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The Special Counsel

January 26, 2018

The President
The White House
Washington, D.C. 20500

VIA ELECTRONIC MAIL

Re: OSC File No. DI-14-3637

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), the Office of Special Counsel (OSC) is forwarding reports from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Veterans Health Administration (VHA), National Transplant Program, National Surgery Office, Washington, D.C., and VA Transplant Centers (VATCs) located throughout the country. I received the disclosure from Mr. Jamie McBride, a registered nurse and program manager for the Solid Organ Transplant Program at Audie L. Murphy Memorial VA Hospital, San Antonio, Texas (San Antonio VAMC). Mr. McBride consented to the release of his name.

Mr. McBride disclosed that the structure and procedures for referring VA patients for organ transplants to a limited number of VATCs throughout the country restrict VA patients' access to life-saving treatment. The structure also causes financial and other hardships to veterans and their families by requiring them to relocate for months to receive treatment. He also alleged that communication problems between VAMCs and VATCs result in delays in care; VATCs apply inconsistent and overly restrictive eligibility criteria for liver and kidney transplants; VAMCs lack the level of specialty care required to care for post-transplant patients; and the VA's unwillingness to perform living donor kidney transplants denies patients timely, life-prolonging treatment options.

On April 15, 2016, OSC referred the allegations to former Secretary Robert A. McDonald for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector (OMI) investigated the allegations, and former Chief of Staff Gina S. Farrisee was delegated the authority to review and sign the agency report. The VA submitted an initial report to OSC on January 30, 2017, and a supplemental report on May 17, 2017. Mr. McBride provided comments in response to each report. OSC has reviewed the reports. This letter provides a summary of the reports, whistleblower comments, and OSC's findings.[1]

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not

I. The Agency Reports and Whistleblower Comments

The VA's initial report confirmed that veterans and their families often must travel to VATCs for transplant care. However, the VA did not substantiate that this was a violation of law, rule, or regulation, gross mismanagement, or a substantial and specific danger to public health or safety. The VA concluded that its network of VATCs, and contracting outside the VATCs if necessary, provide the full range of transplant care. Some VATCs contract with affiliated academic hospitals to provide transplants. The report stated that to reduce the hardship on veterans who must travel to VATCs, the VA reimburses veterans, their attendants, and living donors for travel expenses. The VA also stated that it absorbs the costs of harvesting organs from deceased and living donors "on the grounds that the donor-related harvesting and other associated donor costs are integral to (and part and parcel of) VHA delivering the needed care to the Veteran-recipient."

OMI found that between October 2013 and June 2016, only 10 percent of the 1,500 veterans who received transplants through the VA Transplant Program lived within 100 miles of the VATC where they were treated. OMI determined that those patients living within 100 miles were evaluated and placed on the national United Network for Organ Sharing (UNOS) wait list, used to prioritize transplant patients and match organ donations, more quickly than those living greater than 100 miles from a VATC. The VA stated that eligible veterans who reside more than 40 miles from a VA medical center with a primary care physician or face an excessive burden due to travel may receive transplant care at non-VA hospitals within their communities through the Veterans Choice Program (Choice Program) established by the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).[2]

The VA concluded that there are "challenges" to covering transplants through the Choice Program. The report stated that the VA covers the costs of organ harvesting and donor care for non-VA transplants on the same basis applied to transplants at VATCs. However, the payment rates under the Choice Act are generally limited to the Medicare rates. The VA has found that non-VA providers will not accept the Medicare rates offered for donor care. The VA stated it relies on its contracting authority under 38 U.S.C. § 8153 to cover donor-related costs at negotiated rates, and has found this approach to be "far more successful." A review of VHA's payment records from October 1, 2015 to July 20, 2016 revealed that the VA covered one transplant at a non-VA hospital through the Choice Program, and the VA did not identify any transplants covered

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have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, he is required to advise the appropriate agency head of his determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

[2] Pub. L. No. 113-146.

under § 8153 or other contracting authority. The report only recommended VA consider updating the VHA handbook to conform with the guidance on living donor travel reimbursement in the VHA directive.

