Perverse Incentive System
How Regulations and Perceptions are:
- Costing Lives
- Wasting Dollars
- Dishonoring the Gift of Donation

J. Kevin Cmunt, President and CEO,
Gift of Hope Organ & Tissue Donor Network

CEOT
CUTTING EDGE OF TRANSPLANTATION

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RESOLVING THE ORGAN SHORTAGE

PRACTICE | POLICY | POLITICS

FEBRUARY 25-27, 2016 • PHOENIX, ARIZONA

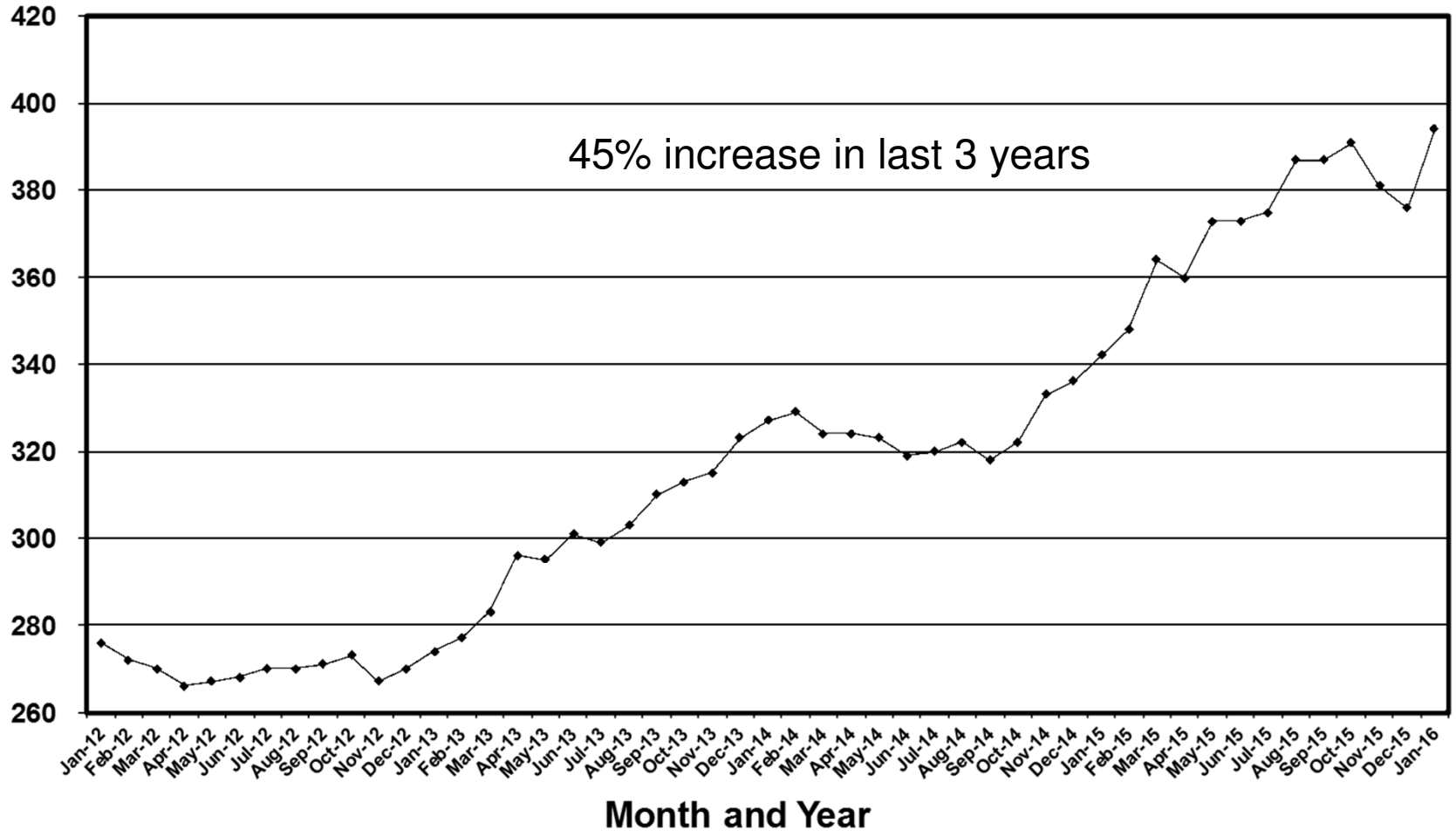
Conflict of Interest Disclosure

- I have no relevant financial relationships to disclose

The Story of Our DSA

ILIP Donors Recovered

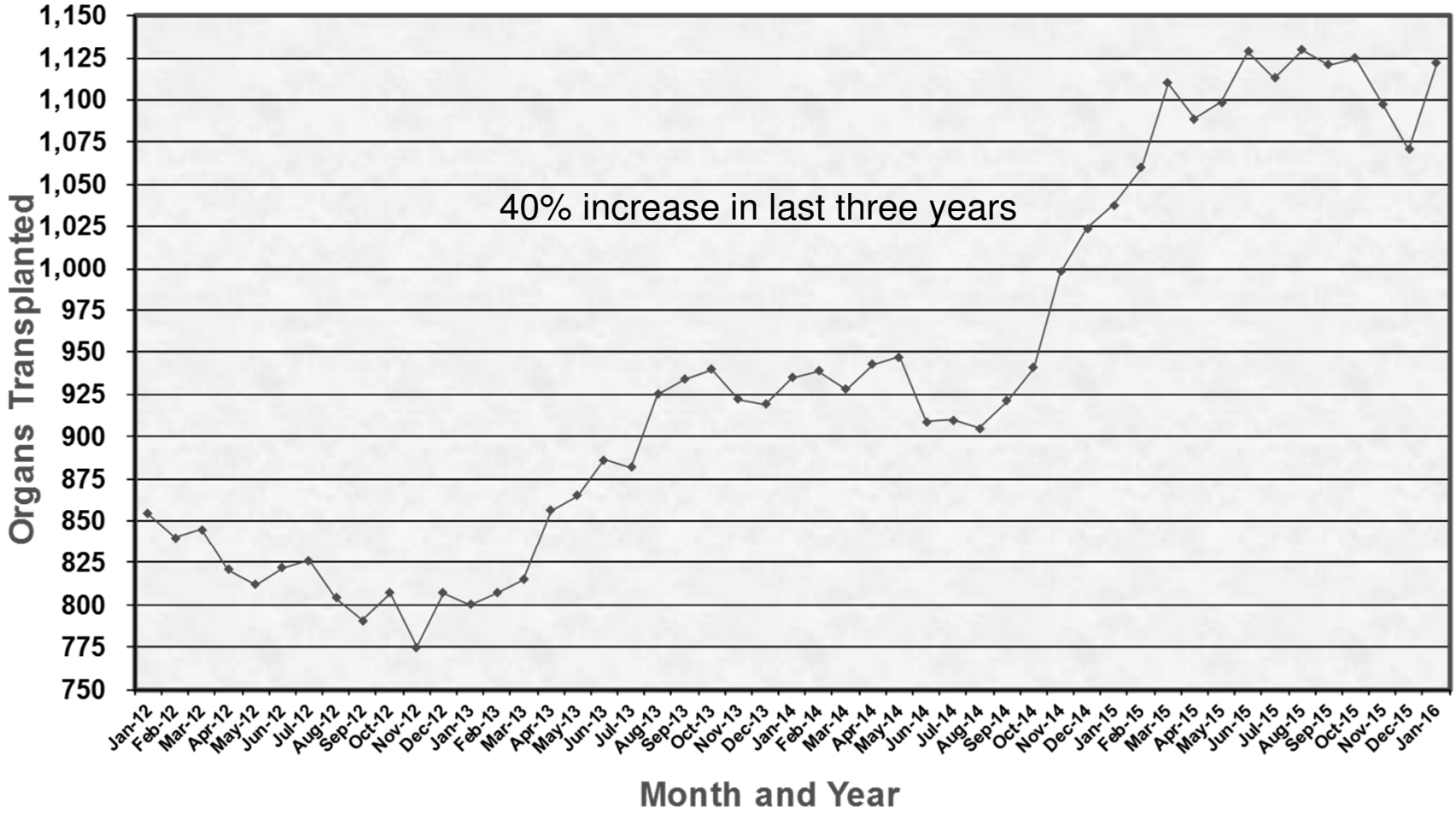
(12-month Rolling Average 2012 through January, 2016)



