

Reply

TO THE EDITOR:

We duly note the insurance challenges discussed by authors Eswaran and Chan. Many insurance payers continue to require fixed pretransplant sobriety periods (ie, the 6-month rule) despite the lack of evidence to support them.⁽¹⁻³⁾ Although payers reserve the right to have skepticism about any center's evolving policies regarding liver transplantation (LT) for alcoholic associated hepatitis (AH), we anticipate that payers' approach to these patients will progress. As transplant centers update their institutional criteria regarding LT for AH, acceptable outcomes are demonstrated in a transparent manner, and professional societies offer guidance, we anticipate that insurance payers' policies will follow suit.⁽⁴⁾ Notably, to achieve success this should include coverage for LT and for essential mental health and substance-use disorder (MH/SUD) treatment before and after LT.

Drinking is one of innumerable behaviors, habits, and choices that affect human health and medical outcomes. Other key transplant examples include patient adherence to medications and clinic visits as well as weight and nutrition management. In an era of alarming alcohol-related trends,⁽⁵⁾ the transplant field must simultaneously work diligently to maintain stigma-free, equitable, high standards for organ allocation while striving to provide excellent MH/SUD care for recurrent alcohol-use disorder (AUD) in LT patients regardless of indication.

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Other meaningful actions by transplant centers may also help. We agree with the importance and efficacy of integrative medicine, embedded MH/SUD care, and longitudinal case management within transplant as highlighted by authors Solga and Spacek. Expansion of pretransplant and posttransplant psychosocial personnel and services that are highly cross-trained in MH/SUD and transplant whenever possible, demonstrates a center's commitment to high level relapse monitoring and its expanded ability to intervene.⁽⁶⁾ Centers must facilitate MH/SUD care plans consistently over the years after transplant given variable trajectories of post-transplant drinking.⁽⁷⁾ Longitudinal use of toxicology (especially biomarkers like serum phosphatidylethanol and urinary ethyl glucuronide) and psychometrics are helpful tools for monitoring patients undergoing LT for AH and for anticipating crises. Given the dense populations and broad geographic areas transplant centers serve, established collaborations with community MH/SUD providers as well as the use of telemedicine may ease insurance payers' concerns about LT patient follow-up and care access. Centers should track and publish a wider array of outcomes with LT for AH. In addition to "harder" survival, graft failure, and slip/relapse outcomes, meaningful "softer" LT outcomes, such as AUD treatment retention, successful AUD treatment re-engagement, regained sobriety, mental health and quality of life metrics, and postrelapse renormalization of liver function tests, will be essential for measuring effective care with LT for AH. Payers may also be reassured to see that, in an age of clinician burnout, transplant centers prioritize the mental health of their own staff given the challenges inherent to managing MH/SUD matters in LT patients. Although LT in AH patients is a vital issue of the day, human behavior, habit, and addiction remain, on the whole, intrinsic to all aspects of LT.

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