, but not so, for an independent OPO.

### 2. Recommendation:

Conduct priority audits of kidney acquisition expenditures of those renal transplant centers that HCFA has designated as organ procurement organizations.

Commentary:

We are in basic agreement with this recommendation and have been working with the Division of Transplantation, HCFA (Baltimore), to establish various aspects for potential review. We intend to continue this endeavor during the year, providing whatever information we can. It should be pointed out that this point could also be a beginning or climax to the recommendation, noted as number one (1) above, serving to eliminate unnecessary items of cost and weed out or at least, identify inefficient operations.

3. Recommendation:

Establish more consistent and rigorous oversight of the HCFA certified organ procurement organizations.

Commentary:

As brought out in the elaboration of the comment within your report, the complexities of the Administration, necessary cooperation and ultimate ruling authority for making determinations and adjustments, needs to be explored more fully before this recommendation can be evaluated further.

4. Recommendation:

Move towards the establishment of only one (1) Medicare certified laboratory for pre-transplant testing in each OPO service area.

Commentary:

The recommendation certainly would provide for cost efficiencies in pre-transplant testing and eliminate much of the duplicate testing and reimbursement that accompanies such activities. However, issues such as speed of test availability, ease of access to testing facilities upon donor identification, and physician, as well as, facility reliance on another entities methodologies and test results complicate the situation. It is not known whether or not legislating a single lab in each area would solve the issues or would only serve to extend the time frames involved in donor procurement, impacting the acquisition levels adversely.

5. Recommendation:

Establish for reimbursement purposes, a standardized nomenclature of pre-transplant laboratory tests.

Commentary:

We have supported the establishment of common nomenclature for laboratory tests in the past, and will continue to do so. However, the complexity of the testing and the methodologies used in developing the various tests and results is beyond the technical expertise of the intermediary. It is our understanding that ASHI is moving towards this end now, and that UNOS may have an impact also. Any efforts on the part of HCFA to assist this process could help to achieve the ultimate goal quicker. There is little doubt that standard nomenclature would be of a benefit to the Program, the intermediary, and probably to beneficiaries who are covered under the renal program.

/jc

## APPENDIX B

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### ENDNOTES

1. It focused on kidney transplantation because at the time the study was conducted Medicare reimbursement was not yet available for other kinds of transplantation.
2. See OIG, "Organ Acquisition Costs: An Overview," OAI-01-86-00108, pp.5-9.
3. Information obtained from Aetna, the Medicare intermediary responsible for oversight of independent OPOs.
4. Office of Research, Health Care Financing Administration.
5. It would probably be advisable to limit the demonstrations to kidney acquisition, since there is a larger historical base of data and a larger number of transplants to rely upon. However, HCFA might consider the feasibility of a separate demonstration involving acquisition costs for hearts used for transplantation. Heart transplants have been covered under Medicare for the past 3 years, with acquisition costs payable on a reasonable cost basis as they are for kidneys.
6. Here, again, we focus on kidney expenditures because they represent the great majority of Medicare reimbursed organ acquisition expenditures. The HCFA might consider whether or not it would be feasible to include expenditures for the acquisitions of hearts in some or even all of the priority audits.
7. In our 1987 report at a time when kidney waiting lists were much shorter, we estimated that these laboratory costs accounted for about 20 percent of kidney acquisition costs.
8. For example, they are unable to compare how much different laboratories are reporting for the same test.
9. In response to our 1987 report, the American Society for Histocompatibility and Immunogenetics (ASHI) indicated that it was working on the development of a standardized nomenclature and would be willing to work with HCFA and the intermediary in this regard.
10. We cited the example of one metropolitan area where each of five renal transplant centers conducts the same basic tests involving a donor organ each time such an organ becomes available. The process, we were told, could add up to eight extra hours to the organ procurement process.

While other reviewers expressed support for this recommendation, Aetna's manager of Medicare Administration (who is responsible for fiscal oversight for the independent OPOs) expressed some reservation, especially with respect to the possible impact on time frames. On the basis of the areas we have visited with single pretransplant laboratories, the process seems to work rather efficiently, certainly more so than in the case cited above with five such laboratories.