

**THE URGENT NEED TO REFORM THE ORGAN  
TRANSPLANTATION SYSTEM TO SECURE  
MORE ORGANS FOR WAITING, AILING,  
AND DYING PATIENTS**

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**HEARING**

BEFORE THE  
SUBCOMMITTEE ON ECONOMIC AND CONSUMER  
POLICY  
OF THE  
COMMITTEE ON OVERSIGHT  
AND REFORM

**HOUSE OF REPRESENTATIVES**

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

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- \* American Society of Nephrology Statement; submitted by Rep. Krishnamoorthi.

*Documents are available at: docs.house.gov.*



**THE URGENT NEED TO REFORM THE ORGAN  
TRANSPLANTATION SYSTEM TO SECURE  
MORE ORGANS FOR WAITING, AILING,  
AND DYING PATIENTS**

**Tuesday, May 4, 2021**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON OVERSIGHT AND REFORM,  
SUBCOMMITTEE ON ECONOMIC AND CONSUMER POLICY,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 12:11 p.m., via Zoom, Hon. Raja Krishnamoorthi (chairman of the subcommittee) presiding.

Present: Representatives Krishnamoorthi, Porter, Bush, Johnson, DeSaulnier, Pressley, Maloney (ex officio), Cloud, and Clyde.

Mr. KRISHNAMOORTHI. The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time.

I would like to welcome everyone to the Subcommittee on Economic and Consumer Policy's first hearing of the 117th Congress. It is an incredibly important one because, today, we are literally covering matters of life and death for many Americans.

This hearing will address, quote, "The Urgent Need to Reform the Organ Transplantation System to Secure More Organs for Waiting, Ailing, and Dying Patients," close quote.

We will begin with a panel of witnesses who will share their personal experiences with the organ transplant system in America.

Now I will introduce our witnesses. Our first witness today is Tonya Ingram. Tonya is currently waiting for an organ.

Then we will hear from Dr. Dara Kass. Dr. Kass is uniquely acquainted with organ transplants, as she is the mother of a transplant recipient and she was a living organ donor to her child, and she's an emergency medical doctor.

And we will hear from LaQuayia Goldring. LaQuayia is also waiting for a transplant.

The witnesses will be unmuted so we can swear them in.

Very good. Please raise your right hands.

Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Very good. Thank you.

Let the record show that the witnesses all answered in the affirmative. Thank you.

Without objection, your written statements will be made part of the record.

With that, Ms. Ingram, you are now recognized for your testimony.

**STATEMENT OF TONYA INGRAM, PATIENT WAITING FOR A TRANSPLANT**

Ms. INGRAM. Thank you.

Good morning. My name is Tonya Ingram. I am a poet, Cincinnati native, Bronx-bred introvert, Los Angeles resident, mental health advocate, cat auntie, Tom Hardy lover, and “The Office” fanatic, and I need a kidney transplant.

I was diagnosed with lupus at 22 years old, and as a result of that, in October 2018, I was diagnosed with end-stage kidney failure. My entire world collapsed.

Since then, I have lived on dialysis just waiting to receive this new form of life. My health is my job. That is my main, primary focus. I have to be aware of the energy I have. I have to take all these medications. I am exhausted most days.

I started telling my story because I have to take my health into my own hands. I have to be my own advocate. I just knew that I would get more out of Instagram than from the actual healthcare system.

Last night, I hooked myself up to a dialysis machine at 9 o'clock at night for the eight hours it would take for a machine to clean my blood. At the age of 29, that's a lot to deal with, and I still have to wait for an organ to be able to have a second chance at living a healthy and long life.

It is a very exhausting process waiting for a transplant. Because of my rare blood type, being on the list could mean that I have to wait 10 years before I can receive a transplant. Ten years is a very long time for anyone. I can't even think 10 years into the future right now, and to know that I won't have a kidney until then is a very daunting and heavy thing.

I know I'm not unique in that sense. That just is what it is. It's waiting. It's hard to know that I'm waiting for life. I'm waiting to live. And I'm standing alongside more than 100,000 Americans, most of whom are waiting for kidneys, though others need hearts, lungs, livers, and other organs.

Imagine reading about a broken system when you are still waiting, to read investigative reporting about literally hundreds of organs going mishandled and lost in transit. Every one of those organs is a shot at life, and yet they're being treated like old luggage.

As I've learned, this is just one problem in a horribly broken organ donation system. To learn that 28,000 organs go transplanted every year, including more than 17,000 kidneys, almost 8,000 livers, 1,500 hearts, and 1,500 lungs, that is unconscionable.

The organ procurement organization that serves Los Angeles where I live is failing, according to the Federal Government. In fact, it's one of the worst in the country. One analysis showed it only recovered 31 percent of potential organ donors. Audits in previous years found that L.A.'s OPO has misspent taxpayer dollars on retreats to five-star hotels and Rose Bowl tickets. The CEO

makes more than \$900,000. Even still, the L.A. OPO has not lost its government contract, and it has five more years to go.

And so I wait. And I hope—I hope that it doesn't always have to be like this. Sometimes when you're in this diagnosis, it kind of feels like this is it and I will just be waiting forever until I'm no longer here, but I think this is the reform that will bring true hope. It's to say that you will get it. I will get this organ. I will get this new chance at life at continuing, knowing that the chapter doesn't have to end here and there is this whole other story that I get to engage with because now I have a second chance at life.

My dream is to have a healthy body, a working kidney, and a life that is mine.

To Congress and the Biden administration, please remember that I am a person with a story before kidney failure, and I'll have a life after kidney failure. Every other patient on the organ waiting list has their own story, their own life to live, if the system will let them. We have so much to live for, and that's why we're fighting for this opportunity to do that—to live.

Please don't make us wait.

Thank you.

Mr. JOHNSON. Mr. Chairman, you should unmute.

Mr. KRISHNAMOORTHY. I thought I—can you hear me now, Hank? OK. I'm sorry.

Mr. JOHNSON. Yes.

Mr. KRISHNAMOORTHY. I said thank you, Ms. Ingram.

I wanted to recognize Dr. Kass for her testimony. Thank you.

#### **STATEMENT OF DR. DARA KASS, LIVING DONOR AND MOTHER OF TRANSPLANT RECIPIENT**

Dr. KASS. Thank you to the committee for having us today. This is a critically important topic.

Sammy Kass is our youngest son. He was born smaller than our other children at just over five pounds.

Babies lose weight right after they're born, but most gain it back in the first couple of weeks. When they don't, we looked for clues to say that something might be wrong.

When Sammy was eight weeks old, we found that he had a condition called alpha-1 antitrypsin deficiency. This is a recessively inherited disorder that neither my husband nor I knew we carried.

Being a doctor and his mom, I was devastated. His liver—his disease was causing him liver damage, which was, in turn, preventing him from gaining weight. We spent the next few months seeing doctors and supporting his needs, watching him closely, aware that a small percentage of babies with this type of liver damage would not get better but would get worse, and would ultimately potentially need a liver transplant.

One afternoon, just shy of Sammy's first birthday, we had to take him to the emergency department because he had a fever. We needed to know if he had an infection in his belly near his liver. After the workup was finished, his doctor pulled me aside and said, Today, he is going to be OK, but he's headed for a transplant. He then looked at me and said, Would you consider being his living liver donor?

At that moment, after nearly a dozen years of being a doctor and a few less being a mom, images raced through my head. I saw patients getting sicker waiting for an organ, and their families exhausted, knowing that the call could come at any time, often in the middle of the night, and sometimes not at all.

I remembered the delays and the frustrations I had personally communicating with the organizations responsible for this process, and I knew in an instant that I could bypass that entire system by becoming a living donor and saving my own son's life. In that moment, the overwhelming fear that I had that Sammy would never receive a new liver vanished.

Living donation is a privilege, and it is not without its risks and complications. The socioeconomic burdens of living donation, like unpaid time off of work; multiple family members becoming patients in one family; and the inability of the donor, like me, to serve as the primary care provider for the transplant patient means that families without means or support or resources may not be able to pursue this route even if it's medically possible.

And living donation is, of course, not possible for all patients, like those who need a heart or a pair of lungs. It was a saving grace for our family, but by no means should be considered the scalable solution.

The backbone of organ transplantation in America is deceased donation, which means—which is managed by a network of organ procurement organizations, or OPOs. We cannot overstate the urgency upon us in reforming the OPO system to ensure that it is functioning and accountable.

As an ER doctor, I had witnessed repeatedly OPOs mismanaging families, communicating poorly, and ultimately leaving organ transplant patients languishing on the waiting list. OPO treatment of communities of color has been deeply substandard, leading to worse outcomes for Black and Brown patients needing transplants as well. And never—not once—has a single OPO in this country lost its government contract despite these very deep breaches in public trust.

While my family's transplant experience reinforced my understanding of the need to support OPO reform, living through this last year of the COVID pandemic has accelerated the urgency for this system to work for all patients. While we've lost over half a million Americans to COVID, millions more who have recovered will have long-term effects from their infection.

Acute COVID infection sets off an inflammatory response in your body that can affect your lungs, your heart, your kidneys, or your liver. And communities of color have been decimated by this pandemic. The fact that COVID infection could cause organ failure leading to transplant means that Black and Brown patients, who are already hardest hit by their COVID infection, will be further harmed by the broken organ procurement system that hurts these patients the most.

You don't have to take my word for it. As Chairman Krishnamoorthi and Representative Porter wrote in February, we must move urgently to implement OPO reforms today to serve COVID-19 survivors tomorrow.

In conclusion, I will reiterate that my family is one of the lucky ones. Even in the face of a devastating diagnosis and a life-altering path for our child, we knew we were in a position of privilege. And now, almost seven years later, my son and I will be able to share—split one chopped liver, and we're here to fight for those who still need their chance.

Thank you very much.

Mr. KRISHNAMOORTHY. Thank you, Dr. Kass.

I'd like to now recognize Ms. Goldring for your testimony.

**STATEMENT OF LAQUAYIA GOLDRING, PATIENT WAITING FOR  
A TRANSPLANT**

Ms. GOLDRING. Good morning. Thank you, Mr. Chairman, Ranking Member Cloud, and subcommittee members, for the chance to testify.

My name is LaQuayia Goldring. I'm 31 years old. I'm in the waiting category of waiting and ailing patient, and I'm trying desperately to avoid becoming a dying patient.

As a toddler, I was diagnosed with a rare kidney cancer called Wilms tumor that took my left kidney. And at the age of 17, I went into complete renal failure and had to get a right kidney transplant.

Unfortunately, in 2017, at the age of 25, I went back into complete renal failure. I'm now—I've now been waiting six years for a second kidney transplant, and every day that I'm waiting, I'm closer to becoming one of 12 Americans who die each day waiting for a kidney transplant.

The only treatment keeping me alive is going to the dialysis clinic three times a week—every Tuesday, Thursday, and Saturday—just to live. And each time, I'm stuck with two needles.

I am currently at the dialysis clinic undergoing treatment as we speak today. I can't miss dialysis ever. Even when COVID-19 hit, I still had to come.

And, of course, I'm grateful for the opportunity to come to dialysis and that it's keeping me alive, but it isn't easy. Each day that I come in here, I undergo changes to my blood pressure, and I get to a point to where I can barely talk, I can barely see, or even be able to walk.

Many a days that I come out of here, I have to be helped or aided to my car, and many a times carried into my home. With my poor kidney function, the many changes causes depression, anxiety, nausea, vomiting, and changes to my appetite and my mood. The longer I wait for a kidney, the longer I feel like my life is hanging in the balance, even though there are plenty of willing donors ready to help. And I know this is the story of many Americans across the Nation.

I look forward to the day that my donor has—the donor calls me and tells me that they have the gift of life just for me, just like when I was 17. I live to honor my first donor's life by being a big sister, advocating for the need of transplantation, and becoming a doctor one day.

Thank you for this opportunity.

And I just want to reiterate we need these organs now. The longer that we sit and wait is the longer that we're closer to death.

I've had to undergo many a treatments, and I've been in heart failure twice and have had to recover. It's not much longer that my body will be able to undergo dialysis.

Thank you.

Mr. KRISHNAMOORTHY. Well, thank you, Ms. Goldring, for your testimony.

By agreement with the ranking member, the chair and the ranking member will each take up to two minutes for questions.

With that, I now recognize myself for two minutes of questions.

Dr. Kass, I'm moved by your courageous act of love and selflessness. What did you know about OPOs that made you think that the organ wait list was not an option for you and your child?

Dr. KASS. So, unfortunately, as an emergency medicine doctor, every time a patient comes in who won't make it, it could be an opportunity to initiate the conversation around organ transplant. And that's the beginning of the frustration oftentimes. Getting that communication started in a timely fashion that also respects the fact that a family has just come in, usually unexpectedly, for the worst day of their life, but you know that there might be a chance to turn that into a gift to somebody else that's been living through that hardship for months or years on end.

I had been a doctor in the ER for about 10 years before I realized that my own child would need a transplant, and I just saw all those conversations not happening when there was a possibility, and I just knew that, especially for a child, who is really, at that point, one year old, knowing the devastation families go through in that moment when they lose a baby that small, I just wasn't necessarily going to—I was going to try to except myself out of that circumstance if possible, because I knew that that process was frustrating, it was flawed, and it often failed. And I just was—you know, the opportunity to bypass that was one I was going to take, even if it meant becoming a patient myself.

Mr. KRISHNAMOORTHY. Wow.

Ms. Ingram, you know, thank you for sharing your story. You know, your resolve is inspiring. You know, what do you plan to do after you get your transplant?

Ms. INGRAM. Thank you. Well, once I get my transplant, I plan to live. As I said in my testimony, I have to perform dialysis every night for eight hours, and that—that's a lot. That's exhausting. I can't do simple things like take a bath. And I think just having a transplant gives that—just new life. It gives me the simple things that most people don't have to worry about.

And at the age of 29, there's so much life ahead of me, and I want to be able to enjoy that and wake up to that every day and not have to worry about, you know, doing dialysis or being exhausted or having to fight my mental health to believe that I'm worthy of living. And so having that transplant is truly, is truly another opportunity to just live the life that—that I want.

Mr. KRISHNAMOORTHY. Thank you so much.

Finally, Ms. Goldring, let me just ask you one short question, which is: Do you feel that as a woman of color, that you are in an especially tough situation trying to get an organ transplant?

Ms. GOLDRING. Yes, I do. It just seems like I've been let down by the system, because I'm having to advocate for myself. And as

a Black woman, it feels like there's not enough education that's available on organ donation for people that look like me, Brown and Black people.

I think that the OPOs could be doing a better job by getting out into the communities and speaking to communities of color and going into the hospital and educating

[inaudible] who could possibly be possible donors and talking to those families and allowing them to know the importance of organ donation and the urgency to—for somebody else to be able to be saved and just what that gift of life could do for somebody else's life.

Mr. KRISHNAMOORTHY. Very good. Thank you.

Mr. Cloud, you're recognized. I went over a little bit, so I apologize. You can have the same amount of time.

Mr. CLOUD. Well, thank you, Chairman, and I appreciate it.

Let me just, first of all, say thank you all for being here. Your courage truly is inspiring, not only in just being willing to come before Congress in a national audience and share your very personal story, but the courage you live with each and every day and the challenges that you face each and every day. It's truly inspiring and, certainly, I'm thankful for the opportunity that we've been able to work together on this issue, and we'll hopefully begin to see some progress on it.

Dr. Kass, I wanted to ask you. You've had some experience in interacting with OPOs, and I know we're going to kind of get some—into the nuts and bolts in the next panel, but just your recommendations, it seems like the incentive structure was all kind of messed up. We maybe have made some progress, but if you could speak to what would be the right things we should be looking at from Congress when it comes to accountability in regards to OPO—

Dr. KASS. So I think—

Mr. CLOUD [continuing]. With your experience.

Dr. KASS. So from my experience, I think the first step obviously is accountability and really objective measures that have to be lived up to by the over 50 OPOs around the country, to say, this is the standard you need to meet, whether it's in the initiation of the conversation, the community outreach and, more importantly, delivery of those organs to patients that need them.

It's really about the fact that this is basically a system that has not had oversight for decades, and we need to start getting to the process of—point where we say, you are not performing, and you're going to lose your contract; that your spending and your reporting can't just be your word, but it has to be objectively measured and it has to be accountable. And then it will translate to lives saved every single day.

The delays in those conversations, the delays in us finding these people to come to the hospital and start those conversations, and then make sure that we get to the point of donation is actual people dying, waiting for those organs. And I can't—

Mr. CLOUD. Right.

Dr. KASS [continuing]. Stress enough that, as an emergency medicine doctor who's there when there's already been one tragedy, the idea that there might be a second due to the delay in the process,

because the linchpin of the entire organ donation system rests with the OPOs, is the actual tragedy we need to solve right now.

Mr. CLOUD. Yes. Well, thank you.

Ms. Ingram and Ms. Goldring, really the question I have for you is: What—this is an opportunity to speak to people, both on the committee, but beyond the committee. What would you want people to know who are—either haven't even—it hasn't crossed their mind to consider organ donation? What would you want just people to know when they're thinking about this issue, considering what they should or should not do in relation to this?

If you want to go first, Ms. Ingram.

Ms. INGRAM. Sure. Well, I mean, for me, it kind of boils down to the simple fact of keeping people alive and just the—what that holds, like, we get to—

Mr. CLOUD. Right.

Ms. INGRAM [continuing]. Sit here right now, and this is living. We get to—right now, I'm looking into the ocean and, like, I just—I get to live. And I feel like there's so many words to, like, describe that, but essentially that's just the gift of being able to have an organ, is to be able to engage and like—and live this beautiful, full life.

And I just—honestly, like, I don't want to die. And that may sound, you know, really intense, but living—just having this diagnosis with lupus has, like, done so much to me that, like, I understand if I had this organ, I can—I can just be. I can tell my story. I can write poems. I can be just a full person, and I want that for myself.

And I'm not just speaking for me, but for everyone who just doesn't want to die. And I just—yes. I think it just boils down to that, just the beauty of life and not taking that for granted.

Mr. CLOUD. Yes, ma'am.

Ms. Goldring?

Ms. GOLDRING. Yes. So I would like to tell everybody that it really is the gift of life. Just to reiterate, you get an opportunity to go from being hooked up to a machine like a dog, whether it's every night or three times a week, to having the freedom to travel with your family once again, to just—to really go—to even go to the bathroom. I mean, we take that for advantage. We take the fact that our hearts and our kidneys work together, or, you know, what our liver does for our body, or just other organs.

By being an organ donor, you give that person or persons a chance to have a life that they've dreamed of, just like you've dreamed of. It's an opportunity to be able to educate other people and to help other families. Like, for me, kidney disease runs in my family, and four of my family members have passed away waiting on kidneys when, you know, somebody else in my town or somebody else even across the Nation knew that organ donation was an option for them, they could have been saved. Somebody else could sign up.

And me, even being a past transplant recipient, I actually signed up to be an organ donor at the age of 16, because I educated myself and I made sure that the day that I go from this Earth, that I'm still able to pass along my—excuse me—my organs so that I can

save a life. You know, if I could be selfless like that, anybody else can as well.

Mr. CLOUD. Yes, ma'am.

Thank you, Chairman.

Mr. KRISHNAMOORTHY. Thank you. Thank you, Congressman Cloud. I really appreciate your questions. And thank you to the witnesses.

I also want to recognize my chairwoman, Carolyn Maloney, who's joining us today, and thank you for her incredible leadership on this and other issues. We're so grateful for your presence.

Now we're going to move to opening statements.

I recognize myself for an opening statement, and then Mr. Cloud will follow.

We just heard from Tonya and LaQuayia how painful it is to wait for an organ transplant, knowing that on the day that organ comes, if it ever comes, their life will be transformed. Too many Americans—over 107,000—are on an organ wait list. Too many—33 every day—pass away before an organ becomes available.

The pandemic is putting further pressure on the strained system as COVID-19 further ravages organs. Simply put, we need to get better at recovering every viable organ. Each one saves a life, and there is one group of people that could step up to save the day.

You may not have heard of organ procurement organizations, known as OPOs, but they play a key role in organ transplants. Today's hearing will explore the dysfunctional system that has allowed OPOs to fail the communities they serve.

OPOs are responsible for organs obtained from deceased donors, which account for over 80 percent of transplants. When a hospital has a potential donor, they call the regional OPO, which is then supposed to retrieve any viable organ and deliver it to a transplant surgeon with a patient ready to receive it.

Given their central role in the transplant process, OPOs need to strive for perfection in their public mission, but unfortunately they've been falling short.

For years, OPOs have faced no outside incentive to perform. They evaded public scrutiny, refusing to reveal data showing their success and failure, hiding behind a wall of jargon and obfuscation.

Each OPO enjoys a regional monopoly under the law with no competition whatsoever. No OPO has ever lost its certification, no matter how poorly it has ever performed. They set for themselves disappointingly low expectations, then congratulate each other for lackluster results with high executive salaries and mutual—and invitations to lavish board retreats.

An effort spanning the Obama, Trump, and Biden administrations has resulted in a rule that will enforce objective performance metrics and create competitive pressure for OPOs to succeed. This bipartisan rule will result in at least 7,300 more transplants each year.

Not only do OPOs fail at their mission to secure organs, they are rife with waste and mismanagement. Unusual among Medicare programs, their costs are 100 percent reimbursed, even costs unrelated to care. So, extravagant executive compensation and luxury perks may be passed off onto the taxpayer. Meanwhile, frontline

OPO workers are overworked and underpaid, hurting their ability to recover every organ possible.

Some OPO failures have been disastrous. Kaiser Health found evidence of hundreds of organs delayed, damaged, or lost in transit. Last year, an OPO delivered lungs for transplant, but never tested a sample they collected for COVID. The lungs were infected with COVID, which killed the transplant patient.

In another case involving two organs, the donor's blood type was incorrectly identified. Tragically, one transplant recipient died, and the other was gravely injured.

OPO reform is an urgent health equity issue. Patients of color are more likely to need an organ for transplant, but unfortunately they are less likely to be referred for consideration, less likely to get on the wait list, and less likely to receive an organ.

OPOs could better serve their patients by engaging with communities of color for donation, but unfortunately OPOs are more likely to approach a potential White donor, and that White organ is more likely to go to a White patient.

OPOs have been blamed, but OPOs have blamed communities of color in return for not donating. But unfortunately they're resting on unfounded stereotypes to justify not trying.

The San Francisco OPO is a model of how it's done. Under the leadership of the first Black female CEO of an OPO, diversity has become a priority, and patients benefited. Total donations went up 29 percent, including 70 percent among Black donors.

OPOs have resisted oversight, and some OPOs have brazenly tried to thwart our investigation here. For the patients that are ailing, I will not let OPOs keep failing them. Saving lives is above politics, and OPO reform is a bipartisan issue.

I want to thank Ranking Member Cloud and my Republican colleagues for joining with us in this effort. We join in a bicameral, bipartisan effort in support of the final OPO performance rule which was arrived at in the Trump administration. Fortunately, the Biden-Harris administration heeded our call to begin in implementing that rule.

I look forward to working with my friends across the aisle in continued oversight and reform that will secure more organs and save more lives.

With that, I recognize Ranking Member Cloud for his opening statement.

Mr. CLOUD. Thank you, Chairman Krishnamoorthi.

It's great that we get to be here today to work on an issue like this, especially in the context of how we've seen Congress working oftentimes. It's great to be able to come together on an issue and work for the—what's best for people.

I do want to thank the witnesses for being here today. As I mentioned before, it's amazing for you to have the courage to come here today and to share your stories. I really, really appreciate it. It helps put a face on the issues that we're dealing with today.

I want to thank also, as I mentioned before, the chairman and colleagues on the other side of the aisle, as well as those who have joined in this effort, on keeping this a bipartisan issue that we can focus on. It's been refreshing. I'm excited to see what we can accomplish as we continue to work on this.

Organ procurement and transplants are not something most people think or talk about every day, yet every day there are 107,000 people who are currently on the national transplant waiting list, and their families cling to the hope that today will be the day they get the call that their life-saving organ is available.

The U.S. system for organ donation and recovery is among the best in the world, but there is a lot of work to be done to make it better. In a perfect system, it's estimated that we can recover up to an additional 28,000 organs per year. That means, of course, thousands more lives saved each year, and the hopes and dreams of so many able to be put in—into motion.

Though perfection isn't possible, striving to ensure we recover and successfully transplant as many organs as possible is literally a matter of life and death for many Americans. Reports of underperforming organ procurement organizations, or OPOs, began exposing what we now know is a very broken system.

In response to President Trump's executive order calling for more reforms of the organ procurement system, the Centers for Medicare and Medicaid Services issued a final rule in December, which, after a brief pause from the Biden administration and thanks to the chairman and the work of this committee, the Biden administration re-issued just about a month ago.

This rule aims to increase performance standards for OPOs and threatens decertification for lackluster performance. Finalization and implementation of this rule is an important step.

However, OPOs are not the only actor in the system and certainly not the only problem. Hospitals which identify potential donors are inconsistent in how frequently they refer in-hospital deaths to OPOs for evaluation and recovery. We need to ensure hospitals know when and how to identify potential donors and who they need to contact to coordinate successful transplants.

We also need to work to ensure that overlooked people in overlooked places have greater access, including increasing diversity of organ availability within the minority communities especially and improve access, and addressing many of the logistical challenges of access for rural communities as well.

Of course, we know there's an ever-growing wait list for organs, and it's complex at times to get on to them, way too complex. We need to ensure that individuals who are eligible to get onto wait lists are on the list so when potential donor is identified, a recipient can be matched.

Transplant centers face complications with insurance companies and certification for making medically sound decisions for their parent—for their patients, and that makes these centers understandably risk adverse, but that means viable organs are being discarded rather than utilized, which of course we know means lives lost. We need to change that.

We need to ensure transplant centers are able to quickly and accurately assess each organ offered to their patients for potential transplant. Perhaps today, with patients, OPOs, and transplant centers represented on our witness panel, we can begin to examine how to fix the system. We must scrutinize the system in its entirety in order to truly bring about meaningful reform.

Again, thanks to the chairman and thanks to this committee for tackling this issue. And thank you very much for the witnesses for being here to, first, share your stories, and for the ones to come for helping us dig into the nuts and bolts of this issue.

I yield back.

Mr. KRISHNAMOORTHY. Thank you, Ranking Member Cloud.

Now, I would like to introduce our second panel of witnesses.

Our first witness today is Donna Cryer. Donna is the president and CEO of the Global Liver Institute, and she's a transplant recipient.

Then we will hear from Dr. Seth Karp. He is the director of the Vanderbilt University Transfer Center.

Next, we will hear from two witnesses from the association of organ procurement—I'm sorry—Association of Organ Procurement Organizations, also known as AOPO, its CEO, Steve Miller, and its president, Joe Ferreira.

Finally, we will hear from Matt Wadsworth. Matt is the president and CEO of an OPO, namely, Life Connection of Ohio.

The witnesses will all be unmuted so we can swear them in.

Mr. Ferreira and Mr. Wadsworth?

OK. Very good.

Please raise your right hands.

Do you swear or affirm that the testimony you're about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Very good. Let the record show that the witnesses answered in the affirmative. Thank you.

Without objection, your written statements will be made part of the record.

With that, Ms. Cryer, you are now recognized for your testimony.

**STATEMENT OF DONNA CRYER, PRESIDENT AND CHIEF  
EXECUTIVE OFFICER, GLOBAL LIVER INSTITUTE**

Ms. CRYER. Thank you.

Good morning. My name is Donna Cryer, and I am the president and CEO of Global Liver Institute.

Thank you so much, Chairman Krishnamoorthi and Ranking Member Cloud and subcommittee members, for your bipartisan support and commitment to solutions to save the lives of the more than 100,000—107,000 Americans who are in need of an organ transplant right now.

I was once one of these people. Because of an autoimmune disease that was diagnosed when I was in eighth grade, my entire digestive tract has been affected. Shortly after I graduated from college, I was told that I had so little liver function left that I would not survive two years without a liver transplant.

Over the course of four months, I experienced multiorgan system failure, lost clotting factors, bleeding out repeatedly, and spent time in both medical and surgical intensive care.

Ultimately, my parents, both school teachers, my mom at my bedside and my father at home taking care of my little brother, were told that I had fewer than seven days to live. Fortunately, an organ was donated within those seven days. But for 33 patients

today and every day, that will not be the case. They will die waiting.

Just last week, professional football player Geno Hayes died while waiting for a liver donation. He was only 33 years old. His loss reminds us that neither fame nor money nor status can ever substitute for a system that works efficiently to connect patients with precious life-saving organs. In fact, if we act today, the entire liver transplant waiting list could be completely eliminated, but that can only be accomplished by holding OPOs fully accountable.

Since the transplant system relies on organ donation and, yes, while we need a holistic solution and everyone striving for excellence, changing allocation policies or tinkering with the other parts is like changing deck chairs on the Titanic. Only solving the organ donation crisis can really solve this problem for people.

So that is why in this era of COVID, where we have seen just the disease ravaging organs and creating new patients in organ failure, we must act with even greater urgency.

Together, patient organizations like the Global Liver Institute, the National Kidney Foundation, the American Association for Kidney Patients, organized medical societies, like the American Society for Nephrology—basically, every patient and medical organization was on one side of this issue with only AOPO on the other. I hope, today, you will go into and explore why that was the case.

All the rest of us worked productively with HHS under both previous and current administrations to enact greater measures for transparency, accountability, and equity in the organ donation system.

Equity matters. Ethically, scientifically, and by law, people of color are 1.5 to 4 times more likely to have conditions leading to kidney and liver failure, but less likely to receive transplants.

Multiple studies have shown that OPO staff are less likely to approach families of color, families who look like mine. They are less likely to have the frequent conversations, the in-depth conversations, to spend time in those conversations that we know leads to successful agreement to donate. And they demonstrate bias in the assumptions of who would be willing to donate. I know from my personal and professional experience that that is simply not the case.

My family's experience attempting to donate is just one example, but unfortunately it's all too common. Despite my father's death in a hospital from a car accident, with all the right decisions by my family with his doctor to keep his organs viable, his organs were not recovered. We brought our whole family and our pastor to be able to communicate our decision to donate, only to be told, rather perfunctorily, that there was nothing we could do; there was nothing to donate. It was devastating to us.

Years of uncorrected poor performance—and I have been working in this transplant community since my own transplant, so I have seen this across 25 years, and I have certainly seen the behavior over the past two years. These activities, this poor performance, have created inequities because some patients, recognizing their low chances of getting a deceased donor organ where they live, travel and list at multiple centers.

Most people can't afford to do this. Basically, patients feel they have to do the work of the OPO, because they can't rely on the organizations paid to find donors.

I will simply end my time today saying that we need to act now. The OPO final rule was only a first step, a critical one, but patients can't wait, and we need to do more.

Currently waiting in all of your home states are 3,888 people in Illinois, 9,899 people in Texas, 21,146 people in California, 1,668 people in Missouri, 4,218 people in Georgia, 4,621 people in Massachusetts, 6,817 people in Pennsylvania, and 4,962 people in Florida. On behalf of these patients, your constituents, and all of those waiting, on behalf of donor families who hope to give the gift of life out of death, and myself, I thank you, and I look forward to your questions.

Mr. KRISHNAMOORTHY.

[Inaudible] Center. You are now recognized for your testimony.

Dr. KARP. I'm sorry. That's me? I couldn't hear part of that.

Mr. KRISHNAMOORTHY. I said Dr. Karp—

Dr. KARP. Yes.

Mr. KRISHNAMOORTHY [continuing]. I'd like to recognize you for your testimony.

**STATEMENT OF DR. SETH KARP, DIRECTOR, VANDERBILT  
TRANSPLANT CENTER**

Dr. KARP. Thank you so much.

Chairman Krishnamoorthi, Ranking Member Cloud, members of the committee, thank you so much for the opportunity to testify today, and thank you so much for taking up this issue.

My name is Seth Karp, and I am the director of the Vanderbilt Transplant Center in Nashville, Tennessee, and surgeon-in-chief of Vanderbilt University Medical Center. These remarks will express how important it is to continue to move quickly forward with the bipartisan effort to increase the number of life-saving transplants performed in the United States.

A great honor of my professional life has been to be the surgeon for patients who need a liver or kidney transplant. In this role, I am part of a team that cares for and, in many cases, cures patients with end-stage organ disease. This team includes the donors and donor families, who in acts of kindness and courage, offer life-saving gifts during a time of immense sadness; the organ donation professionals who help families through the donation process; and the nurses, doctors, pharmacists, social workers, psychologists, psychiatrists, administrators, and all the other essential people who make every transplant possible.

I tell the residents and medical students who want to learn about this wonderful field, in transplantation, time matters. We have 10 hours to get a liver from the donor to the recipient and about one hour to sew it in. For a heart, we have about six hours. Time matters. Transplant surgeons are always thinking about time.

Of course, time also matters in a different way for our patients on the waiting list. Every hour of every day, as we've heard, on average, a patient will die waiting for an organ transplant in the United States.

One of the patients I cared for in the hospital last week and who was waiting for a liver transplant asked me when I thought an organ would become available. That's the question that patients ask, but I know what they're really wondering is whether an organ will become available soon enough. Is there enough time? Time matters in transplantation.

At Vanderbilt, more than a thousand patients wait for an organ. And as we've heard, across the United States, the number is close to 110,000. As Ms. Goldring, Ingram, and Cryer so eloquently testified, time matters.

I studied the United States organ donation system, and aspects of what I see alarm me. Last year, I had the opportunity to cowrite a viewpoint in one of the journals of the American Medical Association with D.J. Patil, former chief data scientist of the United States.

In that article, we provided evidence that the metrics used to judge the performance of organ procurement organizations were basically useless. Until a recent OPO final rule, performance was self-reported, and OPO employees admitted to having gaming the system. When threatened with decertification, one of the OPOs themselves successfully argued that because the performance data was self-reported and unaudited, they failed to meet a reasonable standard, and the OPO should not be held accountable.

In other words, for decades, the metrics supposed to measure performance didn't measure performance, and the results have been disastrous, as you have heard. Using objective data, there is a 400 percent difference in performance between the best-and worst-performing OPOs.

Many OPOs have experienced dramatic increase in their performance with targeted interventions or new CEO hires, and yet, importantly, these OPOs were not flagged as being underperforming.

The only conclusion is that lives have been lost in the unaccountable system. I'm grateful that the culmination of bipartisan work produced a new rule to objectively measure OPO performance. It is imperative this effort be urgently followed with strong regulatory oversight to ensure the number of transplants is increased as quickly as possible. Time matters in transplantation.

The tragedy of organ failure disproportionately affects communities of color in the United States, as we've heard. Black patients comprise 20 percent of the current organ transplant waiting list, despite being only 12 percent of the population. Therefore, the shortage of organs disproportionately—of organ donors disproportionately affects Black Americans. COVID-19 and its differential effect on communities of color will further exacerbate this disparity. On the other hand, increasing the organ supply will help address this disparity.

Whenever I or, quite frankly, most everyone else in the field gives a talk on transplantation, we usually make two points. The first is that organ transplantation is a miracle of modern medicine. The second is the tragedy that there are not enough organs for everyone who needs one.

I no longer use this second point, because I don't believe it. Based on my work, I believe that there are enough organs for pa-

tients who require hearts, lungs, and probably livers, and we can make a huge improvement in the number of kidneys available. In addition to improving OPO performance, new technologies already exist to dramatically increase the organ supply. We need a structure to drive rapid improvement in our system.

The new bipartisan rule revising outcome measures for OPOs is an important first step in increasing the number of transplants, but it must be implemented quickly and effectively. Through your attention, we have had an historic opportunity to save more lives through transplantation. I hope significant progress can be made before the published 2026 step timeline. The urgency is now, and I implore you to act quickly, because, in transplantation, time matters.

Mr. KRISHNAMOORTHY. Thank you, Dr. Karp.

Very powerful testimony from Ms. Cryer and Dr. Karp.

Now I'd like to turn to Mr. Miller and Mr. Ferreira. By previous agreement, you have a combined five minutes to allot between the two of you as you see fit.

You are now recognized for your testimony.

**STATEMENT OF JOE FERREIRA, PRESIDENT, ASSOCIATION FOR ORGAN PROCUREMENT ORGANIZATIONS; JOINED BY STEVE MILLER, CHIEF EXECUTIVE OFFICER, ASSOCIATION FOR ORGAN PROCUREMENT ORGANIZATIONS**

Mr. FERREIRA. Thank you, Chairman Krishnamoorthi, Ranking Member Cloud, and members of the subcommittee. Thank you for inviting the Association of Organ Procurement Organizations to testify at this hearing.

AOPO is a nonprofit organization that leads the organ donation community through innovation, advocacy, and education to pursue the day when every donation opportunity results in lives saved.

My name is Joe Ferreira, and I am the president of AOPO. I am joined today by Steve Miller, who is the AOPO's chief executive officer.

I am also the president and CEO of the Nevada Donor Network, a national and world-leading OPO serving most of the state of Nevada.

As a first-generation American son of parents who immigrated to the U.S. in the 1960's in pursuit of the American Dream, I consider it a true honor to address you, the leaders of our great country.

My mother is a former schoolteacher from Brazil, who runs my father's medical practice. My father, who was also born and raised in Brazil, has been practicing as a physician in the United States for more than 40 years, and at 81 years young, is still on the front lines of the pandemic, taking care of his patients, despite losing several colleagues and friends to the virus.

As my parents have dedicated their lives to healthcare, I have followed in their passions and devoted more than half of my life to facilitate hope and healing to those who suffer and are faced with life and death.

Last year, our amazing team at Nevada Donor Network made the gift of life possible for more than 400 grateful organ transplant recipients. I consider it a true blessing and privilege every day to

work with our team on behalf of the heroic donors and those who desperately wait, some of which we've heard from today.

OPO teams have been on the healthcare front lines for decades ensuring organ donation is possible. OPOs serve as a vital link between donors, their grieving families, and patients waiting for a life-saving organ transplant.

The primary role of an OPO is to coordinate, recover, and allocate organs for transplantation. As well, OPOs educate communities to help people make informed decisions about donation, with the goal of increasing donor registrations. OPOs also provide families compassionate care and grief support before, during, and after donation occurs.

One common misconception is that OPOs are solely responsible for the entire donation and transplantation system when, in fact, OPOs are the intermediary entity, and their success is highly dependent on collaborations with hospitals and transplant programs.

At the start of the donation process, hospitals are responsible for notifying any OPO in a timely manner when a patient is on a ventilator and meets medical criteria to be an organ donor. Additionally, transplant centers must make the decision whether to accept or decline the organs offered by OPOs. It is important to understand the varying roles each of these system partners play to ensure every donation opportunity is optimized to save another life on the transplant waiting list. Working together, we are better.

With sustained incremental growth in donation and transplantation rates over the past decade, continued success relies on an integrated system to save more lives. The subcommittee is right to point out that the donation and transplantation system has room to improve. AOPO is committing to helping OPOs do their part better and launched an aggressive new campaign to deliver 50,000 organ transplants annually by 2026.

The campaign institutes a series of objectives to expand collaboration, reduce health inequities, maximize organ utilization, and drive innovation and research. This effort will complement and exceed the rule expectations leading to more system accountability and stakeholder alignment.

We are proud of what the OPO community has helped accomplish. At the same time, we can and must do better. That is why AOPO supports HHS' efforts to reform metrics used to assess the effectiveness of OPOs.

While AOPO has concerns with some of the metrics introduced, it remains fully committed to using independently verifiable metrics based on sound data to make the organ donation and transplant system more efficient.

In closing, AOPO is ready to work with Congress, CMS, and all stakeholders to leverage our community knowledge, experience, and relationships to further improve the organ donation and transplantation system for the heroic donors, their courageous families, and the patients waiting.

Thank you, and we look forward to your questions.

Mr. KRISHNAMOORTHY. Thank you, Mr. Ferreira.

Now I'd like to recognize Mr. Wadsworth for your testimony.

**STATEMENT OF MATT WADSWORTH, PRESIDENT AND CHIEF  
EXECUTIVE OFFICER, LIFE CONNECTION OF OHIO**

Mr. WADSWORTH. Thank you.

Chairman Krishnamoorthi, Ranking Member Cloud, members of the committee, my name is Matthew Wadsworth, and I serve as the president and CEO of Life Connection of Ohio, the organ procurement organization responsible for facilitating organ donation in northwest and west central Ohio. I consider it a privilege to be able to show up every day and help members of my community, just as I find it a privilege to appear before you today.

The OPO industry is broken, which is to say that all too often it does not serve patients. OPOs are grossly inefficient and unaccountable, and tens of thousands of patients, disproportionately patients of color, die unnecessarily as a result.

For patients, we've turned the organ donor waiting lists into the hunger games, a deadly arena of our own making, in which we watch 33 Americans die every day. The single biggest problem is that patients across the country have absolutely no assurances that they will be served by a high-performing OPO.

Data shows that OPO varies by almost 500 percent, meaning many OPOs are severely failing. But because of regulatory failures, not a single OPO has ever lost a government contract for poor performance in almost 40 years. Simply put, there's been no consequence to OPOs for allowing patients to die.

As geographic monopolies, OPOs are not subject to any competitive pressure to provide high service. As the only major program in all of healthcare 100 percent reimbursed for all costs, we do not face financial pressures to allocate resources intelligently. OPOs are given blank checks with participation trophies as patients are given death sentences.

