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EXPLORING THE IMPLEMENTATION AND FUTURE OF THE VETERANS CHOICE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

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EXPLORING THE IMPLEMENTATION AND FUTURE OF THE VETERANS CHOICE PROGRAM

TUESDAY, MAY 12, 2015

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:45 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Cassidy, Rounds, Tillis, Blumenthal, Sanders, Tester, Hirono, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call the Committee to order. We have a vote on the floor which should be over in the next 10 minutes. I passed Ranking Member Blumenthal going in as I was leaving. He supposedly is on the way, so I will talk a little bit and tell you what I want you to know by the opening statement. If he is not here, I want to start with the testimony from Deputy Secretary Sloan Gibson. If he is here, we will hear from the Ranking Member. Is that fair enough? Is that OK?

[Sen. Blumenthal's staff nodding affirmatively.]

Make a note that his staff said that was OK. [Laughter.]

I hate to get people in trouble.

I want to take a little extra time on this, anyway, because this is a very important hearing for the VA and it is a very important hearing for us.

Last year, culminating in August with the passage of the Veterans Choice bill in the U.S. House and Senate, the VA—every morning I got up, it was bad news: veterans dying in Phoenix, problems in Raleigh, problems in Denver, problems in Orlando, and answers that were incomplete at best—for understandable reasons, because an awful lot of the personnel at the VA were new.

I am the first person to recognize that Robert McDonald had just gotten there. I am the first person to recognize that Deputy Secretary Petzel just had left VA. Secretary Shinseki was gone as well, so there was a transition.

But, to my way of thinking, there is no excuse for the plethora of problems the VA was having, and the transition should have been much better but was not.

The VA demonstrated to me in the last hearing we had on Veterans Choice that they finally were listening. All I was hearing on the 40-mile rule in terms of as-the-crow-flies versus how far the car drives was nothing but stonewalls until finally Sloan walked into that hearing, reached in his pocket, and pulled out a new ruling on the 40-mile rule to make the number of miles driven be the governing factor. I think everybody on this Committee appreciated and agreed with and was happy that VA found a way to do it. I believe we are satisfactorily working toward "the care you need" definition being defined statutorily in such a way to make that change, which will not happen today but will happen in the very near future. I want to commend Deputy Secretary Gibson, Secretary McDonald, and the others for the work they have done on that.

To the VSOs who are in the room, I know some of you do not like the Veterans Choice bill because they fear it will be a replacement for the Veterans Administration. We are not going to replace the Veterans Administration. It will always be there. But you can empower the Veterans Administration, you can empower the veteran by seeing to it they have access to world-class care, in close proximity to where they live, in an affordable amount and a manageable amount, whether it is from the private sector or whether it is from the Government.

In fact, if anything—and this is going to sound harsh, and it should sound harsh—the VA has demonstrated it cannot build a hospital by running over 100 percent, 200 percent, 300 percent, or 400 percent. Every time we can have private sector help given to veterans without having to build a hospital to put the people in, it is saving the VA money, it is saving the United States money, and it is giving the veterans far better services.

What we need is a partnership between the private sector and the Veterans Administration to deliver the ultimate goal, which is to see to it that our veterans get world-class health care and they get it in a timely way. That is my only goal. However we do that, the most important way to do it is to get it done. I think Veterans Choice is the way to do it.

Now, we have had some bumps since Veterans Choice was rolled out. We have had some bumps. I have met with some of our private contractors, and, by the way, I appreciated those meetings and their confidence in the job that we can do. I appreciate the fact that VA is now cooperating I think in ways that it might not have been cooperating before to see to it the two are working seamlessly. If they cannot work seamlessly, it will never work.

The private contractors have to understand their contracts are not just subject to their performance for the veteran, but also their willingness to work cooperatively with the VA. The VA needs to understand that the veteran's health care drives the decision and nothing else.

There are some in VA health care who do not like the non-VA health care provisions anyway. I understand that. But they are going to have to get used to it, because we are going to make this thing work. We are not going to put a square peg in a round hole. We are going to match the round peg with the round hole and make this work for our veterans.

Today's hearing is important to hear a report from the VA and the contractors and then later from the VSOs, understanding that as we talk today, remember, the first person we are here to serve is our veteran. They risk their lives for each and every one of us to be here today. We can expect no less of ourselves to see to it they get the best world-class health care as accessible and affordable as possible from our country and the taxpayer.

With that said, I will turn to the Ranking Member, Senator Blumenthal.

STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for having this hearing. Thank you to each of you for being here today.

We went through a terrible tragedy and debacle not long ago that prompted the Veterans Access, Choice, and Accountability Act, which sought to relieve some of the problems and underlying issues, including deceit and fraud, that caused delays and misreporting within the VA system.

The discussion today is centered on the remaining flaws and failings in the VA health care program, particularly the Veterans Choice Program. As much as this program was established to deal with the immediate crisis of access to care in the short term with an investment of $10 billion to provide direct care services in the community and $5 billion to provide the Choice Program, there is still a lot to be done.

The program was just a downpayment, just a first step, and I believe that it has to be improved even further. There remains, for example, underutilization of the Choice Program. The reasons for it have yet to be determined or discovered. The underutilization may well be the result of a failure to sufficiently publicize or make veterans aware. It may be the result of other more fundamental issues within the program, and I share the Chairman's view that changing the 40-mile rule was certainly a welcome step.

The most important fact that brings us here today—and we cannot lose sight of it—is that we still have not solved the crisis that led to this program. Veterans still wait too long for health care. Health care delayed, in effect, is health care denied for veterans who suffer from health conditions that require immediate treatment.

The VA's most recent data release of May 1 indicates that wait list numbers have increased significantly since the same time last month. In its an April 2 release, 377,300 veterans had appointments scheduled in more than 30 days from the preferred date. As of the May 1st release, that number had jumped by approximately 56,000 to nearly 434,000.

Anybody who believes that this crisis has been solved is living in an alternate universe. It is not the universe that our veterans inhabit.

These delays have real-life consequences. They cannot be tolerated. Too many veterans are still waiting too long for appointments, and I am glad that the VA is finally going out to the facilities with long wait times trying to determine why exactly they are

not utilizing non-VA care options. I notice that a lot of the testimony today talks about further changes to the geographic criteria.

Every time there is an additional change to the 40-mile criteria, more of the $10 billion allocated for the Choice Program will be devoted to paying for access. This money is owed to our veterans because better health care is due them.

I will close on this note. We still do not have accountability for the delays. The Inspector General still has not completed his work. We still have no reports on action, and I mean effective disciplinary action for the delays that were intolerable and still are unacceptable. Accountability is absolutely necessary, and I believe that the Inspector General needs more resources to effectively implement accountability. I will continue to press for the reports and for action by the Inspector General that will send a message to the health care apparatus and professionals in the VA that we really mean what we say when "accountability" is our watch word.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Blumenthal.

Our first panel will be made up of the following individuals:

First of all, Hon. Sloan Gibson. We have become new best friends over the last 4 or 5 months, and I want to thank him publicly in this introduction for his willingness to take on some tough situations. He inherited some tough situations, and I appreciate the fact that he is approaching them in a very positive way. We have got a few more tough ones coming up, so I hope you will maintain that attitude all the way through. I am very appreciative of the cooperation.

To reiterate for those who are present, including the press, Secretary McDonald and Deputiy Secretary Gibson invited the Ranking Member, myself, the House Ranking Member, and the House Chairman to the VA for what they call a "standup," which was in February. We have been invited to come back in June, and I believe the invite is for the entire Committee if they want to come. I think I heard that this morning, so, as many Members who want to go, I want to make sure they are invited to see the way in which the VA is benchmarking itself against itself, so to speak, to try and find better ways to do things and flush out the problems in advance and get them solved earlier. We are looking forward to doing that, and we have got some big problems to solve in the next few months, which will be a testimony or a test, one way or another, to our willingness to work together.

Dr. Tuchschmidt, we appreciate you being here to assist Sloan in any way he needs. I am sure if he gets a tough question, he will defer to you, so we appreciate you being here very much.

To our private providers: Mr. McIntyre, I enjoyed our meeting earlier this week. I appreciate the insights that you gave me. Ms. Hoffmeier, I appreciate your being here today. We look forward to hearing first from Sloan Gibson.

STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JAMES TUCHSCHMIDT, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH

Mr. GIBSON. Thank you, Mr. Chairman. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, we are committed to making the Choice Program work and to providing veterans timely and geographically accessible quality care, using care in the community whenever necessary. I will talk shortly about what we are doing and the help that we need from Congress to make all that happen. First I want to talk very briefly about access to care.

Most mornings at 9 a.m. for the last year, senior leaders from across the Department gather 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 10 percent, and increasing staff productivity. The result: 2.5 million more completed appointments inside VA this year than last. Relative value units, a common measure of care delivered across—used to measure care delivered across the industry are also up 9 percent.

Another focus area for us in 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 appointments completed. Year to date in 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 care at VA. Among those who are enrolled, more are actually using VA for care, and those using VA 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, for example, where we have added hundreds of additional staff, we have increased completed appointments 20 percent this year. I should also note that we have increased care in the community 127 percent in Phoenix over the last year, largely due to the extraordinary effort of TriWest in that particular community.

However, wait times are not down. Wait times are not down in Phoenix because of the surge in additional veterans coming to VA for care plus the veterans that are there asking for more care from VA.

In Las Vegas, we have got a 17-percent increase in veterans receiving care since we opened the new medical center there less than 2 years ago.

In Denver, we have opened outpatient clinics and added more than 500 additional staff. Veterans using VA for care there are up 9 percent.

In Fayetteville, NC, where wait times continue to be a problem, we have increased appointments 13 percent, relative value units up 19 percent, and veterans using VA for care are up 10 percent.

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 reason for increasing demand are an aging veteran population, increases in the number of medical conditions veterans claim, and a rise in the degree of 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 have for years in programs other than Choice. In fiscal year 2013, we 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 $9.9 billion, including Choice, a 25-percent increase in care in the community in just 2 years.

At the same time, we have had a large increase in care in the community, but Choice is not working as intended. Here are some things we are doing to fix it.

On April 24, we changed the measure from straight line to driving distance using the fastest route. This roughly doubles the number of veterans eligible for the 40-mile program under Choice.

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, improvement to the Web site and ramped-up social networking, new mechanisms to gather timely feedback directly from both veterans as well as from front-line staff. These are all already in place or about to launch.

In the longer term, we must rationalize community care into a single channel. The different programs with different rules and reimbursement rates, methods of payment, and funding routes are too complicated. They are too complicated for veterans, for providers, and for VA employees who coordinate care. I am confident we will need your help on that.

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 the Committee, with staff, and with the CBO. It confirms the extraordinary cost that had 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 careful consideration.

While we are working together on an intermediate-term solution, we are requesting Congress grant VA greater flexibility to expand the hardship criteria in Choice beyond just geographic barriers. This authority would allow us to mitigate the impact of distance and other hardships for many veterans.

We also request greater flexibility around some requirements that preclude us from using Choice for services such as obstetrics, dentistry, and long-term care.

As described above, we accelerated access to care in the community this year, anticipating that 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 pro-

gram 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.

Last, we are requesting flexibility in one other area of veteran care: hepatitis C treatment. You are all familiar with the miraculous impact of this new generation of drugs. Veterans that have been hepatitis 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 or appropriation. We moved $688 million from care in the community, anticipating the shift in cost 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 the fiscal year.

We are improving access to care, notwithstanding the reported wait times that you see. That means we have still got work to do on wait times, but 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 allow us to meet the health care needs of our veterans.

We look forward to your questions.

[The prepared statement of Mr. Gibson follows:]

PREPARED STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon. Chairman Isakson, Ranking Member Blumenthal, 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 Tuchschmidt, 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 Web site as a clearinghouse for public information. Veterans and Veterans Service Organizations are the primary audience for the Choice Web site, but care providers also utilize the site's resources. VA expanded the existing VA Community Care Provider Web site 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 (Training-Finder 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 sub-

scribed 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 toward 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.

Chairman ISAKSON. Mr. McIntyre.

STATEMENT OF DAVID J. McINTYRE, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTHCARE ALLIANCE

Mr. MCINTYRE. Mr. Chairman, Ranking Member Blumenthal, and members of the distinguished Committee, I am grateful for the opportunity to appear before you this afternoon on behalf of our company's employees and its nonprofit owners to discuss TriWest Healthcare Alliance's work which we are privileged to do in support of the Department of Veterans Affairs.

I would like to focus my oral testimony on three topics: the realities of this program's implementation, the process of identifying and resolving gaps and those which remain to be resolved, and what I believe to be the art of the possible path going forward.

Mr. Chairman, before the Veterans Choice Program, there was PC3, Patient-Centered Community Care. As you know and as Secretary Gibson has said, purchasing care in the community from community providers has been a long practice of the VA. In fact, in September 2013, after 2 years of planning, VA sought to change that with the awarding to the patient-centered community care contracts to us and Health Net. That contract was designed to have a consolidated, integrated delivery system built in the community to undergird the VA facilities across the 28 States and the Pacific that we are privileged to serve, and make sure at the end of the day that we were not there to replace the VA, that we were there to supplement it.

In fact, it worked as intended. When the furnace lit off in our home town of Phoenix, AZ, 6,300 providers under contract under PC3 leaned forward at the site of the VA medical center to assist them in eliminating the backlog, and by August, 14,000 veterans had moved through that process.

Around the same time, we got a modification to add primary care to those contracts, and within 90 days we stood up a network of primary care providers. We now have over 100,000 providers across 28 States and the Pacific under contract, along with 4,500 facilities, and we are not finished. The reason why we are not finished is that we need to make sure that the networks are tailored to match the demand that exists in a particular market that is not able to be met by the VA facilities itself.

The fact of the matter is that it was a complicated program to set up. It was done under very short order. But it was training, if you will, for what was to come next, because on November 5, after 30 days of work, we were to stand up in support of VA the Choice Program. We had to partner with VA to receive a list of all eligible veterans. We had to design and produce a card and put it out with a personalized letter from the Secretary. We had to stand up a contact center to handle all of the calls coming in. After 2 weeks of design and 2 weeks of hiring and training of 850 people, no one went into 3-hour waits; the phones were answered; but the work had only begun. We have been on a pathway since to try and mature the operations.

The Secretary talked about the 40-mile issue. There are additional refinements that may well be needed and desired in that area, and if so, we stand prepared to support what those might look like. There are some other changes that may well be needed to the program as we go forward.

Second, we need to aggressively identify and resolve our gaps and fix our operational performance, and we are in the process of doing that together. We are modernizing our IT systems, rolling out after Memorial Day, after a 24/7 build, a new portal system that will serve all of the facilities and our own staff as we seek to move the veteran information back and forth between the two facilities as care is rendered downtown. We are in the process of tailoring networks to match the demand that exists in each market across our area.

The Choice Program is up, it is operational, and there are refinements still need. I believe that because of the collaborative work that has been underway between all of us that are engaged in this, we are refining the pieces that need to be refined, we are identifying the policy gaps that need to work, and those things, as the Secretary said, are getting attended to.

I think there are a couple of policy issues, though, that remain the jurisdiction of this particular Committee. One is I would encourage a relook at the 60-day authorization limitation that has been applied. Second, I would respectfully submit that there needs to be harmonization between the two programs and between all of the facets of how the VA buys its care currently, as well as how the VA operates itself in engagement with us in order to make this work right.

At the end of the day, I believe the art of the possible which you sought is truly within our grasp. I would like to point to Dallas, Texas, for a second, if you will permit me to do so. We are under the engaged leadership of the VISN 17 Director. A couple of weeks ago, we sat with the VA medical center Director and the entire staff there, including behavioral health staff, and looked at the full

demand that exists for veterans in that market. We then took out and looked at what is the network that is constructed to stand at its side, which is the base on which Choice rides. In other words, if there is not a network provider, you can set up an engagement with an individual provider to deliver services under Choice.

We then designed a network map that we are now in the process of constructing together, and over the next 90 days, from behavioral health to primary care to specialty care, we will rack and stack the network to meet the demands that otherwise cannot be met by the VA medical center in Dallas. That is being repeated across our entire 28 State area and the Pacific as we seek to do our part to mature the operations of Choice.

It is a privilege to serve in support of those that served this country. It is an honor to serve the veterans from the States that are represented by half of the Members of this Committee, and, Mr. Chairman, I look forward to taking questions after my colleague Donna Hoffmeier is finished with her remarks.

Thank you.

[The prepared statement of Mr. McIntyre follows:]

PREPARED STATEMENT OF DAVID J. MCINTYRE, JR., PRESIDENT AND CEO, TRIWEST HEALTHCARE ALLIANCE

Good afternoon Mr. Chairman, Ranking Member Blumenthal, and members of this distinguished Committee. I am grateful for the opportunity to appear before you this afternoon 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 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 Tuchschmidt, 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 Topeka VAMC purchased 500 MRIs from community providers in a given month, it is critical to know if they purchased 200 in Manhattan, 100 in Hays, and 200 from Salina * * * as they are all considered to be in the catchment area of the VAMC. However, as I am sure Senator Moran can attest to, the Topeka Kansas VAMC has a big catchment area in a huge state. Without that second layer of data, TriWest would almost assuredly build network in the wrong places.

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.

Any new program has challenges with aspects of implementation and operation. And, unfortunately, at the outset of PC3, 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 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 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 con-

tinue 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 toward 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 revaluation 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 toward 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

Mr. Chairman 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.

Chairman ISAKSON. Thank you, Mr. McIntyre.

Ms. Hoffmeier.

STATEMENT OF DONNA HOFFMEIER, VICE PRESIDENT AND PROGRAM OFFICER, VA SERVICES, HEALTH NET FEDERAL SERVICES

Ms. HOFFMEIER. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, I appreciate the op-

portunity to testify on Health Net's administration of the Veterans Choice Program.

Health Net is proud to be one of the longest-serving health care administrators of Government programs for the military and veterans communities. We are dedicated to ensuring our Nation's veterans have prompt access to needed health care 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 implemented PC3 across our regions on a 6-month implementation schedule, completing implementation at the beginning of April 2014. Then in October, after Congress passed and the President signed the Veterans Access, Choice, and Accountability Act of 2014, VA amended our PC3 contract to include several components of the Choice Program. With less than a month to implement Choice, as Dave just mentioned, we literally hit the decks running—I am a Navy veteran, to use a Navy phrase—and we have not slowed down since.

To meet the required start date of November 5, we worked very closely with VA and with TriWest to develop an aggressive implementation schedule and timelines. The ambitious schedule required us to hire and train staff quickly and to reconfigure our systems for the new program.

Despite this very aggressive implementation schedule, on November 5, veterans started to receive their Choice cards, and they were able to call in to the toll-free Choice number to speak directly with a customer service representative about their questions on the Choice program or to request an appointment for services.

Having said that, there certainly have been challenges that have resulted in veteran frustration as well as frustration on the part of VA and, to be honest, even our own staff, including call center and appointing staff. With such an aggressive implementation schedule, there was little time to finalize process flows and make system changes. We literally had less than a week from the date we signed a contract modification with VA to the actual go-live date.

While the cooperation with VA since the start of the Choice Program 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 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 might be addressed quickly.

As I mentioned earlier, we have been working very closely with VA to address these issues. Many of the items simply could not have been anticipated before the start of the Choice Program. Others, however, should have been addressed before the program started, but the implementation timeline did not provide 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 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, we have one overall recommendation for moving Choice forward.

We recommend VA develop a comprehensive, coordinated operational strategy for Choice that clearly defines the program requirements, the process flows, and rules of engagement. This strategy should provide a clear road map for all of us to follow, one that is communicated to all the stakeholders: VA leadership, VISN Medical Center leadership and staff, both contractors, Congress, and, most importantly, the veterans.

While the strategy needs to identify key initiatives and reasonable timelines for implementing those initiatives, it also needs to contain the flexibility to address issues as they arise and make necessary course corrections. The strategy must include resolution of outstanding policy and process issues; development of policy and operational guides that are mandated across the program; comprehensive training of both VA and contractor staff using consistent process flows, operational guides, and scripting; and a clear and responsive process for resolving 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 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 collaborating with VA to ensure the Choice Program succeeds. Working together with the leadership of this Committee, we are confident that Choice will deliver on our obligation to this country's veterans.

Thank you. I look forward to your questions.