The Story of Our DSA

ILIP Organs Transplanted

(12-month Rolling Average 2012 through January, 2016)



The Story of Our DSA

Why Donation Has Increased

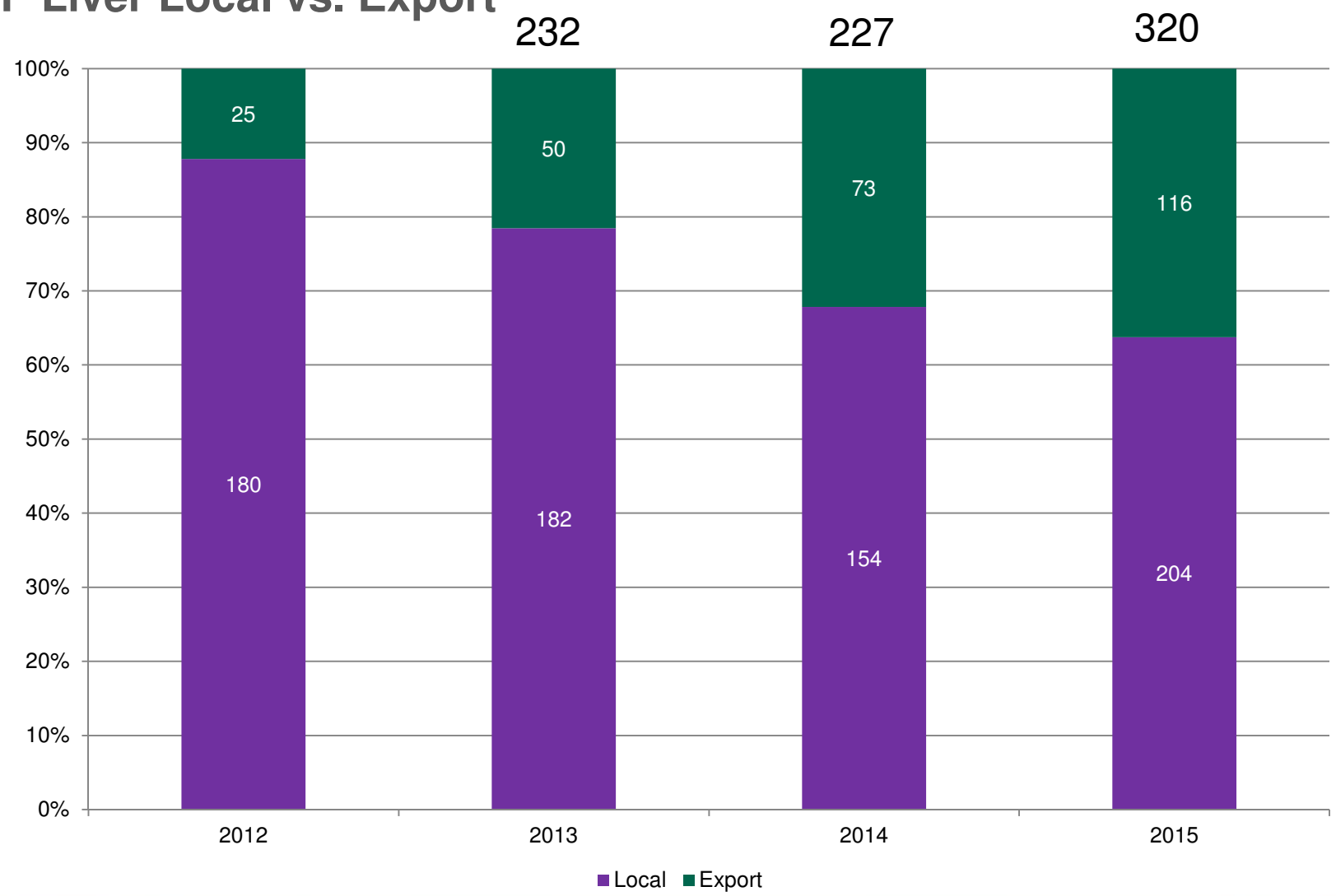
- Specialized Functions
- Encouraged “Can-Do” Attitude
- Focused on Hospital Relationships
- **Increased Operations Staff by 40%**

