A Fairer and More Equitable, Cost-Effective, and Transparent System of Donor Organ Procurement, Allocation, and Distribution

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Disclosure

My comments, suggestions, and opinions:

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Potential Inequities Attributable to Costs and Other Economic Factors

- Multiple listing and travel to increase likelihood of receiving a deceased donor organ – socioeconomic inequities for patients
- Disparity between commercial and government reimbursement – potential to affect patient access, patient selection, and organ acceptance
- Organ Acquisition Charge mark-up – magnifies commercial/government payer disparity
- Medicare Cost Report – provides significant revenue to transplant center donor hospitals versus non-transplant center donor hospitals
- COE focus on survival – disadvantages patients with rare conditions and conditions not recognized by the SRTR

Inequities Related to Deceased Donor Organ Availability

- Great variation in organ availability across the US
- Multiple listing – waiting list registration at more than one transplant center – increases a patient's opportunity to receive an organ
  - Patients that reside in a low availability area can travel to a high availability area
  - Sensitized kidney patients increase their exposure to more donors through multiple listing

Inequities Related to Deceased Donor Organ Availability

- **Travel and multiple listing opportunities**
  - Favor patients with excellent socioeconomic support and insurance plans that permit multiple evaluations and listings
  - Disadvantage patients without socioeconomic support and plans that do not support travel or permit multiple evaluations (including Medicare Advantage and Medicaid)
- **Socioeconomic access inequities are magnified in transplantation**
  - Evaluation, waiting time and urgent travel, care giver support, prolonged hospitalization

Inequities Related to Deceased Donor Organ Availability

- **Possible solution: Wider sharing**
  - Increases costs of transportation of organs
  - Wide variations in OACs complicate reimbursement
    - » Transplant centers need to develop a standard charge; or
    - » OPOs need to develop a standard fee and set of services

Inequities Related to Financial Incentives

- **Transplantation is big business**
  - **High cost and increasing activity led to creation of commercial "Centers of Excellence" (COE's) in early/mid 1990's**
  - **Transplantation is a major source of revenue and operating income for many medical centers**
  - **Operating income is driven by commercially insured patients and commercial COE participation is necessary for success**
  - **Organ allocation and distribution controversies are at least partially caused by the profitability of transplantation, especially liver transplantation**

Inequities Related to Financial Incentives

- Reimbursement for surgeons and transplant centers favors commercially insured patients over Medicare and Medicaid patients
  - Potential to influence patient selection
  - Potential to influence organ acceptance
- Possible Solutions:
  - Increased oversight and regulation (increases costs)
  - Expand Medicare eligibility to non-renal organ transplant candidates

Inequities Related to Costs

- Organ Procurement Organizations (OPO's) are reimbursed for the costs of procurement by the transplant center receiving the organ
  - The Organ Acquisition Charge (OAC) is the highest item on a patient bill, ~ 20% of the total cost of the transplant
  - Transplant centers may mark up the OAC by as much as 20 – 40% to counter the discount for commercial insurance, but they may mark it up more
- Deceased donor organs are a national resource
  - Buying and selling of organs is not legal
  - The OAC mark-up may contribute to the inequity between commercial and Medicare patient revenue

Inequity Due to the Medicare Cost Report

- **Medicare Cost Report reimburses transplant centers for a multitude of services**
  - **Costs are reimbursed in proportion to Medicare patients and deceased donor organs procured at transplant center hospitals**
  - **The donation component can be as high as $4 – 6M per year**
  - **Transplant Centers have a financial incentive to promote deceased donation, but non-transplant center hospitals do not**
  - **This revenue could be shared with non-transplant center donor hospitals or redirected toward organ donation awareness**

Inequity Related to Focus on Survival

- Commercial COE participation
  - Volume and performance criteria required for participation
  - Performance criteria focus on patient and graft survival, not benefit
- Programs focus on survival to comply with COE criteria
  - Disadvantages patients with rare conditions and conditions not risk adjusted by SRTR
  - Penalizes centers for innovation

Five Recommendations to Address Inequities Due to Costs and Other Economic Factors

1. Wider sharing to alleviate geographic disparities that contribute to socioeconomic inequities
2. Minimize financial incentives that favor commercial patients over Medicare and Medicaid patients
    1. Increase regulation and oversight
    2. Expand Medicare eligibility to non-renal organ transplant patients
3. Prohibit OAC mark-up to reduce difference between commercial and Medicare reimbursement
4. Share financial incentive for organ donation with non-transplant center hospitals (and hold all hospitals in addition to OPOs accountable for donation metrics)
5. Focus on benefit rather than survival to avoid disadvantaging patients with uncommon conditions and conditions not risk adjusted by SRTR