

**MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2016**

**TUESDAY, MARCH 10, 2015**

U.S. SENATE,  
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,  
*Washington, DC.*

The subcommittee met at 2:34 p.m., in room SD-124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

Present: Senators Kirk, Murkowski, Hoeven, Boozman, Capito, Cassidy, Tester, Udall, Schatz, Baldwin, and Murphy.

DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION

**STATEMENT OF DR. CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH**

**ACCOMPANIED BY JAMES TUCHSCHMIDT, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH**

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. Let me just start with a brief opener here and say that back in 1984, I came to my first House Appropriations Committee meeting. I would say that, for some of the staff in this room, you may be in this chair one day 30 years from now. And it is a great honor for me to be chairing this subcommittee, to take care of my fellow veterans, and to make sure the Active Duty forces are properly housed and taken care of.

And I am very excited to have testimony from Dr. Clancy and Dr. Tuchschnidt.

And I will turn it over to my august ranking member, Senator Tester.

STATEMENT OF SENATOR JON TESTER

Senator TESTER. Well, thank you, Chairman Kirk. I look forward to working with you, too, and congratulations on assuming the chairmanship of this subcommittee. The issues that will come before this subcommittee are very important.

Secretary Clancy, Dr. Tuchschnidt, thank you for appearing before the subcommittee and thank you for your service to our Nation's veterans. You are facing enormous challenges in restoring the credibility of the Veterans Health Administration (VHA) and

ensuring top-notch healthcare for our veterans. And I assure you that I will do all that I can to assist you in your job and your mission.

The scandals that rocked the VHA over the past year have revealed severe problems in management of the agency's healthcare system. As you noted in your prepared testimony, Secretary Clancy, to say that the VHA had a crisis on its hands in 2014 would be an understatement.

Congress acted swiftly and aggressively in response to that crisis with passage of the Veterans Choice Act. And it is now up to the Department of Veterans Affairs (VA) to use the authorities and resources that Congress has provided to take the necessary steps toward correcting our course.

In doing so, the VA must ensure both transparency and accountability in implementing the act and allocating those resources. VA must also recognize the Choice Act as a temporary program, a bridge to give the VA time and the resources to align its healthcare programs, providers, and facilities to meet the needs of today's and tomorrow's veterans.

I am most interested in how the VA will address these urgent issues while also building its capacity to serve veterans in the years to come, as that capacity will need to be increased.

In Montana, much of the conversation begins and ends with the VA's ability to address medical workforce shortages. It has reached a crisis level in our State. It is impacting the VA's ability to deliver care, and it is undermining the credibility of the VA. It needs to be addressed, and it needs to be addressed soon.

I look forward to your thoughts on how the VHA plans to undertake this mission.

With that, Mr. Chairman, once again congratulations, and I look forward to working with you.

Senator KIRK. Any other members seek recognition?

Mr. Schatz.

Senator SCHATZ. Mr. Chairman, I would be happy to move forward with the testimony, thank you.

Senator KIRK. Thank you.

Proceed, guys.

#### SUMMARY STATEMENT OF DR. CAROLYN M. CLANCY, M.D.

Dr. CLANCY. Good afternoon, Chairman Kirk, Ranking Member Tester, and members of the subcommittee. Thank you for the opportunity to appear before you to discuss the Department of Veterans Affairs' Veterans Health Administration fiscal year 2016 and 2017 medical care advance appropriations budget request.

I am accompanied today by Dr. James Tuhschmidt, Acting Principle Deputy Under Secretary for Health.

As Senator Tester just said, the year 2014 will likely be recognized as one of the most memorable in VHA's history, and to say that we had a crisis on our hands would be an understatement. We realize the significant work that lies ahead.

The good news is that moving forward along with Congress, we have an incredible, amazing opportunity to reshape the future and make long-lasting valuable changes. The Department of VA as a whole is working to rebuild trust with veterans and the American

people, improve service delivery, and set the course for long-term VA excellence in reform while delivering better access to care and benefits.

This includes the Department's MyVA initiative, which reorients VA around veteran needs and empowers employees to assist them in delivering excellent customer service to improve the veteran experience.

As we enter 2015, all of us in the VA healthcare system will be focused on the MyVA initiative, as well as VHA's own Blueprint for Excellence. This blueprint is aligned with the Department's strategic plan and supports the MyVA initiative. The blueprint lays out the themes and supporting strategies for transformation to improve the performance of VA healthcare now, making it not only more veteran-centered, but also veteran-driven by putting our customers in control of their VA experience.

The Blueprint for Excellence will serve as a guide in all of the programs I mentioned in my written statement. I am confident that the deep sense of mission we share will carry us through the next year and any challenges we might face in the future.

I also just want to note that Secretary McDonald and I and all the senior leaders in VA envision that the future of VA healthcare is both that we are a provider, a top-notch provider, and also a health plan taking advantage of getting veterans care in the community when it is needed.

VHA's fiscal year 2016 budget request will support VA's goals to expand access to timely, high-quality care, end homelessness among veterans, and continue to transform the Department through its MyVA initiative.

Through the fiscal year 2016 budget, we will continue to develop and expand our mental health system, as well as our innovative and cutting-edge medical research. We are committed to increasing access to care for veterans, and have placed special emphasis on telehealth services for those in rural and remote locations.

To address the growing number of women veterans, VA is strategically enhancing services and access for female veterans.

Another high priority is ensuring that all enrolled veterans who require treatment for the hepatitis C virus have access to the necessary therapies.

VA is also dedicated to promoting the health and wellbeing of caregivers. The cost of fulfilling this care and other obligations to our veterans grows, and we expect it will continue to grow for the foreseeable future.

We know that services and benefits for veterans do not peak until roughly 4 decades after a conflict ends. Therefore, more resources will be required to ensure that VA can provide timely, high-quality care into the future.

The fiscal year 2016 budget requests additional resources, which are critical toward providing veterans the care that they have earned through their service and sacrifice.

In conclusion, VA is committed to providing the highest quality care, which our veterans have earned and deserve. I appreciate the hard work and dedication of VA employees, our partners from veterans service organizations (VSOs), very important advocates for veterans, our community stakeholders, and our dedicated VA vol-

unteers. I respect the important role that Congress has in ensuring veterans receive quality healthcare and benefits that they rightly deserve.

I look forward to continuing our strong collaboration and partnership with this subcommittee, our other subcommittees of jurisdiction, and all of your colleagues as we work together to continue to enhance the delivery of healthcare services to our Nation's veterans.

Mr. Chairman, members of the subcommittee, this concludes my remarks. Thank you again for the opportunity to testify, and my colleague and I will be happy to respond to any questions from you or members of the subcommittee.

[The statement follows:]

PREPARED STATEMENT OF DR. CAROLYN M. CLANCY, M.D.

Good morning Chairman Kirk, Ranking Member Tester, and members of the subcommittee. Thank you for the opportunity to appear before you to discuss the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) fiscal year 2016 and 2017 medical care advance appropriations budget request. I am accompanied today by Dr. James Tuchschildt, Acting Principal Deputy Under Secretary for Health.

The year 2014 will likely be recognized as one of the most memorable in VHA's history. To say that we had a crisis on our hands would be an understatement. We realize the significant work that remains ahead. The good news is that moving forward, along with Congress, we have an opportunity to reshape the future and make long-lasting valuable changes.

The Department of Veterans Affairs as a whole is working to rebuild trust with veterans and the American people, improve service delivery, and set the course for long-term VA excellence and reform, while delivering better access to care and benefits. This includes the Department's "MyVA" initiative, which reorients VA around veteran needs and empowers employees to assist them in delivering excellent customer service to improve the veteran experience. As we enter 2015, all of us in the VA healthcare system will be focused on the "MyVA" initiative, as well as VHA's Blueprint for Excellence. The Blueprint is aligned with the Department's Strategic Plan and supports the "MyVA" initiative. The Blueprint lays out themes and supporting strategies for transformation to improve the performance of VA healthcare now—making it not only more veteran-centric but also veteran-driven by putting our customers in control of their VA experience. The Blueprint for Excellence will serve as a guide in all of the programs I mention throughout my testimony. I am confident that the deep sense of mission we share will carry us through the next year and any challenges we might face in the future.

VHA's fiscal year 2016 budget request will support VA's goals to expand access to timely, high quality healthcare; end homelessness among veterans; and continue to transform the Department through its "MyVA" initiative, which reorients VA around veteran needs and empowers employees, to assist them in delivering excellent customer service to improve the veteran experience.

The cost of fulfilling this care and other obligations to our veterans grows, and we expect it will continue to grow for the foreseeable future. We know that services and benefits for veterans do not peak until roughly four decades after a conflict ends. Therefore, more resources will be required to ensure that VA can provide timely, high-quality healthcare into the future. The fiscal year 2016 budget requests additional resources which are critical toward providing veterans the care that they have earned through their service and sacrifice.

IMPROVED ACCESS TO CARE

VA is taking multiple steps to expand capacity at our facilities. The fiscal year 2016 budget request provides \$60.0 billion for VA medical care, a 7.4 percent increase above the 2015 enacted level. In addition, the 2016 budget request supports implementation of the Veteran Access, Choice, and Accountability Act of 2014 ("Veterans Choice Act") with the goal of providing timely, high-quality healthcare for our Nation's veterans. The Veterans Choice Act provided \$5 billion in mandatory funding to increase veterans' access to healthcare by hiring more physicians and clinical staff and improving VA's physical infrastructure.

As a result of the Veterans Choice Act, VA is recruiting to hire more than 10,000 additional medical professionals and support staff with funding provided in the act, and expanding our clinical trainee programs. The VHA National Recruitment Program (NRP) provides an in-house team of skilled professional recruiters employing private sector best practices to fill the agency's most critical positions. The NRP has increased its targeted recruitment efforts for mission-critical clinical vacancies that, once filled, will improve access to care.

In addition, the Choice Act increased the maximum award amount of the Education Debt Reduction Program to improve recruiting and retention of medical professionals. The Veterans Choice Act also provided \$10 billion in mandatory funding through 2017 to establish a temporary program (the "Veterans Choice Program") to increase veterans' access to healthcare by allowing certain veterans to elect to receive non-VA care from eligible providers if the veterans qualify based on their place of residence or when VA is unable to schedule an appointment within the VHA's wait time goals. In order to ensure VA's ability to deliver high-quality healthcare to veterans, the Veterans Choice Act also authorized VA to procure 27 new Major Facility Leases nationwide. VA's leasing program provides flexibility to meet shifts in demographics, and the changing service needs of our veterans.

The Veterans Choice Program may provide a measure of short-term relief from the pressure of escalating healthcare needs as current patients in the VA system elect to receive their care through this program. These investments, together with the fiscal year 2016 budget request, will provide the authorities, funding, and other tools to enhance services to veterans in the short-term while strengthening the underlying VA system to better serve veterans in the future.

VA is committed to increasing access to care for veterans, and has placed special emphasis on those in rural and remote locations. Telehealth services are mission-critical to the future direction of VA care to veterans. Telehealth utilizes information and telecommunication technologies to provide healthcare services when the patient and practitioner are separated by geographical distance. The fiscal year 2016 budget requests \$1.224 billion, an increase of \$126 million (11.5 percent) for telemedicine. The number of veterans receiving care via VHA's telehealth services grew approximately 18 percent in fiscal year 2014, and is anticipated to grow by approximately 28 percent in fiscal year 2015. VHA provided care to more than 717,000 patients via the three telehealth modalities: Clinical Video Telehealth, Home Telehealth and Store and Forward Telehealth. This amounted to more than 2,123,000 telehealth episodes of care; 45 percent of these veterans lived in rural areas and may otherwise have had limited access to VA healthcare.

We are appreciative of the Veterans Choice Act's support to improve access as we build capacity within the VA system to better serve those who rely on us for healthcare. My testimony will now discuss key initiatives highlighted in the President's budget request.

#### MENTAL HEALTHCARE

Long deployments and intense combat conditions require comprehensive support for the emotional and mental health needs of veterans and their families. Accordingly, VA continues to develop and expand its mental health system. VA has integrated mental health services into primary care in the new Patient Aligned Care Team (PACT) model. Providing mental healthcare within the primary care clinic minimizes barriers that may discourage veterans from seeking mental healthcare.

