OPTN Liver and Intestinal Organ Transplantation Committee
Acuity Circles Subcommittee
Meeting Summary
October 14, 2020
Conference Call

James Trotter, MD, Chair
James Pomposelli, MD, PhD, Vice Chair

Introduction

The Acuity Circles Subcommittee (the Subcommittee) met via teleconference on 10/14/2020 to discuss the following agenda items:

1. Updating MMaT Calculation

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

1. Updating MMaT Calculation

The Subcommittee continued discussion on the Updating MMaT Calculation project.

Minimum Exception Score

The Subcommittee revisited the discussion on the minimum exception score and were informed the current policy states that standardized exception scores cannot be lower than MELD 15. The Subcommittee was asked if this should also be the case for non-standard exceptions. The Subcommittee indicated the same policy should apply to non-standard exceptions.

Median PELD at Transplant (MPaT)

The Subcommittee also revisited the discussion on the MPaT. The Subcommittee's initial discussion indicated there should not be a change in MPaT. However a member suggested changing national MPaT to also be based around the donor hospital. The Subcommittee Chair commented they would follow up with a pediatric representative to get their thoughts.

New Donor Hospital

The Subcommittee was informed new donor hospitals are added to the UNet^{SM} system frequently and the exact location of a donor hospital can also be updated which could impact MMaT. The proposed MMaT/donor hospital solution would need a system in place to assign an MMaT to each new donor hospital or update MMaT if location changes. Staff are exploring options to have the system automatically assign MMaT when a donor hospital is added or location is updated and will bring those options back to the Subcommittee for review.

MELD/PELD Score Requests

The Subcommittee was informed currently transplant programs request specific scores when submitting a non-standard exception. Reviewers then see those requested scores relative to the MMaT. In the proposed MMaT/donor hospital solution, transplant programs will not be able to submit a request for a specific score as they will fluctuate with each match run. The same change would occur for PELD

requests. Therefore, programs would need to submit requests for MMaT or MPaT adjustments rather than a specific score.

The Subcommittee was asked if they thought transplant programs would be comfortable submitting exception requests for MMaT adjustments. The general consensus of the Subcommittee was this would not be an issue for transplant programs.

Waiting Time for Exception Candidates

The Subcommittee revisited the topic of waiting time for exception candidates and were asked the following questions:

- Should HCC candidates receive time since submission of first approved exception or since submission of second extension (6 month delay)?
- If a candidate is approved for an exception with one diagnosis and then is approved for an exception with a different diagnosis, should he or she receive time since the submission of the first exception?
- Should there be a limit on time between exceptions that are included?

Subcommittee members indicated HCC candidates should receive time since submission of their second extension (six month delay). A member commented the six month delay is important to monitor the tumor behavior, therefore they would not start their time until they've had a six month delay. Other members commented it is reasonable to have their time start after the six month delay.

The Subcommittee agreed candidates approved for an exception with one diagnosis and then approved for an exception with a different diagnosis should only receive time since the submission of the second exception because it is a new diagnosis.

The Subcommittee discussed whether there should be a time limit on time between exceptions. For example, a candidate is approved for an exception four years ago, loses exception, and then is approved again four years later. The Subcommittee recommended that even if there is a large time gap between exceptions, the candidate should still get time back to the first exception. The Subcommittee saw this as a rare event and recommended this approach as it would be the most expeditious for programing.

Approved vs. Assigned

The Subcommittee was informed in current policy, there is no distinction between exceptions that are approved vs. assigned.

- Approved = automatically approved or voted on by NLRB and approved
- Assigned = NLRB did not vote within 21 days and exception score was assigned based on time limit being reached

The Subcommittee was asked for time since submission of first *approved* exception, if the intention is referring to only *approved* exceptions or exceptions that were *approved or assigned* due to the time limit being reached. The Subcommittee agreed the intention is for exception candidates to receive time since first *approved* exception.

The Subcommittee was further informed there are other instances of *approved* vs. *assigned* distinctions that should be clarified throughout the policy and will be part of this project as well.

Along the same lines, the Subcommittee was informed under HCC exceptions, currently candidates with an *approved* or *assigned* HCC exception are eligible for an automatic extension if they meet standardized extension criteria. For candidates whose initial exception was *assigned*, this means that their case is never truly reviewed. The Subcommittee discussed whether HCC candidates whose initial

exception or previous extension was reviewed and *approved* by the NLRB should be able to have extensions automatically approved. Some members commented with the new nature of the national review board, the term "assigned" should no longer be part of the policy language. The Subcommittee recommended this be a subject for the NLRB Subcommittee to discuss further.

Liver-Intestine Candidates

The Subcommittee was informed for liver-intestine candidates, if they are over 18 years old, they receive the equivalent of a 10 percentage point increase in risk of three-month mortality to their MELD score. If they're under 18, they receive additional 23 points to their calculated lab score. In the current system:

- If the candidate has an exception score greater than the lab score plus liver-intestine points, the record is flagged as using an exception
- If the candidate has an exception score less than the lab score plus liver-intestine points, the record is flagged as using liver-intestine points and is a lab score
- If the candidate has an exception score equal to the lab score plus liver-intestine points, the record is flagged as using an exception

The Subcommittee was asked for a scenario where the exception score is equal to the liver-intestine points score, if the candidate should be considered a lab or exception candidate, understanding lab candidates would rank higher than exception candidates in the new tiebreaker being proposed. The Subcommittee requested more information on the liver-intestine candidates and consultation with liver-intestine practitioners before making a decision. As an aside, a member also requested to look at liver-intestine candidate criteria further as part of future discussions.

<u>Next Steps</u>

The Subcommittee will present the final recommendations to the Committee in late October.

Upcoming Meetings

- October 28

Attendance

- **Subcommittee Members**
  - Peter Abt
  - Diane Alonso
  - Sumeet Asrani
  - Derek DuBay
  - Bailey Heiting
  - Shekhar Kubal
  - Ray Lynch
  - Mark Orloff
  - James Pomposelli
  - James Trotter
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
- **SRTR Staff**
  - Michael Conboy
  - Andrew Wey
- **UNOS Staff**
  - Matthew Cafarella
  - Betsy Gans
  - Lindsay Larkin
  - Rob McTier
  - Victor Melendez
  - Samantha Noreen
  - Matt Prentice
  - Karen Williams