With 5000 people on the waiting list in Illinois, 300 deaths per year: Local Transplant should have increased 50%

What Actually Happened??

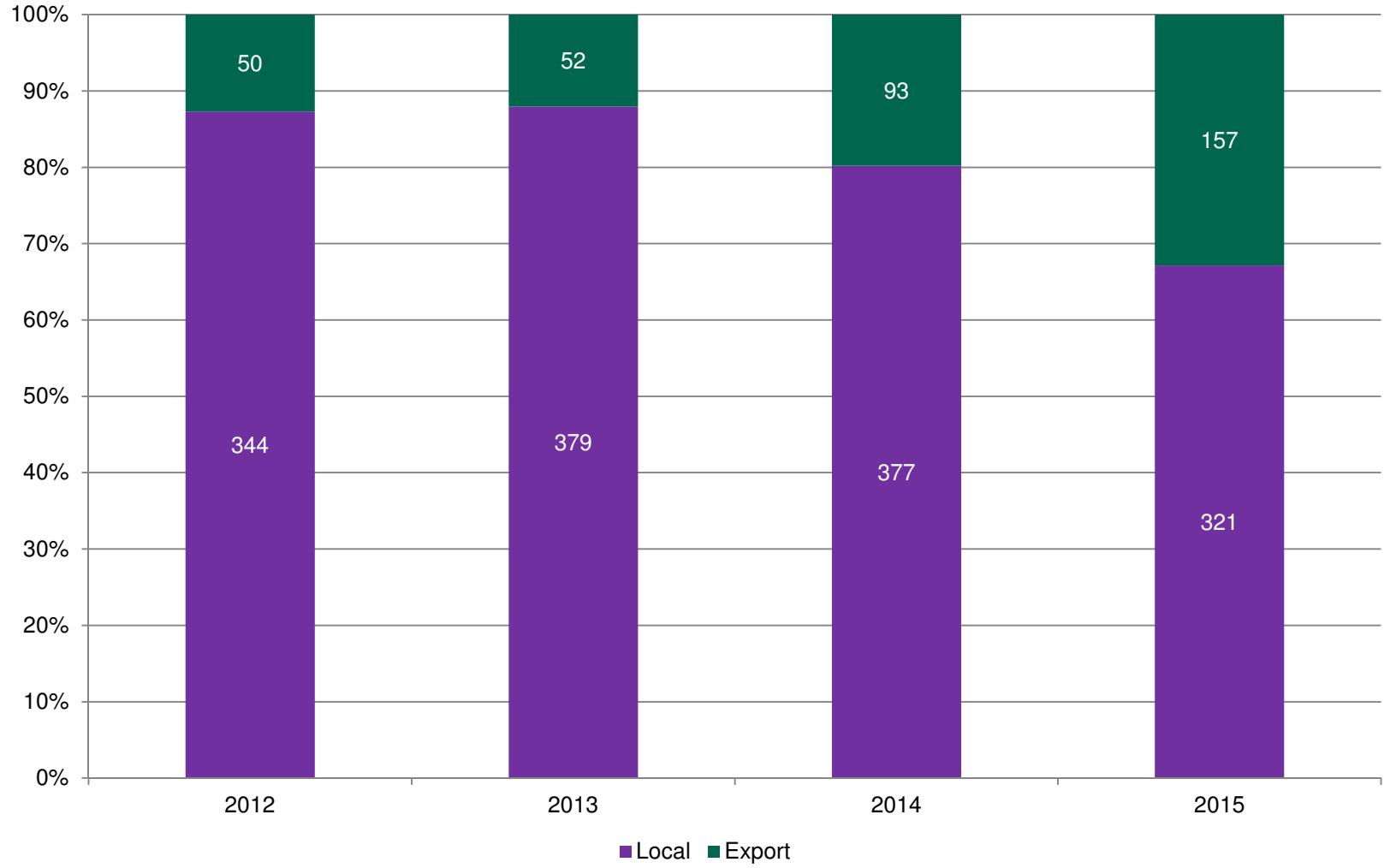
The Story of Our DSA

ILIP Liver Local vs. Export



The Story of Our DSA

ILIP Kidney Local vs. Export



The Story of Our DSA

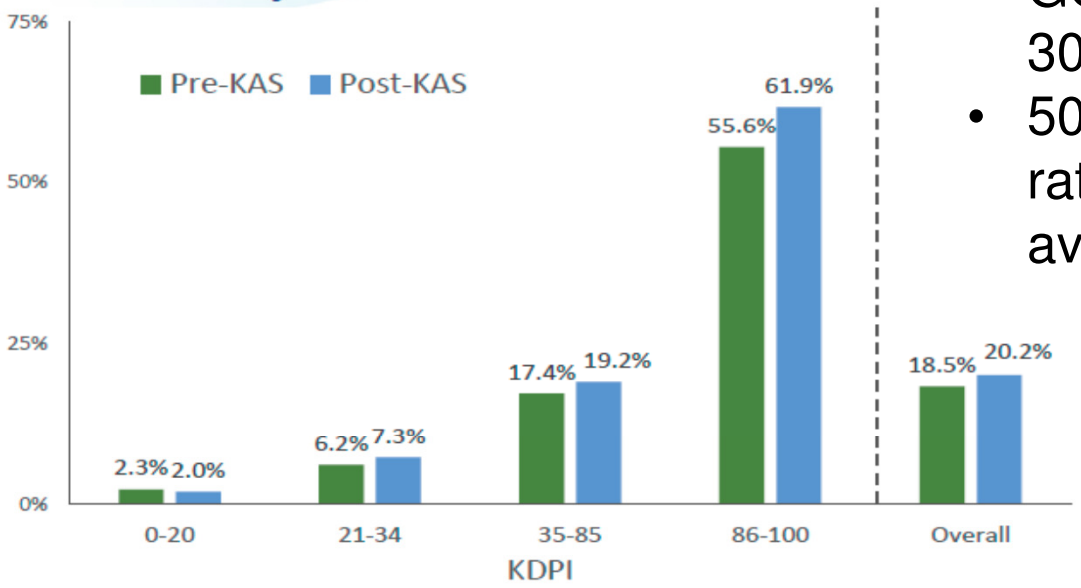
ILIP Kidney Utilization

	2012	2013	2014	2015	Δ 2014 to 2015
Recovered – Total	491	558	622	690	+ 11%
Recovered for Transplant	396	431	579	654	+ 13%
Transplant - Local	345	379	379	301	- 26%
Transplant - Export	51	52	91	157	+ 76%
Recovered for Transplant but not utilized	87 (22%)	99 (23%)	109 (19%)	**196 (30%)**	+ 11%
Imported	43	54	29	49	+ 69%
Net (Import-Export)	- 8	- 2	- 63	**- 108**	+ 71%

