

Kidney Paired Donation Recommendation

Kidney Paired Donation Working Group

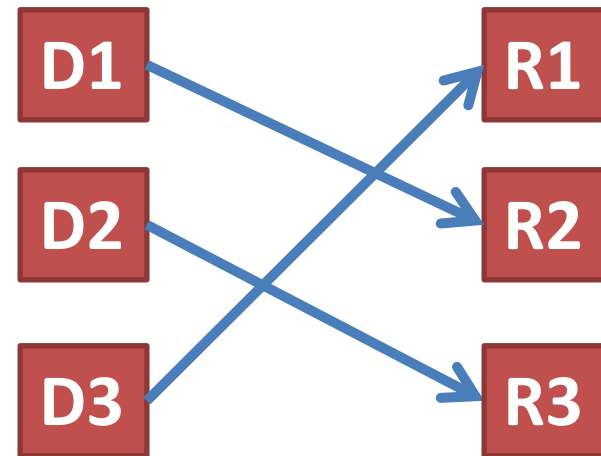
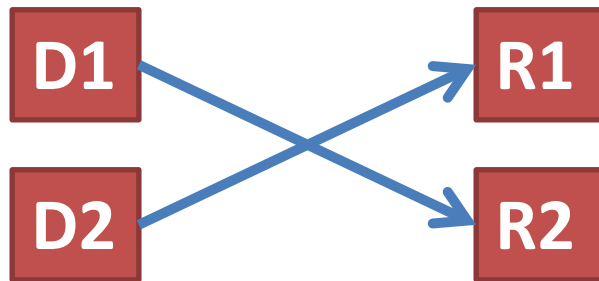
ACOT

March 12, 2015

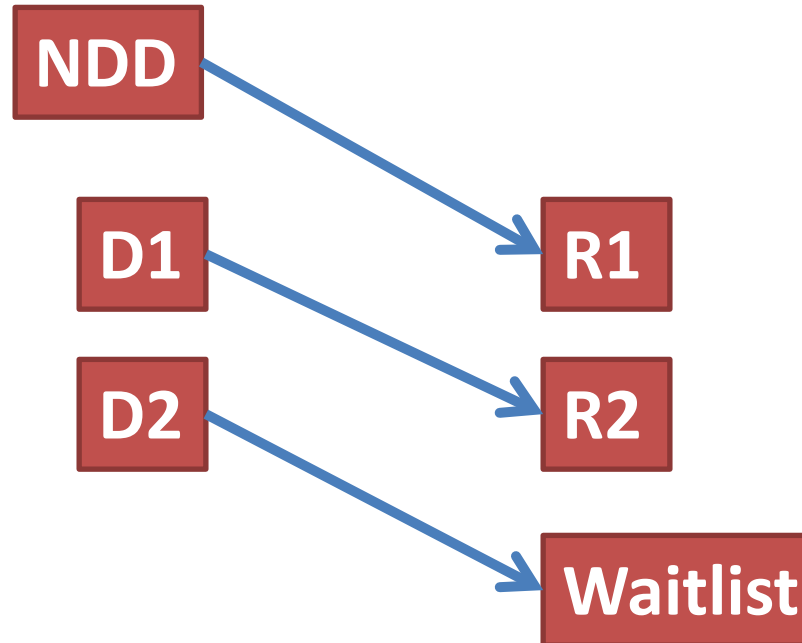
Outline

- KPD Review (updates of previous presentations)
- Consensus Conference on KPD, March 2012
- Recommendation from the KPD Working Committee

