

**ASSESSING THE IMPLEMENTATION OF THE
VETERANS ACCESS, CHOICE, AND
ACCOUNTABILITY ACT OF 2014**

HEARING

BEFORE THE

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

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ASSESSING THE IMPLEMENTATION OF THE VETERANS ACCESS, CHOICE, AND AC- COUNTABILITY ACT OF 2014

Thursday, November 13, 2014

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

The committee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Denham, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, McLeod, Kuster, O'Rourke, Walz.

Also Present: Representatives Murphy, LaMalfa.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. If everybody could take their seats, please. The committee will come to order. Welcome back, everybody. It is great to have you back. Appreciate everybody joining us for this full committee hearing, an oversight hearing today.

I want to ask unanimous consent that several of our colleagues be allowed to join us at the dais, Representative Murphy from Pennsylvania and Representative LaMalfa from California. They have asked to join us, and I would ask unanimous consent. Without objection, so ordered.

As everyone sitting around this dais today is aware, on the 7th of August, the President signed into law the Veterans Access, Choice, and Accountability Act of 2014, which is now Public Law 113-146.

This law was carefully and thoughtfully crafted after months of aggressive oversight by this committee to address the unprecedented access and accountability scandal that had engulfed the Department of Veterans Affairs following allegations, that were first uncovered in this room, that some VA medical center facility leaders were keeping secret waiting lists in an effort to manipulate wait time data and ensure their own executive bonuses.

We are here today to evaluate the progress that VA has made to implement this law in accordance with both statutory requirement deadlines and congressional intent. This includes the effective and timely implementation of the Veteran Choice Program that was designed to provide relief to veterans who reside 40 miles or further from a VA facility or who cannot get a timely appointment.

It also includes the required independent assessment of VA's healthcare system which, in my opinion, should necessarily inform decisions about staffing and infrastructure that are to be made under the law.

Finally, and most importantly, it includes accountability, on which I will focus my remaining remarks. Section 707 of the law authorizes the secretary to fire or demote senior executive service employees for misconduct or poor performance.

It should go without saying that veterans deserve the very best leadership that our government has to offer. Yet, the events of the last year have proven that far too many senior VA leaders have lied, manipulated data, or simply failed to do the job for which they were hired.

It is also clear that VA's attempt to instill accountability for these leaders has been both nearly nonexistent and rife with self-inflicted road blocks to the reform that each of us expects.

When I originally drafted this provision, I believed that it would provide Secretary McDonald with the tools that he needed and wanted to finally hold failing leaders accountable. When President Obama signed it into law, he agreed by saying, and I quote, "If you engage in an unethical practice, if you cover up a serious problem, you should be fired, period. It shouldn't be that difficult," end quote.

Based on these comments, as well as similar statements by Secretary McDonald, I am both perplexed and disappointed at the pace at which employees have, been held accountable.

Even more worrisome is what Secretary McDonald said on November 6th, and I quote, "The new power I was granted is the appeal time for senior executive service employee of the VA has been reduced in half. That is the only change in the law. So the law didn't grant any kind of new power that would suddenly give me the ability to walk into a room and simply fire people," end quote.

Now, it is clear that the secretary and those advising him remain confused about what the law actually does which is much more than simply reduce the appeal time. The secretary can't simply walk into a room and fire an SES employee without evidence warranting that action. But the law does give him the authority to remove that employee for poor performance or misconduct.

The secretary has also cited a plethora of numbers that he says illustrates the department's commitment to holding individuals accountable. For example, he says there is one list of a thousand names of employees being removed and another list of 5,600 names of employees being removed and yet another list of 42 names of senior executives that VA is proposing action on.

So let me take a moment and try to set the record straight. Based on a briefing that VA provided to committee staff yesterday, VA only has one year of aggregated data on disciplinary actions taken against any of its over 330,000 employees making meaningful comparisons against previous years impossible.

Further, the list of over 5,000 mentioned by the secretary is a list of proposed disciplinary actions only and the list of over 1,000 is a list of proposed removals for any type of poor performance, and not necessarily connected to the debacle that we have discussed at length in this committee. Only the list of 42 provided at my request

on a weekly basis includes employees proposed for discipline due to the crisis, which has engulfed the VA over the last year.

What is more, since August 7th, only one SES employee has been removed under the new law and this person's removal was not directly related to patient wait times or data manipulation. I do not understand, in the wake of the biggest scandal in the history of the Department of Veterans Affairs, how just 42 employees, only four of which appear to be senior executive individuals, have been proposed for discipline with none yet removed.

Further, VA has taken the liberty of creating an additional bureaucratic office, the Office of Accountability Review, to review proposed removals and an have created additional bureaucratic delay, a five-day advanced notice of removal which essentially operates like a new internal appeal process.

These questionable actions are nowhere to be found in the law that we wrote and the President signed. In my view, the five-day advanced notice of removal only serves to incentivize poor-performing senior leaders to drag out the disciplinary process while continuing to collect a hefty paycheck or ultimately retiring with full benefits.

Further, it perpetuates the perception that VA cares more about protecting bad employees than protecting the veterans of this country. We should not be providing credit towards a taxpayer funded pension for a time period during which an employee's action caused harm to a veteran.

That is why I am going to be introducing a bill that would give the secretary the authority to reduce a SES employee's pension to reflect the years of service during which they participated in actions that made them subject to their removal.

This proposal is a fair and equitable way to emphasize to poor-performing senior employees that retirement credit is not earned by failing veterans and that their actions have long-lasting and meaningful consequences.

I am not going to get into individual personnel actions at this time since there are serious legal issues at hand that must be dealt with respectively and appropriately. However, I want to make it clear today that I continue to have serious concerns about accountability at the Department of Veterans Affairs in response to what is without a doubt the largest scandal that has ever impacted VA. I am not seeing the corresponding efforts to hold those at fault accountable for their actions.

Deputy Secretary Gibson, as we discussed on the phone yesterday, I have an increasing worry that Secretary McDonald and you are simply getting some bad advice from some of those around you within VA's bureaucracy. I just hope that is not the case.

This is the same issue that I think doomed Secretary Shinseki's tenure. I hope you take my suggestion seriously when I tell you that VA's entrenched bureaucracy must be shaken up in order for any true reform, reform that is so desperately needed to better serve our veterans, to succeed.

I truly appreciate your service and for you being here this morning.

And with that, I now recognize and welcome back the ranking member, Mr. Michaud, for his opening statement.

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

OPENING STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman, for having this very important oversight hearing.

We are here today to get an update from the Department of Veterans Affairs on the implementation of the Veterans Access, Choice, and Accountability Act of 2014. This law, as you know, was passed in August, addressed a number of serious issues the department had with providing timely, quality healthcare to veterans. Long wait times are the problems that got us where we are today.

We shouldn't make veterans wait for the solutions to be implemented. While today is a first public update of the VA's implementation of this law, staff level updates have been occurring on a regular basis since early September.

So I would like to thank you, Dr. Tuchsmidt and Mr. Giddens, and I appreciate the time you have invested in openly communicating with the staff on both the House and Senate side of the committee on the implementation issues and the progress you have been making on those implementation issues.

This is a marked change in the VA congressional relations and I hope that it is a precedent for improving working relationships as we go forward.

The law provided additional resources and authorities to provide for key improvements for veterans, timely access to healthcare, expansion of VA's internal capacity for care, improved accountability, and additional educational benefits.

Today I hope to hear tangible ways veterans are getting the improved outcomes intended. If there are real and reasonable road blocks to implementation, we need to know what they are and how can we fix those road blocks.

With regard to timely access to healthcare, I am aware that the department has expressed serious concerns with the 90-day deadlines under Section 101, the Choice Program. The program requires VA to determine eligibility, authorize and coordinate care, manage utilization, set up a call center, and implement a new payment system.

VA has taken a phased rollout approach in order to balance expedience with effective programs. This may be reasonable, but I want to understand the overall timing and how the Department of Veterans Affairs is handling eligible veterans' access to care through the phased approach. A phased approach to administrative rollout may be okay, but a phased approach to access to care is not.

The law provides \$5 billion for the department to augment staffing and infrastructure. I know the secretary has personally been out recruiting, and I look forward to hearing how successful that effort has been and how many new doctors and nurses VA expects to bring on board and when they expect to bring them on board.

I am also interested in hearing how VA will implement the funds and authority for new infrastructure. We have seen many problems with the Department of Veterans Affairs, constructions problems in the past, and I look forward to hearing the changes VA is making

to the process in order to deliver these new projects on time and within budget.

With regard to accountability, I understand that removing a federal employee is not as simple as many think it should be even with the new authority in the law. I appreciate the difficult position the department is in when it comes to holding employees accountable for wrongdoing and poor performance in a highly charged and very public environment.

That being said, we need to feel that the Department of Veterans Affairs is taking the necessary action to move swiftly as possible and decisively as possible to get rid of those employees who failed the American veterans. The explanation for delays need to be clear, concise, and compelling not just to Congress but to veterans and the American public.

And while much of the focus of the law has been on access and accountability provisions, we should not forget that the law also includes substantial enhancements to the education benefits for veterans and their families, and I look forward to hearing what is being done to implement these provisions of the law as well.

And beyond the Veterans Access, Choice, and Accountability Act of 2014, I know Secretary McDonald has announced a number of reforms aimed at addressing the cultural and structure of the Department of Veterans Affairs. Many of these reforms reflect ideas we have discussed in the past and I am pleased to see them being embraced and actively pursued as well.

And I would encourage the secretary to quickly define detailed execution plans for these concepts and not get stuck in analysis and processes and figure out what actions need to be taken and then take them. Be fearless enforcing these reforms just as our Nation's veterans are fearless in their battles.

Once again, I want to thank the panel for appearing before us today. Look forward to hearing your testimony. We appreciate your time and effort and want to thank each of you for all that you are doing to make sure that our veterans and their families get the access to quality care in a timely manner for our veterans.

I know you have been under a lot of pressure over the last year and look forward to hearing how the new law actually helps relieve some of that burden in what you are doing administratively to help complement the law that was passed and signed by the President.

So, once again, thank you very much, and thank you, Mr. Chairman. I yield back the balance of my time.

[The prepared statement of Ranking Member Michael Michaud appears in the Appendix]

The CHAIRMAN. Thank you very much.

Today we are going to hear from one panel already seated at the table. Joining us from the Department of Veterans Affairs, the Deputy Secretary, the Honorable Sloan Gibson. He is accompanied today by Dr. James Tuchschildt, the Acting Principal Deputy Under Secretary for Health, and Gregory Giddens, the Executive Director of the Enterprise Program for Management Office.

I appreciate you all being here this morning. Deputy Secretary Gibson, please proceed with your testimony.

STATEMENT OF SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JAMES TUCHSCHMIDT, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, GREGORY L. GIDDENS, EXECUTIVE Director, ENTERPRISE PROGRAM MANAGEMENT OFFICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GIBSON. Chairman Miller, Ranking Member Michaud, distinguished Members of the committee, our guiding principles for implementation of the Choice Act have been to do what is right for veterans and to be good stewards of taxpayer resources.

While our challenges are clear, we are turning those challenges into opportunities to improve the care and service we provide to veterans. We are reorganizing VA for success to make sure we maximize those opportunities. We call that reorganization my VA and associated customer service solution that goes along with it because we want veterans to view us as an organization that belongs to them, providing quality care in the ways they need and the ways they want to be served.

My VA entails combining functions, simplifying operations, improving processes, leveraging technology, enhancing efficiency, increasing productivity, and effectively implementing the Choice Act, a 360-degree effort to provide veterans with a seamless, integrated, and responsive VA regardless of how they come to us.

Since May, our top priority has been accelerating care to veterans, moving them off wait lists and into clinics. For example, we have reduced the number of veterans waiting the longest for care by 57 percent.

From June through September, we completed 19 million appointments, an increase of 1.2 million over the same period in 2013. Over a half a million completed appointments were conducted during extended hours of operation, nights and weekends.

We have also improved access using non-VA care. From June to September, we approved 1.1 million authorizations for seven million, more than seven million care appointments in the community. That is about a 47 percent increase from the prior year.

We appreciate the enhanced authorities funding and programs the act provides to ensure veterans have access to healthcare. We will continue to make the best use of them all to get veterans the high-quality care they deserve.

We also appreciate enactment of the Department of Veterans Affairs' expiring Authorities Act of 2014 signed in late September which amended and fine tuned key provisions of the Choice Act. We will continue to work collaboratively with you and your staff to address remaining implementation challenges.

As VA worked through the appropriate rule-making implementation process as required by the law, we conferred frequently with the committee, with veteran service organizations, and with other stakeholders.

We are especially thankful for the opportunity to engage with your staff, Chairman Miller, and those of Ranking Member Michaud and the Senate Veterans' Affairs Committee to under-

stand your intent and to hear your concerns and to work together on making improvements in implementation.

We look forward to continuing this partnership as we implement this complex legislation in a way that allows us to do again the right thing for veterans while being good stewards of taxpayer resources.

Among the challenges that we face in implementing the act's requirements are an estimated \$400 million in unfunded requirements and resources that will be required to implement the provisions of the act over the next couple of years, resources that are not provided by the act.

As mentioned previously, one of the things the act does is it streamlines the process to remove or demote senior executives based on poor performance or misconduct. As Secretary McDonald wrote to the chairman last week, VA is committed to building a culture of sustainable accountability throughout VA. Employees at all levels must understand what VA expects of them in terms of their performance and their conduct and must be held accountable if they fail or refuse to meet those expectations.

I think it is important to understand what the new law does and what the new law does not do. The new law does shorten the time to resolve an appeal. The law does not give VA leaders the authority to remove executives at will. Any removal must still meet stringent evidentiary standards and provide due process. It does not do away with the appeal process.

The law also does not give VA the authority to deprive a senior executive of their property including earned retirement benefits. Only a criminal conviction for treason, sedition, aiding the enemy, or terrorism as provided in statute can deprive a federal employee of an earned benefit.

The objective behind our process, this removal process is for VA removal actions to withstand appeal. If our actions fail to meet the preponderance of evidence standard that the MSPB has established or failed to provide the due process expected under case law, then the Merit System Protection Board will simply overturn the decision, order the employee returned to their position, and direct that their back pay and legal costs be awarded. That would not be what is right for veterans or for taxpayers.

Another critical element of the act is the Veterans Choice Program. As we have discussed with your committee staff during a dozen meetings, VA has identified a number of areas within this section that could present implementation challenges or potentially confuse veterans.

First, there were significant challenges inherent in the 90-day time line. We had to establish a new plan, produce and distribute Veterans Choice cards, determine patient eligibility, authorize and coordinate care, manage utilization, establish new provider agreements, process complex claims, and stand up a call center.

Despite these challenges, VA launched the Choice Program last week with a responsible staged implementation focused on delivering the best possible veteran experience.

Second, we recognize the challenges associated with maintaining continuity of care to ensure the best possible healthcare outcomes

for veterans. This is a vital distinction between the Choice Program and a health plan in the private sector.

As an example, we have made significant investments to provide veterans' access to mental health services in the primary care clinic as part of the holistic, integrated care we want to provide.

As one-third of veterans receiving VA care have a mental health diagnosis, coordinating care including mental healthcare is essential. However, community mental health resources are often readily not available, particularly in rural areas, and are rarely integrated into the private sector primary care experience.

Third, we know that healthcare systems across the Nation face challenges in efficiently sharing treatment information and healthcare records. In order to ensure sufficient continuity of care for veterans who are treated in both VA and non-VA settings, we will continue to work to share information and knowledge with these providers.

Lastly, we modified the 30-day timeliness standard that was set in law for the purpose of Choice Program access to measure wait time from the date preferred by the veteran or the date that is medically determined by their physician.

While this will help ensure that veterans receive timely access to the benefits of the Choice Program, it is not a clinical standard for timely care. To the veteran that needs to be seen today, a 30-day goal is irrelevant. VA's goal will always be to provide timely, clinically appropriate access to care in every case possible in the shortest amount of time possible.

That is really what My VA is all about. We want to provide and veterans to see an organization that belongs to them and provides timely, quality care in the ways they need and want to be served.

We will continue to work closely with the committee on any issues involving implementation of this vital legislation. I thank the committee again for your support. We look forward to working with you in making things better for all of America's veterans.

This concludes my opening statement. Dr. Tuchschildt and Mr. Giddens and I are prepared to answer any questions you or the other Members of the committee may have.