Kidney Discards National Data

Kidney recovery & utilization under KAS

Kidney Discard Rate by KDPI



- GOH Discard Rate 30% overall
- 50% higher discard rate than national average

OPTN | UNOS

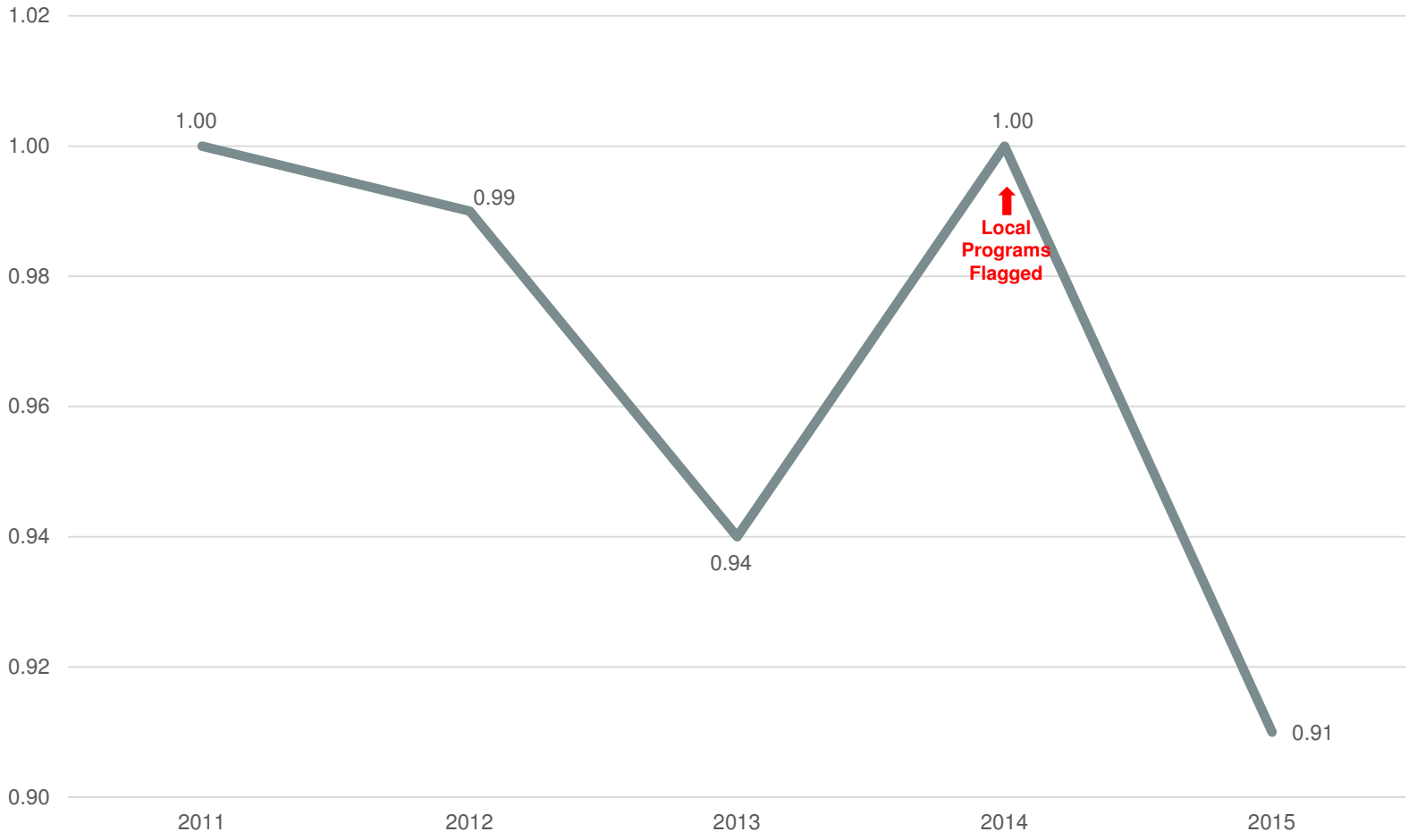
- Kidney discard rates have increased by about 10%.
- Increase largest for, but not limited to, KDPI>85% kidneys.

