

OPTN/UNOS Kidney Transplantation Committee
Meeting Summary
June 15, 2015
Conference Call

Richard Formica, MD Chair
Mark Aeder, MD, Vice Chair

Discussions of the full committee on June 15, 2015 are summarized below and will be reflected in the committee's next report to the OPTN/UNOS Board of Directors. Meeting summaries and reports to the Board are available at <http://optn.transplant.hrsa.gov/> .

Committee Projects

1. Simultaneous Liver Kidney (SLK) Project

Based on feedback from the OPTN/UNOS Board of Directors obtained at the Board of Directors meeting in Atlanta, GA on June 2, 2015, the Committee reviewed and approved changes to the policy language that will be included in the fall public comment proposal. These changes include specifying the level of geographic allocation for SLK.

The SLK Working Group had originally recommended that the SLK apply locally and regionally if the candidate met the SLK medical eligibility criteria. However, when the Committee initially approved the policy language, it did not specify the level of geographic allocation (local, regional, national) for SLK for two reasons: (1) In developing the SLK recommendations, the Pancreas Committee was concerned about the possible impact on kidney-pancreas allocation if SLK allocations occurred at the regional level. (2) Additionally, UNOS staff and the Policy Oversight Committee was concerned that specifying regional allocations for SLK would add another layer of complexity to the multi-organ allocation without resolving the larger ordering issues with multi-organ allocation.

During a SLK presentation at the June Board of Directors meeting, Board members were asked to provide feedback on the following questions:

- Should SLK allocation be extended to regional priority for liver candidates who are eligible for share 35 priority? In liver allocation policy, certain candidates who have a status or a MELD/PELD score at a certain level above 35 are eligible for regional liver allocation.
- Should the Committee bring the SLK proposal back to the Board or wait for the multi-organ allocation issues to be resolved?

The Board gave clear direction that the Committee should extend the SLK allocation to the regional level so those candidates are eligible for liver share 35 priority in their public comment proposal. Additionally, although the Board agrees with the concerns surrounding the complexity of multi-organ allocation policy they supported a quicker timeline for the SLK proposal given that the SLK Working Group and the Committee have already completed the work for the proposal and the multi-organ policy changes are likely to take longer time before being ready for public comment.

The Committee voted to include additional language for local or regional SLK allocation for candidates that meet the SLK medical eligibility criteria. This proposal will be distributed for public comment in August 2015. The Committee anticipates a second

round of public comment in January 2016 before sending to the Board of Directors for approval in June 2016.

2. Revising Kidney Paired Donation (KPD) Priority Points

The Committee reviewed and approved the policy language for the Revising Kidney Paired Donation Priority Points to be distributed for public comment in August 2015. This policy will only apply to the OPTN's Kidney Paired Donation Pilot Program (KPDPP).

The Committee reviewed the results of sensitivity studies performed by the UNOS Research Department at the request of the KPD Work Group. These studies re-optimized over 100 historical KPD match runs to compare the current priority points schedule to other scenarios to assess the impact on the number of matches found and the types of patients receiving matches. Taking the results of these sensitivity studies into consideration, the KPD Work Group recommended the following:

- Maintain 100 base points for all matches
- Maintain existing points for prior living donor, pediatric, and waiting time
- Remove points for same region and same DSA
- Remove negative points for "all other antibody specificities"
- Reduce points for 0-ABDR mismatches
- Adopt a sliding scale for CPRA points
- Increase same-center points
- Award points for candidate and paired donor ABO
- Award points for previous negative or positive but acceptable crossmatches (with or without desensitization)

As a part of this proposal, the KPD Work Group also sought to develop a remedy for failed exchanges within the KPDPP where a donor donates, but the paired candidate does not receive a kidney. The proposed remedy included awarding a maximum amount of priority points and creating additional policy to prioritize orphan candidates to receive transplants in future non-directed donor (NDD) chains.

Committee members specifically discussed the priority points for paired donor ABO, pediatrics, and prior living donors. A Committee member noted that candidates with O blood type continue to be disadvantaged because the priority points do not prioritize in a way that would direct an O donor to an O candidate before offering it to another candidate. However, the proposed priority points award twice as many points for O candidates. The existing policy does not address the difficulty in matching blood types, so this will be the first attempt to balance out this disadvantage. The sensitivity study results showed an increase in matches found for blood type O candidates under this new priority points schedule.

Committee members also discussed the potential impact of the proposed priority points changes on pediatric candidates. The sensitivity studies showed a drop in match rate from 1.9% to 0.8% for pediatric candidates due to a CPRA sliding scale, which awards a substantial number of points for very highly sensitized patients. However, upon further review, the magnitude of this decrease appears to have been artificially inflated because many of the same candidates and donors appear multiple times in the study. The apparent decrease in matches for pediatric patients was driven by the absence of a match for one particular pediatric patient (when using the CPRA sliding scale) who

happened to be matched four different times under the “current policy” scenario. The Committee weighed this evidence and agreed that though matches to pediatric patients may decline due to adoption of a CPRA sliding scale, the impact is expected to be small and increasing matching opportunities for very highly sensitized patients was important. The Committee stressed the importance of monitoring pediatric access to KPD match offers after implementation in order to ensure that the effect is not greater than anticipated.

The Committee also discussed whether the proposed priority points for both prior living donors and pediatrics should be increased or decreased. The Committee discussed whether the points should be lower for these categories because KPD is “donor driven” rather than candidate driven. Some on the Committee felt that prioritizing certain types of patients above others could lead to longer waits for some donors and donors should not be expected to wait indefinitely before donation. Ultimately, the Committee agreed with the priority points for these categories as proposed, which maintain the existing priority points in policy.

Committee members also discussed the time frame for previous negative (or positive but acceptable) crossmatches. The KPD Work Group had an extensive discussion on the time frame for this priority points category and debated whether the policy should include a stipulation of 90 days, six months, or one year. The KPD Work Group had wanted to keep the time frame as broad as possible because there are few opportunities to use this information in matching at this time. Additionally, upcoming KPD histocompatibility programming which requires updating every 90 days and reporting sensitizing events would preclude matching between donors and candidates with a prior negative crossmatch (as long as new unacceptable antigens were entered), despite the points for previous negative crossmatches. This fact alleviated concerns about prioritizing matches based on potentially very old negative crossmatch results. Therefore, the KPD Work Group ultimately decided not to add a time frame to the policy. The Committee did not have concerns about the number of points awarded, but only that positive but acceptable with or without desensitization crossmatches can change over time and may need to establish a timeframe in the future. The success rate for these matches will be monitored upon implementation if this proposal is approved.

Committee members discussed two components of the orphan candidate portion of the proposal – the large number of points awarded and allowing orphan candidates to reject a match offer but retain orphan candidate status. The proposed priority schedule will award 1,000,000 points for orphan candidates. The purpose in awarding the large amount of points is so that an orphan candidate can receive a transplant as soon as possible. This large number of points is merely a mechanism to ensure that if a NDD-chain can be found ending with the orphan candidate that it is chosen by the optimization algorithm. The Committee also discussed whether allowing the orphan candidates to reject a match offer would lead to “cherry picking” so that the candidate could keep rejecting offers with the hopes of getting an ideal offer. However, the Committee did not change the policy language because there may be situations where the kidney offered is unsuitable and the orphan candidate should maintain the right to decline and keep the priority.

The Committee voted to send the proposed policy language for public comment. This proposal will be sent out for public comment in August 2015. If favorable, the Board of Directors will vote on the policy changes in December 2015.

Upcoming Meetings

- July 20, 2015
- August 17, 2015
- September 21, 2015
- October 26, 2015