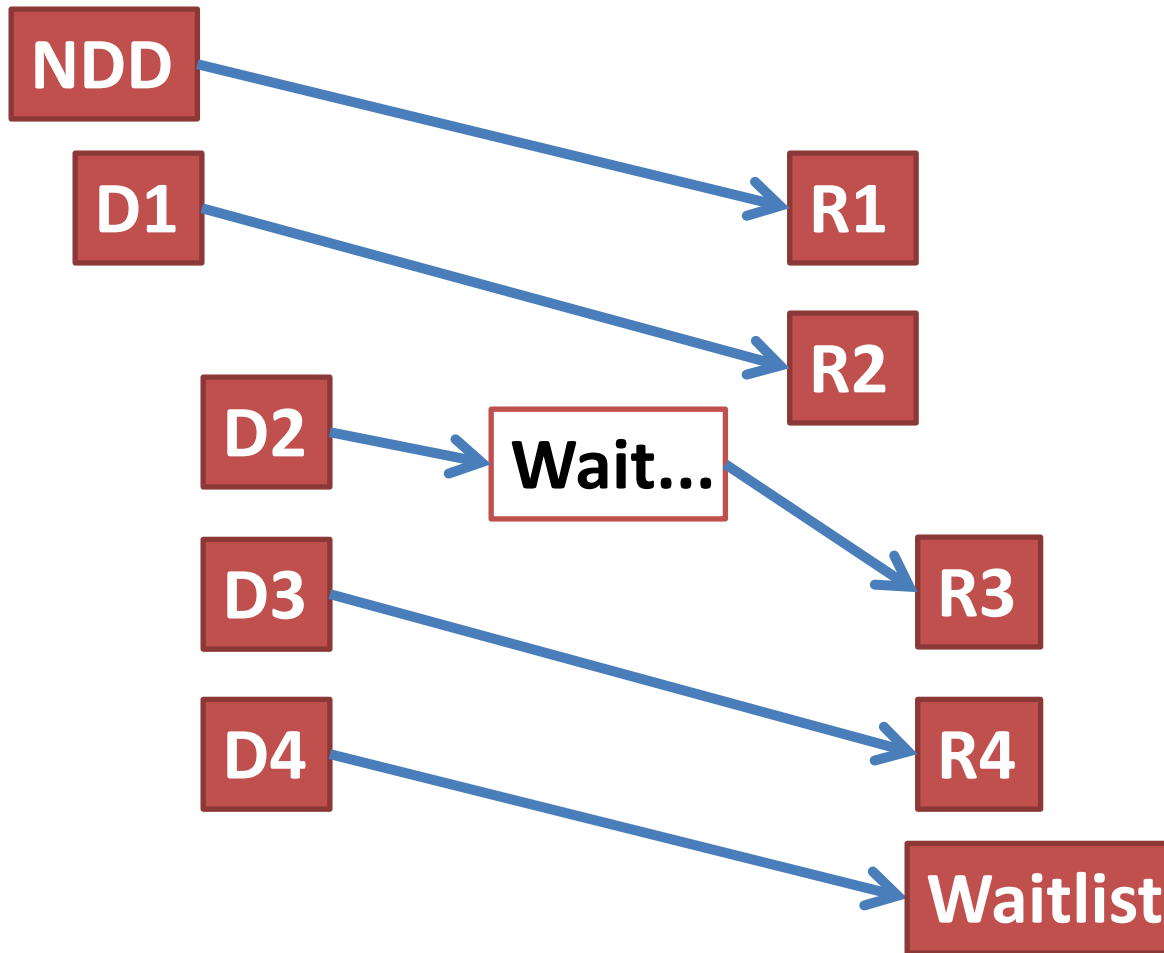
- Straightforward 2-way (or N-way): KPD that happens simultaneously where all pairs exchange donors among themselves



