

ASSESSING THE PROMISE AND PROGRESS OF THE CHOICE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

Wednesday, May 13, 2015

| | Page |
|--|------|
| Assessing the Promise and Progress of the Choice Program | 1 |
| OPENING STATEMENTS | |
| Jeff Miller, Chairman | 1 |
| Prepared Statement | 50 |
| Corrine Brown, Ranking Member | 2 |
| Prepared Statement | 51 |
| WITNESSES | |
| Donna Hoffmeier, Program Officer, VA Services, Health Net Federal Services | 4 |
| Prepared Statement | 52 |
| David J. McIntyre Jr., President and Chief Executive Officer, Tri West Healthcare Alliance | 5 |
| Prepared Statement | 61 |
| Hon. Sloan Gibson, Deputy Secretary, U.S. Department of Veterans Affairs | 7 |
| Prepared Statement | 76 |
| Accompanied by: | |
| James Tuchschtmidt MD, Interim Principal Deputy Secretary for Health, VHA, U.S. Department of Veterans Affairs | |
| Darin Selnick, Senior Veterans Affairs Advisor, Concerned Veterans for America | 38 |
| Prepared Statement | 87 |
| Carlos Fuentes, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars of the United States | 40 |
| Prepared Statement | 91 |
| Roscoe G. Butler, Deputy Director for Health Care, Veterans Affairs and Rehabilitation Division, The American Legion | 41 |
| Prepared Statement | 99 |
| Joseph A. Violante, National Legislative Director, DAV | 43 |
| Prepared Statement | 104 |
| Christopher Neiveem, Legislative Associate, Iran and Afghanistan Veterans of America | 44 |
| Prepared Statement | 114 |
| FOR THE RECORD | |
| Danny Breeding | 119 |

ASSESSING THE PROMISE AND PROGRESS OF THE CHOICE PROGRAM

Wednesday, May 13, 2015

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Bost, Brown, Takano, Brownley, Titus, Kuster, O'Rourke, Rice, McNerney, and Walz.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. Committee will come to order.

Thank you for joining us this morning for today's oversight hearing Assessing the Promise and Progress of the Choice Program. We have two full witness panels ahead of us. So I will keep my opening remarks short in the interest of time.

We all know that the Choice Program was created last summer to address unparalleled access issues for veterans at the Department of Veterans Affairs, and 6 months after it was implemented, the program has successfully linked thousands of veterans with quality healthcare in their own home communities. And I think we can all be proud of that, and I applaud the VA and the two Choice Program third-party administrators, Health Net Federal Services and TriWest Healthcare Alliance for their initial efforts to quickly implement the program and their ongoing efforts to make it work well for the veterans who are in need.

That said, the implementation, and administration of the Choice Program has been far from perfect. I think everybody can admit that, and many veterans are still waiting too long, traveling too far to receive the healthcare that they need. There are many reasons for this: A lack of outreach to veterans who may be eligible; a lack of training for frontline VA and TPA staff; a lack of urgency on the part of many VA medical facilities who continue to adhere to their old ways of doing business. And, of course, I think anyone of us could go on and on.

But during the hearing today we are going to discuss how to eliminate impediments to greater veteran and provider participation in the Choice Program, and how to ensure that VA and TPA staff are properly trained and seamlessly coordinated to respond to veteran and non-VA provider questions, and to ensure the timely

delivery of care. And we will also begin discussing where VA goes from here.

The Choice Program is just one of many ways that VA provides care outside of the walls of the Department. All too often VA's numerous purchased care programs and authorities operate in conflict with one another using different eligibility requirements, different programmatic requirements, and different reimbursement rates to achieve the very same goal. That does not serve VA, the American taxpayer, or, most importantly, our veterans and their families well.

As was stated many times last year, business as usual is not an option. Congress has consistently met the administration's budget request for the Department of Veterans Affairs, and as a result, VA's total budget has increased by 73 percent since 2009. In comparison, veteran patients have increased by only 32 percent since 2009, yet VA has not, and cannot, fully meet the needs of the entirety of their patient population. This illustrates clearly that VA's failures are not a matter of just money. They are a matter of management. There is no one way forward, but there can also be no mistaking that by challenging VA's failing status quo approach to purchased care, we find ourselves at a crossroads of opportunity that never existed before.

I am encouraged by and in agreement with the numerous testimonies today that emphasize the need to build a coordinated, managed care system that incorporates VA along with the needed community options and resources.

While working to improve the Choice Program today, we must all prepare for the Choice Program of tomorrow, one that brings the universe of non-VA care together under one umbrella, so that the care our veterans receive is more efficient and effective, regardless of where it takes place.

I look forward to working with veterans, with VA, with veteran service organizations, and all the interested stakeholders on this effort, beginning with the statements that you are going to be providing for us this morning.

I appreciate, again, everybody being here, and with that I yield to the ranking member for her opening statement.

Ms. Brown, you are recognized.

[The prepared statement of Chairman Jeff Miller appears in the Appendix]

**OPENING STATEMENT OF RANKING MEMBER CORRINE
BROWN**

Ms. BROWN. Thank you, Mr. Chairman, and thank you for calling this hearing today.

As you know, it has been about 9 months since the President signed the Veteran Access, Choice and Accountability Act into law. This hearing is one in a series of hearings designated to follow the progress and abilities of VA to provide healthcare to veterans in the 21st century. I am sure we can all agree that VA provides the best healthcare for returning veterans in this country. However, we all know that there are challenges to this mission, and that the VA cannot do it all.

The Choice Program offers eligible veterans access to healthcare that they may not have had in the past. One of this committee's highest priorities is to ensure that veterans receive the highest quality healthcare in a timely manner and in a safe environment. For those veterans who choose to use the Choice Program, I want to make sure that this is happening.

Mr. Chairman, VA have served the special needs of returning veterans for 85 years and has the expertise in providing services that address their unique healthcare needs. My focus continues to be on ensuring that Veterans Affairs retains the ultimate responsibility for the healthcare of our veterans. Regardless of where they choose to live, the VA is the best system we have to serve the healthcare needs of veterans returning from war. We cannot allow circumstances that would render the system unable to serve the veteran it was built to serve.

The DAV in its submitted testimony said, "Although the VA today provides comprehensive medical care to more than 6.5 million veterans each year, the VA system's primary mission is to meet the unique specialized healthcare needs of the service-connected disability veteran—disabled veteran."

To accomplish this mission, VA healthcare is integrated with a clinical research program and academic environment for over 100 or more outstanding schools of health professions to ensure veterans have access to the most advanced treatment in the world. I believe that says it all.

I look forward to hearing from the Deputy Secretary today and all of the witnesses to learn how the VA can better treat those veterans who have given so much to defend the freedom we all hold so dearly.

I yield back the balance of my time, Mr. Chairman.

[The prepared statement of Ranking Member Corrine Brown appears in the Appendix]

The CHAIRMAN. Thank you, Ms. Brown, for your opening comments.

Joining us on our first panel this morning is Donna Hoffmeier, program officer for VA services for Health Net Federal Services, and David J. McIntyre, Jr., president, chief executive officer of TriWest Healthcare Alliance. And we are also joined by the honorable Sloan Gibson, Deputy Secretary for the Department of Veterans Affairs. Mr. Gibson is accompanied by Mr. James Tuchschnidt, interim principal Deputy Under Secretary for Health.

Thank you all for being here this morning.

Ms. Hoffmeier, please proceed with your opening statement. You are recognized for 5 minutes.

STATEMENTS OF DONNA HOFFMEIER, PROGRAM OFFICER, VA SERVICES, HEALTH NET FEDERAL SERVICES; DAVID J. MCINTYRE JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTHCARE ALLIANCE; HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: JAMES TUCHSCHMIDT M.D., INTERIM PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF DONNA HOFFMEIER

Ms. HOFFMEIER. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Brown, and members of the committee, I appreciate the opportunity to testify on Health Net's administration of the Veterans Choice Program. Health Net is proud to be one of the longest serving healthcare administrators of government programs for the military and veterans communities. We are dedicated to ensuring our Nation's veterans have prompt access to needed healthcare services, and believe there is great potential for the Choice Program to help VA deliver timely, coordinated, and convenient care to veterans.

In September 2013, Health Net was awarded a contract for three of the six PC3 regions. We phased in implementation of PC3 between October 1 and April 1, 2014. Then in October, shortly after Congress passed and the President signed the Veteran's Access Choice and Accountability Act of 2014, VA amended our PC3 contract to include several components in support of the Choice Act. To meet the required start date of November 5, we worked very closely with VA and TriWest to develop an aggressive implementation strategy and timelines. The ambitious schedule required us to develop process flows and to hire and train staff very quickly. Despite this aggressive implementation schedule, on November 5, veterans started to receive their Choice cards and were able to call into the toll free Choice telephone number to speak directly with a customer service representative to ask questions about the Choice Program or to request an appointment for services.

Having said that, we know there have been challenges that have resulted in veteran frustration as well as frustration on the part of VA and our own staff. We had less than a week from the time we signed a contract modification to go live. With such an aggressive implementation schedule, there was little time to finalize process flows, educate veterans and community providers, and make needed system changes.

While the collaboration with VA since the start has been good, there still is considerable work that needs to be done to reach a state of stability where the program is operating smoothly and the veteran experience is consistent and gratifying.

We appreciate the opportunity to offer our thoughts on the future of the Choice Program. The Choice Program is a new program that was implemented, as I mentioned, in record time. As a result, there are a number of policy and process decisions and issues that are either unresolved or undocumented. If Choice is to succeed, these items must be addressed quickly.

As I stated earlier, we are working very closely with VA to address these issues. Many of these issues, however, could not have been anticipated prior to the start of the program.

On the other hand, there are some that should have been addressed before the program began, but the implementation timeline did not afford adequate time to do so.

The identification of policy and operational issues and concerns has been occurring very quickly. As a result, we have struggled to keep up with the developments and to adequately train our staff with the most up-to-date and accurate information. This situation is not ideal.

Based on these dynamics, our top recommendation for moving Choice forward is to work with VA to develop a comprehensive, coordinated operational plan for Choice that clearly defines the program requirements, process flows, and rules of engagement. This strategy should provide a clear, well-defined road map that is communicated to all parties: VISN and VA medical center leadership and staff, both contractors, Congress, and, most importantly, veterans.

While the strategy needs to clearly identify key initiatives and reasonable timelines for implementing those initiatives, it also needs to contain the flexibility to quickly address issues as they arise, and to make necessary course corrections. Key components must include resolution of outstanding policy and process issues, which currently are numerous; development of policy and operational guides that are mandated across the program; comprehensive training of contractor and VA staff using consistent process flows, operational guides, and scripting; and a clear and responsive process for resolution of legitimate issues and challenges.

In closing, I would like to thank the committee for its leadership in ensuring our Nation's veterans have prompt access to needed healthcare services.

I also would like to thank you Congresswoman Brown for your leadership in helping to educate veterans and community providers on the Choice Program. The meetings you convened with veterans and community providers in Jacksonville were invaluable. We appreciate the opportunity to participate in those meetings. We are committed to continuing our collaboration with VA to ensure that the Choice Program succeeds. Working together and with the support and leadership of this committee, we are confident that Choice will deliver on our obligations to this country's veterans.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Hoffmeier appears in the Appendix]

The CHAIRMAN. Thank you very much.

Mr. McIntyre, you are recognized for 5 minutes.

STATEMENT OF DAVID J. MCINTYRE, JR.

Mr. MCINTYRE. Chairman Miller, Ranking Member Brown, and members of the distinguished committee, it is a privilege to be back before you on behalf of our company's nonprofit owners and its employees as you assess the promise and progress of the Veterans Choice Program.

Mr. Chairman, I stood this morning reflecting on the quietness of the Disabled Veterans Memorial at the base of the Capitol, which was built to honor the sacrifices of those whom we all count as our heroes. I thought of the conversation you and I had there that morning of its dedication. Your question to me was whether Choice would be operational on November 5. You stressed the importance of being ready on time, although you admitted that it was a tall order. And you may remember I assured you that I was confident that the VA, our colleagues at Health Net, and we would not fail in the task.

Following the ceremony, grounded in what my responsibilities were, I flew back to Arizona to start the design and construction process with my team, along with the teams from VA and Health Net with an intensity and purpose that endures to this day.

We continue our collaborative work to ensure that the paradigm shift you and nearly every Member of Congress sought in the passage of the Choice Act. Indeed, just as you defined on November 5, the reality did start to take hold, as together we stood up the Choice Program on time. We got cards out with an individual letter from the Secretary to each veteran, and we started taking phone calls.

But, of course, that was just the beginning. Now we have work to do to make sure that we refine the program that you wanted to see brought into place.

Just like the start of the TRICARE program nearly 20 years ago, which I was privileged to be a part of, along with my colleagues at TriWest, there was a lot of work to do to achieve the promise of that program and mold it into what's become one of the best health plans in America. Back then, it took a highly collaborative effort between Congress, the Defense Department, private sector contractors, beneficiary associations, and the VSOs. The same will be true, I believe, of this program, and I believe the same promise exists with this that exists with TRICARE.

As we discussed at the last hearing at which I appeared before the Veterans Choice Program, there was PC3. Actually, PC3 was responsible for assisting the Phoenix VA in addressing the backlogs that were uncovered on April 9. Sixty-three hundred providers in Maricopa County leaned forward at the side of the VA in Phoenix to take care of the more than 14,000 veterans that were backlogged, and we did it by August 17 together.

Now, at the end of the day, that network alone was not going to give us the types of choices that you felt were necessary in order to make this all work. So we continued to grow a network. We now have 100,000 providers contacted in 28 States and the Pacific, and over 4,500 facilities, which include academic medical centers to the tune of about 40 of the academic—40 percent of the academic affiliates that are in our area of responsibility.

Just yesterday the University of California at San Diego signed a contract to be part of the partnership that has been birthed collaboratively in San Diego.

So, yes, we stood it up on time. But as we know, there is a fair amount of work still to be done. We have now refined, at least for the first increment, the 40-mile drive distance. We have gone from ruler to drive time. We are conducting training and more outreach.

We are accelerating the transfer of the daily eligibility file requirement that needs to occur. And we are concluding a pilot in how we will share clinical information on a more timely basis so that the needs of veterans and the information that providers might need would be at the core of what we are doing. There is a clinical policy work group that is meetings on a regular basis to define the gaps that need to be closed in that space.

At the end of the day on our end, we are refining our customer service. We are establishing a new IT platform that we will be rolling out just after Memorial Day after a 24/7 build, and we are seeking from the opportunity to work collaboratively in the marketplace to make sure that the networks are tailored to match the precise demand that a VA facility has. That work is underway.

We need a couple of things from you. One is, I think we should be revisiting the question of whether a 60-day authorization limitation makes sense. Secondly, there is a need, from my perspective, to harmonize the differences between the PC3 program and the Choice Program so that we can make sure that we are leveraging those networks about which I spoke.

Volume is coming. Visits have been made to El Paso, Las Vegas, and other markets. On Friday I will be in Memphis working with the team there.

Mr. Chairman and members of the committee, supporting the care needs of American's veterans is a tremendous honor and privilege. We thank you for that opportunity. We thank the VA for the partnership, and we look forward to working at your side in achieving the promise that Choice presents to America's veterans and their families.

Thank you, Mr. Chairman.

[The prepared statement of Mr. McIntyre appears in the Appendix]

The CHAIRMAN. Thank you, Mr. McIntyre.

Mr. Gibson, you are now recognized for your opening statement.

STATEMENT OF HON. SLOAN GIBSON

Mr. GIBSON. Chairman Miller, Ranking Member Brown, members of the committee, we are committed to making the Choice Program work and to providing veterans timely and geographically accessible quality care, including using care in the community whenever necessary.

I will talk shortly about what we are doing and the help we need from Congress to make that happen.

First, I want to talk briefly about improvements in access to care. Most mornings at 9 a.m. for the last year, senior leaders from across the Department have gathered to focus on improving veterans' access to care. We have concentrated on key drivers of access, including increasing medical center staffing by 11,000, adding space, boosting care during extended hours and weekends by about 10 percent, and increasing staff productivity. The result? 2.5 million more completed appointments inside VA this past year. Relative value units, RVUs, our common measure of care delivered across the healthcare industry, are up 9 percent. Another focus area for improving access has been increasing the use of care in the community.

In 2014, VA issued 2.1 million authorizations for care in the community, which resulted in more than 16 million completed appointments. Year-to-date 2015 authorizations are up 44 percent, which will result in millions of additional appointments for community care. Veterans are responding to this improved access. More are enrolling for VA care. Among those enrolled, more are actually using VA for their care, and among those using VA, they are increasing their reliance on VA care. This is especially the case where we have been investing most heavily due to long wait times.

In Phoenix, where we have added hundreds of additional staff, we have increased completed appointments 20 percent. RVUs are up 21 percent, and authorizations for care in the community are up 123 percent. Much of that is thanks to TriWest Healthcare and their support of care in the community there in the Phoenix market.

But wait times aren't down, because veterans continue to come to VA in increasing numbers to receive their care. In Las Vegas, we have got a 17 percent increase in veterans receiving care since we opened the new medical center there. In Denver, we have opened outpatient clinics and added more than 500 additional staff. Veterans using VA are up 9 percent. In Fayetteville, North Carolina, where wait times continue to be a problem, we have increased appointments 13 percent. Veterans using VA for care are up 10 percent. And in all of these locations, we have had dramatic increases in care in the community.

As Secretary McDonald has testified during budget hearings, the primary reasons for increasing demand are, one, an aging veteran population; increases in the number of medical conditions that veterans are claiming; and a rise in the degree of their disability; and as we can see here, improving access to care.

As I mentioned at the outset, community care is critical for improving access. We use it, and we have for years, in programs other than Choice.

In fiscal year 2013, VA has spent approximately \$7.9 billion on community care other than Choice. In 2014, that rose to \$8.5 billion, and we estimate that at the current rate of growth, VA will spend approximately \$9.9 billion, including Choice, roughly a 25 percent increase in just 2 years.

At the same time, we have had a large increase in care in the community, Choice has not worked as intended. Here are some of the things that we are doing to fix it. On April 24, we changed the measurement from straight line driving distance using the fastest route. This roughly doubles the number of veterans eligible for 40 miles under Choice. But there is much more to do. A follow-on mailing to all eligible veterans is about to go out. We have just launched a major change in internal processes to make Choice the default option for care in the community; additional staff training and communication; extensive provider communications; improvements to the Web site and ramped-up social networking; new mechanisms to gather timely feedback directly from veterans as well as directly from frontline staff. These are all already underway, or in the process of being launched.

In the longer term, we must rationalize community care into a single channel. The different programs with different rules, dif-

ferent reimbursement rates, different methods of payment and funding routes are too complicated. They are too complicated for veterans; they are too complicated for providers; and they are too complicated for our employees who are trying to manage care. I expect that we will need your help on that change.

Next, let me touch on the other 40-mile issue. We have completed in-depth analysis using patient level data to estimate the cost of a legislative change to provide Choice to all veterans more than 40 miles from where they can get the care they need. We have shared that analysis with some members of this committee, with staff, and with the CBO. It confirms the extraordinary cost that has been estimated previously. We have also briefed the staff on a broad range of other options and believe there are one or more options worthy of discussion and very careful consideration.

While we are working together on an intermediate term solution, we are requesting Congress grant VA a greater flexibility to expand the hardship criteria in Choice beyond geographic barriers. This authority would allow us to mitigate the impact of distance and other hardships for many veterans. We need greater flexibility around some requirements that preclude us from using Choice for services such as obstetrics, dentistry and long-term care. We also ask for modification of the 60-day authorization period set forth in the law to bring this more in line with industry standards.

As described above, we accelerated access to care in the community this year anticipating a substantial portion would be funded through Choice. For various reasons, most touched on previously, we will be unable to sustain that pace without greater program flexibility and flexibility to utilize at least some portion of Choice Program funds to cover the cost of other care in the community. We are requesting some measure of funding flexibility to support this care for veterans.

On May 1 VA sent to Congress a legislative proposal providing major improvements to VA's authority to use provider agreements for the purchase of community care. We request your support.

Lastly, we are requesting flexibility in one other area of veteran care: Hepatitis C treatments. You are all familiar with the miraculous impact of the new generation of drugs. Veterans that have been Hep C positive for years now have a cure within reach with minimal side effects. Because of the newness of these drugs, there was no funding provided in our 2015 budget request.

We moved \$688 million from care in the community anticipating a shift in cost for that care to Choice to fund treatment for veterans with these new drugs. It was the right thing to do, but it was not enough. We are requesting flexibility to use a limited amount of Choice Program dollars to make this cure available to veterans between now and the end of fiscal year.

So, we are improving access to care. We are committed to making Choice work and have very specific actions underway to do just that. And we need some help, especially additional flexibility to make it possible for us to meet the healthcare of our veterans.

We look forward to your questions.

[The prepared statement of Mr. Gibson appears in the Appendix]

The CHAIRMAN. Thank you very much. I think we can all agree that using the new generation of drugs is critical for not only the veteran but the long-term cost associated with that.

My question is, what did you request in the 2015 budget? Was there \$100 million or nothing? What—

Mr. GIBSON. For the new generation of drugs, my understanding is that in our request, there was not any funding for the new generation of drugs. When you go back and look at the timeline of these drugs being approved and the expected utilization, we didn't have any kind of clarity at the time of the 2015 budget request.

The CHAIRMAN. Is that because you didn't know what the cost of the drug was going to be? You knew what your parameters were as far as the veterans that were already testing positive for Hep C. Correct?

Mr. GIBSON. We have maintained a working list of veterans that have tested positive for Hepatitis C. I think the questions had to do with what drugs had been approved at the time we were formulating our 2015 budget request and what the costs for those drugs would be and then the anticipated utilization.

The CHAIRMAN. Thank you.

Mr. McIntyre, in your written statement you reference some VA facilities that have, and your quote was, "simply continued to use almost exclusively their historical non-VA care program to buy care from the community providers," end quote rather than using the Choice or the PC3 programs. So can you tell us where the facilities are? We need to know why they are choosing to do that, and is it in, obviously, a particular geographic region of the country?

Mr. MCINTYRE. Congressman Miller, the VA central office is completely engaged in that topic now as a result of a conversation about 6 or 7 weeks ago where we stress tested on both sides the question of whether direct contracts made sense when it was the case that we had actual networks established, and in some cases, established with exactly the same providers in the community. And the Department stress tested that question with us directly, and we have arrived at the conclusion, I believe, based on the behavior of where we are headed, that to the degree that we have networks that are developed, that those are the networks that would be used for the purpose of delivering care unless they needed to themselves be augmented.

So I will go to Dallas, Texas for a second where we had a meeting a few weeks ago. We looked at the entirety of demand between myself, the VAMC director, and the VISN director at the same table with the entire staff to determine what demand they had for everything in the marketplace, and what the network looked like juxtaposed to that demand. And then made the decision at that table that they would be buying their care through that network. We have one more piece to fill in. That is the same conclusion that was reached in Phoenix right after April 10. That is the same conclusion that was reached in Hawaii. We now have an entire network built out in that market, and it got done collaboratively.

So to the degree that we want to leverage the capabilities of the two organizations that have been hired to support the VA, we need the right tools, we need the right collaboration, and then we need to make sure that there is discipline on the other side so that un-

like in Albuquerque, New Mexico, where we happen to have the University of New Mexico in our network, but they also have a direct contract, and 85 percent of the care moves through that non-contracted environment on our side at a higher cost to the taxpayer, we need to start to transition these things with the discipline that is needed. And I believe that the senior leadership responded smartly and appropriately 7 weeks ago, and we have been on a series of visits ever since. The next one of which will be in Memphis, Tennessee on Friday.

Dr. TUCHSCHMIDT. If I could, Mr. Chairman, just to add that we have issued guidance to our facilities to use the Choice Program as the preferred way of gaining care in the community for veterans when we cannot treat them in a timely way. So the first option is to find a VA facility that, in fact, can provide that care, and if we can't provide that care within the time standard that we have, that we use Choice as the preferential channel for which we get that care.

And we are working right now with both TriWest and Health Net to contact the roughly 87,000 physicians and providers that have been delivering care to veterans who are normal otherwise non-Choice purchase care mechanisms to reach out to those folks and to try and get them to join the network so that they can continue to provide care to our patients.

The CHAIRMAN. Thank you.

Ms. Brown.

Ms. BROWN. Oh, I am sorry.

The CHAIRMAN. Mr. Takano.

Ms. BROWN. Then I will have the last statement.

Mr. TAKANO. Thank you, Madam Ranking Member. Thank you, Mr. Chairman.

Mr. Gibson, you know, a very real concern of mine is that for the Choice Program to be successful we need to guarantee a robust supply of non-VA providers to care for our veterans in a timely manner. In my district, and I know many of my colleagues on this committee face the very same issue, we have several primary care and mental health shortage areas. Our providers are already stretched thin trying to care for the non-veteran population. We have to do more to train providers and attract them to underserved areas. And that is why I worked with Representatives Titus and O'Rourke to include the 1,500 GME residencies in the Choice Act.

You mentioned that the initial 200 residencies, in your statement, that the VA has awarded those initial 200 residencies. Can you give me more detail about the VA strategy for awarding these residency slots?

Dr. TUCHSCHMIDT. Sure. Yes. We had about 330-plus requests for new residency slots this year. The intention is to use those 15 and stand up those 15 slots over a roughly 5-year period. I, quite frankly, was surprised that we were going to have as many requests for July as we did. And as you have said, we have awarded 204 positions.

There are criteria in the law that they are for scarce specialties, scarce medical disciplines, and in scarce areas. Right? So those are the criteria that we have awarded.

This year, roughly 74 of those slots are primary care slots, 58 of them are mental health slots, and 38 of the slots went to new or expanding programs in—residency programs in the country. We had a lot of requests from new programs that were starting, particularly in rural areas. We don't own these residency slots, the universities do, and then we are basically financially supporting those slots and supporting the training opportunity for those residents.

New places, particularly smaller places, have to meet certain standards to be—for those programs to be accredited, and they were just not ready yet to accept those positions, I think.

So we have—we are following the criteria that are in the law, targeting hard-to-recruit specialties and rural areas, and I think that next year as we get into the second round of this we are going to find that there are a lot more of the smaller programs, new programs, that are actually going to be up and ready to run those programs.

Just to make this—kind of bring the point home, when we establish a new residency in one of our VA facilities, there have to be call rooms for those residents to sleep in. There have to be work spaces for them to work in. All that kind of stuff. There has to be qualified faculty at that VA medical center to be able to do that work. So you have to recruit that faculty. You have to do the interim projects to have the sleeping quarters and all that kind of stuff, and that is kind of where we are in the process.

Mr. TAKANO. Well, Mr. Tuchs Schmidt, I appreciate all that, what you told me. I am surprised that you were surprised that you had so many applications because, as you know, there is a tremendous shortage of GMEs across this country, especially in rural areas. And I am wondering if there are ways that we can look at more flexibility as to how we deploy these residencies, because they are key to the maldistribution of providers in our country. They tend to gravitate toward areas which already have a robust medical infrastructure, and there are certain parts of our country, especially in the southwest and the rural areas that need these—as you know, where the residencies are located are key to where these physicians actually will choose to practice for the rest of their lives. 60 percent—we have a 60 percent chance of capturing a resident, and in areas like mine where we have a shortage of physicians in the non-VA population, I see—and I understand that we have a shortage within the VA, you know, physicians, and your ability to compete for those physicians to actually work at the VA is—if you are in competition with an environment of a shortage of physicians, we have a real problem. And I would submit to you that we need to work together to increase the level of GMEs, generally, for the VA and non-VA population to really handle this wait list problem.

Mr. TUCHSCHMIDT. Absolutely. And I am happy to go back and talk with our academic folks to see if there is some additional flexibility that we might need to be able to do this.

And I was only surprised because we were starting out of cycle for the first—

Mr. TAKANO. This is truly something where red States and blue States should become purple. Don't you think?

Great. Thank you.

I yield back, Mr. Chairman.
The CHAIRMAN. Thank you.

Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman, and thank you all for being here today.

I am going to read you a letter just very quickly from a veteran service officer.

“Dear Bill,” and that is one of my district people, “Nice to see you again this week in Morristown. Per our conversation regarding the veterans Choice card, all I’ve heard from local veterans in Hawkins County is it’s a joke. Personally, I called the toll-free number and was told by a lady that the area I lived in was not programmed in. I was told to call back in 7 to 10 days to check if the information was available. This was in December after the October rollout. I also heard from a few veterans who were told because of residing in the immediate Rogersville area, we had a VA facility and they could attend there after obtaining their own appointment. They were referring to our CBOC, which has only one primary care doctor, and, by the way, that’s the only doctor there who’s overworked due to patient load. No specialty physicians are located in our CBOC. Hearing other disgruntled stories throughout the Tennessee Department of Veterans Affairs poorly training, I must agree with my fellow veterans I serve, the program is a joke indeed.

Some common sense needed to be implemented before the program was rolled out, mainly the miles issue, and of course realizing the difference between a CBOC and a VA medical center.” And then he goes on to say, “I use the VA healthcare pretty much exclusively. I have only good things to say about my treatment. I am just thankful I hadn’t had to depend on the Choice card for my care. With my service-connected PTSD, I would probably make a fool of myself. With best regards, Congressman Roe.”

So that is what one VSO said. A little bumpy on the rollout.

A couple of other things that I want to bring up that has bothered me with any government program, whether it is the VA or anything else, and this number may be wrong, but we just knew there were veterans out there that could not get care, so rolled this program out, and according to our staff memo here, it says, “As of last week, 53,828 Choice authorizations have been made, and 43,044 appointments have been scheduled.”

We have spent \$500 million doing that, which is \$11,616 per appointment. That seems a little high. And I wonder why that is, why the administrative costs gobble up more money than the care going to the veteran. That just—it boggles my brain, although I will tell you it is actually better than healthcare.gov in Hawaii which was \$24,000 per customer. So you actually are doing half of what they charge in cost. And there are programs out there, whether it is TriWest or Medicare, whatever, systems that already work. Now, I realize putting a network together is difficult. I do know that. That is a big deal you are trying to do countrywide. It is a huge deal.

And another question I have, I guess, Mr. Secretary, for you, you said about the 40-mile limit. How much would it cost to do that? You didn’t mention that. You said it was expensive, but you didn’t put a number on it.

And, secondly, why are we using the veterans Choice card? This was to reduce the backlog, not to just provide service for veterans. Why are we going to that pot of money instead of using money the VA already has in its budget for that? And that was mentioned, and I would like to know why that is going on, because I shouldn't be.

Mr. GIBSON. I am not sure I understood the last question. Why—

Dr. ROE. Well, he just said just a second ago that they were funneling the veterans to the Choice program, not to a program that already exists for their care outside the VA.

And, lastly, concerns I have heard over prompt payment—we talked a lot about that when we were doing this bill, and prompt in the VA in payment is an oxymoron.

Mr. GIBSON. Which of those questions would you like for me to tackle first?

Dr. ROE. Any of them.

Mr. GIBSON. I will start from the end, and then probably have to ask for a reminder.

On prompt payment, you are absolutely right. We are historically—as I have said in the past, we pay low and slow. And that is a challenge for providers.

One of the things that Congress did for us, thank you very much, is you required us to consolidate our payment processing organization at least into a single reporting channel. We were processing payments in 21 different locations—in 21 different organizations in 77 different locations. We have now consolidated the—at least the reporting relationship, and we are now beginning to tackle some of the tough issues that were just being worked around in the past, and as a result, not providing timely payment to providers.

Frankly, the situation has been exacerbated by our acceleration of referral to care in the community. In the first 4 months of this year, the number of claims coming in the door are up 42 percent. So not only are they trying to catch up from the past, they are trying to stay ahead of that kind of a bow wave.

So we are after it in a big way. It bears directly on access to care because we have got to have providers out there.

I would remind you that under Choice, the providers get paid by the TPAs, and the stipulated requirement in the contract is 30 days.

What is the next question that I need to answer?

Dr. ROE. My time is expired, but I will submit those to you because there are several important questions I want the answer to. And I would like to have this letter submitted for the record.

Mr. GIBSON. And I would be delighted to answer them.

The CHAIRMAN. Without objection.

[The prepared statement of Sloan Gibson appears in the Appendix]

The CHAIRMAN. Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

Mr. McIntyre, you mentioned in your written statement that the current rules might require a pregnant veteran to change doctors during the course of her pregnancy, and that just kind of draws attention to something that I have been working on to try to be sure

that our women veterans get the kind of healthcare services that they need. So I would ask you if you have discovered any patterns or any trends of differences between men and women who are using the Choice program? Any tendencies for women to go outside of the VA perhaps more than men for OB/GYN treatment? Can you answer some of those questions so we can be sure that women are being served by this program as well?

Mr. MCINTYRE. Yes, ma'am. And thank you for your critical leadership in that area.

I think it is really early to tell what the patterns are going to look at the end of the day. We have got about 42,000 auths for Choice that have moved through our fingertips over the last several months since this started, and many of them are in—certainly for women's services issues. We could get you a listing of what that looks like and what the volume is juxtaposed to other types of services that are being requested. We do have OB/GYNs in the network.

We also have a responsibility that to the degree that mammograms aren't available, OB/GYNs aren't available and the like, and they are needed and unavailable in the VA, to actually contact a provider on the veteran's behalf and place them with a provider of their choice.

And then as Secretary Gibson said, to pay within 30 days on average. That is actually what we are doing now. Three months ago we were at 90 days. Now we are on average at 30. So we are hitting that speck.

And the focus on women's health issues is really, really important to all of us. We appreciate their service, and we look forward to collaborating with you, particularly as it relates to Las Vegas on that and the other issues in your community.

Ms. TITUS. I appreciate that, and it is so important because many of the VA facilities don't have a resident OB/GYN, and so we want to be sure that they are getting that service. And I especially appreciate you saying that you want to collaborate. I heard you mention you had been to Las Vegas, but Ms. Hoffmeier said that she had been willing to do roundtables with veterans, not just meeting with the doctors. And I wonder perhaps you could partner with me and we could do a roundtable so we can get the word out about the Choice program in—

Mr. MCINTYRE. Ma'am, that would be fabulous. You name the time, the place, the date, and I will be there.

Ms. TITUS. And I got a lot of witnesses here.

Mr. MCINTYRE. Done. And what I will tell you, ma'am, is this. It is not the only time I have been to Vegas.

Ms. TITUS. Well, that is good. We like that too. So—

Mr. MCINTYRE. Not for gambling. I have been there not to leave money in the economy. I have been there to work, and we have been there four times now to meet with the facility and work on tailoring the network related to the demands in that market. And they are leaning forward and doing what they need to be doing on their end on your behalf.

Ms. TITUS. Great. Thank you. We will set that up.

Mr. Secretary, I—thank you. It is always a pleasure to see you, but before I ask a question, I want to just take a minute to asso-

ciate myself with the comments that were made in the veterans hearing on the Senate side yesterday by Ranking Member Blumenthal. He is very concerned, as I am, about taking money from the Choice Act to pay for those outrageous overruns in Aurora, and we need to help the veterans in Denver, but we can't take money from a program that you all said you needed, you needed this money, to serve all our veterans. And now to just say: Oh, well, we don't really need that \$700 million, I don't think is acceptable, and I would like for the record to show that.

Also my question, though, is that you mentioned that you all are in the process of hiring more than 10,000 medical professionals.

What my question is—is that to fill a gap, to fill a hole, or to fill vacancies, or is that in anticipation of needs of the future? Because there is some parts of the country where the veteran population is growing, like Mr. O'Rourke's district, my district. Other places the veterans population not so much.

Could you address that?

Mr. GIBSON. Of course, yes. In fact, the comment in my opening statement was that we had grown net 11,000 medical staff in our medical centers over the last 12 months. We are at any point in time, and we are right now, the number I am remembering, Jim may have a better number, is somewhere on order of 28,000 individual positions that we are working to fill all across VA. That number bumped up because of the Choice Act, because of the number of positions that we are working to fill, that were made possible by that incremental funding. But in the course of our routine turnover, we see between 8 and 9 percent turnover, substantially less than what you see in the private sector in healthcare, but when you look at a staff of some close to 300,000, if you are turning over 8 or 9 percent a year, you are going to have a large number of vacancies open at any point in time. So we are constantly recruiting to fill vacancies across VHA.

Ms. TITUS. Thank you. And we hear a lot about the shortage of doctors, but I know there is a shortage of nurses and other technicians as well. So we need to be aware of that problem too.

Mr. GIBSON. You are absolutely right. Yes, ma'am. We are the largest employer of nurses in the country, and that is a vital position for us to ensure that we are effectively recruiting.

Ms. TITUS. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate you calling this hearing, as well as your great work on expanding choices for our veterans, and I—

Mr. Under Secretary, I do appreciate your statement that Choice is now the default option for care outside the VA, and I will look forward to some description of how you made changes to make certain that happens.

What I want to ask—a couple things. First of all, I find out in this committee we have a lot of differences across our districts, and some have more or less providers, but in my Congressional district, we have about 70 community hospitals and zero VA hospitals. And what I am hearing from those hospitals is a tremendous difficulty of getting into—as an approved provider. They can do it for Medi-

care. They certainly can do it for TRICARE. But it is extremely difficult.

What I would like to ask the TriWest folks is, what does the VA need to do to make sure that these community hospitals that want to serve veterans get in and become an approved provider? What can we do differently?

Mr. MCINTYRE. Well, I think we should compare notes because we have a fairly sizeable network built out in Kansas, and it may be that some think they are not under contract because we used to do the TRICARE work in the State of Kansas, and they actually, in fact, have a network contract to do the work for this work.

And actually Dr. Tuchschildt and I discovered that similar problem in Bend, Oregon. Didn't we, sir? Where someone decided to light both of us on fire, and at the end of the day, within a couple hours, they were trying to explain why it was that they had mistaken the fact that they actually were under contract.

So I would look forward to that dialogue. We have a broad footprint in Kansas. If we need to add it, we will definitely make that happen, because we are responsible for making sure that the care is accessible.

Mr. HUELSKAMP. And I appreciate that, and maybe it is the folks at the VA that are answering the phone, because it is still extremely difficult. We have veterans that are making it through the system and getting those choices. As I have talked about again and again in this committee, it is usually they talk about hours to get to a provider and—when they have a local hospital down the road, and they are still not getting the yeses that they need.

And one of the other things, as far as yeses, I would like the Under Secretary to know about this. At Fort Riley, which is in my district as well, they are building a brand-new hospital, and there are—sometimes they say it takes years for the VA and the DoD to come together to agreement, and the CBOC there is a limited primary care. Actually, all the CBOCs are very limited, which I want to get to in another question, but I wanted the Under Secretary to understand that the folks there would like access. They would—you know, they can serve 10 years at Fort Riley. They would like to step off the base and turn around and still access the care that they have been doing as well.

So the last question of Mr. Secretary would be in reference to the hardship exemption. And how far can you stretch that to meet the needs of these veterans of rural communities to get past this artificial 40-mile barrier, and say, Hey, you know what? The CBOCs are not offering the care, and it makes no sense to calculate 40 miles to a place that doesn't offer anything other than maybe primary care, maybe 4 days a week, maybe 1 day a week, and describe how we can expand that and meet those needs?

Mr. GIBSON. First, very briefly, everywhere I go I find a very strong relationship between the local VA and DoD medical facilities. I will make sure—I have not been to Kansas yet, but I will make sure that we are working to build that relationship with Fort Riley.

Secondly—the second question is?

Mr. HUELSKAMP. Hardship exemption, and how we can use the current law and still expand beyond this artificial—

Mr. GIBSON. Yeah. Well, the flexibility that I referred to here and that we are requesting, the way the language is written right now it has to do with a very limited and very narrow geographic barrier. What we are looking for is much broader discretion so that, you know, for example, the veteran that you described in your letter that we would be able to, much more liberally, address those particular needs for that veteran in terms of the distance traveled and be able to rely on the Choice program to fund that.

I would tell you, part of our challenge here, and I didn't get a chance to answer that part of Dr. Roe's question, as we run even the most conservative assumptions, we are seeing numbers on the order of magnitude of \$10 billion a year. So just completely open the aperture. And—and so part of what we are looking at here as an interim solution is the idea that we would have that kind of discretion. And I might say, for example, if a veteran needs a knee replacement, then traveling some considerable distance to get that knee replacement, maybe that is not unreasonable in order to get it done at a VA hospital. What I don't want to have is that veteran having to travel that same distance to get the physical therapy done after he has the procedure.

Mr. HUELSKAMP. And I am out of time, Mr. Under Secretary. One last point. And appreciate that. I would ask you to look at the hardship exemption to get past this artificial 40-mile barrier as well. And as far as your cost estimates, I don't know if you have done the comparison, but I find it hard to believe that you are doing it more effective and more cheaply than our TRICARE and Medicare system, which is dozens and dozens and dozens, and perhaps hundreds of choices, and in the—in my congressional district, very few choices for VA. So that is a comparison I would like to see.

So I yield back, Mr. Chairman.

The CHAIRMAN. Mr. O'Rourke.

Mr. O'Rourke. Thank you.

Mr. Gibson, at one point in your opening statement, you had mentioned spending up to \$9.9 billion, including Choice on outside care.

What year were you talking about, and what was the amount for Choice specifically?

Mr. GIBSON. Well, we are—what I am talking about is on the pace that we are on right now, I expect that we are going to spend close to \$10 billion on care in the community.

Mr. O'ROURKE. By what date?

Mr. GIBSON. Pardon me?

Mr. O'ROURKE. By what date?

Mr. GIBSON. This fiscal year.

Mr. O'ROURKE. Okay.

Mr. GIBSON. This fiscal year between October 1 of 2014 and September 30 of 2015. This fiscal year that we would spend just under \$10 billion. The challenge that we have is, for a whole bunch of reasons, many of which are internal, some of which we are challenged around in terms of flexibility provisions and things like that, the majority of that has been coming out of our—out of our traditional VA community care budget. We cannot sustain that.

So part of what Jim was describing earlier about—about shifting to make Choice the default option, that is—no pun intended—that is not a choice. We have no alternative but to do that, because otherwise we won't be able to refer veterans to care in the community. And without additional flexibility, there will be other instances where we would otherwise have referred the veteran to care in the country but we don't have the dollars to pay for it.

Mr. O'ROURKE. So having said that, and then you also said in your opening remarks that you wanted to rationalize Choice and community into one channel.

Mr. GIBSON. Yes.

Mr. O'ROURKE. And a request for flexibility. Is the logical conclusion of that that you would just merge those programs into one? And do we need Choice? Should all this go through PC3? Should all of PC3 go through Choice? Do we just need one program?

Mr. GIBSON. Let me, if I may, take one moment, and then I want—because there is context for the answer.

I mention in my statement that we had reviewed with the staff, and we are delighted to do that with members, an array of alternatives that we have been looking at to just basically saying 40 miles from wherever you can get the care. They have to do with limiting it to certain services, limiting it to certain priority groups, and—and then doing some different things in terms of pay structures.

One of the alternatives that I think is particularly interesting and warrants careful consideration is the idea, and this affects other parts of the Federal Government that—let me back up.

VA care—the veterans who we are providing care to right now, 81 percent have either Medicare, Medicaid, TRICARE, or some form of private insurance. And so part of what we are seeing as we cost out this \$40 billion from where you can get the care is a material shift out of Medicare and other primary payers into VA because we don't have the co-pay levels that you find in these other programs. So one idea is you eliminate that economic distortion in the veteran's decision. You make, for example, Medicare the primary payer. You use VA as—to indemnify the veteran up to their Medicare co-pay, and all of a sudden, you have done something to give real choice to the veteran, and, frankly, more efficiently for the taxpayer, so that the taxpayer is not paying twice for the same kind of care.

And the base question I am answering here is?

Mr. O'ROURKE. Well, I was asking about whether the logical conclusion of this is that we are merging the two programs. But I also want to get a question to Mr. McIntyre.

Mr. GIBSON. But as you go to that kind of a scenario, then you step back from that and you ask yourself: How do you optimally organize to execute that?

Mr. O'ROURKE. Yes.

Mr. GIBSON. And I still think it is one single channel.

Mr. O'ROURKE. Yes.

Mr. GIBSON. We can't operate in five or six or seven channels.

Mr. O'ROURKE. So, Mr. McIntyre, tell me how to read these numbers. Since November, El Paso VA has referred 165 veterans through Choice and that same time period referred 4,600 veterans

through the PC3 contract. What conclusion should I draw, what questions should I be asking related to that?

Mr. MCINTYRE. The conclusion you should draw with the third-highest volume in our geographic space is that it is working. We have gaps in performance. There are differences between the two contracts and requirements to providers that need to get streamed out, but the fact of the matter is that the care that is not accessible in the VA facility in El Paso is being delivered downtown. And we are now talking about how do we grow the mental health backbone together to make sure that we can deliver on that, and that is why I was there 2 weeks ago.

Mr. O'ROURKE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. Gibson, it wasn't too many years ago that Florida started a lottery program, and the selling point of the lottery program was the funds that would be derived from that program would be used to supplement education in Florida. The fear was that it wouldn't supplement it, that the base funds would go away. Well, that is what has happened.

Let me assure you there is a \$6 billion item already in your budget for outside fee care. We are not going to let the Choice Program become the lottery funding source for the Department of Veterans Affairs. I got the letter. I am checking now to see on where some of the money has been diverted, and I can assure you that this committee is not going to let the Department purposely delete the funds. I just want to make that very clear. It was designed to supplement. It wasn't designed to replace. And I am not asking for a response. I am just making sure you know where we are coming from, and I think you already know that.

But in your testimony today and in letters that you have sent to us, you have very cautiously woven in some issues that are more management issues than they are budgetary issues. And we will reach a conclusion, may not be the one you like, but we are all going to make sure that the veterans get to use the Choice Program in a way that it was intended so that it is successful.

Mr. Coffman, you are recognized—

Ms. BROWN. Mr. Chairman.

The CHAIRMAN [continuing]. But you cannot use the word "Denver" one time.

Mr. COFFMAN. Aurora, Mr. Chairman, Aurora.

The CHAIRMAN. Okay.

Mr. COFFMAN. Thank you.

Ms. BROWN. I had a question.

Mr. COFFMAN. Thank you, Mr. Chairman. We won't talk about that construction project today.

But let me just say, in Colorado, 9NEWS, one of our local TV stations, did an analysis over the first 4 months and found that there were only 403 veteran Choice appointments scheduled while there were 183,000 appointments scheduled through the VA system. It seems like that there is underutilization, and what can we do? And I think you have expressed some things today.

But let me go on to another one because maybe you have addressed that, but you can elaborate on that. There is a neurologist,

a physician, actually a surgeon that I met with in Colorado who does the followup work on this. When people have Parkinson's, there is a procedure whereby there is I think deep brain stimulation to try and stabilize them. And they are having to go to San Francisco for that procedure from Colorado where we can do it in Colorado.

Under your new definition of the 40 miles, will veterans have the option of staying in Colorado to get that treatment with a provider that is reimbursed under the Medicare rate, or will they have to go to San Francisco to get that procedure done?

Mr. GIBSON. I am going to give you a very honest and direct answer: I don't know. The easy answer would just be for me to say yes. I think I know the procedure that you are describing.

Mr. COFFMAN. Right.

Mr. GIBSON. I have been to San Francisco. I have seen the impact that that has. It is a very, very specialized procedure and one that we have developed some exceptional in-depth experience with. At a clinical level, I think that is part of where that decision winds up being made. If we are looking at the individual patient acknowledging the hardship of travel, looking at the ability to deliver comparable care in the community, then I suspect that is one where we would look at it and say that is a hardship to travel that far for that treatment and therefore we ought to do it here locally.

On the other hand, if we saw material differences in relation to that specific veteran and the capability, the relevant capability, we might look and say we think it is better for this veteran to be able to make that trip. That is an honest answer.

Mr. COFFMAN. Mr. Secretary, Deputy Secretary Sloan Gibson, 9NEWS again did a story about a veteran who had to go to Albuquerque, New Mexico, a 200-mile trip, to get—let's see, he didn't. So it is \$160 worth of travel expenses that he was reimbursed and it was for an x-ray he needed that the cost of which was evaluated at \$160, at least by the investigative reporter. I mean, when we talk about the cost, how are we rationalizing that?

Mr. GIBSON. That is a perfect example of where we have got to use common sense. It makes absolutely no sense, first of all, for the hardship on the veteran to make a trip of 150 miles or whatever it was to get an x-ray. For heaven's sakes, that is just not thinking straight. And being able to provide the kind of flexibility and set the context inside the organization to make those kinds of decisions locally I think is where we wind up taking better care of veterans and, frankly, doing the better thing for taxpayers.

Mr. COFFMAN. Okay. Going back to the issue about the extraordinary travel expenses to send somebody from Colorado to San Francisco to get a procedure, so it is your view that if there is no qualitative difference in terms of offering the procedure in terms of cost savings, that it ought to be done under the Choice Program in Colorado. Am I correct in that?

Mr. GIBSON. You know, the guideline that I hope, and part of what Bob and I both are trying to do, and this is a challenge culturally inside the organization, is move us to more principle-based approach to making decisions instead of rules-based. And so what I would like is that person on the ground looking and saying: What is the right thing for veterans and the best thing for taxpayers

here. And if that means having the veteran stay there in Colorado, then that is the decision that we ought to be making.

Mr. COFFMAN. And let me just follow up very quickly. They are also being sent to San Francisco to do routine things in terms of followup such as periodically, I guess, these, when they do the deep brain stimulation, the batteries have to be changed out. I don't know the medical lexicon associated with that. But they are going to San Francisco for that, and it seems like the followup care certainly could be done in the State of Colorado.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you.

Ms. Rice.

Ms. RICE. Thank you, Mr. Chairman.

Mr. McIntyre, Ms. Titus asked a question specifically about treatment for women. The question I have is that you suggest review of the 60-day authorization limitation?

Mr. MCINTYRE. Yes, ma'am.

Ms. RICE. So you gave two examples of a situation that I am sure we do not want veterans—really, who would want to have to go through that kind of midstream change in terms of treatment when you are talking about serious health issues. So can you just expound on that a little bit more and how you would fix that?

Mr. MCINTYRE. Well, I think the fix is probably going to have to be made by all of you, at least from the standpoint of giving us the flexibility that doesn't currently exist in the law. The way the Choice law was drafted was designed to make sure that there was appropriate utilization, not overutilization, and in the drafting of that, there was a 60-day limitation put on how long an authorization for care could be.

So if you are a person who has cancer, you are probably getting care for more than 60 days. If you are a person who is pregnant, you are probably getting care for more than 60 days. If you are a person that is going through radiation oncology, you are probably getting care for more than 60 days. And I could go on and on as a nonclinician.

And your position is not unique, and that is that that doesn't make a lot of sense. And so I think stepping back, all of us, you, the VA, ourselves, to try and figure out what is clinically rational and what adjustments are made in order to make that work.

Ms. RICE. So what would the solution be?

Mr. MCINTYRE. Because today what happens is, if we receive someone to deliver care, then we contact a provider, we send them the request for an appointment, we send the authorization along with that request for an appointment and all the rules that they have to follow, and then they get that person for care. And 60 days later they have to present them back to us, we have to go back to the VA, under the current rules, to make sure that it is okay to continue to deliver care in the community.

As Secretary Gibson said, it is not rational and it doesn't make any sense. And so I think we just need to lean forward and figure out how to adjust that. We are certainly willing to do our part when you do your part.

Ms. RICE. Well, tell me what our part is.

Mr. MCINTYRE. It would be adjusting the requirement.

Ms. RICE. So it is a language adjustment.

Mr. MCINTYRE. It is a language adjustment. And Dr. Tuchs Schmidt might even have thought about this as a clinician in terms of what is needed.

Dr. TUCHSCHMIDT. Yes. So we totally support this change. There are a number of changes that I think we are prepared to come forward with here shortly asking for changes in the way the Choice Program works. One of these is the 60-day authorization, and I think the issue is clear about continuity of care beyond the 60-day period.

So what normally happens in the industry, quite frankly, is that there is an authorization for an episode of care as opposed to 60 days. So that episode of care, if you are being referred to an obstetrician for your prenatal care and delivery, obviously is not a 60-day episode of care. It is a much longer period of time. If it is for the radiation therapy, it is for a course of therapy, it is not for 60 days.

And so I think what we would like to see happen is that that 60-day window, quite frankly, just get taken out and that we manage this by authorizing episodes of care and using, quite frankly, industry standard utilization management criteria that we use internally and that we have provided to the TPAs.

Ms. RICE. Okay.

Deputy Secretary Gibson, just one question. So we can hear individual stories that some of us might hear from constituents of ours, and they are very compelling, but those, unfortunately, seem too few and far between. Seems to me like the veterans service organizations might actually be privy to more stories that might be more instructive as to how you address a persistent problem.

So does the VA regularly and have you been—I think I know the answer to this—reaching out to the VSOs to ensure that we are not waiting just to get into a situation like this to hear about the horrible story of a handful of people.

Mr. GIBSON. We are at various levels in the organization, from Bob McDonald and I, all the way down to folks in medical centers, are regularly meeting with VSOs. I think I am partly responsible for Bob's cholesterol level back there because we have breakfast together as often as we do. So it is, yes, we do that very closely.

As we do things with Choice, for example, the original letter that we sent out, before we sent it out, we gave it to the VSOs to get feedback. We are getting ready to send another mailer out. We got great feedback from the VSO on things to address and things to fine-tune that they are hearing from their members aren't clearly communicated. So that is a routine part of our approach.

Ms. RICE. Great. Thank you all very much.

Mr. GIBSON. Yes, ma'am.

Ms. RICE. I yield back, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Dr. Wenstrup, you are recognized.

Dr. WENSTRUP. Thank you, Mr. Chairman.

I appreciate all of you taking on these very complicated issues, but I do think that with a lot of perseverance, we have a chance to do some great things here.

First question I have, Mr. McIntyre, do you know offhand what, say, the top five physician services are that are being referred out?

Mr. MCINTYRE. Through Choice?

Dr. WENSTRUP. Yes.

Mr. MCINTYRE. It would be physical therapy.

Dr. WENSTRUP. Physician. Physician.

Mr. MCINTYRE. Physician services?

Dr. WENSTRUP. Yes.

Mr. MCINTYRE. It would depend on market, and it would depend on what is the gap at the VA market by market by market.

Dr. WENSTRUP. I guess I was looking for more what your—

Mr. MCINTYRE. The average? The Secretary may be able to answer that.

Mr. GIBSON. I think primary care is the biggest item.

Dr. TUCHSCHMIDT. Yes.

Mr. GIBSON. By far.

Dr. WENSTRUP. At some point for the record, if you could give me what you think are the top 5 or 10.

Mr. GIBSON. We can give you that breakdown.

The other thing that I think we are going to see over a period of time is those referrals into primary care oftentimes are going to lead to a specialty care.

Dr. WENSTRUP. Another referral.

Mr. GIBSON. And so while we see primary care up here right now, primary care may move down as some of the other specialties move up.

Dr. WENSTRUP. That makes sense to me, especially if you have more primary care doctors at the VA, they would refer directly to a specialist rather than the other way around.

So at TriWest, you manage claims and payment, correct?

Mr. MCINTYRE. Yes, sir.

Dr. WENSTRUP. Okay. But the administrative rules and requirements are set by the VA?

Mr. MCINTYRE. Correct.

Dr. WENSTRUP. As far as paperwork?

Mr. MCINTYRE. Correct.

Dr. WENSTRUP. Okay. So who does the non-VA provider get their check from? Do they get it from TriWest or they it from the VA?

Mr. MCINTYRE. We pay the provider after the provider returns the medical documentation of the encounter to us so that the VA can put it in the consolidated medical record for the veteran. And then the VA pays us

Dr. WENSTRUP. So you pay them before the VA pays you?

Mr. MCINTYRE. Correct. And on average, we are now doing that in 30 days.

Dr. WENSTRUP. Okay. Very helpful.

Now, how does that system compare to other networks that you might be managing as far as the paperwork? That is my key issue. Because one of the complaints is the VA paperwork is so much tougher, so it deters some docs from wanting to be providers.

Mr. MCINTYRE. You know, there are some requirements that are a bit more extensive than they might be under other programs. Probably the biggest challenge that we have is that there is a different set of requirements for PC3, which predated Choice, and for

Choice itself, and the need to harmonize those two things is pretty important, both for the provider, for the provider's staff, for the veteran, for our staff, and also for the VA staff.

Dr. WENSTRUP. Because we are looking for ways that can streamline things that aren't necessarily related to care and get people taken care of, and so it sounds like there is some room for improvement there that we can work on, and I appreciate that.

Is there a capability for a non-VA doctor to directly contract with the VA?

Mr. MCINTYRE. The way it works is that to the degree that we don't have a network provider available—and we have 100,000 now in our network, we will probably have somewhere between 125,000 to 130,000 when we are done tailoring networks—if we can't meet that need that way, then we have a responsibility, based on the instructions that you gave to all of us, to go and seek a provider in the community that would be willing to serve that veteran. So if there is one in a market, we still have a responsibility.

Dr. WENSTRUP. Great.

Mr. MCINTYRE. Secondly, if the person walks in with an individual provider's name, that is the place we start.

Dr. WENSTRUP. Has the SGR fix been helpful in recruitment, considering that it is Medicare rates and now there is some stability to the Medicare rate?

Mr. MCINTYRE. We have been fairly successful in recruiting providers. The other side of it is that we are now opening up the aperture and allowing providers across our geographic expanse to actually identify that they are interested in taking care of veterans under Choice at the Medicare rate.

Dr. WENSTRUP. One of the things that I wanted to ask you, Mr. Gibson, you mentioned about RVUs increasing. Do you think that is because of increased productivity or better documentation in increasing the RVUs or a combination?

Mr. GIBSON. I think it is probably a combination. We have been increasing our focus on productivity. We have built some internal tools to help us do that. That is part of the overall discipline that we are trying to impose on the organization. Once you start focusing on something, you are probably getting better reporting. But when you look at the increase in completed appointments, you realize that there is more work being completed here.

Dr. WENSTRUP. At some point—I am about out of time—but I would like to address further what we are spending, the total cost per RVU in our system, and I know we have talked about that before.

Mr. Chairman, I yield back

The CHAIRMAN. Ms. Brownley, you are recognized

Ms. BROWNLEY. Thank you, Mr. Chairman.

Mr. Secretary, I think we all know that there is a difference in reimbursement rates between the fee basis care, the PC3, and the Choice Act. We know that. And you had mentioned in your testimony that it is somewhat problematic with regards to the Choice Act. And it is true that Choice is the least of the reimbursements to providers of those three programs. It is not the least?

Mr. GIBSON. PC3 is actually typically negotiated at below Medicare rates.

Ms. BROWNLEY. PC3 is.

Mr. GIBSON. It is, yes.

Ms. BROWNLEY. Okay.

Mr. GIBSON. So you have got individual authorizations or other contracts that may be at Medicare or may be a little above Medicare, PC3 below, and then Choice at Medicare. And obviously you can surmise the signals that is sending to the provider community.

Ms. BROWNLEY. Well, that is what I was trying to kind of drill down a little bit more and following up on Dr. Wenstrup. If the Medi-Cal or Medicare rate is less, then is that going to drive in terms of having the providers that we need to access the program?

Mr. GIBSON. One of the challenges that we are going to have as we move to that single network and I think we become predominantly Medicare based is, particularly in rural markets, our ability to attract providers in rural and highly rural markets at Medicare rates. That I expect will be a challenge. We know that is a difficulty already because we already experience that in our other VA care, and that will be one of the areas where I think ultimately we are looking for some modicum of flexibility.

Ms. BROWNLEY. Very good. I think it was you that mentioned some of the positive impacts on the Choice Act or what we have done is to extend office hours at various facilities. I know in my district our veterans are screaming for extended hours with our CBOC and we haven't accomplished that. So I am just wondering if you have some kind of data to show where we are providing those extended hours and where we are not.

Mr. GIBSON. As a matter of fact, we have got very detailed data all the way down at least to the medical center level. I don't know if I have got it all the way down to the CBOC level. When you look at the last year, we are up slightly over 10 percent in total extended hours, 2 years we are actually up almost 27 percent in extended hours care. So it is really one of the things that we are trying to emphasize, but we can focus on the specific outpatient clinic that you are referring to.

Ms. BROWNLEY. Well, that would be great. And I am just interested in what the VA is doing to continue to drive that to. I mean, the goal would be that wherever it is needed, and maybe it is not needed everywhere, but wherever it is needed, that we do have those extended hours.

Mr. GIBSON. Yes, ma'am.

Ms. BROWNLEY. And then last. We provide, I think, in terms of the wait time data and number of appointments for VA care, we have those statistics and it is given to us on a pretty regular basis. In your comments you talk about Phoenix and Denver and Fayetteville, you mentioned those. But I am wondering if you have consistent data for all of the facilities across the country for the Choice Act in terms of how we are doing. It is very hard to measure. We get a lot of this anecdotal feedback, but it is really hard to actually know how we are doing center by center by center.

Mr. GIBSON. In fact, we do have that detailed data down to the facility level for Choice. As you might expect, it is still a very small fraction of the total activity. And so part of our challenge is really what we are in the process now is basically diverting. Folks are used to doing business the way they do.

First of all, veterans are confused by this, providers are confused by this, and our internal staff are used to doing care in the community the way they have always done care in the community. Notwithstanding communication and hours of training and everything else, we still have people that are ingrained in their old habits. And so what we are in the process of doing right now is shifting that over.

We are looking at access writ large and assessing how we are improving access and then underneath that how we are using the different tools that we have, VA community care being one of those broadly and Choice being a part of that. Choice has got to become a dramatically larger segment of that care in the community that we are delivering.

Ms. BROWNLEY. And I heard what the chairman said with regards to your concept of trying to merge all of these programs. If we were going to do that, is the tool that you need is simply budget flexibility or does it go beyond that?

Mr. GIBSON. I think ultimately it likely would involve some kind of budget flexibility because right now we have got two different buckets of money. But I am just presuming that there would be other legislative relief that we would need in the process of trying to consolidate what are today six or seven different channels through which we provide care in the community.

Ms. BROWNLEY. So the Choice Act being underprescribed, what is being overprescribed in terms of your budget?

Mr. GIBSON. I would say our traditional VA care. PC3, it is still a new program, and it is still a very small percentage. It is really our traditional. As I mentioned in my statement, we have been referring veterans for care in the community for years. Folks are used to doing that a certain way. There are providers that they are used to referring their patients to on a routine kind of basis. And so that is what is being overutilized.

The requests that the chairman was alluding to earlier was really one where from our perspective Choice was designed to help accelerate access to care, to make care in the community more available to veterans. That is precisely what we have been trying to do. We have just been using traditional channels to accomplish that as opposed to being able to get all the system and veterans and providers in place to do it through Choice.

Ms. BROWNLEY. Thank you.

I yield back, Mr. Chairman

The CHAIRMAN. Dr. Abraham.

Mr. ABRAHAM. Thank you, Mr. Chairman.

Mr. Secretary, going back to Dr. Roe's line of questioning on what you described as the slow—

Mr. GIBSON. Paying low and slow. That is you say down South.

Mr. ABRAHAM. I would add no pay in certain districts in Louisiana that I am familiar with. And you said you have had 42 percent increase in claims. We understand that. And I understand that you are trying to consolidate the payment system. But objective data, since we have done this, I mean, we have got clinics in my district that are owed well over \$1 million, and they have, unfortunately, to their chagrin, turned veterans away, not that they

want to, but they just can't afford to see them. What is the time now as to payment of that claim?

Mr. GIBSON. Great. Thanks for the question.

What VA historically tried to manage to was to pay 80 percent of claims within 30 days.

Mr. ABRAHAM. But that is not happening.

Mr. GIBSON. Historically, that happened in most VISNs, but VISN 16 was one that chronically underperformed, because I used to have the VISN director in my office repeatedly before she retired and before we consolidated all this stuff about that very issue. In part because of the feedback that we have received from you and other Members in the Louisiana delegation, we have focused very intensively on VISN 16 and specifically on the Louisiana market.

I can tell you in VISN 16, that 80 percent standard that I was referring to, in the month of December in VISN 16, 35 percent of claims were within 30 days.

Mr. ABRAHAM. Okay.

Mr. GIBSON. Today that number, I think it is 78 percent are within 30 days.

Mr. ABRAHAM. Okay.

Mr. GIBSON. In New Orleans per se it is now at 85 percent, still not where it needs to be.

The other thing I would mention very quickly is, and this is part of bringing management focus at an enterprise level to this activity, you never would have organized this way to do this kind of work ever. It is crazy.

We are now focussing on issues, and one of the things we learned is that the industry standard is actually 90 days, 90 percent within 30 days, but it is on clean claims. So my question was, so what percent of our claims are clean? Sixty. Forty percent of our claims don't have authorizations matched up with them. That then sends us back into process improvement, to figure out how we drive process improvement so that we have got a higher percentage of the claims coming in the door that are clean so that we can process those timely. We are after it.

Mr. ABRAHAM. Okay. It sounds like we are making some progress.

Mr. GIBSON. We are after it.

Mr. ABRAHAM. Quick question on Hep C.

Mr. GIBSON. Yes, sir.

Mr. ABRAHAM. Certainly, ethically and morally, as a physician, I know it is much better to treat the disease than the symptom.

Mr. GIBSON. Yes, sir.

Mr. ABRAHAM. And certainly it is more financially advantageous to treat the disease, certainly when you are talking about a Hepatitis C patient.

You said there were \$660 million shifted to the Hep C program. I guess my first question is, where did that money come from? And secondly, how much more money are we talking about knowing, if you do know to date, how many veterans are testing positive for Hep C, and how much money are you anticipating, more than the \$660 million, needing?

Mr. GIBSON. Yes. We moved \$688 million. We moved it from VA care in the community because we expected VA care in the commu-

nity to be shifting those costs to over into Choice. That hasn't happened, as we have described.

At the current rate of new starts for Hep C between now and the end of the year, we will need \$400 million in order to be able to close that gap at the current rate. And that is an urgent issue for us.

I think the intermediate-term discussion really has to do with what is the requirement that we all, Congress and VA, agree that we will manage to. We have today in our records 136,000 Hepatitis C Active veterans and some additional amount that we expect are Hep C positive that aren't in the inventory.

I think, frankly, the requirement we should be managing to is to reach functional zero among veterans that are Hep C positive by the end of fiscal year 2018. And I think then you step back, you look at the cost associated with doing that over a 3-year period of time. But that to me is the discussion that we should be having among ourselves, agree on the requirement, and then it is basically we are into executing.

Because the challenge that we run into is you pick a dollar amount and you wind up in a situation where you are denying a veteran, who is Hep C positive, who comes to see you, he is ready for treatment, he is not abusing alcohol, he is not abusing substances, and he wants the treatment. And if you have managed to a number, you can't provide it. I don't want to put our clinicians in that position. You wouldn't want to be in that position.

Mr. ABRAHAM. Right. Okay.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chairman.

And thank you to our panel.

I want to follow up on a visit that I had last week to White River Junction Hospital in Vermont serving most of my district in New Hampshire. First of all, things are going well. I was very, very impressed, particularly with the mental healthcare. I had a tour of a really outstanding drug and alcohol treatment facility that I wish we could have for my constituents across the district. And I am pleased to see our veterans getting good care. I had a presentation on telemedicine that was fascinating and is very helpful.

What I learned from the folks there is that they actually have a preference for the way they were doing business, and I think you just made a reference to this. They were providing community care as they saw the need, both travel and the appropriateness of care in the community.

And one of the issues that we talked about that was preferable under the previous program was the medical record and the relationship between the provider at the VA and the community provider where the VA was personally engaged in setting up that care. They were able to make a call the day before the appointment to make sure that the vet received the care. They made a followup call, how did it go, do you have any questions, is there anything you need from us. They got the record electronically in a way that was timely, and so that when they came for their next visit at the VA, the VA was aware of the care that they had had.

And so I am happy to work with you. I think, in a bipartisan way, there are folks that want to work with you to make this work. But that is my question, is how can we do better on the transfer of the medical record and, again, just being veteran focused to make sure they get the care they need?

Dr. TUCHSCHMIDT. I am glad to hear that story because that is a really exciting good news story I think there.

I think we have a lot of work to do. We have been traditionally a closed kind of HMO model, much like a Kaiser Permanente, where we can coordinate care, we can coordinate some of those handoffs. And if you look, we have bought more and more care out in the community over—well, really going back since about 2006, 2007, with this year turning out to be probably a banner year.

The challenge we now have is doing what I think you are talking about, is how do we really, if we are getting care outside the system and we have more of an open system, how do we really coordinate that care and manage that care on behalf of veterans, and how do we empower veterans with the right information and tools to make wiser decisions for themselves in that environment?

I think we have a lot to learn, quite frankly. I think all of American healthcare is trying to figure out how to do this. We have a lot to learn. I think that we have really good partners to try and do this. And Dave may want to talk about some of the new portal stuff that you are opening up.

But I think ultimately it is about communicating back and forth with us: How do we exchange information without having to fax and Xerox and all that other kind of stuff and use more of an electronic environment?

Ms. KUSTER. Great.

Mr. MCINTYRE. One of the gaps that we discovered in Phoenix as we and the VA got together to evaluate what went well and what didn't go well as we moved through August 17 was that the pipes that we had set up didn't allow for the efficient movement of information or the effective movement of information.

So prior to that time most of the medical records from the community care were not getting back to the VA even though they were buying the care directly. One of our obligations and Health Net's obligations was to actually make sure that that happens. We built it in before we pay the provider. So there is an incentive to return it. So we got a lot of this back. It went into a portal. And what we discovered was that the VA staff found a very labor-intensive process that did not work.

So we and they sat together in a room with a black belt group that actually helped them redesign what those tools were going to look like. We are rolling those out starting the 26th of May, right after Memorial Day. And so we are revamping the entire process, and every geographic space we are responsible for will now get a rearchitected approach to how that works.

Dr. TUCHSCHMIDT. And just in 10 more seconds, I think ultimately the ideal situation is if we had computable data moving back and forth, if we had the ability to exchange information between electronic record systems in the private community with our system. I think the state of the art across American healthcare is just not there yet to do that in a consistent and reliable way.

Ms. KUSTER. Well, from what we have heard in this committee, it can't be any harder than trying to exchange it with DoD. So thank you very much.

Thank you, Mr. Chair. I yield back.

The CHAIRMAN. Mr. Costello.

Mr. COSTELLO. Thank you, Mr. Chairman.

We are here to talk about the Choice Act, and obviously attendant with the Choice Act is making sure that there is accountability with the Choice Act. So Deputy Secretary Gibson, I want to ask you this question. According to an April 22, 2015, report, reported in the New York Times, the VA has not successfully fired anyone at all for wait time manipulation, which continues to be a source of frustration for many. Is it too hard to fire VA employees who have committed wrongdoing?

Mr. GIBSON. As I come into this organization from the private sector, what I find is it is hard to hire and it is hard to fire, and I think that is the case all across the Federal Government. I would tell you that we use, have used and continue to use every authority that we have at our disposal to be able to hold people accountable. But as we take actions, those actions, by law, have to be able to withstand an appeal.

Mr. COSTELLO. So mindful that there were 110 VA medical facilities who have maintained secret lists, what you are saying is that the actions that are ongoing within the VA are intended to root out those who have committed intentional wrongdoing relative to data manipulation?

Mr. GIBSON. Yes. There were actually 113 sites that were flagged.

Mr. COSTELLO. Very good.

Mr. GIBSON. And when they were flagged, it didn't mean that there was wrongdoing. It meant that there was something in the data in the survey that raised a question. A very large number of those were ultimately cleared by the IG, and we send a letter, a bill of clean health to those organizations so that they and their congressional delegation can become aware of that.

Others, the IG comes back with some questions, and we send in an investigative team where there are those particular questions, and there have been individuals where accountability actions have been taken, everything from a letter of reprimand up to removal. It is a relatively small number. There are dozens of additional of those that are either still with the IG or are still in the process of being investigated internally, and we are going to continue to pursue it until we have gotten through every single one of them.

Mr. COSTELLO. Let me direct your focus now to AIBs. Now, the Philly VARO serves about 800,000 veterans, including some in my congressional district. The IG report came out. Now, they have impaneled an AIB to more closely scrutinize it and I hope name names and start restoring some accountability to identify who did wrongdoing.

There have been AIBs appointed in a number of different—we can go to Denver, Wisconsin, Virginia—in instances where the AIB has not operated as effectively as it should, I am going to put it kindly. How do we go about explaining how those mistakes occurred? Do you think the AIB process is inherently flawed? How

do we make sure that moving forward the AIBs are performing at a high level with the expertise needed and with the independence needed to make sure that when findings are made there are no concerns that things are still being swept under the rug?

Mr. GIBSON. Yes. That is a great question. That was and still is a fundamental concern that I had in my earliest time, in my time as the acting secretary.

Mr. COSTELLO. And does that still persist?

Mr. GIBSON. That is why I set up the Office of Accountability Review. My perception is that VA was in the habit of not exercising appropriate accountability actions in the wake of mismanagement or wrongdoing. That is a generalization, but it was one that I held and still believe generally that that had been the case in the organization.

We set up the Office of Accountability Review in order to create that level of independence as part of recalibrating the organization's accountability action. So every senior executive investigation, every senior leader investigation, and those that are of particular note wind up being managed by the Office of Accountability Review. They appoint the AIB. And on any senior executive issue I am the deciding official. That is how I ensure that we are taking appropriate action in relation to the misconduct.

Mr. COSTELLO. To the appointment of the AIB or to the AIB's findings?

Mr. GIBSON. The Office of Accountability Review appoints the AIB and we ensure that we have got individuals that are independent of the organization where the alleged activity has occurred. The Office of Accountability Review charges that AIB. And on a senior executive, I am the deciding official to ensure—

Mr. COSTELLO. So if an AIB is with a broad brush doing an investigation and as part of that investigation you have senior officials that may be the subject of inquiry, you are signing off on it to make sure that you have the expertise and the independence sufficient to do the investigation.

One final question. Puerto Rico VA, there is a report indicating that a potential whistleblower was threatened with fines of up to \$20,000 for leaking information. Are you familiar with this generally?

Mr. GIBSON. I am generally familiar with it, and I have directed the Office of Accountability Review to dig in.

Mr. COSTELLO. And you can appreciate how important it is for VA employees across the country to have assurances that whomever, if this threat did in fact happen, that it needs to be dealt with swiftly because it is the intimidation element here that shuts down. In Philly VARO, you have some whistleblowers that will not come forward but channel their whistleblowing through another whistleblower who is willing to step up based on the fear of retaliation.

Mr. GIBSON. Bullying, retaliation, intimidation is absolutely unacceptable, and I send that message, Bob sends that message every opportunity that we get. The other thing that I have messaged across the organization is we will not change the culture of VA unless we hold people accountable, and that is why this gets as much of my time and attention as it does.

Mr. COSTELLO. Thank you. I yield back.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. And before I begin, I want to make a couple of quick announcements. First of all, May 26, the opening of the Orlando VA hospital. Is that correct?

Mr. GIBSON. It is, yes, ma'am.

Ms. BROWN. Okay. Good. So I have heard it here and I am going to be down there, so it better open.

And the next thing is on May 29 is when I am planning on going to Denver. So any of the members that would like to go with me on the 29th, that is my date, because I really want to see the facility and really get a on-hands, in-person update on it.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. So that is May 29.

And before I just begin my questioning, also I just want the chairman to know that I voted for the Florida lottery and that was the worst vote I have ever taken in my life, and I regret that one.

Now, on to the questioning. Thank you, Ms. Hoffmeier, for coming to Jacksonville. I thought that was extremely helpful. Not only did we meet with the veterans, but we also met with the stakeholders and various community leaders and organizations to get a clear understanding of the Choice Program.

Some of the veterans were saying that the program wasn't working. Well, the program just started. And one of the things that we in Congress demanded, that we sent a Choice card to all of the veterans, whether they was eligible or not. And so that created some confusion. And can you address that first? Both of you.

Ms. HOFFMEIER. Thank you again, Ms. Brown, for the opportunity to attend the meetings with you in Jacksonville. They were invaluable.

I think there is no question that there has been a lot of confusion created by the card. Actually, we heard that, as you just said, firsthand at the meeting and that was probably one of the most helpful discussion points with veterans after the meeting.

I was asked yesterday a question at the Senate VA Committee hearing that, to be honest with you, threw me a little bit at first but it was whether I had any credits cards. And the reason that was asked was because with a credit card you receive, about a four-page set of rules in teeny, tiny print once a year, and what do most people do with that? Unfortunately, they throw it out. It is too hard to read.

And one of the things that we worked very collaboratively with VA on at the beginning in mailing the cards out was trying to make sure we designed the envelopes and the letters so it was very clear it was official mail and that a veteran would read it. But that may not have been the case in every case. And I think one of the things that we need to continue to do together is to try to make it very easy for veterans to understand the program, and we need to do more outreach and more education, and really would welcome more opportunities like the one we had in Jacksonville with you. So thank you for that.

Ms. BROWN. Thank you.

Dr. Gibson, the article came out in the paper several times that my Jacksonville clinic or vet service is one of the worst in the country. And so I have had many meetings with veterans. And I needed

to know the definition of what is the worst in the country. And of course, it is not the service at the VA. Once they get in there, they think it is the best. It is actually getting in there.

And when we built the clinic, it was already overflowing. And that has happened throughout the country because now that we have this new awareness, then more veterans are coming forward and we have got to figure out how to serve them. And I guess it is a little bit of confusion on all of our parts.

Mr. GIBSON. Yes, ma'am. As I alluded to generally in my opening statement, what we are finding in instance after instance is we take a step, make a major investment to improve access to care, and we get a disproportionate response and additional demand. That is telling us that there is pent-up demand among veterans for additional care at VA. I think clearly that was the case in Jacksonville.

I will tell you, one of my points of frustration. I visited Gainesville, Florida, on the 26th of June. It was on that day that I directed that the team there, that has responsibility for the Jacksonville outpatient clinic, to go find space in the community so that we could expand access to care and get additional providers. We are hoping—we are hoping—to be able to see veterans in that space in August.

And I am told that that is at light speed as we have worked through the acquisition process associated with being able to go lease 20,000 square feet of space. And so that is not responsive to the needs of veterans.

I would tell you, it hasn't come up. We are talking about Choice, we got 27 leases that were authorized in the Choice Act. On average, we are saying right now it is going to take us 5 years to activate those facilities. That is unacceptable. That is not responsive to the needs of veterans.

We have been doing Lean Six Sigma on that process to try to figure out how we accelerate it, and maybe we have trimmed 4 or 5 months off. That is not acceptable. We have to find a better way to do that in order to meet the needs of veterans.

Ms. BROWN. What I want to know is what is it that we can do. You talked about flexibility. We need to know exactly what kind of flexibility that you have had. Because I have talked to some of our stakeholders. For example, you said UF Shands, they want to be partners. All 400 of their physicians have signed up for the Choice Program. I mean, we have a hospital right there, right next to it that can provide additional space. And trying to get the Choice with the community, the other program that is already in place, and what is the difference between the two? I mean, why is it that we can't speed it up?

Mr. GIBSON. We will actually be providing specific language that support each of the individual requests that I have identified in my opening statement, and that includes that kind of flexibility that would allow us to be able to utilize Choice for a lot of that care.

Ms. BROWN. Last thing. I mean, the Denver issue we are discussing and trying to figure out how we are going to come up with the flexibility because we don't need to leave Denver without the funding source that they need. But many Members have said: Well, we don't want to take the money from the Choice Program. And I

certainly don't want to take it from the \$5 billion that we have gotten to provide additional physicians, additional clinics, or whatever we need.

And you say: Well, Denver is not my area. Our responsibility on this committee is for veterans all over the country. And so we have got to work to figure out how we are going to meet these extremely challenging areas of—

Mr. GIBSON. Yes, ma'am.

Ms. BROWN [continuing]. Funding these other facilities that are almost ready, but the cost overruns. And when we say cost overruns, was that a realistic cost in the beginning?

Mr. GIBSON. I think all the evidence indicates that it was not.

Ms. BROWN. You got an answer to my question, though?

Mr. GIBSON. Well, the answer is, yes, we have to find a way to pay for that. In prior years I would tell you there would have been much more flexibility inside VA. We are doing everything we can, Hepatitis C, access to care in the community, additional hiring, accelerating hiring, trying to improve access to care. This is not the time where we can go find \$700 million sitting on the sidelines somewhere. There are no easy answers.

If we are permitted to access the \$5 billion, we will get the minor construction programs into the 2017 budget, we will work all those nonrecurring maintenance items into the 2017 and the 2018 budget to the extent that the budget amount will allow us to do that, so that it is not an open-ended delay in those particular projects. But we are out of alternatives in terms of finding a place to cover that cost.

Ms. BROWN. Well, let me again thank you for your service and all of you all for your testimony this morning.

Mr. GIBSON. Yes, ma'am.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. Thank you for the consideration.

Mr. McIntyre, before I ask a question of you, I just want to say that you used to provide care in Colorado. And I want to commend you. You had an excellent reputation, your whole organization, and you did an exemplary job. So thank you.

Mr. MCINTYRE. Thank you, sir.

Mr. LAMBORN. I know that you pay the providers in your network promptly, it sounds like. But my question isn't that, but how promptly are you paid by the VA so that you in turn can pay the providers in your network?

Mr. MCINTYRE. Well, we are paying the providers with our funds, and then we seek to gain reimbursement from the VA.

I would say at this point it is actually working reasonably well. And it takes a little while to get the gears moving. You have to make sure when you are establishing something new that you have stress tested whether the paper that is being submitted is worthy of payment. So you have got that issue on their side, they have done an appropriate job at that. But we have payment streams that are starting to move.

And I think, based on what we have seen so far, we will hit a rhythm. And I am pretty confident that if we face a problem in that space, given what we are responsible for, that the Deputy Sec-

retary and the team underneath him would be very focused because that is what they have demonstrated today.

Mr. LAMBORN. Do you have a timeframe you could give us?

Mr. MCINTYRE. Timeframe for?

Mr. LAMBORN. On how quickly you are reimbursed?

Mr. MCINTYRE. I could pull some information for you. I don't have it at the top of my fingertips.

We do have a few spaces where we have got some arrears, but those things are being attended to. The challenge is that some of this has to run through each VA medical center given the uniqueness of some of these programs.

Mr. LAMBORN. Okay.

Mr. MCINTYRE. We are in good shape.

Mr. LAMBORN. All right. Thank you.

Now, Mr. Gibson, I am going to ask you about an unrelated matter, because I am going to take advantage of the fact that you are here in front of us today. So you may not be 100 percent prepped on this, but I am sure it is something you are following.

Mr. GIBSON. I will give it a try.

Mr. LAMBORN. Earlier this week there was an article in the Wall Street Journal and it talked about the computerized disability assessments. And it said that there was a high error rate, because probably in the desire to save time. But anyway, the result was there was less human interaction. The reviewer wasn't allowed or the program didn't accommodate individual comments that may help give a more rounded picture, a more complete picture of the disability. So what is your response to that article in the Wall Street Journal?

Mr. GIBSON. Since I have been busy preparing and testifying these last couple of days, I haven't had the chance to do the deep dive on that issue. That is tomorrow. I would tell you, as I am recalling, the person that was quoted in the article had left VA in 2012, had worked at VA for many years, and I suspect the context within which that person had experienced claim processing was one of a paper-based process where you had individuals sitting and turning every single page.

Our duty to assist means that the claims raters are basically looking at every single piece of evidence that sits in that file. Part of what we have done here is gone through a paradigm shift in terms of how we operate and harnessing automation to be a tool for individuals to be able to make well-informed decisions. It is not to take information out of their hands, it is to make the information more readily available. They still have the obligation to review all the evidence in the file when they are making that particular decision.

Now, having said all that, I will do the deep dive starting tomorrow so that I can understand more substantively if there is a particular part of the VBMS system that this individual was making reference to so that I can understand what the specifics are.

Mr. LAMBORN. Okay. Thank you. I think everyone would agree, we want those assessments to be as accurate as possible.

Mr. GIBSON. Absolutely.

Mr. LAMBORN. Not too low or not too high. I mean, it has to be accurate.

Mr. GIBSON. Doing the right thing for veterans and being good stewards of taxpayer resources. It is both at the same time. And if we are granting disability when there is not an entitlement for that, we are not doing the right thing for the taxpayer.

Mr. LAMBORN. Mr. Chairman, maybe we can hear more about that at one of our future hearings. Thank you, and I yield back.

The CHAIRMAN. Thank you very much. We appreciate the first panel.

I would read one thing out of the Choice Act law that says that: It is the sense of Congress that the Veterans Choice Fund is a supplement but distinct from the Department of Veterans Affairs' current and expected level of non-Department care currently used by the Department's medical care budget. Congress expects that the Department will maintain at least its existing obligations of non-Department care programs in addition to but distinct from the Veterans Choice Fund for each of the fiscal years 2015–2017.

Mr. GIBSON. And I am very familiar with that provision, and my interpretation of that language has always been that the idea was don't let VA use Choice money instead of using money for other care in the community programs and then take and divert those funds someplace else. We have done exactly the opposite. We have, in effect, overused care in the community.

The CHAIRMAN. I appreciate it very much, but while I agree with the desire to manage to requirement, you have a budget, and there have been decisions made within that budget that busted the budget. You are trying to backfill that budget now by extracting from one fund and then talking about using the Choice Program as the default program, which sounds great. But when you are pulling money out of the other program that was supposed to be supplemented it is going to drain the money out of the Choice Program much quicker than it was originally intended.

So while I appreciate the magical accounting that your folks have figured out, that is not the intent of Congress. And we will work with you in the budget on Hep C. I get it. But somebody was asleep at the switch on the request. I mean, \$100 million, then it goes to \$600 million, that is almost like the Aurora hospital at 350 to 1.75. Somebody has got to get better at forecasting. And I know you and the Secretary are working very diligently—

Mr. GIBSON. We are.

The CHAIRMAN [continuing]. In order to correct that, so this is not aimed specifically at you, but maybe to the bean counters within the Department that are trying to find the dollars. But this is not a place to look.

And I appreciate very much everybody being here today. We have got a second panel to go to. So thank you very much.

Mr. ABRAHAM. [Presiding.] Appreciate you guys being here.

Joining us on the second panel is Darin Selnick, Senior Veterans Affairs Advisor for the Concerned Veterans for America; Carlos Fuentes, Senior Legislative Associate for the National Legislative Service of the Veterans of Foreign Wars of the United States; Roscoe Butler, the Deputy Director for Healthcare for the Veterans Affairs and Rehabilitation Division of the American Legion; Joseph Violante, Legislative Director for the Disabled American Veterans;

and Christopher Neiweem, the Legislative Associate for the Iraq and Afghanistan Veterans of America.

Thank you for all being here.

Mr. Selnick, we will start with you. You have 5 minutes, sir.

STATEMENT OF DARIN SELNICK, SENIOR VETERANS AFFAIRS ADVISOR, CONCERNED VETERANS FOR AMERICA; CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; ROSCOE G. BUTLER, DEPUTY DIRECTOR FOR HEALTHCARE, VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION; JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND CHRISTOPHER NEIWEEM, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF DARIN SELNICK

Mr. SELNICK. Chairman Miller, Ranking Member Brown, and members of the committee, I appreciate the opportunity to testify at today's hearing on the Choice program, and thank you for your leadership in ensuring that veterans get the quality healthcare they deserve.

Today, true choice in veterans healthcare remains out of reach for most veterans. Like a mirage in the desert, as you move closer, it recedes into the horizon.

Our assessment is that the Choice program has been unsuccessful and is not a long-term solution. As such, we have developed recommendations for comprehensive reform through the bipartisan Fixing Veterans healthcare Task Force. The current rules pertaining to Choice do not represent real choice. Instead, they require veterans to obtain approval from VA before they are able to make a choice. Veterans should not have to ask for permission to select their healthcare provider.

VA implementation of the Choice program has been a failure. For example, the Associated Press has reported "GAO says veterans' healthcare costs a high risk for taxpayers." The number of medical appointments that take longer than 90 days to complete has nearly doubled, and that only 37,000 medical appointments have been made through April 11.

Last fall, CVA commissioned a national poll of veterans. The result showed 90 percent favored efforts to reform veterans healthcare; 88 percent said eligible veterans should be given the choice to receive medical care from any source they choose; 77 percent want more choices, even if it involved higher out-of-pocket costs.

Choice and competition are the bedrock of today's healthcare system. We choose our healthcare insurance provider and primary care physician. Healthcare organizations provide quality and convenient care because they know if they don't, they will lose their patients to someone else. In order to fix the VA healthcare system, both choice and competition must be injected into the system.

VA has recognized this when they said, "Evaluation options for potential reorganization that puts the veteran in control of how,

when, and where they wish to be served. Unfortunately, veterans do not have that control, and will not under the current VA healthcare system. VA needs a 2015 healthcare system. We believe the Veterans Independence Act is a roadmap and solution to do just that. This roadmap was developed by the Fixing Veterans healthcare Task Force, co-chaired by Dr. Bill Frist, former Senate majority leader, Jim Marshall, former Congressman from Georgia, Avik Roy of the Manhattan Institute, and Dr. Mike Kussman, former VHA Under Secretary.

We first developed 10 veteran-centric core principles that serve as the guiding foundation. These principles included: The veteran must come first, not the VA. Veterans should be able to choose where to get their healthcare. Refocus on and prioritize veterans with service-connected disabilities and specialized needs. VA should be improved and thereby preserved. Grandfather current enrollees. And VHA needs accountability.

To implement these principles, we laid out three major categories of reform and nine policy recommendations:

First, restructure the VHA's independent government chartered, nonprofit corporation. And power to make decisions of personnel, IT, facilities, partnerships, and other priorities; second, give veterans the option to seek private healthcare coverage with their VA funds; third, re-focus veterans healthcare and those service-connected injuries to VA's original mission. The key policy recommendations included separate the VA's payer and provider functions into separate institutions.

Establish the veterans health insurance program as a program office in VHA. Establish the Veterans Accountable Care Organization, VACO, as a non-profit government corporation fully separate from VA. Preserve the traditional VA health benefit for enrollees who prefer it, while offering an option to seek coverage from the private sector through three planned choices.

VetsCare Federal. Full access to the VACO integrated healthcare system with no changes to benefits or cost sharing. VetsCare Choice. Select any private healthcare insurance plan legally available in their State financed through premium support payments.

And VetsCare Senior. Medicare eligible veterans can use their VA funds to defray the cost of Medicare premiums and supplemental coverage. Lastly, create a VetsCare Implementation Commission to implement the Veterans Independence Act.