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

The CHAIRMAN. Thank you very much for your testimony.

I am going to jump to the independent assessment for my first question. There has been some criticism that the department hasn't taken sufficient steps to fully meet the intent of Congress with regard to the independent assessment.

VA has only contracted, as far as I know, with MITRE to include their federally funded Research and Development Center, the CMS Alliance to Modernize Healthcare, and the Institute of Medicine. This is not an expert team of independent entities with private sector healthcare expertise as we intended.

Is there any intention to subcontract or competitively compete for industry experts who can effectively assess each of the 12 elements to be covered by this assessment? What, if any, information about the assessment and contracts that have been let have been made public so far? How much money has been expended on the independent assessment to date?

Mr. GIBSON. I will start, Mr. Chairman. I am going to pass it then to Dr. Tuchschiidt. And I expect that some elements of those questions we will have to take for record because I don't think we have got all that data with us.

We actually contracted. The entity that we contracted with, as you accurately stated, is MITRE. The element within MITRE that will be the integrator of the 12 different components of the independent assessment is an organization called CAMH which happens to be an organization, an FFRDC that works closely with the Health and Human Services organization. So we specifically went for an organization that carried the specific qualification of a healthcare organization.

In fact, they will be looking to engage a number of different entities and to ensure that throughout this entire process that what we are doing is tapping into very independent and objective expertise all across the private sector.

Dr. Tuchschiidt.

Dr. TUCHSCHMIDT. Sure. So the part of the assessment that they are doing will be done by the CAMH folks. Some of that, they have partnered with other entities outside of MITRE. So they have partnered with the RAND Corporation to do some of the assessments.

There are some options in there that all the options have been awarded or all of the 11 assessments to the coordinating entity which would be CAMH. They are assembling an expert panel of healthcare executives from private sector across the country, an expert panel that will help guide the assessments that are being done and will help look at the various recommendations coming back from the independent assessments to come together with a unified and common set of recommendations out of that which ultimately we will pass to the commission for their deliberation.

But we thought it was the intention of Congress that this would be independent, so we sought an entity outside of VA to do this. Clearly the law says that if we have different people doing different parts of the assessment we need an integrator. That is what CAMH is.

And I think that the healthcare nature that you want, the expertise that you wanted will be there in this essentially blue ribbon panel that they will be assembling.

The CHAIRMAN. My time is about to expire, too, but I think that we need to sit down and discuss it a little bit. I think Congress's intent was not that a panel would be brought in to testify before this group but that people who were experts in their field would have that opportunity.

While I still have about a minute left, I am referring to the public law. And, you know, the biggest concern that I have about the accountability portion is that there was a 30-day requirement for notice before you removed an employee; is that correct?

Mr. GIBSON. That is provided in Title 5.

The CHAIRMAN. Title 5. And the law removed that. It basically says the procedures under Section 743(b) of Title 5 shall not apply to the removal or transfer under this section.

So where did the five days come from?

Mr. GIBSON. Mr. Chairman, the clear and unequivocal advice from legal counsel has been——

The CHAIRMAN. Wait, wait. Okay. It is counsel. Okay. But the law is clear. The law says there is no period for appeal on the front end, but there is on the back end.

Mr. GIBSON. The case law is very clear that we have to provide a reasonable opportunity to respond to charges. And as you note, under Title 5, that is 30 days. That was shortened to five days. The view is that if we fail to provide that opportunity to respond that the MSPB will view that as a failure to provide due process——

The CHAIRMAN. But, Mr. Secretary, please——

Mr. GIBSON [continuing]. And, therefore, overturn the decision.

The CHAIRMAN [continuing]. Please. If we had intended for there to be an appeals process at the beginning and we put it in at the end, why didn't you just keep it at 30 days? If you are not going to follow the law as it is written, why did you come up with this phantom five-day appeal?

Mr. GIBSON. We came up with five days because we understood that the intent of Congress was to move expeditiously, but we also balanced that against the requirement to provide due process or risk that our decisions be overturned. That simple.

The CHAIRMAN. I understand the risk part, but the secretary keeps going out and saying the law needs to be changed if we want people to be fired immediately. No, it doesn't. The law is clear. It says they should be fired.

Now my question is, should somebody continue to accrue benefits while they await disciplinary action which includes being fired? If you think so, justify that and, if not, will you help me change the law to prevent that from occurring because the taxpayers are tired of paying bonuses and benefits to people who are not serving veterans?

Mr. GIBSON. The law requires that federal employees be paid until a disciplinary action has been effected which, in fact, is in this case a removal decision, not a proposed removal, but a removal decision. As soon as that removal decision is made, they no longer are compensated and they no longer continue to accrue benefits.

The CHAIRMAN. Why can't you remove somebody without pay, suspend them without pay? Why do you allow them to continue to accrue that benefit when you know there is a problem? Just from a personnel standpoint, why don't you or why can't you do that?

Mr. GIBSON. Suspension without pay is a disciplinary action that would be subject to review by the Merit System Protection Board. Again, if we take action, disciplinary action without evidentiary support, we are going to find that that gets overturned.

The CHAIRMAN. Has anybody that has been involved been suspended without pay?

Mr. GIBSON. No. It is disciplinary action.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much.

Just to follow-up on that same line, so if I understand you correctly, what you are saying is even though we have loosened to give you more authority to discipline employees, the concern you have if you fire someone or discipline them and you move too quickly, then that actually could be overturned?

Mr. GIBSON. It is not literally moving too quickly. There are two requirements. The MSPB in their implementing regulations stipulated that we are required to meet the preponderance of evidence standard whether it is removal for misconduct or removal for performance.

And so that is one piece. We have to have evidence. The second piece is that we believe case law is clear that we have to provide a reasonable opportunity to respond to the charges.

What we are talking about here is five days, five days to be able to protect these actions, we hope, from an overturn on appeal for our failure to provide due process.

Mr. MICHAUD. And do you think five days is long enough?

Mr. GIBSON. Obviously we think it is because that is what we proposed. We felt like it was the appropriate balance between what is provided in Title 5 and the intent of Congress.

Mr. MICHAUD. Okay. Thank you.

I understand that the Choice cards are being rolled out in phases right now. For veterans who have waited longer than 30 days on a wait list but have not yet received their Choice card, what is VA doing to reach out to those veterans to let them know that they are eligible?

Mr. GIBSON. Many of those veterans are already being called to determine whether or not they want to exercise their option for Choice. We are going through the entire list of veterans that are waiting more than 30 days, uploading those to what we call the Veterans Choice list so that we hope as early as next week we are able to activate the 30-day group as well and be able to contact those veterans to schedule appointments or to offer them that choice.

Mr. MICHAUD. And of the veterans who are in the Choice Program, do you have any sense on how long it took them to get an appointment?

Mr. GIBSON. I don't know if I understand your question.

Mr. MICHAUD. As far as the veterans that are in the Choice Program that are going to try to get an appointment, do you know how long it is taking them to get an appointment?

Mr. GIBSON. We are still only about five or six days into implementation of the program, so we know that we see the number of calls that are coming in every day, the number of authorizations, and the appointments are beginning to be scheduled. There is a standard stipulated within the contract within which they have to get that appointment scheduled.

How many days, Jim?

Dr. TUCHSCHMIDT. So the authorization has to be made within five days and an appointment within 30 days. We have only had about a week's worth of experience. I can tell you as of yesterday, I think we had about 6,000 of the people in the 40-mile group, here was about 320,000 people in the 40-mile group, had about 6,000 of those contact either Health Net or TriWest. And I believe that first week we have had something around maybe 40 appointments scheduled.

Mr. MICHAUD. And are you keeping an eye to make sure that what the private sector is not going to do, what some of the VA fa-

cilities have done as far as gain in the system on timeliness? Do you have metrics in place or measures in place?

Dr. TUCHSCHMIDT. We do have metrics and we, of course, will be auditing and monitoring what goes on with third-party administrators. I have to say that both of them, both TriWest and Health Net have done an amazing job of really helping us stand up this program in the time frame that we had. And I believe that they are sincerely doing everything in their power to make sure that those veterans are referred into the community.

As you know, sometimes waits in the community are also long. So one of the, I think, tests when the rubber hits the road here is what is the capacity in private sector to really absorb patients in a more timely way than we have been able to provide that care.

Mr. MICHAUD. Thank you.

And how is VA tracking the use of the \$10 billion that had been allocated for the Choice Program?

Mr. GIBSON. All of that will be accounted for separately under the Choice program. This is actually a mechanism very similar to what we set up back in May for the accelerating care initiative where we were allocating specific amounts of funding out into the field.

So we had already established a separate accounting chain to be able to track and record all this information so we will know exactly at any point in time what has been expended and ensured that that only been expended for those Choice Program activities.

Mr. MICHAUD. Great. Thank you.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Lamborn, you are recognized for five minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Mr. Secretary, you have said that an SES employee cannot be fired without what the chairman called a phantom five-day notice period. This is not required within the letter of the law, the bipartisan law that Congress just passed and the President just signed.

As long as poor performance has been documented, I believe and I think the committee believes there is no need for a five-day notice period. In effect, this amounts to an additional appeals period. There is an appeals period that the new law allows for and that the old law, slightly different terms, allowed for as well.

So no one has been fired for poor performance. Maybe some will re—excuse me, for the data manipulation like we saw in Phoenix, Arizona that I am aware of. Correct me if I am wrong. And there is now two appeals processes, a five-day and then the existing or the new appeals process after a person gets notice.

And in addition to that, you are setting up a new office to review administrative removals, and I heard that this new office is going to have up to 30 people in it. So not only has no one been fired for data manipulation and you say the law doesn't allow for an immediate firing. As long as poor performance has been documented, we believe the law says that, and the chairman made a very eloquent description of what the law says, but you are setting up a new layer of bureaucracy with up to 30 people in this new office.

This is what sends a bad message to the public and to veterans and to employees, poorly performing employees at the VA. Nothing is being done.

And how could the law be any clear—that is my first question to you—how could the law be any more clear that someone, as long as poor performance has been documented, can be removed by the secretary without a notice period? How can we make the law more clear than it already is?

Mr. GIBSON. Well, let me answer with a question of my own. Do you want to propose removal of employees that is overturned on appeal?

Mr. LAMBORN. I would like it to survive on appeal.

Mr. GIBSON. We would too. And so we have adopted a process that allows us to meet the evidentiary standard and that we believe will withstand the appeal process with the Merit System Protection Board.

Mr. LAMBORN. You are adding to what the law says though.

Mr. GIBSON. That and nothing—

Mr. LAMBORN. You are adding to what the law says, Mr. Secretary.

Mr. GIBSON. The law isn't just what is sitting in the statute. The law is also the case law that has evolved over a period of years around the removal of federal employees. And the case law is very clear. We have to provide a reasonable opportunity to respond to the charges. And if we fail to do that, we are going to be vulnerable to these decisions being overturned on appeal.

Mr. LAMBORN. But there is an appeals process. There was under the old law and with modifications, there is still one under the new law.

Mr. GIBSON. This is not an appeal process. It is an opportunity to respond to the charges. That is what it is. It is not an appeal process.

Mr. LAMBORN. So what happens during the five days is not an appeal?

Mr. GIBSON. It is not an appeal process. It is an opportunity, a reasonable opportunity to respond to the charges. That is all it is.

The CHAIRMAN. Or resign or retire.

Mr. GIBSON. Let me also make a comment here. The issue has come up a couple of times about the Office of Accountability Review. I am the person. So if somebody doesn't like what we did there, I am the person that you need to blame for that.

There were comments that you made, Mr. Chairman, and you were absolutely right. I think historically we fail to hold people accountable for misconduct and for management negligence in the organization.

And so as we waded into this situation where we had at the peak, I think, 95 or 97 different IG reviews underway all across the organization, we realized, A, that we were going to have a large number of disciplinary actions to consider and, B, where we knew that we were going to have to go through a process of recalibrating accountability within the organization.

And, quite frankly, I was not willing to take those actions as they came out of the end of the IG's pipe and turn them over to VHA as normally would have been the practice in the past. You would

return those to VHA and go form an administrative investigative board and do your own investigation, come up with your own charges and decisions.

Mr. LAMBORN. Mr. Secretary—

Mr. GIBSON. I did not believe that that was adequate.

Mr. LAMBORN. Mr. Secretary, my time is about up. In the view of this Member of Congress, you send the right message to the country, to veterans, and to poorly performing employees by removing them, not giving them an additional appeals process of five days and not setting up a new layer of bureaucracy.

Mr. Chairman, I yield back.

Mr. GIBSON. We are going to send the wrong message to veterans if we wind up having our removal decisions overturned on appeal because there is no further appeal after that. They come back to us and we have got no recourse at that point. We are stuck with them. We are not able to take any additional disciplinary action. We make up all their back pay, all of their legal costs, and I don't think that is what veterans want or expect and I don't think that is what taxpayers expect.

The CHAIRMAN. Mr. Secretary, I wrote a letter to Secretary McDonald and asked for specific statute or case law that led to the department creating the requirement for the five days. I got a response, but I got no case law and I got no statutory requirement.

In his response, he said it would be unconstitutional to fire a career employee without telling him or her why and providing them with an opportunity to respond. Obviously you are going to tell them why when you walk in and you fire them. They have an opportunity to respond after the fact.

Again, we will beat this thing, til the sun goes down and we are going to get up the next day and we are going to be doing it again.

What I perceive you doing is when you give them five days, if that person wants to quit, they just quit. In the past, VA has said that is a disciplinary action. Something has happened. They are not in VA anymore. Well, that is not a disciplinary action.

That person goes on to another agency somewhere in the federal government or they put their papers in and they retire with all the whistles and bells just like happened in Georgia where there was this great fanfare. This person did 42 years of great service. When they knew they were going to be fired, they went ahead, because they had that five-day notice.

So that is the concern that we all have and I think we will all work together in trying to fix it. You claim there is a constitutional requirement. We don't believe that there is. It may take going all the way to the Supreme Court to figure it out, but I think the taxpayers deserve accountability swiftly and correctly. You wouldn't take the effort to fire somebody if you didn't have it. I trust you there.

So, you know, again, I am perplexed, but several other people are probably perplexed as well.

Ms. Kirkpatrick.

Mr. GIBSON. I will see that we provide you the case law, Mr. Chairman.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

Thank you, Under Secretary, for being here today.

My two questions are going to be about critical pieces of the Choice Act. But before I ask my questions, I just want to say that I find it outrageous and my constituents find it outrageous that Sharon Helman is still collecting her salary of \$170,000 after being put on leave in May. And we just want you to know that we are calling for her immediate firing. We want that to happen immediately.

Now I will go to my questions. A critical piece of the Choice Act is the \$5 billion that we provided for the hiring of new medical professionals, but it is a competitive environment out there. We know that.

And so my question really goes to the hiring process and here is why, because if I am a physician's assistant or a nurse and I want to work at the VA and I apply, but it takes six weeks, three months, six months, a year to process my application, I have got to be working, so I am going to find a job somewhere else.

So what are you doing to be competitive within the hiring environment for these medical professionals?

Mr. GIBSON. A couple of things. One, we know we have got extensive opportunities to streamline our hiring processes with providers. Bob McDonald recently approved increased salary ranges for providers to allow us to be more competitive to attract and retain great talent.

I am aware of instances on a case-by-case basis across the country where particularly, for example, with nurses, we have gone in and done market surveys in order to be able to justify changing salary ranges in that particular market area.

We are looking now at doing that same process all across the country in every market to ensure that, in fact, what we have got are salary ranges that are competitive.

We are taking a hard look at the credentialing process and, in fact, ultimately we will move to the same system that the Department of Defense uses for documenting credentialing so that we are able to work very transparently between the two systems.

No doubt that we have got opportunities to streamline. The other thing that we have been doing as part of the push for accelerating care is to accelerate our hiring activity. Oftentimes we wait until the position is vacant and then we study it for a while. We bring it to some kind of a board and then the board finally decides and it is months before we even post the position.

Now we actually, particularly for certain positions, hire into turnover so that we are already out there recruiting and hiring in anticipation of the turnover.

We looked specifically at hiring activity during the second half of 2014, the months from April through September, and I think most of this really happened in the last four months of the year. Net increases in nurses, 1,700, 600 net increase in doctors, 700 net increase in schedulers, all across the organization.

So material improvement, meaningful improvement there in the staffing levels, and we will keep after that. But to your point, we have got continued room to improving the process.

