American Society of Transplant Surgeons

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Carl Berg, MD
President
Organ Procurement and Transplantation Network (OPTN)
United Network for Organ Sharing (UNOS)
700 North 4th Street
Richmond, VA 23219

Dear Dr. Berg:

The American Society of Transplant Surgeons (ASTS) has reviewed and considered the following eighteen proposals out for public comment through December 5, 2014. Below is the Society's position on each proposal.

Proposal for Informed Consent for Kidney Paired Donation (Kidney Committee)
The ASTS ***supports the goals*** of this proposal regarding informed consent for KPD participants. However, ASTS is concerned that the additional requirements outlined in 13.4.C are extensive and will result in confusion on the part of the potential donors and additional administrative burden on transplant centers.

Proposal to Convert KPD Contact Responsibilities and Donor Pre-Select Requirements from the OPTN/UNOS Kidney Paired Donation Pilot Program Operational Guidelines into OPTN Policy (Kidney Committee)
The ASTS supports this reasonable proposal.

Proposal for the Definition of Pancreas Graft Failure (Pancreas Committee)
ASTS ***does not support*** this proposal as written. While we appreciate the need to establish metrics, the current proposal fails to provide an appropriate metric of graft success and/or failure, nor does it provide recommendations for outcome measurements that are applicable across all forms of beta cell replacement. Particularly concerning are the insulin/kg criteria for graft failure. There are some patients who require less than .5U/kg/d pre-transplant and thus may never achieve failure. Additionally, the c-peptide analysis is inadequate. While it may be difficult to use c-peptide to declare failure, it can demonstrate function. A patient could have a well functioning graft and develop insulin resistance from weight gain, medications, etc. and require an insulin dose of .5 U/kg/d and still have a well functioning graft. In the c-peptide data presented, some c-peptides in "non-functioning grafts" were as high as 8. It is hard to consider that graft nonfunctioning irrespective of their insulin dose. This is a complicated, but not urgent, issue and the proposed policy would exacerbate the complexity.

Proposal to Collect Extracorporeal Membrane Oxygenation (ECMO) Data Upon Waitlist Removal for Lung Candidates (Thoracic Committee)

ASTS ***supports*** this timely and reasonable proposal.

Implement the OPTN's Oversight of VCAs (VCA Committee)

ASTS ***supports*** this proposal to implement OPTN oversight of VCAs. The proposal outlines that the projected updates meet five of the six goals outlined in the OPTN strategic plan, listed as (1) increase the number of transplants, (2) increase access to transplants, (3) improve survival of patients, (4) promote transplant patient safety, (6) promote the efficient management of the OPTN. We concur that the proposal meets four of the six goals. However, in considering whether this improves survival of patients, one could interpret the current rule in two ways. VCA is generally not life saving, but rather is embarked upon to improve quality of life. Given that the worldwide experience in VCAs show that both adult and pediatric patients have died after a VCA and one patient has developed a malignancy in the brain due to the immunosuppressive medications used for the VCA, which shortened his life span, the practice of VCA may not be viewed as improving the survival of patients. Alternatively, if the rule brings about an appropriately regulated process for VCA which in turn reduces the risk of death in those undergoing VCA, then count (3) above could be considered to be met.

We support the definition of VCA as an organ delineated in the document for OPTN purposes. This will ensure that physicians will be required to perform VCA procedures at OPTN member transplant centers. Nonetheless, care must be taken not to overburden the field with requirements or limitations that jeopardize the continued viability of research and innovation in this field. As membership criteria are being developed, care must be taken to include professionals with established track records in the clinical development of VCA. This is necessary to continue the development of the field. It is critical to note that, due to the small number of centers involved, each of which has a faculty with a unique background, the advancement of the field in a scholarly, evidenced-based fashion requires the continued leadership of professionals currently engaging in VCA. We strongly recommend that licensed clinicians engaged in VCA at the time the rule was set be allowed to continue in leadership roles to include the role of Program Director and Primary Transplant Surgeon without imposing specific requirements related to board affiliation. As VCA has no specific board, requirements for board certification (which in general eliminates the contributions of individuals who have trained overseas and are not board eligible in the US) will stifle progress in multiple active centers. It will also undermine the funding mechanisms in place for the development of VCA.

It is important to keep in mind that, while VCAs are organs, this does not mean that researchers have developed sufficient knowledge to formulate the type of comprehensive patient selection, outcomes standards, and other policies that have been developed for other organs. While we are experiencing a growth period and more centers are considering performing these procedures, it should be recognized that these surgeries are appropriate for a selected group of patients, and the long-term outcomes and the parameters for patient selection after deceased donation are yet to be defined. The clinical and cost effectiveness of VCA as compared with other alternatives remains unclear. Thus, we believe that regulatory standards should not precede clinical knowledge in areas outside deceased donation. At

present, there should be no conditions established for live donation. The transparency and rigor characteristic of OPTN policymaking processes, in parallel with the time required for the field to mature, will produce outcomes information that will advance the field in an evidence based manner.