We retained the services of HSI to conduct the physical analysis. HSI determined a properly designed version of these policy recommendations is likely to be deficit neutral.

In order to fix veterans healthcare, we must always keep in mind what General Omar Bradley said in 1947. "We are dealing with veterans, not procedures. With their problems, not ours."

That is why we urge you to use the Veterans Independence Act roadmap to develop the legislative blueprint that will finally fix veterans' healthcare. Veterans must be assured that they will be able to get the quality and convenient healthcare they deserve. In this mission, failure is not an option. We are committed to overcoming any and all obstacles that stand in the way of achieving this important mission. We look forward to working with the chair-

man, ranking member, and all members of this committee to achieve this shared mission.

Thank you.

[The prepared statement of Mr. Selnick appears in the Appendix]

Mr. ABRAHAM. Thank you, Mr. Selnick.

Mr. Fuentes.

STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Chairman Abraham and Ranking Member O'Rourke, thank you for the opportunity to present the views of the men and women of the VFW and our auxiliaries.

The VFW has continued to play an integral role in identifying new issues the Veteran Choice Program faces, and recommending reasonable solutions.

Yesterday we published our second report evaluating this important program which made 13 recommendations to ensure that the program accomplishes its intended goal of expanding access to healthcare for America's veterans.

Our initial report identified a gap between the number of veterans who are eligible for the program and the number of veterans who were given the opportunity to participate.

Our second report found that VA has made progress in addressing this issue. Thirty-five percent of second survey participants who believed they were eligible were given the opportunity to participate. That is a 16 percent increase from our initial survey, yet we continue to hear from veterans who report that schedulers they speak to are unaware of the program or unsure how it works. For 30 day-ers, participation hinges on VA staff informing them of their eligibility. The lack of system-wide training for frontline staff has resulted in veterans receiving dated or misleading information. VA must continue to improve its processes and training to ensure all veterans who are eligible have the ability to receive healthcare in their communities.

Our second report also validated that veterans are satisfied with their VA healthcare experience if they receive timely access. 90 percent of survey participants who received care within 30 days reported that they were satisfied with their VA healthcare experience. Satisfaction dropped to 67 percent for participants who waited longer than 30 days.

The 40-mile standard used to establish geographic-based eligibility for the Veterans Choice Program does not properly account for the diversity of the veterans' population. Thirty-six percent of veterans enrolled in the VA healthcare system live in rural areas. Many of them are required to travel more than 40 miles for general goods and services. On the other hand, some urban veterans live within 40 miles of a VA medical center, but are required to travel several hours for their care.

Our second report found that a commute time standard, based on population densities, would more appropriately reflect the travel burden veterans face when accessing VA healthcare.

Section 201 of the Choice Act mandated 12 independent assessments of the VA healthcare system. One of those being carried out by the Institute of Medicine will evaluate how VA measures wait times; however, none of them evaluate the 40-mile standard. Con-

gress and VA must commission a study to determine what is an appropriate measure for the geographic burden that veterans face when traveling to VA medical facilities.

As the future of the VA healthcare system and its purchased care model are evaluated, it is important to recognize that the quality of care veterans receive from VA is significantly better than what is available in the private sector. Moreover, many of the VA capabilities cannot be duplicated or properly supplemented by private sector healthcare systems, especially for combat-related mental health conditions, blast injuries AND service-related toxic exposures, just to name a few. With this in mind, VA must continue to serve as the initial touch point and guarantor of care for enrolled veterans.

Although enrollment in the VA healthcare system is not mandatory, and despite more than 80 percent of the veterans having other forms of healthcare coverage, more than 6.5 million veterans choose to rely on their earned VA healthcare benefits and are, by and large, satisfied with the care they receive.

Moving forward, the lessons learned from the Veterans Choice Program should be incorporated into a single systemwide non-VA care program with veteran centric and clinically driven access standards which afford veterans the option to receive care from the private sector if VA is unable to meet those standards.

More importantly, non-VA care must supplement the care veterans receive from VA medical facilities, not replace it. Ideally, VA would have the capacity to provide timely access to direct care to all the veterans it serves. We know, however, that VA medical facilities continue to operate at 150 percent capacity and may never have the ability to expand care to deliver direct care to all the veterans it serves. VA must continue to expand capacity based on staffing models for each healthcare specialty and patient density thresholds.

However, VA cannot rely on building new facilities alone. When thresholds are exceeded, VA must use leasing and sharing agreements with other healthcare systems when possible, and purchased care when it must.

Mr. Chairman, this concludes my testimony. I am prepared to take my questions you or the committee members may have.

[The prepared statement of Mr. Fuentes appears in the Appendix]

Mr. ABRAHAM. Thank you, Mr. Fuentes.

Mr. Butler, you have 5 minutes.

STATEMENT OF ROSCOE G. BUTLER

Mr. BUTLER. Chairman Abraham, Ranking Member O'Rourke and distinguished members of the committee, on behalf of our National Commander Michael Helm and the 2.3 million members of the American Legion, we thank you for this opportunity to testify regarding the American Legion's views of the progress of the Veterans Choice Program.

The American Legion supported the Veterans Access Choice and Accountability Act of 2014 as a means of addressing emerging problems within the Department of Veterans Affairs. VA's wait times for outpatient medical care had reached an unacceptable

level nationwide as veterans struggled to receive access to timely healthcare within the VA healthcare system. It was clear that swift changes were needed to ensure veterans could access healthcare in a timely manner. As a result, the American Legion immediately took charge by setting up veterans benefit centers, or VBCs, in big and small cities across the country to assist veterans in need and their families as a result of the systemic scheduling crisis facing the VA.

The American Legion VBC's charge is to work firsthand with veterans experiencing difficulties in obtaining healthcare or having difficulties in receiving their benefits.

On November 7, 2014, VA rolled out the Veterans Choice Program, and after 6 months, it is clear the program falls short of the initial projections from the CBO. According to the VA's latest daily Choice metrics dated March 31, 2015, there were approximately 51,000 authorizations issued for non-VA care since implementation of the Choice program, with about 49,000 appointments scheduled. When you compare those numbers to the over 8 million Choice cards issued, one would ask, why did VA issue so many Choice cards?

Nevertheless, the American Legion is optimistic that the recent rule changed by VA eliminating the straight-line rule and using the actual driving distance will allow more veterans access to healthcare under the Veterans Choice Program. The American Legion also believes if VA were to move forward with the 40-mile rule change to only include a VA medical facility that can provide the needed medical care or services, everyone would see increases in utilization and access to non-VA healthcare.

The American Legion applauds the Senate for unanimously passing an amendment reminding the Department of Veterans Affairs that they have the obligation to provide non-VA care when it cannot offer that same treatment at one of its own facilities that is within the 40-mile driving distance from the veteran's home.

We now call upon the House to take up H.R. 572, the Veterans Access to Choice Care Act, and ensure its swift passage. Let's get the bill to the President's desk and make sure we are taking care of our rural veterans.

During a recent visit last month to examine the healthcare system in Puerto Rico, the American Legion learned that VA staff had been mistakenly telling veterans that no one on the island is eligible for healthcare under the Veterans Choice Program because there is no medical facility that is further than 40 miles from anywhere on the island. The American Legion is concerned that as a result of inadequate training, there could be staff at many VA healthcare facilities who failed to receive proper training as a result, and are communicating incorrect information.

While VA has issued a number of fact sheets and press releases, VA has not issued a single national directive and supporting handbook which sets forth VHA policy and operational procedures on the Choice program. VA failure to issue such national policies and procedures and tie them to existing VHA policies and procedures contribute to inconsistencies in implementation and staff failure to understand key principles of the program. Fact sheets and press releases are great, but they are not VHA policy and procedures.

In fiscal year 2014, VA spent \$7 billion on national—on non-VA care. Many of VA's non-VA care and programs are mandated by different program offices and VA central office, and some of the programs are handled outside of VA's fee basis claims processing systems.

VA should streamline its current purchased care model to incorporate all of non-VA's care programs into a single integrated program.

Thank you again, Mr. Chairman, ranking member. I appreciate the opportunity to present The American Legion's views and look forward to answer any questions you may have.

[The prepared statement of Mr. Butler appears in the Appendix]

Mr. ABRAHAM. Thank you, Mr. Butler.

Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Chairman Miller, Ranking Member Brown, and members of the committee, on behalf of DAV and our 1.2 million members, all of whom were wounded, injured, or made ill from their wartime service, thank you for the invitation to testify on progress of the temporary Choice program. While it is too early to reach definite conclusions about this program, we are beginning to see some early lessons. Utilization of Choice program is lower than expected, and that can be attributed to a number of factors.

First, since the crisis erupted last spring, VA has used every available resource to increase its capacity to provide timely care. That probably has shifted some of the demand away from Choice.

Second, VA was slow in rolling out Choice cards and in educating its staff, and that confusion continues to discourage some veterans today.

Finally, some veterans simply prefer to use VA.

Mr. Chairman, we understand that desire to quickly fix the Choice program and to overhaul how VA provide care inside the system and in the community. But it could be a tragic mistake to rush towards permanent, systematic solutions with unknown consequences that would gamble with something as important as—to veterans as VA healthcare system. That is why the Choice Act mandated a commission to carefully study and work towards consensus recommendations on how best to reform VA.

Recently, DAV, VFW, the American Legion, IAVA, and other VSOs signed a joint letter calling on Congress to give the commission enough time to do its job properly. And once the commission issues its final report, then allow sufficient opportunity for stakeholders in Congress to engage in a debate worthy of the men and women who served.

For more than 150 years, going back to President Lincoln's solemn vow "to care for him who shall have borne the battle," the VA healthcare system has been the embodiment of our National promise. Yet you have heard one proposal today from the CVA witness calling for VA to become just another Choice among healthcare providers. But if you actually read their report and look behind their poll-tested sound bites, you can clearly see what they are intending is for VA to be privatized and downsized. And under their proposal, VA could even be eliminated if that is what the market chooses.

But for millions of veterans, the most seriously disabled, there is only one choice for receiving the specialized care they need, and that is a healthy and robust VA. Although VA provides comprehensive medical care to more than 6 million veterans, VA's primary mission is to meet the unique specialized healthcare needs of the Nation's 3.8 million service-connected disabled vets. If VA was privatized, downsized, or eliminated, as the CVA proposal could lead to, would the civilian healthcare system actually be able to provide timely access to specialized care that disabled veterans require?

Even if all disabled—service-disabled veterans were dispensed in the civilian healthcare system, they would be just 1.5 percent of the total adult population. Does anyone truly believe that a market-based private sector healthcare system would provide the focus and resources necessary to ensure the highest standards of specialized care for this small minority in the same way that VA does?

Mr. Chairman, we can and must do better for the men and women who have sacrificed so much for our freedom.

In DAV's written testimony, we have outlined a framework for how to rebuild, restructure, realign, and reform the VA healthcare system. We need to rebuild VA's capacity to provide high-quality, patient-centered care, restructure non-VA care programs to ensure timely and seamless access, realign VA's healthcare services to meet the needs of the next generation of veterans, including women veterans, and reform VA's management with greater transparency and true accountability.

Mr. Chairman, this framework is not intended to be a final or detailed plan, nor could it be at this point. But it offers a pathway forward to a future that would keep the promise Lincoln so eloquently laid out.

That concludes my testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Violante appears in the Appendix]

Mr. ABRAHAM. Thank you, Mr. Violante.
Mr. Neiweem.

STATEMENT OF CHRISTOPHER NEIWEEM

Mr. NEIWEEM. Thank you, Chairman Abraham, Ranking Member O'Rourke, and distinguished members of the committee.

On behalf of Iraq and Afghanistan Veterans of America and our nearly 400,000 members and supporters, thank you for the opportunity to share our views with you at today's hearing, assessing the promise and progress of the Choice program.

IAVA was one of the leading veterans organizations involved in the early negotiations on the Veterans Access to Choice and Accountability Act as it was being drafted and the breadth of its final language was debated. This is a highly complex law that the Department is continuing to work to effectively implement in order to ensure veterans are not left waiting unacceptable lengths of time to receive healthcare services.

My remarks will focus on the experiences of utilizing the VA Choice program IAVA members have recently reported by way of survey research. Additionally, I will provide recommendations Con-

gress and the Secretary must consider in order to get the program operating at the height of its potential.

These recommendations include legislative clarification of the eligibility criteria for assessing the Choice program; strengthening training guidelines for VA schedulers charged to explain the eligibility criteria to veterans; and active engagement with veteran organizations to more broadly identify a comprehensive strategy and plan for delivering non-VA care in the future.

In examining the current criteria for determining which veterans are eligible to use the Choice program, those who must wait longer than 30 days for an appointment and those who live more than 40 miles from a VA medical facility, more statutory clarity is required. Veterans are all too frequently reporting they are unsure if they are eligible for Choice, and VA has, in some cases, been inconsistent in communicating whether or not a veteran can access it in individual cases.

Over one-third of IAVA members have reported they do not know how to access the program. This is compounded by reports that, in some case, VA scheduling personnel are not explaining eligibility for Choice to veterans and are then offering appointments off the grid of the 30-day standards, and sometimes, much later. I know because I had experienced it myself just last month at the VA medical facility here in DC.

The Secretary must continue to engage VA front-facing scheduling personnel with ongoing and evolving training standards so when veterans call the VA, they hang up the phone with the correct or best answer that explains their Choice eligibility. The VA has improved in this area, but with so many veterans still confused about Choice and eligibility nearly 9 months after the program's birth, training criteria must be strengthened and maintained to get it right.

Congress should aid in the Department's implementation efforts by clarifying in law that the 40-mile criteria must relate specifically to the VA facility in which the needed medical care will be provided.

The frustrating example that has surfaced is one of a veteran that requires specialized care in a VA facility outside of 40 miles, but through strict interpretation of current VACAA law is ineligible for participation because a local CBOC may be geographically near the veteran's address, notwithstanding that facility cannot provide the required care.

One of our members illustrated one of these cases with the following statement. "Because there is a CBOC in my area, I was denied. The clinic doesn't provide any service or treatment I need for my primary service-connected disability. The nearest medical center in my network is 153 miles away."

Congress must provide much-needed clarity and work with VA to eliminate cases like those just described. However, VA's action to step up to fix the initial ineffectiveness of the 40-mile rule calculations under regulation as it related to geodesic distance versus driving distance is encouraging. That regulatory correction was much needed, and we applaud the Secretary for leading to make that change happen.

VHA's statistics on Choice utilization among the veteran population as of this month state there have been nearly 58,863 authorizations for care, and nearly 47,000 appointments for care. This data verifies that veterans are out and they are using the program, and VA is making progress to implement what is clearly a complex and historic mandate relating to the punishment of veterans healthcare now and in the years to come.

IAVA is committed to remaining actively engaged with veterans making use of Choice care so we can keep current on the veteran experience. We are mindful that with thousands of appointments for care being concluded, there will inevitably be thousands of unique experiences we want to know about to gauge the satisfaction that these veterans are having with the program. The satisfaction of the veterans utilizing Choice, the cost of the care purchased outside of VA facilities, and understanding issues that come up along the way will allow us to better identify the scope and role of the concept Choice plays in the future.

We appreciate the hard work of Congress, the VA, and the veteran community, and recognize we have to stay focused on improving veteran healthcare delivery in the short term and long term. Robust discussion on the scope and cost of maintaining healthcare networks is complicated and multi-layered, which is why our last recommendation is simple. We must continue to work together and keep communication active among all relevant stakeholders.

Mr. Chairman, we sincerely appreciate your committee's hard work in this area. We also sincerely appreciate Chairman Miller's recently introduced Veterans Accountability Act, which we strongly support, your invitation to allow us to participate in this important hearing, and we stand ready to assist Congress and Secretary Bob McDonald to achieve the best results for the Choice program now and in the future, and happy to answer any questions you or members of the committee may have.

[The statement of Mr. Neiweem appears in the Appendix]

Mr. ABRAHAM. Thank you, Mr. Neiweem.

I have a question for the entire panel, and I will start with you, Mr. Selnick, and we will go down the line.

There are some serious concerns regarding the training the VA and the TPA staff have received during the Choice program. Moving forward, what are your recommendations for the VA and the TPAs to improve their training efforts for the Choice program?

Mr. SELNICK. Yes. Thank you, Mr. Chairman, for that question.

I used to work at the VA, and when I was at the VA for several years, I headed up the VA Learning University, which was the department-wide—first-ever department-wide education training. We did the first-ever strategic plan for VA.

VA has never fully implemented that strategic plan, and it strategically changed where it located its department-wide training over at HR. And so one of the problems is this whole training mechanism is faulty and does not work well.

I know they have been trying to improve that, but VHA has always had a poor record in terms of overall training developments and a lack of ability to go ahead and be flexible in terms of the way it does its training. Having worked at a number of healthcare organizations and understanding how important the flexibility and the

ability to change your training and update your training as needed as new situations come, VHA just does not have the inherent capability to do it. It needs to revitalize and update its strategic plan, and it needs to develop the flexibilities in concert with its EES, the VHA training system in concert with VA—to be able to take care of flex needs such as the Choice program.

Mr. ABRAHAM. Mr. Fuentes.

Thank you, Mr. Selnick.

Mr. FUENTES. So getting more than 300,000 staff members on the same page is going to be difficult, and we understand that, you know. But it is unacceptable that veterans continue to receive misleading information, or even dated information.

You know, we do commend VA for recognizing this issue, and I have to commend Dr. Tuchschnidt for being very receptive to all of our recommendations and being willing to listen to them even though he may not like what we are saying. And we have been informed that they are in the process of rolling out mandatory training for all VHA staff and specialized training for scheduling and fee basis staff. And that second part, I think, is the most important part. Because the scheduling staff and that frontline staff are the ones who are really interacting with the veterans, and they are the ones who really need to know the intricacies and nuances of the program.

You know, I don't think they are there yet, but with support from the leadership, which they have, I feel that they can get there.

Mr. ABRAHAM. Mr. Butler, do you have a comment?

Mr. BUTLER. The key to training is making sure you have articulated, defined policies and operational procedures. Those are the nucleus and the basis for VA staff to use and to educate staff members on the functions and roles of a program.

Prior to my position at the American Legion, I was the deputy director for policy for VA. And so in that area, you have to make sure that when Congress enacts a law, VA develops regulations, there are supporting policies in place to ensure that staff in the field understands the role, the functions, and the procedures for any new law that has been enacted. Without appropriate policies and procedures, that can lead to miscommunication among staff and senior leaders.

So, one of the important elements, as I stated in my testimony, is that VA has not issued any national policies or handbooks that define the operational role and procedures of the Choice program. And it also hasn't linked those policies and—linked anything to any other existing policies and procedures. So while you issue fact sheets and press releases, that is great. But VA needs to look at what are the guiding policies and procedures that they need to provide to field staff so that staff can use that information as a guide for training their staff.

Mr. ABRAHAM. Okay. Thank you.

Mr. Violante, real quickly.

Mr. VIOLANTE. Yes. I would associate myself with the comments made by my colleague from VFW, and just add, I think one of the biggest problems right now are there too many programs out there that have too many criteria that have to be met. And I think it should be simplified. I think we have heard it from both the first

panel and this panel that, you know, there should be one program for outside non-VA care, and it should be simplified.

Mr. ABRAHAM. Thank you.

Mr. Neiweem, real quick.

Mr. NEIWEEM. Yes, Mr. Chairman, I will just be more brief.

First and foremost, the vast majority of VA employees do a really great job when they have the right tools. I would associate myself with Mr. Butler specifically. A training guideline or a memo that can be very brief that could be in their office space. If A, here. If B, here, so that every single VA scheduler says the same thing getting off the phone, and try to create a memo with just that basic information in front of them.

Mr. ABRAHAM. Okay. Thank you. Good answers.

All right. Mr. O'Rourke.

Mr. O'ROURKE. Thank you very much.

You know, first I would like to note that Deputy Secretary Sloan Gibson is still here with us, and he is listening to your testimony right now as the other participants in the last panel are, and I think that is important in demonstrating the VA's commitment to not just listening and responding to us, but listening and responding to you. So I appreciate you being here, Mr. Gibson.

Mr. Fuentes, you, I understand, were working on the Senate side during the development of the Choice Act, and so you may be able to shed light on a question that I think was raised by the chairman of the full committee concerning budgeting. And the CBO when they were scoring the Choice Act assumed that these funds would be fully consumed bill early fiscal year 2016. Early fiscal year 2016 could be, you know, anytime in the next, you know, 6 to, let's say, 12 months. And yet so far we have only obligated \$500 million.

Any light you can shed on the miscalculation there?

Mr. FUENTES. Yes, sir. I did have the distinct pleasure of working for then-Chairman Sanders at the time.

I think the projections on utilization were over-calculated. I mean, VA was given 3 months to implement this very complex program. We are not surprised that there were many issues, to commend VA and TriWest and Health Net, they have been really fixing the problems as they go. I think that participation definitely needs to improve. The number of veterans eligible also needs to be improved, because we know that there are certain issues with the standard. I mean, the VFW is committed to ensuring that that standard serves the best interest of veterans, and we know that it doesn't right now. In terms of wait times, veterans are waiting too long.

Mr. O'ROURKE. I am sorry to interrupt you. I just—I wanted to—I understand that we are all trying to fix it, I am just wondering how the mistake was made in the first place in terms of projecting, but it may have to be a question answered at another time.

I want to follow up on another thing that you said, which was, the need to look at leasing and sharing facilities with other providers in the community.

Could you expand on that.

Mr. FUENTES. So you need to have an innovative look at how to expand capacity. You know, we have learned from many of VA's mistakes that building facilities and large facilities is not always

the best solution. When Fort Riley, Kansas is building facilities, then the local VA should say: Well, you know, what? We don't have the capacity to provide, women-specific services. DoD, MTFs you have been doing that for quite some time. Can we rely on you to meet that need for our veterans?

Same thing with Indian Health Services in Alaska. They are doing a great job of doing that, but in other areas where they are present, we can expand on that, but also, sharing agreements. Denver was originally supposed to be a shared facility with the medical with the school.

Mr. O'ROURKE. Right. And would you expand that to include private hospitals?

Mr. FUENTES. Yes. Better use of affiliated hospitals and hospitals across the street as well.

Mr. O'ROURKE. Not just DoD and other public services, but private hospitals.

All right. I think that is important, and I wanted to give Mr. Violante a chance to perhaps expand on his comments. I feel like you almost presented us with a false choice of privatizing or eliminating VHA, or just doing better with the mandate that we already have. But I am struck by the fact that we have 28,000 open positions within the VA, that wait times, despite the crisis following Phoenix, or at least the attention to the crisis that existed prior to the news about Phoenix, but in almost the year since then, wait times have not improved at the VA. To me, it is really clear that we owe it to veterans to try some things that might be uncomfortable, that may carry some risk with them.

I am not suggesting eliminating the VHA, but wanted to get your comments on what the threshold for experimentation might be, whether we can try pilot projects, for example, to see if we can't work better with private providers in the communities. Love for you to respond to that.

Mr. VIOLANTE. And, again, I don't think DAV has a problem with using private providers. My concern is where—where the report that CVA put out could possibly lead VA. I mean, we believe that no veteran should wait too long or travel too far, no enrolled veteran in VA healthcare. VA needs to be able to address their needs in the community if need be. My only concern is that if we are providing—and, again, whether you call it Choice or purchased care, you know, ARCH, or PC3, VA needs the ability to do that. It is just a matter of how they go about doing it and where that choice lies.

Mr. O'ROURKE. Thank you.

Thank you, Mr. Chairman.

Mr. ABRAHAM. Well, thank you again, gentlemen, for being here and for your patience. It has been some very good testimony. The committee may submit more questioning and we would ask for your expedience in answering those if so submitted.

If there are no further questions, you are now excused. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous materials. Without objection so ordered. I would like to, once again, thank all of you here.

This hearing is now adjourned.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

Thank you all for joining us for today's oversight hearing, "Assessing the Promise and Progress of the Choice Program."

We have two full witness panels ahead of us so I will keep my opening remarks short in the interest of time.

The Choice program was created last summer to address an unparalleled access to care crisis at the Department of Veterans Affairs (VA).

Six months after it was first implemented, the program has successfully linked thousands of veterans with quality healthcare in their home communities.

We can all be proud of that and I applaud VA and the two Choice program Third Party Administrators (TPAs)—Health Net Federal Services and TriWest Healthcare Alliance—for their initial efforts to quickly implement the program and their ongoing efforts to make it work well for the veterans who need it.

That said, the implementation and administration of the Choice program has been far from perfect and many veterans are still waiting too long and traveling too far to receive the health care they need.

There are many reasons for this—a lack of outreach to veterans who may be eligible, a lack of training for front-line VA and TPA staff, a lack of urgency on the part of many VA medical facilities who continue to adhere to their old ways of doing business—and I could go on.

During today's hearing we will discuss how to eliminate impediments to greater veteran and provider participation in the Choice program and how to ensure VA and TPA staff are properly trained and seamlessly coordinated to respond to veteran and non-VA provider questions and ensure the timely delivery of care.

We will also begin discussing where VA goes from here.

The Choice program is just one of many ways VA provides care outside of the Department's walls.

All too often VA's numerous purchased care programs and authorities operate in conflict with one another—using different eligibility criteria, different programmatic requirements, and different reimbursement rates to achieve the same goal.

That does not serve VA, American taxpayers, or—most importantly—veterans and their families.

As was stated many times last year, business-as-usual is not an option.

Congress has consistently met the Administration's budget requests for the Department of Veterans Affairs and, as a result, VA's total budget has increased by seventy-three percent [73%] since 2009.

In comparison, veteran patients have increased by only 32% since 2009.

Yet, VA has not and cannot fully meet the needs of the entirety of their patient population.

This illustrates clearly that VA's failures are not a matter of money, they are a matter of management.

There is no one way forward, but there can also be no mistaking that, by challenging VA's failing status quo approach to purchased care, we find ourselves at a crossroads of opportunity that never existed before.

I am encouraged by and in agreement with the numerous testimonies today that emphasize the need to build a coordinated managed care system that incorporates VA care along with needed community options and resources.

While working to improve the Choice program today, we must all prepare for the Choice program of tomorrow—one that brings the universe of non-VA care together under one umbrella so that the care our veterans receive is more efficient and effective, regardless of where it takes places.

However, I look forward to working with veterans, VA, veteran service organizations, and all other interested stakeholders on this effort, beginning with your statements this morning.

PREPARED STATEMENT OF CORRINE BROWN, RANKING MEMBER

Thank you, Mr. Chairman, for calling this hearing today. As you know, it has been about 9 months since the President signed the Veterans Access, Choice and Accountability Act into law. This hearing is one in a series of hearings designed to follow the progress and ability of the VA to provide healthcare to veterans in the twenty-first century.

I am sure we can all agree the VA provides the best healthcare for returning veterans in this country. However, we all know that there are challenges to this mission and the recognition that VA cannot do it all.

The Choice Program offers eligible veterans access to healthcare that they may not have had in the past. One of this Committee's highest priorities is to ensure that veterans receive the highest quality healthcare in a timely manner and in a safe environment. For those veterans who choose to use the Choice Program, I want to make sure that this is happening.

Mr. Chairman, VA has served the special needs of returning veterans for 85 years and has expertise in providing services that address their unique healthcare needs, including prosthetics, traumatic brain injury, Post Traumatic Stress Disorder (PTSD), and a host of other veterans specific injuries. My focus continues to be on ensuring that Veterans Affairs retains the ultimate responsibility for the healthcare of our veterans, regardless of where they choose to live. The VA is the best system we have to serve the health care needs of the veterans returning from war. We cannot allow circumstances that would render the system unable to serve the very veterans it was built to serve.

The DAV, in its submitted testimony, says "Although the VA today provides comprehensive medical care to more than 6.5 million veterans each year, the VA systems' primary mission is to meet the unique, specialized health care needs of service-connected disabled veterans. To accomplish this mission, VA health care is integrated with a clinical research program and academic affiliation with well over 100 of the world's most prominent schools of health professions to ensure veterans have access to the most advanced treatments in the world." I believe that says it all.

I look forward to hearing from the Deputy Secretary today and all the witnesses to learn how the VA can better treat those veterans who have given so much in defending the freedoms we all hold so dear.

**TESTIMONY OF
DONNA HOFFMEIER
PROGRAM OFFICER, VA SERVICES
HEALTH NET FEDERAL SERVICES
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 13, 2015**



Biography of Donna Hoffmeier

Donna Hoffmeier is Vice President and Program Officer, VA Services at Health Net Federal Services, LLC (Health Net), responsible for the daily leadership and management of Health Net's Department of Veterans Affairs (VA) programs. Her responsibilities include the management and oversight of Health Net's VA lines of business including the Patient-Centered Community Care (PC3) and Veterans Choice programs.

Ms. Hoffmeier has over 30 years of experience, success, and accomplishments in the private and public sectors as a senior executive, professional staff member in the United States House of Representatives, and military leader. Ms. Hoffmeier joined Health Net in 2006. Prior to joining Health Net, she served in a number of positions at UnitedHealth Group, including Vice President, Public and Government Strategy.

Ms. Hoffmeier worked in the federal government for over fifteen years, including five years of congressional staff service and nearly 11 years on active duty in the U.S. Navy. As a professional staff member on the House Armed Services Committee, she was responsible for evaluating and developing policy and legislation affecting the Military Health System. For the majority of her Navy service, Ms. Hoffmeier was a public affairs officer (PAO). Navy assignments included the Office of the Chief of Naval Information, PAO on board the hospital ship USNS Mercy during Desert Shield/Desert Storm, and Officer in Charge of the Navy Broadcasting Service Detachment in Rota, Spain.

A native of Florida, Ms. Hoffmeier earned a Bachelor of Arts degree in mass communication from the University of South Florida.

A History of Partnership

Chairman Miller, Ranking Member Brown, and Members of the Committee, I appreciate the opportunity to testify on Health Net's implementation and administration to date of the Department of Veterans Affairs' (VA) Patient-Centered Community Care (PC3) and Veterans Choice programs.

Health Net Federal Services is proud to be one of the largest and longest serving health care administrators of government and military health care programs for the Department of Defense (DoD) and Department of Veterans Affairs (VA). Health Net's health plans and government contracts subsidiaries provide health benefits to more than five million eligible individuals across the country through group, individual, Medicare, Medicaid, TRICARE, and VA programs.

