



October 1, 2025

Lisa M Stocks, MSN, RN
Chair, Organ Procurement and Transplantation Network (OPTN) Ad-Hoc Multi-Organ
Transplant Committee
One Legacy
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Christopher Sonnenday, M.D.
Vice Chair, OPTN, Ad-Hoc Multi-Organ Transplant Committee
University of Michigan Medical Center
Transplant Clinic | Taubman Center
1500 E Medical Center Dr
Ann Arbor, MI 48109

RE: Public Comment: Establish Comprehensive Multi-Organ Allocation Policy

Dear Ms. Stocks and Dr. Sonnenday:

On behalf of the more than 37,000,000 Americans living with kidney diseases and the 21,000 nephrologists, scientists, and other kidney health care professionals who comprise the American Society of Nephrology (ASN), thank you for the opportunity to provide comment on the proposal entitled “Establish Comprehensive Multi-Organ Allocation” from the Organ Procurement and Transplantation Network (OPTN) Ad-Hoc Multi-Organ Transplant Committee.

While ASN supports the aims to promote equitable access to transplant among multi- and single-organ candidates and to facilitate consistent and efficient allocation, the society strongly believes the placement of all kidney recipients in lower priority categories is suboptimal to nephrologists who care for those with kidney failure as well as those with kidney transplants. While the Society acknowledges the considerable efforts of this ad-hoc committee, we note the lack of representation from the kidney transplant community on the ad-hoc committee. The Society firmly believes this lack of representation results in kidney recipients and their unique considerations are overlooked in this process. In addition to these overarching comments, the Society offers specific feedback on the following *key considerations for commenters* as posed by the ad-hoc Multi-Organ Transplant Committee:

1. Does the community support the donors covered by multi-organ allocation tables?
 - a. The ASN requests that the Ad-Hoc Multi-Organ Transplant Committee adopt objective thresholds (e.g., graft survival probability and clinical criteria) before including a low KDPI kidney in an MOT offer. Low KDPI kidneys have excellent half-life and maximizing life years gained from every organ donor should be a guiding principle.

2. Does the community support the candidate groups covered by the multi-organ allocation tables?
 - a. Overall, the ASN supports adoption of high priority candidate groups in the standardized allocation order to allow more flexibility for OPOs if organs remain available after completion of offers to candidates covered by multi-organ allocation tables. However, the Society also requests consideration of additional safeguards to mitigate negative allocation implications for single kidney recipients.
 - b. A priority for the Society is to protect pediatric and medically urgent kidney candidates — we request that they be given clear, explicit placement ahead of many multi-organ combinations in the multi-organ tables. ASN is particularly concerned with the following recipient categories:
 - i. Pediatric kidney-alone candidates should be sequenced before the MOT for DBD donors aged 11-17 with KDPI 0-34% and DBD donors aged <11 with KDPI 35-85%.
 - ii. Previous living donors as well as those patients that are highly sensitized to many donors require explicit placement so highly prioritized kidney groups aren't inadvertently deprioritized on multi-organ donors.
 - c. A bold consideration is to use one kidney for every low KDPI donor towards MOT leaving the other for a kidney alone candidate first.
 - d. As another overarching comment, the Society again registers that KDPI is not a particularly good marker of organ quality, especially in the context of how it is used in our allocation system and to inform organ offer decisions. At a minimum, ASN would like to see KDRI used in place of KDPI in the short term (and in the long term recommends that OPTN work towards development of a new kidney allocation system, in the context of OPTN modernization and *Securing the U.S. OPTN Act*).
3. Does the community support the order of priority of candidate groups in the multi-organ allocation tables?
 - a. ASN does not support the order of priority of candidate groups in the multi-organ allocation tables. The Society is concerned that priority for all kidneys falls well below expectations and raises concerns of bias against kidney failure patients based on the assumption that such candidates may continue to survive on dialysis indefinitely, a clear misconception about the reality these patients face.
4. Does the community support moving to a “must”/“must not” offer framework for candidates registered for more than one organ and removing “permissible” multi-organ offers?
 - a. ASN is supportive of the must/must not framework as it provides clarity and removes the ambiguity of using “permissible.”

5. Does the community support removing priority for some heart-kidney, liver-kidney, lung-kidney, and kidney-pancreas candidates above kidney-alone candidates?
 - a. ASN requests clarification regarding how safety net kidneys are considered in this framework; an issue that arose as a theme as the Society reviewed the questions posed by the committee. Safety net kidneys—kidneys allocated to a person who has been listed for a kidney within a year of having received another organ transplant—present somewhat of a quasi-multi-organ-transplant situation and ASN recommends that the forthcoming policy proposal explicitly address a recommended approach for how they fit into the overall multi-organ transplant proposal.
 - b. ASN supports the recommendations of additional priorities as already noted above (2b) as well as support for the very highly sensitized kidney candidates as identified by the committee.

6. Does the community support the proposed policy on which organs would follow the primary organ on each match run?
 - a. Yes

7. Does the community support the proposed revisions to Policy 5.6.D: Effect of Acceptance?
 - a. Yes

8. Under the proposed policy, OPOs would be required to execute match runs for organs to be recovered for transplantation and generate the allocation plan before making an organ offer to a primary potential transplant recipient. Does the community support the timing for running the allocation plan relative to executing match runs and making offers to primary PTRs?
 - a. Yes. The ASN believes clarity for OPOs and transplant centers based on clinical judgement vs standardized criteria will reduce variability between OPOs and encourage standardization (to reduce variability between OPOs) with limited, well-defined clinical exceptions so OPOs keep appropriate flexibility but can't routinely deprioritize single-organ candidates.