[The prepared statement of Ms. Hoffmeier follows:]

PREPARED STATEMENT OF DONNA HOFFMEIER, PROGRAM OFFICER, VA SERVICES, HEALTH NET FEDERAL SERVICES

Chairman Isakson, Ranking Member Blumenthal, 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.

A HISTORY OF PARTNERSHIP

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 servicemembers 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 sup-

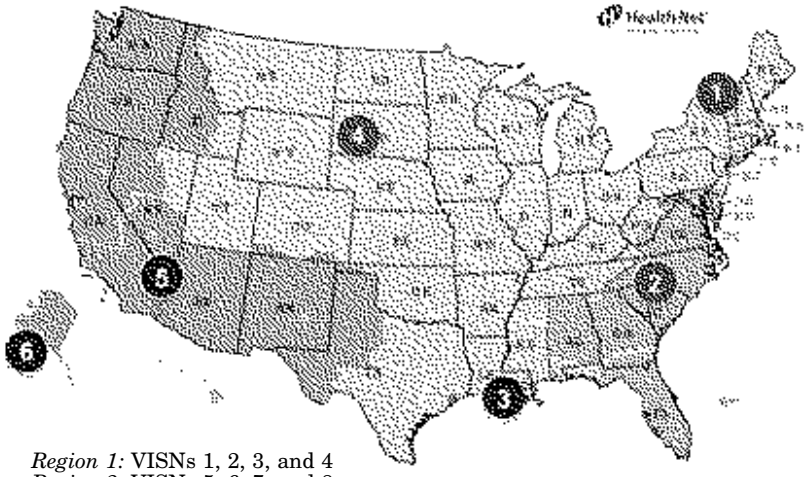
ported VA by applying sound business practices to achieve greater efficiency in claims auditing and recovery, and previously through claims re-pricing. It is from this long-standing commitment to supporting the military and Veterans community that we offer our thoughts on the role of PC3 and Choice in 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, DC; 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 decisionmaking 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 Web site, 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).

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.

Since 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 prompt-

ly, 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 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 canceled 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.

Chairman ISAKSON. Well, thank you all very much. I had all these preplanned questions, but after listening to your testimony, I have canceled all of them. I am going to ask the ones you have raised in your testimony, starting with you, Mr. McIntyre.

It was quick, so I want to make sure I got it. You were encouraging us to look at the 60-day authorization of what?

Mr. MCINTYRE. I would look at the limitation on 60 days for authorized care under Choice. It puts people who have cancer in a position where we need to move them back and forth between the VA medical center. It takes a person who might be with us under Choice because of a pregnancy and does the same. I do not think that was intended. I think it was intentional that there were parameters drafted around it, but the notion that certain types of care would have to move back and forth between the VA medical center and downtown is neither efficient nor effective in the delivery of care.

Chairman ISAKSON. All right. I do not want to spend too much time on this, but this is very important, I think, from listening to your testimony and watching everybody's heads bob. You want to expand the 60-day authorization to a longer period of time?

Mr. MCINTYRE. I think I would leave it to the clinicians in the Department of——

Chairman ISAKSON. No, you are not getting off with that.

Mr. MCINTYRE. OK. I will not get off with that. [Laughter.]

I got it, sir. What I would do is to evaluate which types of care need authorizations that would last more than 60 days. And——

Chairman ISAKSON. So, what you are saying is the 60-day limitation causes things like some cancer treatments, a pregnancy, for example, and things like that, for the patient to have to go back and forth between private and VA health care because of the 60-day limitation?

Mr. MCINTYRE. The administrative process requires us to go back and forth in support of that veteran when it is probably unnecessary, is what I would submit.

Chairman ISAKSON. That is like Medicare's two-night rule in the hospital.

Mr. MCINTYRE. Yes, sir.

Chairman ISAKSON. It is one of those unintended consequences.

Mr. MCINTYRE. Yes, sir.

Chairman ISAKSON. Is there any reason we cannot fix that?

Mr. GIBSON. We are going to work on it, and we will come back to you with a proposal. We think——

Chairman ISAKSON. It seems to me it would be more cost-effective to the VA to do it, to fix it, rather than go back and forth, because there has got to be money involved every time you are doing that. Is that right?

Mr. GIBSON. Yes, sir. There is a fee that is paid for each authorization, but the bigger concern is the potential disruption to the veteran.

Chairman ISAKSON. Efficiency is always less expensive, and that is more efficient, it seems like to me.

Mr. MCINTYRE. Yes.

Chairman ISAKSON. I appreciate your raising that in your testimony.

Mr. MCINTYRE. You are welcome, sir.

Chairman ISAKSON. Ms. Hoffmeier, do you have any credit cards? [Laughter.]

I do not want them. I just want to know if you have got——

Senator BLUMENTHAL. You have the right to remain silent. [Laughter.]

Ms. HOFFMEIER. I am trying to think, which ones do I acknowledge? Yes, sir, I do.

Chairman ISAKSON. OK. Let me ask: do you ever get the annual mailing of the required Government notification of security? It is about four pages long, and the print is so small you cannot read it, and you do not read it anyway.

Ms. HOFFMEIER. I think that goes right in the recycle bin, Mr. Chairman.

Chairman ISAKSON. OK. In your testimony I heard from you a clear statement that we needed to simplify and coordinate the instructions, the rules, and the processes under which Veteran Choice works. Is that right?

Ms. HOFFMEIER. It is, Mr. Chairman.

Chairman ISAKSON. I—go ahead.

Ms. HOFFMEIER. As I said in both my written statement and opening remarks, everything has been moving very, very quickly, and as a result, there are a number of things that maybe have not

been addressed as completely, as ideally, as we would all like to see, which makes it really difficult. I mean, it is hard for us—you know, we talk about this at our level—to keep up with everything. You are talking about call center representatives and appointing clerks that are trying to keep up with all of the developments. Somehow we have to find a way to make it easy, not for us to understand, but for the people that are working closely with veterans to make this program work. They need to understand it.

Chairman ISAKSON. That goes a little bit further than just to you all. I think the veteran needs to have it simpler to understand, too. All the stuff that I did as a businessman, we served people with college degrees and master's degrees, but we wrote everything to an eighth-grade level, which is what the newspapers do as well, because that is the way you can communicate to the majority of the American people. Some of these things—I have not read any medical instructions, but some of these things I read on drug notices when I get my drugs, you know, my regular drugs, the real ones——

[Laughter.]

Chairman ISAKSON [continuing]. Prescriptions. You read all these things you are not supposed to do or you are supposed to watch out for. It is so long and so cumbersome I cannot understand it, so I do not do the right thing sometimes. I think that could be our veterans as well on the instructions they are getting.

Deputy Gibson, I would hope what all of you would do is work together to find some ways to simplify the communication mechanism to the beneficiary, which is the veteran, and the provider, which is the local provider, in Veterans Choice. I know it is complicated and I am not trying to oversimplify, but sometimes out of fear of—or out of a desire to make sure we have covered everything, we cover so much that we do not accomplish the goals. I appreciate both of you raising that in testimony.

My last question is going to be of Mr. Gibson until we come back for a second round, if we do. You kept talking about you wanted us to give you more flexibility.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. Put some meat on that bone. Flexibility on what?

Mr. GIBSON. Well, I would say at the very top of the list is flexibility around the determination of hardship for veterans to be able to have access to Choice care. The way the law is written today, it is restricted to geographic barriers, I think is the language that is in the bill. We want to open that aperture, which would give us much more flexibility to be able to extend care under Choice to veterans.

Chairman ISAKSON. Open that aperture, to be a type of illness?

Mr. GIBSON. It could be a type of illness; it could be distance. There could be an instance where a veteran lives within 40 miles of a VA facility that does not deliver the case, and we want to be able to refer the care into the community while we are working on the intermediate term——

Chairman ISAKSON. In other words—my time is up, so I am going to interrupt you, and I apologize.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. In other words, you want the ability to exercise judgment——

Mr. GIBSON. Yes, sir.

Chairman ISAKSON [continuing]. In what you do in terms of hardships.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. You want the chance to exercise judgment in terms of the 60-day authorization. Is that right?

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. OK. There ought to be ways that we can accomplish both of those things.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. I think in raising those things, Dr. Tuchschmidt is really excited about that answer, or either he needs to leave, one or the other. I do not know. [Laughter.]

Chairman ISAKSON. Whatever the case is, you can help us write that? Because you think those are both determinations we ought to be able to do. Your flexibility on the 60-day authorization sounds to me more cost-effective and less expensive. Yours probably raises some cost questions like are raised anytime you do things like that. In the end, again, we have got to remember the person we want to serve is the veteran.

Dr. TUCHSCHMIDT. Yes.

Mr. GIBSON. Yes.

Chairman ISAKSON. Denying them service because of a misapplied hardship is not the right thing to do.

Mr. GIBSON. Yes.

Chairman ISAKSON. Ranking Member Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Just at the outset, let me say that you will be asked shortly by Senator Sanders, I believe, about the letter that he has written to Secretary McDonald urging that he use his authority as Secretary of Veterans Affairs to break patents on hepatitis C medications for the treatment of veterans suffering from that disease. I would strongly urge that you consider using your authority under 28 U.S. Code Section 1498 to take that action that will make this medication more widely available to veterans who need and deserve it, especially since the VA was involved through one of its employees in the research that undertook this initiative and successfully reached the result.

I want to focus for the moment on the VA's proposal to fund construction costs at the Denver facility, specifically the $1 billion cost overruns out of the Choice Program's provisions for long-deferred maintenance and facility capacity issues in the VA system. These funds were very specifically designated and intended by Congress to improve veterans' health care.

Veterans in my State who are aware of this proposal are absolutely outraged that their health care, specifically the primary care upgrade at the West Haven facility, would be indefinitely deferred because of $1 billion cost overruns in Aurora, CO. I suspect the same reaction will be felt equally deeply by veterans at the more than 220 other facilities whose health care will be compromised as a result of the proposed redesignation of these funds.

I would like assurance from you, Secretary Gibson, since we are talking here about Choice Program funds and we are talking about not just a few dollars here or there but actually one-fifth of all the funds in that $1 billion pot, that you are considering alternatives to that action.

Mr. GIBSON. Senator, we have sent a letter earlier today to this Committee, to the House Committee, and to the Appropriations Committee requesting the increase in the authorization to be able to complete that facility as well as requesting the use of $730 million of those $5 billion to be used to complete the Denver facility. We have identify $100 million——

Senator BLUMENTHAL. Well, I just want to interrupt you because—and I apologize—for me that alternative is a nonstarter. It is just unacceptable, and I have expressed that view to appropriate administration officials. I realize that you are dealing the hand you were dealt. I am simply urging you to consider alternatives. There are alternatives, in my view, responsible and available alternatives that do not involve deferring health care improvements through construction and maintenance at those facilities across the country, whether in Connecticut or Georgia or Montana or Louisiana or Vermont, and all the other States represented on this Committee, as well as many who are not.

Mr. GIBSON. Senator, in years past I would tell you it is very likely that if VA had gone looking for that kind of money, there is a pretty good chance that we could have found it. But because of the work that we have been doing over the past year to accelerate access to care, to make hepatitis C care available to veterans, under the circumstances, we do not have $700 million sitting on the sideline. There are no easy answers here.

Senator BLUMENTHAL. I am not asking you to find $1 billion sitting on the sideline. But this Nation is capable of doing better for its veterans, and a supplemental appropriation, for example, might be an alternative. I am asking you to go back to the drawing board and use different pencils, not necessarily sharpened pencils but different alternatives to compensate for the absolutely unacceptable cost overruns and delays in Aurora. The project should be completed, but not at the sacrifice of health care for other veterans around the country. What I say to you today is not personal to you or to Secretary McDonald, and we have talked at great length about this issue. We have visited that facility together along with the Chairman. I have seen that vast hulking shell of a campus that is a mockery of Government contracting.

We need to address this situation to complete the project, but it cannot be done in effect at the sacrifice of other veterans.

My time has expired. I apologize for interrupting you, and I thank the witnesses for being here today.

Chairman ISAKSON. I would not ordinarily do this, but in light of the question that was raised and for the benefit of everybody at the Committee just to know—and I do not want this to limit anything anybody says, but I think we all have an obligation to ourselves to make out-of-the-box suggestions on what we do about the cost overruns at Denver, particularly those of us that have been there and seen it. I have taken a couple of actions which I will share with the Committee leading up to a meeting we are going to

have tomorrow where I have got the Democrats and the Republican leaders coming together to say, "OK, what are we going to do with this?" Which I hope the VA people are back in their offices saying, "What are we going to do with this, too?" not just saying there is nothing we can do.

I have ordered GAO to do a study of surplus property and that which would be liquidatable to try and find a way to raise money to go to Veterans Choice to offset what might be borrowed from it, which you are dealing with a situation where you have got until about May 20, is about as much time as we have got right now. We need to get at least to July 15, and we have a way to do that. It is going to take an action of this Committee, but getting us to July 15 only gets us time to determine how close to $700 million it is we need, first of all, with the Corps and the Veterans Administration working together to do that.

In that time period, we are going to have to have some interim bridges, which I am working on to present to the Committee tomorrow. But if everybody on the Committee would think outside the box, if it was your problem, if you were in Secretary McDonald's place or Deputy Gibson's place and you had inherited a $700 million shortfall and ran an agency that is the second biggest in the Government, where would you go looking?

I want Sloan to revisit the two places I mentioned to him in Denver, because it seems like to me if we are going to take you out of the construction business, which we are—and that is going to happen, at least to a certain major extent—there are going to be savings in that appropriation unit within your department, and also look at the 77 FTEs you are asking for an increase in the current budget, maybe those FTEs are not as necessary as helping to build that hospital in Denver. I think if everybody is making a contribution like that—it is like that movie, "Dave," when the guy became President, he was a fill-in for somebody. He called the Cabinet in, they got a yellow pad out, and they started working on solutions. We need to get the yellow pad out and start working on solutions and find a way to do it, because not building the hospital is unacceptable, and just saying we are going to borrow funds from the veterans health care benefit, I agree with Mr. Blumenthal, is not the right way to do it.

I apologize for interjecting that, but I wanted everybody to——

Senator BLUMENTHAL. I want to thank the Chairman because he and I have worked together. I am not speaking for the Chairman, obviously, but I have some alternative suggestions as well. I have no pride of authorship—I do not think any of us does—in meeting the needs of completing that facility, but doing it without sacrificing these other projects. So, I will have some specific ideas and proposals tomorrow, as well.

Chairman ISAKSON. My apologies to all the Members of the Committee for taking a little time, and I will turn now to Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you, and Senator Blumenthal, for your comments and for conducting this hearing. Mr. Secretary and others, welcome to the Committee.

I hope to ask a series of questions, but the time on the clock will run quickly. I want to start with a story that I have told before about a Vietnam veteran named Larry. Larry McIntyre lived in Florida and indicates that he is a Vietnam veteran, a swift boat Navy veteran. He indicates while he was in Florida he received excellent care from the VA; moved to rural Kansas, became my constituent; lives about 25 miles from a CBOC and about 3 hours from a hospital. I started this story or this story began in July 2014 when Larry, this Vietnam veteran, needed a cortisone shot. The VA's instructions were, "Come to Wichita," so a 3-hour drive each way to get a cortisone shot.

We raised this topic with Secretary McDonald at a hearing here on September 9. Larry had contacted us and said, "I do not care how it comes, the Choice Act or any other way that the VA can provide this service." We raised this topic with the Secretary in September of last year. Then shortly thereafter, the VISN Director in Kansas City took this issue to heart and at least solved the problem but, unfortunately, temporarily.

In December, Larry was granted an appointment in Hays, the place where the CBOC exists—I should say the CBOC that does not offer cortisone shots, but he got care in the private sector in December of last year.

The doctor who treated him, who provided the colonoscopy, then asked to treat him again and to follow up. The VA denied that request and sent him back to Wichita. They denied that request because he was not eligible for Choice. The CBOC exists within the 40 miles of his home.

He is back to Wichita. Ultimately he then needed—instead of a cortisone shot—a colonoscopy. Same series of events. The outpatient clinic does not provide colonoscopies, and he is trapped in this system of no one telling him what he can do or what he qualifies, except he does not qualify for Choice, go to Wichita. He has done that, but then just recently, last week, he received a letter from the VA approving him for Choice. He then calls TriWest, and TriWest says, "You are not eligible. We do not have you on our list." "But I got this letter." He indicates that he talked to four different operators at TriWest, all who gave him a different answer than anyone else, than the three other operators.

He called the 866 number and was told he was not eligible, got the four different answers, and now we are back to the question of what happens to Larry. My point here is, one, it ought not be Larry's problem to solve what happens to Larry; but even from the beginning, if he was not eligible for Choice, and even if he is not eligible today because the CBOC is there, even though it does not provide the colonoscopy or the cortisone shot, why is someone not at TriWest or the VA telling him, "Oh, we have these other authorities; this would work for you," as compared to just leaving Larry hanging about whether he is eligible and what he should do? How do we solve that problem? I do not think it is totally unique. I hope it is, but I doubt that Larry is the only veteran that experiences this circumstance.

Mr. GIBSON. I doubt that the problem is unique. I suspect there are other veterans that are having similar experiences.

As I described in my opening statement, we are asking for additional flexibility which would give us some more authority to be able to handle that kind of situation inside Choice. We actually handle many of those situations through other VA care in the community routinely, which is why we have incurred so much expense on a year-to-date basis. But we find ourselves running out of resources in order to be able to sustain that. We wind up making suboptimal decisions.

I would tell you, you have just given two great examples. The Chairman asked earlier about whether or not we would be using judgment around the nature of the procedure. The answer is yes. I would tell you, for someone that has a routine requirement like a cortisone shot, there is no reason to travel 150 miles to go do that. That is something that ought to be getting done—we ought to be getting done locally.

For the veteran that has to go get a colonoscopy, I got to tell you, I am not going to drive 150 miles to go get a colonoscopy. That is not going to happen. That is something else that needs to be provided for inside the community.

Now, if a veteran needed a knee replacement, I might say, you know, "OK, under the circumstances make the trip." But for the therapy that has to follow up after that, no, I do not want the veteran traveling 150 miles each time he needs to go to physical therapy.

The challenge that we have is 40 miles from where you can get the care. We keep running the numbers, and the tab is horrendous. It is huge. What we have got to do is find a way to be able to manage this in such a way that we are doing the right thing for veterans at the same time we are being the best stewards we can of the taxpayer dollar.

Senator MORAN. Mr. Secretary, as you know, you and I have had a number of conversations on this topic, and today I am not arguing—I would argue, given the chance, but I will not argue today about whether or not—or how the 40 miles should be interpreted. My point on this episode, one, is the uncertainty and the burden lying in the wrong place. It ought to lie with the VA or TriWest, not the veteran. My second point is that if you have these other authorities, whether or not Larry qualifies for the Choice Act ought not matter in the answer he gets.

Mr. GIBSON. I agree completely.

Senator MORAN. Thank you.

Chairman ISAKSON. Thank you, Senator Moran.

Senator Sanders?

Senator SANDERS. Senator Manchin has kindly yielded to me because I have got to run out the door.

Chairman ISAKSON. To the gentleman that has got to run out the door, Senator Sanders.

STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman. Thank you for the work that you have been doing and for your maintaining the bipartisan spirit of this Committee. Congratulations for all you are doing.

Chairman ISAKSON. Thank you.

Senator SANDERS. I want to just make two points.

First of all, I want to thank Deputy Secretary Gibson and his boss, Secretary McDonald, for the very impressive work they are doing. I understand, as the former chair of this Committee, how easy it is to beat up on the VA, running 151 medical centers, 900 CBOCs, and there is a problem every single day. But, you know what? In a Nation which has a dysfunctional health care system, the private sector also has one or two problems. I will not go into them, but I think we should recognize that when you talk to the major veterans organizations—the American Legion, the VFW, the DAV, the Paralyzed Veterans of America—you know what they say? You have heard this, Mr. Chairman. They say that when people walk into the VA, the quality of care they get is pretty good. I want to thank you for trying to improve that care. I personally will fight vigorously those who want to privatize the VA or dismember the VA. I think our goal is to strengthen the VA. I think our goal is to be creative in terms of using the new program that we have developed so that people can get care in their community locally. That is a good mix. I will oppose efforts to privatize the VA, which is serving our veterans so very well.

I wanted to get to another issue, and Senator Blumenthal touched on it. Today I wrote a letter to Secretary McDonald about an issue that has concerned me for a while, and that is the high cost of the drug Sovaldi, which is a miracle drug, so to speak, which is now treating the veterans of our country who have very high rates of hepatitis C.

Mr. Chairman, to me it is an outrage that you have a company whose profits have soared in the last few years. Their revenues have doubled, I believe, in the last year. They have come up with a drug. They are charging the general public $1,000 a pill for that drug. They are charging, I believe, the VA—I do not know if this is a great secret, but I will tell it anyhow—something like $540 for the drug. Is that right? No comment. All right. That is because the VA negotiates drug prices. But you are running out of money, and we have several hundred thousand veterans today who are suffering with hepatitis C, which can be a fatal disease, and you do not have any money to treat them. Frankly, I think that it is time to talk to Gilead, the manufacturer of Sovaldi, and basically ask them if they are currently being very generous in providing these drugs, hepatitis C drugs, to countries like India and the Republic of Georgia for free. Very generous, for whatever reasons they are doing that. Maybe at a time when their profits are soaring, maybe they might want to respect the veterans of this country who might die or become much sicker because they do not have access to this wonderful product. As Senator Blumenthal mentioned, if they are not prepared to come to the table—and I know you think you have done very well by getting their prices down by half. I am not impressed that you are paying $540 per pill for people who put their lives on the line to defend our country.

I would suggest to them you sit down again with them and tell them that you are prepared to utilize Federal law, specifically 28 U.S.C. 1498, to break the patents on these drugs unless they are prepared to come down significantly lower than they are right now.

It is not a question of taking money—I know you have requested to take money out of the Choice Program. Maybe that is a good idea. It is a better idea to have them treat the veterans of this country with respect and charge the VA a reasonable price rather than ripping off the VA as they currently are.

With that, I would yield.

Chairman ISAKSON. Thank you, Senator Sanders.

Whomever is operating the clock, fell asleep a minute ago, so turn that clock on when they start talking, if you would.

We have Senator Rounds, followed by Senators Manchin, Cassidy, Hirono, Tillis, and Tester.

Senator Rounds?

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman, and I appreciate your work and also the Ranking Member's work with regard to the issues on the hospital in Aurora. I agree that it should not come out of the Choice Program as the alternative.

Mr. Gibson, I was looking back at the notes I have taken here, and you gave some very encouraging notes with regard to some of the stats about some of the areas of the country with regard to some additional care being provided, and that is encouraging. I am just curious. Do you believe that those stats are consistent across the country? Are you finding evidence of that across the rest of——

Mr. GIBSON. Actually, that is—I always worry when people quote averages to me, and what you find is wide disparity across the country in terms of the length of wait times, and, therefore, in terms of the specific areas where we are making the most intensive investments. What I would tell you is where we have been making consequential investments, you pretty consistently see a material improvement in access measured by completed appointments, measured by growth in relative value unit. What we are not seeing pretty consistently is a material improvement in wait times.

When you look behind that you realize that what is happening is as we improve access to care, either more veterans are coming or veterans that are already there are making additional utilization of VA care.

Senator ROUNDS. I am just curious. It sounds almost like we have—and I think Senator Sanders had suggested this in a way, but I really think we have to have the discussion about how we deliver care long term for our veterans. I would love to be able to allow the veterans to make that decision themselves as to how we deliver the care to them. I think the Choice Act allows that to begin. I understand that right now we have got a significant investment, if we have over 150 health care communities—or health care centers and 900 CBOCs right now.

What do you see as the answer here? One of the comments was made that we are looking at providing the Choice opportunity there if the care cannot be met by the VA itself. It sounds to me like what we are saying is that the VA should be making the decision about whether or not they are delivering the care or whether or not the veteran should be making that decision. It sounds to me like maybe we ought to take the other approach here and say if we gave that choice to the veterans, I would suspect that a number of them

who have very great care being delivered to them by VA facilities might very well want to continue that on. There are others that I suspect would say, "Look, I am not near a facility, and I do not expect you to build a new hospital near me."

You have looked at asking for the ability to have flexibility to make that choice. What would happen if we took as an alternative and said—and, once again, I think we are talking about dollars and cents now as being the deciding factor in this case. What would happen if we allowed the veterans to decide for themselves whether they wanted to have the care through a VA facility or through utilizing the Choice Program more fully and skip all of the extra stuff that you have talked about here in terms of the 40-mile rule or whether or not they have already had care and now they have got to go back in after 60 days and so forth? It is still the VA making the decision. Why not—and share with me your thoughts. I am sure this is not a new thought. Share with me your reasoning and logic and why you are where you are at in terms of not allowing the veterans to make that choice themselves.

Mr. GIBSON. Sure, not at all a new thought, and we have spent a great deal of time talking about it and alluded to some options that we briefed the staff on.

One of the things first to keep in mind, 81 percent of all the veterans that we provide care for have either Medicare, Medicaid, TRICARE, or some form of private health insurance. Often, what you see today—you mentioned the fact earlier that veterans, if given the option for Choice, some would elect to stay in. And, in fact, that is precisely what happens today. Roughly half, 40 to 50 percent, somewhere in that neighborhood, depending on whose survey you are listening to. I would tell you my perspective, part of those are deciding to stay because they want to stay, because they are getting great care, they enjoy the camaraderie with other veterans, they have continuity of care there because they have been receiving care for a long time. Others come there because they have an economic incentive to come there, because if they go out to Medicare, they have a 20-percent co-pay for a procedure. You look at that colonoscopy or whatever it happens to be, or the knee replacement, which is an example that we use oftentimes, and the veteran can go get it with Medicare, but he is going to wind up with a $7,500 bill to foot.

I think part of the answer comes—and it is one of the options that we have talked about here—is that we step back and we look at some of the economic distortion that exists today and find ways to eliminate that.

For example, what if Medicare, Medicaid, TRICARE, and other providers became the primary payer and VA indemnified the veteran against a 20-percent co-pay? Then you really are providing the veteran with choice. Then you have really—and you wind up—the taxpayer does not wind up paying twice for the same care.

I think therein lies kind of the answer. This is not about protecting the turf. All we are about is doing the right thing for veterans and being good stewards of taxpayer resources. Wherever that leads us, that is where we are ready to go.

Senator ROUNDS. Mr. Chairman, my time is up, but I think that is something that we should seriously consider on this Committee. Thank you, sir.

Chairman ISAKSON. Thank you, Senator Rounds.

Senator Manchin?

HON. JOE MANCHIN, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Mr. Chairman, thank you very much, and I thank all of you for being here today.

Let me just say that, needless to say, the VA has a lot of problems or has had a lot of problems that you all have been dealt. Some of you have been there longer than others. Some of you have had careers at it. Some of you have come from the private sector.

I have got problems in West Virginia, like every other State. Nobody has problems like Colorado has right now with what is happening there, but let me just say I need to get this on record. I have a situation in Beckley VA medical center. I do not know if it had been brought to your attention or not, if it has got that far up the ladder. Last month, the Office of Special Counsel released a report with substantial allegations of switching anti-psychotic drugs based solely on cost. The providers and doctors said this is what our veteran needs. Then, they made an executive decision that it was too cost prohibitive, cut the medicine, and did not get the right application.

I was told there is a new policy in place that regulates dispensing of these drugs, and I have not been able to obtain a copy of that. At the same time, I am also told that there is a follow-on investigation into the matter. I have not heard much about that.

At the same Beckley VA, the Greenbrier clinic, which operates under Beckley, has been closed three times because of air quality. I am having a horrendous time, because we have a very rural State, trying to get our veterans the care they need.

The only thing I can ask, if it has not gotten to your level, if you can get me an answer back as quickly as you can.

Mr. GIBSON. One, we will get you the regulation.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOE MANCHIN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

VISN 6 BECKLEY VAMC CONGRESSIONAL UPDATE
CURRENT AS OF SEPTEMBER 15, 2015

* GREENBRIER COUNTY CBOC (CLOSURE OF MAXWELTON LOCATION)—

June 1, 2015:

The alternative for long-term options for providing care to affected Veterans is continuing to be evaluated. Beckley VAMC's first action focused on deactivating the current clinic in our systems to enable area Veterans to be eligible to use Veterans' Choice benefits that include authorization to receive care by local providers. Other current actions include investigating the viability of long-term care options to maintain clinical services for the regions' Veterans.

The primary option being pursued at this time is to contract with area providers for services. This option has become more challenging with the recent Choice Act guidance, which 'prohibits new contracts for care except in urgent circumstances as determined by the DUSHOM.' This updated guidance is dated May 12, 2015. VISN 6 drafted a request for Exception to this Policy and forwarded the request to the DUSHOM's office for consideration on May 26, 2015.

Another option being considered is to find replacement space to reestablish the CBOC. A newspaper ad for lease space up to 5,000 usable square feet of outpatient space was or is to be published in the Mountain Messenger (5/22 and 5/29); Valley Ranger (5/24, 5/27, 5/31, 6/3); and Daily News (M-F, X 2 weeks starting 5/25). In order to procure a new lease to replace the Greenbrier CBOC, VA would need to validate the need for the new lease through the Strategic Capital Investment Planning process, and obtain a lease delegation from General Services Administration.

June 15, 2015:

Beckley VAMC is continuing to work with the VISN and VA Contracting to investigate the viability of long-term care options for providing access to care to the Veterans in the Greenbrier Valley. Currently the medical center is working with VA Contracting on parallel paths:

1. The marketing study for lease space ended at 4:30 p.m. on June 12, 2015.
Thirteen interested offerors made contact with the Contract Specialist.
2. The VA is now working on a newspaper ad to seek information on the availability of potential sources with board-certified providers of Primary Care and basic Mental Health in Lewisburg, Rainelle, and Alderson who are interested in a multiyear contractual arrangement. A supplemental email with details of the ad will be provided prior to publication.

July 1, 2015:

The newspaper ad seeking information from sources interested in providing primary care and mental health outpatient services in the Lewisburg, Rainelle, and Alderson (WV) catchment area was or is to be published in the Mountain Messenger (7/3 & 7/10); Valley Ranger (6/28, 7/1, 7/5, & 7/8); and Daily News (M-F, X 2 weeks starting 6/29–7/8). Interested sources are asked to contact Marchelle Peyton no later than 5:00 p.m. on July 10 at Marchelle.peyton@va.gov. The ad information was provided to our Congressional partners via email on June 26.

The medical center is preparing a business plan to be submitted to the VISN that will provide an analysis of the need based on access, workload, and comparison of the various options for providing care noted above.

July 10, 2015 (Interim Email Update):

A local (Beckley VAMC) Review Committee has been established. On July 14, this Committee along with VA Contracting will begin the site survey process of assessing the identified 13 potential "ready to occupy" spaces. VA Contracting is in the process of scheduling these site visits.

July 15, 2015:

DUSHOM approved the waiver for new contracts for care on June 2, 2105.

The community care solicitation resulted in three (3) interested sources. These sources will now be evaluated as to whether they are good community based options in which to provide services to our Veterans.

The marketing analysis and preparation of a business plan is ongoing.

SecVA scheduled to speak with Senator Manchin on July 16.

July 24, 2015 (Interim Email Update):

A final newspaper ad for lease space up to 5,000 usable square feet of outpatient space is to be published in the Mountain Messenger (8/1); Valley Ranger (7/26 and 7/29); and Daily News (M-F, 7/27 to 7/31). Any new interested parties should submit an official response to VA Contracting by 4:30 pm EST on August 3, 2015, no other properties will be accepted after this date. This will conclude the market research and a solicitation will be sent to those properties that meet the Department of Veteran Affairs requirements.

August 1, 2015:

Follow-up to the Congressional conference call held on July 30:

The marketing analysis determined that VA contracted community care is not a viable option at this time.

The focus is on the re-location site for a VA staffed CBOC. The selection of the site is on-going and thoroughly being pursued. Anticipated timeframe for the reopening of the Greenbrier County CBOC is up to 12 months.

Note: The Greenbrier Valley Economic Development Corporation (Mr. Steve Weir) was notified of the VA's intent to not renew the lease on the CBOC (Maxwelton) in writing by the Lease Contracting Officer on April 30, 2015 and May 5, 2015.

The Director will host a Town Hall for the Veterans in the Greenbrier Valley on Thursday, August 6, 2015, at 6:00 p.m. at the West Virginia School of Osteopathic

Medicine, Roland Sharp Alumni Center, 400 North Lee Street, Lewisburg. Announcement will be made via media outlets.

August 10, 2015 (Interim Email Update):

The final marketing study for lease space ended at 4:30 p.m. on August 3, 2015. An additional nine interested offerors made contact with the Contract Specialist. VA Contracting is in the process of scheduling site visits for the local (Beckley VAMC) Review Committee to assess the additional nine spaces this week. This will conclude the market research and a solicitation will be sent to those properties that meet the Department of Veteran Affairs requirements.

Note: Local media coverage of the Town Hall held on Thursday, August 6, 2015, seems to be somewhat misleading often with erroneous information on the process for relocation of the CBOC.

August 15, 2015:

The Beckley VAMC Review Committee completed the assessment of the additional nine spaces on August 14. The reviews for all 22 sites will be collated and a prioritized list provided to VA Contracting by Wednesday, August 19. The solicitation process will begin.

September 1, 2015:

Beckley VAMC provided the list of acceptable properties to VA Contracting as planned. The VA Contracting process will be consolidated and given priority consideration with an anticipated award date of December 2015.

On August 18, Beckley VAMC received an Interim Letter dated August 17, 2015, from the National Institute for Occupational Safety and Health (NIOSH) which provides the results from the analyses for volatile organic compounds (VOCs) and isocyanates from air sampling collected on March 26, 2015 (Attached below) from the Maxwelton location. Also attached for continuity is the Interim Letter dated April 24, 2015 which provides the air sampling results for formaldehyde and carbon monoxide (CO).

September 15, 2015:

The National Contracting Office 6 is continuing to aggressively work on the process for awarding a contract for a relocation site for the CBOC.

* OFFICE OF THE MEDICAL INSPECTOR REPORT TO THE OFFICE OF SPECIAL COUNSEL OSC FILE NUMBER DL–14–3389, DATED NOVEMBER 3, 2014—CLOSED APRIL 22, 2015 (PENDING SUPPLEMENTAL REPORT)

June 1, 2015:

On April 28–April 30, the Office Medical Inspector conducted a supplemental site visit at Beckley VAMC. Beckley VAMC has not received the final report. On May 27–May 28, VA Office of Accountability Review conducted an administrative investigation as part of the follow-up actions to this pharmacy review conducted by the Office of the Medical Inspector. The final report is pending.

June 15, 2015:

Beckley VAMC has not received the final reports on these visits; however, the embedded letter has been sent from the Acting Under Secretary of Health to Senator Capito.

July 1, 2015:

No new information. Beckley VAMC has not received the final reports nor are they listed on the Office of Special Counsel's Web site.

July 15, 2015:

No new information.

August 1, 2015:

No new information.

August 15, 2015:

No new information.

September 1, 2015:

No new information.

September 15, 2015:

The reports from the Office of the Medical Inspector's supplemental review and the VA Office of Accountability Review are pending.

* INTENSIVE CARE UNIT (ICU) RELOCATION—

June 1, 2015:

On May 27, 2015, the ICU unit was temporarily relocated to Ward 3A pending floor repair and replacement. Estimated time for relocation is September 2015.

July 15, 2015:

Nothing new to report.

August 1, 2015:

Renovations are approximately 75% complete and are on target for completion in September 2015.

August 15, 2015:

This project remains on target for completion in September 2015.

September 1, 2015

This project remains on target for completion by the end of September 2015.

September 15, 2015:

The flooring project has been completed and the ICU unit is up and running in its permanent location as of September 10, 2015. This topic is now closed.

* PRINCETON VA CLINIC—

September 15, 2015:

Since the June 8, 2015 opening, there has been a net increase of 200+ Veterans enrolling to receive care or transferring their care to the Princeton VA Clinic in addition to the more than 400 Veterans whose care was transferred from the mobile unit that was parked in Bluefield, WV. The clinic has the capacity to care for 1,200 Veterans.

* ADULT DAY HEALTH CARE UNIT—

September 15, 2015:

The medical center is currently in the process of relocating the Adult Day Health Care program into their new site—the new building located on the left and attached to the medical center. The program will now have the capacity to grow and offer care for more Veterans on a daily basis.

Mr. GIBSON. Two, I believe the follow-on investigation that is referred to here is oftentimes—well, routinely, when the Office of Special Counsel has a finding that substantiates a whistleblower allegation, then if it is medical care, it is turned over to the Office of the Medical Inspector, and we have a team of physicians——

Senator MANCHIN. You all——

Mr. GIBSON. We do. They really bore it out; they come and determine exactly what happened, where the accountability was, and then those oftentimes will come to me.

Senator MANCHIN. Sure. I have already heard that it is at that level now, it has been there. I have been trying to get an answer back.

Mr. GIBSON. We will get you an answer.

Senator MANCHIN. If you can help me, I would appreciate it very much.

Mr. GIBSON. We will do that, sir.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOE MANCHIN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Date: SEPTEMBER 24, 2015
Source: JON COEN, OCLA
Inquiry from: SEN MANCHIN

CONTEXT OF INQUIRY: Please provide an update on whistleblower allegations concerning the Pharmacy Service at the Beckley VAMC

RESPONSE (excerpt from June 9, 2015, Sen Capito Letter attached): In response to OSC's referral of whistleblower allegations concerning the Pharmacy Service at the Beckley VAMC, the Department investigated the allegations and submitted its report to OSC on January 5, 2015. As reported, VA substantiated that the Beckley VAMC Pharmacy and Therapeutics (P&T) Committee encouraged its providers to switch established Beckley VAMC Veterans from aripiprazole or ziprasidone prescribed by Beckley VAMC providers to medications with similar indications. VA also substantiated the allegation that Beckley VAMC management did not communicate the opioid performance measure to Primary Care physicians within 90 days of the beginning of the FY as required by Veterans Health Administration (VHA) policy. The report set forth specific recommendations for corrective and follow-up actions to be taken by Beckley VAMC. Beckley VAMC has fully implemented all of the recommendations.

Beckley VAMC conducted clinical reviews of the condition and medical records of all Veteran patients who were discontinued from aripiprazole and ziprasidone to determine whether any adverse patient outcomes had resulted. Clinical reviews of 137 patients who had been receiving aripiprazole and 45 patients who had been receiving ziprasidone up until that time were completed on November 18, 2014, and January 21, 2015, respectively. Of these 137 Veteran patients, 66 Veteran patients previously on aripiprazole and 19 Veteran patients previously on ziprasidone were changed to other medications with similar indications. There were no patients receiving aripiprazole and ziprasidone concurrently before or after the reviews. As previously stated, the review, validated by the Chief, Mental Health Service Line, found no adverse outcomes as a result of the change in medications.

It is also important to note that based on current information, aside from national guidance (evidence-based prescribing criteria, treatment algorithms, clinical practice guidelines, etc.), there are no "blanket restrictions" for any drugs or treatments for acute medical conditions in place at Beckley VAMC. As a result of the investigation, VA instructed Beckley VAMC to "stop the practice of automatically removing patients from aripiprazole or ziprasidone without a legitimate clinical need." As stated earlier, Beckley encouraged providers to switch Veterans from aripiprazole or ziprasidone to medications with similar indications; however, at no time did they "automatically" remove patients from those therapies as reported. Providers may request any medication, even medications not listed on the VA's National Formulary, through a Special Drug Request (SOR) process when a medication is clinically indicated for an acute or chronic medical condition. Additionally, Beckley VAMC management has formally clarified to staff, via email and in face-to-face meetings, that aripiprazole and ziprasidone are, in fact, available for physicians to prescribe when clinically needed.

With respect to VA's recommendation that Beckley VAMC management take steps to improve the education of its leadership and the P&T Committee on the policy and procedure requirements outlined in VHA Handbook 1108.05, Outpatient Services, and VHA Handbook 1108.08, VHA Formulary Management Process, Beckley VAMC management has taken the following actions:

- On January 25, 2015, during the Medical Staff meeting, providers were educated on the policy and procedure requirements outlined in VHA Handbook 1108.05, Outpatient Pharmacy Services, and 1108.08, VHA Formulary Management Process;
- On March 12, 2015, Medical Center leadership, (including the Chief of Staff, the Medical Center Director, and the Chief of Pharmacy), and members of the P& T Committee were educated about the same information. Additionally, the Veterans Integrated Service Network (VISN) 6 Pharmacy Executive participated (via teleconference) in a Beckley VAMC P&T Committee meeting and during the meeting covered the salient elements of VHA Handbook 1108.08 and 1108.05, especially those related to continuation of therapy; and
- On March 17, 2015, the VISN 6 Pharmacist Executive reinforced the key points of VHA Handbook 1108.05 and 1108.08 to all VISN 6 Chiefs of Pharmacy (or their designee) during a conference call.

VA also recommended that VHA take action to reinforce to all Medical Centers the policy and procedural requirements outlined in VHA Handbook 1108.05 and VHA Handbook 1108.08 related to the processing of formulary medications. This was accomplished on March 13, 2015, when VHA issued such guidance to the field. Notably, this same information was provided to all VISN Chief Medical Officers, VISN Pharmacist Executives, Chiefs of Staff, and other internal stakeholder groups.

With respect to the status of VA's recommendation that, if and as warranted, appropriate action be taken against VAMC leadership and the P&T Committee for approving actions that were inconsistent with applicable VHA policy on prescribing drugs, the Beckley VAMC Director is currently working with VA's Office of Account-

ability Review, a multidisciplinary body which reports to the Secretary through the General Counsel, to determine the need for any such action.

To ensure staffs are able to report suspected violations of policy or law and that such reports are investigated promptly, Beckley VAMC has appointed a full-time Compliance Officer who is available (both in-person and via a telephone hotline number) to receive confidential reports by staff of suspected policy violations. When a complaint is received, the Compliance Officer will notify the Beckley VAMC Director of the complaint and enter the matter into a web-based reporting system where it is to be monitored until satisfactorily closed. As part of the process, the Compliance Officer conducts a fact-finding exercise and presents the findings to the Director, who may take whatever action is deemed appropriate. The manner in which complaints are to be handled and/or resolved will depend upon the nature and facts of each complaint. For instance, the Director may convene an Administrative Board of Investigation to investigate the types of matters covered by VA Handbook 0700. Please note that with respect to suspected criminal activity, VA employees, not only the Compliance Officer, are obligated to report suspected criminal activity to the appropriate law enforcement officials in accordance with 38 CFR §§ 1.200–1.205.

Beckley VAMC maintains posters for the Office of the Inspector General and Joint Commission displayed throughout the facility informing staff, Veterans, and visitors about how to make complaints of suspected waste, fraud, or abuse. Additionally, suggestion boxes can be found throughout the facility making it easy for any person to anonymously submit questions or concerns to the Compliance Officer.

The remaining allegation substantiated by VA was the medical center's failure to communicate the opioid performance measure to all primary care physicians within 90 days of the beginning of the fiscal year. VA recommended the facility take steps to ensure performance measures are communicated to physicians in a timely manner, in accordance with VHA policy (VA Handbook 5007, Pay Administration). On January 21, 2015, Beckley VAMC's Office of Human Resources implemented a standard operating procedure (SOP) requiring service lines to develop, communicate, and implement physician performance pay goals (which are the performance measures plan) based upon the Executive Career Field plan and opportunity for improvement identified by Beckley VAMC. The SOP includes calendar reminders for this action and requires confirmation of completion by each service line before the 90-day deadline.

[June 9, 2015, Senator Capito Letter intentionally omitted.]

Senator MANCHIN. Really what it comes down to, this leads up to everything that we have talked about here, and I think as Senator Sanders says, you know, privatization, this and that. I just truly want—I just care about the veterans. There are going to be an awful lot of them coming back who will need a lot of care. My generation coming out of Vietnam, 40 years later still have tremendous need.

With that being said, do you believe—you come from the private sector. You come from the private sector. You are public. You are public.

Dr. TUCHSCHMIDT. She is private sector.

Senator MANCHIN. Private? Oh, I read here you had 15 years in Government. Those who have more public—more private exposure, would understand. Do you believe we can give better care to our veterans through the private sector? I mean that in the case of the quality of care, the time, and also the cost. I am not saying we are going to shut the VA down. But before we expand, I do not think we are going to build another hospital. I do not think we are going to build anything else. We are going to have to maintain what we have and give better care for more people.

Mr. GIBSON. Sir, I would tell you, no, I do not believe that that is the case. If you look at the typical——

Senator MANCHIN. Tell me why.

Mr. GIBSON. If you look at the typical veteran that we provide care for, they are older, they are sicker, and they are poor. We have a highly fragmented health care system in America, and that is

precisely the person that I do not think fares best when turned loose in that fragmented system. If you go talk to veterans, to a large number of veterans, consistently what you are going to hear, are there instances where they had to wait too long for care? Are there instances where we made a mistakes? Yes, there absolutely are. Fifty-five million outpatient appointments a year.

Senator MANCHIN. Use Alaska as an example. We used Alaska for the Choice. Alaska is the basis for with Choice. We used Alaska and how they were given so much better quality of care and quicker wait times than anywhere else. They do not even have a VA hospital. Who wants to take that one?

Mr. GIBSON. You know that market very well.

Mr. MCINTYRE. If I might, I know Alaska a fair bit, and about a decade of public service experience. I would offer the following: I think it takes both.

Senator MANCHIN. OK.

Mr. MCINTYRE. I think the real question at the end of the day is: Which things fundamentally are done best by the VA directly? Which things have enough demand where it justifies building it? Which things ought to be supplemented by the private sector? Because it is either there is not enough demand to justify a build or where it makes sense to spread the supply simply because of the amount of resourcing that is needed to deliver services. I think that has always been true. I think that is true in the DOD system. That is why you see TRICARE constructed the way it is. Alaska has a joint-use facility in Anchorage. But when you get outside of Anchorage, most of the footprint tends to either be public in the DOD, public through the Indian Health Service, or private. It is those two pieces working together that are ultimately going to deliver what needs to be done.

Senator MANCHIN. Well, I can talk to you all day, but my time is running out, but the thing on drugs, the drug dispensing to our veterans is almost criminal, what we are doing to them. The concoction of drugs we are giving them without proper guidance, and when you look at high unemployment rates in our veterans and look to it as drug addiction, we have got to do something there. Prescription drug abuse is the biggest killer I have in my State of West Virginia, and it is everywhere. It is horrific. But in the ranks of our military and our veterans, it is just absolutely off the charts.

We are putting a prescription drug abuse caucus together, Democrats and Republicans working together. We are going to need your help because this is where we can——

Mr. GIBSON. We would love to participate. We agree with you. We recognize it as a national problem, and it is a problem inside VA.

Senator MANCHIN. Thank you.

Chairman ISAKSON. It is a problem in general society. Thank you, Senator Manchin.

Senator Tillis, then Senator Hirono, followed by Senator Boozman and Senator Tester.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair. Thank you all for being here.

Just a couple of things. One is based on a comment made here earlier about the idea of completely privatizing the VA. I honestly have not had a single serious discussion with any member that saw that as an end state. If they did, if anyone here did, all they need to do is spend some time in the VA to understand the unique nature of what the VA has to offer. There is no other more welcoming place for a veteran than the VA. Not that there are not opportunities for private care. There clearly are already. The non-VA care is a very significant part of what you all do every day, long before Choice was ever implemented. Choice is just another safety valve.

I realize in these Committee meetings sometimes our words carry more weight than perhaps they should. But I do not think anybody should leave this Committee meeting thinking that anybody here has any serious goal or objective to privatize the entire VA.

I want to go back to the point that Senator Blumenthal mentioned. I also have concerns about the overrun in the Denver hospital. I completely understand your predicament. You have got to figure out a way to get it built out. Can you give me an idea of what the thought process was? Because presumably, if you were going to shift that money over for the short-term need to fund the buildout of the Aurora facility, what would that cause in terms of delay or ramping down of what we would be doing with Choice over the period of time that that money would not be available?

Mr. GIBSON. What we basically did is in identifying the non-recurring maintenance and minor construction projects, we have a capital planning process that actually builds a prioritized list that is years long based upon the pace of funding that we normally expect to get. When we looked at the $5 billion in Choice funds, we basically reached into that skip list and pulled a segment out to put into that priority bucket.

What happens now is the substantial portion of those, if we were permitted to do this, in all likelihood would wind up in the 2017 budget because they then would fall back into that prioritized queue.

Senator TILLIS. That is why I was asking the question, because you could infer from some of the discussion that there is a $700 million hit and care not being provided versus taking a look at how that money was spent over time to build the ramp-out of the Choice Program. That is why I was asking. It sounds like there is some leveling assumptions you were making about having the money when you need it.

Mr. GIBSON. That is exactly right. Our commitment has been that we would work this back into the funding stream as quickly as we could. There are hundreds of——

Senator TILLIS. I think that that is critical in order for what you have requested in the letter that you sent us to have any prayer of serious consideration, you need to map out how we would have assurances that it does not really materially affect it because of the way that you would plan to spend that money anyway.

Mr. GIBSON. Thank you. Thank you for raising the issue.

Senator TILLIS. Because, otherwise, I would tend to go back to the well-articulated position of the Ranking Member.

The other question that I had or the thing that I think is very important is we need to get a 5-year, 10-year, 20-year picture of what Choice non-VA care means, to get some parameters set about it, because that is critically important for you to go back and review your capital improvement plan to figure out how to do it. The answer is going to be different depending upon where you are.

Senator Sullivan will rightly say that his State has a higher per capita veterans population of any State in the Nation. I have a veterans population that exceeds the population of several States. The capital planning requirements in North Carolina will be necessarily different than non-VA care, and the Choice mix in Alaska will be necessarily different. We have to come up with that long-term vision so we can relook at the current capital improvement plans based on what appears to be the interest of the Senate to continue down that multipronged path so that you are taking pressure off of capital requirements in some areas and maybe redoubling them in other areas. That is a very important thing that I think this Committee needs to see, but then we need to be very specific about what we want beyond just brick and mortar VA presence in the form of non-VA care and Choice are to get this right.

Mr. GIBSON. If I can make two quick observations. I think you are absolutely spot on. First of all, we have to force ourselves to make certain decisions about what care can be most efficiently delivered in the community. We have talked before, my example the Chairman remembers, optometry. Why would we send a veteran 100 miles to go get his eyes checked and get some glasses? You can do that anywhere. Why would we not be routinely referring that out into the community unless a veteran really wanted to come to VA?

The other issue that we are trying to get at—and we are learning right now, again, working to manage toward requirements rather than just a budget number. What we are seeing is every time we improve access to care with a new facility, with additional staff, demand changes. Part of what we are trying to understand is what are the dynamics.

For example, you look in Phoenix where we know we are underpenetrated in the veteran market. We improve access to care, and we get a disproportionate response back. We have got to understand that market penetration phenomenon because it will affect our capital planning.

I have already talked with the folks in Phoenix about getting beyond looking over the horizon as it relates to demand for care among veterans in Phoenix. We cannot keep incrementally doing this because we are just going to stay behind. We have got to get ahead of that demand. Your points are excellent.

Senator TILLIS. Thank you.

Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Hirono?

HON. MAZIE HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you.

There is a shortage of medical personnel in the VA, and I note in your testimony, Secretary Gibson, that you are going to be cre-

ating some 1,500 new residency positions, and this is a matter that I have discussed with our VA person in Hawaii, because if we can create residency positions in the State, it is more likely that those folks will be able to practice in the State.

How will these residency spots be allocated? By region? By capacity? Are there any you are planning to increase for Hawaii medical students?

Dr. TUCHSCHMIDT. I do not have the list with me today specifically of where the slots are going.

Senator HIRONO. Have you already determined where the residency slots are going?

Dr. TUCHSCHMIDT. Not all 1,500. That is a multiyear plan to deploy the 1,500, and the first round of those started this fiscal year. I, quite frankly, did not think our Office of Academic Affiliations would be able to do it, but they went out and sought applications. There are very specific criteria in the law about them going to underresourced communities and specialties. They went out and specifically sought those. We have awarded several hundred for this first round this year, not as many as we had thought maybe, but a lot more than I anticipated they would be able to award. I can get you specifically where those——

Senator HIRONO. Certainly, because Hawaii has a lot of rural areas on the neighbor islands that are underserved in the VA. Thank you. You can send me the information, or the comparative effectiveness.

Dr. TUCHSCHMIDT. Yes.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MAZIE K. HIRONO TO U.S. DEPARTMENT OF VETERANS AFFAIRS

APPROVED VACAA Positions Round 1 & 2

VISN	Facility Name	Total RFP 1	Total RFP 2	Total Positions
1	Bedford VAMC	0.0	3	**3.0**
1	Providence VAMC	0.5	0	**0.5**
1	Togus VAMC	2.0	0	**2.0**
1	White River Jct VAMC	2.7	2	**4.7**
2	Canandaigua VAMC	0.6	0	**0.6**
2	Montrose VAMC	0.0	2	**2.0**
2	Northport VAMC	5.0	3	**8.0**
2	Syracuse VAMC	0.1	0	**0.1**
4	Lebanon VAMC	0.0	2.5	**2.5**
4	Philadelphia VAMC	1.0	0	**1.0**
4	Wilkes-Barre VAMC	6.0	0	**6.0**
5	Baltimore VAMC	0.5	0	**0.5**
5	Beckley VAMC	2.0	0	**2.0**
5	Huntington VAMC	8.8	0	**8.8**
5	Washington VAMC	2.0	0	**2.0**
6	Durham VAMC	7.5	2	**9.5**
6	Fayetteville VAMC (NC)	2.0	4	**6.0**
7	Atlanta VAMC	2.5	1	**3.5**
7	Augusta VAMC	2.0	4	**6.0**
7	Birmingham VAMC	1.0	0	**1.0**
7	Charleston VAMC	3.0	4	**7.0**
7	Columbia VAMC (SC)	0.3	2.8	**3.1**
7	Dublin VAMC	2.0	0	**2.0**
8	Bay Pines	4.0	0	**4.0**
8	Gainesville VAMC	13.0	8.25	**21.3**
8	Orlando VAMC	11.0	10	**21.0**
8	San Juan VAMC	4.0	3	**7.0**
8	Tampa VAMC	0.0	5	**5.0**
8	West Palm Beach VAMC	3.0	0	**3.0**
9	Lexington VAMC	1.0	0	**1.0**
9	Louisville VAMC	2.0	0	**2.0**
9	Memphis VAMC	8.0	9	**17.0**
9	Nashville VAMC	2.0	3	**5.0**
10	Chillicothe VAMC	1.0	1	**2.0**
10	Cincinnati VAMC	0.0	1	**1.0**
10	Columbus ACC	1.0	0	**1.0**
10	Dayton VAMC	1.5	0	**1.5**
11	Ann Arbor VAMC	0.0	1	**1.0**
11	Battle Creek VAMC	0.0	4.4	**4.4**
11	Detroit VAMC	8.0	0	**8.0**
11	Saginaw VAMC	0.0	2	**2.0**
12	Chicago (Westside) VAMC	4.0	0	**4.0**
12	Hines VAMC	1.0	0	**1.0**
12	Madison VAMC	1.0	6.5	**7.5**
12	Milwaukee VAMC	1.0	3	**4.0**

APPROVED VACAA Positions Round 1 & 2

VISN	Facility Name	Total RFP 1	Total RFP 2	Total Positions
12	Minneapolis VAMC	0.5	0	**0.5**
15	Kansas City VAMC	1.0	3	**4.0**
15	St. Louis VAMC	0.5	17.15	**17.7**
16	Fayetteville VAMC (AR)	0.0	3	**3.0**
16	Jackson VAMC	1.0	0	**1.0**
16	New Orleans VAMC	3.5	0	**3.5**
17	Big Spring VAMC	0.0	7	**7.0**
17	Dallas VAMC	1.0	0	**1.0**
17	El Paso VA HC System	0.0	8	**8.0**
17	Houston VAMC	14.0	0	**14.0**
17	Temple VAMC	12.5	0	**12.5**
19	Denver VAMC	4.0	0	**4.0**
19	Grand Junction VAMC	1.0	0	**1.0**
19	Oklahoma City VAMC	3.0	0	**3.0**
19	Salt Lake City VAMC	7.4	4	**11.4**
20	Boise VAMC	1.0	0.65	**1.7**
20	Portland VAMC	2.4	0.5	**2.9**
20	Seattle VAMC	0.0	7.57	**7.6**
21	Fresno VAMC	0.0	1.67	**1.7**
21	**Honolulu VAMC**	**2.0**	**1**	**3.0**
21	Reno VAMC	2.0	0	**2.0**
21	San Francisco VAMC	1.0	3	**4.0**
22	Albuquerque VAMC	4.8	0	**4.8**
22	Loma Linda VAMC	8.0	6	**14.0**
22	Long Beach VAMC	2.0	0	**2.0**
22	Phoenix VAMC	2.0	6	**8.0**
22	San Diego VAMC	7.5	5	**12.5**
22	Sepulveda ACC	0.0	2	**2.0**
22	West Los Angeles VAMC	2.0	5	**7.0**
23	Sioux Falls VAMC	2.2	0	**2.2**
	Grand Total	**204.22**	**167.99**	**372.2**

* zero approved positions may mean that the facility did not apply

Senator HIRONO. As we look at the request of Secretary Gibson to pay for the Denver facility and we are looking—I think that it is really difficult for us to accept that you want to take money from the Choice Program to do that. I would like to ask you this: When a veteran goes to the VA to get care for a non-service-connected matter and this veteran has private insurance, do you have the authority to get reimbursed from the private insurance company for the care that the VA provides?

Dr. TUCHSCHMIDT. If the patient goes out into the community in our normal purchased care program and has insurance, we will bill that insurance company and collect to offset the cost of the care we provided.

Under Choice, we are actually the secondary payer, so under the Choice Program, the way the law was written, if the patient has

commercial insurance, the commercial insurance is the primary payer, and then we will make the provider whole up to the Medicare rate.

Senator HIRONO. All right. Under the Choice Program that is good because VA becomes the secondary payer. My understanding is that in the first instance, where the veteran goes to the VA and gets the treatment, then often there is no reimbursement from his or her private insurance company. You are telling me otherwise.

Dr. TUCHSCHMIDT. We will bill the private insurance company if the patient has insurance.

Senator HIRONO. Yes. And do they reimburse you?

Dr. TUCHSCHMIDT. Yes, we get paid from them. A lot of the patients that have insurance have Medigap insurance, and without a Medicare EOB oftentimes those insurance companies will not pay for the care because it is not Medicare—the insurance is specifically Medicare gap coverage. We will not oftentimes get paid by those insurers.

Senator HIRONO. You are reassuring me that the VA goes after every dime from the private insurance carriers that you can get your hands on.

Dr. TUCHSCHMIDT. I can assure you we go after every dime we can collect.

Senator HIRONO. That is reassuring.

Dr. TUCHSCHMIDT. About $3 billion a year, yes.

Senator HIRONO. There are some questions about the outreach on the Choice Card Program. There is still confusion out there and whether you found all of the veterans who would qualify for the Choice Card. What are the outreach efforts that you have engaged in? Do you think that you are succeeding in explaining the Choice Program? And, also, to VA employees and community health care providers who need to get training on how to explain the program.

Dr. TUCHSCHMIDT. We originally mailed—we know who the people are who are eligible to get a Choice Card, and we mailed the letter to every one of those people back when the program started in November.

Senator HIRONO. I have talked to veterans, and they found that letter to be rather confusing.

Dr. TUCHSCHMIDT. Yes. We are about to mail a second letter to all of them. Hopefully it is a lot simpler to understand. We have actually tested that with veterans before we put it in the envelope.

Senator HIRONO. Good idea.

Dr. TUCHSCHMIDT. We have made a lot of phone calls and outreach to people. There is no question that I think we can do more to reach veterans through our Web site, through mobile technology, through mailings, and other forms of communication. We need to do a better job of educating them.

Senator HIRONO. Good.

Mr. GIBSON. We do need to do a much better job. One of the things we have got to remind ourselves of is there is no parallel to this out there. It is not like an insurance card where you just walk into your doctor's office and present your insurance card. There is no frame of reference for people to understand how it works. You know, do I have a benefit or do I not have a benefit?

That is one of the reasons it is hard for us to explain and why we have to keep trying.

Senator HIRONO. If giving you feedback from my veterans, for example, could help you all do a better job, I would be happy to pass that on.

Mr. GIBSON. We would love it, yes.

Senator HIRONO. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Hirono.

Senator Boozman, followed by Senator Tester.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman.

Very briefly I would like to ask a question of efficiency. I understand that the third-party administrators (TPAs), TriWest and Health Net, have raised the issue of how much clinical documentation is being sent to them by the VA. Apparently VA is sending the clinical documentation of every veteran who was approved due to having a wait time in excess of 30 days, which presumably is overwhelming the TPAs. You now have a pilot program in VISNs 8 and 17 to only send the clinical information of veterans who choose to participate in the Choice Program. I guess the question is: are the pilots proving successful? Then, Mr. McIntyre and Ms. Hoffmeier, if you would like to comment from your standpoint as to what is going on.

Dr. TUCHSCHMIDT. When we first set up the program, we gave every patient in the system an appointment in our system and put them on the Choice list so that they could decide at any point in time which direction they wanted to go. We have learned through experience over the last 6 months that that does not work. It does not help the veteran. It does not help us. Quite frankly, it is not cost-effective.

We have the pilots. We have just started these pilots to see how this goes and how we can improve those business processes. But we are moving, quite frankly, in the direction of at the point of service offering the veteran—finding out what is the appointment that we can provide in the VA, offering the veteran that appointment or offering them the opportunity to go outside through the Choice Program. At that time, if the veteran chooses to go out, then our staff, much like they do outside of Choice for all of our other purchased care appointments, will work directly with TriWest and Health Net to get that patient an appointment through the Choice Program. At that time, we hope we have learned from our pilots in 8 and 17 how to do this smarter and better so that we will greatly reduce the volume of people that we are referring to the TPA and are only providing medical record documentation for those patients who actually choose to go outside the system.

Senator BOOZMAN. That sounds excellent. Do you——

Mr. MCINTYRE. The pilot is a very good idea. Sitting at the table in the initial design, when we were getting ready to launch, we had 2 days to make a decision. The question was, how do you make sure that all the right information is in the right place to be able to serve people on the front end? The back-end consequences are

now obvious, and making the change makes a lot of sense, and we are looking forward to supporting it.

Senator BOOZMAN. OK. Ms. Hoffmeier?

Ms. HOFFMEIER. The pilot has been going exceptionally well in our area, and, in fact, we just approved a schedule with VA to move forward with implementing the concept across all of our regions here very soon. We are getting the consults in less than 24 hours on the veterans we need. It is very effective.

Senator BOOZMAN. OK. That is excellent. I know that it is kind of a rocky road as you are working through these things, but it is encouraging that you are working through.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

The Patience of the Year Award goes to Senator Tester. Senator Tester?

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. It is just because you have a very, very good Committee meeting here, Mr. Chairman.

Chairman ISAKSON. We got good testimony.

Senator TESTER. I want to thank you and the Ranking Member for having you guys, and thank you for your work.

I just really do not know where to start, quite frankly. First of all, you guys do do a good job. I think the private sector does a good job. You have your fallibilities. Do not think that the private sector does not have their fallibilities, too. They are short on nurses, they are short on docs, they are short on mental health professionals, they are short on facilities, just like you guys are. In the bookkeeping nightmare that may come with this, let me give you an example. Just say I was a vet. I live 50 miles from a CBOC. My nearest hospital is 12 miles away. But that nearest hospital does not have a doctor in it. It is staffed by a nurse practitioner.

Then the questions become: one, is that somewhere you want to have an appointment; and, two, if I do not, guess where the nearest hospital is? In the same town where that CBOC is. I mean, the bookkeeping here is just amazing. I know we are all here trying to do the right thing, and I know you are trying to do the right thing. Still, sometimes even if you do the right thing, people are mad because they think it is the wrong thing. I thank you for that.

Mr. Gibson, you talked about the 40-mile thing as far as not offering the service several times, and you talked about how it does not make any sense if a guy is going to have a set of glasses, why ship them halfway across the country. When you did your analysis, did you also include the savings that would accrue to the VA by not shipping them a long ways away? Because I think that is really important. If I was a veteran and had to do it over again, I probably would have signed up just for this benefit. But, the truth is that if you are talking about what it costs to ship them to the private sector, it also is a savings if just in mileage alone. Did you include that in the overall net dollar figure?

Dr. TUCHSCHMIDT. No. We actually do not in the analysis. We have worked through several options from what 40 miles from the care you need might look like.

Senator TESTER. Yes.

Dr. TUCHSCHMIDT. We have not taken into account a lot of savings.

Senator TESTER. OK.

Dr. TUCHSCHMIDT. We were modeling this for the Choice Program. In the short run, our cost structure is highly fixed; 90 percent of our costs are fixed. There are variable costs, which is mostly the eyeglasses that you do not prescribe, but the rest of the infrastructure, the building, a lot of the people, et cetera, do not go away.

Senator TESTER. Yeah, but the mileage is also not a fixed cost, and if you have to put them up in a room, that is not a fixed cost.

Dr. TUCHSCHMIDT. We have not specifically looked at the bene travel, and then there are two aspects of the bene travel. There is the true cost savings and there is the cost avoided because you have not made them travel.

Senator TESTER. That is correct.

Dr. TUCHSCHMIDT. But, that is not a real savings. That is a cost that you did not realize.

Senator TESTER. Yes, but really? I mean, come on. That sounds like CBO talk here, truthfully. I do not want to debate this, but the fact is that if you are doing the actual cost analysis and you would have spent the money if they went to a facility of yours, you have to include that in the savings. Truthfully, if we are going to deal with honest figures, that savings has to be included, even if it did not accrue.

Mr. GIBSON. Clearly it does have to be included.

Senator TESTER. OK. Right.

Mr. GIBSON. Even though the level of analysis today is orders of magnitude better than what we had initially, all the way down to the individual patient level, we have not picked up some of those incidental costs.

Senator TESTER. Mr. McIntyre, you talked about harmonization, which I have talked with Sloan about regarding the ARCH program, PC3, and Choice. I am assuming you are for harmonization. I read it in your testimony. Just nod your head if that is correct.

Mr. MCINTYRE. Yes, sir.

Senator TESTER. Deputy Gibson, you are for harmonization of those programs. Could you give us some language on how we can harmonize those programs? I do not want to be the micromanager here, but if you guys need language to be able to harmonize those programs, I think it is a reasonable thing to do.

Mr. GIBSON. We need to do that. I think part of that picture is how do we manage the 40-mile issue.

Senator TESTER. Yes.

Mr. GIBSON. I think we need to think through this. Are we going to look at VA becoming a secondary provider to those that have other insurance alternatives? Because it changes the nature of the work.

Senator TESTER. OK. Well——

Mr. GIBSON. It is wrapped up in that. It needs to be a very near-term exercise.

Senator TESTER. Yes, let us deal with that, because I think it is confusing right now, and I think there is a little manipulation going on.

Mr. MCINTYRE. Well, and if I might, one of the issues I was attempting to address and allude to is the fact that we built a network out now I our area that has got 100,000 providers in it.

Senator TESTER. Yes.

Mr. MCINTYRE. The requirements are more extensive than those under Choice if you are a participating provider. Those things need to be blended together so that we do not have disincentive to participate in one program versus another.

Senator TESTER. Fair enough.

Mr. GIBSON. And the reimbursement rates need to be the same.

Senator TESTER. That is exactly right. Hepatitis C, you want some additional dollars, I think $700 million transferred? $400 million?

Mr. GIBSON. Not transferred. If we are allowed to be flexible——

Senator TESTER. Be able to tap it. I do not have a problem with that, by the way. The question I have is if this is a miracle drug, when do you anticipate those costs or hepatitis C to flatten out so you are not going to need those kind of dollars?

Mr. GIBSON. I think the conversation that needs to be held with this Committee, with the House Committee, and with the appropriators has to do with the requirement that we manage toward. I would tell you VA's thought is we should be talking about a requirement where veterans that are hepatitis C positive, we manage that number to functional zero by the end of 2018. That is what I think the requirement should be. So, what we need to do is step back from that and lay out a plan that says this is what would be required——

Senator TESTER. I agree with that.

Mr. GIBSON [continuing]. In order to manage to that requirement, so we are not back and forth about—because the first time we deny a veteran access to the treatment who is hepatitis C positive because he does not have advanced liver disease, everybody thinks we are depriving a veteran of care. We need to reach agreement on what the requirement is.

Senator TESTER. One last question, if I might, since I get the award for being patient. You talked about residency slots, which I think is great and I support and will do everything we can. I believe residencies are 3 years?

Dr. TUCHSCHMIDT. It varies depending upon what the specialty is.

Senator TESTER. How about for internists? How long is that?

Dr. TUCHSCHMIDT. That is 3 years.

Senator TESTER. 3 years. That is what we are short on, right?

Dr. TUCHSCHMIDT. Yes.

Senator TESTER. The question I have is this place changes every 2 years, and to have 3 years in a residency, you have got to have the money for that residency.

Dr. TUCHSCHMIDT. Yes.

Senator TESTER. Talk to me about how this works, because you have got a 2-year—you have got forward funding, but you do not have forward funding for 3 years. What do you do if Congress does something irresponsible—and that has been known to happen a time or two—and does not fund you.

Dr. TUCHSCHMIDT. I think this is actually one of our concerns. These residents all have tales. When we start a new residency slot, all of those slots have to be funded for the duration of that residency training.

Senator TESTER. In that budget.

Dr. TUCHSCHMIDT. Yes.

Senator TESTER. OK.

Dr. TUCHSCHMIDT. Exactly, and that is not the case today.

Senator TESTER. OK. That is important to know as we move forward. When are you going to start the residency program? Is it going to start in this fiscal year?

Dr. TUCHSCHMIDT. Well, we actually do not own the residency slots. They are owned by the Academic Centers.

Senator TESTER. Yes.

Dr. TUCHSCHMIDT. We pay for trainees, offset their salary. The additional slots that we added started this academic yes.

Senator TESTER. This fiscal year.

Dr. TUCHSCHMIDT. The academic year that will start this coming July.

Senator TESTER. In this budget we are dealing with this?

Dr. TUCHSCHMIDT. Yes.

Senator TESTER. So, if your budget comes in a little short, this may be a program that goes bye-bye.

Dr. TUCHSCHMIDT. I doubt it, because we have made commitments at this point.

Senator TESTER. I appreciate it. Thank you, guys, for your work.

I appreciate your flexibility, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Tester. Thanks to all the Members, and thanks to our witnesses. It has been a long and I think very productive hearing. We are on the path to solving some problems and recognizing a few that we need to solve. I appreciate everybody's time and effort very much.

We will take a 2-minute break while we shift nameplates and go to panel two.

Mr. GIBSON. We appreciate the collaborative working relationship, Mr. Chairman. Thank you.

Chairman ISAKSON. That is the only way to do it.

Mr. GIBSON. Yes.

[Pause.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Non-VA Care Programs

The Choice Program was created as an emergency fix to help bring down serious wait times that were keeping veterans from care they needed, but that program is a temporary authority and will expire in a few years. VA now has at least 4 different major authorities to get veterans into non-VA care and they all have different procedures, eligibility requirements, reimbursements, and reimbursement rates. This is inefficient and confusing to providers, VA employees, and veterans alike. VA should be preparing now to create one non-VA care program that is effective and efficient, and complements the care provided by the Department. Please describe the key features and requirements needed for such a future program.

Response. VA agrees that the existence of four programs, with separate statutory and regulatory authorities to access care in the community is confusing for VA employees, providers and ultimately Veterans. While each program serves a specific purpose, VA agrees that the rationalization of these programs would be a welcomed simplification for all. In May, 2015, the Department proposed legislation through

the Department of Veterans Affairs Streamlining and Modernization Act which would allow the development of an established network of approved non-VA medical care providers, expanding Veteran access to care. In addition to this Act, rationalization of non-VA care programs is necessary, and should focus on consistency, simplification of processes, and robust technology, to include:

- Consistent eligibility requirements for all care in the community (or non-VA medical care).
- Eligibility requirements that are written in easy-to-understand verbiage that VA employees can quickly and concisely articulate to providers and Veterans.
- A dynamic provider network that allows VA medical facilities the opportunity to continue to cultivate relationships within their community.
- Simple, consistent payment methodology for all non-VA care.
- Electronic submission of Vendor claims 100% of the time.
- Automation of payments.
- Clearly defined reporting requirements prior to program implementation.
- Robust reporting system that captures national and facility-level data.

Ultimately, the future of care in the community is dependent on developing an approach that is driven by Veteran satisfaction and industry-leading cost-effective care.

Question 2. Denver

Two construction projects in Washington state were among those that were allocated funding from the Choice Act. VA has now asked to reprogram $24.7 million dollars away from those projects to pay for the outrageous cost overruns at the Denver facility. The $5 billion provided in the Choice Act was provided to increase access to care by addressing critical problems at facilities around the country, not to cover the Department's shocking mismanagement of the Denver hospital. These two construction projects in Washington are greatly in need of this funding, and any request to take away from those projects is deeply concerning. Where else can the Department find the money to address the problem in Denver besides taking the funds meant to address critical issues at other facilities? In responding please provide a detailed accounting of such funds and a plan to mitigate the serious deficiencies in the Department's management of major construction.

Response. On June 5, 2015, VA released a comprehensive proposal to the House and Senate Veterans' Affairs Committees. The plan details specific reforms VA has instituted to improve our construction program outcomes and prevent mistakes moving forward. The funding plan for completion of the Denver facility presents options from a Veteran-centric focus that we believe deploys resources efficiently while addressing the emerging needs of VA facilities in a fiscally responsible, budget-neutral manner. For your convenience, the full text of the plan documents is available for download:

1. Letter to Congress
2. Plan for Completion of the Denver Replacement Medical Center
3. Cost Benefit Analysis—Denver VAMC (April 2015)
4. Photos of Denver Replacement Facility
5. VA Accountability Fact Sheet (June 2015)
6. VA Making Progress to Improve Service for Veterans Fact Sheet (June 2015)
7. *MyVA* Transformational Plan (June 2015)

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 3. Mr. Gibson, I would like to take this opportunity to address the importance of timely claims processing and outstanding medical claims for non-VA facilities. As of Feb 9, 2015 the VA had $43.7 million in unpaid medical invoices to non-VA facilities in Louisiana alone. One single healthcare system covering Texas, Louisiana, and New Mexico is owed almost $5.5 million. This is unacceptable, we cannot expect private institutions to render care to veterans if they know that VA will either only pay the claims at 33% or not pay the claims at all.

a. When does the VA expect to eliminate the backlog of claims (older than 30 days) to non-VA facilities?

b. My constituents are still reporting claims assistance hold times ranging from 1–4 hours, what is being done to address this situation as a whole within the VA?

c. When will the VA stop mishandling veterans' paper medical records and allow electronic submission of these claims—in the same way Medicare and virtually all other payers do now?

d. In November and in April, the Chief Business Office said it had reopened a large group of claims VISN 16 had inappropriately denied for lack of medical records after VA employees failed manually scan these records into the system. Chief Business Office leaders have not been willing to report how many of these claim denials were overturned. When will the VA develop metrics that demonstrate the accurate payment of claims in VISN 16 and other poorly performing areas?

VA Response:

a. Purchased Care has developed a specific plan to address backlog elimination and process improvement. The goal is to eliminate the backlog and have only current claims in inventory by December 31, 2015.

b. Due to higher than normal volumes of calls and claim submissions, telephone wait times had increased. However, Purchased Care has implemented several strategies to address the increase and provide customer service to include providing claim status updates via email or paper mail, setting up routine follow-up conference calls with providers, taking voice mails and returning calls in order to alleviate holding times, and the realignment of the V16 call center to Program Administration Directorate to pilot a possible national roll out of call center support if successful. Subsequent to the implementation of the call center pilot in VISN 16 the average waiting time for VISN 16 callers is 15 minutes. Please provide the constituents' names and we will reach out to them to isolate the date called to determine if there were any issues associated with the call center systems.

VA acknowledges there have been instances where clinical documentation was misrouted. Internal controls have been established to ensure clinical documents are scanned correctly at the VISN 16 centralized payment center. A pilot to track clinical documentation has proven to be successful at another location. This pilot reduced customer service wait times and abandonment rates. We have also completed technical site visits to evaluate how well the current software design is meeting business needs in order to implement corrective actions.

c. VA will be expanding that project through VISN 16 in the near future. Providers may also submit medical documentation via CD or DVD and VA staff can upload those digital files. Unfortunately VHA will be unable to accept electronic submission of supporting clinical documentation until upgrades are completed to the Electronic Data Interchange submission systems. That upgrade is anticipated to occur in approximately two years.

d. There were a large number of claims that were reopened and processed during November and April 2014 in VISN 16. VA staff are unable to distinguish the reason why claims were closed during those timeframes. However, VA's Purchased Care office does have a department responsible for Audits and Internal Controls and monitors payment accuracy and addresses specific claims processing errors. In addition VA has established claims processing measures to monitor status of claims at all payment locations. Claims timeliness is monitored daily with weekly conference calls with all payment locations to monitor the status of claims processing and implementation of corrective actions.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DAVID J. MCINTYRE, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTHCARE ALLIANCE

Question 1. Private Providers and Non-VA Care

TriWest and Health Net both play major roles in both the Choice Program and in the Patient Centered Community Care Program. Some very important controls were put into the PCCC program, including requirements to coordinate health care and more oversight of the quality of care. As major contractors administering PCCC regions, each company made certain assumptions about workload and other factors in setting up business plans and provider networks for the PCCC program. How is management of the PCCC contracts affected with large portions of the workload going through the Choice Program instead?

Response. Overall, the biggest challenge we have is explaining some of the billing differences between the PC3 and Choice programs to providers in our network. For the PC3 program, our contract is explicit in its prohibition on providers collecting any funds from the Veteran. One hundred percent of the bill is paid by TriWest on behalf of VA. When that same Veteran is seeking care under the Choice program, the law requires that his or her private insurance provide first dollar coverage if the care is for the treatment of a non-service-connected condition. That creates provider confusion and it is one of the reasons I advocated, what I called "harmonization" of the programs in my opening statement.

Additionally, while we received very little from VA in the way of anticipated volumes for the PC3 program, we were generally assured that referrals for care made to TriWest from VA would result in a patient visit. In that sense, we were able to predict with some level of certainty the staffing we needed to deliver timely service. With the Choice Program, at the outset it was not uncommon that only 15–20% of the eligible patients would ever call us to use the program to receive services in the community. However, we are never really sure from one day to the next what the "uptake" rate will be from the Choice-eligible population. That creates substantial challenges in appropriately staffing for needed services on a daily and weekly basis.

Obviously, it is our hope that as we continue to partner with VA and educate Veterans about the benefit of the program, some stability in expected utilization will occur. But, for now, it is a constant challenge to monitor over or under staffing for needed services.

The only other issue is the multiple different reporting requirements that have us segmenting out workload by program. We certainly understand that it is important to track activity in ways that assure accurate accounting and program utilization. However, at times, the segmentation can present a picture of individual programs in isolation of the entirety of the efforts to provide care and service to Veterans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO DAVID J. MCINTYRE, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTHCARE ALLIANCE

Question 2. Mr. McIntyre, After listing the challenges in your testimony that TriWest confronted in implementing a Patient Centered Community Care (PC3) across 28 States to give VA medical centers a consistent way to provide veterans access to care from a network of providers, you described a pilot done in the collaboration with the Dallas VAMC. At what point, was it decided to implement a pilot? If you are finding the pilot successful, why wasn't that a strategy before implementation in 28 states to avoid some of the challenges you listed?

Response. The pilot program in Dallas was specifically targeted at a challenge brought about by implementation of the Choice program; not the PC3 program. When the Choice program was first implemented, a major issue that was identified was the fact that providers in the community would need clinical consults (medical notes that also include the recommended or suggested specialty service needed) prior to providing services. There were only two ways for VA to provide that information to TriWest so that we could, in turn, hand it to community providers: provide it all up front or provide it only when needed following outreach from a Veteran.

The second option certainly seemed to be a more efficient and effective way to provide the information. However, given the short timeframe of 90 days to stand up the program in its entirety and the backlog of patients on wait lists when the program went live, we all were rightly concerned that VA had no personnel operations or processes through which it could receive requests for those records and turn them around in a timely fashion. While we all wished it was not the case, we were forced to deal with the reality that attempting this at the outset could very well lead to more delays, not fewer.

As such, we started the program with a system whereby VA sent a consult for every Veteran deemed eligible for care under the Choice program rules outlined by Congress regardless of whether the Veteran reached out to TriWest for care. It was our hope that this would ensure that TriWest would have all of the necessary information to help the Veteran as soon as he or she decided to reach out to the Choice program for assistance in obtaining a community care appointment. As the program grew, the number of clinical consults sent to TriWest grew right along with it. Yet, it was still the case that fewer than half of those eligible patients were reaching out to the Choice program for appointments.

At this point, TriWest and VA realized that there were more than enough staff processing consults that we could comfortably begin to implement the more efficient and effective solution we all wanted to attempt initially. And we started to test that operationally in Dallas, Texas in the form of a pilot program.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DONNA HOFFMEIER, VICE PRESIDENT AND PROGRAM OFFICER, VA SERVICES, HEALTH NET FEDERAL SERVICES

PRIVATE PROVIDERS AND NON-VA CARE

Question. TriWest and HealthNet both play major roles in both the Choice Program and in the Patient Centered Community Care Program. Some very important controls were put into the PCCC program, including requirements to coordinate health care and more oversight of the quality of care. As major contractors administering PCCC regions, each company made certain assumptions about workload and other factors in setting up business plans and provider networks for the PCCC program. How is management of the PCCC contracts affected with large portions of the workload going through the Choice Program instead?

Response. Both PCCC and Choice support providing eligible Veterans with access to health care through a comprehensive network of community-based, non-VA medical professionals and facilities. The PCCC contract, awarded to Health Net in September 2013, was phased in over a six month period, with services beginning in January 2014. In October 2014, VA amended the PCCC contract to include several components of the Choice Act (such as production and distribution of Choice Cards, establishment of a call center, and other administrative functions) and required very fast implementation in one month.

PCCC and Choice are designed to achieve the same objective of enabling VA to provide all eligible Veterans with access to the care they need in the local community. In support of PCCC and Choice contract requirements, we have developed policies and processes to meet requirements to coordinate Veterans' healthcare and provide oversight of quality. For example, in building provider networks, we tailor the network to meet the Veteran's health care needs, as identified by the VA Medical Center that is submitting authorizations while meeting the specific requirements of PCCC and Choice. Choice Program participation requirements make it easier for providers to participate, and as a result we are able to get Choice providers on-board more quickly, which enhances Veterans' access to community care.

Currently, the range of options (e.g., PCCC, Choice, affiliate agreements/direct contracts, individual authorizations) for non-VA fee care is confusing for Veterans, providers, and VA staff. As VA discusses options to streamline the programs for non-VA care through greater use of PCCC and Choice, we would anticipate greater efficiency in care delivery.

Chairman ISAKSON. All right. Welcome back to the Senate Veterans' Affairs Committee. It was a good first panel. I apologize to our second panelist that it took so long, but I think it was beneficial, and from the participation you all were illustrating by the looks on your faces, I am sure you enjoyed it, too. Thank you very much.

For our second panel we have Mr. Roscoe Butler, the Deputy Director for Health Care for The American Legion. Roscoe, good to have you.

Darin Selnick, Senior Veterans Affairs Advisor for Concerned Veterans for America.

Joseph Violante, National Legislative Director, Disabled American Veterans.

Mr. Bill Rausch—who is missing in action right now, or AWOL—Political Director for Iraq and Afghanistan Veterans of America.

And Carlos Fuentes, Senior Legislative Associate of the Veterans of Foreign Wars.

We welcome all of you for being here today, and we will start with you, Mr. Butler.

STATEMENT OF ROSCOE G. BUTLER, DEPUTY DIRECTOR, HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. BUTLER. Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, on behalf of our na-

tional 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 wait times for outpatient medical care had reached an unacceptable level nationwide as veterans struggled to receive access to timely health care within the VA health care system. It was clear that swift changes were needed to ensure veterans could access health care in a timely manner. As a result, The American Legion immediately took charge by setting up veterans benefits centers (VBCs) in large 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 VBCs' charge is to work firsthand with veterans experiencing difficulties in obtaining health care or having difficulties in receiving their benefits.

On November 5, 2014, VA rolled out the Veterans Choice Card Program, and after 6 months, it is clear the program fell short of the initial projections from the CBO. According to the VA latest Daily Choice Metrics dated November 30, 2014, 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 these 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 change by eliminating the straight-line rule and using the actual driving distance will allow more veterans access to health care under the Choice Program.

The American Legion also believes that 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 health care.

The American Legion applauds the Senate for unanimously passing an amendment reminding the Department of Veterans Affairs they have the obligation to provide non-VA care when it cannot offer the 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 Community Care Act, and ensure its swift passage. Let us get these bills 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 health care 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 health care under the Veterans Choice Card Program because there is no medical facility that is further than 40 miles from anywhere anyone lives on the island. The American Legion is concerned that as a result of inadequate training, there could be staff at many health care facilities who failed to receive proper training

as a result of bad communications and providing incorrect information to veterans.

Recently, The American Legion learned that the VA contract with Health Net and TriWest required these third-party administrators to report Daily Choice Metrics. However, this contractor requirement has now expired, and the TPAs are no longer required to report these daily metrics. The last report VA provided to VSOs was dated March 31, 2015. The American Legion is concerned that since the TPAs are no longer required to provide these daily metrics, VA can easily lose track of the numbers.

The American Legion calls on 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. In fiscal year 2014, VA spent over $7 billion on non-VA health care. Many of the non-VA purchased care programs are managed by different program officers in VA's central office, and some of these services are handled outside of VA's fee-basis claim processing system. VA should streamline its current purchased care model to incorporate all of VA's non-VA care programs into a single integrated purchased care model.

Congress should also look into streamlining the VA's non-VA care statutory authorities. Once Congress gets a better sense of how the Choice Program will play out over the next couple of years, VA's non-VA care statutory authorities should be consolidated and rationalized incorporating lessons learned from the VA Choice Program.

Thank you, and, again, Mr. Chairman, Ranking Member Blumenthal, I appreciate the opportunity to present The American Legion's views and look forward to answering any questions you may have.

[The prepared statement of Mr. Butler follows:]

PREPARED STATEMENT OF ROSCOE G. BUTLER, DEPUTY DIRECTOR, HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal, 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 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 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

[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

[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

Moran calculated the distance from Helm's home in Norcatur, 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 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

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[3] Commander to Congress: We face 'historic opportunities'–February 26, 2015: http://www.legion.org/washingtonconference/226220/commander-congress-we-face-%E2%80%98historic-opportunities%E2%80%99

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

[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

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 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 additional to this information, VHA should include the timeframe 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.

Chairman ISAKSON. We appreciate the Legion's willingness to follow up and come to all our hearings and give us the testimony we need. Thank you, Roscoe.

Darin Selnick, senior veterans affairs advisor for the Concerned Veterans of America.

STATEMENT OF DARIN SELNICK, SENIOR VETERANS AFFAIRS ADVISOR, CONCERNED VETERANS FOR AMERICA

Mr. SELNICK. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, I appreciate the opportunity to testify at today's hearing on the implementation and future of the Veterans Choice Program, and thank you for your leadership in ensuring that veterans get the quality health care they deserve.

[6] Department of Veterans Affairs VHA Directive 6330- December 15, 2008: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1814

Today true choice in veterans 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 is not a long-term solution. As such, we have developed recommendations for comprehensive reform through the Fixing Veterans Health Care Taskforce.

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 health care provider.

The VA implementation of the Choice Program has been a failure. For example, the Associated Press reported, "GAO says Veterans' Health Care 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 results showed that 90 percent favored efforts to reform veterans health care, 88 percent said eligible veterans should be given the choice to receive medical care from any source they choose, and 77 percent said they want 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 and convenient care because they know if they do not, 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 the system.

VA recognized this when they said "evaluate options for a 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 health care system.

VA needs to have a 2015 health care system. We believe the Veterans Independence Act is the road map and solution to do just that. This road map was developed by the Fixing Veterans Health Care 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 developed ten veteran-centric core principles that serve as the guiding foundation. These ten principles included: the veteran must come first, not the VA; veterans should be able to choose where to get their health care; 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 as an independent, Government-chartered nonprofit corporation, empowered to make decisions on personnel, IT, facilities, partnerships, and other priorities.

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

Third, refocus veterans' health care on those with service-connected injuries—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 nonprofit 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 plan choices:

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

VetsCare Choice: Select any private health care 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 costs of Medicare premiums and supplemental coverage.

Last, create a VetsCare Implementation Commission, to implement the Veterans Independence Act.

We retained the services of HSI 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 fix and be the future of veterans health care. Veterans must be assured that they will be able get the access, choice, and quality health care they deserve. In this mission, failure is not an option.

We are committed to overcoming all and any obstacles that stand in the way of achieving this important mission, and we look forward to working with the Chairman, Ranking Member, and all Members of this Committee to achieve this shared mission.

Thank you.

[The prepared statement of Mr. Selnick follows:]

PREPARED STATEMENT OF DARIN SELNICK, SENIOR VETERANS AFFAIRS ADVISOR, CONCERNED VETERANS FOR AMERICA

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

Nearly as we approach the one year anniversary of the passage of the *Veterans Access, Choice and Accountability Act of 2014*, 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 is not a tenable long-term solution. As such, we have developed recommendations for comprehensive reform through the Fixing Veterans Health Care Taskforce.

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 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 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."
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 nonprofit 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.

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[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.

[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.

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 fix and be the future of veterans health care. Veterans must be assured that they will be able get the access, choice and quality 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.

Chairman ISAKSON. Thank you, Mr. Selnick.

Let me just interject at this point. I have read—and I am sure Sen. Blumenthal has, too—the Fixing Veterans Health Care Report that your organization did, which is an outstanding report. I think it basically could be called "Ultimate Choice," if I am not mistaken. Wouldn't that be a good name for it?

Mr. SELNICK. Yeah, that would be a good name.

Chairman ISAKSON. Your representation of the changes are probably far more broad than some on the panel might look for us to do in terms of preserving what VA does without giving choice, but I want to commend you on that and let you know we are watching what you recommended. We are taking a look at it. We are trying to make sure—Senator Blumenthal and I have one underlying principle: we are going to make Veterans Choice work. It is not an option that it might work; if it does not work, we will think of something else. We are going to make it work. How it works is going to take the very best ideas and input, and your organization's report is one of those that is going to help us a lot, as is each stakeholders' input. This is going to be a process of evolution as we go, but one thing is for sure: we are not just hoping it is going to be over one day. We are going to make it happen one way or another.

Mr. SELNICK. Thank you.

Chairman ISAKSON. Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Chairman Isakson, Ranking Member Blumenthal, 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 on the temporary Choice Program. While it is too early to reach conclusions about this program, we are beginning to see some lessons.

As of last week, almost 54,000 Choice authorizations have been made and 43,000 appointments have been scheduled. By comparison, about 6 million appointments are completed monthly inside VA and another 1.3 million appointments are completed outside VA using non-VA care programs other than Choice.

A number of reasons likely contributed to this lower than expected utilization of the Choice Program. Since last spring, VA has used every available resource to increase its capacity to provide timely care that may have shifted some of the demand away from Choice.

VA was slow in rolling out Choice cards and in educating its staff. We also have high-risk troubling reports of a significant lag time between when a VA clinician determines a veteran is eligible for Choice and third-party administrators can see this authorization in their system.

Finally, some veterans simply prefer to go to VA. The bottom line is we do not have adequate information today and need to take steps to gather sufficient data before making any permanent changes. We must study private sector wait times and access standards, coordination of care, patient satisfaction, and health outcomes for those who use the Choice Program.

Mr. Chairman, recently DAV, VFW, the Legion, IAVA, and others wrote to congressional leaders to extend the mandate of the Commission on Care to allow at least 12 months for its interim report and at least an additional 6 months for the final report. We called on Congress to refrain from making any permanent, systemic changes until after the Commission submitted its recommendations and then allowed sufficient opportunity for stakeholders and 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 health care system has been the embodiment of our national promise, yet today some are proposing to make it just another choice among health care providers, while others are calling for the VA to be downsized or eliminated. But for millions of veterans wounded, injured, or ill from their service, there is only one choice for receiving the specialized care they need, and that is a healthy and robust VA.

Although the VA provides comprehensive medical care to more than 6 million veterans, the VA's primary mission is to meet the unique, specialized health care needs of the Nation's 3.8 million service-connected disabled veterans. If VA was downsized or eliminated, the private health care system would be unable to provide timely access to the specialized care they require. Even if all dis-

abled veterans were dispersed into private care, they would only be 1.5 percent of the total adult population. Does anyone truly believe that a market-based civilian health care system would provide the focus and resources necessary for this small minority in the way VA does?

Mr. Chairman, while it is far too soon to settle on how to reform the VA health care system and integrate non-VA care, we can at least outline a framework for rebuilding, restructuring, restructuring, realigning, and reforming the VA health care system.

First, rebuild and sustain VA's capacity by recruiting, hiring, and retaining sufficient clinical staff, and by funding a long-term strategy to repair and maintain VA facilities.

Second, restructure the many non-VA care programs into a single integrated extended care network which incorporates the best features of fee-based, ARCH, PC3, and other purchased care programs and provide this program with a separate and guaranteed funding source.

Third, realign and expand VA health care to meet the diverse needs of future generations of veterans, including women veterans. This should include new urgent-care nationwide with extended operating hours.

Fourth, reform VA management by redesigning its performance and accountability report and restructuring its budget process by implementing a PPBE system, which stands for planning, programming, budgeting, and execution.

Mr. Chairman, this framework is not intended to be a final or detailed plan, nor could it be part of one at this point. But it offers a new pathway toward a future that truly fulfills Lincoln's promise.

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

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Isakson, Ranking Member Blumenthal, 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, and 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 that 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 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 to provide VA sufficient space to deliver timely, high-quality care. 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, 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 receives 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 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 be performed 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, and certainly if VA is eliminated outright, 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 a "choice." Instead, they would end up with fractured care, receiving care through a combination of VA and non-VA providers.

And if VA care was 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 maintain 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 receive their care. VA must buildupon 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 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. Congress must provide a single, separate and guaranteed funding mechanism for this VA Extended Care program. To make this program effective, VA must complete the research discussed above related to private sector access standards in order to establish new clinically-based access policy that is informed, objective and based on rigorously established objective 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 necessary. In addition, there must be a new, transparent, and dedicated review and appeal process capable of making rapid decisions to ensure veterans have timely access based on their medical needs.

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. These services would be delivered by dedi-

cated doctors and nurses in existing VA facilities, or smaller urgent care clinics strategically located in new locations around the country, such as in shopping malls. The VA, like any large health care system should provide walk-in capability for urgent care needs of eligible veterans. 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.

Chairman ISAKSON. Thank you very much.

Mr. Rausch?

STATEMENT OF BILL RAUSCH, POLITICAL DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. RAUSCH. Chairman Isakson, Ranking Member Blumenthal, 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.

As you know, 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 being debated. It is a highly complex law that the Department is working hard 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 to us 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 rec-

ommendations 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 continued active engagement with veterans organizations to more broadly identify a comprehensive strategy and plan for delivering non-VA care in the community moving forward.

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 in some cases has been inconsistent in communicating whether or not a veteran can access it in individual cases.

Based on our most recent survey data, over one-third of our members have reported they do not know how to access the Choice Program. This is compounded by reports that in some cases VA schedulers are not explaining eligibility for Choice while offering appointments outside the 30-day window. The Secretary and VA senior leadership must continue to engage VA front-facing scheduling personnel with ongoing and evolving training standards, so when veterans call the VA they receive consistent and clear understanding of their eligibility for the choice program. The VA has improved in this area, but with so many veterans still confused about eligibility, 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. This frustrating example that continues to surface is one of a veteran that requires specialized care in a VA facility outside the 40 miles, but through strict interpretation of the current VACAA law is ineligible because a local CBOC or other facility may be geographically near the veteran's address, notwithstanding that facility cannot provide the required care.

One of our members illustrated this recently by stating, "Because there is a CBOC in my area, I was denied. The clinic does not 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 needed clarity and work with VA—and it sounds like you are—to eliminate cases like those just described.

There have been encouraging developments related to the implementation of the Choice Program, specifically VA's action to step up and fix the initial ineffectiveness of the 40-mile rule calculations, as it related to the geodesic distance versus driving distance. That regulatory correction was much needed, and as a result there are hundreds of thousands of new veterans who are now eligible for the Choice Program. On behalf of our members, we applaud Secretary Bob McDonald and Deputy Secretary Sloan Gibson for their leadership in listening to their customers, our veterans, to make that change happen.

VHA's statistics on Choice utilization among the veteran population as of this month state there have been nearly 59,000 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 yet important program.

IAVA is committed to remaining actively engaged with the veterans making use of the Choice Program so we can keep current on the veteran experience. We are mindful that with thousands of appointments being concluded, there will inevitably be thousands of unique experiences, and we want to gauge those levels of satisfaction with our members for this program. The satisfaction of 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 realize a veteran-focused strategy and plan for non-VA care in the community moving forward.

We appreciate the hard work of this Congress, the VA, and the veteran community and recognize we have to stay focused on improving veteran health care delivery in the short and long term. Robust discussion on the scope and cost of maintaining health care networks is complicated and multilayered, which is why our last recommendation is simple and something we have touched on before: 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 me to testify again, and we want you to know we stand ready to assist this Congress and our Secretary to achieve the best results for the Choice Program now and in the future. We look forward to taking your questions.

Thank you.

[The prepared statement of Mr. Rausch follows:]

PREPARED STATEMENT OF BILL RAUSCH, POLITICAL DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, 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 working hard 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 continued active engagement with veteran organizations to more broadly identify a comprehensive strategy and plan for delivering Non-VA care in the community moving forward into 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.

Based on our most recent survey, over 1/3rd of IAVA members have reported they do not know how to access the Choice 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 and VA Senior Leadership must continue to engage VA front-facing scheduling personnel with ongoing and evolving training standards, so when veterans call the VA, they receive consistent and clear understanding of their eligibility for the Choice program. 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 continues to surface 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 or other facility 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.

There have been encouraging developments related to the implementation of the Choice Program, specifically, the VA's action to step up and fix the initial ineffectiveness of the 40mile rule calculations under regulation, as it related to geodesic distance vs. driving distance. That regulatory correction was much needed and as a result there are hundreds of thousands of new veterans eligible for the Choice program. On behalf of our members we applaud Secretary Bob McDonald's leadership for listening to his customers, our veterans, 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 me to testify before you again, and we want you to know 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.

Chairman ISAKSON. Thank you very much.

Mr. Fuentes?

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

Mr. FUENTES. Chairman Isakson, Ranking Member Blumenthal, on behalf of the men and women of the VFW and our Auxiliaries,

I would like to thank you for the opportunity to present our views on the Veterans Choice Program.

Before I begin, I just want to say that VFW opposes VA's change to the way veterans choose to use the Veterans Choice Program. Veterans must have the opportunity to explore their private sector options before rejecting their VA appointments. This change is a bureaucratic convenience that will negatively affect veterans' experiences.

The VFW continues to play an integral part in identifying new issues the Veterans Choice Program faces and recommending reasonable solutions. Yesterday, we published our second report evaluating this important program, which made 13 recommendations on how to ensure it accomplished its intended goal of expanding access to health care for America's veterans. Our initial report identified a gap between the number of veterans who were eligible for the program and those who were given the opportunity to participate.

Our second report has found that VA has made progress in addressing this gap. Thirty-five percent of second survey participants who believed they were eligible were given the opportunity to participate. That is a 60-percent increase from our initial survey.

For 30-dayers, participation hinges on VA schedulers informing them of their eligibility. The lack of systemwide training for frontline staff has resulted in veterans receiving dated or misleading information. VA must continue to improve its processes and training to ensure that all veterans who are eligible for the program are given the opportunity to participate.

Our second report also found a decrease in patient satisfaction among veterans who received non-VA care. This has been a direct result of veterans not being able to find viable options in the private sector.

The 40-mile standard used to establish geographic-based eligibility for the Veterans Choice Program was based on eligibility for TRICARE Prime. However, there is a distinct difference between the veterans population and the military population. Thirty-six percent of veterans enrolled in VA health care live in rural areas. Thus, measuring the distance servicemembers travel to military treatment facilities and using that same standard to measure distance traveled by veterans to VA medical facilities does not appropriately account for the diversity of the veterans population.

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 health care. Regardless, Congress and VA must commission a study to determine the most appropriate geographic-based standard for health care furnished by VA.

As the future of the VA health care 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 VA's capabilities cannot be duplicated or properly supplemented by private sector health care—especially for combat-related mental health, blast injuries, or 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 all enrolled veterans. Although enrollment in the VA health care system is not mandatory, and despite more than 75 percent of veterans having other forms of health care coverage, more than 6.5 million of them choose to rely on their earned VA health care 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 opportunity to receive private sector health care if VA is unable to meet those standards. More importantly, non-VA care must supplement the care that veterans receive from 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 115 percent capacity and may never be able to build enough capacity to provide direct care to all the veterans that they serve.

VA must continue to expand capacity based on staffing models for each health care 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 health care systems and affiliated hospitals when possible and purchase care when it must.

Mr. Chairman, this concludes my testimony. I am prepared to answer any questions you may have.

[The prepared statement of Mr. Fuentes follows:]

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

Chairman Isakson, Ranking Member Blumenthal 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 rollout 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 works 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. For example, a veteran from Elko, Nevada, who is eligi-

ble for the Veterans Choice Program as a 40-miler told us she wanted to explore mental health care options in her community, but was unable to find a mental health care provider able to treat veterans, so she decided it was best to continue receiving telemental health care from VA.

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 issues 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 condi-

tions. 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.

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 servicemembers 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 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.

Chairman ISAKSON. Mr. Fuentes, at the beginning of your testimony, you said VA must immediately address—and I could not write fast enough to put it down, but I could not find it in the printed testimony. What was that very first, right in your first two or three sentences?

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[1] "Socialized or Not, We Can Learn from the VA," Arthur L.Kellermannhttp, RAND Corporation. August 8, 2012, 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.

Mr. FUENTES. My first statement was regarding the change that Dr. Tuchschmidt actually just announced on how veterans elect to use the Choice Program. Right now they are scheduled an appointment at VA, and if that appointment is beyond 30 days, then they keep that appointment, and they call TriWest or Health Net and explore what their options are in the private sector. That means that they are making an informed decision when they decide to essentially reject their VA appointment.

If you change that to having the veteran make the election before exploring their private sector options, it is not an informed decision and actually leads to veterans, if they go to the private sector, having to go to the back of the line and restart their VA scheduling process all over again.

Chairman ISAKSON. OK. I want to make sure we understand or I understand this. I am a veteran that lives more than 40 miles from a clinic, so I am eligible for Veterans Choice. You are saying I should make the private appointment through TriWest and make a VA appointment anyway, and then choose which one I want? I should not automatically go to the private provider?

Mr. FUENTES. For 40-milers, they currently do and I believe they should continue to just contact TriWest and Health Net. However, for 30-dayers, if VA cannot schedule an appointment within 30 days, then they refer me to TriWest. But from talking to TriWest for dermatology for example, the average appointment is 60 to 90 days. So, now I am choosing between waiting 60 days in VA to waiting 90 days in the private sector. I should know that the wait time in the private sector is 90 days before making that choice.

Chairman ISAKSON. OK. Well, Deputy Gibson, will you answer this question. If I am a veteran and I am more than 40 miles from a clinic and I have got my card, can I automatically call TriWest and make an appointment?

Mr. GIBSON. If you are more than 40 miles, yes, sir, you can. The example that he is citing is where it is 30 days' wait time, and the proposed process would truncate—we were talking before, Senator Boozman mentioned about all of the administrative material, the clinical information that is being sent over. What we are trying to do is to streamline that part of the process.

You know, in this particular case, if the veteran is not pleased with the appointment, that process happens within a couple of days, and they should be able to come back to VA to say, "I was not able to get a timely appointment," or the TPA refers the authorization back.

But it is a consequence of making the change, rather than booking the appointment in VA and referring the veteran over to the third-party administrator.

Mr. FUENTES. Mr. Chairman, just to be clear, there are two distinct processes—one for 30-dayers and one for 40-milers, and I think one of the issues that the proposed change is looking to address is no-shows and cancellations. So, when the veteran accepts an appointment in the private sector, TriWest or Health Net, then tells the local facility this veteran has chosen Choice, cancel that appointment; however, currently a VA scheduler or a VA staff member has to go and manually cancel the appointments. This will

prevent that. However, this will come at the cost of the veteran's experience.

Chairman ISAKSON. That is what I was getting to, because I was hearing a potential problem there with two appointments being made, one of them not kept, but nobody letting each other know which is happening first.

Mr. FUENTES. There are better ways to address that issue. I feel that an automated process could work. Develop a more seamless way for TriWest and Health Net to notify VA that the veteran has accepted a private sector appointment.

Chairman ISAKSON. Now I am going to open a hornet's nest, but I am going to go ahead and do it anyway. I had to pay a $30 penalty for not keeping an appointment back in Atlanta for some health care I was getting. I think we cannot put everything on the shoulder of TriWest or the VA. If somebody does not do their job by letting VA and TRICARE know which appointment they are going to keep, I would be the first person to say there ought to be a penalty to that person for not keeping the appointment, assuming the communication was complete. I know there are going to be some people who are not going to like that idea, sounding like a co-payment, but practically, it gets everybody's attention. If we are going to be more efficient, I think everybody has got to be part of the efficiency, including the veteran who is getting the benefit. I just wanted to put that in there—not to shake a hornet's nest. I thank you for raising that issue because that is very helpful.

Senator Blumenthal?

Senator BLUMENTHAL. Thanks, Mr. Chairman. You know, we have been talking a little bit about how to pay for the Denver cost overrun, and——

Chairman ISAKSON. We just figured it out. [Laughter.]

Senator BLUMENTHAL. The Chairman has told me that we just figured it out. Now this has been a more productive afternoon than you could ever have hoped. [Laughter.]

I want to thank all of you for thinking through these issues in such a constructive and positive way. I was taught as a trial lawyer, "Never ask a question if you do not know what the answer is going to be;" however, I want to ask a kind of open-ended question. Given that the Choice Program and the Choice and Accountability Act creates this fund of $15 billion, my view is that the potential raid on this money and the effort to use it as a kind of slush fund to pay for cost overruns in Aurora and Orlando and New Orleans and Las Vegas where, in fact, in total there have been $2.5 billion in cost overruns is a real threat to veterans health care. We can debate how much private care should be provided and how much it should be through VA facilities, but there is no question, in my mind at least, that VA facilities are an essential part of the health care mix of opportunities that we provide to our veterans.

Therefore, to say we are going to defer projects and delay construction on those facilities all around the country to pay for cost overruns in those medical facilities under new construction is a very dangerous threat.

Let me make that statement and throw it out to you for comment.

Mr. BUTLER. I would say that our national commander has gone on record to state his position that he opposes taking money from the Choice Program and using that funding to support other means. I have heard a lot of interesting conversations today about exploring other options, thinking outside of the box. I think that Members of Congress and VA need to do just that. They need to put their hats on and to think about what is best for veterans. How can we come to a resolution that would serve veterans best without taking money from a program that is early in its infant stage and then utilizing that funding for other means or purposes? If that is an option, that should be the last option after you have explored all the other options.

Mr. SELNICK. Let me just chime in. I would agree with him in what you are saying in that we do not want that money raided. I worked at the VA from 2001 to 2009. I worked in VHA for 3 years. Every time there was a management failure, $300 million IT program, a failure and they scrapped it, there was not accountability, and it was just "Give me more money, give me more money."

It is like an alcoholic. You cannot give them more alcohol if they are failing. You have got to fix it in other ways.

I always liked, having been in the VA, that you should do an audit of the books, because I saw lots of money put off the table. Now, maybe that money is not off the table anymore, off to the sidelines, but I would sure love to see an audit to see what is really there and what is really not.

Mr. FUENTES. Veterans should not suffer because VA is unable to get its house in order. The VA must atone for its gross mismanagement. It should find cost savings in this program and in other programs in any way it can. Ultimately, Congress does have an obligation to ensure VA has the resources it needs to complete this project. Additionally, further delay and funding uncertainty will only lead to higher cost overruns.

Mr. VIOLANTE. There is no easy answer, and I believe that the facilities are necessary and must be completed. Where that money comes from is another question, but I think it was said it is about veterans, and veterans need to be cared for. Congress needs to find the money somewhere to continue these. It should never happen again. I think VA should get out of the business of building hospitals.

Mr. RAUSCH. We would agree in regard to the construction, and just more broadly, any and all cost overruns at VA provide a high risk of not providing the highest-quality care to veterans. That is the bottom lime, whether it is for construction or anything else. IAVA supports the Secretary's budget request. We also support his request for greater flexibility. As I said in front of this Committee in the previous hearing, in theory, without greater flexibility to move money within those 72-plus line items, in theory, it would allow him to move more money back into Choice. We support his request for that, but more broadly, we believe Choice is an opportunity to better understand how veterans and where veterans want to receive the health care that they deserve. That, frankly, ties into what I think everyone is talking about, which is a strategic plan for coordinated care in the community. Care in the community, again, Mr. Chairman, I think that was a phrase you used in the

previous hearing, and we have started to use that because ultimately we believe that whether Choice stays in its current form or fashion, we think it is an opportunity to better understand the customer, our members, so the VA can move forward with a strategic plan to provide the best services possible.

Thank you.

Senator BLUMENTHAL. Well, I appreciate all of your answers, which confirm my views, and the Chairman and I have stated those views. The Chairman has stated and I have as well that we have alternatives, different options, that we think absolutely have to be explored. We look forward to working with you on those options and also on this concept of accountability, which all of you have mentioned. You heard me talk about it earlier, which is includes looking backward, holding people accountable who, in effect, are responsible for this nightmarish debacle, and also looking forward. I might mention, Mr. Violante, in your written testimony you discuss the VA's need to redesign its performance and accountability report. You make reference to the Department of Homeland Security's similar regiment known as planning, programming, budgeting, and execution, PPBE, as a possible model. I am sure there are other models as well.

To your point, Mr. Rausch, I have said that the VA ought to be out of the business of construction, that it should be the Corps of Engineers or some other agency that takes over this function. No disrespect to the VA, but it is not within their job description to manage these mammoth, multimillion-dollar, in fact, billion-dollar projects on which the future of VA health care depends.

You know, when you and I go to build a house, ordinarily we are not our own contractors. Maybe some of you are, but we try to get a little professional help to do it. That may be an inexact analogy, but for all the Government agencies, not just the VA, this should be some professional center of management that maximizes resources, reduces costs, makes it energy efficient, decides what materials and designs should be incorporated.

I think we have a lot to discuss going forward. I welcome your participation, and I thank the Chairman for this hearing. Thank you all.

Chairman ISAKSON. Thank you, Senator Blumenthal.

Let me just echo everything that Senator Blumenthal said and point out a couple of things.

Originally, in our first hearings, the VA people who testified told us on the 40-mile rule in terms of distance driven versus crow flying, that that was going to expand the number of people being eligible for VA Choice and was going to cost more money.

Now that we have talked about the care you need and that definition, which we are working on, one of the estimates is it is going to cost more money than we planned.

We understand that to go from Point A, which was a disaster in Phoenix that led to all the problems that caused Veterans Choice, to where we want to go is going to take time, it is going to take money, and it is going to take coordination, which is where the coordination work comes from. There are savings in coordination once you accept a few principles. Principle one is that if you use the private sector well and the veterans like it and it is an alternative to

make the veteran system work—it is not a substitute, but in certain cases at times it is an alternative—then you are saving the VA money in cost; you are getting the private sector investment, and you are getting better health care to the veteran.

I am willing to look at this in a macro sense. We just did a budget in the Congress. It is a 10-year budget that balances in the tenth year. VA has got some problems. It is going to probably take 10 years to financially solve it, but you have got to begin that at some point in time.

Hopefully, as we work through this problem on Denver and get the resolution on who builds what and when they build it, we also look at it in a macro sense for how we find the savings to pay for the changes we need to make. Eventually, we are going to have a delivery system that is probably less costly than building the bricks and mortar. It is going to take us a while to get there.

With that said, I want to thank all of you for being here. Thank you for your service to America, and I appreciate the time everybody has given us today.

[Whereupon, at 5:07 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Mr. Chairman, Thank you for holding this hearing. As the daughter of a World War II veteran, I believe making sure our country keeps the promises we've made to our Nation's heroes should be at the top of our list of priorities, all of the time. Taking care of our veterans when they come home is a fundamental part of who we are as a nation and we must make sure that the Department of Veterans' Affairs (VA) has the tools and resources it needs to provide critical care and support. It is part of the cost of going to war.

Ensuring that all veterans receive quality care in a timely manner remains a critical issue. The Department must work quickly resolve challenges associated with the implementation of the Veterans Access, Choice, and Accountability Act. I continue to hear from veterans about delays and confusion in getting care through the Choice Program—and delays in filling positions created by this legislation. This is very concerning to me.

No doubt, the $5 billion we gave to build and strengthen VA for the long-term is making a difference in some areas, but there is much more to be done. In my home state of Washington, we are seeing some positive effects of this legislation in addressing critical shortages, as several VA medical centers have already announced they will hire hundreds of new medical care staff. They will also be able to upgrade and expand many of the facilities in Washington.

It is critical that VA uses that $5 billion as it was intended by Congress: to hire more providers, create more usable clinical space, and improve access to care for veterans. The Department should not be diverting this money from those serious needs to make up for the failures in constructing the Denver hospital.

Despite this, low utilization of the Choice Program and increasing delays make it clear that it's time to start planning now for what the future of non-VA care will look like. The Choice Program was a temporary, emergency authority. When it expires, VA needs to have one reformed program in place to help veterans access care outside VA in a way that complements services provided by VA, provides coordinated care with strict quality of care requirements, has consistent processes and eligibility rules, and is cost effective. I look forward to working with all of you on this important task.

Finally, I would also like to thank both panels of witnesses for testifying at this hearing. Your hard work is very important for us as we work to make sure there are adequate resources to provide veterans the benefits and care they have earned.

Veterans Choice Program

Second Report

Compiled by the Veterans of Foreign Wars of the U.S.

May 11, 2015

VFW
VETERANS OF FOREIGN WARS
NO ONE DOES MORE FOR VETERANS.

BACKGROUND:

More than a year ago, whistleblowers in Phoenix, Ariz., 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 deputies to resign.

As the crisis unfolded, the Veterans of Foreign Wars of the United States (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 VA health care 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).

The program became operational on November 5, 2014, meaning VA and its partners had three months to stand up an expansive network of private sector health care providers who meet the program's requirements and are willing to treat veterans. As a result of the complexity of the program and the short implementation requirement, the VFW knew issues would arise.

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 remained a top priority for VA and Congress. As a result, several issues that accompanied the roll-out have been addressed.

The VFW continues to play an integral part in identifying issues the Veterans Choice Program faces and recommending reasonable solutions to such issues. In an effort to ensure the program serves the best interest of America's veterans, the VFW has continued to publicize our national veterans' help line, 1-800-VFW-1899, and our VA Health Care Watch webpage, www.vfw.org/VAWatch, where veterans can learn about the program and share their experiences.

The following report includes highlights and data trends that the VFW has identified over the first six months of the Veterans Choice Program's implementation. It includes analysis of what has changed since our initial report and new trends the VFW has identified.

FINDINGS:

The VFW's initial Veterans Choice Program survey was conducted from December 5, 2014, to February 5, 2015, and received 2,511 responses. The second survey was conducted from February 6, 2015, to April 6, 2015, and received 2,155 responses. They were both identical and logic-based, meaning the questions participants were prompted to answer were based on their initial responses. Additionally, the VFW has received more than 160 Veterans Choice Program specific inquiries from veterans via the VFW's health care helpline, general email inbox, and the Action Corps Grassroots Network. Below is a summary of the results from the second survey with comparisons to the initial survey:[1]

- 45 percent of the 877 survey participants who attempted to schedule an appointment after November 5, 2014, reported waiting more than 30 days for a VA appointment – an increase of 10 percent from the initial survey (35 percent of 746).
- 35 percent of the 1,151 survey participants who believed they were eligible for the Veterans Choice Program were offered the option to receive non-VA care –an increase of 16 percent from the initial survey (19 percent of 1,069).
- 46 percent of the 390 survey participants who were offered the choice to receive non-VA care reported that they chose to continue receiving VA care, which was not significantly different from the initial survey (47 percent of 198).
- 50 percent of the 307 survey participants who reported living more than 40 miles from a VA medical facility and were given the option to receive non-VA care chose to continue receiving VA care, which was not significantly different from the initial survey (50 percent of 166).
- 31 percent of the 74 survey participants who reported waiting longer than 30 days for VA care and were given the option to receive non-VA care chose to continue receiving VA care, which was not significantly different from the initial survey (38 percent of 21).
- 75 percent of 1,658 survey participants reported that they were satisfied with their VA health care experience –a decrease of five percent from the initial survey (80 percent of 2,002).
- 90 percent of the 397 survey participants who reported waiting less than 30 days for VA care were satisfied with their VA health care experience which is not significantly different from the initial survey (92 percent of 413).
- 47 percent of the 196 survey participants who chose non-VA care reported that they were satisfied with the Veterans Choice Program –a decrease of 10 percent from the initial survey (57 percent of 97).
- 19 percent of the 201 survey participants who chose non-VA care reported waiting longer than 30 days for non-VA care appointments – an increase of 10 percent from the initial survey (9 percent of 99).

[1] Enrollment in the VA health care system is a prerequisite for eligibility under the Veterans Choice Program. Findings have been controlled for enrollment.

ANALYSIS:

Results from our second Veterans Choice Program survey indicate that the implementation of the program has improved. However, several issues must be addressed to ensure the program accomplishes its intended goal of improving access to timely and high quality non-VA health care options when VA health care is not readily available.

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 second survey indicates that VA has made significant progress in addressing the participation 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. Although VA has made progress, VA medical facilities must continue to properly train their frontline staff to ensure veterans who are eligible to receive care outside of VA are afforded the option to do so. 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 example, a veteran from Washington, DC, had his primary care appointment canceled by VA and was given a replacement appointment that was more than 30-days from his preferred date. The veteran asked if he was eligible for the Veterans Choice Program, but was told by the scheduler that she had "no familiarity with that program."

For 30-dayers, participation hinges on frontline staff. When VA schedulers are unable to schedule veterans within VA's wait time standard – 30 days from the time a VA provider deems an appointment clinically necessary (clinically indicated date) or if no such date exists, the date a veteran prefers to be seen – they place such veterans on the Veterans Choice List (VCL) and should inform veterans of their eligibility for the Veterans Choice Program. The VCL is then transferred to the program's third party administrators, or contractors, to verify eligibility for veterans who call the program's call centers seeking non-VA care appointments. 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 and often results in veterans receiving dated or misleading information. To mitigate this issue, VA has developed system wide training for all VHA staff, which it plans to roll out 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 believes that such training can be effective only if VA implements quality assurance processes to verify proper use of the VCL and whether frontline staff is properly informing veterans of their ability to receive non-VA care through the program. For example, the program's contractors, Health Net and TriWest, monitor their call center representatives to

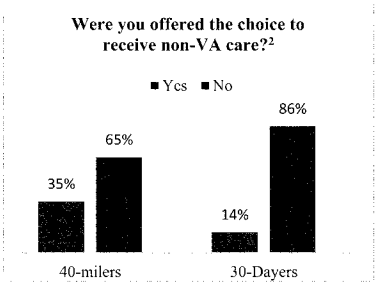
ensure they provide accurate information about the program. Doing so allows them to identify call center representatives who need remedial training. They also utilize quality assurance mechanisms to improve training to make certain veterans receive high-quality customer service. VA can benefit from adopting similar processes to ensure VA staff provide high quality customer service and adheres to training objectives.

The VFW acknowledges that the participation gap will not be eliminated with training alone. Regardless of how well VA trains its frontline staff, human error will lead to veterans not being properly informed of their eligibility for the program or being left off the VCL. To mitigate this issue, VA plans to automate the VCL process. The VFW applauds this initiative.

Currently, 30-dayers rely on VA staff to add their names to the VCL in order to participate in the Veterans Choice Program. On the other hand, veterans who have been designated as 40-milers are automatically eligible for the program and may contact the contractors directly. Results from our survey indicate that 40-milers were 21 percent more likely to be offered the opportunity to receive non-VA care than 30-dayers. This indicates that an automated eligibility process for 30-dayers is likely to lead to more veterans being offered choice.

The VFW is also concerned that veterans on the VCL are not being properly informed of their eligibility. VA's latest patient access data shows that nearly 432,000 appointments had a wait time longer than 30 days. Each of those appointments should have been reflected on the VCL. Yet, only 51,000 non-VA care appointments have been authorized throughout the life of the program.

Chart I



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.

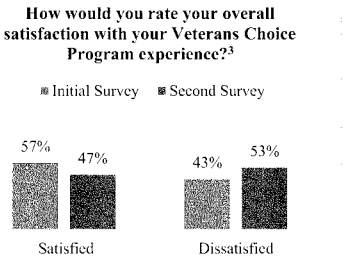
The VFW has learned that several VA medical centers have developed their own processes to ensure 30-dayers are added to the VCL. At the Washington DC VA Medical Center, the medical center's business office reviews appointment from the previous day and verifies that veterans who have an appointment wait time of 30 days or more have been added to the facility's VCL, and informs veterans who were not previously added to the VCL of their eligibility for the program. VA must

[2] This chart shows aggregate data from both surveys. Only participants who reported living more than 40 miles from a VA medical facility, waiting beyond 30 days for a VA appointment, or being unable to schedule a VA appointment were prompted to answer this question. 1,418 survey participants reported living more than 40 miles from the nearest VA medical facility, 652 reported waiting longer than 30 days for their VA appointments.

collect and disseminate such best practices to improve implementation and increase the number of veterans who are afforded the opportunity to receive non-VA care when VA care is not accessible.

The VFW is also concerned with the decrease in patient satisfaction among veterans who received non-VA care through the Veterans Choice Program. As illustrated in chart II, 47 percent of 196 second survey participants who chose to use non-VA care reported they were satisfied with the Veterans Choice Program. This is a 10 percent decrease from the initial survey (57 percent of 97).

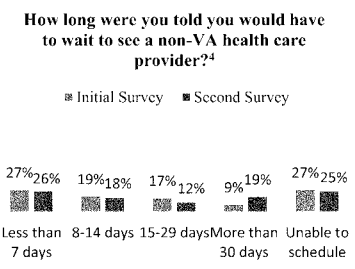
Chart II



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 their communities. One veteran who contacted the VFW needed to see an urologist in Andalusia, Ala., through the Veterans Choice Program. However, the veteran kept his VA appointment with the Montgomery VA Medical Center because there was no better option in his community.

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.

Chart III



Results from our surveys also indicated that the decline in patient satisfaction may be due in part to the increase in the number of veterans waiting longer than 30 days for non-VA care. Nineteen percent of the 201 second survey participants who chose non-VA care reported waiting more than 30 days for their non-VA appointments. This is a 10

[3] Only veterans who reported choosing non-VA care were prompted to answer this question. 97 participants of the initial survey answered this question. 196 participants of the second survey answered this question.

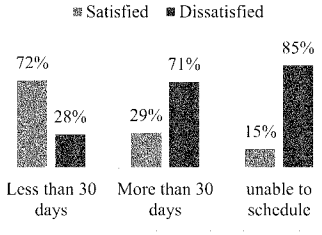
[4] Only participants who reported choosing non-VA care were prompted to answer this question. 97 participants of the initial survey answered this question. 196 participants of the second survey answered it.

percent increase from the initial survey (9 percent of 99).

As illustrated in chart IV, our surveys also found that participants who waited fewer than 30 days for non-VA care were 43 percent more likely to be satisfied with their non-VA care experience than participants who waited more than 30 days. Additionally, only 15 percent of participants who were unable to schedule a non-VA care appointment reported being satisfied with their non-VA care experience.

Chart IV

How would you rate your overall satisfaction with your Veterans Choice Program experience?[5]



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. Feedback from veterans indicates that non-VA care appointments are being delayed due to local VA medical facilities not providing in a timely manner the medical documentation necessary for non-VA health care providers to complete appointments.

[5] This chart shows aggregated data from both surveys. Only participants who reported choosing non-VA care were prompted to answer this question. 293 survey participants answered this question – 170 of them reported waiting less than 30 days for a non-VA care appointment, 45 reported waiting longer than 30 days, and 78 reported they were unable to schedule an appointment.

Other veterans report that they are unable to schedule follow-up appointments because the local VA medical facility has not approved the follow-up treatment.

For example, a veteran in Fredericksburg, Va., was authorized to receive back surgery through the program, but his appointment was delayed because the Richmond VA Medical Center had not sent needed 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. Local facilities must develop streamlined secondary authorization processes to ensure such scheduling delays do not occur.

The VFW has learned that the delay in transmitting medical documentation is likely to be the result of the requirement for local VA medical facilities to transfer medical consult information to the contractors for every veteran added to the VCL, regardless of whether or not such veteran elects to use the Veterans Choice Program. Given the large disparity between the number of veterans on the VCL and the number of veterans who receive appointments through the program, the majority of the medical information sent to the contractors is not used.

To mitigate this issue, VA and its contractors have begun piloting a process to only send the medical consults of veterans who elect to use the Veterans Choice Program. Once a veteran requests a non-VA care appointment, the contractor will request the medical documentation it needs to schedule the veteran's appointment. Doing so eliminates extraneous documentation

from being sent to the contractors and provides relief to administrators responsible for the collection, transmission, receipt, and processing of this sensitive information. This process, however, is reliant on VA medical facilities having appropriate Non-VA Care Coordination (NVCC) staff to provide timely responses to requests from the program's contractors. If NVCC teams are improperly staffed, veterans will likely continue to face referral backlogs, exacerbating access issues.

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 VA medical facilities. 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.

Feedback from veterans shows that receiving non-VA care through the Veterans Choice Program streamlines the prescription process and eliminates the burden of finding their own private sector provider willing to accept payment from VA. It also benefits VA medical facilities by easing the administrative burden on facility NVCC staff and ensuring medical documentation is returned for future care coordination. VA must issues 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

Automating the processes VA uses to implement the Veterans Choice Program is a step towards improving participation. The VFW's initial report highlighted several flaws in the way VA calculates wait times. Unfortunately, this calculation remains problematic. 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 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 the VA medical facility or the Veterans Choice Program.

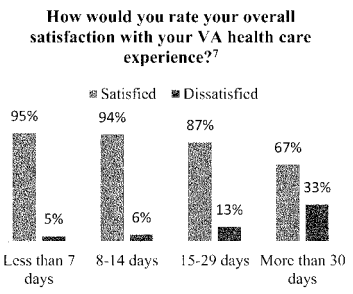
Furthermore, VA's wait time standard is not aligned with the realities of waiting for a VA health care appointment. Forty-five percent of the 1,464 survey respondents who have scheduled an appointment since November 5, 2014 reported waiting more than 30 days for their appointment. Yet, VA data on more 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. [6]

Unfortunately, VA's preferred date metric is a figure determined subjectively by VA schedulers when veterans call to make an appointment. As a result of this subjectivity, the VFW has long disputed the validity of this figure, to include pointing out the fundamental flaws in VA's preferred date calculations in our initial report. With this in mind, the VFW's surveys have consistently relied on wait time perceptions reported by veterans and do not account for VA's calculation of preferred dates.

However, results from our surveys indicate that veterans who wait more than 30 days for VA health care are less likely to be satisfied with the care they receive from VA than those who wait less than 30 days. This indicates 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.

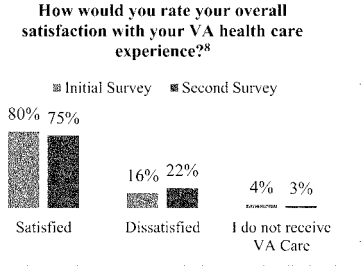
Chart V



[6] "Pending Wait Times Using Preferred Date," Department of Veterans Affairs. May 1, 2015, http://www.va.gov/health/docs/15_April_2015_Pending_04302015.pdf

Patient satisfaction will ultimately be based on how veterans perceive wait times, not how VA estimates wait times.

Chart VI



Results from our second survey also show that the number of veterans waiting more than 30 days for their VA appointment increased 10 percent compared to results from our initial survey. The VFW is concerned that such an increase has led to a decrease in patient satisfaction among users of the VA health care system. Seventy-five percent of 1,658 second survey participants reported being satisfied with VA health care. This is a five percent decrease from our initial survey. VA must take veterans' perceptions into account when establishing standards to measure how long veterans wait for VA health care.

The VFW is also concerned that a lack of capacity at VA medical facilities has also contributed the increase in the number of veterans waiting more than 30 days for VA health care. Local VA medical facilities

[7] Participants who chose to receive non-VA care were not prompted to answer this question. 2,002 initial survey participants answered this question. 1,658 second survey participants answered it.

[8] Veterans who reported choosing non-VA care were exempt from answering this question. 2,002 participants of the initial survey answered this question. 1,658 participants of the second survey answered this question.

must ensure all clinics are properly staffed to meet demand. They must periodically evaluate the wait time data for each clinic and determine if they need to increase capacity. In order for such practice to succeed, VA must also adopt a wait time standard that measures the true time a veteran waits for VA health 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. 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 whether VA's wait time standard is an appropriate system wide access standard for health care furnished by a the VA health care system. The VFW will monitor IOM's work to ensure its recommendations serve the best interest of veterans.

Geographic Eligibility

In our initial report, the VFW recommended that the geographic eligibility for the Veterans Choice Program be changed from geodesic, or straight-line, distance to driving distance to ensure eligibility for the program is aligned with the realities of traveling to VA medical facilities. Earlier this year, VFW National Commander John W. Stroud delivered that message to the President of the United States, the Secretary of Veterans Affairs, Congress and the American public. During a joint hearing of the Senate and House Committees on Veterans' Affairs, Stroud said that distance for the Veterans Choice Program should be measured "as the crow drives, not as the crow flies."

On March 24, 2015, VA announced it would change the way it calculated distance for the Veterans Choice Program from straight-line distance to driving distance. The change went into effect April 24, 2015. The concerns and advocacy of VFW members led to this significant change, which has given nearly 300,000 additional veterans the opportunity to choose whether to receive their health care closer to home 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, the VFW continues to hear from veterans who report that their local Community-Based Outpatient Clinics (CBOCs) are unable to provide them the care they need, so VA requires them to travel long distances to a VA medical center. VA's 40-mile rule change was unable to address this specific issue due to statutory restrictions. 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.

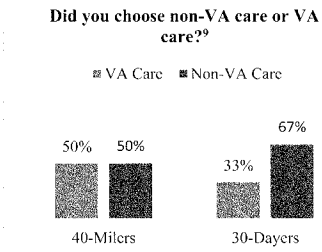
The VFW strongly believes that any geographic standard should also account for the diversity of the veteran population. According to VA's Office of Rural Health, rural veterans represent 36 percent of the more than 9 million veterans enrolled in the VA health care system. Many of these

veterans live in sparsely populated areas and are required to travel more than 40 miles to reach most goods and services. One such veteran who contacted the VFW needed to see a dermatologist in Florence, Ore., through the Veterans Choice Program. However, the closest private sector dermatologist the veteran was able to locate was 70 miles away from his home. Conversely, the VFW has heard from urban veterans who live within 40 miles of a VA medical facility and report that they are required to drive for more than an hour to receive their care.

In fact, our surveys found that 40-milers are more likely than 30-dayers to be given the opportunity to receive non-VA care, but are less likely to use it. Fifty percent of the 477 participants who reported living more than 40 miles from a VA medical facility elected to stay with VA health care when given choice, which is 17 percent more than 30-dayers who were given choice (33 percent of 95). This indicates that the arbitrary system-wide, 40-mile eligibility requirement does not properly account for the travel burden veterans face.

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. VA must have the authority to make clinically based exceptions to any established standard. 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.

Chart VII



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 that can be addressed more quickly through non-VA care.

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 to high-quality care. 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

[9] This chart shows aggregated data from both surveys. Only participants who reported being offered non-VA care were prompted to answer this question. 95 participants reported waiting longer than 30 days for their VA appointment. 477 participants reported living more than 40-miles from a VA medical facility.

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 care than private sector hospitals.[10]

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 first option for veterans to receive health care and it must always 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 continue to provide the veterans it serves a continuum of care that is unmatched by any other 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 access standards. Such a program should include a reliable case management mechanism to ensure veterans receive proper and timely care and include a robust quality assurance mechanism to ensure system wide directives and standards are met. Without such quality assurance mechanisms to ensure VA medical facilities adhere to system wide standards and directives, veterans' health may be at risk.

The VFW also believes that 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 to all veterans who need it. We know, however, that they currently do not, and the needs of today's veterans demand solutions that deviate from VA business norms.

[10] "Socialized or Not, We Can Learn from the VA," Arthur L.Kellermannhttp, RAND Corporation. August 8, 2012, www.rand.org/blog/2012/08/socialized-or-not-we-can-learn-from-the-va.html

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, 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 must be used.

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 improvements will not happen overnight. Veterans cannot be allowed to suffer in the meantime, and 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 VA, Congress, our veterans service organization partners and other stakeholders to monitor changes to the Veterans Choice Program and VA's purchased care model; evaluate what is working; identify shortcomings; and work toward reasonable solutions. This report is only the third in our series of reports on the state of VA health care and the implementation of the Veterans Choice Program.

Moving forward, the VFW is developing a pinpointed Veteran Choice Program survey that will gather qualitative data to determine what influences veterans to choose non-VA care or stay with VA health care when given choice. The VFW will utilize VA's patient access data, previous survey responses, and feedback from veterans to identify VA medical facilities that have embraced the Veterans Choice Program and VA medical facilities with high wait times but low utilization of non-VA care.

The VFW has an obligation to the veterans we serve to get this right. We will continue to serve as the "canary in the mine" on VA health care, working to ensure that our nation's veterans receive the quality, timely health care that they have earned.

RECOMMENDATIONS:

- VA must provide frontline personnel standardized training and implement quality assurance mechanisms to ensure its medical facilities adhere to training objectives, system wide directives, and clinical practice guidelines.
- VA must collect and disseminate best practices to enable seamless implementation of the Veterans Choice Program.
- VA should automate the process to notify 30-dayers of their eligibility for the Veterans Choice Program.
- VA's wait time standard must be adjusted to appropriately account for clinical need, acuity of care, type of specialty, and how veterans perceive wait times.
- Wait time based eligibility for the Veterans Choice Program must be modified to allow veterans to receive non-VA care if care cannot be provided at a VA medical facility within the clinically indicated date.
- Eligibility for the Choice Program should be expanded to give veterans the opportunity to receive health care in their communities if their local VA medical center or system does not offer the care they need.
- VA must ensure the proposed Medical Appointment Scheduling System has a compliance aspect to preclude schedulers from using prohibited scheduling practices.
- The Veterans Choice Program's 40-mile standard must be properly evaluated to ensure it appropriately accounts for population density based differences veterans face when traveling to VA medical facilities.
- VA must properly utilize all of its non-VA care authorities in cases where VA cannot readily provide care due to lack of available specialists, long wait times, or geographic inaccessibility.
- VA must ensure that Non-VA Care Coordination (NVCC) teams at all VA facilities are adequately staffed with professionals capable of handling the influx of work.
- VA must remain the guarantor and coordinator of health care for all veterans enrolled in the VA health care system.
- VA must ensure the care veterans receive from non-VA care providers meets department and industry quality and safety standards.
- Congress and VA must consult with veterans service organizations and other stakeholders to determine how to incorporate best practices into a single, system wide, non-VA care program.

METHODOLOGY:

This report was compiled from internal VFW data collected through various means of outreach. VFW staff analyzed a total of 4,666 responses from two different Veterans Choice Program surveys and over 5,000 direct inquiries from veterans via the VFW's health care helpline, 1-800-VFW-1899, the VFW general email inbox, vfw@vfw.org and the VFW's Action Corps Grassroots Network.

In order to determine the significance of comparison between variables, the VFW's raw data was analyzed to determine a trend in overall effect. Correlations were computed on all variables, specifically whether a veteran was enrolled in the VA health care system, to determine the appropriate analysis to complete. For variables that met the assumption of an analysis of covariance (ANCOVA), enrollment was controlled for and the effect was reported as either significant or non-significant based on the threshold of $p = .05$. For relationships where enrollment did not meet the preliminary assumptions of an ANCOVA, an analysis of variance (ANOVA) was conducted using the same criteria. A paired-sample t-test was conducted for certain variables in each survey to determine an overall effect, also using the same threshold. All variables were screened for general normality of distribution and existence of univariate, bivariate, and multivariate outliers before proceeding with the above stated analyses.[11]

[11] Statistical analysis was conducted by, Eliann R. Carr, a Doctor of Philosophy candidate at the University of South Dakota, who currently serves in the South Dakota Army National Guard. Carr is also an Air Force veteran who served as an inaugural VFW-SVA Legislative Fellow in March 2015.

Appendix I: Correlations for aggregated data from both surveys[a]

		VCP_Fam	Distance	WaitTime	NonVA_WaitT	Offer	VA_Satis	VCP_Satis	Rec_VA	REC_VCP
VCP_Fam	Pearson Correlation	1	.021	.088**	.063	.212**	-.009	-.032	-.005	-.137*
	Sig. (2-tailed)		.158	.000	.262	.000	.579	.574	.786	.016
	N	4665	4595	1662	316	2432	3646	309	3643	306
Distance	Pearson Correlation	.021	1	.038	-.153**	.203**	-.051**	.125*	-.056**	.094
	Sig. (2-tailed)	.158		.124	.006	.000	.002	.028	.001	.100
	N	4595	4595	1662	316	2432	3646	309	3643	306
WaitTime	Pearson Correlation	.088**	.038	1	.142	-.071*	-.494**	-.109	-.303**	-.140
	Sig. (2-tailed)	.000	.124		.223	.041	.000	.272	.000	.232
	N	1662	1662	1662	76	837	1559	104	1558	75
NonVA_WaitT	Pearson Correlation	.063	-.153**	.142	1	.c	.c	-.562**	.c	-.448**
	Sig. (2-tailed)	.262	.006	.223		.000	.	.000	.	.000
	N	316	316	76	316	316	1	129	1	306
Offer	Pearson Correlation	.212**	.203**	-.071*	.c	1	.250**	.113	.149**	.c
	Sig. (2-tailed)	.000	.000	.041	.000		.000	.079	.000	.000
	N	2432	2432	837	316	2432	1879	243	1877	306
VA_Satis	Pearson Correlation	-.009	-.051**	-.494**	.c	.250**	1	-.036	.622**	.c
	Sig. (2-tailed)	.579	.002	.000	.	.000		.652	.000	.
	N	3646	3646	1559	1	1879	3646	159	3643	0
VCP_Satis	Pearson Correlation	-.032	.125*	-.109	-.562**	.113	-.036	1	.025	.653**
	Sig. (2-tailed)	.574	.028	.272	.000	.079	.652		.754	.000
	N	309	309	104	129	243	159	309	159	128
Rec_VA	Pearson Correlation	-.005	-.056**	-.303**	.c	.149**	.622**	.025	1	.c
	Sig. (2-tailed)	.786	.001	.000	.	.000	.000	.754		.
	N	3643	3643	1558	1	1877	3643	159	3643	0
REC_VCP	Pearson Correlation	-.137*	.094	-.140	-.448**	.c	.c	.653**	.c	1
	Sig. (2-tailed)	.016	.100	.232	.000	.000	.	.000	.	
	N	306	306	75	306	306	0	128	0	306

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
c. Cannot be computed because at least one of the variables is constant.

Appendix II: Statistical analysis of differences between the initial and second surveys.

Variables	ANCOV/ANOVA/t-test
Wait of 30 days or more for VA health care	$F(2,1648) = 18.23, p \leq .001$
Wait of 30 days or more for non-VA health care	$t(80) = -43.99, p \leq .001$
Offered choice	$F(1,171) = .41, p \leq .526$
Satisfaction with VA health care	$F(2,3601) = 24.53, p \leq .001$
Satisfaction with non-VA health care	$F(1,307) = 4.51, p = .035$
40-milers offered choice	$F(1,182) = .48, p = .491$
30-dayers offered choice	$F(1,16) = .003, p = .956$
Awareness of the Veterans Choice Program	$F(2,4523) = 135.37, p \leq .001$
Recommend VA health care	$F(2,3598) = 16.98, p \leq .001$
Recommend non-VA health care	$F(1,304) = .24, p = .623$
Recommend the Veterans Choice Program	$F(1,304) = .24, p = .623$

Appendix II: Statistical analysis of differences between variables of aggregated data from both surveys

Variables	ANCOV/ANOVA/t-test
Satisfaction by wait time	$r(1559) = -.494, p \leq .001, R^2 = .244$
Offered choice – 40-milers vs. 30-dayers	$F(1,1718) = 48.15, p \leq .001$
Choice – 40-milers vs. 30-dayers	$t(10) = 2.89, p \leq .016$
Offered Choice by awareness	$F(1,2430) = 114.61, p \leq .001$

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