



The Honorable Chiquita Brooks-LaSure  
Hubert H. Humphrey Building  
Room 314G-01  
200 Independence Avenue SW  
Washington, DC 20201

June 28, 2021

Re: CMS-1752-P – FY 2022 IPPS Final Rule

Dear Administrator Brooks-LaSure,

The National Kidney Foundation (NKF) appreciates the opportunity to comment on the proposed FY 2022 inpatient rule. The CMS inpatient payment system is vitally important for patients affected by kidney disease because of the unique nature of the Medicare benefit for patients with kidney failure, or end-stage kidney disease (ESKD), also known as end-stage renal disease (ESRD). The Social Security Amendments of 1972 extended Medicare coverage to individuals with kidney failure needing either maintenance dialysis or a kidney transplant to survive. Medicare still covers the majority of the ESKD population, even as the share covered by Medicare managed care and private insurance has grown. In 2016, Medicare was the primary payer for 441,162 patients with ESKD and the secondary payer for 63,340 more.<sup>1</sup> Dialysis, usually delivered in a standalone facility, is the default treatment for these patients. Dialysis is not, however, the optimal treatment for many of these individuals. Kidney transplants are preferable to dialysis in terms of survival, quality of life, and spending. Many kidney transplants are cost saving relative to maintenance dialysis and all kidney transplants are cost effective in terms of survival and quality of life when compared to dialysis.

The IPPS has an essential role in helping to improve the access of Medicare beneficiaries, the bulk of the ESKD population, to a kidney transplant by ensuring that the Medicare payment incentivizes transplant centers to accept and transplant as many organs as possible for their patients. Increasing the number of people who are able to benefit from the advantages that a kidney transplant can provide is NKF's most important goal, one that has historically been shared by the Department of Health and Human Services (HHS) and CMS. In 2017, NKF convened a consensus conference to develop recommendations on improving organ utilization and reducing kidney discards. It is estimated that every day, 12 patients die waiting for a kidney while 10 kidneys are thrown away. A key recommendation from the meeting was to create a risk-adjusted payment system for Medicare financed kidney transplants within the IPPS. Prior to FY 2021, there was only a single DRG for kidney transplant. Conference participants noted that the purpose of a risk adjusted payment system was to "ensure that organs that are clinically and economically beneficial in the long term are not declined due to the financial challenges in the short term."<sup>2</sup>

In the FY 2021 IPPS, CMS created a differential payment for transplant cases where the patient received dialysis during the inpatient stay and after the date of the transplant. We greatly appreciate CMS' acknowledgement that transplant clinical practice is changing to better utilize marginal organs

<sup>1</sup> [https://www.usrds.org/media/1734/v2\\_c09\\_esrd\\_costs\\_18\\_usrds.pdf](https://www.usrds.org/media/1734/v2_c09_esrd_costs_18_usrds.pdf)

<sup>2</sup> <https://onlinelibrary.wiley.com/doi/epdf/10.1111/ctr.13419>

and transplant patients who may not have previously been viewed as an ideal candidate. These practices are in the best of interest of patients and should be applauded, but also place financial strain on transplant programs, strains that are being exacerbated by new organ allocation policies that call for broader sharing of organs. In our comments on the FY 2021 IPPS, we noted the importance of not extracting Medicare dollars from the kidney transplant DRG to fund the new severity adjusted payment. We understand that sidestepping the budget neutrality of the inpatient payment system is not feasible for CMS, but reiterate this comment, nonetheless. It is antithetical to the goals of health policy to provide optimal, cost effective, equitable, patient-centered treatment to defund any kidney transplant for the purposes of reimbursing another.

While the differential payment for kidney transplants requiring dialysis is a fundamental step in supporting Medicare beneficiary access to transplant, many transplants require substantial resources at the time of transplant, not all of which are based on the need for dialysis. Acute tubular necrosis (ATN) causing delayed graft function (DGF) that requires hemodialysis is not the only factor that drives transplantation costs. Other factors include high levels of donor specific antibodies; cardiac care and monitoring in older transplant recipients; and the use of expensive, but highly effective biologic agents to reduce the risk of rejection.

We ask CMS to continue to use every lever at its disposal to encourage transplantation. Reimbursement through the IPPS must keep pace with rapidly evolving transplant practices that may increase the cost of some transplants but provide savings to the Medicare program overall when compared to spending on dialysis. We are committed to providing any new data on the differential costs of transplants to CMS as they become available. Please do not hesitate to reach out to Miriam Godwin, Health Policy Director, at [miriam.godwin@kidney.org](mailto:miriam.godwin@kidney.org) with any questions or concerns about the contents of this letter.

Sincerely,



Kevin Longino  
CEO and Transplant Patient



Paul Palevsky, MD  
President