9. Would it be feasible to report HLA Typing prior to generating a multi-organ allocation plan?
 - a. HLA typing is already standard for kidney and pancreas allocation and required for most match runs, but timing is critical. OPOs typically do rapid donor typing, typically low-resolution at the time of donor evaluation, which is then confirmed with high-resolution typing later in the process. For multi-organ allocation today, the OPO may begin making offers before high-resolution HLA typing results are finalized, especially for organs with more urgent ischemia considerations (heart, liver, lung). ASN recommends this ad hoc MOT committee reach out to the OPTN Histocompatibility Committee to ensure alignment.

10. What challenges do members anticipate if the policy proposal is implemented and how should the OPTN support members to ensure successful implementation and promote compliance?
- a. With any suggested change in allocation, a stepped implementation plan will be needed to provide sufficient education to surgeons, physicians involved in donor acceptance, coordinators, and to understand how priority flows in MOT allocation. Without broad training, decision-making may default to old practices. Potential methodologies include simulation exercises and webinars with open panels for questions and discussion. OPOs must generate a donor-specific MOT allocation plan quickly, balancing multiple organ match runs. Centers will need to interpret new tables, rules, and mandatory vs discretionary offers, which could initially cause confusion and inconsistent application. The Society recommends periodic yet regular review to allow rapid mid-course corrections.
 - b. DonorNet® and match run software must be updated to support donor-specific multi-organ plans, which are more complex than single-organ runs. Risk of technical errors, delays, or center misinterpretation without clear user interfaces and training.
 - c. Centers may differ in how aggressively they accept MOT offers; variability could disadvantage certain patient groups. Single-organ candidates (especially kidney, lung) may perceive disadvantage if communication isn't clear and transparent.
 - d. Members may worry about enforcement: What happens if an OPO or center doesn't follow the MOT allocation plan exactly? Transparency is key to avoid erosion of trust in the system
 - e. Consider piloting in select OPOs before national rollout, allowing refinement. Alternatively, consider piloting phased implementation by organ type.
 - f. Consider development and deployment of public dashboards showing:
 - Number of MOT transplants by organ type,
 - Impact on kidney wait times (esp. pediatrics, highly sensitized), and
 - Outcomes of kidneys transplanted in MOT recipients vs kidney-alone recipients.
 - g. Introduce a real-time OPTN help desk for OPOs during go-live period.
 - Policy guidance that clarifies “must” vs “should” vs “may” for multi-organ offers.
 - Non-punitive compliance checks early on (educational audits) to help members adjust without fear of penalty.

11. The Committee has previously identified the following groups for additional post-implementation outcome monitoring to ensure that these candidates/recipients are adequately prioritized in the proposed MOT allocation tables. Are there other groups or topics that should have additional post-implementation monitoring to help identify and remediate any unintended impacts?
- a. ASN reiterates the following key points:
- High-quality, low-KDPI kidneys are sometimes drawn into multi-organ offers. The OPTN should monitor how often this happens and compare outcomes vs if kidneys had gone to kidney-alone candidates. Specifically track survival of kidneys transplanted as part of MOT procedures vs kidneys transplanted alone, to ensure utilization is efficient and kidneys are not wasted.
 - MOT allocation could inadvertently shift organ quality away from older single-organ candidates if MOT recipients are consistently prioritized. The OPTN should track recipient age distributions and outcomes.
 - OPOs may differ in how rigorously they apply MOT rules. The OPTN must monitor variability across OPOs to ensure uniform implementation.
 - For pediatrics, highly sensitized kidney candidates, and prior living kidney donors, there is a need to monitor wait times, offer rates, and transplant rates before and after policy implementation.
 - Multi-organ transplants tend to occur at large centers with more resources. Monitor whether access disparities widen by race, insurance type, or geography.
 - Track whether transplant programs decline more kidney-alone offers post-MOT (believing they have fewer opportunities), which could worsen discard rates.

Summary:

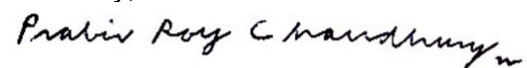
ASN is strongly supportive of a single national policy guiding multi-organ (and single-organ) offers but has reservations about the broader approach to allocation using a continuous distribution system (that may use this policy as a component). ASN has expressed concerns about the impending shift to a continuous distribution system for kidney allocation^{1, 2} and maintains these concerns at present. As another overarching comment, the society again registers that KDPI is not a particularly good marker of organ quality, especially in the context of how it is used in our allocation system and to inform organ offer decisions. At a minimum, ASN would like to see KDRI used in place of KDPI in the short term (and in the long term recommends that OPTN work towards development of a new kidney allocation system, in the context of OPTN modernization and Securing the U.S. OPTN Act implementation). Finally, the Society acknowledges the considerable efforts of this ad-hoc committee but notes the lack of representation from the kidney transplant community. The Society firmly believes this lack of representation results in kidney recipients and their unique considerations are overlooked in this process.

¹ ASN comments to OPTN. September 2023. <https://www.asn-online.org/policy/webdocs/23.9.19FINALEfficiencyandUtilizationContinuousDistribution.pdf>,

² ASN comments to OPTN. September 2024. <https://www.asn-online.org/policy/webdocs/24.9.24DraftContinuousDistribution.pdf>

Again, ASN appreciates the opportunity to comment on this Proposal to Establish Comprehensive Multi-Organ Allocation Policy and hopes its recommendations are useful to the TCC. Please contact ASN Principal for Kidney Health Guidance, Sarah Sampsel, MPH at ssampsel@asn-online.org with any questions or to discuss this letter in more detail.

Sincerely,

A handwritten signature in black ink that reads "Prabir Roy-Chaudhury" with a stylized flourish at the end.

Prabir Roy-Chaudhury, MD, PhD, FASN
President