

OPTN/UNOS Liver & Intestinal Organ Transplantation Committee
Meeting Minutes
January 19, 2017
Conference Call

Ryutaro Hirose, MD, Chair
Julie Heimbach, MD, Vice Chair

Introduction

The Liver & Intestinal Organ Transplantation Committee (hereafter, the Committee) met via Citrix GoToTraining teleconference on 01/19/2017 to discuss the following agenda items:

1. National Liver Review Board Proposals
2. Liver Redistricting Update

The following is a summary of the Committee's discussions.

1. National Liver Review Board Proposals

The Committee reviewed the history of the National Liver Review Board (NLRB) project and discussed whether to change the recalculation of MELD scores every six months in post-public comment.

Summary of discussion:

NLRB History

The Vice Chair reviewed the history of the NLRB project for the Committee. The changes to HCC criteria for auto approval passed the Board in December 2016. These changes excluded from automatic approval patients with high AFP serum levels and other patients that have poor post-transplant outcomes or low dropout rates. Due to feedback from the regional meetings, the proposal voted on by the board omitted small well treated tumors from the auto approval changes. Because the HCC exceptions proposal went to the Board in December, it is unnecessary for regional representatives to discuss this aspect of the project at the upcoming regional meetings.

MELD Recalculation

In the NLRB policy proposal, the median MELD at transplant (MMAT) is recalculated every 6 months. Each candidate's score may go up, down, or stay the same. If the score is going to drop, it won't drop until the candidate is due for an extension. The Committee previously agreed on this provision to diminish the negative impact for the person whose score is going down. In discussing the issue prior to public comment, the Committee felt that leniency should be given to candidates whose scores would drop since the impact on them would be negative. If a score stays the same or goes up, the score would change at the 6 month recalculation point.

UNOS staff pointed out to liver leadership that this system creates an equity issue for candidates whose scores would stay the same or go up. For example, Candidate 2 has a MELD score of 27 that is recalculated to be a 25. Because his score is going down, the NLRB proposal would allow Candidate 2 to stay at MELD 27 until the next 6 month MMAT update. Thus, Candidate 1 with a score that stays at 25 should be competing with the Candidate 2, but can't because the other candidate's MELD score is higher than it should be (registering at 27 instead of 25). This situation puts Candidate 1 at a disadvantage. The Committee was trying to avoid the inequity by delaying implementation of lowered MELD scores. However, the solution the Committee chose creates another inequity.

In the discussion, several Committee members expressed support for removing the delay for lowered MELD scores. Instead, all candidates would see the change at the 6 month recalculation immediately – whether their scores went up, down, or stayed the same.

Next steps:

The Committee is looking for feedback from regions on this specific issue. If the regional and community response from public comment indicate that the process should be changed, then the Committee will respond to the feedback in post public comment changes before the NLRB proposal goes to the Board.

2. Liver Redistricting Update

The Committee reviewed the Redistricting Subcommittee’s meeting on liver redistribution options. The Committee also discussed the pros and cons of using MMAT as a metric for liver redistricting.

Summary of discussion:

Review of Subcommittee Call

The Committee reviewed the alternatives for liver redistribution that were discussed during the Redistricting Subcommittee teleconference call on December 29, 2016. The Chair asked that the program modeling the neighborhoods alternative to redistricting include certain parameters to make it easier to compare neighborhoods with the other redistricting proposals. The SRTR is analyzing the 8 districts, neighborhoods and concentric circles concepts using a 150 mile radius from the donor hospital (which was used in the previous modeling for 8 districts) but also modeling according to DSA of the donor hospital. The cohort used will include Share 35 data but not provide extended post-transplant outcomes to consider. Since a lot of change has occurred since the Committee submitted the 8 district proposal for public comment in August 2016, UNOS communications and liver staff are working on a document that summarizes the three proposals the Committee is currently evaluating to address geographic disparity.

MMAT as a Metric

A Committee member raised a concern about using MMAT as a metric to determine how to redistribute livers nationally. The Committee member suggested that while using MMAT may decrease geographic disparities, it may also cause national median MELD scores to rise. The Chair agreed that the MMAT may increase slightly (using the earlier SRTR cohort, it was predicted to go from 28 to 29), but rejected the suggestion that MELD would rise drastically, since none of the modeling had predicted that outcome.

The Committee member suggested that the Committee use greatest benefit rather than sickest first as an approach to fixing the rise in MMAT. He reasoned that using benefit would lead to programs being more selective about who they transplant, whereas MMAT may lead to worse post-transplant outcomes and more futile transplants. The Committee member suggested that average MELD at transplant will go up because sicker patients with higher MELDs are being transplanted.

The Vice-Chair noted that the Committee member’s concern with rising MELD and using a benefit formula addresses allocation issues, but the current effort of the Committee to fix geographic disparities is a distribution concern rather than an allocation one. Changing the areas of distribution, as the Committee seeks to do with this proposal, is not unrelated to allocation, but the Committee decided on its metrics based on measurable correlations to distribution. The Chair suggested that current benefit formulas aren’t strongly predictive of post-transplant outcomes. The Committee would need a more robust, predictive model to use as an allocation algorithm.

The Chair noted that the metrics discussed don't correlate with supply and demand the way transplant rates, number of donors per waitlisted patients, and MMAT by geographic area does. The effort of the Committee is to equalize the system for patients with higher MELD scores. The current system of Share 35 helps the very sickest patients but fails to provide the same support for patients nearly as sick, for example, patients with MELD scores 29+. The Chair suggested a possible modification to the Committee's approach in which the lab MELDs and not exception MELDs were included in the MELD score sharing. Other Committee members seemed receptive to that idea. The Committee also discussed modifying the proposal so that older/less good livers go local first, while better/younger livers travel. Potentially, these would be valid modifications to the proposal to make the system fairer.

Liver Advisory Panel

The Committee briefly reviewed a meeting of the liver advisory panel, which will convene in Miami on January 24, 2017 before the ASTS Winter Symposium. The panel will include members of the transplant community representing diverse viewpoints on the redistricting issue. The panel will look for a common path forward to try to find a solution that is acceptable to a majority of UNOS regions. The panel will discuss the three redistricting solutions currently under discussion.

Next steps:

The Committee will review feedback from the Liver Advisory Panel during its next teleconference call on February 16th.

Upcoming Meetings

- February 16, 2017 (teleconference)
- March 9, 2017 (teleconference)
- April 3, 2017 (teleconference)
- April 20, 2017 (teleconference)
- May 8, 2017 (Chicago)