For over 25 years, in partnership with DoD, Health Net has served as a Managed Care Support Contractor in the TRICARE Program. Currently, as the TRICARE North Region contractor, we provide health care and administrative support services for three million active-duty family members, military retirees and their dependents in 23 states. We also deliver a broad range of customized behavioral health and wellness services to military service members and their families, including Guardsmen and reservists. These services include the worldwide Military and Family Life Counseling (MFLC) program providing non-medical, short-term, problem solving counseling, rapid-response counseling to deploying units, victim advocacy services, and reintegration counseling.

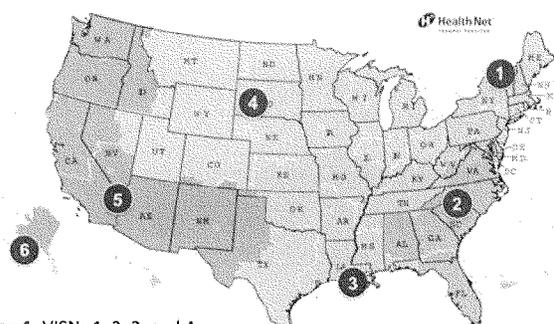
As an established partner of VA, Health Net has collaborated in supporting Veterans' physical and behavioral health care needs through Community Based Outpatient Clinics (CBOCs) and the Rural Mental Health Program. We also have supported VA by applying sound business practices to achieve greater efficiency in claims auditing and recovery, and previously through claims repricing. It is from this long-standing commitment to supporting the military and Veterans community that we offer our thoughts on the role of PC3 and Choice in augmenting VA's ability to provide eligible Veterans with timely access to needed health care services.

The Evolution of PC3 and Choice

The Department of Veterans Affairs developed Patient-Centered Community Care (PC3) to provide eligible Veterans access to health care through a comprehensive network of community-based, non-VA medical professionals. Care is available through PC3 when local VA Medical Centers cannot readily provide the needed care to Veterans due to limited capacity, geographic inaccessibility or other limiting factors. Services available through PC3 include primary care, inpatient specialty care, outpatient specialty care, mental health care, limited emergency care, limited newborn care for enrolled female Veterans following delivery, skilled home health care, and home infusion therapy.

In September 2013, Health Net was awarded a contract for three of the six PC3 regions. These regions include 13 of 21 VISNs; 90 VA Medical Centers in all or part of 37 states; Washington, D.C.; Puerto Rico; and the Virgin Islands.

Figure 1: Health Net Federal Services' Contracted PC3 Regions 1, 2 and 4



Region 1: VISNs 1, 2, 3, and 4
 Region 2: VISNs 5, 6, 7, and 8
 Region 4: VISNs 10, 11, 12, 19, and 23

Health Net phased in implementation of PC3 across our regions during a six month implementation period, with services starting for the first VA Medical Centers on January 6, 2014. We completed implementation of all remaining VA Medical Centers by April 1, 2014. Originally covering only specialty care, the PC3 program was expanded to include primary care in August 2014.

In August 2014, with the leadership of this Committee, Congress passed and the President signed into law the Veterans Access, Choice, and Accountability Act of 2014 (VACAA, Public Law 113-146, "Choice Act"), which directed the establishment of a new program to better meet the health care needs of Veterans. The law directs the establishment of a Veterans Choice Card benefit that allows eligible Veterans who are unable to get a VA appointment within 30 days of their preferred date or the date medically determined by their physician; reside more than 40 miles from the closest VA healthcare facility (there are different mileage rules for some states, such as New Hampshire and Hawaii); or face other specific geographic burdens in traveling to a VA facility to obtain approved care in their community instead.

In October, VA amended our PC3 contract to include several components in support of the Choice Act such as production and distribution of Choice Cards; establishment of a Choice call center to answer Veteran's questions about the Choice program and to verify eligibility for it; appointing services for eligible Veterans with Choice-eligible community providers; and claims processing. Since VACAA required implementation by November 5, 2014, we worked collaboratively with VA and TriWest (the contractor for the other three PC3 regions) to develop an implementation strategy with extremely aggressive timelines. This ambitious schedule allowed for minimal time to hire and train staff and to reconfigure our systems for the new program, which contains many requirements that differ from PC3 and therefore have to be

tracked and recorded separately. Despite the fast-paced implementation schedule, on November 5th, Veterans started to receive their Choice Cards and were able to call in to the toll-free Choice telephone number and speak directly with a customer service representative about the Choice program.

Engaging Collaboratively

From the start of discussions on implementation of VACAA, the VA Chief Business Office, Contracting Office, and senior VHA officials have worked closely with both contractors to establish priorities, provide policy guidance and develop process flows. As Choice implementation progressed, more policy and process items were identified. We collectively agreed to establish a Steering Committee and several Work Groups to address these items and to provide an effective forum for VA to provide clear policy decisions and program requirements. This approach has been valuable in identifying policy and process gaps, facilitating decision making designed to resolve any issues, and ensuring consistency across all regions. We have committed to making the appearance of the programs seamless for Veterans across the country, regardless of where they reside or which contractor provides service.

A key component to the success of both PC3 and Choice is acceptance by community providers. To accomplish our goal of providing Veterans with timely access to care in the communities in which they reside, Health Net proactively recruits providers to both PC3 and Choice. This is another area of collaboration with VA. In addition to public-facing, self-service information found on the Health Net website, we have attended community conferences to educate and engage providers.

A specific example of collaboration between VA and the Choice contractors to educate and engage providers is the effort to integrate Federally Qualified Health Centers (FQHCs). We are working very closely with VHA's Office of Rural Health on this effort, and participated with VA at the National Rural Health Association annual conference and National Association of Community Health Centers webinar. In addition, we have been very successful in working with the Virginia Primary Care Association to contract 26 FQHCs as VA Choice providers; our approach to outreach in Virginia has become a model we will pursue in other states. This collaborative effort has been invaluable in engaging the FQHCs – to date, we have recruited a total of 115 FQHCs to participate in Choice (27 FQHCs) or join our PC3 network (88 FQHCs).

Health Net also has spoken with several Members' offices about conducting provider outreach in their home districts. Recently, Health Net participated in two Choice education and outreach meetings organized by Ranking Member Brown in Jacksonville, Florida. These meetings provided an excellent opportunity to educate both Veterans and community providers on the Choice program. They also enabled Veterans and community providers to discuss challenges they have experienced with obtaining services through Choice. Based on the invaluable feedback from participants in these meetings, we have been working on some process enhancements to simplify participation for providers and to identify either process gaps or policy decisions that may be impacting the Veteran's experience with Choice. I would like to thank Ranking Member Brown for the opportunity to participate.

Results to Date

Under PC3, from program inception in January 2014 through April 13, 2015, VA has provided Health Net with over 150,000 authorizations for care in 75 specialty areas and primary care. The top six areas of specialty care, comprising about 50 percent of authorizations include: optometry, physical therapy, podiatry, primary care, orthopedics, and colonoscopy. To meet demand, Health Net's network presently includes almost 76,600 providers. Since the beginning of April 2015, Health Net has successfully recruited over 4,200 additional providers, including 27 hospitals.

From the inception of the Choice program in November through the beginning of May 2015, we have answered about 550,000 calls, with the vast majority of those calls coming from Veterans seeking information on Choice or requesting an authorization for care. About 30,000 Veterans have opted-in to the Choice Program with almost two-thirds eligible based on wait time. About 16,500 authorizations have been made for wait list eligible Veterans and nearly 10,000 authorizations have been issued for mileage-eligible Veterans. With the recent change in eligibility criteria based on driving distance, we expect a significant increase in demand for care for mileage eligible Veterans.

Moving Forward

Implementation of any new program is challenging, particularly when the change is significant and the implementation period is condensed into a very short timeframe. Working collaboratively with VA and our colleagues at TriWest, we were able to effectively stand up the Choice Program by November 5th, as required by the statute. In achieving this milestone, Choice cards were mailed out to all Veterans identified as eligible by VA, calls to the Choice 866 number were answered promptly, and Veterans have been able to exercise the option of obtaining care within their local community when the VA capacity is limited or the VA facility is far from the Veteran's home. Having said that, we know there have been bumps in the road with the accelerated rollout of Choice – delays in eligibility information being available, confusion over program details, and incorrect or sometimes conflicting information provided to Veterans. These bumps have understandably caused a level of Veteran frustration.

While the collaboration with VA since the start of the Choice program has been solid, there still is considerable work that needs to be done to resolve outstanding policy and process questions, adequately ensure appropriate staff training, conduct provider outreach, and enhance Veteran education. To that end, we would like to offer a few key recommendations for enhancing Choice that we believe will facilitate achieving a state where the program effectively optimizes VA capacity and enables VA to provide all eligible Veterans with access to the care they need in a consistent and gratifying manner.

1. **Consolidate non-VA programs**

Currently, there are multiple options for non-VA care, including Choice, PC3, local agreements/direct contracts and individual authorizations ("Fee"). Each option has different reimbursement levels, different requirements for community providers (requirements for return of medical documentation, credentialing, etc.), and different

“administrators” (VA Medical Center non-VA care staff, VA contracting staff, PC3/Choice contractors). These various options create enormous confusion with non-VA (community) providers, Veterans, VA Medical Center staff and contractor staff. Reducing the number of non-VA care options would help to reduce confusion.

We understand VA is about to address this issue. We commend VA for its efforts to resolve the challenges created by these multiple options for delivering care to Veterans when VA lacks the capability or capacity to provide it directly. VA has informed us of a number of key initiatives being planned to streamline non-VA care and to ensure Veterans have access to Choice. We fully support these efforts.

To ensure success as we move forward in support of Choice, we recommend VA develop a coordinated implementation strategy that clearly defines each initiative and lays out an execution schedule that is both aggressive and achievable. Currently, we receive around 10 percent of the non-VA care volume through PC3 and Choice. Moving from 10 percent to 100 percent requires a well-defined road map that is communicated to all key stakeholders – VISN and VA Medical Center leadership and staff, both contractors, Congress and most importantly, Veterans. As this effort moves forward, it is critical that certain steps be taken:

- Outstanding policy and process issues must be resolved
- Comprehensive training of VA and contractor staff must be conducted using consistent process flows and scripting
- Policy and operational documents and/or manuals should be developed and provided for use by VA facilities and both contractors

2. **Eliminate unnecessary impediments to community provider participation**

Consolidating options into one approach that also minimizes VA-unique requirements for community providers would have a very positive impact on the willingness of community providers to participate in Choice. Specific community provider challenges and impediments to participation include:

- Medical documentation requirements that are not consistent with commercial/community standards. VA requirements for medical documentation are often more detailed than accepted standard of practice in commercial health care. For example, PC3 and Choice require specific elements, short timelines, and provider signatures. VA asks for more documentation and more specific detail, such as provider social security numbers, than is typically provided in private sector health care. In addition, many of these requirements are not present in other non-VA care options.
- Delays in payment of medical claims due to return of medical documentation. Providers are not paid until medical documentation is returned and accepted by VA. This delays payments to providers who have already legitimately provided

the services and complied with the requirements to return medical documentation. Continued delays in payment will result in dwindling community provider participation and access problems could return.

- High level of appointment no-shows in the community. Currently, we are required to schedule appointments for Veterans we are unable to reach by phone, and then notify these Veterans of their appointment by mail. This process increases Veteran no-show rates and causes frustration with community providers. Community providers have no ability to bill VA for these no-shows, nor can providers bill the Veteran a fee. This process also creates frustration for VA Medical Center staff because Veterans show up for VA appointments that may have been cancelled due to their scheduled community appointment. More importantly, it means Veterans may not receive needed care in a timely manner. We think a modification to this process would reduce community provider reluctance to participate.
- Confusion on where to send documentation and claims. This issue is largely related to multiple non-VA care options and would be substantially aided by a more coherent (and smaller) set of options in non-VA care programs.
- Lack of timely follow-up for authorizations on needed additional services requested by provider for appropriate clinical care. PC3 and Choice services are authorized for "episodes of care." Once an episode of care is complete, additional authorizations are necessary, even for follow-on care that is normally considered standard of practice. This issue currently is being addressed by VA and much progress has been made already to ensure timely approval of requests for additional services. We appreciate VA working collaboratively with us to address this challenge.
- Primary care in 60 day increments for 30 day wait list eligible Veterans is difficult for primary care providers outside of urgent care settings.
- The 60-day limit on an episode of care under the Choice program creates challenges in certain clinical areas, such as chemotherapy, radiation oncology, and complicated obstetrics. With these types of care, it could be harmful to bring the patient back to VA part way through a course of treatment because the VA has availability at the 60 day point and the patient is no longer wait list eligible. There is similar risk if the patient changes address during a course of treatment but is still close enough to receive care from the Choice provider but is no longer eligible by distance criteria. Some flexibility to support continuity of care when it is important to veteran outcome would be very helpful.

Committed to Veterans' Choice

In closing, I would like to thank the Committee for its leadership in ensuring our nation's Veterans have prompt access to needed health care services. We believe there is great potential for the Choice program to help VA deliver appropriate, coordinated, and convenient care to Veterans. We are committed to continuing our collaboration with VA and TriWest to ensure Choice succeeds in providing Veterans with timely access to care when VA is unable to provide it. Working together, and with the support and leadership of this committee, we are confident that the Choice Program will deliver on our obligation to this country's Veterans.

Statement
David J. McIntyre, Jr.
President and CEO
TriWest Healthcare Alliance

House Committee on Veterans' Affairs
May 13, 2015

Good morning Mr. Chairman, Ranking Member Brown, and members of this distinguished Committee. I am grateful for the opportunity to appear before you this morning on behalf of our company's non-profit owners and employees to discuss TriWest Healthcare Alliance's work in implementing the Veterans Choice Program (VCP). More importantly, I look forward to discussing our ability to achieve our collective potential in meeting the needs of those who deserve our very best... our nation's Veterans.

Our Background

TriWest is intentionally in business only to serve those who serve; which has been the case for nearly 20 years. And during our entire history, the company I was fortunate to help found with a group of non-profit health plans and University Hospital Systems, and have been privileged to lead since, has focused exclusively on providing access to needed care when it is not able to be provided by the federal systems on which those in uniform rely. Our first 17 years were spent helping the Department of Defense (DoD) stand-up and operate the TRICARE program. And while we no longer support the DoD in that line of work, I'm proud of the work that we did to assist DoD in making TRICARE the most popular health plan in the country and meet the needs of millions across 21 states who relied on us for that support. And, as those of us who were around at the time can attest, we know it was neither an easy nor painless road. Now, working together with VA, I believe we can achieve the same results for the Veterans who look to VA for their health care needs.

PC3 Performance

Mr. Chairman, before VCP, there was PC3.

In September 2013, TriWest was awarded a contract to stand-up and implement the brand new Patient Centered Community Care (PC3) program across 28 states and the Pacific. Initial access to specialty care from network providers began in January of 2014, with the rest of the program coming online over the months that followed.

PC3 was intended to be a nationwide program giving VA Medical Centers (VAMC) an efficient and consistent way to provide access to care for Veterans from a network of credentialed providers in the community. We are pleased to be sharing this work in support of VA with our

long-time colleagues in the TRICARE work, Health Net. And, I want to assure this Committee that we are working together very collaboratively to leverage our collective knowledge so that VA benefits from it as they and you seek to fashion strategies that will optimize VA's direct delivery system and supplement that care with access to care in the private sector when and where it is needed.

Important to the success of PC3 was that the cost to VA, quality, and processes would be consistent all across the country. Community providers, VA staff, and Veterans would know how the program works. Congress and VA health care executives could more accurately budget for non-VA care costs. The facilities could turn to consolidated networks, tailored to their needs just like DoD did with TRICARE, versus inconsistently buying on their own. And, claims payment challenges for providers would be a thing of the past.

The promise of that vision is still there today.

However, the implementation of PC3 was not without challenges. And, overcoming those challenges has been a huge focus for TriWest and our VA partners during the first year of its operations.

For those of us at TriWest, a big challenge at the outset was the absence of data showing the VAMC's needs and historical purchasing patterns. As you might expect, it is very difficult to build a network of providers when you don't know the volume, configuration or location of demand. This led to some initial mismatches in our network and significant unexpected cost as we had to recalibrate the network once we received the needed information. Put simply, we had more of some services than VA would ever need in some places. But, we also had less of some services in other places than it turns out VA needs in order to ensure that care is both in sufficient supply to meet the need and reasonably close to where the Veterans reside. I want to compliment our contracting officer, Mara Wild, for tirelessly staying on the pursuit of this critical information over the course of nine months... information that we are putting to good use in our efforts to optimally calibrate the networks to meet the need.

Being able to effectively project volumes based on solid information not only assists with making sure that networks are tailored properly to support each VAMC and Community-Based Outpatient Clinic (CBOC), and the Veterans who rely on them for care, it also ensures that we have the staff necessary to administer the program and meet the tight performance specifications. The PC3 contract is designed to pay us only after care is ordered, appointments are made, the medical documentation is returned to VA to be inserted in the Veteran's consolidated medical record, and we have paid the provider. That means staffing levels are all at risk to us. If we hire too many staff and VA does not use the program, we lose money... effectively paying the government for the privilege of doing the work. But, if we hire too few, it can lead to delays in the receipt of care as we struggle to meet demand. So obviously, getting this as close to right as possible is very important.

There are few programs structured this way, as even TRICARE, Medicare plans, and private insurance have premiums being paid in advance to cover both the anticipated administrative costs and the projected health care risk.

Yet another challenge has been voluntary utilization of the PC3 program by each VA medical facility. As noted above, my colleagues and I at TriWest and our owners who call most of the communities in our area of operation home, built a network of providers based in part on estimates derived from historical fee basis care purchasing. However, much to our surprise, we've painfully discovered that many facilities have simply continued to use, almost exclusively, their historical non-VA care program to buy care from community providers... even when we had network providers. In fact, some of our network providers were the same providers from whom they continued to buy directly. While some VAMCs have largely abandoned this practice, we have had a very difficult time understanding why this practice has been allowed to continue such that only about 15% of total purchased care has been bought through this mechanism and VCP, in spite of all the money and man hours that have been spent in constructing these networks.

Beyond that, we see provider confusion as we attempt to convince them to join a network when they are already seeing Veterans through the legacy programs. Even worse, when a provider does join the TriWest network but continues to receive referrals for services from both VA and TriWest, they quickly notice that the requirements, rates, and claims processes are often completely different. And yet, to the provider, it is a Veteran being referred for care by VA.

Voluntary utilization of PC3 at the local level has also exacerbated the challenges with staffing because even when utilization data is available, we cannot assume such workload will come through the contract. We have to consider how much volume each local medical facility will move through the networks, and its related processes, as we determine how much staff is needed to do the work. And, as you might expect, those projections are extremely difficult to make with any accuracy... even with the talented and experienced staff we have attending to that task.

There is, however, hope. I would like to compliment my fellow panel member, Dr. Jim Tuchschildt, for the direction that he and the rest of VA's leadership have given to the team at VA that this practice is to come to a halt. Instead, their direction is that the networks that were constructed to support them and programs, such as VCP, which extend options further for Veterans, are to be used rather than resorting to direct purchasing of care.

Mr. Chairman, fortunately, the first year of PC3 operations has also had a lot of successes. In fact, I'd say that in spite of the challenges I've just noted, we have made some amazing progress together in a very short span of time.

The most important element of that progress is that more workload is coming through this contract than when it started. In January 2014, the first month of operations for PC3, TriWest

received approximately 2,500 requests for care. This past April, we received over 21,000. As I just noted, whether to use the contract is still seen as voluntary throughout the system. So, when more care comes through the contract, it is evidence that more VAMCs see the benefits of using consistent processes, rates, and network to obtain needed, quality care for Veterans. In the long run, when these programs are the vehicle for the vast majority of care purchased outside of VA, the consistency will benefit the entirety of the non-VA care program.

Concurrent with, and certainly not unrelated to the growth in utilization, the partnership between VA and TriWest has matured substantially over the past year. And that maturity has helped us to focus on better matching the needs of local Veterans with the providers in the network, and ensuring those providers are in the right communities served by the VAMC. For example, while it is important to know that the Biloxi VAMC purchased 500 MRIs from community providers in a given month, it is critical to know if they purchased 200 in Pensacola, FL; 100 in Mobile, AL; and 200 in Biloxi... as they are all considered to be within the catchment area of the Biloxi VAMC. Without that second layer of data, however, TriWest would almost assuredly build network in the wrong places causing longer travel than necessary.

The work we are doing at each other's side, and the appreciation of what is needed for us to execute with reasonable effectiveness for VA in support of Veterans is allowing us to grow the provider network smartly. One year ago, there were just over 50,000 network providers serving VAMCs in Regions 3, 5, and 6. Today, we've crossed the threshold of 100,000 providers in the network devoted to caring for Veterans in need of services from providers in their community. More of those providers are in more communities where the needs exist. And we aren't done yet, which I will talk about in a few minutes.

It is also important to make sure when you ask a provider to render care that they get paid on time and accurately for their work. Not only is it proper, but that is the way to ensure they are likely to agree to serve another Veteran when the need arises. As we all know, when you have to spend time chasing the bill payer, it adds to expense and makes the work less attractive. And, we want this work to be attractive... just as it was with TRICARE when we worked to help the DoD reengineer claims processing at the start of the program which put us on a path to becoming the fastest and most accurate payer with which most of our provider network dealt.

When I testified before this Committee last June, I noted that any new program has challenges with aspects of implementation and operation. And I pointed out that we were not paying our claims as quickly as we would like. In fact, I think we were averaging close to 90 days in June of 2014. That simply isn't the case any longer. Experience, focus, and refinements have successfully brought us to a place where our average clean claim is now being paid in fewer than 30 days. Providers who render quality care to our Veterans deserve timely payment of their claims. And we are committed to honoring their service at our side by doing just that.

On the way to improving the PC3 experience for Veterans, VA, and providers, it turns out that we also were just getting warmed up in preparation for the ultimate program implementation run which came in October of 2014 with the first indication that the new VCP would become a modification to the PC3 contract. And, the intensity was about to pick up several-fold.

Implementing the Veterans Choice Program

To be exact, we would ultimately have one month for the implementation of this massive new program that would “go live” on November 5, 2014.

I recall vividly that during one of the initial discussion sessions VA had with potential industry partners in mid-September 2014, it was said by some in the room that 12-18 months was the needed timeframe in which to stand up a program of this magnitude. And while there certainly were imperfections on Day 1, and we continue to refine operational processes internally at TriWest and between VA and us, I’m very proud of what we all accomplished in such a short timeframe. And I would like to focus for a moment on what went right, before I share with the Committee what remains a challenge and what I hope we all can focus on for the future as we seek to achieve an effective and efficient program for those we are all privileged to serve.

As this Committee is aware, the law mandated that all Veterans enrolled for care with the VA Health Care system as of August 1, 2014 receive a Veterans Choice Card. At its core, this required printing those cards and mailing them off to Veterans. But, in reality, it involved so much more.

First, we had to partner with VA to receive a list of all Veterans eligible to receive the card. We were informed early on that the list would contain nearly nine million names. Of course, in order to ensure that a list of that size can be used for its intended purpose, formatting is crucial. Working together with VA and our colleagues at Health Net, we agreed on a template of the fields that would be provided to us. We then made that template available to the card printer we selected once the design was available to us because they had a week to get the first batch of cards printed, stuffed, and into the mail.

At the same time, we worked with our colleagues at Health Net to parse out all of that data and break it up so that each of us would have the right list of Veterans for each area served. After completing that project, we knew there were just under four million Veterans eligible in the area of our responsibility.

Just knowing who was to receive a card was not enough. We also had to load all of that data into our customer relations management (CRM) system so that when those cards arrived in the mail and Veterans called the number on the back, we knew who those Veterans were when we answered the phone. And I’m proud to say that we had that system up and operational in advance of “go live” day.

While we are on the topic of phones, at the same time all of the data loading and print work were occurring, we were also standing up a call center infrastructure big enough to serve the outreach from all of those who would receive the cards as well as providers and others in the general public who learned about the new benefit and had questions.

To accomplish this task, we worked directly with Verizon and our call center partner to establish a cloud-based system that would support a single, public-facing phone number (866-606-8198) where a Veteran; a provider; or a VA staff member encountered a message from the Secretary about the program and then was routed to the appropriate agent representing us based on their zip code to receive supportive services. Again, in fewer than 30 days, we designed and stood this up and it was staffed with nearly 800 people by November 4, 2014 so that we would be ready to serve Veterans in need.

I would submit that our most important accomplishment is what did not happen. No computers crashed. No busy signals occurred. In fact, there were no long waits for the phone to be answered by a live person. In less than 30 days, working together with VA and other partners, we stood-up a contact center that worked.

In those first 30 days, we also had to work with VA to develop a means of learning who was eligible for VCP at any given time. As you know, the law created two distinct types of eligible Veterans: those waiting longer than 30 days to receive needed care; and those residing more than 40 miles from the closest medical facility of the department. TriWest would need to know which Veterans qualified under which category of eligibility because the range of services available differs greatly.

Those residing more than 40 miles from the closest VA medical facility are eligible to receive through VCP any needed medical care covered by VA. TriWest is delegated responsibility to make determinations of medical necessity. As such, our only issues in serving this population are whether the care is medically needed, and whether there is a provider close-by who agrees to provide that service. As many members of this Committee know, if you live more than 40 miles from the closest VA medical facility, it is likely you live in a rural or highly rural area. As such, it is often not only VA that is far away, but it can be difficult to locate some types of specialty and subspecialty providers due to their scarce supply.

For the 30-day waitlist population, the task proved much more difficult because it was not only necessary to know that you were on the eligibility list, but we needed to understand what service(s) the Veteran needed. For this, we would need clinical information (known as a "clinical consult") from the referring VA provider.

In an effort to expedite the provision of that clinical information, given the very short time in which to stand this up, an initial decision was made by VA leaders to send us all clinical consults related to any Veteran on the Veterans Choice List (VCL). The initial waitlist alone contained

information on over 34,009 Veterans. For each of those names, we would also receive via fax information documenting their respective clinical need. Then, we had to match that clinical information with the registry created by the card-mailing file and the updates created by the eligibility file so that we could help Veterans in need of service when they called. This process has proven to cause the most challenges in operation of VCP.

Nevertheless, in the six months the program has been operational, TriWest has processed over 40,000 authorizations for care. And we have seen growth in the use of the program every month with the exception of a slight drop between January and February of this year. In November 2014, we processed approximately 2,600 authorizations (more than the first month of operation under PC3). By April 2015, the number was 10,600; growth of nearly 400%.

As I mentioned earlier, while we certainly had many successes about which I am proud, I am by no means suggesting that all went right in our implementation. And I think it is very important that we outline what went wrong if for no other reason than because Veterans and their representatives in Congress deserve to know and understand our challenges. After all, at the end of the day, we are ever mindful that we are all spending taxpayer money.

First, and foremost, we suffered from a lack of training time. We had less than two weeks to hire and train hundreds of people just to answer phone calls from Veterans and describe or explain a complex new program. It is no understatement to say that most who worked to get VCP up and operational worked 100 hour weeks during that 30-day period... in order to understand what was envisioned by the law and then design the approach and stand-up operations. Given the brief amount of time to do all that was required, one of the greatest challenges was to gain a solid base of understanding of this valuable new benefit, and get the operation design set so that we could sufficiently explain both to others. And, we were not alone in that challenge. Among those most impacted, beyond the Veterans we were all aiming to serve, were the new staff in the call centers, as they only had five to seven days in which to grasp the information versus the typical two to three week period one ought to provide. I am sure others, including VA, struggled with the same.

Obviously, the lack of training led to less than optimal customer experiences. Information provided to Veterans was at times inaccurate or confusing. And some Veterans were left frustrated. I want to apologize for that. But, in apologizing, I also want to assure this Committee that we did everything in our power to train and educate this new team in the very short period of time we were allotted. In the end, it was simply not enough time. And, we are doing our best to stay on top of making sure that our staff has the right knowledge base of the program in order to provide solid customer service... even as this program continues to be refined, creating a need for re-training.

The training of our staff was not the only challenge that impacted the customer service experienced by Veterans who called the Choice line. As noted above, there are many areas where

cooperation and collaboration between VA and TriWest needs to occur every day to ensure solid performance of VCP. I think it is fair to say that as hard as it was for TriWest to train hundreds of new staff, it is vastly more complicated for VA's leadership to train thousands – maybe even tens of thousands – of administrative and scheduling staff all across the United States so that their engagement with Veterans would be informed. Not only that, but this challenge left us in a place where our staff and Veterans struggled with the impact of encounters with insufficiently trained personnel on whom they had to rely for information in order to achieve a positive customer experience.

Another challenge in early implementation of VCP was the timely receipt of the eligibility file. As I mentioned earlier, VA worked with us to create a template that would allow their team in the Eligibility Office to push regular information to us about which Veterans were eligible for VCP. But, the Eligibility Office also needed to obtain that information every day from clinics all across the country. It was always the goal to provide a new file every night so that when a Veteran called us the next day, we knew of their eligibility. In reality, even to this day, there is at least a five-day lag in between when a Veteran is told there is a wait time in the clinic that provides them eligibility for VCP and when that information can be used by TriWest to serve the Veteran.

There are many reasons for this delay. But, none of them are related to a lack of hard work. In fact, I would like to publicly acknowledge the incredible work done by Laura Prietula and her team in the Eligibility Office. She is a dedicated public servant who seeks to deliver outstanding work every day and from our experience many nights she is there too. And, there are many others like her in VA working tirelessly in an attempt to get this benefit to where we all want it to be. The hope is that some level of automation is coming to this program and to this area in particular. But, it was not available on Day 1 and that has led to some challenges and frustration.

Still another challenge has been the receipt of the clinical consultation information from VA which, as noted earlier, is necessary to schedule an appointment with a provider. For those eligible for VCP by virtue of their inclusion on the 30-day waitlist, TriWest must have a clinical consult for use when helping to make an appointment. The information in the consult tells the provider in the community why the Veteran is being referred to them for services. Providing this information is standard practice and good clinical care. And for some services, it is even required by Medicare, insurance policies or other accrediting organizations. For example, no imaging center will provide an MRI, CT, or other sophisticated imaging study without a physician order. This order would be in the clinical consult.

Because this information comes from hundreds of different clinics all across the VA system, receipt of that information in a consistent fashion has been a challenge. Without it, however, we are left with no alternative but to tell a Veteran who calls the Choice line that we are waiting on

clinical information from VA. Needless to say, when we tell a Veteran we know they are eligible, and yet we still cannot help them, the frustration is enormous.

As I noted above, the consult is supposed to come to TriWest automatically for every Veteran who is placed on the VCL. Unfortunately, we only know what we don't have when a Veteran calls for an appointment and can't receive one. I also do not want to lay all of the challenges in this area at VA's feet. The fact is, many times when we call for consults that we do not believe we have, we are told by VA staff that they were already sent. This no doubt frustrates VA staff too.

The good news is that recently we implemented a pilot program in VISN 17 in collaboration with the Dallas VAMC which is testing whether a process of requesting on our end can be met with a response on VA's end within 24 hours. Initial data suggests that it is working well. If the evidence continues to show promise, it will mean that Veterans all across the country can expect a consistent customer experience under which we can all assure them that we will have the information necessary to make an appointment within 24 hours of them calling us. And no longer will VA be responsible for sending thousands of clinical consults every day for Veterans who may not use VCP. I would submit that this is a win-win.

This looming success in addressing one of our collective challenges flows from the collaborative work in which we, Health Net and VA have been engaged since the beginning of the year. Just a little over 60 days from the start of VCP, we began to sit down together to map the gaps in process and customer service and blueprint how to resolve them. The focus of this work is to identify the components of our individual and collective work, or the policies and approaches that underlie them, that are in need of re-engineering or refinement to ensure that Veterans receive the access to care that was envisioned with the enactment of VCP.

This work is highly collaborative and involves leadership at all levels of the three organizations. In fact, just last week we all met for a day-long summit on Clinical Issues where we identified problems, discussed solutions and made the changes that will close gaps. This was on the heels of our regular, monthly day-long summit during which we focus on needed administrative process changes or refinements. Those issues are brought to the table by a myriad of integrated topical workgroups that meet in many cases several times a week.

It is intense and focused, just as should be... as we are trying to quickly address the processes we all know need attention in order to improve this critical program and meet the intended objective of VCP.

I would submit that this approach is yielding effective change and refinement at great speed for a program of this magnitude that was stood up very quickly and across a vast geographic expanse. And, I want to offer that the focus and intensity on the part of those involved and the

collaboration present is unlike anything I have ever seen in my 30 years of engagement in this space.

For our part, not only are we engaged at a macro level, but we are operating in this same fashion within our company... which is how we have accomplished successful and quick refinement and improvement since the early days of TRICARE nearly 20 years ago. We have also engaged our long-time partner in such work, the world-renowned Customer Service Institute at Arizona State University, to conduct customer service gapping and blueprinting with the Phoenix VA and within our own organization.

The very early indications are that this time-tested approach, mirroring that of the most highly regarded customer service brands in America, is beginning to yield results that matter.

The customer experience under VCP is getting better with each passing day. Information provided by TriWest staff is more consistent and more accurate; providers are more familiar with the program; and we have recently begun an initiative that allows any provider in our region to register online with us to be a VCP provider. Knowing who is willing to treat a Veteran under VCP, even if they are not already a TriWest network provider, will go a long way towards speeding up the appointing process.

Additionally, we are updating our entire CRM system so that our staff and all of the VA staff across our regions who interact with us in the IT environment will have more information about each Veteran right at their fingertips. Construction of these brand new tools was conceived of through the collaborative process of which I just spoke. We have condensed design and testing of these new systems to weeks and are using a 24/7 build strategy in order to rollout the new tools just after Memorial Day rather than waiting until next year, which would be the case using normal construction schedules.

It has been my experience that many customer service failures are due to the fact that line staff (those on the phone or on the ground) simply do not have access to the information needed to help a customer. When information is available, resolution of problems is possible. This new effort and these new tools will lead us down that road.

That said, there are many improvements needed that will require longer-term planning, collaboration, and perhaps even legislative change to what you passed last Summer. And I would like to take a moment to discuss a few of those and how, if they are pursued, VCP and PC3 can help bring an entirely better experience to the Veteran in need of health care services.

Refining the Veterans Choice Program for the Future

One area I would respectfully suggest is in need of review is the 60-day authorization limitation in the VACAA statute. While we understand there were reasons to include the time duration

limitation, I would respectfully suggest that it is leading to an increasing number of circumstances where quality and continuity of care are not the ultimate determining factors in the treatment of a Veteran. As a quick example, under the strictures of the statute, a Veteran sent through VCP for radiation oncology services because the local VA could not see him or her within 30 days, could have that service “recaptured” by VA after the first 60 days in the community if the local VA now has capacity. I am not a clinician. But, my Chief Medical Officer tells me that only under extreme circumstances should you change radiation oncology services in the middle of treatment. Yet, we understand that the statute leaves no alternative to continue that care through VCP.

The same circumstance would apply to maternity care. If the initial appointment was more than 30 days out, a female Veteran could be sent through VCP to a community OB/GYN. However, after 60 days, VA would have to reassess their capacity and could recapture the care, requiring the Veteran to change provider mid-pregnancy. Again, I know there were reasons for the requirement. However, I would respectfully suggest a reevaluation to allow for some flexibility when it is in the best interests of the patient.

Additionally, I would respectfully suggest that there is a need to harmonize all of the disparate programs that now exist to provide non-VA (or community) services to Veterans. I noted earlier that voluntary use of the PC3 contract made it difficult to predict with any reasonable accuracy how much network would be needed for certain services and where that network was needed. It is also true that even if I can accurately predict network needs, it is difficult to convince providers to join a network when they already receive work directly from VA at better rates with fewer requirements. It sounds odd to say, but in some instances we’re competing against VA to provide services to VA. Harmonizing the programs in some manner would help alleviate this challenge.

I also mentioned that without knowing, generally, the overall volume of services VA will need from my company, it is difficult to staff accurately for workload. But, again, it is difficult to predict workload when local facilities simply have options every day on the program through which they intend to purchase services.

I think the net result of both of these challenges that stem in some manner from multiple different programs come through loud and clear in the recent IG report which found a lack of savings under the initial year of the PC3 program. The IG noted that there were instances in which timely appointing wasn’t available through TriWest or network providers were not close by. While I do not know the exact cases the IG reviewed, I know it is true that when workload exceeds our imperfect projections we find ourselves with inadequate network and a lack of staff. And that will lead to delays in appointing and difficulties finding providers. As an aside, I might note in response to another aspect of the IG report, that measuring first year savings of the PC3

program against implementation fees designed to cover five years of operations is a little bit of apples-to-oranges comparison.

Nevertheless, I am pleased to say that I understand VA intends to take some steps to create a hierarchy of options that local non-VA care staff will be expected to follow. This will go a long way towards providing everyone: VA staff, Veterans, community clinicians, and my team with the information we all need to bring timely care to Veterans using a consistent process with predictable rates.

This new effort on VA's part does lead me to one additional observation on what is needed for the long-term health of these programs. We must focus on a better collaborative planning process when changes are needed.

I've noted at length the challenges we experienced in implementing VCP; partly due to the short implementation schedule. Yet, just in the last few weeks, we saw an implementation of VA's new determination on eligibility under the 40-mile rule. I want to be clear and say that this is a tremendous change for Veterans. It is absolutely true that one of the most frequent complaints to our call center was the "crow flies" determination. However, there were only three weeks between the time it was determined that the rule would change and when VA sent out letters to just over 128,000 Veterans in our three regions notifying them of this change.

In just the first week following the letter, workload to our call center for VCP more than doubled. And, we understand that there are likely additional changes coming as well that VA is working on.

The challenge will be to synchronize them effectively so that we have the best chance to make sure that sufficient staff are hired and trained to meet the increased demand, or to agree among all effected that the change needs to be made quicker and that it is acceptable for capacity to catch up to demand.

Regardless, we are "All In"!

One of the areas I know that is being worked diligently within VA is how to ensure that the networks we are constructing and the providers who want to serve at our side in support of Veterans are being utilized. And, that is to be applauded.

The Art of the Possible

At the ground level, I am thrilled at the strong collaboration that is emerging all across our geographic area of responsibility. It is being supported by one of the superstars from our area, Joe Dalpiaz, as he is taking his time to completely engage at the side of his colleagues and me to fashion the "art of the possible".

We started with one of the largest facilities in the VA system, which is under his engaged and watchful eye, and sat down with the Director and non-VA care team to look at all of the demand they have for community services and where the VA's needs are. Then, we produced an assessment of whether the network we have built is sufficient to meet VA's full demand. Where a bit more service is needed, we are discussing the optimal strategy to bring it to a fully tailored state so that Veterans in that community will have exactly what they need, when they need it ... whether it is from a VA medical facility or with a community provider. Of course, a Veteran will also be free to select a provider of their choice to the degree that one does not exist within VA or the network.

This effort includes primary care and specialty care, to include behavioral health. And, I am confident of the success that will come from this completely engaged and collaborative effort, which will have each leader within VA knowing what they have at their disposal inside VA and in the community to meet the access needs of Veterans...

My confidence in this process is bolstered by the fact that this is exactly what we did together with DoD in TRICARE that led to phenomenal success in our area of responsibility and it is what we have now accomplished together with the VA leaders in Phoenix and Hawaii... where networks are now completely tailored to demand. These early successes were the result of the great collaborative effort involving not only the local leaders and staff, but the tireless work of several in VA: Sheila Cain, Greg Frias and Tommy Driskill.

We have prioritized the areas in which we will begin this work in collaboration with the VA leaders that Joe and I have met with over the last five weeks. This ensures that we can quickly move the needle once VA communicates its intention to the provider community that VCP is the pathway, and ensures its own staff on the ground is lined up behind the objective of this being the purchasing tool for care when it is unavailable in VA, or from a nearby DoD facility or academic affiliate.

For the purpose of illustration, I would like to highlight what will come from this as it relates to one of the biggest needs at the moment... timely and convenient access to behavioral health care.

To be sure, VA is the gold standard in understanding the behavioral health needs of our Veterans. But, there are many instances in which we may be able to help them free up space in VA for their most acute patients by working with providers in the community.

Next, I am matching that demand (both behavioral health and all other services) against the network we have in the catchment area of the VAMC. And I am doing that in a fully transparent way right in front of the VAMC Director. Where I have what he needs, he will know it. And he will also know what I am missing.

Next, the VAMC Director will begin notifying local providers that he will be sending all of his community care through PC3 and VCP and there will no longer be (with few exceptions) local, direct contracts. Then, my team will set out on an aggressive schedule to build the network that can fill in the gaps identified by the “map-and-gap” analysis. Community providers will know that VA’s future purchasing will be through the consolidated network. We will provide regular updates to the team at the VAMC. And as network growth occurs, so too will workload, which means I can plan for the hiring and training of staff on a timeline to deliver.

In the very long run, VAMCs can use this process to analyze “make/buy” decisions. Obviously, there is a tremendous need for many services at VA medical facilities. But, there are also many exigent circumstances that VA must confront in every community. Internal VA expansion may be desirable and justifiable. However, perhaps the physical space does not exist; the facility may be landlocked; or, most commonly, the community itself has a shortage of the type of providers VA requires to meet the needs of Veterans, which makes direct hiring difficult.

In those instances, it is my hope that they will find a robust network to be an asset they can use in planning and delivering. Perhaps the marginal use of time from a dozen community providers can better meet the needs of the Veterans than hiring one internally because of some challenges I’ve just mentioned. And, perhaps hiring directly is the right thing to do. That decision should always rest with VA and Congress.

To be clear, I am not suggesting in any way that PC3 or VCP should replace the direct care provided by the VA health care system. But, I do believe that greater knowledge of what is available locally from a network of providers could help VA in the long run plan for and deliver quality health care in a more timely fashion.

I believe that is what you envisioned in the passage of VCP... and, I believe the successful fulfillment of that vision in support of those who have borne a high cost in defense of freedom is very much the “art of the possible.” We look forward to doing our part as you refine and modify policies and authorities to give us the final tools that will be needed to accomplish the success that we all desire.

Conclusion

Chairman Miller and members of the Committee, my colleagues and I at TriWest truly believe that if we are transparent about the needs and the shortcomings, collaborate together with VA to fill the gaps, and then implement them as quickly as possible, we will earn the trust of Veterans and collectively meet their needs. And believe me, I know we must earn this trust.

Supporting the care needs of America’s Veterans is a tremendous honor and privilege for me, all of the employees of TriWest, our non-profit owners, and most importantly the providers in our markets that have leaned forward at our side to say we will serve a few of our fellow citizens

when they have needs that are unable to be met by VA directly. We are humbled by the service and sacrifice of America's Veterans and their example reminds us constantly of the high cost of freedom. We take our responsibility very seriously and VA, Veterans, and this Committee can be sure that our entire focus is on ensuring that our work in support of VA and the Veterans who rely on them for their care is fitting of the sacrifices of our heroes and is worthy of their trust.

This concludes my formal testimony. I'd be happy to answer any questions you might have.

**STATEMENT OF THE HONORABLE SLOAN GIBSON
DEPUTY SECRETARY OF VETERANS AFFAIRS
BEFORE THE
VETERANS' AFFAIRS COMMITTEE
OF THE HOUSE OF REPRESENTATIVES**

MAY 13, 2015

Good morning. Chairman Miller, Ranking Member Brown, and Members of the Committee--thank you for the opportunity to participate in this hearing and to discuss the progress of the Department of Veterans Affairs' (VA) implementation of the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act). I am accompanied today by Doctor James Tuchs Schmidt, Interim Principal Deputy Under Secretary for Health.

Implementing the Veterans Choice Program

The Veterans Choice Program is helping VA to meet the demand for Veterans healthcare in the short-term. VA is focusing on ensuring the program is implemented correctly and seamlessly as well as on creating the most positive experience for all Veterans.

VA's goal is always to provide Veterans with timely and high-quality care with the utmost dignity, respect, and excellence. For the Veteran who needs care today, VA's goal will always be to provide timely access to clinically appropriate care in every case possible. However, as we have shared with staff for the Senate and House Committees' on Veterans Affairs, users of the Veterans Choice Program have identified aspects of the law that are challenging. We are working diligently to address these challenges and to turn them into opportunities to improve VA care and services. My testimony addresses the progress we have made thus far.

Eligibility for the Veterans Choice Program

President Obama signed the Veterans Choice Act into law on August 7, 2014. Technical revisions to Veterans Choice Act were made on September 26, 2014, when the President signed into law the Department of Veterans Affairs Expiring Authorities Act of 2014, and on December 16, 2014, when the President signed the Consolidated

and Further Continuing Appropriations Act, 2015. On November 5, 2014, VA published an interim final rulemaking that implemented section 101 of Veterans Choice Act.

The Veterans Choice Program, established by section 101 of Veterans Choice Act, requires VA to expand the availability of hospital care and medical services for eligible Veterans through agreements with eligible non-VA entities and providers. Under section 101, some Veterans are eligible for the Choice Program based on the distance from their place of residence to the nearest VA medical facility. The Choice Act does not state how distance should be calculated for purposes of determining eligibility based on place of residence. The most common methodologies for calculating the distance between two places are by using a straight-line and by following the actual driving path between the two points. In the initial interim final rulemaking, VA adopted a straight-line measure of distance to determine eligibility based on residence, consistent with certain statements in the legislative history.

During the public comment process for the rulemaking, VA received many comments questioning the use of the straight-line distance instead of driving distance. By contrast, VA received no comments in support of the use of straight-line distance. After considering extensive feedback, VA decided to amend the interim final rule to change the method used to determine the distance between a Veteran's residence and the nearest VA medical facility from a straight-line distance to driving distance. The general intent of the Choice Act is to expand access to health care for veterans, and the use of driving distance allows more veterans to participate in the program and receive care closer to home. Moreover, from the standpoint of a veteran, the most relevant question is how far he or she must actually travel to receive care, not the length of a straight-line route.

I am happy to report that on April 24, 2015, VA published a second interim final rule adopting this change, effective immediately. VA estimates that this change almost doubles the number of Veterans eligible for the Veterans Choice Program based on place of residence. We understand one frustration for Veterans is that according to the Choice Act, the Veteran is eligible for hospital care and medical services if the Veteran resides more than 40 miles from the medical facility of the Department, including a Community-Based Outpatient Clinic (CBOC), that is closest to the residence of the Veteran. This criterion bases eligibility on the proximity of the nearest facility,

regardless of the availability of the needed care at that site. VA is a regionalized system; so we recognize that every CBOC does not deliver the services needed by every Veteran. We acknowledge this is problematic and have carefully studied the issue and potential solutions, recognizing the constraints of VA's authorities in the program under current law and the significant budgetary impact that would accompany the potential solutions, which could range from \$4 billion to \$34 billion per year.

We have presented our analysis of the issue to the Congressional Budget Office and staff of the Senate and House Committees' on Veterans Affairs, and we are continuing to work with Congress to find an economically sound solution.

Revisions to the Beneficiary Travel Program

Based on Veterans' feedback, we are using the fastest route by time calculation to determine eligibility for the Veterans Choice Program. This is different from the method that had been previously used by the Veterans Health Administration (VHA) Beneficiary Travel Program, which determined mileage reimbursement based on the shortest route. This route determination method may not have been a "common" route traveled by our Veterans to their healthcare appointments. However, we now believe the Beneficiary Travel Program standard should be altered as well to reflect the fastest route by time calculation and ensure consistency between both programs.

To reduce variation in mileage calculation between the two programs, VA will now calculate mileage reimbursements under both programs based on the fastest route by time. In most cases, the change will provide equal or greater mileage reimbursements to Veterans.

Veterans Choice Program Outreach Efforts

We understand that the Choice Program is not working as well for Veterans as it should, in part because Veterans, VA employees, and community providers do not understand how the program works. We continue our outreach efforts to increase Veterans' awareness of the program. With VA now determining eligibility for the Veterans Choice Program based on driving distance to the nearest VA medical facility, to include CBOCs, more Veterans are now eligible for the Veterans Choice Program. Beginning April 25, 2015, these newly eligible Veterans were sent a letter informing

them that based on their place of residence, they are eligible to immediately participate in the Veterans Choice Program. The letter also provides guidance to the Veterans on how to verify their eligibility and access care.

When we initially launched the Veterans Choice Program, we mailed explanatory letters to over eight million Veterans, with their Choice Cards. This month, we are planning to send a mailer regarding the Veterans Choice Program to the same group of Veterans. The mailer assists Veterans in determining if they are eligible for the Veterans Choice Program and provides guidance on how to confirm their eligibility and schedule their next appointment.

We will continue to focus on outreach and communicating with Veterans to ensure they understand the Choice Program, to include: establishing a reoccurring Veterans survey to measure their knowledge of the program; strengthening and expanding our social media strategy for Veterans, families, and caregivers; and, conducting program-related town halls at VAMCs.

Veteran Choice Program Employee Training and Education

We acknowledge that there are gaps in understanding the Veterans Choice Program and related business processes among VHA staff. We continue our outreach to VA facility leadership to improve employees' understanding of the Choice Program and to address any reluctance our staff may have to send patients into the community to use the Choice Program. Our staff are more familiar and comfortable with assisting Veterans with existing VA community care programs. We must ensure they are adept with the Choice Program, as well.

It is important that our staff understand and use the program properly.. To date, VHA has conducted a variety of training including, but not limited to, in-person training, webinars, virtual training, teleconference, and other means. We, at VA, will continue to reiterate the distance standard rule change. On April 24, 2015, Interim Undersecretary Clancy sent a message about the Veterans Choice Program to all employees and included a reference called the Five Questions About the Veterans Choice Program, further explaining recent updates and how to assist Veterans in accessing the program. In addition to the Interim Under Secretary's message, the Network Directors and Medical Center Directors will be sending their own messages to their employees, and

Service Line Chiefs will be meeting with their employees in person to further discuss the program and to ensure that all employees understand the program.

As I mentioned in testimony to the Senate Veterans Affairs Committee on March 24, 2015, we are sending teams of experts, including staff from our Third Party Administrators (TPA), Health Net and TriWest, as well as VA leadership, to 15 facilities in each of their catchment areas. These facilities were selected based on the high number of Veterans waiting for care and low utilization of the Veterans Choice Program. The experts will hold discussion sessions regarding needs of the medical centers, and the Third-Party Administrators (TPA) network's capacity to provide care. During this time, we will review data regarding needs and utilization, and identify gaps in TPA provider networks. An action plan will follow each visit.

Educating Third Party Providers on Veterans Choice Program

As we work to solve Veterans' issues, we must also ensure non-VA providers are informed about the program and how to best serve Veterans. We use a variety of means to conduct outreach and to educate and inform community healthcare providers about how to participate in the Veterans Choice Program. Since the Choice Program started, Secretary McDonald has met with national health care organizations, such as the American Medical Association and the American Association of Medical Colleges to discuss the Choice Program as well as other aspects of VHA's transformation.

In November 2014, VA established the Choice website as a clearinghouse for public information. Veterans and Veterans Service Organizations are the primary audience for the Choice website, but care providers also utilize the site's resources. VA expanded the existing VA Community Care Provider website to include new information on the Veterans Choice Program, as well as how to become a Veterans Choice Program provider. Additionally, community provider training is a contractual requirement of VA's TPAs, Health Net, and TriWest, which have provider pages that they use to engage in targeted outreach to non-VA healthcare providers and to deliver training and information as they build their networks.

Recognizing that the Veterans Choice Program is connecting community care providers with Veterans to a greater extent than ever before, VHA is providing broad access to Veteran-relevant training and information for providers who may not be

familiar with military culture. Recently, VA established VHA TRAIN (TrainingFinder Real-time Affiliate-Integrated Network), an external learning management system to provide valuable, Veteran-focused, accredited, continuing medical education at no cost to community healthcare providers. Since the launch of VHA TRAIN on April 1, 2015, more than 1,520 people have created an account or subscribed to VHA content through a previously established account. The first course offerings, four modules of *Military Culture: Core Competencies for Health Care Professionals*, have already seen over 347 registrations and 179 course completions. VA will add dozens of Veteran-care training courses to VHA TRAIN throughout 2015.

Rationalizing All VA Community Care Programs

Beyond the Veterans Choice Program, VA has, for years, utilized various authorities and programs in order to provide care to Veterans more quickly and closer to home. In fact, the Department spent over \$7.012 billion on VA community care in Fiscal Year 2014 to help deliver care to eligible Veterans where and when they want it. In Fiscal Year 2014, Veterans completed 55.04 million appointments inside VA, and 16.2 million appointments in the community.

We recognize though, that the number and different types of VA community care programs and authorities may be confusing to Veterans, our stakeholders, and our employees. Navigating these programs to determine the best fit for a Veteran may be challenging. Therefore, we are currently working to streamline channels of care, billing practices, mechanisms for authorizations, etc., with the goal of creating a more unified approach to community care.

Refining Business Processes

We are also focused on looking internally at the business rules and internal processes that govern the Veterans Choice Program. It is our hope that stepping back to revise our own practices and focus on long-term work plans will create more efficient processes that will engender better and timelier care experiences for Veterans as well as better business relationships with our VA community care providers. Managing the Veterans Choice Program effectively requires us to have broad visibility of data. We are refining our data analytics to develop more thorough management and oversight of the

TPA performance. In order to support the VA community care providers that treat our Veterans, we are refining the oversight of payments for services provided. We are also continually working with the TPAs to help them develop their healthcare networks to support Veterans' healthcare needs.

Pilot programs in VISN's 8 and 17 are beginning to send clinical documentation only when a Veteran contacts the TPA for an appointment. The TPA then requests information from the VA site and VA provides that information within 24 hours. There is very little wasted effort and the TPA is assured of getting the proper information. With the current practice, VA sends clinical documentation to the TPA on every Veteran regardless of whether they intend to use the Veterans Choice Program. This creates a tremendous burden on both the facility, who must compile and send the material, and the TPA who must store all of this data. Currently, the pilot is doing well, and we look forward to rolling this process out across the Nation.

More broadly, VA sent to the Congress on May 1 an Administration legislative proposal entitled the "Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act." This bill would make critical improvements to the Department's authorities to use provider agreements for the purchase of VA community medical care—in order to streamline and speed the business process for purchasing care for Veterans when necessary care cannot be purchased through existing contracts or sharing agreements. We urge your consideration of this bill, which will provide VA the right legal foundation on which to reform its purchased care program. And, that is critical for Veterans' access to health care.

Choice Act: Funding

We are thankful for the Veterans Choice Act's funding to help us overcome our access issue. As of April 30, 2015, of Section 801's \$5 billion for enhancements to VA staffing and facilities, we have obligated almost \$304 million to increase access to care for Veterans at our VA Medical Centers. The \$304 million includes an estimated \$143 million obligated for hiring medical staff. In addition, we have obligated more than \$145 million for infrastructure improvements. These improvements include legionella mitigation, non-recurring maintenance, minor construction and information technology improvements. Of Section 802's \$10 billion dedicated to the Veterans Choice Program,

VHA has obligated more than \$500 million for healthcare, Beneficiary Travel, pharmacy, prosthetics, and implementation costs. As we implement the improvements described above, we expect these obligations to grow.

VHA Staffing

VHA is in the process of hiring more than 10,000 medical professionals and support staff, leveraging the funds provided by Congress in the Choice Act. These healthcare professionals will augment the current baseline of employees already providing care to Veterans – with the goal of further improving timely access to care. As reported in the Veterans Choice Act Section 801 Spending Plan provided to the House and Senate Committees on Veterans' Affairs on December 3, 2014, VHA expects to complete these hires by the end of Fiscal Year 2016. VHA is making good progress, with roughly 25 percent of the more than 10,000 staff now on-board. Using the resources provided by the Veterans Choice Act, VHA will continue to aggressively market, recruit, hire and credential medical professionals and support staff to ensure we make full use of this opportunity to deliver quality care to Veterans.

Additionally, the Department appreciates the changes to the Education Debt Reduction Program authorized by Section 302 in the Choice Act. This Program provides a valuable tool for the Department to recruit and retain eligible, high-quality staff to VA.

Sections 105 and 106: Paying VA Community Medical Care Providers

The Department understands the importance of complying with requirements of the "Prompt Payment Act" and making timely payments to VA community medical care providers. The organizational changes implemented in Section 106 that consolidated payment of claims under centralized authority serve as the basis for further improvements in the prompt payments.

Section 106 of the Veterans Choice Act required the Department to transfer authority to pay for healthcare and the associated budget to the Chief Business Office no later than October 1, 2014. In seven weeks, we re-aligned more than 2,000 positions and over \$5 billion dollars in healthcare funding to the Chief Business Office from the VISNs and VA Medical Centers. This realignment established a single, unified

shared services organization responsible for payment functions and implemented centralized management which will allow us to leverage business process efficiencies going forward. We are in the process of refining and implementing standard processes and performance targets, and monitoring to ensure processing activities are performed and measured consistently across VA. This will enable us to deliver exceptional customer service to Veterans and VA community medical care providers. In addition, Choice Program claims processing and payment was centralized to ensure efficiency of processing and accuracy of payments.

We acknowledge that claims processing timeliness must improve. To date, our efforts include expediting hiring, maximizing the use of contract staff, implementation of involuntary overtime, and implementing tiger teams to maximize efficiencies with people, processes, and technology. Our current standard is to have at least 80 percent of our inventory under 30 days old.

Section 201: Independent Assessments

Section 201 of the Veterans Choice Act requires VA to enter into one or more contracts with a private sector entity or entities to conduct an independent assessment of the hospital care, medical services, and other healthcare furnished by VA, specifically assessing areas such as staffing, training, facilities, business processes, and leadership. Our work on Section 201 Independent Assessments resulted in completion of the first legislative milestone on November 5, 2014, by awarding a contract to the Centers for Medicare and Medicaid Services' Alliance to Modernize Healthcare (CAMH) to serve as Program Integrator for the independent assessments. The program is now progressing towards the second legislative milestone—completing the independent assessments by July 3, 2015. CAMH, supported by the Institute of Medicine and a diverse team of assessment subcontractors, are currently in the Discovery and Analysis phase.

To date, the teams have interviewed hundreds of VA and VHA staff as well as assessed over 80 medical facilities across 30 states, Washington D.C., and Puerto Rico. The teams have completed a landmark "Organizational Health Index" Survey to capture the perspectives of VHA employees nationwide, and VA has provided access to

its data, systems, and records by sharing over 1,000 data sets, reports, and other critical documentation.

A Blue Ribbon Panel of 16 healthcare experts, with substantial executive-level experience, has held two meetings and will continue to do so to regularly advise CAMH on the independent assessment. This panel, along with CAMH and their sub-contractors, will ensure that the recommendations resulting from Section 201 meet the needs of Veterans and establish a foundation for transforming VA into the preeminent 21st-century model for improving health and well-being.

New Residency Program Positions

The Veterans Choice Act provided VA the opportunity to expand physician residency positions by up to 1,500 positions over five years. The law gives priority to the disciplines of primary care and mental health and to sites new to Graduate Medical Education (GME), in health professional shortage areas, or with high concentrations of Veterans.

VHA has conducted extensive outreach to the academic community to ensure we generated interest in these new residency positions. The first Request for Proposals (RFP), released in the fall of 2014, resulted in 204 positions being awarded to VA sites and their academic affiliates. These first residents will start July 1, 2015. The process for distribution of the Veterans Choice Act positions continues, with the second of five annual RFPs anticipated for release in late spring/early summer 2015. VA plans to award between 200-325 positions each year for the next four years.

As part of the Veterans Choice Act expansion, facilities new to GME (or with extremely small residency programs) were offered funds for infrastructure support. These funds will offset specific administrative or clinical costs incurred in running a residency program and will enable these smaller facilities to become more successful in hosting residency programs. Last, in order to encourage small VA facilities to engage in residency education, VA will issue planning grants to incentivize the formation of new affiliation relationships.

Conclusion

We are grateful for the close working relationship with Congress as we make progress in implementing the Veterans Choice Program. Mr. Chairman, we will

continue to work with Veterans, Congress—especially this committee—VA community care providers, VSOs, and our own employees to ensure the Choice Program is working well and delivering great healthcare outcomes for Veterans.

I again thank the Committee for your support and assistance, and we look forward to working with you in improving the lives of America's Veterans.



Statement of

Darin Selnick,

Senior Veterans Affairs Advisor, CVA

before the

House Veterans Affairs Committee

concerning

Assessing the Promise and Progress of the Choice Program

May 13, 2015

Thank you Chairman Miller, Ranking Member Brown, and Members of the Committee. I appreciate the opportunity to testify at today's hearing on the choice program and your leadership in ensuring that veterans get timely and convenient access to the quality health care they deserve.

As we approach the one year anniversary of the passage of the *Veterans Access, Choice and Accountability Act of 2014*, the unfortunate fact is that true choice in veteran's health care remains out of reach for most veterans: like a mirage in the desert, as you move closer it recedes into the horizon. Our assessment is that the choice program has been unsuccessful, and, as such, we have developed recommendations for comprehensive reform through Fixing Veterans Health Care Taskforce.

The current rules pertaining to choice do not represent not *real* choice. Instead they require veterans to obtain approval from VA before they are able to make a choice. Veterans should not have to ask for permission to select their health care provider.

The VA implementation of the choice program has been a failure. For example, the Associated Press has reported that "GAO says Veterans' Health Care Costs a "High Risk" for Taxpayers"¹ and that "The number of medical appointments that take longer than 90 days to complete has

¹ Associated Press. "GAO: Veterans' Health Care Cost a 'High Risk' for Taxpayers" New York Times Online. ABC News Online, 11 Feb. 2015. Web. 11 Feb. 2015.

nearly doubled.”² They have also noted that “only 37,648 medical appointments have been made through April 11”.³

Last fall, Concerned Veterans for America commissioned a national poll of veterans. The results of that poll showed that 90% favored efforts to reform veteran health care, 88% said eligible veterans should be given the choice to receive medical care from any source they choose and 77% said give veterans more choices even if it involved higher out-of-pocket costs.

Choice and competition are the bedrock of today’s health care system. We choose our health care insurance, provider and primary care physician. Health care organizations provide quality, timely and convenient care, because they know if they don’t, they will lose their patients to someone else. In order to fix the VA health care system, both choice and competition must be injected into system.

Secretary Bob McDonald’s VA has recognized this in a fact sheet wherein they promise to “evaluate options for a potential reorganization that puts the Veteran in control of how, when, and where they wish to be served”.⁴ Unfortunately veterans do not have that control and will not under the current VA health care system.

The outmoded VA health care system that currently exists needs to become a 2015 health care system. We believe the Veterans Independence Act is the roadmap and solution to do just that. This roadmap is part of the Fixing Veterans Health Care report developed by a Bi-Partisan Policy Taskforce co-chaired by Dr. Bill Frist, former Senate Majority Leader, Jim Marshall former Congressman from Georgia, Avik Roy of the Manhattan Institute and Dr. Mike Kussman, former VHA Under Secretary.

The solutions and actions recommended are designed to provide concrete reforms to dramatically improve the delivery of health care to the 5.9 million unique veteran patients served by the VA.

We first developed ten veteran-centric core principles that serve as the guiding foundation. These ten principles are:

1. The veteran must come first, not the VA
2. Veterans should be able to choose where to get their health care
3. Refocus on, and prioritize, veterans with service-connected disabilities and specialized needs
4. VHA should be improved, and thereby preserved
5. Grandfather current enrollees
6. Veterans health care reform should not be driven by the budget
7. Address veterans’ demographic inevitabilities
8. Break VHA’s cycle of “reform and failure.”

² Associated Press. “VA Makes Little Headway in Fight to Shorten Waits for Care” ABC News Online. ABC News, 09 April. 2015. Web. 09 April. 2015.

³ Associated Press. “\$10B Veterans Choice program more underused than previously thought” Stars and Stripes Online. Starr and Stripes, 23 April. 2015. Web. 23 April. 2015.

⁴ “The Road to Veterans Day 2014 Fact Sheet” http://www.blogs.va.gov/VAntage/wp-content/uploads/2014/09/RoadToVeteransDay_FactSheet_Final.pdf, accessed May 5, 2015.

9. Implementing reform will require bipartisan vision, courage and commitment
10. VHA needs accountability

In order to implement these principles, we laid out three major categories of reform and proposed nine policy recommendations.

First, restructure the VHA as an independent, government-chartered non-profit corporation, fully empowered to make difficult decisions on personnel, I.T., facilities, partnerships, and other priorities.

Second, give veterans the option to seek private health coverage with their VA funds.

Third, refocus veterans' health care on those with service-connected injuries – which was the VA's original mission.

These reforms are carried out by nine policy recommendations:

1. Separate the VA's payor and provider functions into separate institutions, the Veterans Health Insurance Program (VHIP) and the Veterans Accountable Care Organization (VACO).
2. Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.
3. Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from Department of Veterans Affairs.
4. Institute a VA Medical Center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).
5. Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.
6. Preserve the traditional VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector through three plan choices.

VetsCare Federal: Full access to the VACO integrated health system with no changes to benefits or cost-sharing

VetsCare Choice: Select any private health insurance plan legally available in their state, financed through premium support payments.

VetsCare Senior: Medicare-eligible veterans can use their VA funds to defray the costs of Medicare premiums and supplemental coverage ("Medigap").

7. Reform health insurance coverage for future veterans.
8. Offer veterans' access to the Federal Long Term Care Insurance Program.

9. Create a VetsCare Implementation Commission, to implement the Veterans Independence Act.

To understand the fiscal impact of these policy recommendations, we retained the services of Health Systems Innovation Network to conduct a fiscal analysis. HSI determined a properly designed version of these policy recommendations is likely to be deficit neutral.

In order to fix veterans health care we must always keep in mind what General Omar Bradley said in 1947: “We are dealing with veterans, not procedures; with their problems, not ours”.

That is why we urge you to use the Veterans Independence Act road map to develop the legislative blueprint that will finally fix veterans health care. Veterans must be assured that they will be able get the quality, timely and convenient health care they deserve. In this mission, failure is not an option.

CVA and the co-chairs of the taskforce are committed to overcoming any and all obstacles that stand in the way of achieving this important mission. We look forward to working with the chairman, ranking member, and all members of this committee to achieve this shared mission.

STATEMENT OF

CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

“Assessing the Promise and Progress of the Choice Program”

WASHINGTON, D.C.

May 13, 2015

Chairman Miller, Ranking Member Brown and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I thank you for the opportunity to present the VFW's thoughts on the current state of the Veterans Choice Program.

More than a year ago, whistleblowers in Phoenix, Arizona, exposed rampant wrong-doing at their local Department of Veterans Affairs (VA) hospital through which veterans were alleged to have died waiting for care, while VA employees manipulated waiting lists and hid the truth. In the months that followed, similar problems were exposed across the country, and the ensuing crisis forced the Secretary of Veterans Affairs and many top Veterans Health Administration (VHA) deputies to resign.

As the crisis unfolded, the VFW intervened by offering direct assistance to veterans receiving VA health care; publishing a detailed report, *“Hurry up and Wait,”* which made 11 recommendations on ways to improve VA's health care system; working with Congress to pass significant reforms; and working directly with VA to implement reforms.

In August 2014, Congress passed and the President signed into law the *Veterans Access, Choice, and Accountability Act of 2014 (VACAA)* with the support and insight of the VFW. This critical law commissioned the Veterans Choice Program, which now offers critical non-VA health care options to veterans who are unable to receive VA health care appointments in a timely manner (30-dayers) or who live more than 40 miles from the nearest VA medical facility (40-milers).

In an effort to gauge veterans' experiences and evaluate how the program was performing, the VFW commissioned a series of surveys and compiled an initial report on how the program performed during the first three months of its implementation. The VFW's initial report included six specific recommendations regarding participation, wait time standard, geographic eligibility, and non-VA care issues that needed to be addressed. Fortunately, the Veterans Choice Program has been a top priority for VA and Congress. As a result, several issues that accompanied the roll-out have been resolved.

The VFW continues to play an integral part in identifying new issues the Veterans Choice Program faces and recommending reasonable solutions to such issues. Yesterday, we published the second report on the implementation of the Veterans Choice Program. All our reports can be found on our VA Health Care Watch Website, www.vfw.org/VAWatch. Our second Veterans Choice Program report found that the implementation of the program has improved. However, more work remains. The second report includes 12 recommendations regarding several issues that must be addressed to ensure the program accomplishes its intended goal of improving access to high quality health care for America's veterans.

Participation Gap

The VFW's initial report identified a gap between the number of veterans who were eligible for the Veterans Choice Program and those afforded the opportunity to receive non-VA care. Our report found that VA has made progress in addressing this gap. However VA must continue to improve its processes and training to ensure all veterans who are eligible for the Veterans Choice Program are given the opportunity to receive timely access to health care in their communities.

Thirty-eight percent of second survey participants who believed they were eligible for the program were offered the opportunity to receive non-VA care. This is a 12 percent increase from our initial survey. Yet, the VFW continues to hear from veterans who report that the schedulers they speak to are unaware of the program or are unsure how it works.

For 30-dayers, participation continues to hinge on VA schedulers informing veterans that they are eligible for the program. The lack of system wide training for schedulers and frontline staff has led to a reliance on local facility driven training, which VA admits has resulted in inconsistent training. To mitigate this issue, VA has developed system wide training for all VHA staff, which it intends to implement later this month. VA will also conduct specialized training for scheduling staff to ensure they are familiar with the Veterans Choice Program's business processes and know how to properly serve eligible veterans.

The VFW applauds such efforts, but we are concerned that training will not have the desired outcome if VA fails to implement proper quality assurance processes. For example, the program's contractors, Health Net and TriWest, monitor their call center representatives to ensure they provide accurate information about the program. Doing so allows them to identify call center representatives who need remedial training. They also utilize quality assurance mechanisms to improve training to ensure veterans receive high quality customer service. VA can benefit from adopting similar processes to ensure VA staff provide high quality customer service and adhere to training objectives.

The VFW acknowledges that the participation gap will not be eliminated with training alone. Regardless of how well VA trains its staff, human error will lead to veterans not being properly informed of their opportunity to receive health care in their communities. To address this issue, VA implemented the Veterans Choice Program Outreach Campaign to contact more than 100,000 veterans who were initially eligible for the Veterans Choice Program as 30-dayers. The program concluded in February and resulted in VA staff transferring approximately 30 percent of the veterans it contacted to the Veterans Choice Program call centers. VA would benefit from implementing an automated letter or robocall system that would continue the work of the Veterans Choice Program Outreach Campaign.

The VFW's second Veterans Choice Program report also found a decrease in patient satisfaction among veterans who received non-VA care through the Veterans Choice Program. Feedback from veterans shows that the primary reason for the decline in satisfaction has been a direct result of their inability to find viable private sector health care options. Many veterans have reported that they chose to keep their VA appointments because they were unable to find private sector providers closer than their VA medical facilities, or their appointments at VA were earlier than what they were able to obtain in the private sector.

Health Net and TriWest have candidly acknowledged that scheduling veterans within 30 days is unattainable in certain instances. The reasons differ case by case, but are generally associated with a lack of availability in the private sector or a delay in receiving the VA medical documentation needed to schedule an appointment. For example, TriWest reports that in many communities wait times for a new dermatology patient are often 60 or even 90 days out. This indicates that health care in the private sector is not widely available for all specialties, especially when veterans seek veteran-specific care that does not exist in the private sector, such as spinal cord injury and disorder care, polytrauma treatment and services, and specialized mental health care.

The VFW is concerned that local facilities may also contribute to the delay or inability to schedule non-VA care appointments through the Veterans Choice Program. Our report found that some local VA medical facilities were slow to provide the medical documentation needed to schedule appointments through the program. We also found that some VA medical facilities were slow to process requests for follow-up treatment through the program. For example, a veteran in Fredericksburg, Virginia, was authorized to receive back surgery through the program, but his appointment was delayed because the Richmond VA Medical Center had not sent the medical documentation his private sector doctor needed to schedule his surgery. After receiving surgery, the veteran was prescribed postoperative physical therapy. Unfortunately, he was unable to schedule his physical therapy appointments until the Richmond VA Medical Center approved the treatment. It took nearly a month for his non-VA physical therapy to be approved.

Furthermore, the VFW is concerned with the lack of private sector providers opting to participate in the program. Due to reimbursement rates and requirements to return medical documentation, some private sector providers have been reluctant to participate in the Veterans Choice Program network when they have a preexisting agreement with a VA medical facility. Such agreements often allow for higher reimbursement rates or do not require the non-VA provider to return medical documentation. The VFW is concerned that the reliance on local agreements has limited Health Net's and TriWest's ability to build capacity by expanding their Choice networks. VA must issue clear directives on how to properly utilize purchase care programs and authorities to ensure local medical facilities do not prevent the Veterans Choice Program's contractors from expanding their networks to better serve veterans.

Wait Time Standard

The VFW's initial report highlighted several flaws in the way VA calculates wait times. Unfortunately, our second report found that this flawed metric is still being used. VA's wait time standard still requires veterans to wait unreasonably long and remains susceptible to data manipulation.

VA's current wait time standard requires a veteran to wait at least 30 days beyond the date a veteran's provider deems clinically necessary, or clinically indicated date, before being

considered eligible for the Veterans Choice Program. This means that a veteran who is told by his or her VA doctor that he or she needs to be seen within 60 days is only eligible for the Veterans Choice Program if he or she is scheduled for an appointment that is more than 90 days out, or more than 30 days after the doctor's recommendation. The VFW remains concerned that veterans' health may be at risk if they are not offered the ability to receive care within the timeframe their VA providers deem necessary, regardless of whether the care is received through a VA medical facility or the Veterans Choice Program.

Furthermore, VA's wait time standard is not aligned with the realities of waiting for a VA health care appointment. Forty-five percent of the 1,464 survey respondents who have scheduled an appointment since November 5, 2014 reported waiting more than 30 days for their appointment. Yet, VA data on more than 70.8 million pending appointments between November 1, 2014 and April 15, 2015 shows that fewer than seven percent of such appointments were scheduled beyond 30 days of a veteran's preferred date.

VA's preferred date metric is a figure determined subjectively by VA schedulers when veterans call to make an appointment. The VFW has long disputed the validity of this figure, which we outlined in detail in our initial report. Our second Veterans Choice Program report found that veterans who perceive they wait longer than 30 days for care, regardless of how long VA says they wait, are more likely to be dissatisfied than veterans who perceive that VA has offered them care in a timely manner. Patient satisfaction is fundamental to the delivery of health care. Ultimately, satisfaction is based on how long veterans perceive they wait, not how VA estimates wait times. VA must take veterans' perceptions into account when establishing standards to measure how long veterans wait for their care.

The VFW and our Independent Budget (IB) partners have continued to call for VA to develop reasonable wait time standards based on acuity of care and specialty. Arbitrary system-wide deadlines do not fully account for the difference between the types and acuity of care veterans receive from VA. Waiting too long for health care can be the difference between life and death for veterans with urgent medical conditions. For example, a veteran with severe post-traumatic stress disorder should not be required to wait 30 days for treatment.

As part of the 12 independent assessments being conducted by the MITRE Corporation, et al., which were mandated by section 201 of VACAA, the Institute of Medicine (IOM) is currently evaluating if VA's wait time standard is an appropriate system wide access standard. The VFW will monitor IOM's work to ensure its recommendations serve the best interest of veterans.

Geographic Eligibility

On March 24, 2015, VA announced the most significant change that has occurred since the Veterans Choice Program was created. VA listened to the concerns of countless veterans and changed the way it calculated distance for the Veterans Choice Program from straight-line distance to driving distance. The change went into effect on April 24, 2015 and gave nearly 300,000 additional veterans the opportunity to choose whether to receive their health care through private sector providers or travel to a VA medical facility. The VFW applauds VA for taking the initiative and fixing an issue that confused veterans and caused frustration.

However, this change did not address another significant flaw in eligibility for the Veterans Choice Program. The VFW continues to hear from veterans who report that their local Community-Based Outpatient Clinics are unable to provide them the care they need, so VA

requires them to travel long distances to a VA medical center. In order to properly account for the travel burden veterans face when accessing VA health care, geographic eligibility for the Veterans Choice Program should be based on the calculated distance to facilities that provide the care they need, not facilities that are unable to serve them. For example, a veteran from Jacksonville, Florida, is required to travel to the VA medical center in Gainesville to see a neurologist because the Jacksonville clinic does not have a neurologist on staff that can see her.

The 40 mile standard was based on eligibility for TRICARE Prime. However, there is a distinct difference between the military population and the veteran population. According to VA's Office of Rural Health, youths from sparsely populated areas are more likely to join the military than those from urban areas. During their service, they are likely to live near military installations, which often have military treatment facilities. However, when they leave military service, 36 percent of veterans who enroll in the VA health care system return to rural areas. Although VA has made an attempt to expand capacity to deliver care where veterans live, it has not been able to, nor should it in some instances, expand its facilities to cover all veterans. Thus, using the same standard to measure distance that service members and their families travel to military treatment facilities to measure distance traveled by veterans to VA medical facilities, does not properly account for the diversity of the veteran population.

Feedback we have received from veterans indicates that a commute time standard based on population density (urban, rural, highly-rural) would more appropriately reflect the travel burden veterans face when accessing VA health care. However, the VFW recognizes that any established standard will be imperfect. Thus, VA must have the authority to make clinically based exceptions. Regardless, a study must be commissioned to determine the most appropriate geographic eligibility standard for health care furnished by the VA health care system. IOM is currently evaluating the way VA calculates wait times, yet no one has been asked to evaluate whether the 40-mile standard is appropriate.

While changes are made to the Veterans Choice Program, VA must fully utilize all of its purchased care programs and authorities, such as the Patient-Centered Community Care Program, to ensure veterans have timely access to high quality care. The VFW continues to believe that veterans should be afforded the opportunity to obtain care closer to home if VA care is not readily available, especially when veterans have an urgent medical need.

VA's Purchased Care Model

The Veterans Choice Program was intended to address the inconsistent use of VA's decentralized non-VA care programs and evaluate whether national standards for access to non-VA care would improve access. The VFW is committed to ensuring such standards serve the best interest of veterans who rely on VA for their health care needs. Fortunately, the Veterans Choice Program is succeeding in improving access to care for thousands of veterans. The problem remains that many veterans who are eligible for the program have yet to be given the opportunity to receive non-VA care.

As the future of the Veterans Choice Program and VA's purchased care model are evaluated, the VFW believes it is important to recognize that the quality of care veterans receive from VA is significantly better than what is available in the private sector. In fact, studies conducted by the RAND Corporation and other independent entities have consistently concluded that the VA

health care system delivers higher quality health care than private sector hospitals.¹ Additionally, independent studies have also found that delivering VA health care services through private sector providers is more costly.²

Moreover, many of VA's capabilities cannot be readily duplicated or properly supplemented by private sector health care systems – especially for issues like combat-related mental health conditions, blast injuries, or service-related toxic exposures. With this in mind, the VFW believes that VA must continue to serve as the initial touch point and guarantor of care for all enrolled veterans. As advocates for the creation and continued improvement of the VA health care system, the VFW understands that enrollment in the VA health care system is not mandatory. Yet, more than 9 million veterans have chosen to enroll and 6.5 million of them choose to rely on VA for their care, despite 75 percent of them having other forms of health care coverage. Additionally, veterans who have chosen to utilize their earned VA health care benefits are by and large satisfied with the care they receive.

The VFW believes that veterans should continue to request a VA appointment prior to becoming eligible for non-VA care. This will ensure that VA upholds its obligation as the guarantor and coordinator of care for enrolled veterans, which includes ensuring the care veterans receive from non-VA providers meets department and industry safety and quality standards. Doing so allows VA to provide a continuum of care that is unmatched by any private sector health care system.

Moving forward, the lessons learned from this important program should be incorporated into a single, system-wide, non-VA care program with veteran-centric and clinically driven access standards, which will afford veterans the option to receive care from private sector health care providers when VA is unable to meet such standards. Such a program must also include a reliable case management mechanism to ensure veterans receive proper and timely care and a robust quality assurance mechanism to ensure system wide directives and standards are met.

Non-VA care must supplement the care veterans receive at VA medical facilities, not replace it. Ideally, VA would have the capacity to provide timely access to direct care for all the veterans it serves. We know, however, that VA medical facilities continue to operate at 119 percent capacity, and may never have the resources needed to build enough capacity to provide direct care to the growing number of veterans who rely on VA for their health care needs.

VA must continue to expand capacity based on staffing models for each health care specialty and patient density thresholds. However, the VFW recognizes that in the 21st century, VA cannot rely on building new facilities alone. When thresholds are exceeded, VA must use leasing and sharing agreements with other health care systems, such as military treatment facilities, Indian Health Service facilities, federally-qualified health centers, and affiliated hospitals when possible and purchase care when it cannot.

To ensure the VA health care system provides veterans the timely access to high quality health care they have earned and deserve, VA must conduct recurring assessments and future years planning to quickly address access, safety, and utilization gaps. The VFW recognizes that these

¹ “Socialized or Not, We Can Learn from the VA,” Arthur L. Kellermann [http, RAND Corporation. August 8, 2012, www.rand.org/blog/2012/08/socialized-or-not-we-can-learn-from-the-va.html](http://www.rand.org/blog/2012/08/socialized-or-not-we-can-learn-from-the-va.html).

² “Comparing the Costs of the Veterans’ Health Care System with Private-Sector Costs,” Congressional Budget Office. December 10, 2014, <https://www.cbo.gov/publication/49763>.

improvements will not happen overnight, but veterans cannot be allowed to suffer in the meantime. Non-VA care must continue to serve as a reliable bridge between full access to direct care and where we are now.

The VFW is committed to working with Congress, VA, our veterans service organization partners and other stakeholders to continue monitoring changes to the Veterans Choice Program and VA's purchased care model; evaluate what is working; identify shortcomings; and work toward reasonable solutions.

A copy of the VFW's second Veterans Choice Program report has been sent to the Committee and I kindly request it be included in the record.

Mr. Chairman, this concludes my testimony. I am prepared to take any questions you or the Committee members may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2014, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

STATEMENT OF
ROSCOE G. BUTLER, DEPUTY DIRECTOR, HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"ASSESSING THE PROMISE AND PROGRESS OF THE CHOICE PROGRAM"

May 13, 2015

Chairman Miller, Ranking Member Brown, and distinguished members of the committee, On behalf of our National Commander, Michael Helm, and the 2.3 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's views of the progress of the Department of Veterans Affairs veterans choice program.

Background

The American Legion supported the passage of H.R. 3320, the "*Veterans Access, Choice, and Accountability Act (VACAA) of 2014*" that was signed into law on August 7, 2014 as Public Law (PL) 113-146; as a means of addressing emerging problems within the Department of Veterans Affairs (VA). VA's wait time for outpatient medical care had reached an unacceptable level nationwide and veterans were struggling to receive access to care within the VA healthcare system. It was clear that swift changes were needed to ensure veterans could access health care in a timely manner. Congress implemented this law to ensure when VA could not provide access to timely, high-quality health care inside the VA health care system; eligible veterans could elect to receive needed health care outside the VA health care system as a temporary measure until VA corrected its wait-time problem. The law authorizes veterans who were enrolled as of August 1, 2014, current eligible, or recently discharged combat veterans, the ability to be seen outside the VA by an approved non-VA health care provider if they are unable to schedule an appointment within 30 days of their preferred date, clinically appropriate date, or live more than 40 miles from a VA medical facility.¹

Assessment of the Choice program to date

On November 5, 2014, The Department of Veterans Affairs Veterans Health Administration (VHA) started the Veterans Choice program in three stages of implementation. The initial step VHA took was to mail 320,000 choice cards to enrolled veterans who reside more than 40 miles from any type of VA medical facility. On November 17, 2014, VHA initiated the second stage

¹ Public Law 113-146- August 7, 2014: Veterans Access, Choice, and Accountability Act of 2014:
<http://www.gpo.gov/fdsys/pkg/PLAW-113publ146/pdf/PLAW-113publ146.pdf>

by mailing the choice card to those veterans who were currently waiting for an appointment longer than 30 days from their preferred date or the date determined to be medically necessary by their physician. The third and final stage was to mail choice cards and letters to the remainder of all veterans enrolled in the VA health care who may be eligible for the Choice Program in the future. The card mailings included a letter explaining how to verify eligibility and use the choice card. As of February 2, 2015, according to the latest Daily Choice Metrics obtained from VA Health Net, one of the third-party administrators (TPAs) authorized 16,644 veterans to be seen outside the VA healthcare system under the Choice Program, of which 13,733 appointments were scheduled. Similarly, TriWest, another TPA issued 34,909 authorizations, and scheduled 34,909 appointments. Based on this information, the authorizations totaled 50,936 and appointments scheduled totaled 48,642. When you compare the number of authorizations and appointments scheduled to the 8,671,993 Veterans Choice Cards issued, one can easily arrive at a conclusion that the program is off to a slow start. However, The American Legion is optimistic that the recent changes used to calculate the distance between a veteran's residence and the nearest VA medical facility, moving from a straight-line distance to actual driving distance, will allow more veterans access to care under the Veterans Choice program.

Recently, The American Legion learned that the portion of VHA's Veterans Choice contract with Health Net and TriWest, which requires the TPA's to report Daily Choice metrics, has expired and the TPA's will no longer be reporting this information to VA. The American Legion is concerned that if the TPA's are no longer required to provide this type of information the number can be easily manipulated and may become an issue in the future. The American Legion calls upon Congress to require VHA to continue reporting these daily metrics throughout the duration of the contract, or explain how they will continue to track this information. One of the critical functions of the original legislation was to provide metrics on how and where the program was being used as a bellwether to indicate where VA needed to improve capacity in their system or efficiency of care delivery. By examining where the Choice program is used most heavily, stakeholders should be able to determine where improvements are needed in VA's overall care network.

Actions needed to eliminate impediments to greater veteran and physician participation

On February 25, 2015, American Legion National Commander Michael D. Helm stated during his congressional testimony before the Senate and House Veterans' Affairs Committees that one of the biggest challenges he has seen with the implementation of the Veterans Choice Card Program is the confusion over VA's definition of a VA medical facility.

On November 5, 2014, VA published a regulation which defines a "VA medical facility" as a VA hospital, a VA community-based outpatient clinic (CBOC), or a VA health care center. VA further stated that they "...included these types of VA facilities because they provide medical care or hospital services that may be provided as part of the program".² However, there is no consideration as to whether the VA medical facility can provide veterans the needed medical

² Federal Register, 79 FR 65571: <https://www.federalregister.gov/articles/2014/11/05/2014-26316/expanded-access-to-non-va-care-through-the-veterans-choice-program>

services. In many cases, veterans are being referred from a CBOC to the parent VA medical center which can be over 150 miles further away without taking into account travel times and road conditions. This can significantly impact veterans' ability to maintain their appointments, which directly impact VA's appointment cancellation and no-show rates.

During The American Legion's Commander's testimony, Senator Moran (KS) emphasized the importance of providing non-VA health care to veterans. Senator Moran calculated the distance from Helm's home in Norcatour, Kansas to the nearest VA medical facilities. *"It's 267 miles to Denver, 287 miles to Wichita, 287 miles to Omaha, and 100 miles to the nearest Community Based Outpatient Center (CBOC). I appreciate the perspective that this commander will bring about caring for all veterans regardless of where they live in the United States."*³

On March 27, 2015, American Legion National Commander Mike D. Helm praised the Senate for unanimously passing an amendment to remind the Department of Veterans Affairs that they have the obligation to provide non-VA care when it cannot offer that same treatment at one of its own facilities that is within 40-miles driving distance from a veteran's home. According to Commander Helm, the call to VA to clarify its stance was embodied in an amendment, offered by Senator Jerry Moran, R-Kansas, to Senate's budget Resolution 11.⁴

"This bill simply calls on VA to do what it already had the authority to do," National Commander Michael D. Helm said. "Intent is everything. When Congress passed the Veterans Access, Choice and Accountability Act last year, it once again gave VA this authority. I say 'once again' because VA had this authority on a fee-basis long before the Choice act. Despite this authority, VA was trying to find loopholes by denying people who were near VA clinics that did not offer the needed services the right to use an alternative provider".

"We applaud Senator Jerry Moran for writing this amendment, even though it's a shame that such a common sense measure needs to be spelled out repeatedly for VA. We call on the House to pass this measure quickly and send an unmistakable message to VA."

Efforts to ensure adequate training of VA staff regarding the Choice program

The American Legion is concerned that due to improper training, some VA medical centers are not offering Choice access to their veterans at all. On a recent visit last month to examine the healthcare system in Puerto Rico, The American Legion discovered VHA staff had been mistakenly telling veterans that no one on the island is eligible because there is no medical facility that is further than 40 miles from anywhere on the island. The American Legion also heard scattered reports of similarly confusing directives about the program from some other

³ Commander to Congress: We face 'historic opportunities'-February 26, 2015:
<http://www.legion.org/washingtonconference/226220/commander-congress-we-face-%E2%80%99historic-opportunities%E2%80%99>

⁴Congress.gov: <https://www.congress.gov/bill/114th-congress/senate-concurrent-resolution/11>

medical facilities, in contradiction to what was being expressed by VA Central Office directives. This can only occur when employees are not adequately trained, which can result in miscommunication. Better understanding of programs and communication between VA and the veterans they serve is essential to the success of any VA program.

In a recent Senate Veterans Affairs hearing, Debra Draper Director of Health Care Issues Government Accountability Office (GAO) stated:

“the veterans health care system was added to the high-risk list due to ambiguous policies and inconsistent processes; inadequate oversight and accountability; information technology challenges (such as outdated systems that lack interoperability); inadequate training for VA staff; and unclear resource needs and allocation priorities.”⁵

Since the implementation of the Veterans Choice Program, The American Legion has seen and heard from veterans nation-wide, that there was a complete lack of training and knowledgeable staff regarding the program requirements, rules and regulations. The American Legion is concerned when the Veterans Choice program was rolled out, VA did not issue an official national policy to its health care facilities outlining VA’s policy, procedures and program requirements. However, VHA Directive 6330, “Directives Management System” (DMS), states:

“It is VHA policy that VHA Central Office, VHA Veterans Integrated Service Networks (VISNs) and their field facilities establish and maintain a DMS, in accordance with this VHA Directive and corresponding Handbooks, regarding “directive” and “non-directive” media. Directive documents contain mandatory policies, procedures, and, as indicated, oversight monitoring requirements”.

This directive establishes mandatory VHA policies for VHA Programs.⁶ According to VHA Directive 6330, VHA can issue two types of policy Directives, a VHA DMS Directive or a VHA Temporary Directive.