VA has many entry points for mental healthcare, including 150 medical centers, 830 Community Based Outpatient Clinics, 300 Vet Centers providing readjustment counseling, 80 Mobile Vet Centers, a national Veterans Crisis Line, VA staff on college and university campuses, and a variety of other outreach efforts. Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Transition and Care Management Teams are located at every VA Medical Center to welcome returning veterans, and to provide specialized care management services as they transition from Department of Defense to VA.

VA implementation of integrated mental health services in the PACT program has resulted in substantial increases in the number of VHA patients each year who receive Primary Care—Mental Health Integration encounters, rising from 131,589 in fiscal year 2008 to 699,454 in fiscal year 2014. Between 2005 and 2014, the number of veterans who received mental healthcare from VA grew by 71 percent. This rate of increase is more than 3 times that seen in the overall number of VA users. The increase in the number of mental health encounters or treatment visits, from 10.5 million in 2005 to 19.6 million in 2014, has been even more dramatic—an 87 percent increase. As a consequence of these trends, the proportion of veterans served by VA who receive mental health services has shifted substantially. In 2005,

19 percent of VA users received mental health services, and in 2013, the figure was 27 percent. We anticipate VA's requirement for providing mental healthcare will continue to grow.

The fiscal year 2016 budget requests \$7.455 billion, an increase of \$349 million (4.9 percent) to ensure the availability of a range of mental health services, from treatment of common mental health conditions in primary care to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions. We will continue to focus on expanding and transforming mental health services for veterans to ensure accessible and patient-centered care, including treatment for post-traumatic stress disorder (PTSD), ensuring timely access to mental healthcare, and treatment for military sexual trauma.

We are committed to ensuring the safety of our veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing veterans' access to high-quality mental healthcare and programs specifically designed to help prevent veteran suicide. Losing one veteran to suicide shatters an entire world. Veterans who reach out for help must receive that help when and where they need it in terms that they value.

#### HEPATITIS C VIRUS

VA places a high priority on ensuring that all enrolled veterans who require treatment for the Hepatitis C virus (HCV) have access to the necessary therapies. Chronic infection with HCV is the most common blood-borne infection in the world and is a major public health problem facing not only VHA but the United States in general. VA has approximately 174,000 veterans in care with HCV, making VHA the largest single HCV provider in the United States. The fiscal year 2016 budget requests \$690 million to capitalize on the availability of new therapies to improve access to and quality of HCV care. The new drugs will save veterans' lives.

#### SPECIALIZED CARE FOR WOMEN VETERANS

The number of women veterans enrolling in VA healthcare is increasing, placing new demands on a VA healthcare system that historically treated mostly men. In fiscal year 2014, there were more than 2 million women veterans in the United States, accounting for more than 400,000 users of VA healthcare services. To address the growing number of women veterans who are eligible for healthcare, VA is strategically enhancing services and access for women veterans. The fiscal year 2016 budget requests \$4.659 billion in total for women veterans healthcare, an increase of \$502 million (12.1 percent).

VA strives to be a national leader in the provision of healthcare for women, thereby raising the standard of care for all women. VHA works to ensure that timely, equitable, high-quality, comprehensive healthcare services for women veterans are provided in a sensitive and safe environment at VA facilities nationwide.

Reproductive mental health is also an area of increasing focus. This area of specialty addresses the fact that reproductive health transitions (for example before, during, or after pregnancy or menopause) can increase susceptibility to or exacerbate current mental health conditions. One of VA's goals is to transform reproductive mental healthcare delivery across the VA for women veterans by enhancing collaborations between mental health, primary care, pharmacy and women's health.

VA is stepping up to meet the needs of a growing women veteran population and enhancing primary care to meet their needs. We will continue addressing gaps and working to provide the compassionate care and welcoming environment our women veterans deserve.

#### CAREGIVER SUPPORT PROGRAM

VHA recognizes the crucial role that family caregivers play. They are partners in helping veterans as they recover from injury and illness, in supporting veterans in their daily lives in their communities, and in helping veterans remain at home. The Caregivers and Veterans Omnibus Health Services Act of 2010, also referred to as the Caregiver Law, has allowed VA to provide unprecedented support and services to family caregivers of eligible veterans. After the law was enacted, VA established a comprehensive National Caregiver Support Program, with a prevention and wellness focus, which includes the use of evidence-based training and support services for family caregivers.

The fiscal year 2016 budget requests \$555 million for total obligations, an increase of \$73 million (15.1 percent) from 2015, of which \$469 million is for the monthly stipends paid to designated primary family caregivers under VA's Program of Comprehensive Assistance for Family Caregivers, an increase of \$58 million (14.1 percent). The increases to the stipend obligations are due to the increases in the under-

lying hourly wages used to calculate the monthly stipend rates combined with the designation of additional primary caregivers.

In addition to the Program of Comprehensive Assistance for Family Caregivers, VA offers a variety of services and resources through the General Caregiver Support Services including: local Caregiver Support Coordinators, the National Caregiver Support Line staffed by licensed social workers, the VA Web site dedicated to family caregivers, as well as the Peer Support Mentoring Program. Additionally, VA offers a menu of training and provides many educational opportunities for veteran caregivers. VA is dedicated to promoting the health and well-being of caregivers who care for our Nation's veterans, through education, resources, support, and services.

#### ENDING VETERANS HOMELESSNESS

The administration has made the elimination of veteran homelessness a national priority. Between 2010 and 2014, overall veteran homelessness dropped by 33 percent, and we have achieved a 42 percent decrease in unsheltered veteran homelessness. Through unprecedented partnerships with Federal and local partners, we have greatly increased access to permanent housing, a full range of healthcare including primary care, specialty care, and mental healthcare; employment; and benefits for homeless and at risk for homeless veterans and their families. As a result of these investments, in fiscal year 2014 alone, VA provided specialized homeless services to nearly 260,000 homeless or at-risk veterans. Nearly 72,000 veterans and their family members were placed in permanent housing or were prevented from becoming homeless.

In fiscal year 2016, VA will continue to focus on prevention and treatment services. The fiscal year 2016 budget request of \$1.4 billion provides for VA homeless-related programs, including case management support for the Department of Housing and Urban Development (HUD)-VA Supportive Housing program (HUD-VASH), the Grant and Per Diem Program, VA justice programs, and the Supportive Services for Veteran Families program. Ending homelessness among veterans remains a top priority for VA. We are committed to achieving the goal of ending homelessness and we will not rest until every homeless veteran has a place to call home.

#### ADVANCES IN MEDICAL AND PROSTHETIC RESEARCH

The 2016 budget includes \$622 million for development of innovative and cutting-edge medical research for veterans, their families, and the Nation. One example includes continuing the Million Veteran Program (MVP), a groundbreaking genomic medicine program, in which VA seeks to collect genetic samples and general health information from one million veterans in the next 5 years. MVP will help provide answers to many pressing medical questions and lead to improvements in care and prevention to veterans and the Nation. MVP complements the Administration's Precision Medicine Initiative, which seeks to improve treatment of disease by improving our understanding of gene-environment interactions and their influence on the development, progression and treatment of disease.

VA supports a range of studies on post-deployment mental health concerns such as PTSD, depression, anxiety, substance abuse, and suicide. Research aims to:

- Describe the incidence and prevalence of mental health disorders;
- Identify their risk factors;
- Quantify their effect on health outcomes;
- Understand the basic mechanisms of individual disorders;
- Identify effective treatments; and
- Develop models of care that will deliver effective treatments more quickly, widely, and reliably to veterans in need.

The fiscal year 2016 budget request also includes funding for a new strategic initiative toward building a learning healthcare system that is responsive to new information, adapts to implement more effective clinical practices, and is committed to an ongoing mission of excellence, supported by a culture of self-reflection and continuing education. In addition to the direct appropriation, medical research will be supported through an additional \$1.2 billion from VA's medical care program and other grants, contracts and cooperative agreements.

As part of one of the largest integrated health systems in the United States, VA's research program benefits from clinical care and research occurring together, allowing research to be directly coordinated with veterans' care. Indeed, VA research is often the only source of Federal effort addressing important sequelae of combat and military occupational exposures; VA leads the national effort in areas ranging from neuroprosthetics to social reintegration of injured veterans.

## CONCLUSION

In conclusion, VA is committed to providing the highest quality care, which our veterans have earned and deserve. I appreciate the hard work and dedication of VA employees, our partners from Veterans Service Organizations—important advocates for veterans—our community stakeholders, and our dedicated VA volunteers. I respect the important role that Congress has in ensuring veterans receive quality healthcare and benefits that they rightfully deserve. I look forward to continuing our strong collaboration and partnership with this subcommittee, our other committees of jurisdiction and the entire Congress as we work together to continue to enhance the delivery of healthcare services to our Nation's veterans.

Mr. Chairman, members of the subcommittee, this concludes my remarks. Thank you again for the opportunity to testify. My colleague and I will be happy to respond to any questions from you or other members of the subcommittee.

## FRONTLINES TO LIFELINES LEGISLATION

Senator KIRK. Let me start out with the first question. The first question is, have you been able to review our legislation called Frontlines to Lifelines?

Dr. CLANCY. I have had a chance to review that, and I have also been—

Senator KIRK. Let me just interrupt you there. This is legislation that would take the corpsmen and trained first responders in the medical side of the Active Duty force, to bring them quicker into VA.

Go ahead.

Dr. CLANCY. Thank you. I have had a chance to review that and also to speak at some length with one of our colleagues from the Lovell facility in North Chicago, which is a facility that we share with the Department of Defense, and they share our excitement about this as well.

We have had a similar pilot program going on in VHA for the past 2 to 3 years. About 15 of our facilities participated in this, and those facilities that participated were very enthusiastic about the program.

I think most imagined that these corps-men and -women would be the best fit with emergency department care, and, in fact, many were. But about a third of those people actually ended up doing other things that no one had envisioned, for example, working with patients who have indwelling IV lines for chemotherapy or antibiotics who are getting care at home.

I actually think the potential for this kind of role in the future is bigger than we can even imagine right now. So right now, we are actually working with the Office of Personnel Management to get these positions classified.

For some of these individuals, this will be a very important entry point to the VA, and then getting educational benefits to go on to other kinds of career opportunities. So several of the people who enrolled in our program or participated went on to become physician assistants. One went to medical school. Others will, I think, actually be able to develop a full career within the Veterans Health Administration or, frankly, in other healthcare systems.

## HINES VAMC WHISTLEBLOWER

Senator KIRK. Let me follow up with a question about whistleblowers. I want to ask you about Germaine Clarno, who is working in the Hines VA. She is a very prominent whistleblower who told

us about waiting lists and everything. She has had a lot of retribution against her by VA leadership.

I want to ask you, is there a way that we can address the protection of this specific whistleblower?

Dr. CLANCY. So the Secretary, Deputy Secretary, and I, and, again, all of our senior leaders, have made it very, very clear that retaliation or poor treatment in any fashion of whistleblowers, whether those are official whistleblowers who register with the Office of Special Counsel or people who step forward and make their concerns heard, is completely unacceptable.

I will say I just spoke with the network director for that network the other day, and she told me they had just had their labor-management forum. She thought their relationship with Germaine was quite good.

You know, whistleblowers play a very, very valuable role in our system, in any system, bringing forth complaints. Sometimes we don't like hearing that news, but it is almost always valuable. And we take that opportunity for what it is worth.

Senator KIRK. I would say, in my experience with Hines VA, it is an utterly corrupt culture there. And we are looking at you being a change agent there. Thank you.

So let me go for any questions to Shelley Moore Capito, a new member of the subcommittee.

Senator CAPITO. Thank you, Mr. Chairman. Thank you for letting me go to the front of the line. We have another committee meeting that I am going to be chairing here in about 10 minutes, so I appreciate it. I want to thank the ranking member, too. I don't know if you are a party to this, but I will thank you for it.

Thank you, Dr. Clancy, for coming and visiting me in my office yesterday. It is very, very helpful to have great communication, and I appreciate your efforts there.