Ms. KIRKPATRICK. Thank you.

My second question goes to the Choice Program. I know that you are sending out the Choice cards now. My concern is that a lot of

rural veterans have post office boxes and what I am hearing is that a letter is first sent to them. They have to verify their post office box.

Here is the problem in my district. I think there is an assumption that they have to go pick up a utility bill. But in my district, we have thousands of veterans who don't have running water or electricity. They rarely go to their post office box because there is nothing there.

What are we doing specifically to reach out to those veterans who have post office boxes? And let me just say that the VSOs have offered to help reach these veterans, actually physically go out to their homes. And so I would just like your thoughts and comments about that.

Mr. GIBSON. Sure. We are actually in the process of sending letters to all of the veterans whose address, post office box address would suggest that they may reside more than 40 miles from the nearest VA medical facility, offering them several different, as easy as possible ways in order to be able to give us their residential address so that we can determine definitively their eligibility, not their eligibility, their access to the benefit under the Choice Program.

I had not considered instances where veterans don't go to their post office box or the opportunity for us to enlist the help of VSOs. That is a wonderful idea and we will pursue that.

Ms. KIRKPATRICK. Thank you very much.

I yield back my time.

The CHAIRMAN. Thank you.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

Thank you, Mr. Secretary, for your attendance and your testimony.

A sum of \$5 billion was appropriated in the VA reform bill to increase the hiring of physicians and other medical staff to improve VA's physical infrastructure. However, no report has been given to Congress, to my knowledge, by the VA on how the department intends to use the funds.

Without the proper staffing assessment, how does the department know how many positions and which facility will yield optimal benefits for veterans seeking the quality of care they have earned and deserve?

Dr. TUCHSCHMIDT. Sir, I think we have shared our preliminary information with your staff on our intentions for the spend plan, but we will be sharing a formal plan with you as soon as that is ready.

Mr. BILIRAKIS. Well, when do you anticipate that being ready?

Dr. TUCHSCHMIDT. Probably within the next couple weeks here it should be finalized, I would think. We are putting a document together that not only has the plan but kind of exactly what each of those line items entails and some information about it so that it is more than just looking at a spreadsheet.

We currently have plans to hire about 9,600 staff with that money. Some of the money is for staffing. Some of the money is set aside for IT-type things. So when we hire a new person, they have

got to have a workstation to sit at. And when we have new space, we have to put, you know, LANs, WANs, and cabling and all that other stuff in there.

And then the balance is really for leases and NRM projects and those kinds of things. But we plan to hire about 9,600 staff across the country. We have gone through a very detailed process of literally reaching out to each medical center, asking them to look at what additional staff they need or space, for that matter, to improve access and specifically how will it improve access. And then that plan has been aggregated at a national level.

Mr. BILIRAKIS. How far along are you with that? I mean, have you reached out to every medical center in the country?

Dr. TUCHSCHMIDT. Every medical center is done. That work is basically done and it is now being put together in a final plan that is in draft form right now.

Mr. BILIRAKIS. Who makes the determination as to what staffing, the regional Director, which staffing is needed as far as the services provided?

Dr. TUCHSCHMIDT. We have asked the facility, each facility to come up with that plan, that it be aggregated at the VISN level, and then come back to us.

Mr. BILIRAKIS. When you mention facility, is that hospitals, clinics—

Dr. TUCHSCHMIDT. Hospitals.

Mr. BILIRAKIS [continuing]. CBOCs? Just hospitals?

Dr. TUCHSCHMIDT. The CBOCs all work for the facility, right? So we have asked the facility leadership to take on that project.

Mr. BILIRAKIS. Okay. Thank you.

Mr. Secretary, included in the Veterans Access, Choice, and Accountability Act, it authorized 27 facility leases including one in Pasco County, Florida. Authorizing these leases will surely improve the timeliness for veterans to receive the care they need in my district and in 17 other states around the country.

While I am encouraged that veterans in my district will have the option to visit a one-stop consolidated clinic, I remain concerned regarding the time expected and the completion of these facilities.

What is the process for VA to keep members who have these leases in their districts apprised of the progress of these initiatives and what engagement with the community of the leases does the VA intend to conduct to ensure the necessary services will be offered at these various facilities?

Dr. TUCHSCHMIDT. So we have a number of leases that we are standing up. We have two that are in the works right now and then we have a number that will be coming in fiscal year 2016. We will absolutely be working through the process with the community and the stakeholders in the community both to find property in the first place and to make sure that the services that are being placed there are appropriate.

Mr. GIBSON. Let me jump in, Jim.

Dr. TUCHSCHMIDT. Yes.

Mr. GIBSON. You know, the other issue, I happen to agree with you, it takes too long to get these off the ground. And so we have looked at the typical time line from where we are right now with

an authorization in place to completion. It is as long as four or five years. And I think that is unacceptable.

We have already visited with OMB. They are going to work with us on finding ways to compress that time line to be able to accelerate that. We are already doing things with standardized design so that we are not reinventing design with each facility that we go look at.

To your point, we have got to work through the site selection issues because those oftentimes add an awful lot of time and effort to the overall process, but we have got to find ways to deliver these more quickly. My guess is that in the private sector, they would be able to go from where we are to a completed facility in three or four years. We have got to find a way to do it faster.

Mr. BILIRAKIS. Thank you, Mr. Secretary. I want to ask you a couple questions.

Just briefly, Mr. Chairman, with regard to this, just follow-ups. Will you assure me that the community will have input—

Mr. GIBSON. Yes, absolutely.

Mr. BILIRAKIS [continuing]. On the site location?

Mr. GIBSON. Yes.

Mr. BILIRAKIS. And the services provided, the future services provided—

Mr. GIBSON. Yes.

Mr. BILIRAKIS [continuing]. The additional services? You will assure me of that?

Mr. GIBSON. Yes. Yes.

Mr. BILIRAKIS. All right. Thank you, Mr. Chairman. I appreciate it. I yield back.

The CHAIRMAN. Dr. Tuchs Schmidt, did you say they would be initiated in 2016 or they would be finished in 2016?

Dr. TUCHSCHMIDT. I think that the contracting action happens in 2016. We are not going to have anything. Out of these 27 leases, we are not going to be seeing patients at any of those facilities in 2016.

The CHAIRMAN. Again, but you are going to start the contracting in 2016?

Dr. TUCHSCHMIDT. No. Looking down through the 27 leases that we have got here—

The CHAIRMAN. Leases that are already way, way, way behind.

Dr. TUCHSCHMIDT. And what we will do is work through the finalization of the requirements to inform the design process. That then sets the stage for the contracting action to commence. Somewhere in there, we have got to get GSA to delegate authority for us under these leases. They have to delegate everything.

Seventeen of the 27 leases are actually above GSA's authority to delegate, so we have got to figure out some way to work around those particular issues and then we have got to give the contractor, whoever we wind up contracting with the time to build the facility.

The CHAIRMAN. Okay. Thank you.

Dr. Ruiz.

Dr. RUIZ. Thank you. Thank you, Mr. Chairman, ranking member.

Our veterans have spoken and I join them in their message in saying that anything less than the highest standard of healthcare

that is veteran centered will not be tolerated. In implementing the Veterans Access, Choice, and Accountability Act, that must be the sole standard by which we judge ourselves.

I hosted a workshop that educated 70 medical professionals in high-demand specialties for the VA in my district about how to work with the VA Loma Linda and TriWest to provide veterans with healthcare in their communities. Our goal was to get more veterans high-quality, veteran-centered care and recruit physicians to see our veterans in the community. And we will continue to speak with the medical professionals that attended to measure the success of the event.

I received a call from Secretary McDonald, which I really appreciate, to discuss the event and I shared with him the lessons that we learned. And I think that it is important that we discuss these lessons learned so that all of us on the podiums here can implement these in our own district as well.

But based on the feedback that we got with the debrief and the phone calls that we did, the three take-aways was, one, our physicians don't even know who to begin to call, so there is not a very clear streamlined understanding of who can they call to sign up for TriWest or Loma Linda VA folks.

So I think helping them navigate the system very clear and concise and streamline is very important and I think that creating a how-to guide and frequently asked questions and answers about how they can provide care to veterans would be very beneficial and start putting it out there now and standardizing that around the country.

And I will continue to hold these workshops and collaborating, and I look forward to working with all of you so that we can create benchmarks that can be replicated throughout our country for our veterans.

However, we can't recruit physicians in areas that have shortages already to begin with, areas in rural America where that is where we need the physicians in the VA to begin with. In my area, I represent Riverside County, which has the ninth largest veteran population in the country, more than 50,000 veterans reside in my district.

But, unfortunately, the Inland Empire where I am from in Southern California has one of California's lowest numbers of physicians per capita. So we definitely have a physician shortage plan. And I understand part of the law is to recruit more physicians through GME programming.

How do you plan to implement the new GME positions in the Veterans Access, Choice, and Accountability Act to increase access to care for veterans in under-served areas or areas with high physician shortages to begin with like the Inland Empire in my county?

Mr. GIBSON. I think your suggestion on more robust communication of the provider community is a great idea. We will take that for action.

Let me ask Dr. Tuchschtmidt to talk about our effort in the GME area.

Dr. TUCHSCHMIDT. Yeah. And let me just start by saying that for providers in your community who would like to participate in the Choice Program, the 800 number actually has an option. So option

one, I know we all hate these things, but option one, press one if you are a veteran, press two if you are a provider, press three if you are someone else.

So they can call the third-party administrators, TriWest or Health Net directly to get information. And we are working to put together a provider information packet that will help them understand.

With respect to the GME, I am actually really excited about this. We have a plan to stand up 300 new resident positions in underserved areas and particularly in areas where we need physicians, the 300 per year.

This year, quite frankly, I think we were all talking and were not anticipating that we would get a great response given the short time line between now and when the academic year starts, but for the 300 potential slots we are targeting for the next academic year got over 400 requests for additional resident slots.

So some of those may be established programs that want to expand those programs. Some of them may be wanting to start new programs. Some of them may be community medical centers who want to start a family practice residency program. So we are working with those.

I think the challenge is going to be for those sites to actually stand up those programs.

Dr. RUIZ. I appreciate that and I appreciate you prioritizing the low physician to population ratios that exist. And it is time now to begin building pipelines of individuals who want to serve in the VA. And the place you can find those is in the military.

When I was in Haiti working with the 82nd Airborne as a medical Director for a nonprofit right after the earthquake, there were plenty of medics that were pre-med. And, in fact, I wrote a letter of recommendation for several for medical school.

If we can identify them early while they are in the Department of Defense, put them in a pipeline program, into those GME slots after the medical schools that contract with the VA and the Department of Defense, then those are the ones that will be committed to providing high-quality, veteran-centered care in our VAs.

Dr. TUCHSCHMIDT. I couldn't agree with you more.

The CHAIRMAN. Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here.

And I am just going to go. I am going to sort of take the theme of providing care. You all have some work to do in your shop. Let me just give you an example of what happened in my district recently.

A GI doctor was hired, all cleared by the local, cleared to the VISN, and quit his job. He is waiting to be hired at the VA, but his paperwork is at some central office, some black hole here in Washington.

So during this political campaign, I have got my staff on the phone to somewhere here in Washington to get this doctor who is approved, who could be seeing patients. So he goes out and gets another job as locum tenens during that time until the VA finally bumbles along and gets him hired. Those things are so frustrating.

You cannot imagine how frustrating that is to see that after all this.

And I walk out of the VA hospital Monday from a ceremony there. I bump into a veteran that doesn't even live in my district, but he has driven two and a half hours to get there for his appointment that he has waited four months for. And he got three calls to come to that clinic appointment. And he shows up that day and his doctor is not there.

And the guy has got severe pain in his neck. He has had a spinal fusion surgery from a neurosurgeon who is a very close friend of mine. The man needs an epidural steroid injection. He is fuming. He has got to ride two and a half hours back to Knoxville now.

But, fortunately, I have some friends there. I made some calls to friends of mine and these are VA friends I am talking about. We then get this man an appointment down in Knoxville so he doesn't have to come back.

That is the kind of thing that every person sitting at this dais hears every time you go to a VA. And my question is, when is it going to stop?

And that is the thing I am so frustrated with is that I spent, as Dr. Ruiz did, an enormous amount of time during this October period listening to people at the VA.

Let me tell you what else you have to do. I want to work with you on this. I am a primary care doctor. Until you reform how the primary care doctors—that is the tip of the spear—provide the care. You can't hire enough doctors or train enough doctors ever to get it done.

I look at what they have to go through to actually see a patient and what I had to go through to actually see a patient. And Mr. Michaud is not here. There is not going to be any gain in the system on the private sector. Patient shows up. I take care of him. I get paid. If the VA will write the check, I will get paid.

And they have incredible teams. You guys have teams put together that I could have only dreamed of in private practice. And, yet, they are so bureaucratic and slow, they can't see many patients.

So I wish you would sit down with a private practitioner like myself and like several others sitting around here and let us help you, show you how to do that and then use that as a metric across the country to create more efficiencies.

We had a young psychiatrist here from St. Louis that the psychiatrists were seeing six people a day. We can't train enough psychiatrists in 50 years to see to the needs at the VA.

And I appreciate the effort you are doing, but there is a real shakeup that needs to happen. And this mid-level bureaucracy that is apparently a filter that is slowing all this down, you need to get after that. And I can't imagine why it would have taken anybody but a piece of paper, a signature to have a doctor working.

Mr. GIBSON. Let me offer up quick. Your story of the physician hiring frustrates me at least as much as it frustrates you. And I run into those stories still and do everything I can to clear away the bureaucratic obstacles that get in the way.

What we have got to do is revise the system so that we don't have to intervene, either of us individually on a case-by-case basis.

I am deeply disappointed in the story you tell me about the veteran that came for his appointment and the doctor was not there. Thank you for intervening on his behalf.

I want to ask Dr. Tuchschiidt to comment on the third observation that you have made about primary care physicians.

Dr. TUCHSCHMIDT. Yeah. Let me also just say I am the black hole in central office. I admit that. That is my job to approve those. I try and approve them immediately when they come in. But as of the beginning of this month, we delegated approval out in the field up to \$350,000 a year. They don't have to come to me below that level as of the beginning of this month.

We have actually, to your suggestion, been benchmarking with Kaiser Permanente and others and we are in the process right now of developing practice management standards and tools to deploy to try and improve some of those processes.

Dr. ROE. My time is about up, so I don't want to interrupt you, but you can't have physicians doing clerical work.

Dr. TUCHSCHMIDT. Yes.

Dr. ROE. You can't have them going out and walking out and having to call to make the appointment. I mean, I know when I saw somebody, the most valuable time you have is the physician's time. And so when someone comes in, you have got to be able to put that in the record, hit a button, have somebody else do all that stuff.

The other thing I want to talk just very—Mr. Chairman, if you would give me ten more seconds—is the spacing. I hear all the time that the physicians don't have enough room to work in. I can tell you as an efficient primary care provider, it takes three to four rooms for me to work. I can be very efficient with that.

You give me one or two rooms, you have slowed me down by 30 percent. It does take time for a woman or a man to get their clothes off. Somebody has got to do that. That takes time. While they are doing that, you can be seeing somebody else.

I had a different motivation where I was to be efficient in my practice. I don't see that in the VA system, but I think you have got real problems with space and then the way your clinical, the primary care people I am talking about work. So I am willing to work with you on that.

Dr. TUCHSCHMIDT. We are in agreement with you.

Dr. ROE. I yield back. I appreciate it.

The CHAIRMAN. Thank you.

Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chairman, and thank you very much for being with us today.

I want to just tell a quick anecdotal story that a member of my staff who is a veteran received his card last week and we were all very excited. We walked through the letter that veterans received.

And I just want to make sure in terms of the volume of calls and questions because it was great to receive the card and it was nice to celebrate that for Veterans Day, but it was very clear that the card wasn't going to do anything until you went through the steps of eligibility and making sure that you are authorized to use the card.

So, number one, I worry a little bit about veterans that somehow think the card has some magic to it and they go to a private provider and then end up with a big bill they didn't expect.

Number two, the question that was raised in a memo provided to us by the staff about the co-pays and deductibles and is there sufficient communication for the veteran to understand that they may end up with a financial obligation that they would not have had if they had been seen through the VA?

And I have another question, but I would love to have someone address that.

Mr. GIBSON. I will start out and Dr. Tuchs Schmidt may want to jump in.