Source: UNOS/OPTN Kidney Transplant Committee Fall 2015 Presentation

The Story of Our DSA

Kidney O:E Ratios

2012 through 2015



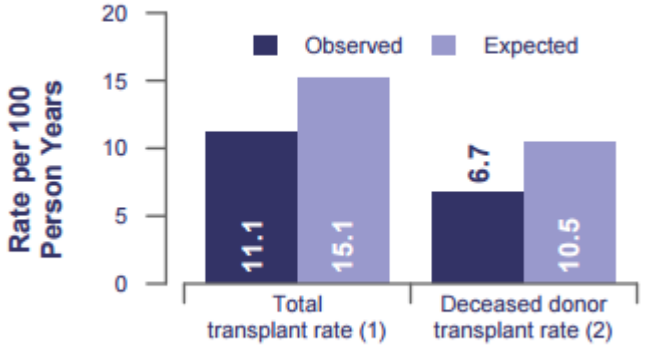
Conclusion

- We discarded approximately 65 kidneys that should have been transplanted based on OE and National discard rates
- Local program transplant should have been 150 to 200 kidneys higher (108 net export + 65 excess discards)
- Could we have eliminated ½ of the deaths on the waiting list in Illinois?

Question: Why were these organs not transplanted in our DSA?

ILIP Flagged Local Kidney Programs

Figure A2. Transplant rates
07/01/2014 - 06/30/2015



(1) Statistically lower (p<0.01)
(2) Statistically lower (p<0.01)

Figure A2. Transplant rates
07/01/2014 - 06/30/2015

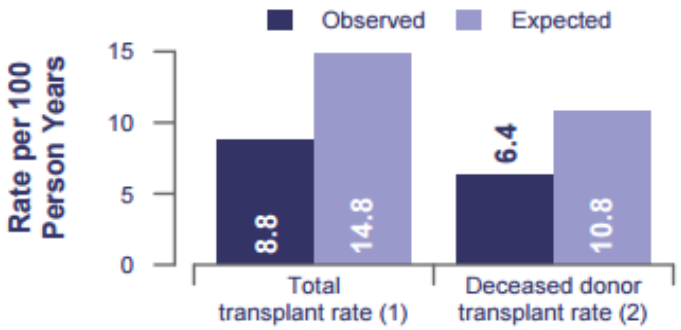


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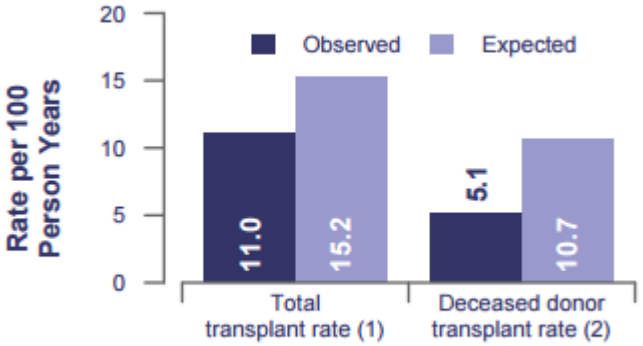
Figure A2. Transplant rates
07/01/2014 - 06/30/2015



(1) Statistically lower (p<0.01)
(2) Statistically lower (p<0.01)

- **Largest Programs average transplant rates apx. 60% of expected in 2015**

Source: SRTR Transplant Center Reports
http://www.srtr.org/csr/current/Centers/TransplantCenters.aspx?organcode=KI; Accessed 02/22/2016

Regulations and Perceptions

What we heard from our Programs:

- **Fear of Flagging results in decreased transplants**
  - Natural tendency of programs is to “go conservative”: Reduce marginal organ usage
- Cost of transplant with marginal organs goes up
  - Increased DGF, dialysis required etc.
- Patients want “best” kidney, won’t accept high KDPI

Impact on System Costs

Impact on Kidney Standard Acquisition Charges

Issue: ILIP discarded approximately 60 kidneys that should have been transplanted

Kidney only donors are not the issue

Year	# Kidney Only Donors	# Kidneys Utilized	Utilization Rate
2014	27	41 of 54	76%
2015	25	38 of 50	76%

- Excess Discarded Kidneys are primarily from marginal Liver donors
- CMS requires costs to assigned to kidney if there is intent to transplant
- **Should we even recover these kidneys, from Marginal L-K donors??**