The report substantiated that physicians at San Antonio VAMC do not believe they have the training and capability to independently care for post-transplant patients. The report stated that the "VA is concerned that . . . physicians responsible for caring for patients who have undergone liver transplantation expressed concern about their ability to do so without readily available in-house liver transplant expertise." Nevertheless, the VA concluded that these concerns did not constitute a substantial and specific danger to public health, because the physicians "had some training and experience in caring for these patients and because additional expertise was locally available from private medical providers in the San Antonio area." The report did state, however, that a threat to patient care could develop with the expected retirement of the kidney transplant supervising physician. The report recommended that San Antonio VAMC review the post-transplant care of all liver transplant patients to ensure that the standard of care was met.

Although Mr. McBride provided information demonstrating communication problems among multiple VAMCs and VATCs, OMI addressed only the communications between San Antonio and Houston. The VA's initial report substantiated that there were communication problems between the San Antonio VAMC and Houston VATC. However, the report found that the problems were addressed when a new Director of Transplantation Services was hired in Houston.

Additionally, OMI found that the rate of veterans receiving living donor kidney transplants at VATCs is lower than the national rate. Although OMI did not find evidence of barriers to living donor transplants, OMI was concerned that the lower rate may be the result of barriers not observed. Without further review, the VA concluded that it did not substantiate that the VA is unwilling to provide living donor transplants. The report recommended that the National Surgery Office encourage providers to consider using living donors and ensure that there are no barriers.

In his comments, Mr. McBride refuted the VA's statements regarding the availability of transplants in the community through the Choice Program and VA contracts. He provided documents contradicting the VA's representation that it covers organ harvesting and donor-care costs, but that non-VA providers will not accept the Medicare rates offered under the Choice Act. The documents showed that the VA has declined to cover organ harvesting and donor-care for transplants at non-VA hospitals, because the VA considers this to be a "non-veteran expense item" and "non-veteran care." He asserted that non-VA hospitals do, in fact, accept the Medicare rates, noting that more than 50 percent of transplants in the community are performed at those rates. Mr. McBride also provided a "[Veterans Choice Program] Exceptions List," issued by the VA on January 17, 2017, listing solid organ transplants as an exclusion from the Choice Program. In addition, he provided materials from a National Surgery Office meeting in

March 2017 outlining the VA's revised policy on transplant care in the community, which he asserted created new barriers to veterans' access to community care.

Mr. McBride also commented that the VA failed to address many of the significant hardships veterans and their families experience when required to travel long distances for months or years to receive transplant care at VATCs. He asserted that some veterans decline transplants and die because of this issue. Mr. McBride also rebutted OMI's conclusion that the lack of in-house specialty care does not pose a danger to post-transplant patients, noting that this issue is not unique to the San Antonio VAMC.

OSC forwarded the contradictory information provided by Mr. McBride to the VA and requested that the VA's supplemental report include a statement of the VA's current policy on veterans' access to transplant care in the community, including the payment rates offered for organ harvesting. OSC also requested that the report include the number of VA patients who have undergone transplants at non-VA hospitals pursuant to a § 8153 contract. OSC also noted that it expected the supplemental report to cover the full scope of the alleged communication problems between VAMCs and VATCs.

The VA's supplemental report outlined the findings of an independent physician review of care provided to 80 patients who were evaluated for and/or received liver or kidney transplants at VATCs. The review, performed by a liver transplant surgeon and a transplant nephrologist not associated with the VA, revealed that the standard of care was not met in 2 of the 70 kidney transplant cases. In both cases, the Nashville VATC found the patients unsuitable based on their minimal coronary artery disease and declined them for transplant. The independent reviewer determined that the VATC applied the exclusion criterion in an overly restrictive manner. The report stated that both patients ultimately underwent kidney transplants at the Houston VATC. The VA concluded that these two cases did not represent a danger to public health because the system allows second opinions and appeals. The VA concluded that "the VA national policy worked as intended." The report recommended that the Nashville VATC review coronary artery disease as a relative contraindication for kidney transplants and receive clinical education and training, if necessary.

