



ASTS Responses to OPTN Proposals Open for Public Comment

March 15, 2023

Continuous Distribution of Kidneys and Pancreas – Committee Update

The ASTS is in support of the concepts behind the Continuous Distribution of Kidneys and Pancreata being undertaken by the OPTN committees. This is not truly a proposal nor are there final details being submitted for comment, so we cannot agree or disagree with this Committee Update as a whole. We will comment on particulars within your latest document for this Public Comment Period ending March 15, 2023.

We agree with the concept discussed that kidney allocation needs to weigh the longevity of deceased donor grafts more heavily in the allocation system design. We agree with having better correlation with the KPDI and EPTS as per the prior LYFT proposal during KAS development. The system must change the major advantage the high CPRA candidates (CPRA 99.51 to 99.98) have in receiving organ offers, especially when this is in opposition to longevity considerations and also to fairness considerations as most of these high CPRA candidates are receiving their subsequent transplant, not their first transplant, and with much shorter waiting time than the average recipient.

We agree with the following three concepts:

Increased Longevity: “This scenario increased the weight/importance of transplant outcomes from 10 percent to 40 percent divided between human leukocyte antigen DR (HLA-DR) and longevity matching. The weights for all other attributes were decreased proportionally.”

The details of how longevity is estimated are very important. In the original LYFT simulations, longevity of patient survival was based on the actual kidney being offered with candidate, donor and interactive variables for each offer. This considers HLA matching, potential function of organ (KDPI and other interactions), and potential survival of recipient (EPTS with interactive terms) for each organ offer. This also needs to appropriately measure the decreased expectations for subsequent transplants compared to first transplant recipients.

Increased Placement Efficiency/All Donor Efficiency: “This scenario increased the weight/importance of proximity efficiency from 10 percent to 30 percent. The weights for all other attributes were decreased proportionally.”

ASTS feels the distance should involve population densities so organs may need to travel less far in highly dense areas, but further in lower population density areas of our country to allow for relatively equal access.

Harder to Place Kidneys/High KDPI Efficiency: “This scenario increased placement efficiency for harder to place kidneys (high KDPI) with an increased donor weight modifier for KDPI 86-100 percent.”

ASTS believes the placement of these hard to place organs is complex and must involve the groups who actually offer the organs and accept the organs in most programs since they alone understand the challenges of transplanting these organs at all hours of the day. Centers need better organ filters so they can more granularly list patients for various types of hard to place organs. In turn, centers need to be accountable for listing their patients appropriately. These organs also need oversight forgiveness in addition to the standard "risk adjustment" which is not felt by most centers to truly estimate risk, especially if we want centers to transplant more of these kidneys which likely were not truly in the set of organs developing the prior risk adjustment variables.

The ASTS is very concerned that once this concept of Continuous Allocation for Kidney and Pancreas becomes policy, the point assignments and other adjustments to the allocation factors could be done by a small group of individuals under operational rules falling outside the policy development cycle with public input. We would strongly suggest a provision to all the Continuous Allocation distribution organ proposals that mandates that any change in point assignment or other calculation that results in a change in simulated allocation to more than 5% of recipients be put forth for formal Public Comment. This would alleviate concerns that a small group could have unfair influence on national organ allocation/distribution.

Summary of ASTS Suggestions for Kidney and Pancreas Committee Consideration:

Distribution consideration based not only on distance, but population density and distance to help increase the proximity efficiency attribute weight and not disadvantage rural candidates where longer distances are required for fair access.

Pediatric candidates:

Require each transplant program to adjust distance acceptable to their program. Review this annually and consider adjusting allowance of distance acceptable to program.

We agree with adjusting the CPRA priority. CPRA points should allow for equal access, not increased access as has been the case in the current KAS. We also agree that high CPRA should have a negative value in longevity considerations.

Dual Kidney:

Considerations for improved utilization:

- Allow centers to only list a small percentage of their candidate wait list as accepting Dual Kidneys so real thought is put into this decision and the best candidates are chosen and ready to be transplanted.
- Initial allocation of dual kidneys based more stringently on objective criteria such as eGFR and/or donor age or size of donor/kidneys. OPOs are not offering many kidneys out as dual kidneys until after they have many declines for single kidney alone offers. Dual kidney offers should be the primary offer for some donors.

En Bloc Kidneys:

- Allocation of en bloc kidneys based more stringently on size and/or age of donor.
- Allow centers to list a small percentage of their WL for these organs

Pancreas allocation:

Agree that for facilitated pancreas offers, some number of offers to standard programs on the WL

should be done. This could be as short as two different programs refusing the offer for the top candidates on the standard WL, but it should encompass some standard offer attempt.

KP offers:

KP candidates could be given a large number of points for CAS and limited by distance to mimic the current circles since this has been working per the report. For example, give all the KP candidates an additional 20 points within 250 NM and they would appear above all but the most highly sensitized kidney alone candidates within that area.

Kidney Minimum Acceptance Criteria (MAC) should be updated to allow for more granular choices by the transplant programs for their patients.

'Offer Filters' should allow transplant programs to set several different filters for various groups of patients so they can set filters based on what the programs consider acceptable offers for those different groups of candidates. For example, a center can create five different groups within their waiting list and assign each patient within one of those groups to the appropriate Offer Filter. This should help efficiency of allocation and help programs remain within the expected organ Acceptance Rate metric while still entertaining more difficult to place organs for some of the candidates on their list.

Released Organs:

We agree with the discussion as written.

Kidney and Pancreas Review Boards Workgroup:

We agree with the discussion as written.

ASTS Position: Neutral