#### VA CHOICE CARD AND RURAL AREA ACCESS TO CARE

We talked about the VA Choice Card when you were in my office, and we talked about some of the problems that I have heard anecdotally, and you acknowledged that it hasn't rolled out and hasn't been as used in such great numbers as the hope was in the beginning. For a rural area, though, it is extremely important.

But what is the VA doing to make sure that patients seeking assistance through this hotline are not falling through the cracks? Somebody calls and wants to use the VA Choice Card, how do you follow up with that veteran?

Dr. CLANCY. A really great question. I am going to start and then turn to Jim, because he's been doing a very deep dive on this.

I want to make it clear that we had to stand up, essentially, a new insurance program in about 90 days and, in fact, the feedback we got from many large, well-established insurance companies in the private sector was that they expected that it would take about 12 to 18 months to stand up a program. However, we got this implemented on time.

Each one of our facilities has a Choice Champion to help veterans if the entire process doesn't go quite as seamlessly as it does. We have tried a variety of communication venues to get the word out because, after all, every single veteran enrolled in our system

got a Choice Card in the mail. We finished all those mailings by the end of January, starting first with those who lived more than 40 miles from any of our facilities. And there is information online. We are working with the VSOs to get good information out, trying a variety of venues.

And, in fact, we also have a public service ad, if you will, which I think has been sent to all of your offices. So any of you who can put that on your homepage, we would be most appreciative. So it is just another way for veterans to know about this.

Do you want to add to that, Jim?

Dr. TUCHSCHMIDT. Sure. So any veteran who is in the 40-mile group, they don't need to go through the VA at all. They can automatically call the 866 number for the third-party administrator (TPA) and will automatically be directed to the right TPA for their geographic area. And they have a standing authorization to get the care that they need.

For those patients who are in the 30-days group, actually, when we first launched this program, there were about 120,000 of those people. We have reached out by telephone to call every one of them to coordinate their care with the TPA. So we have tried to contact them. And if we can't, we try three times, and we leave voicemail. And if we get the person on the phone and they say they want to have care through the Choice program, we do a warm handoff right then and there to the TPA to help them get their care coordinated.

Patients who have subsequently ended up on the list are instructed to call the TPA, and they will work with them, if they choose to use the Choice program. We find a lot of veterans when they tell us at the time that they are making an appointment—oftentimes a follow-up appointment, that is the vast majority of them—if we can't get them an appointment, we book them an appointment in the VA. So there is always a fallback, even if it is not within 30 days, and then tell the veteran how they can contact TPA, provide either TriWest or Health Net and authorization, and the veteran can call them.

If the veteran accepts an outside appointment, the third-party administrator calls us so that we can cancel that appointment within the VA. We are in the process—

#### 40-MILE RULE

Senator CAPITO. I am going to stop you there very quickly because I only have a minute left.

On the 40-mile limit, we had this discussion yesterday, living in West Virginia, 40 miles can take you 40 minutes or 3.5 hours, depending. That is an exaggeration, but it can take quite a bit of time. So we were asking for some adjustments there in terms of driving time, or driving miles instead of just how the crow flies.

#### OPIOID PRESCRIPTION

The last thing, since I am running out of time, we did talk about this but the opioid prescription issue within the VA. Many people are reliant on it. I recounted a Stan White from my district, who lost his son, who makes a very compelling case that there were some conflicting prescriptions with some outside use of other

things, something I think that you all are monitoring very closely here.

And I know it may hurt some people on the other side who have good, repeated use of pain killers and need that, but I would still encourage you to continue to look, because there is a high incidence of overdose within the VA population, to make sure that those conflicts are resolved.

With that, I thank both of you, and I thank the chair and ranking member. Thank you.

Senator KIRK. Mr. Tester.

Senator TESTER. Yes, thank you, Mr. Chairman. I will start with a thank you to Dr. Clancy for getting the VA Montana permanent director position filled. It allows me to have somebody that I can hold accountable, as well as you. So we thank you for that.

#### CHOICE ACT STAFFING ASSESSMENT

The Choice Card required a staffing assessment of each VA medical facility. When will we see that assessment?

Dr. TUCHSCHMIDT. The Secretary signed off on it. And my understanding is it was being couriered over today.

Senator TESTER. Oh, we will get it today. That is good.

It is my understanding that assessment calls for a detailed analysis of the VA succession planning for leadership positions at medical facilities, much like we had in Montana. The VA's proposed budget also requests a legislative change to the appointment and compensation system for VA medical center directors and network providers. I assume that is all in that report?

Dr. TUCHSCHMIDT. Yes. All of the required sections are there.

Senator TESTER. Okay. You have seen the report?

Dr. TUCHSCHMIDT. I have seen the report.

Senator TESTER. Do you think it will expedite our ability to get medical directors in quicker?

Dr. TUCHSCHMIDT. Well, I am not sure the report in and of itself will do that, but there, certainly, is a lot of information that we have gleaned out of putting the data together. And I think that we have clearly significant recruitment challenges recruiting hospital directors. And I think Montana has probably been a good example.

Senator TESTER. We will get into that in a minute.

Do you think you will need any legislative changes to be able to do what you think is necessary to fill positions as quickly as possible?

Dr. TUCHSCHMIDT. I can't comment on that right now. We are looking at legislative changes that are in the queue right now.

Senator TESTER. Okay. It would be great.

I don't know when the markup is going to be on this bill, Mr. Chairman.

It would be great if you could get those legislative changes to us with some time to be able to visit about them.

In recent years, Congress provided significant resources and additional tools to be able to address workplace shortages across-the-board. Unless Montana is an exception, I would say, we are losing ground.

When do you think the VA will start making progress to address the staffing issues that are out there, whether it is doctors, nurses, administrative personnel, whatever it might be?

Dr. CLANCY. So part of the reason I know that Secretary McDonald and I are coming out to visit with you in Montana is precisely to try to figure out what other opportunities there might be to recruit people there.

I think at some of our facilities, they can do a better job, and we are committed to helping them do a better job to do local market surveys, so they know when they need to up the salaries, for example, of nurses, depending on what local competition is paying.

One of the issues that surfaced in Phoenix was that, in addition to the other challenges they had, they had trouble recruiting schedulers. There was a huge turnover because they were getting better jobs with other Federal departments in the same area.

So it is that kind of thing. I don't think that we need legislative change, but I think we need better business processes that are more rapid in responding to that kind of market force.

Senator TESTER. Okay. I got that.

Well, it will come from your end down, to be able to make sure that is implemented.

#### CREDENTIALING

Mental health counselors and marriage and family therapists make up about 40 percent of the overall health independent practice workforce in the private sector. However, they make up less than 1 percent of the VA mental health workforce. Can you tell me why that is?

Dr. CLANCY. One of the issues has been our requirements. Credentialing is a very important function of most healthcare systems, and we have wanted to hire people who have the best skills to meet veterans' needs. And so we have wanted to hire graduates of programs that are accredited.

In some States, California being one example, they graduate a lot of master's level people where the university is accredited but not the program. The good news is that a lot of those programs are starting to get accredited now, so I think that will open up a pipeline for us.

Senator TESTER. Okay, let me ask you this. When you are looking at hiring folks, are there policies that say that they aren't to be hired right out of college, that they need to have worked in the system, in mental health, in particular?

Dr. CLANCY. It depends on the job description. So if you are going to be mental health counselor, yes, then you do need probably post-bachelor training. Depending on other jobs, whether you are going to be a clerk or administrative assistant, it all depends on the job. Healthcare being—

Senator KIRK. Doctor, if I could interrupt you, I would just say, I want to jump in here on credentialing and say that is the number one way that I found that whistleblowers are silenced. The VA leadership will say to a doctor, "If you don't shut up, we are going to tell everybody on the credentialing board that you are not qualified, so you won't be able to be a cardiologist anywhere." This is a way to get someone who is highly qualified to be quiet.

Dr. CLANCY. I have not had specific examples of that brought to me, but if you know of specific examples, or Germaine or other people do, please, I would want to address them. It falls into the same category as general whistleblower issues that we discussed.

Senator TESTER. I would follow up and just point out, and this is very parochial, but I am aware of a person who went to VA, they had an opening in Montana. VA didn't hire them. They went to work in the private sector, contracted back to VA. That very same person, who was working for a private sector group, they could have hired cheaper. I just want to point that out.

I have another round of questions. Thank you, Mr. Chairman.

Senator KIRK. Mr. Schatz.

Senator SCHATZ. Thank you, Chairman Kirk. I appreciate the accommodation. I have another subcommittee hearing with Senator Capito.

#### MENTAL HEALTH PROFESSIONALS IN RURAL AREAS

Following up on Senator Tester's question related to mental health services, access to mental health services remain a tremendous challenge, particularly in rural areas. And I understand you are continuing to suffer from a mental health professional shortfall.

But I am wondering, of the 9,600 new hires that the VA plans to make, what percentage of them are going to be mental health clinicians? And how many of them are intended to provide services in the rural context?

Dr. TUCHSCHMIDT. I don't have those exact numbers, but I can get them for you.

Dr. CLANCY. I will say just generally, Senator, that the two areas where we are going to have the most trouble recruiting are mental health and primary care. A lot of that I think is going to reflect our need as a department, with all of our resources and, frankly, any other partners we can work with, to try to get to students and professionals very early in the pipeline.

I think the help that you have given us through the Choice Act with the debt-reduction programs, particularly now that we can pay the lenders directly, it turns out to be a huge thing that is in the Choice Act. It will be very, very helpful. The Clay Hunt Act helps some more.

But in general, if people aren't looking to get into that path at a critical juncture in their careers, which is generally going to be the last couple of years of medical school for doctors, we are going to have a problem.

And you have probably seen recent reports from the Association of Medical Colleges about what shortages of doctors were, so we are going to be in tough competition with the private sector for both groups of professionals.

#### CREDENTIALING

Senator SCHATZ. I would just add, in following up on Senators Kirk and Tester's line of questioning, in this space, that part of the problem is credentialing. And I understand you want psychiatrists and you want qualified mental health professionals, but you also want case management. You also want peer counseling. And you have lower thresholds for credentialing and you have the oppor-

tunity, at a lower price, to provide real mental health services. And so there is a tendency in any bureaucracy, not just yours, but there is a tendency in any bureaucracy to kind of push the work up, and for people of good faith to focus on credentialing and Q.M. where you are really comparing no service at all from getting somebody some help and back in the pipeline.

Dr. CLANCY. No, and we rely a lot on the two groups of individuals that you just mentioned, especially case managers. It is huge, because a growing proportion of the veterans we serve have multiple chronic illnesses, so they have mental health disorders as well as other medical problems. And coordinating that is a big, big challenge.

Dr. TUCHSCHMIDT. I would just like to add that we also have an array of mobile vet centers. So not only do we have our stationary vet centers around providing, I think, many of the kinds of services you are discussing, but we also have the mobile vet centers.

One of the things that we are doing right now through the Choice legislation is looking at those to say what telehealth capacities do they need, what is the productivity of those, and the schedule for those vans.

So we are doing a lot of work right now to look at how we can use that resource, particularly in rural areas, to reach out to veterans.

#### STIGMATIZATION OF MENTAL HEALTH CHALLENGES

Senator SCHATZ. I will just add, finally on this issue, you have the general trepidation that a lot of veterans have in terms of availing themselves of services at VA, but you also have the special challenges of the stigmatizations of mental health challenges. And some of this is changing generationally, depending on what war or conflict your veterans are coming from. But some of this has to go all the way down to the line level so that people are greeted to a welcoming environment when they enter VA and not made to feel like they have done something wrong or displayed some sort of weakness, in terms of wanting to avail themselves of mental health services.

Dr. CLANCY. Yes, so two points I would just make there, Senator. One is that many people find the vet centers, which are separate from, but a very vital asset for us, but they are separate from the main medical facilities, to be a much easier place to go in and share their problems.

Many recent veterans, in particular, who don't like government and actually don't want to have much to do with government, find these centers a whole lot easier to deal with.

The other place where I think we are making great inroads is integrating mental health professionals into primary care. As a primary care internist, I can't tell you how many times I have had that sensitive conversation with a patient and everyone agrees, we both agree, that the next step is going to be seeing some kind of mental health professional, except it doesn't happen.

When that person is down the hall, and you can literally walk the veteran down and introduce them, that is what we sort of mean by a warm handoff. It makes a huge difference.

So we think that voltage drop, if you will, will go down quite a bit.

Senator SCHATZ. Thank you.

Senator KIRK. Dr. Cassidy, a new member of the subcommittee.

Senator CASSIDY. Dr. Tuchsmidt, you were one of my resident fellows at L.A. County Hospital. May I point out, I have grayed far worse than you. And you are a very good instructor, so good to see you again, Jim.

Dr. Clancy, thank you for the phone call yesterday. Very helpful. And thank you for the material you gave.

#### MENTAL HEALTH VISITS NO-SHOW RATES

Now let me ask, we have both spoken yesterday and at the previous hearing regarding missed opportunities, folks who are no-show. And you were nice enough to give me this data from the Louisiana facilities. And you already have fiscal year 2015, so I assume that is fiscal year-to-date.

So, actually, my gosh, Shreveport is getting worse with mental health for females going 23 percent missed to 26 percent missed, to 29 percent no-show rates, going in the wrong direction.

Now the conversation we had on the phone was very helpful, and you used a term that I have told you I have already used again, that seeing something like that is diagnostic of a problem. You don't know the problem, but you know there is a problem.

So that said, it is getting worse. What is the VA doing with this real-time data? This is going south, you know what I'm saying?

Dr. CLANCY. So the first thing that we do is we review data from across our system on an almost daily basis with our Deputy Secretary, both about how we are doing in terms of access and wait times, as well as what we see as inputs to problems with the access and wait times, and the missed opportunities rates is something there.

The other thing that we are doing, in the case of your State, is trying to get a terrific network director in there, the last one having stepped down at the end of calendar year 2014. We have an acting person in there now.

Senator CASSIDY. The network director would be over the entire system. But I suspect there is something particular about that hospital and particular about that mental health unit.

Dr. CLANCY. One of the things that I, in gathering this data for you, have become very interested in, is looking at—the table I gave him, by the way, for his facilities has all veterans on one side and female veterans on the other.

In some areas for some conditions, one of the issues for female patients, in general, is sometimes childcare. Some of our facilities have a way of dealing with that, others actually don't. But I think it is very important to know why it is that people aren't showing up.

And I think, frankly, we have to do a better job in getting the word out and reminding people. Across our system, we do see that the missed opportunity or no-show rate for patients coming in for mental health visits tends to be higher than for other visits.

Senator CASSIDY. And increasing. I would just point that out.

And knowing that you have only been on the job for a short period of time, this is just going in the wrong direction.

Dr. CLANCY. Yes.

Senator CASSIDY. And I encourage my colleagues, because Dr. Clancy was nice enough, I asked her for the granular data and she got it for the clinics in my State, showing the no-show rate. In private practice, that should just not happen. People are getting follow-up phone calls. And the fact that it is growing is not best practice. It is not standard practice.

Secondly, we spoke yesterday. In my medical practice, I knew there were many that would come to see me and then subsequently go see the VA. I knew they had coverage, because I wasn't seeing them in the public hospital where I worked, but in my private practice.

#### THIRD PARTY INSURANCE BILLING

So the next question is, knowing that there are those who have dual coverage, and that the VA is allowed to bill third-party insurance companies in some cases, I am told that there is potentially \$6 billion billed last year but only \$2 billion collected.

Knowing the generalized problems the VA has, it is easy to imagine that it was a failure of systems, but it could be just the normal sort of contract disputes between an insurance company and a provider.

Any comments on that? We're leaving \$4 billion on the table. Can we get some of that money to the taxpayer?

Dr. TUCHSCHMIDT. I am not sure about the amount we billed. We collected about, I want to say it is around \$3.2 billion, is my recollection.

The biggest reason that we don't collect, I think, is that a lot of the third-party insurance that our veterans have is essentially Medigap insurance. And without an explanation of benefits (EOB), that Medigap provider doesn't pay that claim, right, because there was no Medicare service.

So we find that a lot of those claims go unpaid in our system.

#### NONRECURRING MAINTENANCE

Senator CASSIDY. Let me ask one more thing quickly. You have a supplemental appropriations, a second bite, if you will, which is \$1.3 billion. And you know, that is a substantial amount of money. And it includes \$247 million for nonrecurring maintenance (NRM).

First question, why was this not included in the regular budget request for fiscal year 2016? Secondly, knowing that you received \$5 billion in section 801 last year, some of which could be spent on nonrecurring facility management, how much of that was spent?

Again, a lot of money, second bite, some of it seems it should be included in the regular budget, and there is also supplemental money last year. Any elaboration on that?

Dr. TUCHSCHMIDT. Yes, so of the \$5 billion, roughly half of that is being spent on NRM and construction on space requirements. The other half is being spent on people. The space requirement is really frontloaded to this year, and people kind of more backloaded to the next year, because of the time it takes to recruit.

And the amount of NRM requested in the budget, it is really a re-estimation of what we need to really meet our needs, particularly to have enough exam rooms per provider.

Senator CASSIDY. I yield back. I am over time. Thank you.

Senator KIRK. The Senator for Connecticut.

Senator MURPHY. Thank you very much, Mr. Chairman and Senator Tester. It is an honor to be on this subcommittee with both of your leadership. Great to see both of you.

CHOICE ACT SECTION 802

Dr. Clancy, you have about \$10 billion through 2017 in mandatory money with which to implement the Veterans Choice programs. Is that right?

Dr. CLANCY. Yes.

Senator MURPHY. And this is in part to follow up to your question and answer with Senator Capito. You have seen maybe a slower than expected take-up thus far, but you are doing everything within your power right now. You are taking all of the necessary steps to make sure that the take-up is accelerated and that everyone that is eligible for this program is going to be able to take advantage of it. You are confident that you are taking those steps?

Dr. CLANCY. Yes.

Senator MURPHY. And so, let's just imagine for a moment a point at which having taken all of those steps, having done everything that you believe and collectively that we believe is necessary to have that program reach as many people as possible, you aren't then on track to expend the totality of that money. We have talked about just in the last half an hour a number of other needs within the VA, whether it be mental health needs, whether it be coordination services. Every single one of us probably has a list of capital projects that we would like to see undertaken.

If perhaps the estimate that we put into the law doesn't actually turn out to be the case, how do we make sure that some of these other needs are taken care of or that you have the ability to take care of some of these other needs?

Dr. CLANCY. So I started this off in response to the chairman by saying that we felt it was important for us to present a budget that reflected our honest need for requirements, what it took to serve veterans. We have also requested flexibility in terms of this \$10 billion of mandatory dollars.

It becomes particularly acute, and we had a brief chance to chat about this previously, because we have two big buckets or opportunities to help veterans get care in the community. One is what we call non-VA care and does include Project ARCH and things like that, which comes out of our budget.

That is discretionary, and then there is this mandatory pile.

At one point, we thought many of the veterans for whom we are now buying care in the community with non-VA care, we would be doing that with Choice. That is not our experience to date.

We have some continued process improvements to make, and I would also expect, just looking at the experience with the rollout of managed care in the private sector, that we will start to see a more enthusiastic uptake. I just don't know how steep that curve is for Choice. We know that many people who have long-estab-

lished relationships with providers are not the first people to jump on-board a new option, so they are going to be a little slower to try something new.

If we don't see that, that is why we are requesting flexibility, both to make sure that we can have a seamless experience for veterans, whether it is in our facilities through telehealth or by getting care in the community or addressing other underlying needs, like you just said.

So it is a bit of juggling act. And unfortunately, our budget puts us in a funky position, because we have so many different lines to manage.

You know, the example Secretary McDonald used was to imagine if you had a checking account for gas and one for food, and the food one is getting empty, and the price of gas drops, and you are hungry, right? I mean, that is actually the way we are trying to manage our budget right now, and that is what gets clunky. That was the request for flexibility.

Senator MURPHY. Well, I appreciate those comments. I think, as I mentioned, that our responsibility first is to make sure that we are building out this Choice program in a way that is true to the law, but I hope we would work with you to make sure that we don't leave this funding on the table, should we realize that we have the ability to reprogram it to the other needs that we probably can all pretty quickly agree on.

Mr. Chairman, that is my only question. Thank you very much.

Senator KIRK. The Senator for all of Alaska.

#### ALASKA AND THE CHOICE PROGRAM

Senator MURKOWSKI. Thank you, Mr. Chairman. Welcome to the subcommittee, and I'm pleased to have you back at the helm here, Mr. Chairman.

I want to speak just a minute about the situation in Alaska. Sometimes I feel a bit like a broken record in trying to describe why it is so different, why it is so unique, the highest veteran population per capita amongst the States; second lowest population; facilities, very, very limited facilities, very disperse. We don't host a full service VA hospital, but we do have opportunities that we have created because of other Federal systems, whether it is working within the Indian Health Service (IHS).

We have more patients than providers. We just simply don't have doctors that are taking Medicare-eligible individuals.

So as we built out this legislation last year, quite honestly, it was going to be a very, very hard fit for Alaska. Initially, it was going to be that folks were paid on the Medicare rate, which, of course, in Alaska is lower than anything else. It would have chased everybody away. We have that adjusted.

But still, we are limited to participation in the Choice Card program to a Medicare provider. And again, we just don't have the providers to go around. I am told that central office has reduced Alaska's VA budget for partnerships and purchased care about \$78 million now. And because what we have done, what we built out over the years are all of these alternatives so our veterans can find some level of services, this is a problem for us.

We just simply do not have facilities in these places where our veterans live. For so many years, the veteran was put on a plane to Seattle, to fill the gaps. We had some long battles in this subcommittee and others. Secretary Shinseki really stepped up and helped address how we could, again, fill in these gaps for services for our providers.

And we work in partnership with our native health system. And by all accounts, this is working for us.

The Choice Card, on the other hand, is untested. The provider needs to be willing to accept the card. Again, we have more patients than providers.

I am concerned about where we are. The question, this is perhaps a little broader than what you have had from others, is, does the VA have enough flexibility to ensure that Alaska's veterans don't lose the gains that we have fought so hard to put into place? We are moving to the Choice Card, but are we going to see, almost by default, an erosion of the level of access that we have been able to build up over the years, utilizing other Federal partners?

Dr. CLANCY. I see absolutely no reason why we would see an erosion. You are right that it is early days for the Choice program, and we are committed to working with you.

First, we are committed to finding any flexibility that we can, vis-à-vis the 40-mile rule. There is one—

Senator MURKOWSKI. We are already—

Dr. CLANCY. Yes.

Senator MURKOWSKI. All veterans in Alaska are enrolled.

Dr. CLANCY. Not relevant to Alaska, for sure.

When you say that there has been a cut in the budget for purchased care, I think that what you are seeing is that, as a result of the Choice Act, we have consolidated a lot of the funding for purchased care to our central business office. But that doesn't necessarily mean that we are buying less purchased care.

Thus far, our experience would suggest that that is not the case. And in fact, in the middle of our access crisis, when things felt particularly acute, what I learned was that some of the facilities in Alaska are very, very good at the coordination that goes on there, because they have had to be, and that is terrific.

We also have spent to date about \$10 million on partnerships with the Indian Health and Tribal Services. And I couldn't close this without acknowledging that Alaska has long been a source of inspiration for us, because of the Nuka clinic, which has won so many awards and really has inspired many of our efforts in primary care.

Senator MURKOWSKI. Well, I appreciate that, and I encourage you all to remember that we've had to think outside the box. We've had to be creative. And we have done it to relative success. So again, we would hate to see any erosion.

#### RECRUITMENT AND RETENTION IN ALASKA

Very quickly in my remaining time, and this goes to Senator Tester's issue about recruitment, in many cases, the issue for us with VA care in Alaska has not been the wait to see a VA provider, but it has been this extraordinarily heavy caseload that our providers have, particularly in our community based outpatient clinics

(CBOCs). And you have all heard the example of the CBOC there in Wasilla. You had a physician begging for help, begging for help, and they couldn't provide anybody to her. She eventually leaves.

VA continues to make the excuse that we just can't get providers to Wasilla. This is the second largest community in the State now. It is on the road system. IHS seems to be able to recruit for places like Barrow, Kotzebue, Nome, all off the road systems.

I can't figure out what the problem is here, and I would like to know, Dr. Clancy, that you are looking at this here, you are evaluating it, you are trying to figure out what it is that we are doing, because just an interim fix isn't addressing the needs of our veterans out there.

Dr. CLANCY. No, I hear you. And, I would say that recruiting and retention is probably our biggest number one challenge, particularly for some areas that are not well-served.

I did speak with your colleague Senator Tester yesterday, wondering if we might actually figure out working with the University of Washington, since it reaches out to those four States, including Alaska and Montana, to try to figure out if we can get more students into rotations that would have a focus on VA. So that is on my list of opportunities to explore.

But I hear you, that we have to get more people up there.

Senator MURKOWSKI. We will keep pushing on that.

Thank you, Mr. Chairman.

Senator KIRK. The Senator for the land between Kenosha and Rhinelander.

#### TOMAH VAMC INVESTIGATIONS

Senator BALDWIN. And a few other places. Thank you, Chairman Kirk, and thank you, Ranking Member Tester.

I would like to focus on two problems within the Veterans Health Administration, both nationwide and in Wisconsin, and ask what the VHA is doing to put solutions in place.

It is apparent to me that the VHA lacks clear and appropriate system-wide policies and protocols, as well as suffers from inadequate oversight of individual facilities. By way of example, at the Tomah VA Medical Center in Wisconsin, current and former employees and patients have brought to my attention allegations of inappropriate opioid and benzodiazepine prescribing practices, and abusive administrative authority, including retaliation against whistleblowers.

While the Tomah VA is currently the subject of a VA investigation led by you, Dr. Clancy, it is my hope that we can answer a few fundamental questions here today.

In the case of your current investigation into the over-prescription of opioids and retaliation at the Tomah VA Medical Center in Wisconsin, my office did bring a number of these concerns to the attention of the VA's central office in June of last year, and asked for an investigation at that time.

However, the VA central office forwarded the letter to the regional VA office, VISN 12, to respond instead of looking into the matter on its own. Six months later, you have launched an investigation, full investigation.

So why didn't the VA launch an investigation when my office first contacted the central office in June of last year?

Dr. CLANCY. So there were a number of investigations ongoing led by the network, and in retrospect and as we have discussed, the then-network director retired—or, he didn't retire; he's way too young for that—left at the end of October for a job in the private sector.

What has surfaced for me is that there is less than a complete understanding about which issues at a network level are shared with central office, and that is a set of issues that we are working on very hard right now.

I think the good news, and looking back at the timeline and going over all of this detail by detail for the past several years with the current acting network director, I think a lot of what they did was quite appropriate. There was an unfortunate miscommunication, or actually it was a communication, I will say that, and we have now clarified that for all of our facilities.

When the director of the facility was told you may not share this inspector general's report with anyone, we have now clarified for all of our facility and network directors that those reports can be shared and should be shared, not only beyond the facility with the network but with the central office.

Senator BALDWIN. So that I can cover a little more territory, and I will stay around for a second round of questions, but to be clear, this wasn't a letter to the inspector general. This was a letter to the VA central office in June of last year.

So what happened with that letter is rather than the central office responding, VISN 12, the network, responded on June 27, and ticked off a list of actions already taken to improve Tomah's prescribing practices, making it seem like everything was under control at Tomah, and ended by suggesting that I contact the chief of staff at Tomah directly if I had any further questions.

It ends, "Thank you for your inquiry and the opportunity to address the concerns raised by your constituent. If you have any additional questions, please contact David Houlihan, M.D., chief of staff," and lists the phone number.

However, the Tomah chief of staff is at the center of a series of allegations regarding inappropriate prescribing practices and creating a culture of fear and intimidation at the facility.

Do you believe that this was an appropriate response and a correct assessment of the situation to give a United States Senator?

Dr. CLANCY. With the perfect clarity that comes with hindsight, I would say no.

Senator BALDWIN. All right.

Dr. CLANCY. I did not see that letter. And as you said, it was referred to the network. I would very much hope that we would have a different set of actions right now.

It has uncovered for me, in addition to the very specific circumstances at Tomah, some of the unique challenges of making sure that we have fair practices at some of our smaller facilities. At a larger facility, for example, Milwaukee, the chief of staff sees patients and has their practices reviewed. It is very easy to blind that just because it is a larger place. And by the way, he's an internist.

At Tomah, this person is a psychiatrist. It is very, very difficult to actually blind their practices for the purposes of peer review. And, as you know, there are currently a number of investigations going on now, and we are not waiting, per our announcement yesterday and the fact that our Deputy Secretary is in Tomah today, yesterday and today. So that is where we are.

Senator BALDWIN. Will there be an opportunity for a second round of questions?

Senator KIRK. I think we will go in the regular order.

How are we doing here?

We can give you additional time, if you like.

Senator BALDWIN. I appreciate it, then.

At least three veterans—Thomas Patrick Baer, Jason Simcakoski, and Jacob Ward—who were treated at the Tomah VA have tragically lost their lives. Jason Simcakoski died at the facility.

And I know there was a broad review involving the joint commission, but you are leading an investigation of the Tomah VA right now, which includes evaluating the treatment of patients. So I am asking, does your current investigation include an evaluation into the care that Jason Simcakoski received at the Tomah VA?

Dr. CLANCY. The network had led an evaluation and review of that, which included both people from the network—that is to say, outside the facility—and also involved in external review from our partner that we work with a lot, the quality improvement organization in California, Livanta. And that was prior to the investigation that was launched in January.

And at this point, the inspector general is also reviewing that death. Their final report has not been done. I have had an informal conversation with them, but we are staying on top of that.

Senator BALDWIN. Jacob Ward also passed away of a drug overdose after he left the Tomah facility. However, he reportedly was treated with opioids when he was a patient at Tomah.

I'd ask, does your current investigation include an evaluation of the care that Jacob Ward received while at Tomah?

Dr. CLANCY. His care and his ultimate death are being reviewed right now.

Senator BALDWIN. Okay. And then Thomas Patrick Baer passed away at the Gundersen Lutheran hospital in La Crosse, Wisconsin, after being transported from the facility at the Tomah VA. He initially sought care at the Tomah facility for a stroke, yet reports indicate that Tomah did not have a working C.T. scanner and failed to give him anticoagulants and didn't have an operational helicopter available to transport him quickly to another facility that could care for him.

Does your current investigation include an evaluation of the care of Thomas Patrick Baer?

Dr. CLANCY. We have conducted a review of his care and his death. And his death and experiences are also currently under review by the Office of the Inspector General as well. In addition to that, as a result of our own review, we have identified deficiencies in care that we are addressing right now.

It is a bit separate from the opioid safety issue, but there were clearly missed opportunities to identify the fact that he was prob-

ably having some of those symptoms while sitting in the waiting room, and in addition to the fact that he should have been sent to the other facility in Tomah. Their CAT scan was down for preventive maintenance, which happens, but he should have been sent to the other facility.

Right now, we are actively exploring how it is that we might exploit our capabilities, both at Tomah and across the system, to make sure that veterans presenting with possible stroke could get their care by telehealth, if there is not a stroke team on-site, because today, if you have a stroke in Tomah, regardless of whether you are a veteran or not, it is not a great place to do it. It's much better to be in Madison, because they have all the capabilities there. But we have the capability to actually link those two.

So that will be coming. But right now, it is under review by the inspector general.

Senator BALDWIN. Mr. Chairman, I have two more questions, if you'll indulge me. Otherwise, I can wait for a second round.

Senator KIRK. I know this is a really important issue. I would like to give a chance to Mr. Boozman to eventually ask his questions.

#### HOMELESS VETERANS REINTEGRATION PROGRAM

Senator BOOZMAN. Thank you, Mr. Chairman.

Dr. Clancy, in your opening statement, you addressed veterans homelessness, which is, certainly, an issue that all of us on the committee care about and glad that you singled that out.

I noticed in your testimony that you mention that HUD Veterans Affairs Supplemental Housing (HUD-VASH) programs that provide permanent housing to many veterans. Senator Tester and I have introduced a bill to reauthorize the Homeless Veterans Reintegration Program (HVRP).

Are you supportive of reauthorizing HVRP?

Dr. CLANCY. We are supportive of anything that will help us with homeless veterans, for sure.

What I can say is the one thing we have learned in terms of addressing this important problem, which is one of our top three priority goals for the Department, is that you have to get people in housing first, then you can address all other problems. So just as we have managed to work with partners in the Los Angeles community to dissolve a longstanding lawsuit and are trying to take advantage of the land there, there is almost no option that we wouldn't look at across the system to help people get into housing, and then address their other needs for healthcare, for employment, and so forth.

Senator BOOZMAN. Good, Dr. Clancy. And that brings up what we are trying. Part of this bill, what we are trying to do is that, in HUD-VASH, as the law stands now, if a veteran receives housing through an assistance program, they then become ineligible for HVRP because, technically, they are not homeless anymore.

That seems crazy. That is only perpetuating the cycle of homelessness with many of these veterans.

In our bill, we make a clarification of the law and allow veterans who are receiving housing through HUD-VASH to participate in a HVRP. And again, I would ask you if you would support that kind

of change, which is a very commonsense change that Senator Tester and I are trying to get done.

Dr. CLANCY. We would be happy to work with you on that.

What we know is we have made big improvements, in terms of homeless veterans, so that is great. But we have a long way to go.

Senator BOOZMAN. Good.

Dr. CLANCY. We have reduced the number by about a third, and some cities have been able to announce that for the moment they have solved the problem—New Orleans, Phoenix, and so forth. But we have to make that happen everywhere.

Senator BOOZMAN. I know it is an issue that everyone is working really hard on. Again, it doesn't seem to make sense to provide housing and then say, "Well, they are not homeless anymore," and then eliminate benefits that could break the cycle, which we are all trying to do.

#### HEPATITIS C DRUG TREATMENT

Let me ask you about hepatitis C. There are the new drugs on the market now that have up to a 97-percent cure rate. They truly are miracle drugs. That said, they come with a steep price tag. And I know that you are able to negotiate and a pill that normally costs \$1,000, you are paying \$540. That is a very, very good thing.

One thing, though, that I am a little bit concerned about in the budget, you requested \$7 million less for fiscal year 2016, \$690 million as compared to fiscal year 2015, \$697 million then. The projected advanced appropriation for fiscal year 2017 is \$660 million. So you can see it is going down, which is a \$30 million reduction.

I guess the question is, why are we decreasing funding for hepatitis C, in the sense that we have this cure, which is very expensive, and in making that cure now, certainly, long term, are going to save the VA a tremendous amount of money as opposed to all the problems that we get with hepatitis, in the sense of liver failure and the very expensive things that come up in the future?

Dr. CLANCY. Sure. Just to take a quick moment to brag on things I had nothing personally to do with, but all of the science about screening for and treating people with hepatitis C really comes from VA, which is a really good thing.

Some part of the change in budget may, in fact, be due to the fact that they are now shorter courses, these newer drugs. I can't overstate how important that is. The older drugs, some of which made you feel like you had the flu for a year, had very high drop-out rates. So it didn't matter if the drug worked, because people stopped taking them. They felt awful.

Now we have newer treatments that were employed enough to emerge on the market, sort of off-budget cycle, which is why we need to make a big investment.

And very recently, we were able to arrange a negotiation with a company. I think it used to be part of Abbot AbbVie—am I saying that correctly?—which comes out of North Chicago, for a greatly reduced price per course of treatment, so we are giving you our best estimate.

Some of this has to be an estimate, because it depends on the genotype of the virus, and so forth.

But I think we are in good shape to cure this for many of the veterans who are affected. There is a little bit of estimation that goes on, as well, about screening newer veterans, in terms of how many cases—

Senator KIRK. Dr. Clancy, if I can interrupt you a little bit. I understand the economics of this treatment. It's about \$83 grand for a full course of treatment. That obviates the need for a liver transplant, which otherwise could cost the VA \$300 grand.

That is my understanding. Is that your understanding of the economics of the situation?

Dr. CLANCY. That would be one way to look at it, yes.

Senator BOOZMAN. Actually, with you getting the reduced prices, it is probably better than that, isn't it? I think that is the conventional, if you are a regular patient.

Dr. CLANCY. The newer treatment is somewhere between 20 and 30 for a course of treatment, yes. It is just unclear how many veterans that will be the best fit for.

Senator BOOZMAN. I would just ask you to look at that. Again, we are dealing with a case that we truly do have a miracle drug. It's lots of money. As you mentioned, the side effects and the cure rate is just, like I said, it truly is a miracle drug.

So thank you, Mr. Chairman.

Dr. CLANCY. The other point I would just make is, it is much easier to administer in our system. The older drugs mostly had to be done by specialists. Now primary care clinicians can do this. It is much, much easier to give out.

Senator KIRK. Let me recognize the Senator for the greater Albuquerque metroplex.

Senator UDALL. Thank you, Chairman Kirk.

And congratulations, Senator Tester, for your assumption of power in this subcommittee.

I want to echo what Chairman Kirk said here. He pointed about the Frontlines to Lifelines Act. I am an original cosponsor, and I think this legislation is tremendously important for vets and transitioning vets. We have seen that in New Mexico. So I thank you for your hard work on that.

Dr. Clancy, thank you for taking the time to be here with us on the VA budget. This budget, as you know, is of utmost importance to our Nation's veterans and to veterans in New Mexico, for sure.

Last year, I submitted concerns from employees at the VA to the VA Office of Inspector General, and these concerns centered around issues of scheduling and timeliness of VA care. But ultimately they were about a loss of trust between the VA and many of our veterans, a trust that I think the VA is still trying to recover.

In New Mexico, the controversy has led to the appointment of a new director of our VA hospital. And New Mexico veterans and I really appreciate this new director and his efforts. He's traveling the State. He's meeting directly with veterans, holding a series of town halls, really trying to put himself in a position of turning around what happened there at the VA.

And most veterans I have spoken to believe that the care that they receive at the VA is second to none, if they can get in the door and get the care.

And this budget, I appreciate very much, helps support that. This budget, however, also helps to ensure that the VA's care remains second to none in the future, and that improvements are made where care is lacking.

For example, in your document, you talk about, and I am quoting here, "VA researchers are pursuing," and this is an area I think you are very familiar with because you headed up the research part of the establishment for 10 years, "VA researchers are pursuing a way to address Iraq and Afghanistan veterans' most pressing mental and physical health issues." And they include, PTSD, traumatic brain injury (TBI), traumatic limb loss, sensory dysfunction and loss, pain, and polytrauma.

And the work the VA researchers do in these areas also benefits veterans of all ages, just like you were pointing out with the hepatitis C research. And we really appreciate your efforts in that area.

#### OPEN-AIR BURN PITS REGISTRY

My question focuses on open-air burn pits, and veterans coming in contact with burn pits and then getting serious illnesses, respiratory illnesses and others. And it seems to me, in looking at all these lists and looking at the VA research justification, in the justification, the VA mentions mental health, homelessness, pain management, TBI, and a number of other areas, except exposure to open-air burn pits. In fact, the only mention of the open-air burn pits that I could find in the justification was that the registry has been created.

Dr. Clancy, I am asking you if the VA is not making open-air burn pits research a priority in this budget on par with other signature ailments of Iraq and Afghanistan, then just what is the VA planning on doing with the registry and how does the VA intend to research ailments caused by exposure to these open-air burn pits?

Dr. CLANCY. So thank you for the question. It is a topic that I am particularly interested in, in part because I have some close colleagues who have taken a great interest in this outside of VA.

There has been a little bit of research done in the VA, some of it coming out of Northport, New York, but we have a lot more to learn. So I am personally quite thrilled by the brisk, enthusiastic response to opening this registry. It took us a little bit longer to get launched than we had hoped, but I want to say that we have tens of thousands of people enrolled right now.

I think the first step that will offer us is generating hypotheses, what seems to be the most promising. The prior research I cited was a very small, well-done study, but actually to look at much larger numbers of individuals to see what their experiences have been.

I might yield to my colleague here, who is a pulmonologist, if you had more to say about the burn pits. Okay.

Senator UDALL. She's covered it all, yes? She's not even an expert in pulmonology.

Dr. CLANCY. So I think that will be a first step, and I think that we are likely to learn a lot that we didn't know about this. And some of that I think is going to come from figuring out what was the exposure, really. That is a huge area of investigation for us,

writ large, whether you are talking about agent orange, or the C-123 planes, or other types of exposures.

We just got a report today from the Institute of Medicine on getting some clarifying guidance for people who were exposed to toxins at Camp Lejeune. I think we are going to see more and more of this in the future, and I think the airborne issues will be a big part of that.

Senator UDALL. Thank you, Dr. Clancy, for your work there. And do you think you need additional authorities to work with both public and private research institutions to share information in the registry and allow that research to take place between veterans' research and out in the private sector, universities and places like that?

Dr. CLANCY. I don't think we do right now. But if I should perceive any barriers, I will be on your doorstep to let you know.

Senator UDALL. Okay. Thank you very much.

Sorry for running over a little, Chairman Kirk.

#### CHOICE ACT

Senator KIRK. Let me start the second round here and ask you about the Choice Act. I understand the Department is using some pretty low utilization expectation numbers from veterans. I would ask you, do you have good third-party validation on those numbers? If we get it all wrong, the committee may under-appropriate and you may not have enough money to take care of people as we promised in the act.

Dr. CLANCY. So just about every aspect of VA healthcare will be assessed by independent organizations. That was written into the law. And frankly, we welcome that. I think it is an incredible gift. And, in fact, I spoke to the Blue Ribbon Panel, along with Dr. Tuchschnidt, a few weeks ago, just to thank them in advance for all the hard work they are going to do.

I am not surprised by the low utilization at this point in time. I think the bigger question is what happens over the next 3 to 6 months to a year. And that we are just going to have to watch very closely.

But I will tell you that we are consulting with private industry, who knows a lot more about the insurance business than we do, both with an eye toward getting help with problem-solving right now, as well as trying to figure out what capabilities we need to bring in-house.

Senator KIRK. Thank you.

Senator TESTER.

Senator TESTER. Yes. Thank you, Mr. Chairman.

#### NOMINEES FOR UNDER SECRETARY FOR HEALTH

Dr. Clancy and Dr. Tuchschnidt, one has an "interim," the other has an "acting" before their name. At the VA hearing we had last week or 2 weeks ago, I asked the Secretary, and he said he was going to put some names forward. That hasn't been done yet.

Has he indicated to you when he's going to put names forth, for you guys?

Dr. CLANCY. I heard what you heard. That is all I can say right now.

## RECRUITMENT OF PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Senator TESTER. Okay. We will follow up with him. I think it does speak to the problem, quite frankly.

Can you tell me to what extent does VHA grant full practice authority to physician assistants and nurse practitioners?

Dr. CLANCY. Right now, our policy is that, as you know, there is great variation among the States, so as a Federal system, all of our professionals have to be licensed in a State. And if you are a nurse practitioner, for example, that comes from a State that gives a lot more latitude to nurse practitioners, then you have the opportunity to use that, depending on which facility you are in and so forth.

Senator TESTER. Are you actively recruiting nurse practitioners and physician assistants in those States in which they have that authority?

Dr. CLANCY. They can work anywhere, as long as they are licensed in a State. What we are looking at now is whether we should have a system—

Senator TESTER. So let me get to recruitment. Are you actively recruiting those folks?

Dr. CLANCY. Yes.

Senator TESTER. Okay, good.

Dr. CLANCY. Without question.

## REIMBURSABLE PAYMENTS TO NON-VA PROVIDERS

Senator TESTER. I am going to give an example. You tell me how pronounced this is in the VA.

Kalispell Regional Medical Center in Kalispell, Montana, is owed more than \$500,000—these are their numbers, not yours—in 2014. That is the bad news. The good news is, 2015 payments are coming in just fine.

Number one, is this an outlier? And number two, if it isn't an outlier, how are we taking care of this? And quite frankly, from a parochial standpoint, how are you dealing with Kalispell Regional Medical Center right now? Go ahead.

Dr. TUCHSCHMIDT. So we centralized under the Choice Act. We centralized the funds. So we track our timeliness of payments.

Senator TESTER. Yes.

Dr. TUCHSCHMIDT. They did deteriorate. And right now, we have a corrective action plan to get back on track by the end of April. I don't know about Kalispell, per se, but I wrote it down. I will go follow up on that.

Senator TESTER. Okay.

Dr. TUCHSCHMIDT. We do have some places where we—

Senator TESTER. How many Kalispells do you have out there?

Dr. TUCHSCHMIDT. That I don't know, but I can tell you that we had about 2,400 people, places, bills, that we owed beyond a year, and we are trying to catch up with those.

Actually, most of them are disputes about whether the care that was rendered was authorized by us.

Senator TESTER. Yes.

Dr. TUCHSCHMIDT. But we are working to resolve all of those by the end of—

Senator TESTER. I don't need to tell you the trouble there. I mean, if we are talking about building partnerships, and they are not getting paid, it's tough to build a partnership, okay?

Dr. TUCHSCHMIDT. You are preaching to the choir.

Senator TESTER. Okay, all right.

#### GRANTS FOR STATE EXTENDED CARE BUDGET REQUEST

The priority list for building projects, your priority list, 2015 fiscal year, \$409 million for projects, yet your request is \$80 million—\$80 million for a program that needs \$400 million.

Can you give me thoughts on why you requested \$80 million, and whether we are doing anything more than just treading water when it comes to facilities? And if these numbers are wrong, tell me, because I am getting it from these guys, you know?

Dr. TUCHSCHMIDT. So I think we have our 27 leases that we are pursuing. Some of those are funded in prior fiscal years, so that we are now bringing online. So we have a significant need, for sure, for construction. In fact, I would think it is probably—

Senator TESTER. This is for extended care facilities, by the way, not the whole baby, just the extended care facilities, to be clear. I'm sorry.

Dr. TUCHSCHMIDT. Yes. Your \$80 million number threw me off. I wasn't sure.

Senator TESTER. Sorry. I should have prefaced that. Keep going.

Dr. TUCHSCHMIDT. Yes. So I don't have the specifics on the extended care facilities, but I am happy to get that information to you, so that you have that.

Senator TESTER. Okay. We want the budget to match the need. I think that is going to be the challenge for this subcommittee. I am giving you flexibility in making sure that you have enough money to meet the needs of the veterans out there.

And when it comes to extended care facilities, in particular, the \$409 million vs. \$80 million, that is less than one-fifth, less than 20 percent. So it is a big issue.

Thank you, Mr. Chairman.

Senator KIRK. The Senator for King Cove, Alaska.

Senator MURKOWSKI. Thank you, happy to be the Senator for King Cove, Alaska, Mr. Chairman.

#### PATIENT-CENTERED PRIMARY CARE CONTRACT IN ALASKA

Let me ask about the patient-centered primary care contract for the State. I will tell you, I was a little bit surprised to learn after the contract was issued that the PC3 contract provides and that the contractor may set the reimbursement rates for the care that is referred outside of the VA system. But as you know, we don't have managed care within the State. We have more patients than providers, as I mentioned, and providers reject managed care.

TRICARE does not allow its contractor to set rates in the State. So when we learned that TRICARE was charged under its contract with negotiating rates in Alaska, again, it really gets your attention. It really surprised you there.

So we were told that when the PC3 contract was entered into, my staff checked with your folks at the VA to ensure that the contractor was aware of the need to pay market rates there in the

State. We were assured at the time that the contractor knew about that.

But what we are beginning to get now are complaints, and I will acknowledge that they're sporadic complaints, but complaints that the providers are not getting market rates.

We heard just recently from an anesthesia group that was very frustrated in working with the PC3 contract and is considering no longer serving our VA patients, which, of course, is exactly the opposite direction of where we want to take this.

Is this something that the VA is monitoring?