Further, OMI found that two of six VATCs use a higher body mass index criterion in determining suitability for kidney transplants. However, the independent reviewer found no evidence that the standard of care was not met due to overly restrictive application of this criterion in the cases reviewed. Despite the varying criteria used by VATCs and the two kidney transplant cases noted above, the VA did not substantiate that VATCs apply inconsistent or overly restrictive eligibility criteria in evaluating patients for liver and kidney transplants.

The VA's supplemental report reiterated its explanation that the VA does not generally use the Choice Program for transplants because most non-VA providers will not accept the VA's rates that are capped at Medicare rates. The VA did not acknowledge

or explain the conflicting evidence showing the VA has declined to cover organ harvesting and donor costs altogether for non-VATC transplants on the basis that this is "non-veteran care." Further, the VA did not address the evidence that the VA lists solid organ transplants as an exclusion from the Choice Program. In light of this information, the VA did not provide sufficient clarification of the VA's current policy on access to transplants in the community. The VA stated that it was unable to provide any information on the payment rates offered for organ harvesting for transplants at non-VA hospitals. Despite reporting the VA paid for 13 solid organ transplants in the community during fiscal years 2014 and 2015, the VA stated it could not confirm whether any were covered pursuant to a § 8153 contract. The supplemental report did not address the allegations of communication problems among multiple VAMCs and VATCs.

Mr. McBride refuted the VA's supplemental report's conclusion that VATCs do not apply inconsistent and overly restrictive eligibility criteria, noting that the criteria used by some VATCs are not the acceptable standard in the community. Moreover, he argued that these criteria deny veterans access to transplants, pointing out that non-VA hospitals in the community outperform VATCs in the number of kidney and liver transplants provided. Mr. McBride also noted that the two patients who were declined by the Nashville VATC and ultimately received transplants at the Houston VATC faced extensive delays in getting listed on the UNOS wait list and receiving transplants. He also disputed the VA's finding that the standard of care was met in all ten liver transplant cases reviewed, noting that the evidence in one case alone demonstrated that the patient died due to a delay caused by the failure of the receiving VATC to update the patient's status on the UNOS wait list as required. He further noted that following his interview with OMI, he continued to provide evidence to the OMI team; however, no one from OMI ever followed-up with him. He concluded that "[t]his system is a travesty, and no amount of manufactured reports will hide the fact that this a failed process."

II. Conclusion

I have reviewed the original disclosure, the agency reports, and the whistleblower comments. I have determined that the reports meet the statutory requirements; however, the findings do not appear reasonable. OSC identified several discrepancies and deficiencies in the evidence and findings presented in the VA's initial report, and provided the VA an opportunity to clarify and resolve those issues in its supplemental report. However, the VA did not address the conflicting information regarding the availability of transplant care in the community and the coverage of organ harvesting and donor care through the Choice Program. Nor did the VA address the full scope of the allegations, such as the cause of VA's low rate of living donor transplants and communication problems among multiple VA facilities. For some findings, the VA did not acknowledge the consequences and potential harm to veterans, such as the delay veterans experienced while appealing and seeking second opinions in cases where a VATC applied overly restrictive criteria, and for post-transplant patients who receive care from physicians who do not believe they are capable of providing proper care. Further,

aside from travel reimbursement, the VA did not address the other significant hardships and barriers to care imposed on veterans who must travel long distances for months to VATCs. The VA identified only one transplant in the community covered under the Choice Program and a small number through other contracting arrangements; yet the VA did not offer recommendations to improve veterans' access to community care.

As required by 5 U.S.C. § 1213(e)(3), OSC has sent a copy of this letter, an unredacted version of the agency reports, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also filed a copy of the letter to the President, redacted reports, and whistleblower comments in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures