OPTN Liver and Intestinal Organ Transplantation Committee
Meeting Summary
May 15, 2025
Conference Call

Scott Biggins, MD, Chair
Shimul Shah, MD, MHCM, Vice Chair

Introduction

The OPTN Liver and Intestinal Organ Transplantation Committee (the Committee) met via WebEx teleconference on 05/15/2025 to discuss the following agenda items:

1. Data Report: Modify Organ Offer Acceptance Limit
2. Discussion: National Liver Review Board (NLRB) & Continuous Distribution
3. Review & Discussion: Match Run Analysis
4. Break-out Groups: Match Run Analysis
5. Discussion: Match Run Analysis
6. Project Idea Discussion

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

1. Data Report: Modify Organ Offer Acceptance Limit

The Committee previously submitted a request to analyze the impact of the Modify Organ Offer Acceptance Limit project. This data report was reviewed.

Data summary:

- There was a steady increase in the percent of Status 1A/1B removals for the reason of death or too sick to transplant from April 2024 to September 2024, followed by a decrease in the percentage.
- The median number of offers sent to Status 1A/1B and MELD/PELD 37+ candidates with an open final acceptance was one offer.
- Roughly 4 percent of Status 1A/1B and MELD/PELD 37+ removals between May 29, 2024 and November 26, 2024 for the reason of death or too sick to transplant had an offer while having an open final acceptance response on another match run.

Summary of discussion:

The Committee discussed the impact of the modification to *Policy 5.6.C: Organ Offer Acceptance Limit* on Status 1 and high MELD candidates. The Committee expressed concern that the current system does not allow for multiple organ acceptances, which is particularly problematic for Status 1 or critically ill patients. A member noted that although the data shows limited measurable harm, the policy has not resulted in improved outcomes or increased organ utilization for this group. The member stated that for Status 1 candidates, there are no alternative options to transplant.

A member noted that at any given time, only a small number of Status 1 candidates are active on the match run, which may explain the lack of significant statistical findings. However, another member

emphasized that policy decisions have previously been made to save as few as 5–10 lives per year, and this situation should not be treated differently.

A member shared a clinical scenario in which a donor family withdrew an hour before the scheduled operation, leaving a critically ill candidate without a transplant option. The member suggested that permitting two active acceptances may help mitigate these risks.

A member added that increased use of DCD donors complicates the issue further, as these donors often do not progress to donation. The member estimated that up to 50% of DCD offers fail due to timing or viability issues. The Committee agreed that this unpredictability supports allowing two active acceptances, at least in DCD scenarios.

The Committee discussed the need to define what constitutes a second acceptance and when that second offer should be released. A member suggested that the second offer should be released once the operating room is committed to the first.

The Committee emphasized that any proposed policy changes must be clearly defined to avoid unintended consequences. The Committee agreed that allowing two active acceptances for Status 1 patients, and potentially for high MELD or DCD cases, would be a targeted and manageable policy solution.

A member noted a decrease in post-policy death rates among exception candidates and speculated that this could be due to the increased acceptance of DCD donors for this population. However, the Committee acknowledged that this observation was not statistically significant.

The Committee agreed that two active acceptances for Status 1 candidates should be allowed and to further evaluate whether this should be extended to high MELD or DCD cases.

Next steps:

The Committee will determine a path forward to proposing their agreed upon solution.

2. Discussion: National Liver Review Board (NLRB) & Continuous Distribution

The Committee discussed whether other instances unrelated to medical urgency should warrant a non-standard exception pathway in liver continuous distribution.

Summary of discussion:

The Committee discussed how exception policies and the National Liver Review Board (NLRB) should be integrated within the transition to continuous distribution. Members acknowledged that while the move to continuous distribution will significantly impact the transplant community, preserving familiar elements of the current system—such as the use of non-standard exceptions and median MELD at transplant (MMaT) —may ease the transition and make it more acceptable. The Chair noted that non-standard exception requests can be submitted for anything and, if approved, will tie back to the medical urgency score. However, members emphasized that any expansion of exception pathways must be approached carefully.