It is truly hard to find a more important system with less accountability. Leadership matters. If patients need Congress and the Department of Health and Human Services to demand the very best leadership from OPOs across the country, historically they have not.

I became CEO of Life Connection of Ohio in January 2020. Since then, we are on track to nearly double organ recovery in our service area within a two-year period, propelling us to be one of the best OPOs in the country. These numbers demonstrate how rapidly an OPO can improve with motivated leadership.

When I arrived to Life Connection, I was welcomed by 32 of the most committed people you will ever meet, but they are overworked and understaffed. By being transparent with the supportive board of directors, we were able to transform the organization during a pandemic and experience rapid growth. We now have almost 90 team members dedicated to serving our families, hospitals, and donor heroes.

My fear is that these same opportunities for growth exist all over the country, but we won't see them until after the 2026 recertification cycle. By then, more than 60,000 Americans will have died on the organ waiting list.

We at Life Connection of Ohio consider it our responsibility to bid on failing OPO territories, and I'm here to tell you that several of my high-performing peers are ready to expand their service

areas as well. There are better options available for patients currently saddled with failing OPOs.

When oversight bodies began to awaken to system failures, the Association of Organ Procurement Organizations, or AOPO, architected a misinformation campaign to confuse Congress and our regulators that can only be described as antipatient and antiaccountability. AOPO wrongly lobbied against the OPO rule, including arguing that holding failing OPOs accountable would be destabilizing, but this paradigm is exactly wrong.

Too many OPOs are failing, and the greatest danger to patients would be if the status quo were perpetuated. Take, for example, AOPO's recent launch of a social media campaign eliciting patients to hashtag support OPOs. This is a perfect encapsulation of the problem with our industry. Far too many OPOs believe patients exist to support them when the exact inverse should be true.

As of this morning, I, along with five other OPO CEOs, have withdrawn as AOPO members and are committing to principles of transparency, accountability, and patient-centric performance improvement.

But the fundamental problem is that such commitments from OPOs are still optional. Most patients in need of transplant will not survive another five years until the 2026 accountability cycle. Too many patients are dying today, and I appreciate everything this committee is doing on their behalf.

Thank you.

Mr. KRISHNAMOORTHY. Thank you. Thank you, Mr. Wadsworth.

Now we are going to start with member questions, and I now recognize myself for questions as well.

Mr. Wadsworth, you just announced that your OPO and at least five other OPOs are leaving AOPO. I presume your decision is in part because, as you said today in your opening statement, quote, AOPO is investing heavily in anti-accountability, lobbying, and misinformation campaigns designed to stall reform, correct?

Mr. WADSWORTH. Correct.

Mr. KRISHNAMOORTHY. I presume your decision is also because, as you said in your statement, quote, AOPO's actions are so antipatient and antiscience, right?

Mr. WADSWORTH. Correct.

Mr. KRISHNAMOORTHY. And as you said in your January letter to our subcommittee, you support the new oversight measures of OPOs because none of the current oversight is, quote/unquote, functionally effective, right?

Mr. WADSWORTH. Absolutely, yes.

Mr. KRISHNAMOORTHY. Well, it appears you support oversight and, unfortunately, AOPO does not.

Mr. Ferreria, I would like to turn to you. You run the OPO called the Nevada Donor Network. I have your OPO's 2019 financial statement filed with the CMS. It appears that your OPO spent roughly \$6 million in 2019 on administrative and general expenses. Interestingly, in 2019, I see your OPO spent approximately \$146,000 on travel meetings and seminars alone, and your itemization of administrative and general has an interesting line item for \$576,000 for, quote/unquote, A&G. It took me a minute,

but that means you have an administrative and general sub-category in your administrative and general category. Very vague.

Now, Mr. Ferreria, I was informed by Mr. Wadsworth, a former executive of yours at the Nevada Donor Network, that your OPO has season tickets to the NHL's Las Vegas Golden Knights. Isn't that correct?

Mr. FERRERIA. That is correct, Mr. Chairman.

Mr. KRISHNAMOORTHY. And you also have season tickets to the Las Vegas Raiders too, right?

Mr. FERRERIA. That is correct.

Mr. KRISHNAMOORTHY. And according to Mr. Wadsworth and others, your OPO took a board retreat to Napa Valley in 2018?

Mr. FERRERIA. That is correct.

Mr. KRISHNAMOORTHY. And Sonoma in 2019, right?

Mr. FERRERIA. That is correct.

Mr. KRISHNAMOORTHY. Mr. Ferreria, what you're spending on the Raiders, the Golden Knights, Napa Valley, and Sonoma have one thing in common: They have nothing to do with recovering organs for ailing and dying patients on the organ transplant list. You know, Medicare covers all of the costs of OPOs. We want our taxpayer money to be spent on collecting organs, not on an extravagance. And so I'm going to be asking this committee to direct Mr. Miller and you, as the president of the AOPO, to provide us with five years of itemized general and administrative expenses.

Mr. Ferreria, according to the project on government oversight, quote, behind closed doors OPO executives have impugned individual Members of Congress, amid discussions of a, quote, drip, drip, drip strategy to delay or, quote/unquote, slow roll our congressional investigation.

Mr. Ferreria, you're not trying to obstruct my committee's investigation, are you, sir?

Mr. FERRERIA. No, I am not, Mr. Chairman.

Mr. KRISHNAMOORTHY. Mr. Ferreria, I want to bring up something called exhibit A.

Can you please put up exhibit A, clerks?

This exhibit A is an email that my committee received from some whistleblower folks, and in it it describes a call in which you participated in mid-January of this year. You see your name highlighted at the top, Joe Ferreria, CEO of Nevada OPO.

I want to direct your attention to the bottom parts that are highlighted, which was a readout of this call. It says: The counsel that the OPOs hired to assist with the COR response has advised them that the OPOs should send slow and incomplete answers so that his team—namely me, my team—gets distracted and moves on.

Mr. Ferreria, after what you've heard and seen this morning, you don't think that I'm going to be moving on from this investigation, do you?

Mr. FERRERIA. No, Mr. Chairman.

Mr. KRISHNAMOORTHY. That's good, because I'm not moving on. I'm going to stay focused on making sure that OPOs and AOPO live up to the standards that they should live up to and that our Medicare tax dollars are spent properly.

I yield to Mr. Cloud for his five minutes of questioning.

Mr. CLOUD. Thank you, Chairman. Appreciate it.

Mr. Wadsworth, could you discuss the effect of the warp incentive? It's been said that the past rule was—it warps the incentive mechanism for OPOs. Could you speak to that and talk about what the benchmarks could be—should be?

It's been stated, I think Ms. Cryer pointed out that, you know, the new rule is a good first step, but there's still a lot of work to be done. What could we do—what should be done to ensure that that incentive structure is—aligns with what should be the proper motivations for organizations like yourself and OPOs?

Mr. WADSWORTH. Yes, absolutely. I think the steps that have been taken with this new rule—although, you know, it's not perfect, right? We're never going to get it perfect—is already motivating for OPOs to perform better. You know, the work that Dr. Goldberg and Dr. Lynch did with determining this CALC metric was really instrumental in the improvements we at Life Connection of Ohio.

As far as incentives to perform, I'm not sure what incentive would be better than, you know, hearing from recipients like we have today. You know, it is life and death, like they've shared, and we get up every day ready to do everything we can to try to save as many lives as we can. I don't—I'm not sure what other incentive there needs to be, honestly.

Mr. CLOUD. I agree that should be. But as we're looking at oversight and accountability, I'm guessing, what are the measurables that we should have? Because they obviously—first of all, nobody was looking at them. You know, when you're self-analyzing yourself, you're going to look great in the mirror. But, you know, as we're looking to bring oversight and accountability to this, what should those metrics be?

Mr. WADSWORTH. Yes. Using something that we can't manipulate, like the ICD-10 codes is good. I mean, if we look at donors per million population, organs transplant per million population like they do in other countries, that's great as well, but you're not taking into account varying death rates across the country.

So I think the ICD-10 codes is a great start. I know there's been conversations about ventilated deaths possibly being a good metric. That'd be great as well. The conversion rate, which we've used in the past, is easily manipulated and completely inappropriate, which we've seen—which we've now seen.

Mr. CLOUD. Right. I appreciate it.

Dr. Karp, you spoke to the fact that you said the measurables were basically useless, and then you also spoke of new technologies and improvements in the system because time is so critical. Could you speak to some of the same things Mr. Wadsworth did, but then also talk maybe about some of those new technologies that are available and what improvements we can make to the system?

Dr. KARP. I thank you, Ranking Member Cloud. So I appreciate the question very much. I'm going to give you just a kind of a quick story about some work that was done by colleagues of mine, Dr. Brianna Doby, Malay Shah, and Ray Lynch. And what they did was they took this new CALC metric and they looked at the Indiana OPO. They went there and they did some targeted interventions, and over a very short period of time, they were able to increase the donation rate by about 44 percent.

But the key there is that if you look at their performance reports prior to the intervention, they were not seen as underperforming.

Mr. CLOUD. Right.

Dr. KARP. So you've got a huge increase in this group and—

Mr. CLOUD. Yes.

Dr. KARP [continuing]. Everybody wins. The Indiana OPO, they are super happy because they get to do what they love to do, which is to give organs, get more organs. The patients in Indiana are happy, and the researchers are happy. This is a win for—and Medicare happy because it saves money. People's lives are saved. So everybody wins when we put these metrics in place, and it can be done, and this is evidence that that's the case.

And then the second question was, technology—

Mr. CLOUD. Just some of the, yes, technologies and improvements in the system, just—

Dr. KARP. Yes. So this is pro—this is incredibly important as well. In 2019, there were six heart transplants that were performed using donors after circulatory determination of death. And I don't want to get into the technical aspects of that, but in 2019, that number was six. In 2020, that number was 126. This is a new technology. This is a way that we can increase the number of heart transplants done in the United States dramatically.

And if we think that there were 500 patients in the United States waiting for a heart in 2020, 500 patients that either died or were delisted because they were too sick, and you think in one year using a technology, we got another 100 transplants, if we could get another 500 transplants out of that technology, we could almost eliminate deaths on the heart transplant waiting list. That technology exists. It exists today, but we don't have a mechanism for getting it out to everybody that could use it, and it's going to run itself through the system. It's going to take too much time.

Mr. CLOUD. You mentioned that there was a 44 percent increase in a short amount of time.

Dr. KARP. Right.

Mr. CLOUD. What was that time? Are we talking months? Year? Years?