Dr. TUCHSCHMIDT. So I don't know about the PC3 contract in Alaska provisions, per se. I wasn't really involved at the time the PC3 contract was constructed, but I will go look at that.

I will tell you that I think you are raising probably one of the most significant issues we face, and it is not just for Alaska right now. I think that one of the things that we are doing really prompted by the Choice legislation is to ask kind of ourselves what is the future of purchased care in VA? What does that look like? What does a VA health plan look like? We have employed Deloitte to help us do an assessment of our current purchased care processes.

And I think we have a whole smorgasbord, quite frankly, of options from local contracts to the spot market to sharing agreements, to PC3, to Choice, to Project ARCH.

Senator MURKOWSKI. And they can be different all over the country.

Dr. TUCHSCHMIDT. And they are different all over the country.

And I think one of the things that we are going to be doing over the next few months is sitting down and saying, "How do we reconcile all of this?" And quite frankly, TriWest tells me almost on a daily basis what an awful position we have put them in, because they are going out to the same providers that we are contracting with, saying, "Would you like a PC3 contract? And by the way, we have a Choice contract over here." And it is mind boggling.

So we definitely have to resolve this. I think you've hit the nail on the head.

Dr. CLANCY. If I could just make one point?

Senator MURKOWSKI. I would ask you to look not only at Alaska but look across the system, because it just doesn't seem to be trending right here for us.

Dr. CLANCY. We would not want one-size-fits-all, right, because the markets are very different.

Senator MURKOWSKI. Right.

Dr. CLANCY. Alaska is going to be very different than Wisconsin, for example, or New Mexico. They are just very different constellations, ecosystems, if you will, of medical services. But at the same time, we have a lot of work to do to try to rationalize this because if it is illogical for us, it is going to be much, much harder to give veterans a seamless, terrific experience every time.

Senator MURKOWSKI. Yes, I appreciate that.

#### VA AND DOD MENTAL HEALTH DRUG FORMULARY

One last question, and, Dr. Clancy, we were trying to connect yesterday as I was traveling cross-country, and we weren't able to

do it, but I think you were alerted. I had read the op-ed piece in the Washington Post this weekend by the former Vice Chief of Staff of the Army, General Chiarelli, suggesting that the VA's mental health drug formulary is just too narrow to ensure that the medications that the Department of Defense provides, when that individual separates and then moves over to the VA side, that they can be maintained after he leaves service.

Now, it is my understanding that you have attempted to address this through regulations. General Chiarelli suggests in his op-ed—in fact, is pretty emphatic—that the regulations aren't sufficient, that they leave broad loopholes.

Can you tell me where we are with this? Does he have valid concerns here?

Dr. CLANCY. So first, given his work and interest in mental health, traumatic brain injury, and so forth, I mean, I have huge respect for his contributions and building awareness of these issues. What I can tell you is we are working very closely with the Department of Defense to ensure as seamless a transition as we possibly can for servicemembers who are leaving the military and coming to VA.

As a result, in particular, of the executive action issued by the President in August, focused on improving mental healthcare, a whole series of actions, we actually have directed all of our facilities and clinicians that servicemembers can continue their medications at least until they can have time to be evaluated by a clinician in VA.

Some drugs that are good for short-term treatment may not be the ideal choice for longer term treatment, and it is often very common with the chronic use of drugs to treat different mental health disorders that you are going to need to make changes. You know, one antidepressant works for a while, but then it doesn't work so well and so forth.

And we do that for other medications as well. We would be happy to come and give you a full brief on that.

I think a little bit of what happened was that the commission that General Chiarelli was working on, which has just delivered its report to the Department of Defense, the military compensation and retirements—I can never remember the entire acronym—was working independently, as they very much wanted to, at the time when this executive action and other activities were in process.

Senator MURKOWSKI. I would be curious to know and understand a little bit more, because I thought, at least the way that the General had outlined it, it appeared that we were not syncing the systems. And when the systems don't line up, then it is the veteran and the veteran's care that suffers.

So I don't know whether he's correct in that. We do still have loopholes that need to be addressed. But if you can provide me with a little more information on that?

Has the Department been in contact with the General about his recommendations, do you know?

Dr. CLANCY. I have been trying but have not managed to connect with him.

Senator MURKOWSKI. Okay. All right.

Dr. CLANCY. He is actually part of the Blue Ribbon Panel that is reviewing all of these independent assessments, but cell phone land didn't make it possible.

Senator MURKOWSKI. All right. I appreciate it.

Thank you, Mr. Chairman.

Senator KIRK. The Senator from Wisconsin.

Senator BALDWIN. Thank you.

#### TOMAH VA INVESTIGATION ON WHISTLEBLOWERS

We have already had an opportunity to converse, Dr. Clancy, about concerns raised by some of the whistleblowers in the Tomah investigation who want to speak up but feel that they can't because of confusing guidance they have received by managers and supervisors at the Tomah VA regarding Health Insurance Portability and Accountability Act (HIPAA) privacy concerns, privacy regulations, and the so-called section 7332 data, which I understand to be related privacy issues.

So I would ask you to give me an update right now as to whether there will be updated guidance that your team of investigators can share. And will you ensure that once there is clarified and updated guidance, that everyone who wants to speak up and meet with and discuss and talk with your investigators are able to do so, because we are getting mixed messages even as of earlier today as to whether that updated HIPAA guidance has been put together?

Dr. CLANCY. I appreciate you sharing what you are hearing from many people. The Drug Enforcement Administration (DEA) went into Tomah to do an investigation. They had been there in the past, and apparently, I don't think that was productive or didn't lead to any definitive conclusions.

But very recently they went in and there was a little bit of confusion, some of which was that our regional counsel was advising us that they didn't have the right paperwork to be looking at information that was sensitive at the patient level.

I have been informed by the acting network director that they have resolved those issues. But since you are hearing this even today, we will loopback. I know that Sloan Gibson, as I said, is on the ground today, reinforcing for people that we want to hear from everyone who has concerns about this or other issues.

Senator BALDWIN. Right. And it was in a conversation with him earlier today that it sounds like they may not have definitively resolved those concerns, and so I am very eager to have that done.

When do you expect to complete your investigation? And will you make the full report public at that time?

Dr. CLANCY. So we will be making at least summaries of it public. As you know, the investigations on the clinical side are protected by peer review privilege, in the same way they would be at any other hospital. But we will be releasing a summary of the results from the first phase of clinical investigation.

The second phase, when it is done, we will have some kind of summary as well, although it too will be a protected peer review, mostly so that we can get at all the facts. And as our announcement yesterday indicated, in our work for the past few weeks, in terms of rolling out this new tool to make it easier, much, much easier for primary care clinicians to do the right thing, we are not

waiting until all the investigations are done to make improvements that we can see right now. So that is nursing care and the urgent care part of Tomah, with respect to the care that Mr. Baer got and other issues there.

It is also about safe prescribing of opiates. And the tool that we announced yesterday, as I think you know, was all about making it quite visible to clinicians in a very easy way which of their patients are on opiates, what kind of dose have they had, the urine drug testing, are they on benzodiazepines, and other things where there might be an adverse reaction, and so forth.

It also allows them to see whether patients getting those narcotics from other points of care in our system.

Senator BALDWIN. I would just state for the record that absolute transparency is so critical here. There have been numerous concerns raised about unpublished reports, about lack of transparency in the oversight of the Tomah facility. And I will want to press further on that when it comes to the final report of this investigation.

#### OPIOIDS PRESCRIPTION

Lastly, you have talked already a little bit about the VHA's review of how opioids are prescribed system-wide. Since this is an appropriations subcommittee hearing, I would ask, are those efforts prioritized in your budget request?

Dr. CLANCY. I think that that is on-going work that is built into our medical care budget, but I have to get back to you on that, in terms of how that has happened.

This initiative was fully rolled out in February 2014, and we have seen system-wide decreases in the use of opioids, so that is good.

But we are also seeing, when we actually have this new tool and look at our dashboards, that, frankly, we need to up our game at Tomah and across the system. And again, this new tool will help people do that.

I don't know how much it is specifically identified. It is no different than we don't have a separate line item for, say, high blood pressure or diabetes. But we can, certainly, give you an accounting of what all this is costing, if that would help.

Senator BALDWIN. That, and as you do system-wide overhauls, as you try, and as non-VA medical systems try to roll significant protocol changes, those are big undertakings.

Dr. CLANCY. Yes.

Senator BALDWIN. And in many systems, it fails because adequate attention and emphasis isn't put on it.

Dr. CLANCY. Yes.

Senator BALDWIN. We want to make sure that you are in a capacity to get everyone's attention system-wide, so as we work on the appropriations subcommittee marks, I want to be in communication on that. Thank you.

Dr. CLANCY. Thank you.

I will just say, for the record, one of the things that I found actually quite thrilling was, as a result of being part of many, many phone calls across our system, so I reach more than 2,000 primary care docs and facility directors, network directors, and really over the past few weeks to say this is really important, we are making

progress, and it is not easy, because 50 to 60 percent of the veterans that we serve have some kind of chronic pain issue, as compared to about 30 percent of Americans. I actually got a lot of fan emails saying thank you.

And some part of that, I believe, Senator, is about these patients have other issues too, and we want to pay a lot of attention to opioid safety and making sure we are helping and deploying every tool in our toolbox in terms of pain management to help these veterans. But we don't want to miss dealing with their other medical issues, as well. And I am starting to hear that from some of our primary care docs. So I think this tool will be helpful.

Senator KIRK. Let me just add my concerns to the Senator from Wisconsin's.

I have been warned through my family and patients that I have seen, including an ex-staffer of mine, there is a growing method in medicine just to give the patient happy pills, which emphasize opioids, and get them pretty heavily addicted. We are very worried about that. The Tomah facility was called in the press the candy store.

#### GAO REPORTS VHA A HIGH-RISK PROGRAM

Let me close with one last question. The Government Accountability Office (GAO) has said that VHA is a high-risk government program. Do you agree with that assessment by the GAO? Could you comment on that?

Dr. CLANCY. You know, I think by every criterion, given our experience in 2014, it would be hard to make a strong argument that we shouldn't be on their high-risk list. The one question I had for them, they did come and give us a heads-up, and I wanted to know what were the criteria for getting off the list. There are some high-risk lists in government programs that can be hard to get off of, for a variety of reasons. And they actually assured me that with improvements—I think they were blown away when we said we welcome your reports and we are paying far more attention to them in a systematic fashion than we have in the past. In fact, I was glad they were sitting down. I thought one of them was going to hit the floor when we said that.

I think they have perceived in the past that we weren't necessarily attentive to their findings. And to that I would say, with new leadership, it's a new day.

Senator KIRK. I will note our clerk told me about some Navy leaders who one time said, "Don't give me another budget increase because it encourages my leadership to not make choices." As long as you are receiving steady increases, you are in a culture that will not make any tough choices. That may be the lesson here.

Dr. CLANCY. Well, what I would say is the budget that we have presented for fiscal year 2016—

Senator KIRK. He corrects me that that was Admiral Mullen, the Chairman of the Joint Chiefs of Staff, who said that.

Dr. CLANCY. I would never disrespect any individual publicly. I will simply say the budget that we submitted represents our very best effort to reflect to you a true requirement, as best we see it, to meet veterans' needs.

And I will also say that Secretary McDonald is strongly committed to finding all possible efficiencies. But you can't really get there until you kind of address the backlog of need.

Senator KIRK. Thank you. I think we have kind of beat this to death.

Senator Hoeven.

Senator HOEVEN. Thank you, Mr. Chairman.

Senator KIRK. You get the patience award now.

Senator HOEVEN. Thank you.

Senator KIRK. Go ahead.

Senator HOEVEN. I would like to thank both of you for coming today to testify. And, Dr. Clancy, to pick up on some things that you and I talked about earlier, thanks so much for the earlier conversation.

#### REIMBURSEMENT FOR NON-VA NURSING HOME CARE

The first one I want to pick up is provider or VA reimbursement to nursing homes. Right now, as you are aware, when a veteran stays in a nursing home, if the reimbursement comes through Medicare, the Centers for Medicare and Medicaid Services (CMS), then that nursing home is not required to comply with the small business contracting requirements. But if the reimbursement comes through the VA, then they are, which means that in many cases, a nursing home won't take VA reimbursement for taking care of a veteran, which denies veterans opportunity for care closer to home.

So I believe that that is something we need to remedy. I talked to both Secretary McDonald and yourself, but I would like to know what you believe we can do to ensure that nursing homes aren't subject to that small business contracting requirement, so that they will accept VA reimbursement.

Dr. CLANCY. I will first acknowledge that I have not been burdened by a legal education and say that what I understand from our legal team is that we need a much stronger basis for provider agreements that we have used in the past than we have right now. And we would look forward to working with you on that.

Senator HOEVEN. Well, what we need to get to is, what authority did you have to provide reimbursement and not subject the nursing homes to that requirement? And does it require a statutory fix, in which case, I am more than happy, in fact—

Dr. CLANCY. Yes, it does require a statutory fix, and we will follow up with you with specific language and needs.

Right now, our only alternative, it appears, is to use contracts, which, as you acknowledge, can be very, very difficult for some of the providers who can provide great care to veterans to comply with.

#### PROVIDER AGREEMENT LEGISLATION

Senator HOEVEN. I have legislations to do that. I have talked to Senator Isakson, who is the chairman of the Veterans' Affairs Committee. He's supportive. So I would like to go work with you on the wording and have your support and see if we can't pass that this year.

Dr. CLANCY. Terrific. I will come visit with my general counsel.

Senator HOEVEN. Thank you.

CHOICE ACT'S 40-MILE RULE

The other is, on the Veterans Choice legislation, which I very much support and cosponsored, the challenge that I talked to you about earlier, and that is under the 40-mile rule, we have situations where we have individuals who are within 40 miles of a CBOC, community-based outpatient clinic, but a long way away from a VA healthcare facility where they can get full services.

So in cases where they have proximity of 40 miles or less to that CBOC, they can face long-distance travel to get to medical services that the CBOC doesn't provide, which can be a real problem, versus being able to get those services from a local provider, if they are more than 40 miles away.

So somebody is actually disadvantaged by being within 40 miles. They can be forced, like in our case, in our State, to travel in excess of 300 miles one way to get the health services they need rather than getting them locally when a CBOC doesn't provide them.

So that is a real challenge for us, in terms of the Veterans Choice Act, that we need to address and would like your input on what you think is the best way we can accomplish that.

Dr. CLANCY. So we are working through an array of options right now. Full credit to Dr. Tuchschildt, who is leading this. There are one or two minor tweaks that we could make that I think will help some veterans, but that is actually kind of at the margin.

I think more than that, we are probably going to definitely need your assistance, because we are going to need some legislative change or amendments to make that possible.

And I did come back after our conversation and explain to Jim about the great map in your office with all the pins and that you were illustrating the distances travelled. I get that.

One of the challenges we have right now, and again this gets back to our request for flexibility, for some of the specific examples you gave me, the gentleman who travelled 300 miles to get a shot, for example, not technically eligible for Choice right now, as the law is written, we actually could arrange something through our non-VA care program. Again, that comes out of our budget choices and mandatory separate allocation. That is why we are looking for a little bit of flexibility. But we are looking for relief on the 40 miles, because it has been a big problem for many, many veterans. I can't say we have heard from all of them, but we have heard from many.

Senator HOEVEN. And I think if there is statutory help or flexibility that we can give you there, that is what we want to do. Like I say, I am already working with Senator Moran of Kansas on legislation to do that. But it can actually be a cost savings for the VA because there may be cases, or I think in many cases, getting that procedure close to home may actually save the VA money, versus that veteran travelling to a healthcare center, getting it there, having to travel back, and then all the time and cost to travel and lodging, and/or him or her missing their work and that kind of thing.

So there may be some work we have to do with CBO, but I think this is a fix that, one, serves veterans, two, can be cost-effective.

And we need to nail down what authorities you have, so where can we do this administratively? And we need, you didn't call him an ombudsman, but a person at each of the VA health facilities that can actually provide these decisions for when individuals can get the services at a local healthcare provider, versus traveling to the VA facility.

Dr. CLANCY. Yes. I am not sure ombudsman is quite the right word. But effectively, we have a champion for the Choice program at each facility, so that is a good thing. And we have other people who deal with non-VA care.

Ultimately, I think, we need to have a more logical way for veterans not to have to worry about this and to figure out that they are on the wrong end of the facility. "I went to the wrong department. Now I need to go over here to get what I need." We need to be integrating that in a way that is logical and completely easy for veterans. That is where we need to get to.

Senator HOEVEN. And that is what we need to understand is, do your Choice Champions have enough flexibility to provide the authority to get this healthcare locally when it makes sense, or is there something else that is needed so that you can actually deliver on this?

Dr. CLANCY. That is a process that we are doing a deep dive on right now, to figure out how we can do this and where do we need legislative help, and that includes the 40 miles. So we will be back to you in the very, very near future.

Senator HOEVEN. Thank you.

#### ADDITIONAL COMMITTEE QUESTIONS

Senator KIRK. Thank you.

All right, let's wrap her up. Let me thank our witnesses for coming and tell you that the record will remain open until the close of business on Friday.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

#### QUESTIONS SUBMITTED TO THE OFFICE OF INSPECTOR GENERAL DEPARTMENT OF VETERANS AFFAIRS

##### QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

*Question.* The Veterans Affairs Office of Inspector General (OIG) completed a report in March 2014 regarding the Tomah VA Medical Center in Tomah, Wisconsin. The VA OIG has conveyed that it shared the report with Tomah VA Medical Center leadership. My office contacted the Tomah VAMC on April 7, 2014, on behalf of a constituent and requested a full review and investigation of various concerns, including concerns about opioid and benzodiazepine prescribing practices at the facility. In his response, Mario DeSanctis, Tomah VA Medical Center Director, did not mention the existence of the March 2014 VA OIG Report.

At the March 10, 2015, hearing, Dr. Clancy stated that the director of the facility was told not to share the report with anyone. However, Dr. Clancy further stated that those reports can and should be shared.

Who told Tomah VA Medical Center leadership not to share the March 2014 VA OIG report?

*Answer.* There is some confusion about the difference between administrative closures and OIG final reports. In March 2014, the OIG administratively closed our inspection of the Tomah VAMC. The OIG did not tell the Tomah VAMC leadership not to share the March 2014 administrative closure report with anyone, including the VA Central Office. In advance of a July 3, 2014, briefing with the Tomah VA

Medical Center Director, Tomah VAMC Organizational Improvement Analyst, and Veterans Integrated Service Network (VISN 12)—VA Great Lakes Health Care System Quality Management Officer, an OIG physician sent the Tomah VAMC Director the report of administrative closure. He advised the Tomah VAMC Director that because the report was an internal document, copies should not be distributed to others. A similar advisement was given to the VISN 12 Network Director prior to a briefing on July 16, 2014. This advisement in no way was intended to mean that the contents could not be discussed with or shared with senior Veterans Health Administration (VHA) officials. The intention was to protect the contents from external disclosure because, as an administrative closure, it had not been reviewed for potential redactions by the OIG Release of Information Office for public release under the Freedom of Information Act (FOIA). This is consistent with the OIG's advisement to Senator Baldwin's staff at a July 22, 2014, briefing to submit a FOIA request to obtain the administrative closure. The version provided to Senator Baldwin on August 29, 2014, and subsequently posted on the OIG Web site on February 6, 2015, contained redactions by the OIG Release of Information Office pursuant to the Freedom of Information Act.

We also note that advisements against external distribution of draft reports are routine. For example, OIG draft reports issued to VA officials for comment bear the following warning:

"This is not a final OIG report and is subject to revision. Recipients of this draft report must not, under any circumstances, show or release its contents for purposes other than official review and comment. It must be safe guarded to prevent publication or other improper disclosure of the information it contains. This draft and all copies of it remain the property of the OIG."

While the administrative closure report was not initially sent to VHA Central Office officials when it was sent to the Tomah VAMC and VISN 12 Network Directors, VHA Central Office staff were well aware of the allegations since April 13, 2011. The OIG Hotline sent an information copy of the allegations to staff in the office of the Deputy Under Secretary for Health for Operations and Management at VHA Central Office on April 13, 2011, when the OIG Hotline sent a case referral to the VISN 12 Network Director for review, fact-finding, and potential corrective action.

The issues under review at Tomah were the frequent subject of discussion at regular OIG-VHA monthly meetings between the Assistant Inspector General for Healthcare Inspections and senior VHA Central Office staff, to include the VHA Chief of Staff and VHA Management Review Service (MRS) Director. In addition, on March 11, 2014, the Assistant Inspector General for Healthcare Inspections provided VHA Central Office senior staff with a list of open complaints that the OIG was working (including Tomah) and the major topic of concern (medication management, pain management, quality of care) to further their ability to take whatever action they deemed appropriate. The Tomah administrative closure was signed a few days later on March 14, 2014.

*Question.* Please describe the VHA's current policy for the sharing of OIG reports that are distributed to local VA facilities. In addition, please include answers to the following questions:

*Answer.* The liaison office between VHA and the OIG is VHA's MRS, which is located in VHA Central Office. The OIG sends MRS copies of all draft OIG reports that deal with VHA including reports by the OIG's Office of Healthcare Inspections on individual facilities. We request that any comments to OIG draft reports from the facility or the VISN be routed through MRS so as to ensure that VHA Central Office is aware of the report. VHA will provide more detailed information on their internal practices directly under separate correspondence.

*Question.* Are local VA facilities currently directed to make OIG reports available to the public?

*Answer.* OIG draft reports are considered pre-decisional and as such include the following warning when the report is with VA officials for comment:

"This is not a final OIG report and is subject to revision. Recipients of this draft report must not, under any circumstances, show or release its contents for purposes other than official review and comment. It must be safe guarded to prevent publication or other improper disclosure of the information it contains. This draft and all copies of it remain the property of the OIG."

With regard to a final OIG report, the standard distribution list includes the Veterans Health Administration in VHA Central Office for all reports whether they are national reports or a report on a single facility. If it is a single facility report, the

Director of that facility and the VISN Director who has management oversight of that facility are included in the distribution. Also included in the standard distribution list for all OIG reports are all OIG oversight committees and the Members of Congress who represent the facility or who may have constituents who use the facility. The OIG electronically distributes the final report to all addresses at the same time. This is how reports are routinely published. We also post all final reports on our public Web site the same day as they are issued to VA. Members of the public who subscribe to the OIG's email distribution program or to our Really Simple Syndication (RSS) feed, which automatically downloads new content when posted to our Web site, also receive reports at the same time the reports are issued.

The Tomah Administrative Closure was not processed this way because it was not a final report. As stated above, the closure was provided to facility and VISN management prior to a conference call and a meeting with OIG staff. When Senator Baldwin's office contacted the OIG about a similar issue, we communicated to her office that the OIG had performed an inspection, held a teleconference briefing, and subsequently provided a copy of the report to that office as allowable under the Freedom of Information Act and the Privacy Act.

The OIG has changed its policy regarding administrative closures in March 2015. As a result of a review of OIG decisionmaking practices on closing reviews administratively, the then-Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and the Release of Information Office. This process will ensure consistency in decisionmaking regarding when and how public release of related documents is handled.

*Question.* Are local VA facilities currently directed to share OIG reports with Members of Congress?

*Answer.* For final OIG reports, the OIG shares the report according to a standard distribution list that includes the OIG's oversight committees and Members of Congress who represent or have constituents who may use the facility or facilities that are the topic of the report.

*Question.* Are local VA facilities currently directed to share OIG reports with congressional committees with jurisdiction over the VA?

*Answer.* For final OIG reports, the OIG shares the report according to a standard distribution list that includes the OIG's oversight committees and Members of Congress who represent or have constituents who may use the facility or facilities that are the topic of the report.

#### SUBCOMMITTEE RECESS

Senator KIRK. We will also have our next hearing on Tuesday, March 17.

I close this hearing. Thanks, everybody.

[Whereupon, at 4:12 p.m., Tuesday, March 10, the subcommittee was recessed, to reconvene Tuesday, March 17, at a time subject to the call of the Chair.]