Kidney Bean Counting: Overcoming the Financial and Administration Burden of Paired Donor Exchanges

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Conflict of Interest Disclosure

- I have no relevant COIs to report but do have ongoing consulting arrangement with ASTS and with University Hospitals in Cleveland
- No off-label use will be described in this presentation

Kidney Bean Counting

1. Basic Principles – who pays donor expenses?
2. CMS vs. Commercial Payors
3. Different Payment Methods – Pros and Cons
4. Physician Charges
5. Complications
6. Make up your mind, CMS!

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- Donor should not incur any hospital or physician costs
- **All** hospital and physician costs follow the recipient
- Payors generally follow CMS lead

Kidney Bean Counting: Regulations

- CMS has referred to three documents in response to inquiries:
  - Provider Reimbursement Manual 2771.A
  - Medicare Claim Processing Manual Publication 100-04, Chapter 3, Section 90.1.1
  - Program Memorandum 9-26-2003
- **TO DATE: There have been no formal, published changes in CMS policy**

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Components of Cost

1. Evaluation Costs
2. Donation Hospitalization Costs
3. Post Care
4. Physician Charges
5. Complications

Polling Question

- At my center, we retain all donor evaluation costs but charge the recipient hospital for the donor hospitalization
- At my center, we retain all donor costs
- At my center, we use a LD SAC that covers evaluation and donor hospitalization
- At my center, we charge the recipient hospital for both the evaluation and hospitalization using an itemized invoice
- I don't know or other

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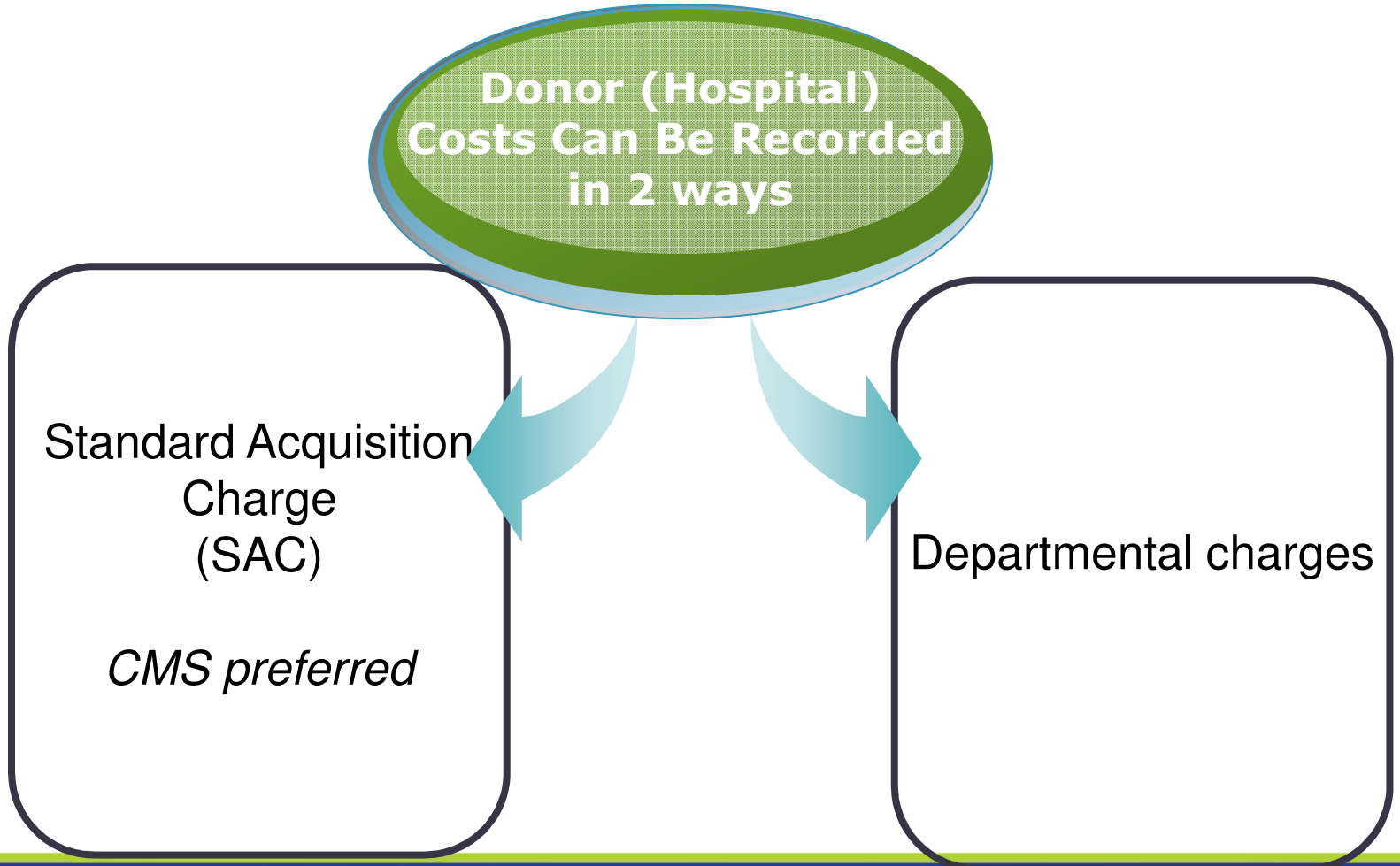

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Standard Acquisition Charge (SAC)

- Not a charge representing the cost of a specific kidney but a charge that represents the AVERAGE cost associated with acquiring that type of kidney (in this case, living donor kidney)
- All-inclusive (direct & indirect)
- Includes physician evaluation services up to the admission to the hospital for donation or transplantation
- Usually calculated once per year
- Includes the costs of ALL donors and recipients – not just Medicare recipients

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Standard Acquisition Charge -
Cost Report

All donor costs (live and deceased) + all recipient evaluation costs

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# of kidneys transplanted

=

SAC for <u>your</u> institution

Medicare reimburses transplant center for the percent of patients who are Medicare

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Standard Acquisition Charge – Commercial Payors

$$\frac{\text{All donor costs (live and deceased) + all recipient evaluation costs}}{\text{kidney transplants in FY}}$$

=

FULL COST SAC per recipient

- Mark-up applied
- Standard Acquisition Charge on hospital bill
  - Fee for service: Discount on charges applied
  - Case rate/global rate: Reimbursed as part of case or global payment

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Standard Acquisition Charge – KPD

All live donor costs (donor only NO recipient costs)

# of live kidneys successfully donated

=

live donor SAC for <u>your</u> institution

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SAC Considerations

Advantages of SAC

- Eliminates questions of when individual donor costs were incurred
- Dilutes issues of multiple donors for a single recipient, etc…
- Can be transparent between centers as soon as match is made (KPD)

Disadvantages of SAC

- Differences in overhead could cause difficulties in KPD
- How are "extra" costs treated (i.e. recipient center requests additional tests in KPD)?
- Isolating donor costs may represent new administrative processes for some centers (KPD)

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Departmental Charges

- Itemized bill for costs associated with a specific donor for a specific recipient can be billed to the recipient transplant center
- Transplant centers must bill SAC to Medicare or third-party payors for organs acquired and transplanted

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Departmental Charges

SAMPLE INVOICE	
Name: Sally Jones	Patient ID #: 99999999
Address: Any town, USA 99999	
Transplant donor evaluation and acquisition services for recipient:	
Name: Lucky O'Malley	HI #: 00000000
Address: Big Transplant Center, USA 99999	
Tissue Typing	
Chest X-ray	
EKG	
Chem 20	
CBC	
Operating room minutes, etc…	

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Departmental Charges: Considerations

Advantages of DC

- Allows for exact costing of the specific donor in KPD

Disadvantages of DC

- Adds complexity in determining when/which donor costs should be included in KPD
- Can't recover costs for multiple donors
- Difficult to recover staff time and other overhead

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National Standard Acquisition Charge – KPD

All live donor costs for donors designated for KPD including professional fees

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# of live kidneys successfully donated

=

live donor SAC for ALL participants

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Average Cost Per Organ by FY

Fiscal Year	Medicare Payment Per Organ	Organ Cost If used 3% annual inflation	Dialysis Medicare Payments Per Patient Year (USRDS)	Total Transplants (UNOS)
1996	$ 28,635	30,917	52,879	19,765
2010	$ 56,101	46,765	86,608	28,661
Increase 1996 to 2010	**96%**	**51%**	**64%**	**45%**

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Cost Drivers

- Increased overhead resulting from regulatory requirements
- Increased costs of OPOs, HLA (also paid on Cost Reports)
- Education about allowable costs on Cost Report
- The system is not designed to incentivize cost reduction

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National SAC Considerations

Advantages of National SAC

- Predictable costs
- Eliminates questions of when individual donor costs were incurred
- Dilutes issues of multiple donors for a single recipient, etc…
- Encourages participation in KPD
- Eliminates concerns about professional fees
- Could represent additional revenue opportunity

Disadvantages of National SAC

- Have to determine how to deal with pro fee – cannot put on cost report
- How are "extra" costs treated (i.e. recipient center requests additional tests in KPD)?
- Incentivizes "dumping" of difficult pairs
- Could drive costs of KPD out-of-market

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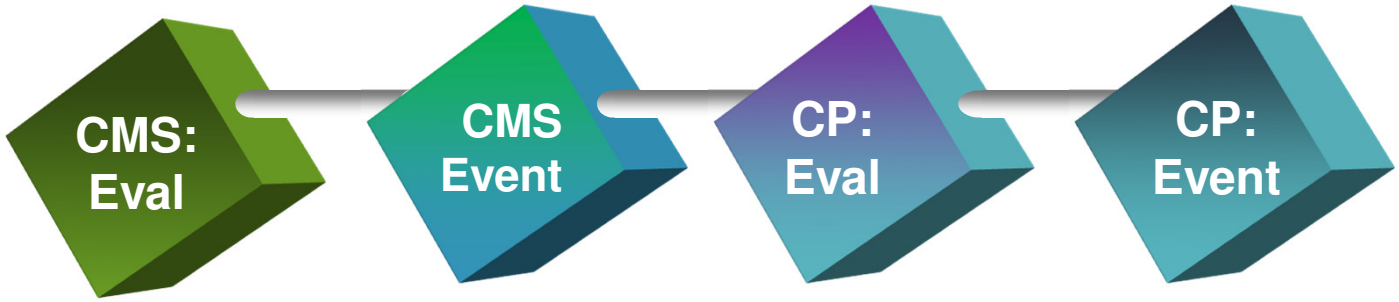
Physician Services



CMS: Eval	CMS Event	CP: Eval	CP: Event
Standard Acquisition Charge: Part A Cost Report Fee for service	Recipient Part B: Fee for service	**Standard Acquisition Charge: Fee for service**	**Recipient Insurance: Fee for service or global/ case rate**

Donor Complications

- Donor hospital bills recipient's part A or B
- Physician bills recipient part B
- Commercial payors are a mixed bag but in general after 90 days, donor insurance should be billed or recipient hospital or recipient is responsible

Donor Complications in KPD

This is obviously an area that could lead to controversy

Who decides:

- What to treat?
- How to treat?
- Where to treat?
- If it's a donation-related complication?
- What if recipient is no longer eligible?
- Contractual agreements between transplant centers should spell this out BEFORE transplant occurs

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Make up your Mind, CMS!

- NO published changes to SAC methodology or allowing donor hospital to retain donor costs
- However, some CMS representatives have said that they would support donor hospital retaining evaluation costs
- Some have voiced support for a national SAC but not really
- Commercial payors have voiced support for National SAC, even offering additional reimbursement – but not really

Sample MOU for KPD

Financial: Recipient Reimbursement to Donor Facility/Physicians – Highlights

Facility Fees:

1. Participating hospitals will develop a Standard Acquisition Charge (SAC)
2. As Medicare also allows invoicing by departmental charges (individual full costs for that particular donor's evaluation and donation); this billing method will also be accepted. NMH will use the SAC methodology.
3. Transportation costs are billed to the recipient hospital directly or by the donor hospital
4. Donor complications The recipient hospital will remain responsible for the costs of any donor complication that occur six months after the donation in the event the recipient's insurer denies any claims related to donor complications. .
5. The determination of donor complications is solely the judgment of the donor surgeon or his/her designate as documented in the patient medical record.

Physician professional fees

Donation Event:

1. Donor routine follow-up and donor complications (solely by the judgment of donor surgeon documented in the patient's medical record)
    1. Medicare Primary – Donor physician(s) will bill CMS; if denied – donor physicians will write off the expense
    2. Case rate – will be billed to recipient insurance; if denied, paid by recipient hospital at CMS allowable rate
    3. Other insurance/fee for service – will be handled in single letter as referenced above.

Incomplete or failed transplant:

1. In the event that a donation happens but implantation cannot occur into intended recipient due to recipient factors, recipient hospital will use its best effort to find a listed recipient for the kidney consistent with UNOS allocation rules by running a match run list for the recipient hospital's center and make the donated kidney available for transplantation. Recipient hospital should have run this list as part of a viable back-up plan prior to transplant surgery. If recipient factors that made transplant impossible resolve at a later time, the initial intended recipient should be considered a stranded recipient.
2.
3. If for any reason one transplant occurs but another cannot be completed, and it is not possible to abort the other procedure(s) without risking the donor or kidney, the transplant will proceed to completion and the recipient considered stranded. This provision applies to situations that would also include a transportation failure or other mishap resulting in an unusable kidney. The participating hospitals must notify affected hospital immediately upon discovering an issue that may prevent successful completion of planned transplant.
4.
5. Treatment of stranded recipients: The parties in this agreement agree to prioritize finding a donor for a stranded recipient in any chains or exchanges involving unpaired or anonymous donors (donors who present with no intended recipient).
6. Once a donor kidney enters recipient's surgical field, the transplant will be considered to be complete, regardless of its outcome beyond that point, and the intended recipient will not be considered to be a stranded recipient.
7. Sample will be here

Polling Question

Which billing method do you believe is best?

LD SAC

Departmental Charges

National SAC

THANKS!