Dr. KARP. In less than a year.

Mr. CLOUD. Less than a year.

Dr. KARP. Yes.

Mr. CLOUD. So, Mr. Ferreria, Mr. Miller, the question that I have for you then, you have a goal to improve 50,000 organ transplants by 2026, but we're talking about we need substantial improvement pretty quick, and obviously people are dying every day every time we don't see improvement. What can we do to have improvement on a much faster pace than 2026?

Mr. FERRERIA. Thank you very much for that question, Congressman.

Mr. CLOUD. What obstacles are in the way?

Mr. FERRERIA. Sure. And I—just to be clear, the goal is to reach 50,000 annual transplants by 2026, but the work to be able to do that and possibly exceed that begins right away. And so we've already set about mobilizing the AOPO members and collaborations with the stakeholder associations to begin that work today, and

that actually started when we decided to launch this campaign and complement HHS' and CMS' work.

And so I just want to be clear to the committee and the leaders of the committee and the general public that it doesn't necessarily mean that we are going to wait till 2026 to improve. We've already taken the initiative to support this role and are going to improve the system before that time, so that once we get to 2026, we are transplanting more people that are in critical need.

Mr. CLOUD. I would just, you know, continue to point out, there's some people—some organizations obviously able to do—make great gains very quickly, and urgency is of the essence. So thank you.

I yield back, Chairman.

Mr. FERRERIA. I couldn't agree with you more, Congressman.

Mr. MILLER. Ranking Member Cloud?

Mr. KRISHNAMOORTHY. I'm going to have to now go to the next member.

Chairwoman Maloney, you are recognized for five minutes.

Mrs. MALONEY. Thank you.

Thank you so much, Chairman Krishnamoorthi and also Ranking Member Cloud, for your leadership on this very important bipartisan issue.

Mr. Wadsworth, I commend you and other OPO leaders who have announced you are leaving the Association of Organ Procurement Organizations to join a new innovation cohort committed to data transparency, collaboration on best practices, and health equity. These OPOs are doing the right thing by putting patients first. Among them is LiveOnNY, which covers my home district.

Mr. Wadsworth, do you believe that increased data sharing through the innovation cohort will help improve their performance?

Mr. WADSWORTH. Absolutely, yes.

Mrs. MALONEY. The innovation cohort has committed to publicly releasing a vast trove of valuable data, including detailed referral data about potential donors, OPO financials, and OPO staffing models. As a result, researchers in the public will finally have insight into the inner workings of OPOs.

Mr. Miller, will you commit that the Association of Organ Procurement Organizations will follow the innovation cohort and share the same data from all its OPO members?

Mr. MILLER. Congresswoman, I'm not familiar with the data you're talking about, but we have

[inaudible] internal where we are—we've revamped our accreditation program to focus on data-driven performance improvement, and that is what we're committed to. It's similar to what the cohort is speaking about. I can't commit right now to providing that to the public, but that is something we will consider. We will take your request under consideration.

Mrs. MALONEY. Well, we'll be following up with you. Because OPOs provide a public service, their data should be public. UNOS, the entity that manages the U.S. transplant list under contract with the government, stores valuable OPO data, but UNOS prohibits OPOs from sharing performance data with the public and only allows some data to be distributed publicly.

Mr. Miller, would you help OPOs to perform better—or don't you think it would help, that they would perform better, if UNOS made more of its data public?

Mr. MILLER. I can't speak to the UNOS data, Madam Chairwoman. What I can say is that we'll commit to following up with you on our transparency efforts. So I can't speak on behalf of another organization.

Mrs. MALONEY. OK. Let's now turn to you, Dr. Karp. As a transplant surgeon, you need the best and most accurate information about an organ that's going to be put into a patient. And I was horrified to hear about a case in which an OPO incorrectly identified a donor's blood type, affecting two organs. Tragically, one transplant recipient died and the other one was gravely, gravely hurt.

Should the government take a more improved look, a closer look at improving the technology used for tracking donations and transplants?

Dr. KARP. Yes, absolutely.

Mrs. MALONEY. It's awful to consider that someone so close to a life-saving operation can have their procedure delayed, become injured or worse because of lack of care by an OPO, which we heard from our prior witnesses.

My time has expired, and I yield back to the chairman and ranking member on this very excellent hearing. Thank you for including me.

Mr. KRISHNAMOORTHY. Thank you, Chairwoman.

Is Congressman Clyde with us?

He may have stepped away for a moment, in which case, let me recognize Congresswoman Cori Bush for five minutes.

Ms. BUSH. OK. Thank you. I'm having a little bit of a small issue. OK. There we go.

All right. Thank you so much, Mr. Chairman, for convening this important hearing, and to the ranking member as well. St. Louis and I absolutely thank you.

So as a former transplant nurse myself, kidney/liver and kidney/pancreas, I personally treated and counseled patients suffering through chronic and severe illnesses. Black and Brown patients are more likely to suffer from illnesses like kidney failure and less likely to get an organ transplant. For them, the promise of receiving an organ is too often delayed or denied because there aren't enough organs available.

I've watched this system fail dying patients. Time and time again, I watched this. I've watched the system fail young people, older adults, and far too many Black and Brown people. Our failing organ donation system is a death sentence for thousands.

My time treating transplant patients has stayed with me, and I cannot overstate the urgency of this issue. We must do everything in our power to fix this system.

In St. Louis, nearly 1,100 people are currently waiting for a life-saving organ transplant that may never come. Each OPO is solely responsible in its region for obtaining organs for transplant from deceased donors and facilitating transplants. Each OPO is a monopoly. If the OPO fails at securing organs, no one else can provide this service. Like, that's the thing, no one else can do this work. It's so critical that OPOs pursue every potential organ. They must

invest resources to build relationships with hospitals and communities.

Mr. Wadsworth, in a letter to this subcommittee, AOPO complained it was unrealistic to pursue 100 percent of organs. Yes or no, if OPOs invest in staff and built the right relationships with hospitals, shouldn't that be their goal?

Mr. WADSWORTH. Yes.

Ms. BUSH. Thank you. I agree.

I would rather hear solutions from OPOs than excuses. It's outrageous that providers would make referrals for potential donor patients to an OPO, and yet the OPO will not go to the hospital to assess the patient and speak with the patient's family about donation. Like, showing up seems like it would be the bare minimum.

I've had patients who have waited for years to go on donation lists. They turned their lives upside down to make dialysis appointments, to be there three days a week, altering their diets, fell into depression, and were traumatized because OPOs refused to show up.

Dr. Karp, AOPO's own documents show that one OPO only approached 11 percent of the families of potential donors referred by hospitals. That means they ignored nearly 90 percent of those families? That's a shocking gap between referrals and followup.

So if OPOs approached more families of potential donors, do you think it would increase the number of organ donations? Yes or no.

Dr. KARP. I'm proud to say that Vanderbilt is the largest donor hospital in the country, and we have OPO staff onsite 24/7, and it makes a huge difference.

Ms. BUSH. Huge difference; oh, my gosh.

How would the lives of patients on organ donation waiting lists, especially patients of color, improve if OPOs were required to operate under these higher standards?

Dr. KARP. Everybody wins.

Ms. BUSH. Everybody wins. Thank you.

Mr. Miller, many of your OPOs keep millions of dollars sitting around. Based on recent tax filings, OneLegacy in Los Angeles has over \$110 million in net assets and in a related foundation. Mr. Miller, instead of sitting on massive piles of cash, shouldn't OPOs be deploying that money to train staff on outreach, best practices, and ensuring staffing is sufficient to visit potential donor families?

Mr. MILLER. Congresswoman, what I would respond by saying is those decisions are made with the board of OneLegacy. I can't speak to their decisions on what they do. I can only speak to what we at AOPO would do.

Ms. BUSH. OK. All right. This issue is literally a matter of life or death. I came to Congress to save lives because too many of my neighbors, my loved ones, and my community members are dying because of broken systems and broken processes, and it's somebody else's fault and it's somebody else's job, and in between that, people actually die, like, lives are lost; all reasons that could be prevented. We must not wait to ensure that we're doing the absolute most to protect and save lives.

Thank you, and I yield back, says this nurse.

Mr. KRISHNAMOORTHY. Thank you, Congresswoman Bush.

I'd like to now recognize Congressman Clyde for five minutes.

Mr. CLYDE. Thank you.

Thank you, Mr. Chairman. Thank you for holding this very important hearing. And I want to thank all the witnesses who are here today to discuss this very important issue. I'm sure we all recognize the goal of the OPOs is to save lives. Life is a very precious thing, and I'm sure everyone here would agree with that.

I just wish there was as much support for saving the lives of unborn children as there was for everyone who has already been born. Whether it's the life of someone who has a Social Security number already or won't get one for 6 to 9 more months. Life is just precious. And I certainly want everyone who needs a life-saving transplant to get one and to get one in a timely manner. I think that's very, very important, and I think that's all a goal—or that's a goal that we all share.

You know, I am a little disappointed that we're discussing race as a factor in organ transplant. We're all one race, in my opinion. Color makes no difference to me. We're the human race and, to me, the interjection of race into this discussion is very concerning. Discrimination based on race was outlawed almost 60 years ago through the Civil Rights Act of 1964.

Now, I'm not a medical doctor. I have very little knowledge of medicine. But last year, there was an article that came out in LifeSource, and it says, Does My Race &

Ethnicity Matter in Organ Donation?

And so my question here is for Dr. Karp. In your experience, would you agree that a donor's organs are more likely to be a clinical match for a recipient of the same ethnicity? Could you comment on that? Is that actually a factor or not? I mean, we're all human beings. We're all—you know, have similar bodies.

Dr. KARP. Yes. So there definitely are certain HLA types that are more common that is race based, so the answer to that question is yes.

Mr. CLYDE. OK. All right. And so if you have more of one particular race—more donations of one particular race then, naturally, you would have more actual matches of that particular race. Is that—would—is that correct?

Dr. KARP. That would tend to be the case.

Mr. CLYDE. OK. All right. All right. OK. That's just a question that I wanted to clear up here. So that's all I have.

And I yield back, Mr. Chairman.

Mr. KRISHNAMOORTHY. Thank you, Congressman Clyde.

I'd like to now recognize Congressman Johnson, also from Georgia, for five minutes.

Congressman Johnson, are you still with us?

OK. Maybe Mr. Johnson stepped away.

I think I should be recognizing Mr. DeSaulnier, Congressman DeSaulnier for five minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. I want to thank you and the ranking member for this hearing.

I want to thank the whistleblowers and the advocates for better performance.

