Executive Summary

The cost of health care is substantial and it is vital that resources are used in a thoughtful, effective fashion. Complex services such as solid organ transplantation require careful patient selection in order to assure optimal outcomes.

In order to better assist the Arizona Health Care Cost Containment Services (AHCCCS), a Medical Executive Advisory Committee was formed consisting of representatives from the following Arizona transplant programs:

- Banner Good Samaritan Medical Center (AZGS)
- Mayo Clinic Hospital (AZMC)
- St. Joseph's Hospital Medical Center (AZSJ)
- University Medical Center University of Arizona (AZUA)

The committee proposes that instead of eliminating the transplant benefit in patients, AHCCCS collaborate with the transplant community to develop appropriate risk stratifications in order to maximize the benefits ratio, optimize utilization of resources, and capitalize on excellent outcome measures. The committee further proposed the following recommendations, which are based on current evidence published in the literature as consensus statements or national best practice guidelines:

All Solid Organ Transplants

Absolute Contraindication	Relative Contraindication
Systemic and/or Uncontrolled Infection	Inability to give informed consent
History of or Active able Malignancy (<5 years; prostate cancer <3 years)	Primary non-function/recent graft loss < 1 year
Significant Peripheral Vascular Disease (not correctable with surgery)	Active Psychiatric/Behavioral Disorder
AIDS	
History of non-compliance that has not been successfully remediated	
Insufficient Social Support	
Active Alcohol, Substance Abuse, and/or Tobacco use requires 12 months of documented abstinence in a structured rehabilitation program and a minimum of 3 negative screening tests	

Heart Transplantation

Current restriction: *Eliminate coverage for non-ischemic cardiomyopathy (45% of all AHCCCS covered transplants*

Proposed:

Absolute Contraindication	Relative Contraindication
Patients ≥60 years of age	Significant Chronic Pulmonary Disease (FVC < 50%, irreversible FEV1 < 50% and DLCO (corrected) < 40% adults/< 50% children)
BMI (adults) of ≥ 35 kg/m^2	
Patients that have received a previous heart transplant	
Patients with permanently damaged kidneys (creatinine clearance ≤ 35)	
Patients with permanently damaged liver	
Patients with active hepatitis C infection	
Severe Irreversible Pulmonary Hypertension (PVR > 6 Wood units after vasodilators – may qualify for combined Heart/Lung Transplant)	
Chronic Ventilator Dependence/Significant Lung Disease	

Pancreas Transplantation

Current restriction: *Limit coverage to simultaneous Kidney/Pancreas (SPK) transplant. Eliminate coverage for Pancreas only and Pancreas after Kidney (PAK).*

Proposed:

Absolute Contraindication	Relative Contraindication
Patients ≥ 55 years of age	Ejection Fraction < 40% or Shortening Fraction < 27%
BMI (adults) of ≥ 37 kg/m^2	
Significant, Uncorrectable Pulmonary/Cardiac Disease	
Chronic Ventilator Dependence	

Lung Transplantation

Current restriction: *Eliminate coverage*

Proposed:

Absolute Contraindication	Relative Contraindication
Patients ≥60 years of age	
BMI (adults) of ≥ 35 kg/m^2	
Patients that have received a previous lung transplant	

Liver Transplantation

Current restriction: *Eliminate coverage for diagnosis of Hepatitis C*

Proposed:

Absolute Contraindication	Relative Contraindication
Patients ≥ 70 years of age	Ejection Fraction < 40% or Shortening Fraction < 27%
BMI (adults) of ≥ 37 kg/m^2	Post-Transplant Lymphoproliferative Disease (PTLD) unless no active disease by PET and resolved adenopathy on CT/MRI
Restrict HCC tumors outside of Milan criteria (> T2 disease)	
Significant, Uncorrectable Pulmonary/Cardiac Disease	
Chronic Ventilator Dependence	
Non-Carcinoid Neuroendocrine Tumor	
MELD ≤15	

In addition to the above, the committee recommends, in collaboration with AHCCCS, further delineation of the evaluation process. In collaboration with AHCCSS, an ongoing review of costs and measures to review cost reduction at all levels, while maintaining the best care for the patient, will be implemented by this committee. This would include a closer working relationship with AHCCCS and referring physicians to eliminate redundancies in the system thereby enhancing cost savings.

Each of the transplant programs is responsible to form a Financial Executive Advisory Committee to oversee the selection process and follow-up of transplant patients. One of the roles of the committee will be to work with AHCCCS to make sure that tests are not reordered and duplication of data is eliminated, as well as perform an in depth analysis of the use of generic medications and an on-going review of cost saving opportunities without affecting quality outcomes.