A VHA DMS directive establishes mandatory VHA policies for VHA Programs. These Directives must be recertified every 5 years. A VHA Temporary Directive defines policy that has a limited time span or new program policies that will be incorporated in DMS Handbooks at a later date. A Temporary Directive carries an expiration date and is not issued for longer than 5 years. If the policies prescribe short-term requests for reports, data collection or implement special short-term programs, they are issued as temporary directives with a 5-year (or less) expiration date specified.

The lack of VHA policies and procedures outlining the Veteran Choice program requirements and procedural guidance for VHA field facilities staff to follow has significantly undermined VA’s ability to educate and provide appropriate guidance to its employees. These policies and

⁵ GAO Testimony: Veterans Affairs Health Care, Addition to GAO’s High Risk List and Actions Needed for Removal, GAO-15-580T <http://www.gao.gov/assets/670/669927.pdf>

⁶ Department of Veterans Affairs VHA Directive 6330- December 15, 2008: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1814

procedures when implemented are often used by VA staff to properly train employees throughout the health care system.

The American Legion believes when a new law is passed implementing new program requirements or changes, VHA should be required to provide Veterans Service Organizations and Congress a detail communication plan outlining it plans to implement the changes required by the law to include plans for staff training. In addition to this information, VHA should include the time frame for issuing any VHA Directives and Handbooks.

Increasing access to care by streamlining VA's multiple Non-VA care programs into a single integrated purchased care model

VA spent over \$5.5 billion on Non-VA care in Fiscal Year 2014. Many of VA's non-VA purchase care programs are managed by different program offices within VHA, and purchases for Contract Nursing Home, VA's State Home, Home Health, Dental and Bowel and Bladder services are handled outside of VA's Fee-Basis Claims Processing System. VA needs to streamline its current purchase care model to incorporate all of VA's non-VA care programs into a single integrated purchase care model.

Congress should also look into streamlining VA's non-VA care statutory authorities. Currently, there are eight statutory authorities, including the new Choice Act. Once Congress gets a better sense of how the Choice Program will play out over the next couple of years, the eight statutory authorities should be consolidated and rationalized incorporating lessons learned from the Choice Program.

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the 2.3 million veteran members of this organization.

For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org.



National Service & Legislative Headquarters
 807 Maine Avenue, S.W.
 Washington, D.C. 20024-2410
 Phone (202) 554-3501
 Fax (202) 554-3581
 www.dav.org

**STATEMENT OF
 JOSEPH A. VIOLANTE
 DAV NATIONAL LEGISLATIVE DIRECTOR
 COMMITTEE ON VETERANS' AFFAIRS
 UNITED STATES HOUSE OF REPRESENTATIVES
 MAY 13, 2015**

Chairman Miller, Ranking Member Brown, and Members of the Committee:

On behalf of the DAV and our 1.2 million members, all of whom were wounded, injured or made ill from their wartime service, thank you for the opportunity to testify before the Committee today to discuss the implementation of the temporary "choice" program authorized by the Veterans Access, Choice and Accountability Act of 2014 (VACAA), and how it fits into the larger issue of providing high-quality, timely care to America's veterans.

It has been just over a year since the waiting list scandal exploded in Phoenix; nine months since passage of the VACAA; six months since the first "choice" cards were mailed out; and just over three months since the mailing of nearly 9 million "choice" cards was substantially completed. While it is still far too early to reach significant conclusions about whether this program will achieve its intended purpose, we are now beginning to see the outlines of early lessons from this grand experiment.

Today's hearing is an appropriate opportunity to examine the challenges VA has faced in implementing this unprecedented, temporary program, to explore some of the reasons for the lower-than-expected usage, to consider changes and improvements to the program so that it can achieve its short-term goal of providing timely and convenient access for veterans seeking health care, and to start the discussion about how best to reform the VA health care system so that we never face this kind of access crisis again.

ORIGINS OF THE VA HEALTH CARE ACCESS CRISIS

Mr. Chairman, in order to evaluate the success of the "choice" program, it is important to understand the underlying causes of the access crisis that precipitated enactment of VACAA. While the scandal that enveloped VA last year certainly involved mismanagement in Phoenix and at other VA sites, we have no doubt that the principle reason veterans were put on waiting lists was the mismatch between funding available to VA and demand for health care from VA by veterans, a phenomenon that is hardly new. In fact, this mismatch has been regularly reported to Congress by DAV, our partners in the *Independent Budget* (IB), and others for more than a decade.

In May 2003, the bipartisan Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans examined chronic VA funding shortages in the wake of growing waiting lists at VA, which had resulted in the suspension of new enrollments for nonservice-connected veterans. At that time, 236,000 enrolled veterans were already waiting more than six months without any appointments—a much higher number than during last year's crisis. However, despite clear evidence of inadequate funding, successive Administrations and Congresses failed to adequately increase VA funding to address the heart of the mismatch, or to end the moratorium on new enrollment. Unfortunately, that mismatch continues today.

Mr. Chairman, over the past decade, the IB has recommended billions of dollars to support VA health care that the Administration did not request and Congress never appropriated. Over that period, we and our partner veterans service organizations have presented testimony to this Committee and others detailing shortfalls in VA's medical care and infrastructure budgets. In fact, in the prior 10 VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$7.8 billion less than the amounts we recommended. Over the past five budgets, the IB recommended \$4 billion more than VA requested and Congress approved. For this fiscal year, FY 2015, the IB had recommended over \$2 billion more than VA requested or Congress appropriated.

The other major contributor to VA's access crisis is the lack of sufficient physical space to examine and treat all veterans in need of care. Over the past decade, the amount of funding requested by VA for major and minor construction to sustain its medical centers and clinics, compared to the amount appropriated by Congress, has been more than \$9 billion less than what the IB estimated was needed. Over the past five years alone, that shortfall was more than \$6.6 billion, and for this year the VA budget request is more than \$2.5 billion less than the IB recommendation.

Mr. Chairman, we are all aware that funding levels for VA have risen every year for more than a decade, and we appreciate that fact. However, the demand – as measured not only by enrollees and users, but more importantly by the number of appointments – has risen even faster. In addition, the cost of care is rising not just due to medical inflation, but also because of the increased cost of specialized care provided to so many veterans being treated for traumatic physical and mental injuries, many from the ongoing wars in Iraq and Afghanistan. When VA does not have enough physicians, nurses and other clinical staff, and when VA's facilities are not being properly maintained, repaired, replaced or constructed, veterans will be required to wait for care. It was under these circumstances that DAV and many others supported the emergency VACAA legislation last year, but our support was predicated on a number of very important conditions and principles.

BACKGROUND OF THE TEMPORARY CHOICE PROGRAM

First, DAV and all major veterans organizations agreed that the most important priority was to ensure that any veteran waiting for necessary medical care was taken care of, whether that care was provided inside VA or in some form of care in the community. Second, in setting up the new "choice" program, Congress established a separate and mandatory funding source to ensure that VA would not need to make a choice between providing care to veterans who chose

to receive their care at VA and paying for those who chose to access care through the non-VA “choice” program. In fact, one of the primary reasons that VA’s purchased care program had struggled to meet veterans’ needs was the fact that it lacked a separate, mandated funding stream. Going forward, Congress and VA must ensure that funding for non-VA extended health care, however that program might be reformed, remains separate from funding for the VA health care system.

Another principle that was central to our support for the “choice” program was the coordination of care, which is vital to quality. Care coordination helps ensure that the veteran’s needs and preferences for health services and information sharing are met in a timely manner. VA’s use of third party administrator (TPA) networks helps to assure that medical records are returned to VA, that quality controls are in place on clinical providers, and that neither VA nor veterans are improperly invoiced for these services. VA’s use of the TPA structure has many similarities with VA’s Patient Centered Community Care (PC3) program. Through PC3, VA obtains standardized health care quality measurements, timely documentation of care, cost-avoidance with fixed rates for services across the board, guaranteed access to care, and enhanced tracking and reporting of VA expenditures. While the use of TPAs for non-VA care does not guarantee that coordination of care and health outcomes will meet the same standard as an integrated VA health care system, it remains an important component of how non-VA care should be provided in the future.

Finally, and most importantly, while the VACAA established a temporary “choice” program to address an immediate need for expanded access, it also included a significant infusion of new resources to rebuild VA’s capacity to provide timely health care. As we have testified to this Committee and others, the underlying reason for VA’s access crisis last year was a long-term, systemic lack of resources to hire enough physicians, nurses and other clinical professionals, along with a lack of usable treatment space to meet the demand for care by patients. Regardless of how both VA and non-VA care health care programs are reformed in the future, unless adequate – and separate – funding is provided for both, veterans will likely continue to have unacceptable access problems.

CHALLENGES FACING THE CHOICE PROGRAM

According to VA, as of last week, 53,828 Choice authorizations for care had been made to date by the TPAs and 43,044 actual appointments for care had been scheduled. By comparison, according to VA, about 6.4 million appointments are completed each month inside the VA health care system, and another 1.3 million appointments are completed outside VA each month using non-VA care programs other than the “choice” program, including the fee-basis, contract care, PC3, Access Achieved Closer to Home (ARCH) and other programs.

A number of reasons likely contributed to this lower than expected utilization of the “choice” program. On the positive side, since the most recent access crisis gained attention last spring, the VA has used every available resource to increase its capacity to provide timely care at facilities across the nation. VA health care facilities expanded their days and hours of operation; mobile health units were deployed to areas with higher-than-average demand; and VA made

greater use of existing non-VA care authorities. VA's ability to expand its capacity on a temporary basis may have shifted some of the demand away from "choice."

It is also very clear that VA was slow in rolling out "choice" cards and in educating its own staff about how and when the "choice" program could be utilized. In part this was due to the extremely aggressive implementation schedule in the law. However, even today we are hearing reports of VA personnel who do not understand the "choice" program or its role among non-VA care authorities. As a result, some veterans who are eligible for "choice" are not being properly referred to the program, and some veterans who are eligible for non-VA care programs, such as PC3, are inappropriately being referred to "choice." Both of these factors may have deterred some veterans from exploring their eligibility for the "choice" program. VA must do a better job of ensuring that all VA employees understand the proper role and relationship of all non-VA care programs, including "choice."

We also continue to hear troubling reports of a significant lag time between when a VA clinician determines a veteran is eligible for "choice" and the time that the TPA can see this authorization in its system. In some cases, we have been told up to 30 days or more could be required. VA must determine the cause of such unacceptable delays, whether IT related or not, and ensure that there is a rapid and seamless handoff from VA to the appropriate TPA. Such delays certainly might dampen veteran interest in using the "choice" program.

Another possible contributing factor for the low utilization is the restrictive manner in which the 40-mile distance criterion mandated by VACAA was implemented. The bill established two primary access standards to determine when and which veterans would be authorized to use the new "choice" program: those who would have to wait longer than 30 days or travel more than 40 miles for VA care. Unfortunately, due to cost and scoring implications, the 40-mile standard was crafted, interpreted and implemented in a way that was more restrictive than logic and common sense would dictate, although VA has now revised that criterion in part.

As was clearly stated in the report accompanying the law, the determination of whether a veteran resided more than 40 miles from the nearest VA medical facility was based on a geodesic measurement, essentially the distance in a straight line from point-to-point, or "as the crow flies." Fortunately, following further discussions between VA and Congress, this distance criteria has been revised so that the calculation of 40 miles is now done by the shortest driving distance in road miles. This change has expanded the number of veterans eligible under the distance standard and could lead to some increase in utilization.

The second inequity in the distance criteria is that the measurement is taken from the veteran's residence to the nearest VA medical facility regardless if that facility can actually provide the service required by the veteran. As has been acknowledged by the law's primary sponsors, these restrictive standards for measuring 40 miles were due to the high cost estimates received from the Congressional Budget Office (CBO) during the bill's consideration, and a need to lower that projected cost. As we have testified previously, such a measurement makes no logical sense and should be changed in the temporary "choice" program.

However, it is important to note that creating a system that will allow VA to immediately determine whether a service is or is not available at a VA and/or private facility, or will be available within a 30-day window, could be very difficult. Furthermore, VA has indicated that the number of veterans who may live farther than 40 miles from a VA medical center, where most VA specialty care is delivered, could rise to as high as 3.9 million, which could significantly expand the utilization of the program.

Finally, another reason so few veterans have used the "choice" program may be because they simply prefer to go to the VA. Even with the "choice" card, some veterans with non-urgent medical needs may prefer the VA physician, treatment team, or facility they know, rather than look for a new, unknown provider in the private sector. The bottom line is that we simply do not have sufficient data to determine exactly which factors are behind the low utilization rates at this point. Therefore, it is absolutely essential to take steps now so that we have sufficient data and analysis before it is the appropriate time to consider permanent changes to the VA health care system.

LEARNING FROM THE CHOICE PROGRAM

The "choice" program is an unprecedented experiment, launched during a crisis in order to address a short-term emergency need. Therefore, it is incumbent upon us to ensure that the proper measurements and metrics are in place in order to evaluate the success of the program and learn the appropriate lessons. Unfortunately, a number of important questions and metrics at present are not being studied.

The "choice" program was principally intended to address the unacceptable waiting times facing veterans to receive care within the VA by allowing them to choose private care providers. As such, it is imperative that VA measure the time that veterans wait for appointments, including follow-up appointments, when authorized to go outside the VA. It is also necessary to understand what the waiting times, or access standards, are for the private sector, both in general and in detail. After all, the waiting time for a routine dermatology appointment should not be the same as that for a serious cardiac condition.

One of the key questions, and one of the primary contributing factors to the waiting list scandals, was unrealistic access standards in place at VA, which were subsequently repealed. It is important for VA to develop new and realistic standards, regardless of the future structure of non-VA care, not only for waiting times, but also for travel distances. As we and others have pointed out in prior hearings, the distance that is reasonable to expect a younger veteran in relatively good health to travel may be significantly different from what a 90-year old World War II veteran with serious physical disabilities would be required to travel. Furthermore, these standards must be clinically based to ensure the best health outcomes, not randomly set for financial or political reasons.

Mr. Chairman, given the importance of determining appropriate access standards, we would recommend that Congress authorize a comprehensive and independent study to review the access standards used in the private sector, and to make recommendations for such standards for the VA health care system.

In order to properly evaluate the “choice” program, VA must also collect, study and analyze data on patient satisfaction and health outcomes for those who use private providers through the “choice” program. VA needs to establish baseline data from which it can compare satisfaction for those who use “choice,” those who use other non-VA care programs, and those who use VA care. Measuring health outcomes may prove more challenging, given that it takes many years before true outcomes are known; however, since this is the ultimate measure of success, VA must begin to explore appropriate research, analysis and metrics that could be implemented now in order to help with such analysis in the future.

Another key area that must be evaluated is the coordination of care for veterans who go outside the VA, both through the “choice” program and other non-VA care authorities. Over the next couple of years, veterans may find themselves receiving care inside VA as well as outside, and VA must be able to determine how well that care is coordinated through the various programs. It is imperative that VA carefully monitor how and what kind of medical information is transmitted back and forth between VA and non-VA providers.

THE CONGRESSIONALLY-MANDATED “COMMISSION ON CARE”

In addition to the temporary three-year “choice” program and the investment of new resources in the VA health care system, the VACAA also requires the creation of a “Commission on Care” to study and make recommendations for long-term improvements to best deliver timely and high quality health care to veterans over the next two decades. Specifically, the law requires that members of this Commission be appointed not later than one year after the date of enactment of Public Law 113-146, which would be no later than August 7, 2015. The President, Majority and Minority Leaders of the Senate, Speaker and Minority Leader of the House, will each appoint three members of the Commission, with the President designating the Chairman.

Under the law, once a majority of appointments is made, the Commission must hold its first meeting within 15 days, and then it is provided only 90 days to produce an interim report with both findings and recommendations for legislative or administrative actions, and then only 90 additional days to submit a final report.

Mr. Chairman, last month, DAV, PVA, VFW, The American Legion, IAVA and a number of other VSOs wrote to Senate and House leaders to call for extending the mandate of this Commission to allow at least 12 months before the interim report is due, and at least six additional months before the final report is presented to Congress. In our jointly signed letter, we argued that, “... 90 days does not provide nearly sufficient time for a newly constituted Commission of 15 individuals – each with their own unique background, experience and understanding of the current VA health care system – to comprehensively examine all of the issues involved, to conduct and review sufficient research and analysis, and to discuss, debate and reach agreement on specific findings and recommendations that could change how health care will be delivered to millions of veterans over the next twenty years.”

In addition, we called on Congress to refrain from taking any, “...permanent, systemic changes ... until after the Commission has had sufficient opportunity to consider how best to

deliver health care to veterans for the next two decades, submitted its recommendations, and then allowed sufficient opportunity for other stakeholders and Congress to engage in a debate worthy of the men and women who served.”

By gathering essential data and performing crucial research over the next year or so, the Commission, Congress and other stakeholders would be able to work together to ensure that veterans receive the health care they have earned. However, it is also important that before we engage in a debate about how to structure both VA and non-VA care programs, we gain a consensus about the proper role and responsibility of the VA.

THE PRINCIPLE MISSION OF VA HEALTH CARE

One hundred and fifty years ago, only a month before the Civil War ended, President Abraham Lincoln stood on the East Front of the U.S. Capitol to make his Second Inaugural Address, in which he made a solemn promise on behalf of the nation “...to care for him who shall have borne the battle, for his widow, and his orphan...” Those words which are engraved on the entrance of the Department’s building here in Washington, DC, were spoken just one day after Lincoln signed legislation to create the very first federal facility devoted exclusively to the care of war veterans, which ultimately evolved into today’s VA health care system.

Since that date, leaders of Congress and Presidents of all parties have been united in their bipartisan support of a robust federal health system to care for veterans. But after a very difficult year filled with a waiting list scandal and a health care access crisis – which resulted in the resignation of a sitting VA Secretary – there is now discussion about how and whether to keep that promise to the men and women who served. While we certainly agree that change and reform are needed at the VA, we have a sacred obligation to ensure that America never abandons Lincoln’s promise.

While the VA health care system has long been the embodiment of our national promise, some are now proposing to make it just another “choice” among all health care providers, while others are calling for VA to be downsized or eliminated altogether. For millions of veterans wounded, injured or made ill from their service, their only “choice” for receiving the specialized care they need is a robust VA.

Although the VA today provides comprehensive medical care to more than 6.5 million veterans each year, the VA system’s primary mission is to meet the unique, specialized health care needs of service-connected disabled veterans. To accomplish this mission, VA health care is integrated with a clinical research program and academic affiliation with well over 100 of the world’s most prominent schools of health professions to ensure veterans have access to the most advanced treatments in the world.

Furthermore, in order to achieve the best health outcomes, it is necessary to treat the whole veteran, and that is exactly what the VA is organized to do. VA provides comprehensive, holistic and preventative care that results in demonstrably improved quality, higher patient satisfaction and better health outcomes for the veterans it serves. For those veterans who rely on

VA for care, those who have suffered amputations, paralysis, burns and other injuries and illnesses, we believe they deserve the “choice” to receive all or most of their care from the VA.

If the VA health care system ends up being downsized as a result of allowing all veterans to leave VA through expanded “choice” programs, some or all of the 3.8 million service-connected disabled veterans who rely on VA for their health care today would no longer have the “choice” to receive all their care from VA. Instead, they would end up with fractured care, receiving care through a combination of VA and non-VA providers.

And if VA was eliminated outright and no longer an option for seriously disabled veterans, would the private health care system be able to provide timely access to the specialized care they require? While the private sector also treats many of the same conditions that VA specializes in – including amputations, paralysis, severe burns, blindness, traumatic brain injury (TBI) and even post-traumatic stress disorder (PTSD) – there is simply no comparison with the frequency, severity and comorbidities routinely seen by VA physicians. Even if all 3.8 million disabled veterans were dispersed into private care, they would still make up just 1.5% of the adult patient population. Does anyone truly believe that a market-based civilian health system would provide the focus and resources necessary to advance the level of care for this small minority in the way that a dedicated, federal VA system would?

SETTING A NEW FRAMEWORK FOR REFORMING VA HEALTH CARE

While it is far too soon to settle on how to reform the VA health care system and integrate non-VA care, we must begin to establish at least a road map to guide us. We propose a new framework to meet the needs of the next generation of America’s veterans based on rebuilding, restructuring, realigning and reforming the VA health care system.

First, we must rebuild and sustain VA’s capacity to provide timely, high quality care. That must begin with a long-term strategy to recruit, hire and retain sufficient clinical staff at all VA facilities. In addition, VA must gain the commitment and funding to implement a long-term strategy to repair, maintain and expand, as necessary, usable treatment space to maximize access points where veterans can receive their care. VA must build upon its temporary access initiatives implemented last year by permanently extending hours of operations around the country at CBOCs and other VA treatment facilities to increase access for veterans outside traditional working hours. To provide the highest quality care, we must strengthen VA’s clinical research programs to prepare for veterans’ future health care needs. In addition, we must sustain VA’s academic affiliations to support the teaching and research programs and to help support future staffing recruitment efforts.

Second, VA must restructure its non-VA care program into a single integrated extended care network. This will require that VA first complete the research and analysis related to the “choice” program discussed above, and allow the Commission on Care to complete its work. Then based on that research and data, VA must develop an integrated VA Extended Care Network which incorporates the best features of fee-basis, contract care, ARCH, PC3, “choice,” and other purchased care programs. However, this will only work if Congress also provides a single, separate and guaranteed funding mechanism for this VA Extended Care program. To

make this program veteran-centric, VA must complete the research discussed above related to private sector access standards in order to establish a new clinically-based access policy that is informed, objective and based on rigorously established factual evidence. In addition, VA must develop an appropriate and effective decision mechanism that ensures that veterans are able to access VA's Extended Care Network whenever medically-necessary, as well as a new, transparent, and dedicated review and appeal process capable of making rapid decisions to ensure veterans have timely access.

Third, we must realign and expand VA health care services to meet the diverse needs of future generations of veterans, beginning with VA expanding urgent care clinics with extended operating hours. The VA, like any large health care system should provide walk-in capability to meet the urgent care needs of enrolled veterans. These services would be delivered by dedicated doctors and nurses in existing VA facilities, or smaller urgent care clinics strategically situated in new locations around the country, such as in shopping malls. In addition, VA must extend access to care further through enhanced web-based and tele-medicine options to reach even the most remote and rural veterans. And with veteran demographics continuing to change, VA must eliminate barriers and expand services to ensure that women veterans have equal access to high quality, gender-specific, holistic, preventative health care. VA must also rebalance its long-term supports and services to provide greater access to home- and community-based services to meet current and future needs, including expanding support for caregivers of veterans from all generations.

Fourth, VA must reform its management of the health care system by increasing efficiency, transparency and accountability in order to become a veteran-centric organization. VA can begin by developing a new patient-driven scheduling system, including web and app-based programs that allow veterans to self-schedule health care appointments. To support responsible organizational behavior, VA should redesign its Performance and Accountability Report (PAR) to establish new metrics that are focused on veteran-centric outcomes with clear transparency and accountability mechanisms. VA's budgeting process would benefit by implementing a more transparent and accountable system known as PPBE, which stands for planning, programming, budgeting and execution. This approach is already working for the Departments of Defense and Homeland Security, and there is legislation pending to bring the same to VA. Finally, VA must hold all of its employees – from the Secretary to receptionists – to the highest standards, while always balancing the need to make the VA an employer of choice among federal agencies and the private sector.

Mr. Chairman, the framework outlined here certainly is not intended to be a final or detailed plan for reforming VA, nor could it be at this point with so much unknown, but it offers a new pathway that could lead toward a future that would truly fulfill Lincoln's promise. DAV is convinced that the VA health care system has been, can be and must be the centerpiece of how our nation delivers health care to America's wounded, injured and ill veterans.

While the VA faces serious challenges, the answer is not to abandon it, or to destroy it. Instead, we must honor the service and sacrifices of our nation's heroes by creating a modern, high-quality, accessible and accountable VA health care system. Anything less breaks Lincoln's

promise, ignores our sacred national obligation, and leaves our veterans to fend for themselves in a private sector health system ill prepared to care for them.

That concludes my testimony and I would be pleased to address questions from you or other Members of the Committee.



Statement of Iraq & Afghanistan Veterans of America
House Committee on Veterans' Affairs
May 13th, 2015

**Statement of Christopher Neiweem
Legislative Associate
at
Iraq and Afghanistan Veterans of America
before the
House Committee on Veterans' Affairs
for the
Hearing: "Assessing the Promise and Progress of the
Choice Program"
May 13, 2015**

Chairman Miller, Ranking Member Brown and Distinguished Members of the Committee.

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our nearly 400,000 members and supporters, thank you for the opportunity to share our views with you at today's hearing Assessing the Promise and Progress of the Choice Program.

IAVA was one of the leading veterans organizations involved in the early negotiations on the Veterans Access to Choice and Accountability Act (VACAA), as it was being drafted and the breadth of its final language was debated. This is a highly complex law that the Department is continuing to work to effectively implement in order to ensure veterans are not left waiting for unacceptable lengths of time to receive health care services.

My remarks will focus on the experiences of utilizing the VA Choice Program IAVA members have recently reported by way of survey research. Additionally, I will provide recommendations Congress and the Secretary must consider in order to get this program

operating at the height of its potential. These recommendations include: legislative clarification of the eligibility criteria for accessing the choice program, strengthening training guidelines for VA schedulers charged to explain the eligibility criteria to veterans, and active engagement with veteran organizations to more broadly identify a comprehensive strategy and plan for delivering Non-VA care in the future.

In examining the current criteria for determining which veterans are eligible to use the Choice Program, those who must wait longer than 30 days for an appointment and those who live more than 40 miles from a VA medical facility, more statutory clarity is required. Veterans are all too frequently reporting they are unsure if they are eligible for choice and VA has, in some cases, been inconsistent in communicating whether or not a veteran can access it in individual cases.

Over 1/3rd of IAVA members have reported they do not know how to access the program. This is compounded by reports that in some cases VA scheduling personnel are not explaining eligibility for choice to veterans and are then offering appointments "off the grid" of the 30 day standard--sometimes much later.

The Secretary must continue to engage VA front-facing scheduling personnel with ongoing and evolving training standards, so when veterans call the VA, they hang up the phone with the correct or best answer that explains their choice eligibility. The VA has improved in this area but with so many veterans still confused about choice eligibility--nearly 7 months after the program's birth--training criteria must be strengthened and maintained.

Congress should aid in the Department's implementation efforts by clarifying in law that the 40-mile criteria must relate specifically to the VA facility in which the needed medical care will be provided. The frustrating example that has surfaced is one of a veteran that requires specialized care in a VA facility outside of 40 miles, but through strict

interpretation of the current VACAA law, is ineligible for participation because a local CBOC may be geographically near the veteran's address, notwithstanding that facility cannot provide the required care. One of our members illustrated one of these cases with the following statement: "Because there is a CBOC in my area I was denied. The clinic doesn't provide any service or treatment I need for my primary service connected disability. [The] nearest medical center in my network is 153 miles away." Congress must provide much-needed clarity and work with VA to eliminate cases like those just described.

However, VA's action to step up to fix the initial ineffectiveness of the 40-mile rule calculations under regulation, as it related to geodesic distance vs. driving distance is encouraging. That regulatory correction was much needed and we applaud the Secretary for leading to make that change happen.

VHA's statistics on choice utilization among the veteran population as of this month state there have been nearly 58,863 authorizations for care and nearly 47,000 appointments. This data verifies that veterans out there are using the program and the VA has been making progress to implement what is clearly a complex and historic mandate relating to the furnishment of veteran health care now and in years to come.

IAVA is committed to remaining actively engaged with the veterans making use of choice care so we can keep current on the veteran experience. We are mindful that with thousands of appointments for care being concluded, there will inevitably be thousands of unique experiences we want to know about to gauge the satisfaction with this program. The satisfaction of the veteran utilizing choice, the cost of the care purchased outside of VA facilities and understanding issues that come up along the way will allow us to better identify the scope and role the concept of choice plays in the future.

We appreciate the hard work of Congress, the VA, and the veteran community and

recognize we have to stay focused on improving veteran healthcare delivery in the short and long-term. Robust discussion on the scope and cost of maintaining healthcare networks is complicated and multi-layered, which is why our last recommendation is simple: we must continue to work together and keep communication active between all relevant stakeholders.

Mr. Chairman, we sincerely appreciate your Committee's hard work in this area, your invitation to allow us to participate in this important hearing, and we stand ready to assist Congress and Secretary Bob McDonald to achieve the best results for the choice program now and in the future.

I am happy to answer any questions you may have.

Short Biography

As Legislative Associate, Christopher maintains Congressional relationships and supports advocacy programs. Chris spent 6 years in the U.S. Army Reserve as a military police

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NCO and served an honorable tour of duty in Operation Iraqi Freedom detaining Enemy Prisoners of War (EPWs) and performing base security and customs in 2003 during the Iraq war. He completed a Bachelors Degree in political science from Northern Illinois University in 2007 and served as a congressional intern for Congressman Donald Manzullo who previously represented Illinois' 16th congressional district. He completed a Masters Degree in 2011 from the University of Illinois at Springfield in political affairs; during this period he completed an internship with the lobby firm Cook Witter Inc. He has been working in the veteran policy space for 4 years.

Statement on Receipt of Grants or Contract Funds

Neither Mr. Neiweem, nor the organization he represents, Iraq and Afghanistan Veterans of America, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

STATEMENT OF DANNY BREEDING

Nice seeing you again this past Monday in Morristown. Per our conversation regarding the Veterans Choice Card, all I have heard from our local veterans in Hawkins County "its a joke". Personally I called the toll free number and was told by a lady that the area I lived was not "programmed" in. I was told to call back in 7-10 days to check if information was available. This was in December after the October roll out.

I have also heard from a few veterans that they were told because residing in the immediate Rogersville area, we had a VA facility, and they could attend there. (after obtaining their own appointment) They were referring to our CBOC, which only has a primary care physicians are in our OBOC.

Hearing other disgruntled stories through The Tennessee Department of Veterans Affairs quarterly training, I must agree with my fellow veterans I serve, the program is a joke indeed. Some common sense needed to be implemented before this program was rolled out ... mainly the miles issue and of course realizing the difference between a CBOC and a VA Medical Center.

Bill, I use the VA Health Care pretty much exclusively, I've only good things to say about my treatment. I'm just thankful I haven't had to depend on The Choice Card for care. With my Service Connected PTSD, I would probably make a fool of myself!

Regards, and my best to you and Congressman Roe,
Danny Breeding
VSO/Hawkins County