Data Collection and Submission Requirements for VCAs (VCA Committee)

ASTS ***supports*** the uniform data reporting requirements, which facilitate the formation of a comprehensive database. Likewise, we support the establishment of organ allocation policy for VCAs. We urge the agency to avoid regulatory standards that precede clinical knowledge in areas such as living donation, and urge the agency to include in the final regulation a provision that makes it clear that OPTN policies in this area may deviate from those established for other organs in a manner that recognizes the research status and early developmental situation of these promising procedures.

Improving the OPTN Policy Development Process (Executive Committee)

ASTS supports many of the concepts outlined in the proposal. However, we are concerned with several aspects and believe it ultimately fails to address the goals of the policy proposal. ASTS strongly supports streamlining the policy development process and shortening the timeline(s). The alignment of public comment periods and board/committee meetings is a positive step. We are concerned about the classification of "types" of policies including *routine* and *non-controversial*. Instead, we encourage OPTN to prioritize proposals that are integral to the function of the OPTN and establish different work processes to guide other "non-essential" policy development. Finally, we are concerned that the absence of opposition will be considered a surrogate for affirmation, which does not promote confidence or efficient function within the OPTN.

Proposed Changes to the OPTN Bylaws Governing Histocompatibility Laboratories (Phase II) (Histocompatibility Committee)

ASTS defers to ASHI for their evaluation of this policy proposal.

Proposal to Establish a QAPI Requirement for Transplant Hospitals and OPOs (MPSC)

ASTS ***does not support*** this proposal, which duplicates efforts by CMS and is contrary to the spirit of ACOT's August 2012 recommendation to the HHS Secretary related to unnecessary burdens and inconsistent requirements for transplant centers and OPOs. The proposal would require transplant centers and OPOs to have a QAPI plan and allow MPSC to review such plans upon request. ASTS is not objecting to the need for a QAPI program (which is already required by CMS) but instead to the duplicative requirements that are contrary to recent actions designed to reduce the administrative burden on transplant centers and OPOs by streamlining, to the extent possible, OPTN and CMS processes. As written, the policy promotes the chasm between CMS and OPTN oversight whereas CMS policy should be sufficient. ASTS would support language that says if a program is not CMS approved a QAPI program should be in place.

Definition of a Transplant Hospital (MPSC)

While ASTS appreciates the spirit of the proposal, we ***do not support*** it as currently written. Generally, the proposal is vague, contrary to other oversight bodies (i.e., CMS, the Joint Commission, etc.), and incongruent with changing healthcare mergers, system delivery, and the current healthcare economy.

The proposal would require that transplant programs under one provider number must be connected by a bridge or tunnel which does not represent current practice nor the thoughts and needs of our constituents.

It appears that the MPSC is approaching this backwards. First, the MPSC has added an evaluation plan consisting of a subcommittee that would review applications and make recommendations to the board, but the proposal lacks strict criteria. Secondly, the proposal states that **after** implementation, the MPSC will review current OPTN transplant hospitals to determine whether they meet the new definition. Non-conforming hospitals will be given two years to conform. ASTS strongly disagrees with this approach and instead encourages MPSC to conduct the review **now** in order to understand how many transplant hospitals will be affected.

Proposal to Implement Pre-Transplant Performance Review by the MPSC (MPSC)

ASTS is in support of policies that improve patient care, increase access to transplantation, optimize post-transplant outcomes, maximize organ utilization, and provide the tools to objectively study metrics to achieve the aforementioned. Furthermore, ASTS understands the need to provide similar tools to the MPSC. The Society is cognizant of the difficulty inherent in the task of developing these tools and the policies necessary to operationalize them. Also, ASTS commends the stated goal, namely to mitigate the risk aversion that has occurred due to the high level of scrutiny associated with the emphasis on transplant outcomes, and understands the extent of the thoughtful deliberations that went into the current policy proposal. However, **the ASTS is unable to support the Proposal to Implement Pre-Transplant Performance Review by the MPSC using composite performance metrics (CPM) in its current form, and is opposed to its adoption and implementation.** Overall we feel that the proposal is immature and needs significant additional refinement and that implementing it in its current form will unfairly deprive some patients of needed transplantation and will increase risk adverse practices, resulting in further reductions in transplants.

The major fundamental conceptual flaw in the current proposal is that there is no linkage between the CPM and either post-transplant recipient outcomes or organ performance. The intent of this policy is to provide a tool to assess transplant programs' pre-transplant functionality in terms of waitlist management, access to transplantation, and organ acceptance. However, this fails to provide information that addresses the question of fundamental importance to patients when selecting a transplant center, i.e., what is the likelihood that they will get transplanted and do well following transplantation? The example provided in the policy proposal highlights this problem. The example cites three programs that have poor post-transplant performance and as such are identified for review. However, their CPM scores indicate that they are performing better than would be expected in providing access to transplantation. A more holistic analysis would indicate that they are serving their patients quite well. And, although the example notes that the MPSC would take this into consideration when adjudicating the transplant centers' status, the policy specifically states that CPM data will only be used internally and will not be made public. **The lack of transparency does a disservice to both the transplant center in question and their patients**. Excellent CPM scores do nothing to negate the negative impact that flagging for "poor" post-transplant performance has in regard to public perception, third party contracting, and institutional programmatic oversight. Similarly, patients are not provided

with important information about a program's overall performance and may feel compelled to seek treatment at centers that are less conveniently located or outside their insurance networks. **Although the proposal indicates that an intent-to-treat analysis was considered using the construct of "Life Years Following Listing" (LYFL), the argument against this approach is non-persuasive.**

The lack of linkage to organ functional performance is additionally problematic. For example, if center A turns down an offer for a suboptimal organ, and that organ is subsequently accepted and transplanted by center B, and the organ fails (e.g. due to primary non-function), then this is **still counted against center A in the proposed schema, despite the fact that center A made the correct decision of turning down the organ that ultimately did not work**.

Adding pre-transplant monitoring without balanced reduction in post transplant flagging will only add to the risk aversion mindset. As revealed in a number of recent publications, the typical response by programs flagged by UNOS is to adopt a more conservative mode of practice, reducing their transplant volume. By the estimates provided in the accompanying analysis, an additional 19 and 8 kidney and liver programs will be flagged each year under the proposed CPM scenario. The proposal will in no way alleviate the propensity to risk aversion since post transplant flagging will remain unchanged, but instead will increase risk aversion by addition of flagging based on CPM, resulting in further reductions in the number of transplants performed.

Alternatively, most transplant surgeons and physicians acknowledge that the combination of a marginal organ transplanted into a marginal candidate may be a recipe for disaster. For these patients, centers often are restrictive and will only accept organs that are not marginal in quality. And, although the proposal contains risk adjustment for both the patient and the organ in question, this risk adjustment is limited and lacks important variables and co-morbid conditions for which adequate data is lacking, but nonetheless is utilized by clinicians when selecting the appropriate organ for a particular recipient. Examples of information that is important but not incorporated into the risk adjustment include such items as renal biopsy findings, patient frailty, cardiac status, and hypercoaguable states. One can hypothesize that **transplant centers may be inclined to deny listing to higher risk patients if they have the chance of being doubly "flagged" for poor organ acceptance rates and for potential suboptimal outcomes.** However, these patients might be best served by being transplanted rather than the alternative of no transplant. Therefore, we reiterate, **there is no empiric data on how the proposed policy will affect transplant center behavior**.

We are strongly opposed to the use of waitlist mortality as a metric in the manner described. First, waitlist mortality is in part a consequence of listing practices. Over emphasis on waitlist mortality will undoubtedly encourage a more conservative listing practice, precluding a transplant opportunity for those patients who stand to benefit the most. As has been repeatedly demonstrated in the literature, the greatest benefit from liver transplantation is derived by those with the greatest waitlist mortality—the highest MELD. Discouraging listing such patients for fear of a higher waitlist mortality rate would do a great disservice to transplant patients in general. For an exaggerated example, if one center lists one risky patient (foregoing listing 9 others to avoid high waitlist mortality) and successfully transplants that patient, they would have zero waitlist mortality. Another center which lists 10 high risk patients and

successfully transplants 4 would have 60% waitlist mortality but will have saved 4 times as many lives. Each of the patients who died while on the waitlist would have died anyway if not on the waitlist, so how have we helped such patients by discouraging their listing? Further, the data provided indicating that waitlist mortality is not correlated with transplant rate and organ acceptance rate makes it fallacious to think that increasing transplant rate or organ acceptance rate will mitigate waitlist deaths. The lack of linkage likely results from geographic differences in organ availability and listing practices.

The proposed policy is inconsistent in its differential utilization of mortality after listing as criteria for assessment between liver and kidney programs. The rationale for not including waitlist mortality for kidney transplant programs is that kidney programs often do not provide the pre-transplant care for many of their patients. However, the same may be true for liver transplant centers. Geography, with patients living remotely from a transplant center, or restrictions of third-party payers regarding non-transplant care, may make it impossible for liver transplant centers to provide substantial pre-transplant care to large numbers of their waitlisted patients.

Overall, the proposal provides inadequate justification for giving waitlist mortality twice the weight of transplant rate and organ acceptance rate. In the supporting literature accompanying the policy proposal, it is noted that utilizing the CPM will result in only a small number of programs selected for review. This is not reassuring. Unfortunately, **the number of transplants performed annually has been relatively static over the last 7 years. And, the number of live donor transplants has declined. With the ever-growing number of patients awaiting transplantation, the transplant rate continues to decline. <u>The ASTS questions whether a transplant program comparative analytic approach is best if nationwide access to transplantation continues to decline.</u>**

ASTS offers these additional minor points for consideration:

a. For the case of offer acceptance rates, dual organ transplants should be excluded as there has not been adequate modeling for risk adjustment specifically in this population.
b. The geography adjusted transplant rate does not adequately consider associated compensatory measures occurring in areas of the greatest organ shortage such as greater recovery and utilization of organs from high DRI donors.
c. The Bayesian statistical methodology applied is complicated and unlikely to be easily understood by patients and centers.

In summary, the ASTS believes that the current proposal, although well intentioned, is unlikely to improve access to transplantation and is not in the best interests of the patients and UNOS member transplant programs. While pre-transplant CPM may aid the MPSC in its task of evaluating transplant center performance, the Society believes alternative, more holistic, transparent, and constructive measures should be considered instead.

Proposal to Reduce the Reporting Requirements for the Deceased Donor Registration Form (OPO Committee)

ASTS ***supports*** this proposal as written.

Proposal to Address the Requirements Outlined in the HOPE Act (OPO Committee)
ASTS ***supports*** this proposal. The OPO Committee has been proactive, thoughtful and inclusive in the development of guidelines for HIV positive donors.

Proposal to Allow Collective Patient and Wait Time Transfers (Operations and Safety Committee)
ASTS ***supports*** this proposal that adds efficiency to the process of transferring patients to a separate receiving center.

Proposal to Automatically Transfer Pediatric Classification for Registered Liver Candidates Turning 18 (Pediatric Committee)
ASTS ***supports*** this proposal.

Policy Rewrite Parking Lot "Quick Fixes" (Policy Oversight Committee)
ASTS appreciates the follow-up to these issues left unresolved at the conclusion of the plain language rewrite. While the majority of the proposed changes are insignificant and provide greater clarity, we would be remiss if we did not mention that a language change from "should" to "must" in 1.4.D, 1.4.E, 9.3.F, 9.3.G, 9.3.G.iv appears to change recommendations into policy and will add regulatory burden(s).

Clarification of Multi-Organ Policies (Policy Oversight Committee)
ASTS ***supports*** the proposed rewrite with clarification of existing policies as it does not change any current rules and does not alter the current allocation system. However, we are disappointed that the proposal fails to address the more significant revisions which are necessary to improve survival of multi-organ transplant patients. Heart/lung candidates are greatly disadvantaged in that they can only get the heart/lung if they are at the top of the heart list. If they are on the top of the lung list, they will be bypassed for a status 1A heart candidate.

Within the policy proposal, OPTN seeks input as to whether the language is more easily understood and if the proposal supports current clinical practice. In response to this request, ASTS offers the following:

- Start times: This language basically says that the team accepting the organs must agree on a start time and, if not, the offer can be withdrawn. This language seems extreme, and we encourage OPTN to seek alternative language.
- Allocation to candidates not on the match run: This language appears to stipulate how a recipient may receive an organ if not on the match run. This is typically forbidden, and it is difficult to understand under what circumstances this would occur with the exception of a designated donor situation. The transplant center should be held accountable for the correct listing of its candidates. Last minute addition of organs is not an acceptable practice and should not be facilitated by national policy.
- Other multi-organ combinations: This is based on multi-organ allocation in association with the heart, lung and liver. The proposal states that within the same Donor Service Area (DSA) as the candidate, the second required organ (most commonly the kidney) is allocated with the primary organ. This is the accepted practice. However, the proposal goes on to say that outside the candidate's DSA, while the primary organ can be offered, the second organ does not have to be allocated. ASTS views this as an active and flawed practice used to deter broader sharing of

organs. For example, if an outside liver/kidney candidate is offered only the liver, this forces the candidate center to either turn down the offer altogether or to transplant a liver alone into a candidate who has been accepted as a liver/kidney candidate. In such cases, the only beneficiary is the donor DSA local transplant center. The proposed language fails to stop this practice.

Proposal to Clarify Definition of Organ Transplant and Transplant Date (Policy Oversight Committee)
ASTS ***supports*** this proposal.

Thank you for the opportunity to comment on these proposals. Please do not hesitate to contact me or Kim Gifford, ASTS Executive Director, if you have any questions or require additional information.

Sincerely yours,

Peter G. Stock, MD, PhD
President