We took great pains as you would expect with the drafting of the communication. We also went out to VSOs and had VSOs not only review it but actually get it in the hands of veterans and have veterans review it and provide us that feedback.

So part of what you are seeing and the tension that you have just described between, they have to take some steps to access the care that they are eligible for. This would have been someone in the 40-mile group. And that is one of the reasons because there is a potential liability associated with co-pays just like there is with VA.

If a veteran is out seeking care for a nonservice-connected condition or they have third-party insurance and different circumstances, there may be instances where the veteran is accountable for some of that cost.

We have done things in interpreting the legislation and with policy decisions that we have made and regulation that we have promulgated to make the operation of the Choice Program from the standpoint of co-pays look absolutely as close as we could possibly make it look to traditional non-VA care because we didn't want to set up a situation where the veteran was going, oh, well, I want care in the community, but I want to use this. I don't want to use the Choice card.

Ms. KUSTER. Yes.

Mr. GIBSON. And so we eliminated those obstacles, but there are, in fact, instances where the veteran could be obligated for some of the cost.

You want to—

Dr. TUCHSCHMIDT. Yeah. And I think we have, you know, we have said from the get-go that in designing this program, we want to do the right thing by the veteran, right? That is number one priority.

I think that we have pretty much resolved the issue with the VA co-pay, so we will be setting that at zero at the time that the veteran is being seen so they don't have an out-of-pocket cost at the visit. We don't honestly believe we can determine what that co-pay is until after we get a statement, an explanation of benefits back.

With respect to third-party co-payments, technically that is a contract between the patient and his or her insurance company which we have no control over. However, the way we have tried to implement this, I think that most of the time we will be able to cover that co-pay through the way the Choice payment is made.

But if the patient has expensive care, has hospitalizations, procedures, has let's say Medigap insurance with a high deductible, the fact of the matter is that they may be subject to co-payments. And we have done everything we can to educate VSOs, our partners, and we will be educating veterans to the fact that that is part of the way the Choice Program has been designed.

Ms. KUSTER. Okay. So I think communication and education through the VSOs.

The other question I have and just hearing from my colleague, New Hampshire as we just recognized Veterans Day and had a wonderful celebration, turns out we have one of the highest percentages in the country, 11 percent of our citizens are veterans which is pretty incredible in terms of the service.

But as you can imagine, then we have a lot seeking service. And the ARCH Program has been very popular and I understand the Veterans Access, Choice, and Accountability Act allows for continuation of that.

But could you address for me how that will happen? It is important for our rural veterans and they like it. It works for them. And I just wanted to get clarification in terms of how it is impacted by the Choice card.

Dr. TUCHSCHMIDT. So the legislation extended the ARCH Program. We have extended the contract temporarily while we are renewing the ARCH Program. So it will remain in place essentially as it has existed in the past going forward.

Ms. KUSTER. Okay. I appreciate that.

I yield back. Thank you.

The CHAIRMAN. Mr. Flores.

Mr. FLORES. Thank you, Mr. Chairman.

Mr. Secretary, I appreciate you joining us. I also appreciate the work that you and Secretary McDonald and the team are doing to work with Congress and this committee in particular to build the VA for the 21st century.

A few weeks ago, the Austin American-Statesman Newspaper published an article about the VISN Waco Center of Excellence for Research on returning war veterans. And I will ask the chairman if he will introduce this in the record.

I am not trying to change subjects because we are still on the same subject and the subject is what is the underlying root cause of the issues that the VA is struggling with. And it turns out that it is a troubled culture that needs to be fixed and that needs to have a change in personnel to do that.

And you are working on that. Now, we are not necessarily happy with the direction you are going with that, but the comments have been that that has been discussed already.

What I would like to do is talk a couple of other things. One is this committee and my office have requested an update, a briefing with someone from the VA regarding the Center of Excellence between now and December the 11th. I would like for your all's commitment that you would do that.

The second thing is that the Center of Excellence totally failed in its objective to try to find the underlying causes of TBI and PTSD and to try to help the VA come up with some groundbreaking research to address these critical issues that are

facing today's war fighters, but it just utterly failed. Not one MRI was produced in order to assist with this project. And, you know, tens of millions of dollars were wasted in the process.

A whistleblower brought this to our attention. And this is where I get back to the culture. That whistleblower and some of the other whistleblowers who participated in letting America know about the problems faced incredible retaliation. And you saw the hearings we had back in the summer where when the waiting list issue came up, the bureaucracy retaliation against whistleblowers, it goes beyond the pale.

And so I urge you to continue to work on that part of the culture as well. There should be no retaliation. They should be celebrated as people who are trying to make the system better.

Anyway, so two things and I will be brief. One is I would like your commitment to have that briefing for this particular Center of Excellence and, two, that you will remember that we need to fix the culture of retaliation as part of our overall attempts to fix the culture at the VA.

Thank you.

Mr. GIBSON. One, we will commit to having that briefing to you before the 11th of December as you have requested. Two, I have said repeatedly and continue to say we will not tolerate whistleblower retaliation.

I have worked very closely with Carolyn Lerner, the special counsel of the United States, first on restoring employees who have been the object of retaliation and ensuring that they are basically made whole in that process and then coming in immediately behind that through the much maligned Office of Accountability Review to conduct the investigations into the retaliatory behavior to ensure that we are holding those individuals accountable for that behavior.

I agree with you that they should be put up on a pedestal and I have agreed to participate, I think it is the 4th of December, with the Office of Special Counsel where they are going to be recognizing two whistleblowers from Phoenix. And I will be joining them in that forum.

Mr. FLORES. Okay. Thank you for your responses.

I yield back.

The CHAIRMAN. Thank you.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, I wanted to first start on a positive note. I hear from a number of veterans in my community that go to the VHA clinic in El Paso that they receive exemplary care in a timely fashion. And more importantly, I am beginning to hear from veterans who did not used to receive that care in a timely fashion and they are telling me that they are now able to get appointments.

And so I appreciate your leadership and the VA.

Mr. GIBSON. We have both been working on that for a while.

Mr. O'ROURKE. That is right.

Mr. GIBSON. So I am glad for that feedback.

Mr. O'ROURKE. Your visit to El Paso, I think, had an impact, so appreciate that.

But I want to follow Dr. Roe's lead in using an anecdote to describe the challenges that remain. I was recently at the VA and

while there and asking veterans about the quality and access to care that they have been receiving ran into a gentleman who was there for a mental healthcare appointment. And he had called the day before to confirm that appointment.

I have no idea how many months in advance that appointment was made nor do I know how many miles he drove to be there. The appointment was confirmed the day before. He showed up on the appointed day at the appointed time only to be told that the mental healthcare provider that he was there to see no longer worked at the VA and had not worked there for months.

And that was obviously deeply disappointing, but what was unforgivable to me was that he was then told to go back home, call back tomorrow to schedule another appointment. Luckily I was there. We were able to take him up to the third floor to the executive suite. And we waited for the Director to come out of a meeting and were able to obtain an appointment for him the next day.

So that brings me to my question. You have ten mental healthcare vacancies still in El Paso despite all of the good work. And to Dr. Ruiz's question about getting these providers in historically under-served areas like El Paso which had the worst wait times for existing patients in the entire country, fourth worst for new patients for mental healthcare, what are we doing to attract and retain those providers?

You mentioned earlier that you are increasing what we are paying. We talked about GMEs. Tell me a little bit more about how we are going to close the gap on mental healthcare.

Dr. TUCHSCHMIDT. So I think we have all of the recruitment, retention efforts that we have underway for both physicians and for nurses. With respect to physicians, we have worked to get expert healthcare consultants, recruiters to help us bring in physicians.

I think that the story that you tell of a patient who gets there for an appointment and doesn't have a provider is just unacceptable. I mean, whether there is a vacancy and somebody left or not, there should be contingency planning at every one of our facilities. We have been communicating that. And it just should not happen.

Mr. O'ROURKE. So I would love by the numbers to understand what you are doing, how much more you are paying to attract somebody to a clinic like El Paso. And I have learned that when you recruit a psychologist or a psychiatrist to a clinic instead of a hospital, they are earning less and they are being offered less.

And so do we need to harmonize those levels so that you are getting folks to the right place, but—

Dr. TUCHSCHMIDT. I don't—

Mr. O'ROURKE. And I am sorry to interrupt, but it brings up the more important issue, I think, of accountability. And were the anecdote I just described to have happened a year ago, it would still be unforgivable. But to have happened after all the scrutiny and attention and focus that we have brought to this issue, how are those people still there who are running the El Paso VA?

And so, you know, to the chairman's point and so many others who have made this, I 100 percent accept Secretary Gibson's explanation and fully believe that you are doing the right thing to ensure that once disciplinary action is taken, it is sustained and is

not overruled and we don't reintroduce these bad actors into the system.

But having said that, when can we expect to see these changes? I mean, it is straining credibility for us and the American public to know that these folks responsible for such egregious malfeasance and negligence are still in their jobs. When are we likely to, within this calendar year, within the next six months, to see the firings that we have been expecting?

Mr. GIBSON. I will come back to you within 24 hours to answer your question definitively. I am aware of certain actions, but I don't know exactly where we are in that process. And so rather than give you a speculative answer, I would rather give you a definitive answer.

I would tell you the question in my mind remains in this particular instance whether there is malfeasance or misconduct or whether we have got a situation where it is a really, really tough situation and we are not bringing to bear the resources that we need to be able to bring to bear, but I will be back to you within 24 hours with a definitive answer to your question.

Mr. O'ROURKE. Thank you. And then I will share that with the committee.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you.

Mr. Huelskamp, you are recognized.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

If I might follow-up on the information request from my colleague from Texas, he did say earlier that I guess not a single VA employee had been suspended without pay.

Is that an accurate statement that you made earlier?

Mr. GIBSON. Well, suspension without pay is a disciplinary action, so I can't tell you. I have not suspended anyone without pay.

Dr. HUELSKAMP. I misunderstood you. I thought—

Mr. GIBSON. It is a disciplinary action. So in order to take the disciplinary action, we—

Dr. HUELSKAMP. No. I understand that. I understood you to say earlier that not a single VA employee had been suspended without pay. Was that—did I misunderstand that statement earlier from you?

Mr. GIBSON. No. That is exactly what I said.

Dr. HUELSKAMP. Okay. Okay.

Mr. GIBSON. And I said it in the context of the question about suspending in the process of a disciplinary action being brought.

Dr. HUELSKAMP. Okay. I would also like—

Mr. GIBSON. I couldn't tell you of the 5,600 actions that we referred to earlier whether or not any of those—

Dr. HUELSKAMP. Have any VA employees—

Mr. GIBSON [continuing]. Involved suspension without pay or not.

Dr. HUELSKAMP [continuing]. Lost their bonuses?

Mr. GIBSON. Pardon me?

Dr. HUELSKAMP. Have any VA employees lost their bonuses as a result of these scandals?

Mr. GIBSON. Well, in fact, no VA senior executive in VHA will receive a bonus in 2014.

Dr. HUELSKAMP. Prospectively has any lost their bonus?

Mr. GIBSON. There was——

Dr. HUELSKAMP. Mr. Gibson——

Mr. GIBSON. I think we have had this conversation before in here. There was one instance of one employee where a bonus was paid in error and we were able to, I am going to use civilian language, claw that back. But now that action itself has been appealed under statute. Otherwise, once a bonus has been paid, it becomes the employee's property and we don't have the authority to take that property.

Dr. HUELSKAMP. Has any VA employee been fired? Have you gone through the entire process of removing an employee yet?

Mr. GIBSON. Yes.

Dr. HUELSKAMP. Okay. If you would provide a list. Obviously we won't know the names, but a list of how many of those have actually lost their jobs as a result of this.

I want to follow-up with some questions on the VA Choice and how that was implemented. Why exactly did you decide to implement that in phases?

Mr. GIBSON. The fundamental concern was that if we send out nine million cards to veterans on the 5th of November, realizing that approximately 8.3 million of those veterans would not have an immediate benefit under the act, what we would do would be to create chaos and jam the phone lines with people calling to get explanations——

Dr. HUELSKAMP. Nobody has immediate access?

Mr. GIBSON [continuing]. That would prevent veterans that do have access to care.

Dr. HUELSKAMP. I understand that. But the folks that were waiting for months, you have chosen to wait even longer. Why are those that were waiting, that was the focus of so much scrutiny, why have you decided you have got to wait longer than those that were in this 40-mile radius?

Mr. GIBSON. Many of those people that have been waiting, we have been working those in the ordinary course of business as part of what accelerating access to care has been about for the last five and a half months, since the middle of May, if I am counting the number of months correctly.

Dr. HUELSKAMP. What I am not clear on is what is the start date? When you say, okay, the clock has now started, does that continue to move back because you have yet to start that phase?

Mr. GIBSON. The start date for the group in the 40-mile section is——

Dr. HUELSKAMP. No, the wait time.

Mr. GIBSON [continuing]. The 5th of November. Those in the wait time, what has been posted in regulation is the 5th of December. Our expectation is the start date is going to be sooner than that. And we will post that start date within the next several days.

Dr. HUELSKAMP. So if you don't get the cards out or you don't officially start then, that phase just waits and waits and waits until you actually pick a start date?

Mr. GIBSON. That group waits until we post in regulation to say we are now activating the 30-day wait time standard under the Choice Program. It does not necessarily wait for them to receive

their card because as I mentioned earlier, we are populating the Veterans Choice——

Dr. HUELSKAMP. Well, I am not worried about when they receive the card so much as when they get the care.

Mr. GIBSON. Correct, yes.

Dr. HUELSKAMP. And I don't remember anything in the law that said that you get to pick when the 30-day start time or 30-day wait time actually becomes the start date for that second phase. If you could provide that to me, I would appreciate it.

Mr. GIBSON. We could have rolled this program out in such a way that it would have been a disaster for veterans and we chose not to do that.

Dr. HUELSKAMP. Well, if you are still waiting for care, I would say, Mr. Gibson, it is still a disaster for that veteran.

One of the other items I would like to note as well, and this has been a failure from various folks in the department, just a local issue, but I think it raises broader concerns in Liberal, Kansas which has a very limited VA facility, not full services. You promised again and again to have a full-time doctor there, promised and never delivered. That is happening again and again.

Now you are still telling them just because they have limited services that if they want any services, they still have to drive the six-hour round trip to Amarillo to get those services when we have got a great hospital just down the street less than a mile away. And you say, no, you can't receive it there because of limited services that are available at the VA clinic there.

Is there a reason you have chosen to say a VA clinic is a restriction? If you had that one in your community, all of a sudden, you can't go to your local hospital and pick your doctor. But could you describe how you come to that reasoning because there are veterans in Liberal who would like to go to the doctor and you don't even have a full-time clinic there, don't have a full-time doctor? You are saying too bad, you still have to drive six hours for care.

Mr. GIBSON. The language in the statute was very clear, to the nearest VA medical facility. I would ask the question back to you.

Dr. HUELSKAMP. That is the current law, Mr. Gibson.

Mr. GIBSON. What was Congress's intent? And if Congress's intent was to make it 40 miles from where——

Dr. HUELSKAMP. Well, it wasn't Congress's intent to wait until December to take care of the wait times.

Mr. GIBSON. And we don't intend to wait.

Dr. HUELSKAMP. And under the current law before this one passed, you had plenty of options for non-VA care. You could have let them go, before August 6th, you could have let them go to the Liberal Hospital. Your VA chose not to do that. Don't you have that authority?

Mr. GIBSON. We had a budget in fiscal year 2014 for non-VA care of about \$6 billion and we spent it.

Dr. HUELSKAMP. So you do have that authority to allow them to go to the local hospital?

Mr. GIBSON. Within the constraints of our budget, we do have that authority where we deem that it is clinically necessary to do so.

Dr. HUELSKAMP. Okay. Well, driving six hours. Mr. Gibson, you don't drive six hours for care. Veterans in Liberal, Kansas do today and we have got to fix that.

I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And, Deputy Secretary Gibson, thank you and gentlemen for being here.

And you are here and I think it is important for you to hear each of our stories. We have heard this and both the bad and the good that come out of it because we know our role is to improve upon what is working and to make those changes.

I, like my colleagues, Mr. O'Rourke, Dr. Roe, had a gentleman was waiting, excessive wait time, 75 days, continued to feel bad, feel bad. Finally, one day, he couldn't take it anymore. Drove to the Mayo Clinic where he was told he needed immediate prostate cancer surgery.