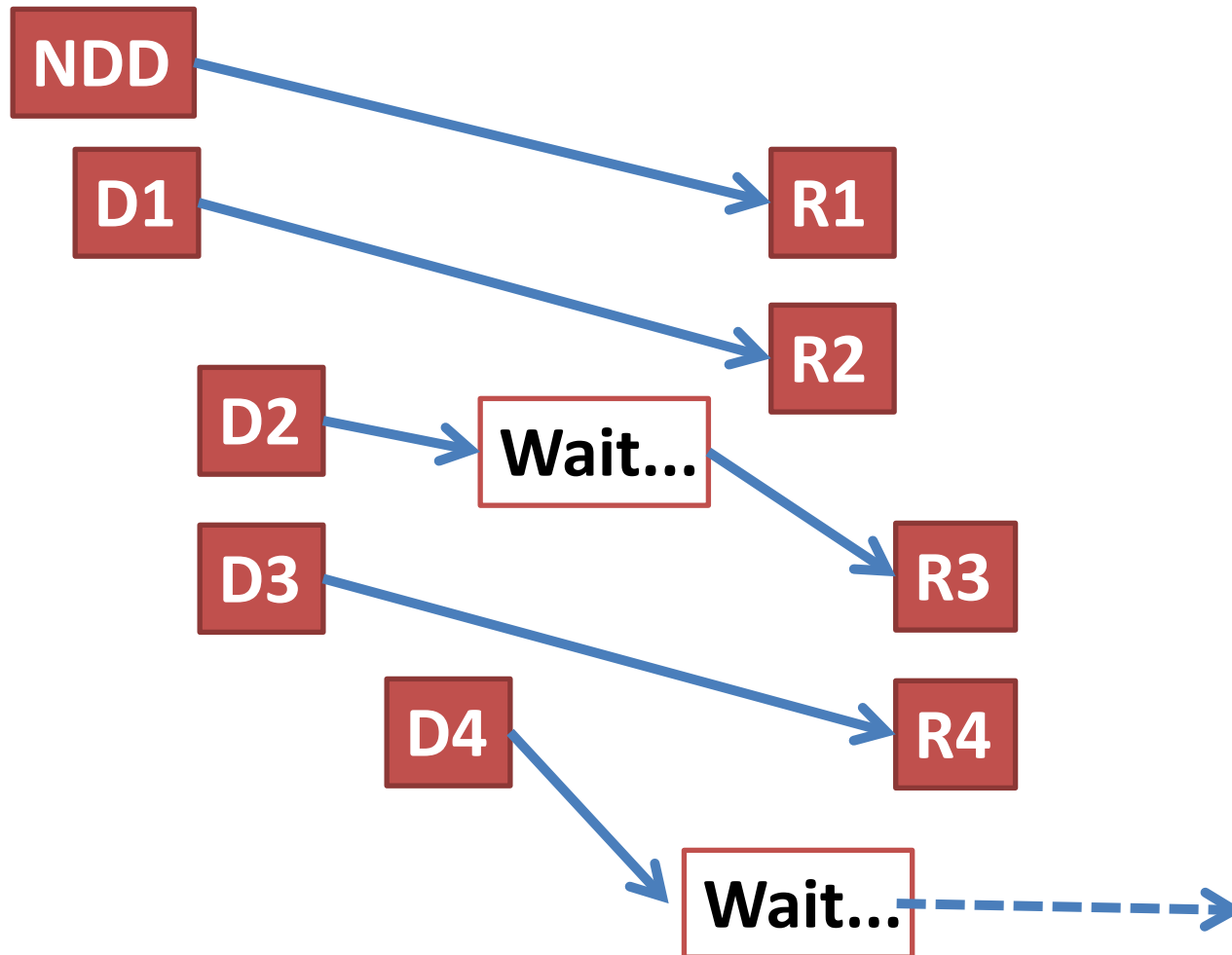
- Domino (closed chain): 2-way (or N-way) KPD started by NDD and ending in the waiting list (all happen simultaneously)