Several members supported limiting exceptions to medical urgency, citing the risk that allowing multiple exception types could enable transplant programs to potentially game the non-standard review processes to artificially boost candidate scores. The Chair agreed and cautioned that having different review boards evaluate separate requests without insight into each other's decisions could create

unintended consequences. The Committee stressed the importance of coordination and transparency among review boards.

There was general agreement that exceptions should not be used to fill policy gaps; instead, systemic issues should be addressed through broader policy development. Members discussed whether to continue using MMaT as a benchmark and considered new modeling tools to better understand how MMaT impacts the composite allocation score. Some members advocated for modeling a percentage-based scaling method, similar to lung, to guide requests in a consistent and intuitive way.

Members noted that understanding how identified attributes will affect access remains a challenge. Until there is more clarity, the Committee agreed that exceptions should remain focused on medical urgency in the first version of continuous distribution. Future versions of continuous distribution may explore additional pathways—such as exceptions based on body size or biologic disadvantage—but these will require further modeling, policy refinement, and education.

The Committee emphasized that the implementation of exceptions under continuous distribution should maintain simplicity and consistency. Education for review board members and clear guidelines will be essential to avoid confusion and maintain equitable access. The Committee concluded that while future expansion is possible, initial exception policies should remain narrow, targeted, and closely monitored for impact.

Next steps:

The Committee will ask the community for feedback on their decision to continue to have non-standard exceptions tied only to medical urgency.

3. Review & Discussion: Match Run Analysis

The Committee reviewed the purpose of the match run analysis and reviewed the information needed to submit a request.

Summary of discussion:

There were no questions or comments.

4. Break-out Groups: Match Run Analysis

The Committee divided into two groups to discuss 1) the outcomes that are sought in a match run analysis and 2) draft a set of weights for a composite allocation score.

5. Discussion: Match Run Analysis

Summary of discussion:

The Committee discussed the outcomes that they would like the match run analysis results to show. The breakout group drafted the following outcomes:

- Status 1A/1B should be at the top of the match
- MELD 35+ should be at the top of the match
- Pediatric candidates should be at the top of the match
- Liver-intestine candidates should be at the top of match runs for liver-intestine donors
- The new policy should do a better job at matching low-BSA donors with low-BSA candidates
- Blood type O candidates should maintain similar priority as the current policy

- Blood type B should maintain similar priority as the current policy
- HCC/exception candidates should maintain similar priority as the current policy
- The distance between donor hospital and transplant program should be increasing for candidates farther down the match run (i.e., distance should increase as candidates become less urgent)

A member highlighted that Status 1A/1B candidates, high MELD patients, pediatric candidates, and liver-intestine candidates should consistently receive the highest priority across all match runs. Members agreed with this list of outcomes and emphasized that the first four are the most important. A member stated that the Committee generally supported how Acuity Circles is working so they would like to maintain some of the main outcomes while removing the hard boundaries for distance.

Another member added that pediatric candidates should potentially be prioritized above all other groups, citing ethical considerations and their small population size. Another member cautioned that prioritizing pediatric candidates above Status 1A may not be appropriate given the critical condition of those candidates. The Chair agreed with prioritizing pediatric candidates but noted the importance of ensuring that viable organs are utilized and not lost due to cutdowns or inefficiencies.

The Committee discussed the set of weights for various composite allocation scores. The breakout group drafted three different composite allocation scores each emphasizing different priorities such as medical urgency, travel efficiency, and pediatric access. The breakout group noted that future iterations of the match run analysis will include more complex donor modifiers such as split liver and liver-intestine. A member suggested that weighting of attributes could vary by donor type (e.g., DCD vs. DBD) and supported incorporating donor modifiers into future models.