Impact on System Costs

Kidney Acquisition Fees

Direct Costs	Kidney Only	Kidney/Liver	Liver Only	Incremental Kidney
Hospital Costs/Prof Fees	$13,300	$13,300	$13,300	$0
Trans/Shipping/Packaging	3,000	3,800	2,200	1,600
Laboratory Testing	7,785	8,185	2,335	5,850
Procurement Fees	1,250	1,250	-	1,250
Pump Supplies	3,400	3,400	-	3,400
Total Costs	$28,735	$29,935	$17,835	$12,100
Cost per Organ	$14,368	$9,978	$17,835	$6,050

Above costs do not include allocation of overheads and salaries

Impact on System Costs

Kidney Acquisition Fees

Kidney Procured		100
Liver Procured		50
Kidney Transplanted	38.0%	38
Liver Transplanted	86.0%	43
Incremental Kidney Revenue	$36,800	$1,398,400
Incremental Kidney Cost	$6,050	$605,000
Incremental Revenue/Cost		$793,400

16% utilization rate for kidneys is the “break-even” point for liver kidney donors

Impact on System Costs

Kidney Acquisition Fees

- 60 discarded kidneys @ $34,000 = $2,000,000 in lost reimbursement
- CMS Requires costs be spread over transplanted kidneys
- Result: ILIP forced to raised 2016 SAC for Kidneys by $2000!

I

CMS Regulations force underutilization of marginal organs:

CMS regulations force increase in cost of kidneys!

PS: How much post transplant care does $2MM buy you??

Opportunities for Improvement

We Can Solve This Problem

Change the Regulations!

UNOS CMS and HRSA need to get on the same page:

- Three projects on-going this year at UNOS to address the issue
- Need to stay focused and make sure change happens this year
- CMS and HRSA need to engage fully and agree to adopt new UNOS measures simultaneously

Nationally we are wasting 500 to 1000 kidneys per year, Every Year until we fix this problem

Note: We have the same problem and opportunity with other organs too!

Opportunities for Improvement

We Can Solve This Problem

Financial Incentives

- Issue: using high KDPI kidneys results in increased DGF and higher patient costs of care
- Proposal: Explore method to provide programs with reimbursement for incremental costs for each transplant done with a high KDPI kidney
- Question: Would this increase local utilization?

Opportunities for Improvement

We Can Solve This Problem

Change Perception

SRTR data shows that use of high KDPI kidneys does not harm a program's ability to meet regulatory requirements

Need to educate programs, more discussion of successful programs (e.g. Oshner for marginal livers, UC Davis marginal kidneys)

Need to educate insurance carriers and patients that OE, acceptance rates and transplant rates are more important than simple 1 year survival rates

This will take time and we can't wait. There are things we can do now to improve utilization

Opportunities for Improvement

We Can Solve This Problem

Targeted Kidney Allocation

Protocol:

- Donors with KDPI ≥ 85%, ≥60years old, or ≥50 years old with Hx of CVA or HTN
- In addition to the initial cross-match list generated per protocol, a targeted allocation list is generated **Pre-procurement**
- Each center has the option to select **one** candidate meeting the following criteria for the Targeted Allocation List
  - Suitable to receive an ECD kidney with more advanced vascular disease/histologic injury
  - Transplant ready and available
  - Absent DSA
- In cases of limited center interest, participating centers may add additional name(s) to generate a list maximum of 7 candidates
- Kidney allocation follows UNOS priority listing.
- Failure to allocate the kidney under this protocol is considered a strong indicator of no local interest and further cross-match testing is not allowed due to delay in regional/national allocation.

Opportunities for Improvement

We Can Solve This Problem

Targeted Kidney Allocation

KDPI > 85	2014	2015
# of Donors meeting Criteria	76	90
# of Times utilized	20	21
# of Kidneys transplanted	14	18

Honoring the Gift of Donation

Gift of Hope Vision:

That every opportunity for donation is successful

When a family says “yes” to donation, we make a promise to do everything we can to maximize that gift

Families want and expect that their loved ones organs will be used to highest benefit possible

We owe them better than we are doing now

All data other than Slides 10 and 11 provided by Gift of Hope