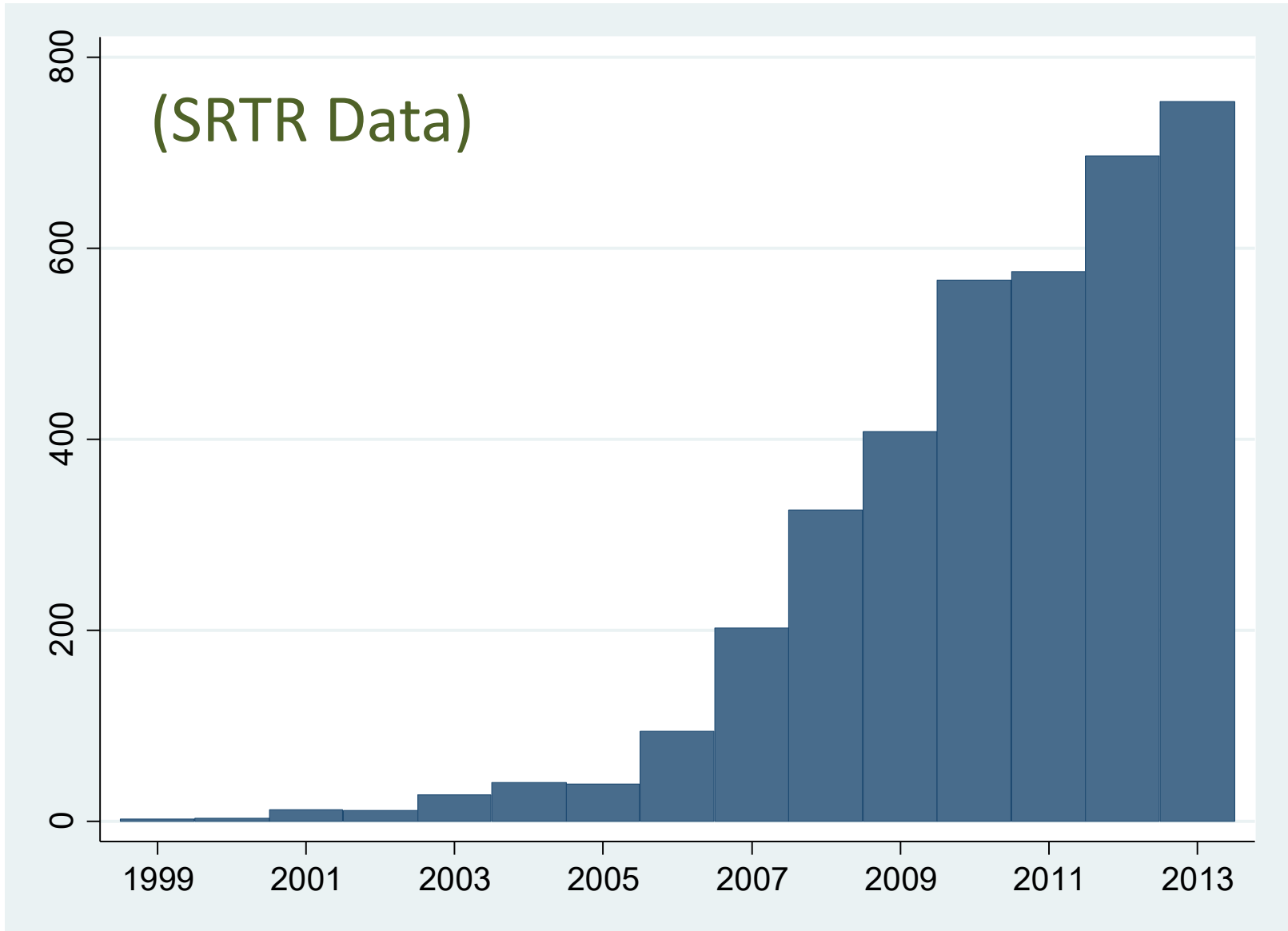
- Non-simultaneous domino (closed chain)



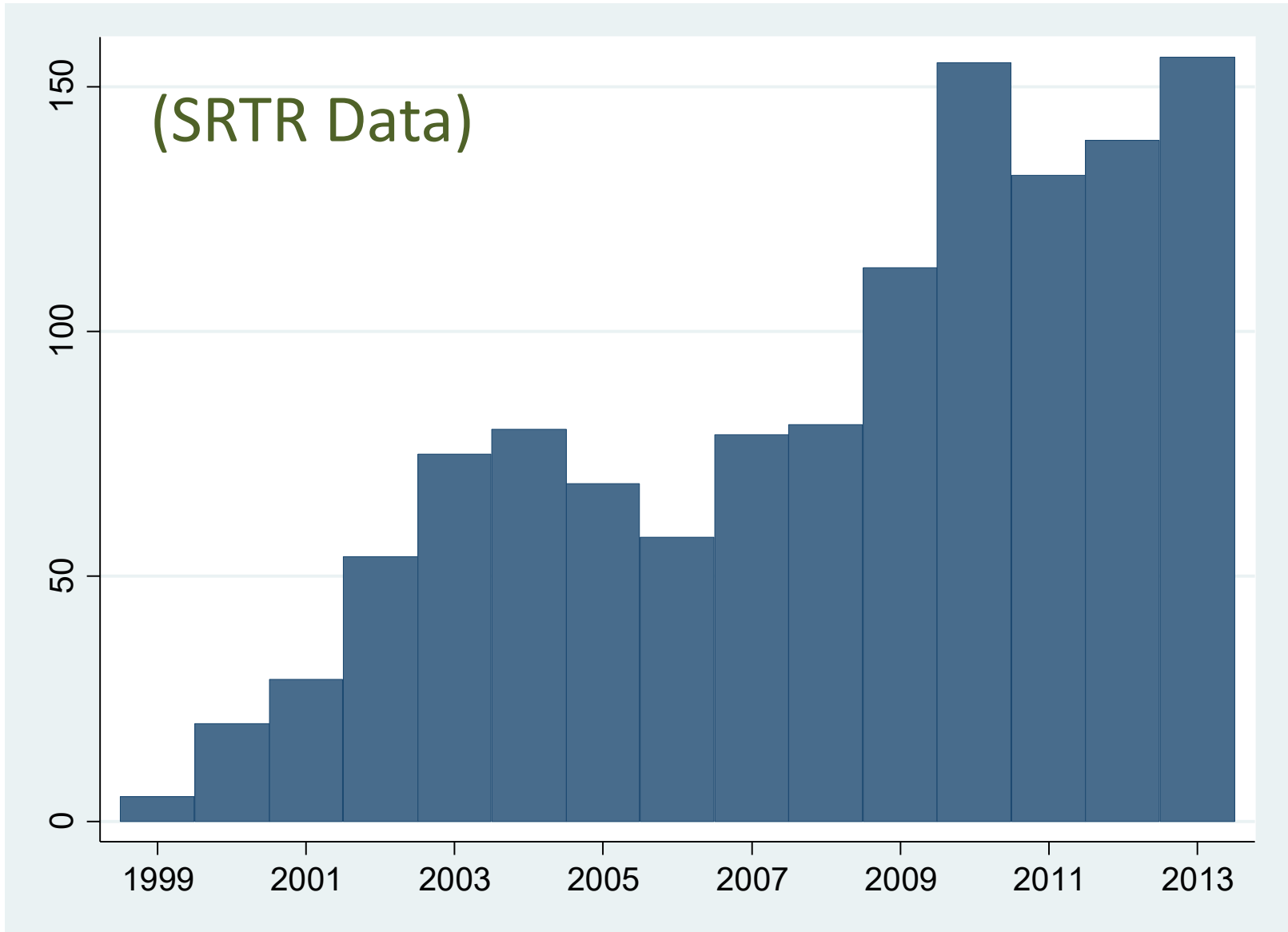
- Non-simultaneous chain (open chain)



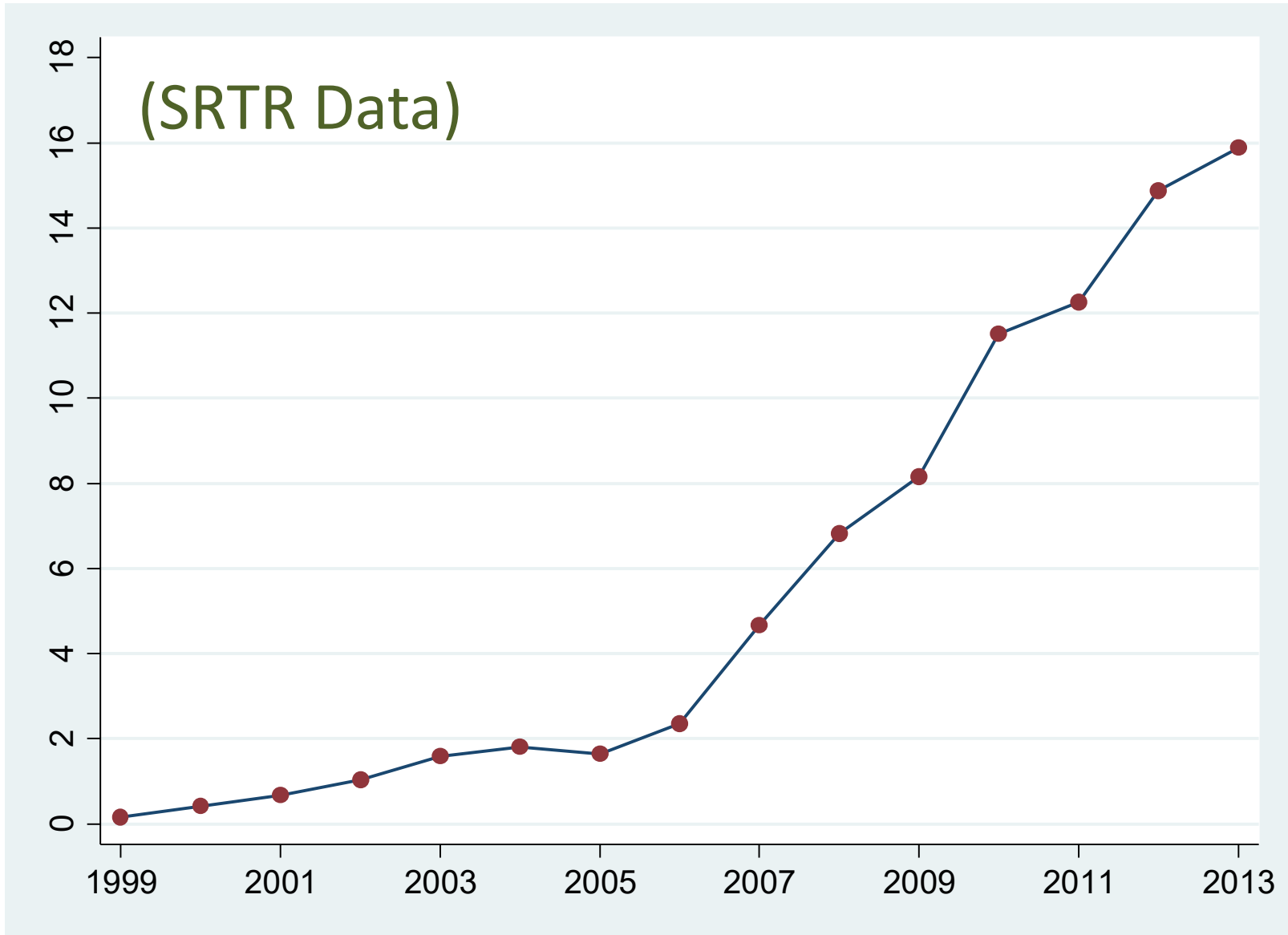
KPD in the US: >4200



NDD in the US: >1300



KPD+NDD: 16% of LD Transplants



Unanswered Questions

- Chains
 - Are longer chains really better, or do they just attract more media?
 - When do you stop the chain?
 - To whom does the last kidney go?
- Matching Priorities
- Optimization
 - Dynamic versus batch

Unanswered Questions

- Financial
 - Usually donor bills recipient insurance
 - More complex when at different centers
 - Who covers donor complications?
 - Who pays for multiple donor/NDD evaluations?

Costs of KPD

1. Evaluation of incompatible donors
2. Evaluation of NDDs
3. Histocompatibility testing
4. Center-level administration
5. KPD program administration
6. Kidney shipping costs
7. Donor surgeon professional fees
8. Donor complications/follow-up

KPD Financing Strategy Goals

- Transfer costs from the donor hospital to the recipient hospital
- Eliminate the volume disparity between centers
- Reimburse for donor services by out-of-network providers
- Present consistent/predictable costs for payers
- Remain compliant with CMS regulations

KPD SAC Strategy

- A fee for KPD is defined (not trivial to define) and agreed on by CMS (and other payers)
- Each center is paid the KPD SAC for every KPD transplant they perform, above and beyond payment for conventional live donor transplant
- National SAC?
Center-Level SAC?

Consensus Conference 3/12

- Donor Evaluation: Rodrigue/Serur
- Histocompatibility: Reed/Leffell
- Geographic Barriers: Segev/Hanto
- Financial: Rees/Zavala
- Allocation Policies: Gentry/Leichtman
- Implementation: Delmonico/Melcher

Consensus Recommendations

- All potential living donors should be informed about KPD early in the educational process, prior to compatibility testing
- A centralized information resource for NDDs should be developed by the transplant community. Because of their potential to trigger multiple transplants, all NDDs should be informed about KPD.

Consensus Recommendations

- The greatest benefit for candidates can be achieved in a single well-functioning registry that encompasses the successful aspects of currently operating registries
- National SAC would best serve KPD in the United States financial model

Payer Recommendations

- ...the designation of a national organization to administer and provide oversight to KPD would best meet the needs of expanding access to KT in a fair and equitable manner.
- We are impressed by a number of ingenious and resourceful regional and local approaches that have been used...
- However, considering the scope of the national KT needs, we believe that a national system that maintains the foresight and flexibility to foster innovative approaches to KPD will allow management of one seamless national effort.
- ...to be successful, a national KPD program would be managed under the auspices of HRSA. (Irwin et al, AJT, 2012)

Recommendation

Kidney paired donation (KPD) plays an emerging role in the United States, now comprising more than 10% of live donor kidney transplants. The current decentralized organization of KPD programs is not optimal in terms of equity of access, broad participation by centers and patients, donor safety, and transparency. Providing a nationally accessible KPD system with incentives to participation in this system rather than in smaller, decentralized programs would improve equity of access and facilitate participation by centers and patients. Implementation of a standardized reimbursement model (such as a standard acquisition charge) would improve donor safety by ensuring medical care for donors, in addition to providing an equitable framework for reimbursement of KPD transplants. Evaluation of all KPD programs by a centralized group would improve transparency.

To address these issues, we recommend that the Secretary identify a national KPD contractor responsible for implementing a nationally accessible KPD system, identifying optimal matching strategies, and encouraging participation by all transplant centers. The contractor would also be responsible for (1) administering a standardized reimbursement model for KPD costs, donor workups, and post-donation medical care that would be available to centers fully participating in the system; (2) evaluation of KPD programs and transplant centers that choose to perform KPD outside of the national registry; (3) balancing the needs of current and future patients; (4) striving towards equity in patient access to kidneys; (5) ensuring quality through frequent and critical assessment of equity and efficacy; and (6) recommending process and/or policy changes as appropriate.

Thank You

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