Mr. Miller, it seems clear from the evidence that, in the instance of Watergate, there were people who said that the coverup was worse than the crime. It's hard to believe that in this instance. But

it seems as if you moved in a direction to increase lobbying, as the chairman indicated in his opening comments, when the Congress started to provide more interest in oversight and deficiencies.

Mr. Chairman, do you hear me OK?

Mr. MILLER. Congressman—

Mr. KRISHNAMOORTHY. I can hear you now.

Mr. DESAULNIER. OK. Sorry. Let me just try to quickly—Mr. Miller, the questions are directed at you.

And, again, I want to thank the chairman and the ranking member and all the people who have come forward to push for greater performance standards on the OPOs.

And I'll tell you, this is my first experience. When I was in the state senate in California, I carried a bill for a constituent whose daughter couldn't get a transplant because of her ethnicity.

It provided for paid leave for folks who are getting transplants and was signed by Governor Schwarzenegger, with Steve Jobs in attendance. It was a celebration, but it left me with a very bad taste in my mouth because it became clear to me that many of the people in this industry were less interested in saving lives than in making money.

Mr. Miller, a question of lobbying, inappropriate lobbying, particularly the timing. You changed the tax status of your organization in 2020 when it was becoming evident that the Congress was pursuing more oversight, and it seems as if you were raising membership fees in order to pay for that. Is that true?

Mr. MILLER. No, Congressman. We were—when I was hired 14 months ago, part of what I was focused on, and when I—during the hiring process was increasing advocacy. That was what the search committee made clear to me.

But as part of—when you spoke about this change to its 501(c)(6), when I came on board, I wanted to ensure that we had best in practices government's practices. And so I hired an outside law firm that specializes in nonprofit corporate governance, and they have been doing the review, and that review continues ongoing.

And as part of their review, they noted that a 501(c)(6) is more appropriate for the activities at AOPO will—wants to undertake. So that is what drove that decision. And to be clear, when this process is over, we will still have a 501(c)(3), which will be a foundation, and a 501(c)(6). That's a common practice among trade associations and membership associations.

Mr. DESAULNIER. So just let the record show that Mr. Miller, in his answer, did not answer the question about raising more fees. It seems like an amazing coincidence that while you were doing this, you were raising more money at the same time we were looking at more oversight. Not inappropriate that you want to advocate, but I think very telling that you're raising funds to, it appears to me, to protect CEOs, for instance, that were making almost \$600,000 a year, even though they were poor-performing OPOs.

Mr. Ferreria, may I ask you a question? Is it true that, directly or individually, you personally have an ownership interest in Origin Biologics?

Mr. FERRERIA. Me personally, that is incorrect, Congressman.

Mr. DESAULNIER. Do you have any prospective conflict of interest with Origin Biologics or any other organization?

Mr. FERRERIA. I do not, not that I'm aware of, Congressman.

Mr. DESAULNIER. OK. Appreciate that.

Mr. Chairman, thank you again for your oversight. I appreciate the witnesses' answers. And I look forward to you continuing, along with the ranking member, to provide rigorous oversight so that people can live longer and better lives. Thank you so much. I yield back.

Mr. KRISHNAMOORTHY. Thank you, Mr. DeSaulnier. I'm going to use your 30 seconds left and ask Mr. Wadsworth a question.

Do you agree with me that lobbying by AOPO has increased five-fold over just the past few years?

Mr. WADSWORTH. I'm not familiar. I mean, I know they've increased the amount of money that they've spent toward it, but I'm not familiar with what the lobbying efforts have been over that period of time.

Mr. KRISHNAMOORTHY. It's gone up five times, to \$1.5 million as an industry.

And, Mr. Wadsworth, I want to just say one other thing, which is, isn't it true that the reason why the number of organs transplanted each year over the past several years is not because of an improved performance but because of the national opioid epidemic?

Mr. WADSWORTH. I believe so, yes.

Mr. KRISHNAMOORTHY. So more people have died because of the opioid epidemic, leading to more organs being available for transplantation. It's not because of improved performance.

Now, let's go to Congressman Johnson. You are recognized for five minutes.

Mr. JOHNSON. Thank you, Mr. Chairman, and thank you for holding this very important hearing today. And I'm proud to be a part of this subcommittee, as it delves into issues of life and death such as this.

People of color face disproportionate need for organ transplantation, and they also face disproportionate challenges at each stage of the organ transplantation process, and they suffer worse health outcomes as a result.

Black Americans are three times more likely than White Americans to have a kidney failure. Despite this, Black kidney patients are less likely to be identified as transplant candidates, less likely to be put on a wait list, and less likely to receive a transplant. And even when Black Americans do receive a transplant, they receive lower quality kidneys.

Ms. Cryer, studies show significant bias in the medical field toward Black patients when determining whether they are a suitable candidate for transplant. In your personal experience and in your work in patient advocacy, what kinds of discrepancies have you seen in how patients of color are assessed for potential organ transplant?

Ms. CRYER. Thank you so much for that question, Mr. Johnson. As you are well aware, there are multiple studies in peer review journals that speak to the fact that not only African Americans, Hispanics, Native Americans, Asian and Pacific Islanders experience racial bias and setbacks in every part of the transplant sys-

tem, whether it's being placed on the donor list. Certainly, families are not approached appropriately in many cases by OPO staff when they do show up.

And I'll speak particularly to that point and what I'd like to see moving forward in the OPO reform. We would like to see investments in languages that are spoken by the community. Educational resources should be, as required by law, for those with English—limited English proficiency. They should be in the languages spoken by the community. They should be hiring diverse staff to have those most crucial conversations with families. The data shows, and certainly experience and commonsense shows as well, that having people of color approaching families of color result in more donations. Families want to donate.

In my time on staff at UNOS, certainly, speaking to groups in churches and baseball stadiums and everywhere in between about organ donation, increasing the trust of communities, the awareness of the effects of organ donation and transplantation for people within their own communities, for friends and neighbors.

When you work with organizations in Black fraternities, in sororities, and organizations like Links for Life, which created an organ donation community-based program, those are the types of investments that high-practicing, high-performing, best-practicing OPOs should be investing in to reduce the number of patients who are left waiting or, unfortunately, die waiting for a transplant. And those are the—

Mr. JOHNSON. OK. Thank you.

Ms. CRYER. Thank you.

Mr. JOHNSON. This past year, I had a meeting with an OPO in my state, LifeLink of Georgia, which is under investigation. In our conversations, they asserted that Black Americans had equal access to organs and experienced no disparities in the transplantation process, something that we know to be categorically false. OPOs are failing people of color at every step of this process, and the numbers show it.

Data from HHS indicates that, while White people on the wait list have 50 percent—or have a 50 percent chance of getting a transplant each year, the number is closer to 25 percent for Black people.

Ms. Cryer, apart from clear physical costs, what is the emotional toll that the waiting for organ transplant takes on patients and also on their families?

Ms. CRYER. The emotional cost is huge. My parents waited outside my door in intensive care for weeks, for months, thinking of losing their oldest daughter. I talk now to patients who are in similar situations. The rates of anxiety, of depression are compounded by the feeling that the system does not work for us, by never having met an organ procurement staff. For those who are transplant recipients but are then again in the position of waiting for an organ, never asked to be on a speaker's bureau to talk to their community to be leveraged and to be asked to be part of the solution.

It is doubly devastating to not only have a life-threatening condition, but to believe there is no one on your side helping you to succeed and move on to successful transplant.

Mr. JOHNSON. Thank you, Ms. Cryer.

And thank you, Mr. Chairman. I yield back.

Mr. KRISHNAMOORTHY. Thank you, Congressman Johnson.

Now I just seek unanimous consent to introduce a couple statements for the record, one from the National Council on Disability and one from the American Society of Nephrology.

Without objection, so entered.

Mr. KRISHNAMOORTHY. Now I'd like to recognize Congresswoman Ayanna Pressley for five minutes.

Ms. PRESSLEY. Thank you, Mr. Chairman, for convening today's hearing on the need to reform our country's organ transplant system.

The facts are certainly damning, and the testimony from today's first panel illustrates the heartache, the distress, and the consequences of inaction.

In my district, the Massachusetts Seventh, we have six transplant centers, and the majority of my constituents are people of color. We must confront the racial injustices in our organ transplantation system as a matter of life and death, because it quite literally is. So, in the spirit of our former chairman, Elijah Cummings, it is my duty to remain in efficient and effective pursuit of the truth, and so I'll dive right in.

Mr. Wadsworth, the American Journal of Public Health published a study finding, quote, the odds that a family of a White patient was approached for donation were nearly twice those for a family of an African American, unquote. Mr. Wadsworth, when a hospital refers a potential donor to an OPO, does the OPO report to anyone whether they approach that potential donor's family about donation and the conversations they have?

Mr. WADSWORTH. They would report to the administrator on call likely, oversee the dispatch of that staff member to go have that conversation and guide whether they're ready to have that conversation or not, hopefully in collaboration with the hospital.

Ms. PRESSLEY. Is it true that OPOs likely have that data which would show how well they engage with communities of color? I'm a firm believer in that which gets measured gets done, so that data collection and that transparency is so important.

Mr. WADSWORTH. Yes, absolutely. That data is easily pulled from our EMR.

Ms. PRESSLEY. Well, definitely, I think we need greater transparency to know when OPOs are disregarding potential donors simply because of their race. That will tell the story.

So, Ms. Cryer, could you tell us about your personal experience with OPOs failing to approach Black families?

Ms. CRYER. Yes, absolutely. I think the issue that you just raised is the reason why we wanted to have the rules changed to transparent, objective, verifiable, publicly available data, because before, they could have just said that, you know, there were no patients of color that they approached and given themselves perfect marks for reporting everyone.

Moving forward, that can't happen, and that's what we want to keep a spotlight. There will be more objective data and people—OPOs measured based on the entire donor potential objectively

found from hospital records and ICD-10 codes and death certificates, CDC data, for example.

And so we will be better able to address disparity and inequities in transplant with—even better than we have now and fewer anecdotes and, well, in my case, personal observations over close to a quarter of a century of working in this community and hearing directly from families who wanted to donate were not approached, seeing missed calls and missed staff not being onsite reported from my OPO colleagues as I visited them around the country. And so we know this to be true. Now we have an opportunity to have more objective, publicly verifiable data for us all know the extent of the problem and to be able to act.

Ms. PRESSLEY. That's right. Thank you.

And, Mr. Miller, why are Black people being routinely ignored by OPOs when it comes to donating organs?