Members discussed adding a fourth scenario that increases pediatric priority while reducing travel efficiency weight. The Committee discussed the potential to have all pediatric candidates appear at the top of all match runs. The Committee was reminded that absolute prioritization within a continuous distribution system may conflict with the intent of eliminating rigid classifications. Another member clarified that while continuous distribution encourages nuance, certain categories like Status 1A may still warrant distinct priority due to the urgency of their condition.

A member questioned how much weight should be given to blood type in the score. The Chair responded that certain blood types, especially O and B, are disadvantaged in the current system and may warrant additional points to balance access.

The Committee agreed upon the following three draft composite allocation scores for the first match run analysis request. The Committee acknowledged that these scenarios are a starting point to understand the impact of various attributes in order to further refine weights.

- Scenario 1: Medical urgency and BSA focused
    - Medical urgency score: 60%
    - Blood type: 3%
    - BSA: 12%
    - Pediatric priority: 15%
    - Prior living donor priority: 3%
    - Geographic equity: 2%

    - Travel efficiency: 5%
- Scenario 2: Middle ground/Pediatric focused
    - Medical urgency score: 52%
    - Blood type: 4%
    - BSA: 5%
    - Pediatric priority: 20%
    - Prior living donor priority: 5%
    - Geographic equity: 4%
    - Travel efficiency: 10%
- Scenario 3: Travel efficiency focused
    - Medical urgency score: 40%
    - Blood type: 4%
    - BSA: 4%
    - Pediatric priority: 10%
    - Prior living donor priority: 5%
    - Geographic equity: 10%
    - Travel efficiency: 27%

The Committee agreed to submit the outcomes and three drafted composite allocation scores to the SRTR for development of a match run analysis.

Next steps:

A match run analysis request will be submitted to the SRTR.

6. Project Idea Discussion

A member raised the topic of reevaluating the definition of presexisting liver disease for Status 1A eligibility. The member noted that there are candidates with preexisting liver conditions, such as NAFLD or autoimmune hepatitis, who experience acute events like acetaminophen overdose. The member questioned whether the current definition is too restrictive and suggested modifying it to be less restrictive.

Another member proposed adding a safety net mechanism for liver-intestine and intestine-alone transplant candidates, similar to existing policies in kidney and lung allocation. Members agreed this was a small but important population and supported adding it to the project list for further exploration, especially given their frequent complications like renal dysfunction.

A member discussed the potential to modify the lab update schedule to help address concerns for candidates on medication such as Terlipressin that may affect their MELD score. The group agreed the update schedule could be adjusted, and the proposed change seemed non-controversial.

The final project idea discussed involved creating a living donor swap mechanism for incompatible donor-recipient pairs. The idea would allow an incompatible living donor to proceed with donation to another recipient, while the original intended recipient receives a MELD exception if the donation goes through. A member referenced similar approaches in domino liver transplants, where the domino donor received a high MELD exception score, and noted that this new proposal could incentivize more living donations. The Committee agreed to revisit the concept in more detail later.

Next steps:

The Committee will continue to discuss project ideas.

Upcoming Meetings

- June 6, 2025 at 2 pm ET (teleconference)

Attendance

- **Committee Members**
  - Allison Kwong
  - Chris Sonnenday
  - Christine Radolovic
  - Erin Maynard
  - James Pomposelli
  - Joseph DiNorcia
  - Kathy Campbell
  - Lloyd Brown
  - Marina Serper
  - Michael Kriss
  - Neil Shah
  - Omer Junaidi
  - Scott Biggins
  - Shimul Shah
  - Shunji Nagai
  - Tovah Dorsey-Pollard
  - Vanessa Cowan
  - Vanessa Pucciarelli
- **SRTR Staff**
  - Jack Lake
  - Katie Siegert
  - Nick Wood
- **UNOS Staff**
  - Alina Martinez
  - Benjamin Schumacher
  - Betsy Gans
  - Ethan Studenic
  - Kaitlin Swanner
  - Keighly Bradbrook
  - Laura Schmitt
  - Matt Cafarella
  - Meghan McDermott
  - Niyati Updahyay
  - Susan Tlustly