Mr. MILLER. Congresswoman, I can't speak to the specific case of Ms. Cryer or specifics. What I will tell you is what we're working on. And I would agree with Ms. Cryer, we need to get better. The system needs to get better. And what we have done is convened a [inaudible] diversity, equity, and inclusion task force. And what they are—they are finalizing their recommendations, and part of that is setting standards and setting metrics of how do we look at OPOs and how can we as AOPO and the OPO community get better in our outreach to communities of color.

Ms. PRESSLEY. All right. Reclaiming my time.

There's really just—there's not an answer because there's no justifiable answer for this discrimination. The San Francisco OPO has made significant progress in including the Black community in the organ donation and transplant process, and the OPO there is led by Janice Whaley.

In fact, she's the first Black woman CEO of an OPO who rejected the racist tropes that communities of color wouldn't donate, and in a single year, donations rates went up by 29 percent, including an increase of 95 percent among Asian donors, and 70 percent among Black donors, and 40 percent among Latinx donors.

Mr. Wadsworth, when OPOs invest the proper resources into ensuring all communities are included in the organ donation process, have they seen results?

Mr. WADSWORTH. Absolutely, yes.

Ms. PRESSLEY. So some OPOs objected to the CMS rule because it stopped them, in my opinion, from using racist metrics to obscure failures in serving communities of color. Let's look at exhibit B, showing comments from several OPOs.

L.A.'s failing OPO, OneLegacy—I'm not sure if you can see that—at the bottom it blames the diverse communities in L.A. for its failure to serve them. The director suggested it was, quote, racially discriminatory, unquote, if expectations were not lowered because they serve a diverse population.

Mr. Miller, did you subject these AOPO members to discipline for that irrational, irresponsible, and biased approach? Yes or no.

Mr. MILLER. Congresswoman, this is the first I'm seeing this.

Ms. PRESSLEY. OK. Will—and what's your reaction? Will they be disciplined for that irrational, irresponsible, and biased response?

Mr. MILLER. I would have to—need time to review this document. As I said, this is the first time I'm seeing this.

Ms. PRESSLEY. OK. I'll reclaim my time then. OK.

Well, look, in the data that is before you in exhibit C, in fact, Mr. Miller, we see AOPO supported the efforts of its members to risk adjust for race, which is unacceptable. CMS rejected OPO's racist request to lower expectations for OPOs serving diverse communities stating that, quote, we are not aware of a biological reason why race, as an independent factor, would affect the decision to be an organ donor or the number of organs transplanted, unquote.

Mr. Miller, will AOPO commit today to stop advocating for racial risk adjustments? Yes or no.

Mr. MILLER. Yes, Congresswoman.

Ms. PRESSLEY. Well, I think today's hearing shows how we have to be intentional in rooting out racist methodologies in our organ procurement process and throughout healthcare. It is exactly why, in partnership with Representative Barbara Lee, I've introduced the Antiracism and Public Health Act, in order to confront racism and public health head on. It declares racism a public health crisis, because it is, and it helps us to put an end to these disparities, like the ones that we've seen play out in our organ transplantation system.

Thank you, and I yield.

Mr. KRISHNAMOORTHY. Thank you, Congresswoman.

Now I'd like to recognize Katie Porter, Congresswoman Katie Porter, and thank her for her incredible partnership with the committee on this very, very important issue.

Ms. PORTER. Thank you very much, Mr. Chair.

This hearing is about saving lives, not partisan politics. We're here because organ procurement organizations, called OPOs, are trusted by the government and by the American people to honor the wishes of donors and save the lives of patients.

Mr. Miller, I want to talk to you about the conversion rate metric that OPOs have used to report their work to the government. This is a rate of how, quote, successful, quote, OPOs are in transplanting those organs that have been available from eligible donors. Is that right?

Mr. KRISHNAMOORTHY. You need to unmute.

Mr. MILLER. Sorry. It took me a second to unmute.

Congresswoman, in my time, I'm not aware of the conversion rate. Obviously, that's the current metrics. In my time, we've been focused on the new metrics. So you can—

Ms. PORTER. You don't understand the metrics that were in use until a couple weeks ago?

Mr. MILLER. They are in use. What I'm saying is I don't have a deep understanding of them. So—

Ms. PORTER. You have a shallow understanding of how we measure whether or not we're saving lives or not?

Mr. MILLER. No, I'm not saying that. I don't have a deep understanding, is what I'm saying.

Ms. PORTER. OK. Well, let's find out what your understanding is, because you're compensated to do this job. The way this works is there is a numerator in the question—in the conversion rate metric. There's an numerator that the number of donors from whom

the OPO actually recovers organs, and then there's a denominator, which is eligible deaths. So let's say that OPO "A" was able to get 60 organs out of 80 eligible deaths.

Mr. MILLER. OK.

Ms. PORTER. OK?

Mr. MILLER. Yep.

Ms. PORTER. Of this, this comes to 75 percent. You following the math so far?

Mr. MILLER. I'm following your math, Congresswoman.

Ms. PORTER. Great. Now, let's say that OPO "B" was able to get 70 donors out of 100 eligible deaths.

Mr. MILLER. Right.

Ms. PORTER. Can you reduce this to a percentage for me, 70 over 100?

Mr. MILLER. Seventy percent.

Ms. PORTER. Seventy percent. All right. So under this conversion rate metric, which has been in effect, then it looks to me like this is the more successful OPO, OPO "A." They have a higher conversion rate. They would be rated as more successful.

Mr. MILLER. Correct.

Ms. PORTER. Has there been, in the prior rules, a standard definition of what counts as an eligible death?

Mr. MILLER. It's my understanding, no, there has not, and that is part of the new—

Ms. PORTER. So if an OPO didn't want to count certain eligible deaths, certain possible donors, they didn't have to. They could essentially define eligible deaths for themselves. Is that correct?

Mr. MILLER. That is my understanding, Congresswoman.

Ms. PORTER. And, Mr. Miller, that means they might miss out on another 10 donors. I mean, this OPO went after 20 more people, and as a result, got 10 more donors. But under this prior metric, they look like they're performing worse. Why would you ever defend this kind of metric?

Mr. MILLER. I have not defended that metric. I—

Ms. PORTER. Reclaiming my time.

Mr. Miller, I don't want to humiliate you today by reading your emails to my office into the record in which you argued against the new metric. Would you like to restate whether or not you lobbied for or against the new metric? Did you lobby against the new metric? Yes or no. You are—yes or no.

Mr. MILLER. We lobbied for improvements to the new metrics. We were not lobbying against the new metrics. We were simply—Congresswoman, you—what you're saying is correct, we want common definitions. You are completely correct, and that is—

Ms. PORTER. Right. So you want a common definition, that's what the new rules deliver, but you didn't like the new rules because you had other—apparently other issues with it. My point here is that you were defending a system in which OPOs—you were operating under a system in which OPO "B" looks like they're much worse than OPO "A", but in reality, it could just be the case that OPO "B" is going after every possible donor, regardless of race, regardless of whether it's hard, regardless of whether they might not get turned down, regardless of whether or not it might be easy.

They are trying to honor the wish of every donor and save every life.

OPO “A”, on the other hand, they only had 80 eligible deaths because, say, maybe the CEO of that OPO wanted to go on vacation and they took the OPO’s private jet, which is supposed to be used for transporting organs, and therefore that jet wasn’t available to go pick up the organs from these other deaths. Could that have happened under this scenario?

Mr. MILLER. That, I’m not aware of, Congresswoman. I can’t respond to that specific allegation.

Ms. PORTER. Well, that is an actual—that literally happened. An OPO CEO went literally on vacation. This is not a hypothetical story with the jet. They literally jetted off to vacation and left donors who were unable to honor others with the gift of life and left patients to die because they weren’t pursuing every possible eligible death, every possible donor. That’s what actually happened.

And you have fought the changes in these rules every step of the way. We have the correspondence from our office, and I would be happy to introduce it into the record.

Mr. Wadsworth, as an OPO CEO, would you say that these new metrics recently set into law are more accurate, that they address the problem that I’ve identified here?

Mr. WADSWORTH. Would, yes.

Ms. PORTER. And are these realistic metrics that an OPO, if they’re doing their job, could achieve?

Mr. WADSWORTH. Absolutely, yes.

Ms. PORTER. And will these new metrics increase the number of organs transplanted annually and encourage OPOs to go after every possible organ, to take every opportunity to honor what donors wanted and to help save patients’ lives?

Mr. WADSWORTH. Absolutely, which is why I think it’s so important to expedite this and implement it right way in terms of the—

Ms. PORTER. So glad you asked that. Mr. Wadsworth, how quickly could you implement this new system?

Mr. WADSWORTH. I could get to work right away, right now.

Ms. PORTER. Tomorrow?

Mr. WADSWORTH. Yes, absolutely.

Ms. PORTER. That is so good to hear, Mr. Wadsworth, because tomorrow, somebody is at risk of dying in this country, somebody will die in this country while they’re waiting for an organ. Thousands of patients waiting on a life-saving organ cannot wait while the Association of Organ Procurement Organizations lobbies and tries to stop rules and procedures just to make it simply clear whether an OPO is doing the life-saving work of retrieving organs and putting them into patients in need.

Thank you so much. I yield back.

Mr. KRISHNAMOORTHY. Thank you so much, Congresswoman Porter.

We are now—have concluded with the questions. In closing, I’d like to thank our panelists for their remarks. I want to commend my colleagues on both sides for participating on this important conversation. I want to thank Ranking Member Cloud for his partner-

ship and, of course, as I said, Congresswoman Porter, for her partnership with me in furthering this investigation.

I'll just close with this. In the Project On Government Oversight, they're called POGO, they quoted a set of meetings that members of AOPO recently had, basically saying they were going to continue to slow roll and prevent fulsome cooperation with this investigation. And they said, quote/unquote, Krishnamoorthi would go away.

I want to make it very clear to AOPO, as well as all the OPOs, I'm not going away, and we are not going away. The issues here are about life and death, and because of that, you can expect more and more inquiries from us the more and more you obstruct our investigation. We are going to pursue every avenue to implement this rule even faster than what the Biden administration has proposed, and we are going to try to reward those OPOs that actually try to fulfill their mission and try to save lives.

And so please convey this to all your OPO colleagues: This committee is on the case and we're not going away, we are actually going to accelerate our efforts, and we're going to pursue this as far as we can. Thank you so much.

With that and, without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the chair, namely me, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as promptly as you are able.

This meeting is adjourned. Thank you.

[Whereupon, at 1:06 p.m., the subcommittee was adjourned.]