That is the bad obviously that he waited excessive wait time. The good is is that we called and within six hours, we had the fee for service agreement. And the next day he was in for his surgery. Two weeks ago, I was with he and his family and Steve is now in the recovery.

The family is incredibly grateful, but I am embarrassed that they are grateful to me because that veteran should have been able to do that on their own. And I think as long as these stories go, and I think we all know here, that is one veteran whose wife called with no other where to go, called the congressional office and got some action.

But I do think we should note the responsiveness and the cultural attitude on the fee for service, and it is a challenge.

I think, Dr. Tuschmidt, you were very right, the private sector capacity. Mayo Clinic said it is not that he might not have waited for us in that initial appointment. It is just that there has to be a way to triage these cases that are so critical. And they convinced me that there are ways to do that, to make sure that if it wasn't so pressing, we could have put them in there.

My question to you is, and I think this is a conversation that should be done, and this committee is doing the exact work it should be doing, asking how we implement that, and Congress's intent is an important part of this. What I am curious about is the implementation of this law, and this is one small piece, where is that intersection with the restructuring of VA that we know needs to be done? Is it helping? Is it promoting? It was meant to be a catalyst in that direction, but I don't think anyone on this committee thought that this was the end. It was the first step.

So maybe if you could just articulate a little bit to me how it fits into the broader restructuring and how it enables us to get to that.

Mr. GIBSON. I think it gets at the very essence of creating—or focusing on the veteran experience, and focusing everything we do around the veteran. So what the Choice Program does is, is it basically allows us to accelerate care using additional resources in the community, thanks to the funding that Congress provided, to be able to accelerate care while we are doing the internal capacity building the, you know, points that have been brought up about

primary care protocols, and the number of treatment rooms, and compensation issues associated with physicians, and streamlining hiring practices while we are engaged in all of that activity, the Choice Program gives us the time to be able to do that while we are still delivering the care that veterans deserve.

So I see that as a central part of what we are doing, I think it's also clear that it drives us toward the more holistic view of VA. We have been providing substantial amounts of non VA care, and I think this pushes us harder to ensure that we are maintaining continuity of care for veterans, and ensuring that veterans we are managing that care—this is beyond what a health plan does—that we are managing the care and delivering the kind of healthcare outcomes that veterans need.

Mr. WALZ. We need to figure out a way—and I say all of us, and this includes the VSOs and how you are communicating with them because this is truly the real challenge because the ultimate cost of this, and to be very clear, Steve and Matt Kerry got—and he believes it too, he could have got equal care that he got at the Mayo Clinic for the treatment of that had he been able to get in.

Now, the question I have is, is that I don't think your budget would allow just for all the things if it has to go the way that this one was solved. And how are we figuring out how to communicate that triage then, and Mr. Huelskamp's issue is exactly right and it's the same with mine, in this case Steve lived hours away from the nearest facility too, and it wasn't that he wasn't willing to go, it's just that in a crisis situation the Mayo Clinic was next door. How are we trying to come to grips with that, an honest dialog on both capacity? Because I see it, and we heard about this—I thought that was a great hearing we had where a gentleman said he looks out his window and he sees four private sector hospitals, and he knows that they are 72 percent capacity every day, he saw that as 28 percent capacity that could be utilized in another way. Are we getting at that?

Dr. TUCHSCHMIDT. Yes. So I think this is a really important point, and, you know, what I would say is that we have traditionally been a provider of care and we make a decision when we can't provide it in a timely way to go out and buy it for somebody. What the Choice Program has done—and we are having discussions right now, quite frankly, that are, for many people, very anxiety producing—that in our future is not about being a provider organization only. We are now entering a realm where we, quite frankly, are running a health plan.

Mr. WALZ. Yeah.

Dr. TUCHSCHMIDT. Where the veteran, the patient decides what happens to them, and where they go, and how they get care, and what care they get. And this is a huge cultural shake up, quite frankly, for us as an organization. And I think that we are now engaging in discussions about what does that mean for our future? What does that mean for our traditional purchase care program?

So the Choice Program, if the legislation expires in three years and goes away, will have bought us time to build our capacity. But it's proposing, quite frankly, much more significant care.

Mr. WALZ. I couldn't agree more. As I yield back my time, my suggestion was is on the vision of the defense, quadrennial defense

review, and that that's what we need there, and that so I—this is a small piece, but I yield back, but thank you for that.

Mr. BILIRAKIS [presiding]. Thank you. Mr. Wenstrup, you are recognized for five minutes.

Dr. WENSTRUP. Thank you, Mr. Chairman, thank you all for being here today. When we are talking about the Veterans Choice Program, where can I get information specifically for providers that are private sector providers that want to be providers for VA, whether it's a hospital system? Because I've had that question come to me in my district where a hospital system would like to help with the backlog, even if it's a short term event. And also they would be willing to do it at a lower rate than the standard rates for the procedures and things that they could engage in.

Dr. TUCHSCHMIDT. So, again, the 800 number that we have, there's a line there for both veterans but also for providers who want information. We have been talking with the American Hospital Association, with the AMA, I have a meeting coming up with American Hospital Association specifically to try and help use those two entities to get information out to providers, but any provider that wants to I am sure can contact TRICARE or Health Net directly. And I am happy to have them contact me, and I will serve as a functionary to make sure something happens.

Dr. WENSTRUP. Yeah. If there's something that you could get to me to provide some details, I will share it with those—

Dr. TUCHSCHMIDT. I would be happy to do that.

Dr. WENSTRUP [continuing]. That come to me in that realm. And then the other question I have is as we are trying to do the independent assessment. How much information is being gathered, or how much are we engaging with the private sector to really assess the VA system?

Dr. TUCHSCHMIDT. So I think the, as I mentioned earlier, the KNH entity, so MIDR is working with other partners in the community, so they are very committed to finding people with the right competencies to do those various assessments. There are some of them that they will do, so their expertise, quite frankly, is in kind of policy and modeling, but they will have already reached out to RAND Corporation to do some of this work, the Institute for Medicine is doing part of the work, and as I said there will be—they have put together a group of healthcare industry executives from around the country to really be a private sector benchmark panel to help guide not only the assessment —so they put together a set of tools that can be used in terms of when people are doing these assessments making recommendations, how do we know what is good and what is bad coming out of this, and that group is helping to vet that. And then will ultimately be the group of people that help craft the final set of recommendations that come out of this process.

Dr. WENSTRUP. That's great, I think that's important. Obviously, we have a lot of successful providers and systems in place in the private sector, and so their input is key. Thank you very much, I yield back.

Mr. BILIRAKIS [presiding]. Thank you. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for the work that you are doing, and I know that my veterans at home are starting to feel hopeful that there's real change taking place, and I appreciate all of your efforts.

I wanted to ask a specific question on how is the VA implementing Section 401, and 402, and 403, and educating service members about eligibility to seek VA care for military sexual assault?

Dr. TUCHSCHMIDT. So we have already reached out and started reaching out to guard units to educate them about the services that are available through—for military sexual trauma counseling within our organization. We have both outpatient programs and we have inpatient programs around the country.

We are currently—the part we struggle with most is really around the issues with active duty service members. So we clearly believe it was the intent of Congress that by providing this service available through the VA it would be a safety valve for service members who have military sexual trauma to be able to come to the VA anonymously to be able to get that care.

We have been in conversations with DoD about how that might work. They have concerns that the care would be anonymous, and that they would not have information that might reflect on the fitness for duty of active duty service members. And it's really hard to try and figure how when a patient might need to go to an inpatient unit for a couple weeks of intensive therapy that they leave their active duty station and nobody kind of knows about that.

So we are trying to work through those issues with the Department of Defense now, with a clear intention of being able to implement that part of the law in a timely way.

Ms. BROWNLEY. So when you say you have reached out, does that include training?

Dr. TUCHSCHMIDT. Well, right now what we are—the training for?

Ms. BROWNLEY. The training for all of the folks that need to know and how to present, you know, this right to be able to receive treatment.

Dr. TUCHSCHMIDT. For guard members we have begun that work, right? That was the easiest part of this—

Ms. BROWNLEY. Okay.

Dr. TUCHSCHMIDT [continuing]. To put in place. The harder part of this is for the active duty people.

Ms. BROWNLEY. So on the DoD side then, do you have a solution that you are trying work through with DoD?

Dr. TUCHSCHMIDT. We are in constant ongoing meetings with them to try and work through these issues, and try and figure out how this will actually work. We routinely exchange medical record information. In fact, that when we would go to bill, for example, TRICARE for an episode of care, we would submit medical record documentation. We don't believe that's what you intended, and so that's why we are in conversations with them to try and figure this out. I don't think we have locked everything down that we need to at this point.

Ms. BROWNLEY. Thank you. And another question is regarding your process for implementing our long-term space plan, and want-

ing to know the steps the VA is taking to ensure that there are periodic updates, you know, based on new data on terms of what real wait times are, and the increased demand on services, and wanting to know, you know, the status, how that's going, and do we—should we expect—are we going to receive a new updated plan during the next fiscal year?

Dr. TUCHSCHMIDT. Yeah, I would anticipate that there would be a new plan. We are doing something, I think, for the—I have been in the system for 20 something years and it will be the first time we do this—so we are essentially adopting the PPBE model used by DoD and other places in federal government.

So for the first time this year we will be going out, with a lot of planning data, to every facility and asking them to begin developing requirements from the bottom up for their program. People, space, things that they need to be able to be effective and to close performance gaps.

I think that we have our enrollee health projection model, which is a great actuarial tool to tell us how many people we are going to take care of, what kinds of services they need, what that is likely to cost, but then we have to get to the next step of saying, okay, to effect that, what are the requirements necessary to do that, and what is that going to take in each place in which we deliver care. People, things, and space to be able to be effective.

And we are about—we have been piloting the tools and the process, we have been working, actually, with people from the department in the department VA Office of Policy and Planning to do this work. And I think it's going to really fundamentally change the planning process for us in terms of trying to get to the requirements that you are talking about.

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

Mr. BILIRAKIS [presiding] Thank you. Ms. Walorski, you are recognized for five minutes.

Ms. WALORSKI. Thank you, Mr. Chairman, and gentlemen, thank you for coming today and providing answers to our questions. I wanted to just take a second and publicly individually reach out, thank VA Secretary McDonald who told us, when we met him, that if he could be of service that he would individually reach out, and he reached out in an emergency in my district and the Second District in Indiana with a young couple, Erin and Eric Olson, he had been mis-diagnosed at a C block in my district, and his health was degenerating at a rapid rate, no diagnosis whatsoever.

And I called the Secretary, they moved in our behalf and on behalf of this family, and he too was diagnosed with cancer, and they moved and facilitated him to IU Research Medical Center in Indiana which is very close to the VA hospital. He since has been diagnosed, he is under treatment right now, and he is beginning to improve, and there's light at the end of the tunnel. I appreciate his commitment to honor that.

And to echo what Representative Walz just said, and some of my other colleagues, it just kind of adds—that kind of a scenario is good and bad. We are grateful when that happens because we just saved a life of a veteran, but we can't make calls on behalf of, in my district, 57,000 veterans and their families, and it just kind of, to me, just sheds light on the fact that to all of us, and I think to

our districts in America, this is still a very, very urgent matter, this is still a five alarm fire, and I think America is willing to give a little bit of time to say we understand the comprehensiveness of this but I think they are going to want to see action at probably the same rapid rate that we do. So I just wanted to pass that along.

But just a clarifying question. For those senior executives that retired during that five day interim period, that new five day period, in lieu of possible removal they leave, is there anything on the record to say that they were slated for removal so there's some kind of a trail that says these folks possibly left because of that, they were at least on that list?

Mr. GIBSON. Whether an employee resigns or retires, the proposed removal action winds up becoming a permanent part of their file. So any other federal agency will, if they were considering hiring this particular individual, would see that as part of the file.

Ms. WALORSKI. And my other question, which again is a follow-up from many hearings we have had before, is this issue of the VA and IT, and I have a bill coming up in a couple of weeks that we are going to have a hearing on, but the new law required a technology task force to conduct a review to look at that VA scheduling system. The Northern Virginia Technology Council conducted visits at VA medical centers in Richmond and Hampton to observe the scheduling operations and interview the staff. Do you consider the results of that—what they obtained at those medical centers to be representative of the entire system?

Mr. GIBSON. I think as we have gone through the findings in the NVTC report, I would say that it affirmed an awful lot of what we believe we knew already. It also reiterated a fair amount of information that was part of the Booz Allen Hamilton report that was done back in 2008. I think it was useful and very helpful. It's an independent point of validation in many instances, you know, the point that came up that Dr. Roe mentioned earlier about the need for treatment rooms, that was one of the things that showed up in the NVTC report. Didn't have anything to do with the scheduling system, basically they were looking and saying, one of your obstacles to providing access to care is you got medical facilities here that only have one treatment room per provider. We are never going to make optimal use of our providers when we have got that kind of constraint operating.

Ms. WALORSKI. Can I just follow up real quickly before you answer? So that 2008 report, it's six years later now, have all the issues been addressed in that 2008 report as far as inconsistencies and recommendations?

Mr. GIBSON. You mean from the 2008—

Ms. WALORSKI. The 2008 report. If it paralleled—

Mr. GIBSON. No. No.

Ms. WALORSKI. So why haven't they, if it's been six years?

Mr. GIBSON. Well, that—you may or may not recall that was a report where there was a—questions were asked back in May with other individuals sitting here about the report, and by-and-large the comment was folks were not even aware of the existence of the report. I had not been—I had only been here for three or four

months, but that report got issued and basically it went in somebody's desk drawer.

Ms. WALORSKI. Right. But as you recall in some of the hearings that have gone on only in the last two years since I have been here, there were a lot of the information given to this committee that there was no problem whatsoever with the scheduling system with the VA, nobody ever said it was a 1985 system, the gentleman in charge of your IT system sat right there and when I said, do you have everything you need, resources and money, and we are good to go, the answer was an overwhelming yes, even during the budget time. So here we are now 2014, the Booz Hamilton report was out there in 2008, there's a mandate in this new law, where are we with the scheduling system and this whole idea of mandatory compliance now?

Mr. GIBSON. Yeah, the Booz Hamilton report went far beyond—

Ms. WALORSKI. Right.

Mr. GIBSON [continuing]. The scheduling system, as did the NVTC report.

Ms. WALORSKI. Right. But where are we specifically on the scheduling system?

Mr. GIBSON. Specifically on the scheduling system, four different tracks—I will call it three different tracks of work that are underway right now. A whole series of patches to the existing system, we are on the tail end of that, probably within the next couple of months we will have completed all those patches. We have led a contract for major enhancements to the existing scheduling system. Those are supposed to start coming online in the spring of 2015, so a near term solution.

Those also include creating the ability for us to field some apps that have been created that will actually allow veterans to request appointments, and one of the other apps actually allow veterans to directly schedule an appointment, but we have got to have the ability to catch it when the veteran sends it. And then in parallel, and we think we are literally a matter of days away from a contracting action for the acquisition of a commercial, off the shelf, state of the art scheduling system.

Now that system, in all likelihood, won't be up and running until sometime in '17 which is why we are doing these other things in the meantime. I should indicate though, and it's reaffirmed in the NVTC report, the schedulers that they talked to in field said the scheduling system isn't the impediment, it's the lack of appointment slots. They basically came back and said, well, schedulers say it's okay. We know it needs to be replaced—

Ms. WALORSKI. Right.

Mr. GIBSON [continuing]. We know it doesn't provide the functionality that we need to have, and so we are pressing on to get that done. But that's not the obstacle from the schedulers' perspective.

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

Mr. BILIRAKIS [presiding]. Thank you. Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you. And thank you all for what you have been doing to try to fix these problems and implement this bill. I would like to go back to the issue of the shortage of doctors in the private sector because this is very serious in Nevada and in Las Vegas. We are at the bottom, like 50th or 45th or something, for all different types of specialists. So I would like to go back to that issue.

Several of us worked very hard to get the provision in the bill to create the new residencies. And I heard you say that you are given, I think, 300 a year and you have already got 400 applicants. I want to be really reassured that those residencies are going to go to places where there's the need, I don't want them to just to go UCLA because its already got a great program, or Johns Hopkins, or—go where the need is.

The second part of that is where there is a need is also where they may not be able to support residencies at this time, so it's kind of a double hit. That's true in Las Vegas, we are getting a new medical school, Terro is growing, we have got the new hospital, but we are not going to be able to apply this year, hopefully next year. Can you explain kind of how you are going to distribute those, and how—I have got a working group right now that's meeting to be sure we will be eligible for some of them, what you might recommend to that group that you look at for some of the qualifications?

Dr. TUCHSCHMIDT. Sure. So we can get you—I can get you specifically information about kind of what the requirements are so that you personally have that information. But, you know, I think that the intent of the law as we interpret it is that those slots are to go to meet underserved areas and needs, and not go to UCLA necessarily. Not that there's anything wrong with UCLA.

Ms. TITUS. No, right, right.

Dr. TUCHSCHMIDT. So I think the intention is there. There are, you know, many community hospitals that establish family practice residencies and other residency programs that are not medical schools. We do not own residency slots, they are owned by an academic partner, so those slots are—they set up a program and get approval through the ACGME for those positions. We fund them essentially, and in return, those residents rotate through our institutions, and we provide some of the training.

I think the challenge clearly is for a place that has not had a residency program to be able to recruit and retain faculty, to be able to teach, to be able to meet all the accreditation standards that ACGME has for those programs, and it certainly takes a critical mass of residents to be able to meet all the work hour restrictions and everything else that they have, and maintain a viable program.

But I can certainly make sure that you get information that you can pass along. And I think the best thing that you all can do, actually, is encourage hospitals or other institutions in your districts that are interested in that to contact our Office of Academic Affiliations to get information.

Ms. TITUS. Maybe I can get somebody from the office to come meet with that group in Las Vegas—

Dr. TUCHSCHMIDT. I would be happy to—

Ms. TITUS [continuing]. To provide that.

Dr. TUCHSCHMIDT [continuing]. Make that arrangement for you.

Ms. TITUS. That would be great. And then kind of related to that, you also mentioned that you are worried about these kind of middle man organizations like TriWest being able to find enough people in the private sector to be part of this program.

I remember asking the Director of that, who was sitting right where you are, if wasn't this going to be a problem, and his exact words were, "oh, no, we are going to just ask doctors to step up, they will just step up to help veterans." Well, if they are not there they can't step up, and I think that was a little optimistic anyway. Can you tell me what you are doing to monitor those groups to be sure that they are providing the services?

Dr. TUCHSCHMIDT. So we monitor today the referrals that we make to TriWest and Health Net through PC3, our PC3 contract. And we know how quickly they can place patients, we know how quickly—or how often those authorizations are returned because they can't find a provider.

The good thing about, I think, the Choice Program, I mean, so we set up PC3 really to be our preferred provider network, and TriWest and Health Net established contracts with those providers.

Under the Choice Program, you have provided, I think, a really good tool in terms of the provider agreement authority that we have, which allows—so the veteran will be able to choose any willing provider that meets certain criteria, they have to be Medicare provider, federally qualified health center, et cetera, et cetera. But once that's done, TriWest or Health Net will be able to reach out and get an agreement with that person for the Choice Program, even if the provider doesn't necessarily want to be part of the PC3 network.

Ms. TITUS. Okay.

Dr. TUCHSCHMIDT. I think the one issue that we have that really does need to be addressed expeditiously is the fee structure in Alaska. The Medicare rates will not buy much care, not many willing providers in Alaska that are interested there. I know that you all are aware of that and your attention to that in a timely way would be really helpful.

Ms. TITUS. Thank you. Just really quickly, Mr. Gibson, as you were talking about expanding, and improving, and changing the VA, kind of as Mr. Walz was suggesting, this is just the beginning, not the end. I hope you will look at those maps, all those different maps that divide the country up into different regions. In Nevada, we are split into three parts for VHA, and then at the same time we are in with California for VBA, they just don't make sense. Will you look at that?

Mr. GIBSON. We don't think they make sense either.

Ms. TITUS. Okay, good. Thank you.

Mr. BILIRAKIS [presiding]. Thank you. Dr. Benishek, you are recognized for five minutes.

Dr. BENISHEK. Thank you, Mr. Chairman. Thanks, gentlemen, for being here this morning. I think the Mr. O'Rourke incident where this veteran was told to go home and call back for an appointment, I mean, just the fact that that would happen to somebody, it really emphasizes to me the need for change in the culture. I mean, that an employee would think that was the satisfactory

thing to do to somebody who had been waiting that period of time. And I know that you all realize, you know, that you got a lot work to do in order to change that culture.

And I want to talk about a couple specifics. You know, I used to do colonoscopies at the VA, and I have been hearing that there's still a backlog of colonoscopies within the VA. How many veterans have been waiting 12 months or longer for a screening colonoscopy? Dr. TUCHSCHMIDT, do you have any idea?

Dr. TUCHSCHMIDT. I don't have that number, but I can get you that number.

Dr. BENISHEK. Yeah. I wish you would. And, you know, the associated number of cancers that are discovered, you know, to me, you know, the cohort of veterans that we have fits the age group for colon cancer, and I know that in my own circumstances, you know, we found more advanced cancers than should have been found because of the delay. Is there anything in particular that you are doing to address these backlog issues?

Dr. TUCHSCHMIDT. Well, I think there's two things. So the first thing I would say is that under the Choice Program that you all generously gave us, veterans will be able to go out for that care today.

Dr. BENISHEK. Are they being told that?

Dr. TUCHSCHMIDT. Yeah. So under the—we are—if you are in the 40 mile group, you have already gotten your card and been informed of that benefit. We have polled the list of patients who are waiting for appointments or a procedure.

Dr. BENISHEK. Well, I'm kind of concerned about this 40 mile thing, too. You know, like for example, in my district with most patients are within 40 miles of a VA facility, but there may not be any doctors there, there may not be any facilities to do a colonoscopy, and that type of thing. And I am concerned that we are not going to get—they are not going to get their care yet because they are technically within the 40 miles but there's no provider there. Are those people going to get the care they need in a timely fashion?

Dr. TUCHSCHMIDT. So if we can't provide that care within 30 days of a clinically appropriate date or the veterans preferred date, they will go to the Choice Program. We will offer them that option. So we are polling people today who are waiting more than 30 days, electronically, and we will be providing that list—

Dr. BENISHEK. All right. Well, that's what I wanted to hear, but let me ask you another thing. You know, when I was doing colonoscopies at the VA, they were doing three a day, and then when I came we started doing ten a day, you know, with the same amount of staff and everything. That kind of stuff is still happening within the VA. So what is being done to make sure that the performance numbers that, you know, in order to address these backlogs that people are doing things efficiently and effectively enough, and have the tools to do that so we are not having these backlogs. What's been happening there that's different than what's been happening in the past?

Dr. TUCHSCHMIDT. Right. So we have put a number of practice management tools in place so that we are training and educating

supervisors on how to manage some of these kinds of issues. We have our——

Dr. BENISHEK. Who is in charge of that? Is that you?

Dr. TUCHSCHMIDT. No, it's our——

Dr. BENISHEK. Is this happening differently in each different VISN, or is there somebody central in the VA——

Dr. TUCHSCHMIDT. So there's a national program——

Mr. BENISHEK [continuing]. That's kind of been acting on this?

Dr. TUCHSCHMIDT [continuing]. National program in the ADUSHOM's office under Philip Matkovsky to be able to develop the training materials and to roll out this program. Additionally that we have our productivity tool, I can tell you in GI in the last half of the year, the productivity amongst gastroenterologists increased in the double digits. So I think——

Mr. BENISHEK. Like ten percent you are saying, at least?

Dr. TUCHSCHMIDT. It was about 15 or 16 percent.

Mr. BENISHEK. Well, you see that's the type of thing that I run across talking to physicians within the VA, is that there seems to be a lot of inertia into getting change done that will affect the efficiency within the VA, and I——

Mr. GIBSON. Let me just touch on that for a moment. We have been talking about accelerating care across the department. Every morning—we didn't happen to meet this morning—every morning at 9:00 a.m. there's something called the Access Care Stand Up. Senior leaders from VHA and from all across the department are in our integrated operations center and we are going through hard data about steps that are being taken to accelerate access to care, all across the entire organization. Report outs on wait times, and appointments, and the like. Once or twice a week we have the senior leaders from the particular medical centers joined by VTC, and they deliver us a specific report on the things that they are doing to deliver—to accelerate access to care.

I was in Birmingham Monday and Tuesday of this week, and over the last couple of months they have gone in looking at their appointment blocks and they have created an additional 900 slots across 14 different clinics, all of this using some of the productivity tools that Dr. Tuchschtmidt is talking about to be able to manage to these requirements.

This is a fundamental change for VA, managing to requirements, as opposed to simply managing to the budget, and, you know, if somebody gets seen they get seen.

Dr. TUCHSCHMIDT. We can poll calls in some of our data but, you know, if you look at our completed appointment data today, 98 percent of our appointments are completed within 30 days.

Mr. BENISHEK. I wish I could trust you with all those numbers, but.

Dr. TUCHSCHMIDT. I know.

Mr. BENISHEK. I would like those numbers for the colonoscopies.

Dr. TUCHSCHMIDT. I will get you those.

Mr. BENISHEK. Thank you.

Mr. BILIRAKIS [presiding]. Thank you. Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Dr. Tuchschtmidt, you may be aware that one of my top priorities as a member of the con-

ference committee that produced the Veterans Access Choice Accountability Act was the inclusion of graduate medical education residency slots, and I was very pleased to see that 1,500 additional slots were included.

I also represent Riverside County as does Dr. Ruiz, and I share the same issue that Ms. Titus has in Nevada. Just be clear, the process you followed for this first year of allocating the 300 slots, you have reached out exclusively to those medical schools that have preexisting academic affiliations with the VA medical facility; is that correct?

Dr. TUCHSCHMIDT. I am not sure that we only reached out to facilities that we already have affiliations with. I think we put a general announcement out so that other partners, I mean, we were out looking for—we are interested in having partners that are not currently affiliated with us.

Mr. TAKANO. So those slots—so you are interested in going beyond those medical schools that already have existing relationships with the VA?

Dr. TUCHSCHMIDT. Yes. Now, some of those medical schools may, like the WWAMI program in the Northwestern part of the United States, may, in fact, be supported by, like the University of Washington, but they run many rural residency programs. But we are definitely looking for new affiliates.

Mr. TAKANO. Are you interested in thinking outside the box, maybe funding residencies that may address ambulatory care that may not be centered at a hospital?

Dr. TUCHSCHMIDT. The answer is yes. So as I said, we know that there are many community hospitals that, for example, that will run family practice residency programs, so we definitely are interested in those kinds of partnerships.

Mr. TAKANO. I am very glad to hear that. Will the VA Central Office determine both the number of slots going to a VISN as a whole, and the number going to each medical facility or medical school? In other words, will you be delegating this decision to the VISN in terms of—

Dr. TUCHSCHMIDT. No.

Mr. TAKANO [continuing]. Or will you be making direct decisions about—

Dr. TUCHSCHMIDT. The Office of Academic Affiliations awards specific slots to qualified applications.

Mr. TAKANO. Well, I, like Ms. Titus, would be interested in having folks from the VA come out. We have a new medical school, the newest of the university medical school's established, we are certainly—and we have, as Dr. Ruiz mentioned, the ninth largest veterans population by county in the country, we certainly would appreciate an ability to locate some of these slots at a public university, medical school, that is subsidized by the taxpayers that ostensibly would offer probably a less expensive education, further inducement for those medical students to maybe locate at the VA.

Dr. TUCHSCHMIDT. I would be happy to have that done.

Mr. TAKANO. And as you know, just a question, and I'd hate to be doing Mr. O'Rourke's representation, but the shortage of psychiatrists within his district, is there no medical facility in his district now that currently trains the VA doctors?

Dr. TUCHSCHMIDT. That I can't answer, but I can tell you that, you know, there's a shortage of mental health practitioners both psychiatrists and mental healths, you know, advance practice nurses and social workers in the country in general. We went through an enormous hiring process a few years ago, hiring about 3,000 mental health practitioners into the VA organization.

I live in Oregon and I can tell you that I know that we recruited most of the mental health practitioners, oftentimes out of some of those counties. We have actually, about a year ago, took the kind of caps off of hiring of psychiatrists in terms of salary so that we could make much more flexible hiring decisions, competitive decisions, with psychiatrists.

Mr. TAKANO. Well, as you know, this whole GME issue is very salient here because there's a 60 percent chance, greater chance, that a physician is going to locate where they do their residency. So, hence, it's really important that we don't privileged the pre-existing agreements of the medical schools with the VA hospitals that we look to alternatives so that we can get physicians to locate in communities where there are indeed shortages. Unless GME how we use—how we deploy these GME slots is going to be very, very important.

Dr. TUCHSCHMIDT. Really important point.

Mr. TAKANO. Well, thank you so much. I yield back.

Mr. BILIRAKIS [presiding]. Thank you. Mr. Jolly, you are recognized for five minutes.

Mr. JOLLY. Thank you, Mr. Chairman. And thank you all for being here today. Thank you. And, Secretary Gibson, I want to say thank you personally for the spirit with which you have tried to bring change and I know Secretary McDonald has as well. I have a question more on the VBA side, in fact, entirely on the VBA side, so I apologize to come at you from left field.

We have all had the stories of VHA wait list and the human consequences of those. I can tell you, at least in our district, the sheer number of concerns are on the VBA side, and the wait times on VBA. Not really a specific question but just kind of a question about changing culture since you arrived, and Secretary McDonald, with all the focus on the VHA, my concern is there's this pending—it's just going to take a media story or two and all of a sudden we are going to be talking about VBA a few months from now. What is being done on the VBA side, or is there a plan for future action?

Mr. GIBSON. Sure. We continue to be very much on track for eliminating the backlog, that is disability claims more than 125 days since submission, by the end of fiscal year '15. I am still—I remain confident that that's going to happen.

And we continue to refine processes, centralized mail, the imaging processes, and some of the automated decisioning tools that we are being able to bring to bear to expedite that, the growth, and fully developed claims. Almost 40 percent of our incoming claim volume is fully developed claim, and that's really not being felt yet fully in terms of our productivity because we continue to work older claims before we work newer claims. So I think that's all augurs very positively on the disability claim side.

I would tell you where I am concerned is in non-rating claims, things like dependency claims and the like, fiduciary administra-

tion, administering fiduciary relationships on behalf of veterans, and claims that are in the appeal process, not necessarily that have been sent to the board formally but that are still in VBA because that's where the majority of the claims sit.

You know, we have got a laundry list of initiatives—automation initiatives, staffing initiatives, and the like—that we are executing within the context of the resources that we have got. But you may or may not recall when I came in on the 24th of July and said we need \$17.6 billion, there was actually \$360 million in there for VBA, for us to be able to hire staff, for non-rating claims, appeals, and fiduciary work.

Mr. JOLLY. So still a personnel and resources—

Mr. GIBSON. It is still a personnel and resource intensive issue for us.

Mr. JOLLY. Is there any room to begin to look at how we assign presumptions in certain cases based on an MOS or where somebody was deployed? I know there is some use of that right now but, for instance, I think we talked in here before the number one benefit application being hearing loss, and can we increase the presumptions based on an MOS perhaps as a way of expediting some—

Mr. GIBSON. That's a good question. I don't know the extent to which that specific idea has been aired out, and we will take a look at it and come back to you.

Mr. JOLLY. And the last one I would bring to your attention and I know it's resources so I'm not expecting an answer today. The sheer number now has gotten to the point where even the Congressional backlog, and the regional offices are being very honest and working very well with us, but they are happy to share with us that—listen now, I don't know if this number is exactly right, but I think about 1,700 Congressionals in our region and so I understand how the staff balance all those Congressionals, but then we have—it's changing the model of casework a little bit in Congressional offices because constituents are coming back saying, what really is the benefit now of coming to a member of Congress, where historically they had seen a benefit. And we are able to work closely with the regional office and improve the timeliness, and also in some very specific cases certainly be of help together with the VA.

I would just bring that to your attention as well as the department continues to look at the VBA side. Again, the more human stories are on the VHA side, but the sheer number of calls out of frustration are really on the VBA side.

Mr. GIBSON. I understand. Thanks for raising the Congressional issue because I really hadn't heard that anywhere.

Mr. JOLLY. Sure. Well, and understand the climate, right. So right now given some of the new stories, folks go to their member of Congress, and rightfully so, that's our job to fight for them, and that's just increasing the volume that then we are bringing to the regional office and asking for assistance.

Mr. GIBSON. I will do a deeper dive.

Mr. JOLLY. Thank you very much. Thank you. Thank you.

Mr. GIBSON. Yes, sir.

Mr. BILIRAKIS [presiding]. Ms. Brown, you are recognized for five minutes.

Ms. BROWN. of Florida. Thank you. And thank you, Mr. Secretary, and thank you for staying on, and it's been a real joy working with you. And also with the secretary when he visited Florida—we went to the medical school together, and he talked to those residents and they were just very interested in the program, and I think you all going out talking to the medical schools is very—they were very engaged, and very interested in participating.

I just want to clear up a few things since it's been a lot of discussion about what constitutional rights that the VA employee have as relates to their jobs. And I understand that the United States Supreme Court has ruled that you have to have these posts, and posts action process for appeal or else they can throw the whole cases out. Can you elaborate on that a little bit?

Mr. GIBSON. Ma'am, I am not—I don't know that I am familiar with the Supreme Court decision there, but I do believe that Congress' ultimate decision to provide an appeal mechanism and the authority that was passed, I think, reflected the body of case law that existed, and the conclusion that you would need to do that in order to withstand judicial scrutiny.

Ms. BROWN of Florida. I know you cut down, I think it used to be longer, but now it's five days, but that process has to be there in order for it to be legal.

Mr. GIBSON. The case law is very clear about providing a federal employee an opportunity to respond to charges. And so that really happened—today's under Title V, it's 30 days, as I mentioned earlier, trying to adhere to the spirit of Congress' intent, we shortened that to the minimum amount that we thought we could and still meet the requirement to provide a reasonable opportunity to respond. And then, that then is not really an appeal, that is just an opportunity to respond, a final decision is made, and then the appeal process happens after that.

Ms. BROWN of Florida. Afterwards.

Mr. GIBSON. Very expeditiously in line with provisions of the law.

Ms. BROWN of Florida. One of the concerns when we the process at the Gainesville hospital, some attention was brought to it because of the scheduling process, they hadn't been trained or they didn't have the equipment, so they were doing part of it on paper, and we corrected that issue.

Mr. GIBSON. That absolutely has been corrected, yes, ma'am.

Ms. BROWN of Florida. One other thing. I think it's very important that we have a comprehensive program. When you think about the mental health, which we are all interested in, and making sure we have the adequate providers, but it's not just the mental health, it's also the housing issue. It's comprehensive. What are we doing to work with our stakeholders to make sure we have the partners we need to address some of the homelessness or some of the other problems that we experience in the system?

Mr. GIBSON. That's a great question. I oftentimes point to the work going on in veteran homelessness as what I would characterize as really best in class collaboration across the federal government, up and down government through federal government, states, and local government, and then across into the nonprofit sector and the private sector.

When you get inside of the work that is going on on veteran homelessness, it's really remarkable that the way that government has come together with the private sector, true partnership kind of collaborative effort, and I think that's the reason we are making the traction, that we are getting the traction that we are in reducing veteran homelessness. Still not as fast as we want to reduce it, so we've got more work to do. But we are making progress there.

Ms. BROWN of Florida. And those stakeholders, what are we talking about? Companies like CSX and others that—they are coming to the table, and I want to thank you all for bringing them to the table.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN of Florida. Because that is making a difference in how we address the needs of the veterans. We all participated in the November the 11th celebration, but the point is we have got to work together with our stakeholders.

Mr. GIBSON. Yes, ma'am, you are absolutely right. I think my perspective, there are three areas where we have to rely on that kind of broad collaborative engagement, veteran homelessness is certainly one of those, mental health is one of those, and then I was at the U.S. Chamber of Commerce last night career transition. Those are really the three where looking for these kind of public private partnerships are absolutely essential if we are going to meet the needs of our veterans.

Ms. BROWN of Florida. Once again, thank you for staying on, thank you for your service. I mean, I think it's a misnomer to let the veterans think that we are in a crisis mode. I mean, I appreciate the leadership and the fact is they should be confident that we are going to work together as a team to make sure we address their issues.

Mr. GIBSON. Yes, ma'am, thank you.

Ms. BROWN of Florida. Thank you.

Mr. GIBSON. Secretary Bob said I can't leave, so I don't think I am going anywhere.

Ms. BROWN of Florida. Thank you, and I yield back the balance of my time.

Mr. BILIRAKIS [presiding]. Thank you. Representative Lamalfa, you are recognized for five minutes.

Mr. LAMALFA. Thank you, Mr. Chairman and committee members, for allowing me to sit in on this hearing here, and Mr. Secretary and your colleagues for being here today, you have a hard job. I know the frustration and anger directed sometimes for new people on the block, you know, there's a context there, but hang in there. You're trying, I think, so.

When you look at the map of America, especially the red and blue one, you see that much of America, most of it is very rural, not in population, but in its geography, and so we have many veterans that live in those rural areas. And so a big part of the Choice Act was to give some of them the opportunity to have a better opportunity to get to care they need that's proximate to them. Take northern California for example.

Now when we see that Ms. Kirkpatrick was talking about post office, for example. We see that in the Redding area they are threatening to close a mail processing center. All mail in northern

California that's in land will go to Sacramento to an area that's probably the size of Illinois. So we know the mail is going to slow down, that's just one factor.

We see that the facilities veterans need for specialty care are generally going to be in Sacramento or the bay area, if they are going to go to a VA facility. Now we have great facilities in Chico, California, and Redding, California, that can do much of these same things.

So let's say you live in Tulelake, California, an area which the federal government incentivized World War II vets to settle after the war, and you are a long ways from anywhere up there as far as that. So if maybe Yreka is nearby, what has my understanding one doctor in a broom closet there. Or maybe you have to go to Medford, or maybe you have to go to Reno, all those are least an hour and a half away with the geographical, weather, other challenges for that veteran to go to. And when they get there, do they even have the facilities they need to do specialty care such as chemo or the more difficult things to administer.

So what we are looking at is that we are hearing that the interpretation by the VA is that Congress didn't write this wide enough or narrow enough, whatever it is, to define that the veterans have more choices. And so we are frustrated because this is the intent. Certainly wasn't the intent of the Committee here or the House for veterans to—that are within 40 miles of a facility but there's no specialty care there that somehow like—have an example, and we will take Yreka, California, haters of VA facility here. And so that means you are within now the VA web, but you don't have any chance of getting what you need, you have to go to another VA one since you are within, as the crow flies, 40 miles.

Now you are in that category of having to stay in VA. You have to go all the way to the bay area which is a five hour drive for probably at the speed of which a veteran in their 80s may drive, or if they can get the shuttle bus at 4 a.m.

So you see where we are going here is that the interpretation of what we are looking for is that I always think the tie should go to the veteran. They have served honorably, and that they are still being put through these hoops. I know there is still more time you need to get this opened up and get the cards out, but what can you tell me today—and going backwards just a little bit under the old law into the new law—how often did the VA use that authority really to previously allow that veteran to go to that private service that is nearby?

Mr. GIBSON. Sure. A couple of comments, and then Dr. Tuchschiidt may have a thought or two to add.

First of all, as I mentioned a couple of times in my opening statement, at every turn when we were interpreting actions under the law, we were looking to do the right thing for veterans, and be the best stewards we could be of taxpayer resources.

So, we haven't seen the final numbers on fiscal year '14 appointments completed in the community, but I am going to guess somewhere in the neighborhood of 18 million. Eighteen million appointments completed in the community, not in VA, that were referred out of VA into the community during fiscal year '14.

Mr. LAMALFA. Pardon me. And you said you were limited by \$6 billion—

Mr. GIBSON. Correct.

Mr. LAMALFA [continuing]. In budget to do that? Is that what you are—

Mr. GIBSON. Correct.

Mr. LAMALFA [continuing]. Saying the real limitation is?

Mr. GIBSON. Correct, yes. And so first of all, we are already referring an awful lot of veterans, including rural veterans for care in their community.

Secondly, as we look at the Act, and if we look and try to understand the intent of Congress, and then we go talk with the Congressional Budget Office to learn how it was scored, clearly the legislation was scored based on 40 miles geodesic distant from the nearest VA medical center.

Mr. LAMALFA. As the crow flies, right?

Mr. GIBSON. As the crow flies, that's right.

Mr. LAMALFA. We don't have a lot of crows that do—anyway.

Mr. GIBSON. So one of things that we did is we were looking at this trying to make the right decision here, so we say okay, how can we evaluate the—is there some way that we could afford to open the aperture here and interpret this differently? And so we took, for example—and I will get Jim to help me with the numbers, if he recalls them—so we took, for example, and says okay, how many veterans have we got that live 40 miles from a level two medical facility? Still not a level one, still don't do everything at a medical center, at a level two medical center, but we do a lot of things, lot of specialty care. And it was somewhere on the order—

Mr. LAMALFA. Would chemo be one of those? Because we have a veteran that has to—that can go 15 miles—and then we are getting way into time here—but 15 miles instead will be required to go 85 for 15 minutes, five days a week. So does level two include chemo? Because that's the kind of thing we are looking—

Mr. GIBSON. Level two I would expect would include chemotherapy. And he will correct me if I say something wrong.

Mr. LAMALFA. Okay. We are really going to have to come back and talk—

Mr. GIBSON. Because what happens when you do that is you then open up about a fourth of your veteran population for eligibility for that care. Round numbers, we are talking somewhere in the \$30 billion range—

Mr. LAMALFA. Okay.

Mr. GIBSON [continuing]. Be able to fee all that care out to the community.

Mr. LAMALFA. I am going to have to stop here because of time again. But I would like to confer with you on that because our—a stat we got is that 438 veterans in northern—the north half of California, the stat would be—is that they would be the ones to be able to use this card in this context here, which is not going to do anything for the backlog, so I would like to clarify that with you at a later date.

And also just a moment on due process. We are talking about due process for employees that you can hardly touch, we have had

a veteran where they came to his door, two agents, seized his DD-214, and they have cut off his benefits, he and his wife are in their 80s, they need this, and this document is somewhere now without a receipt, and also they have not had their day in court. Meanwhile, their benefits are cut off. If they have been accused of something, they have a right to at least have that day soon because their benefits are gone.

Mr. GIBSON. Please provide me the veteran's name.

Mr. LAMALFA. Okay. This and—well, anyway. Thank you, I appreciate the indulgence, committee.

Mr. GIBSON. Thank you.

Mr. BILIRAKIS [presiding]. Member yields back, correct?

[No response.]

Mr. BILIRAKIS [presiding]. Okay. Yeah, Representative Murphy, thank you for your patience, you are recognized for five minutes.

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman, and as a former member of this committee, I appreciate the opportunity to come back and ask some questions as a followup to the Pittsburgh nightmare which goes on.

The Pittsburgh VA Hospital had a problem with Legionnaires' disease where several people died and several were sickened by it. Part of the problem that occurred is the VISN Director received a bonus of some \$60,000 and we raised questions about that, even though it was being investigated at that time, they still went ahead and gave this—and the award was for infection control, of all things.

Other things have come up with this too. As of today we learned that the former head of the hospital has just been let go permanently, but there's another problem that occurs and that is the deputy secretary—excuse me—the deputy Director of the hospital, David Cord, was involved in a chain of emails which we found that—where decisions were made to withhold information from the media while Legionnaires' disease was discovered, and while Legionella was found in the water system.

A time when it would have been critically important to notify the public, if you have these symptoms and you have been to the VA, tell us. Instead they intentionally withheld information.

We also found emails where they disparaged Senator Bob Casey of Pennsylvania and myself as if somehow asking questions was wrong as opposed to asking themselves what did they do wrong.

Now we find out that David Cord has been promoted to head of the Erie VA. I think that is indefensible and incomprehensible, and it sends a terrible message to the employees of the VA system that, you know what, if you hide information, and even though people die, you are going to get promoted. Even Terry Wolf, the former Director who just got fired, she told Cord, don't withhold this information.

And let me tell you an incident that I was involved person to phone. Mr. Cord called me, along with the Director Wolf was on the phone too, but he told me, he says, "We just want you to know there's no waiting list at the Pittsburgh VA." And I said, "Well, first of all, coming from you I am not sure I believe it because you guys distorted and withheld information before. But secondly, why are you calling me out of the blue to tell me this? Somehow I don't

trust this information. You mean you have no waiting list on”—and I began to name every possible medical specialty I could think of, oncology, dermatology, everything. “No, no waiting list, no waiting list, we get to everybody withing 30 days, oh, podiatry is a little bit longer.” I said “Something still doesn’t smell right here, but okay.”

Forty minutes later I got call from Congressman Mike Doyle, represents city of Pittsburgh and the Pittsburgh VA, and he said, “Did you hear about this waiting list?” “What waiting list?” “Well, they had 700 names on the list that went back two years for people for the near list, and I guess they didn’t call that a waiting list because they weren’t really waiting for an appointment because they didn’t have an appointment yet.” And I said, “What do you call that time between when they first call to say I need service from the VA, and the time you get back to them? I call that waiting.”

Mr. GIBSON. I call that a waiting list too.

Mr. MURPHY of Pennsylvania. Exactly. Now you just promoted him. Disparaging comments he made about a senator and me as if we are doing something wrong by investigating. People died in this process, he is involved in a chain of people withholding information from the public, and now this as well where he directly misled me on information. I want you to look into that, because if you are trying to change the morale of the VA and hold people accountable, again, it is incomprehensible to me that a man like this is told he is promoted.

The comments I have heard from employees in the VA is, what are we supposed to do? Whistle blowers get fired. Whistle blowers get demoted. We get disparaged and here is someone who—I will be a witness if you want to testify in this—who has been lied to. I hope you will look into this, it’s an important issue.

Mr. GIBSON. I will look into the allegations that you raise about the wait list conversation. I am, obviously, not aware of that. I would also tell you, very early on—if I am not mistaken I believe it was shortly after I became the acting secretary—I went back on Pittsburgh, and asked folks to go back and look at all of the investigative material.

There were, as you might expect, thousands and thousands of pages of material, IG review, criminal review, FBI, and the like. Because the question I was asking was, were there instances where there was misconduct or management negligence where accountability action should have been taken that had not been taken. And what I was able to determine was that in every instance where there was some culpability identified, there had been some action taken.

Now, I would tell you I might not have agreed, and in all likelihood, would not have agreed with the nature of those actions, but I had no leeway to go back and address those because those actions had been closed out completely. I had no new evidence to use to be able to pursue those particular instances, except in one instance, and that’s the one instance that you referred to just a moment ago.

Mr. MURPHY of Pennsylvania. Well, I hope you will continue to review these things. I sent a letter a year ago asking to give us some information on what were some of the other instances and problems that people had, and what disciplinary action was going

to take place, and we have yet to hear back on those. It's been a year and I would love to have that information. There's other things I look for——

Mr. GIBSON. We will go back and look at the response to that, because I am not aware that we have had any congressional responses that are outstanding for the period of time.

Mr. MURPHY of Pennsylvania. Thank you. The Chairman has been gracious enough to let me ask some questions, there's several other things I would like to discuss with you and the new secretary to make some recommendations. I am a Lieutenant Commander in the Navy and I do my drill time at Walter Reed Bethesda Hospital, and I know we still have problems with the continuity between DoD and VA, and that sometimes people are kept in the military beyond retirement, or beyond the date of separation just to try and continue to get them care because they feel if they get into the VA system they will be lost and won't get the same qualitative care.

We shouldn't have a system like that, we should have one with a smooth, easy handoff where people are confident about the care they will get, and I would love to talk to you about some more ideas with that. With that, Mr. Chairman, I thank you, and I yield back.

Mr. BILIRAKIS [Presiding]. Thank you. If there are no further questions, anyone—yes? You are recognized.

Ms. BROWN of Florida. Yes. I just want to make one comment as to what he just said about DoD and the VA. We have worked a long time to get that continuity between the VA and DoD, and I don't know necessarily it's necessarily the VA's resistance, but we in Congress keep pushing for it because it needs to be seamless, that transfer, that is one of the problems.

For a long time, you know, the veterans couldn't get the service because we couldn't get the files because it burned up in St. Louis place, somewhere. So, I mean, it's not necessarily just the VA's problem with the system. Can you respond to that?

Mr. GIBSON. I think that's a fair statement. I would tell you over the past several years it's clear that there's been a vast amount of progress made, but I would also tell you that there's still a gap, and too many servicemen and women fall through that gap, and that we are committed to do everything we can, working collaboratively with the Department of Defense to close the gap.

Ms. BROWN of Florida. Thank you, and I yield back my time.

Mr. BILIRAKIS [presiding]. Thank you. The ranking member has no further comments, the panel is now excused. Thank you very much, Mr. Secretary, for your testimony.

Mr. GIBSON. Thank you, Mr. Chairman.

Mr. BILIRAKIS [presiding]. I ask unanimous consent that all members have five legislative days to revise and extend their remarks, and include extraneous material.

Without objection, so ordered.

Once again, I thank all of our witnesses and audience members for joining in today's conversation. This hearing is now adjourned. Thank you.

[Whereupon, at 12:35 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF JEFF MILLER, CHAIRMAN

Good morning and thank you all for joining us for today's Full Committee oversight hearing.

As everyone sitting around this dais today is well aware, on August 7, 2014, the President signed into law the Veteran Access, Choice, and Accountability Act of 2014 (Public Law 113-146).

This law was thoughtfully and carefully crafted after months of aggressive oversight by this Committee to address the unprecedented access and accountability scandal that engulfed the Department of Veterans Affairs (VA) following allegations—first uncovered in this very hearing room—that some VA medical facility leaders were keeping secret waiting lists in an effort to manipulate wait time data and ensure their own executive bonuses.

We are here today to evaluate the progress VA has made to implement it in accordance with both statutorily required deadlines and Congressional intent.

This includes the effective and timely implementation of the Veteran Choice Program, designed to provide relief to veterans who reside forty miles from a VA facility or who cannot get a timely appointment.

It includes the required independent assessment of VA's healthcare system which, in my opinion, should necessarily inform decisions about staffing and infrastructure that are to be made under the law.

Finally, and most importantly, it includes accountability, on which I will focus my remaining remarks.

Section 707 of the law which authorizes the Secretary to fire or demote Senior Executive Service (S-E-S) employees for misconduct or poor performance.

It should go without saying that veterans deserve the very best leadership that our government has to offer.

Yet, the events of the last year have proven that far too many senior VA leaders have lied, manipulated data, or simply failed to do the job for which they were hired.

It is also clear that VA's attempt to instill accountability for these leaders has been both nearly non-existent and rife with self-inflicted roadblocks to real reform.

When I originally drafted this provision, I believed that it would provide Secretary McDonald the tools he said he needed and wanted to finally hold failing senior leaders accountable.

When President Obama signed it into law, he agreed with me by saying, "If you engage in an unethical practice, if you cover up a serious problem, you should be fired. Period. It shouldn't be that difficult."

Based on these comments—as well as similar statements by Secretary McDonald himself—I am both perplexed and disappointed at the pace at which employees have, in fact, been held accountable.

Even more worrisome is what Secretary McDonald said on November 6th that, and I quote, "The new power I was granted is the appeal time for a senior executive service employee of the VA has been reduced in half. That's the only change in the law. So the law didn't grant any kind of new power that would suddenly give me the ability to walk into a room and simply fire people."

It is clear that the Secretary, and those advising him, remain confused on what the law actually does, which is much more than simply shorten the appeals process.

No, the Secretary can't simply walk into a room and fire an S-E-S employee without evidence warranting that action, but the law does give him the authority to remove that employee for poor performance or misconduct.

The Secretary has also cited a plethora of numbers that he says illustrate the Department's commitment to holding individuals accountable.

For example, he has said there's one list of a thousand names of employees being removed, and another list of five-thousand six hundred names of employees being removed, and yet another list of forty-two names of senior executives VA is proposing disciplinary actions on.

So let me take a moment to set the record straight.

Based on a briefing VA provided to Committee staff yesterday, VA only has one year of aggregated data on disciplinary actions taken against any of its over 330,000 employees, making meaningful comparisons against previous years impossible.

Further, the list of over 5,000 mentioned by the Secretary is proposed disciplinary actions only and the list of over 1,000 is a list of proposed removals for any type of poor performance.

Only the list of 42—provided at my request on a weekly basis—includes employees proposed for discipline due to the crisis which has engulfed VA this year.

What's more, since August 7th, only one S-E-S employee has been removed under the new law and this person's removal was not directly related to patient wait times or data manipulation.

I do not understand, in the wake of the biggest scandal in VA's history, how only 42 employees—only four of which appear to be senior executives—have been proposed for discipline with none yet removed.

Further, VA has taken the liberty of creating an additional bureaucratic office—the Office of Accountability Review—to review proposed removals and an additional bureaucratic delay—a five-day advance notice of removal—which essentially operates like a new internal appeal process.

These questionable actions are nowhere to be found in the law we wrote and the President signed.

In my view, the five-day advance notice of removal only serves to incentivize poor-performing senior leaders to drag out the disciplinary process while continuing to collect a hefty paycheck before ultimately retiring with full benefits.

Further, it perpetuates the perception that VA cares more about protecting bad employees than protecting our nation's veterans.

We should not be providing credit towards a taxpayer-funded pension for a time period during which an employee's actions caused harm to veterans.

That is why I will soon be introducing a bill that would give the Secretary the authority to reduce an S-E-S employee's pension to reflect the years of service during which they participated in actions that made them subject to removal.

This proposal is a fair and equitable way to emphasize to poor-performing senior employees that retirement credit is not earned by failing veterans and that their actions have long-lasting and meaningful consequences.

I won't get into individual personnel actions at this time since there are serious legal issues at hand that must be dealt with respectfully and appropriately.

However, I want to make it very clear today that I continue to have very serious concerns about accountability at the Department of Veterans Affairs.

Again, in response to what is without a doubt the biggest scandal that has ever impacted VA, I am not seeing the corresponding efforts to hold those at fault accountable for their actions.

Secretary Gibson, as we discussed yesterday on the phone, I have an increasing worry that Secretary McDonald and you are getting bad advice from some of those around you within VA's bureaucracy.

I hope that is not the case.

This is the same issue that I believe doomed Secretary Shinseki's tenure and I hope you take my suggestion seriously when I tell you that VA's entrenched bureaucracy must be shaken up in order for any true reform—reform that is so desperately needed to better serve our veterans—to succeed.

I thank you all once again for being here this morning.

PREPARED STATEMENT OF RANKING MEMBER MICHAEL H. MICHAUD

Thank you, Mr. Chairman.

We are here today to get an update from the Department of Veterans' Affairs on implementation of the Veterans Access, Choice, and Accountability Act of 2014.

This law, passed back in August, addressed a number of serious issues the Department had with providing timely, quality healthcare to veterans. Long wait times are the problem that got us here. We shouldn't make veterans wait for the solution to be implemented.

While today is the first public update on VA's implementation of this law, staff-level updates have been occurring on a regular basis since early September.

Dr. Tuchschiidt and Mr. Giddens, I appreciate the time you have invested in openly communicating with staff from the House and Senate Veterans Affairs Committees on implementation issues and progress.

This is a marked change in VA—Congressional relations, and I hope it is a precedent for improved working relations going forward.

The law provided additional resources and authorities to provide four key improvements for veterans—timely access to healthcare, expansion of VA's internal capacity for care, improved accountability, and additional education benefits.

Today, I hope I hear tangible ways veterans are getting the improved outcomes intended. If there are real and reasonable roadblocks to implementation, we need to know what they are and how to fix them.

With regard to timely access to healthcare, I am aware that the Department has expressed serious concerns with the 90-day deadlines under section 101, the Choice Program.

The program requires VA to determine eligibility, authorize and coordinate care, manage utilization, set up a call center, and implement a new payment system.

VA has taken a phased roll-out approach in order to balance expediency with an effective program. This may be reasonable, but I want to understand the overall timing, and how the Department of Veterans' Affairs is handling eligible veteran's access to care throughout the phases. A phased approach to administrative rollout may be okay, but a phased approach to access to care is not.

The law provided \$5 billion for the Department to augment staffing and infrastructure. I know the Secretary has personally been out recruiting. I look forward to hearing how successful that effort has been and how many new doctors and nurses VA expects to bring onboard and when.

I am also interested in hearing how VA will implement the funds and authorities for new infrastructure. We have seen many problems with the Department of Veterans' Affairs construction problems in the past, and I look forward to hearing the changes VA is making to the process in order to deliver these new projects on time and within budget.

With regard to accountability, I understand removing a federal employee is not as simple as many think it should be, even with the new authorities in the law. I appreciate the difficult position the Department is in when it comes to holding employees accountable for wrong-doing and poor performance in a highly charged and very public environment.

That being said, we need to feel that the Department of Veterans' Affairs is taking the necessary actions to move as swiftly and decisively as possible to get rid of those people who failed America's veterans. The explanation for delays needs to be clear, concise and compelling, not just for Congress, but for veterans and the American public.

While much of the focus of the law has been on the access and accountability provisions, we should not forget that the law also includes substantial enhancements to the education benefits for veterans and their families. I look forward to hearing what is being done to implement these provisions as well.

Beyond the Veterans Access, Choice and Accountability Act of 2014, Secretary McDonald has announced a number of reforms aimed at addressing the culture and structure of the Department of Veterans' Affairs. Many of these reforms reflect ideas we have discussed in the past, and I am pleased to see them being embraced and actively pursued.

I encourage the Secretary to quickly define detailed execution plans for these concepts. Do not get stuck in analysis and process—figure out what actions need to be taken, and then take them. Be fearless in facing this reform, just as our nation's veterans are fearless in their battles.

Mr. Gibson, Dr. Tuschmidt Mr. Giddens, thank you for appearing today. We appreciate your time, efforts and look forward to your testimony.

Thank you Mr. Chairman and I yield back the balance of my time.

PREPARED STATEMENT OF HON. CORRINE BROWN

Thank you, Mr. Chairman and Ranking Member, for calling this hearing today. I am pleased the Deputy Secretary is here today. I enjoyed working with you as Acting Secretary and am glad you stayed on at the VA. I also appreciate you deciding to keep the Baldwin Park VA Medical Center open after the Orlando facility opens. Thank you for your service.

I was pleased to be on the conference committee that negotiated the Veterans Access, Choice, and Accountability Act.

As the most senior member of the House Veterans' Affairs Committee, I strongly believe that the VA provides the best care for our nation's servicemembers returning from protecting the freedoms we hold most dear, and I am committed to VA continuing their critical mission of serving our veterans. VA has served the special needs of returning veterans for over 75 years and has expertise in their unique healthcare needs, including prosthetics, traumatic brain injury, Post Traumatic Stress Disorders (PTSD), and a host of other veterans specific injuries. My focus continues to be on ensuring that the VA retains the ultimate responsibility for the healthcare our veterans receive, regardless of the provider.

The VA operates 1,700 sites of care, and conducts approximately 85 million appointments each year, which comes to 236,000 healthcare appointments each day.

The latest American Customer Satisfaction Index, an independent customer service survey, ranks VA customer satisfaction among Veteran patients among the best in the nation and equal to or better than ratings for private sector hospitals.

It is incumbent upon us to ensure the VA has final authority over the care that veterans receive whether at the VA or at non-VA providers. We need to continue to work with our veteran stakeholders to ensure the VA has all the resources it needs to provide superior healthcare to our veterans. This includes providing the necessary resources to address the ever increasing population of women veterans.

I have been on this committee for 22 years. In fact, when I came here, Jesse Brown was the Secretary and his motto was "Putting Veterans First." I am encouraged by the current Secretary, Bob McDonald, and his plan for "My VA."

The VA is the best system we have to serve the healthcare needs of the veterans returning from war. We cannot destroy this system. I feel very strongly about that and I don't want to be the only one saying that. We need to protect the system for the veterans.

PREPARED STATEMENT OF HON. SLOAN GIBSON

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the House Committee on Veterans' Affairs, thank you for the opportunity to discuss with you the Department of Veterans Affairs' (VA) implementation of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146), also known as "the Act." VA's goal has been, and always will be, to provide Veterans with timely and high-quality care with the utmost dignity, respect and excellence. However, we as a Department are aware of the challenges we face. We want to turn these challenges into opportunities to improve the care and services we provide to our Nation's Veterans. That is why our Veterans and VA employees nationwide understand the need for reform and are pleased Congress passed and President Obama signed into law the Veterans Access, Choice, and Accountability Act on August 7, 2014. We are committed to providing Veterans with the best possible care-experience, while also meeting our obligations to be good stewards of the Nation's tax dollars.

Prior to the law's enactment, VA was already making progress moving Veterans off of wait lists and into clinics. From May 15, 2014, through the end of fiscal year 2014, the Electronic Wait List went from over 57,000 appointments to under 24,000, nearly a 60-percent reduction. The New Enrollee Appointment Request list went from 64,000 to 2,000, which is nearly a 97 percent reduction. The Veterans Health Administration completed over 18 million appointments from May 15 through September 30, 2014, an increase of 1,200,000 over the same period in 2013, and made more than 1,089,202 total non-VA care authorizations from May 15 to September 30, 2014, a growth of 346,393 (47 percent) over the same period in 2013. On average, each authorization results in 7 appointments, thus these non-VA care authorizations have the potential to generate 10.8 million appointments. While this is encouraging progress, the Department's goal is to provide all Veterans with timely, high-quality, clinically appropriate care. Veterans are our customers—we will use all authorities we have to continue get Veterans off wait lists and into clinics.

Overview of the Veterans Access, Choice, and Accountability Act

VA appreciates the enhanced authorities, funding, and programs now available under the Act to ensure Veterans have timely access to safe and high-quality healthcare. The Department has been working hard to implement this highly complex piece of legislation in a way that provides Veterans with the best possible care-experience. This legislation appropriated \$5 billion to hire physicians and other medical staff and improve VA's infrastructure to reduce the shortfall in our capacity to meet the healthcare needs of Veterans in a timely way. As we have shared with the Committee, the Department is finalizing the required plan for spending the \$5 billion, but we are also striving to ensure that we allocate these incremental resources as good stewards for our Nation. We have also come to realize that implementation of some of the legislation's requirements will require additional resources not covered by the \$5 billion. The 27 leases authorized in the Act begin the process of implementing our long-term space plan. The Act also provided \$10 billion to purchase needed care from the community while we build that internal capacity.

The legislation also provided us with great tools that we believe will improve our ability to recruit and retain high-quality clinical staff. At the same time, the Act also gave VA enhanced authority to propose the removal or demotion of senior executive employees based on poor performance or misconduct. We know that we cannot tackle our long-term issues without cultural change and accountability. While the new law shortens the time a senior executive, proposed for removal by VA, has to

appeal VA's decision, it does not do away with the appeal process or guarantee VA's decisions will be upheld on appeal. Secretary McDonald and I have been clear that when evidence of wrongdoing is discovered, we are holding employees accountable and taking action as quickly as law and due process allows.

VA appreciates enactment of the Department of Veterans Affairs Expiring Authorities Act of 2014 (Public Law 113-175), which was signed into law on September 26, 2014, that amended and fine-tuned key provisions of the Act to improve our ability to deliver Veterans the best possible care-experience. VA believes, with the help of Congress, more work is necessary to further refine the Act and address remaining implementation challenges. As VA engages in the appropriate rulemaking and implementation processes required by the law, we will continue to communicate openly where such challenges exist. We will work to address sources of confusion and continue to solicit input from stakeholders. We are grateful for the ongoing engagement of members of Congress and their staff in the discussions we have held to date. VA will continue to work with other Departments, Congress, Veterans Service Organizations, and other stakeholders to ensure that our implementation of this legislation optimally benefits Veterans in a manner consistent with our obligation to be good stewards of taxpayer dollars.

Addressing Challenges within the Veterans Choice Program

One program required by the Act that is particularly critical to Veterans is the Veterans Choice Program authorized by section 101. As we have informed the Committee in over 10 telephonic and in-person meetings held between Committee staff and VA personnel regarding implementation of the Veterans Choice Program, VA has identified a number of areas within section 101 that could present implementation challenges or result in confusion for Veterans.

For example, as you are aware, the 90-day timeline to establish a new health plan capable of producing and distributing Veterans Choice Cards, determining patients' eligibility, authorizing care, coordinating care and managing utilization, establishing new provider agreements, processing complex claims, and standing up a call center has been particularly challenging. In fact, we received overwhelming feedback from the marketplace about the significant challenges of meeting the law's aggressive timeline. Despite the timeline, VA launched the Choice Program on November 5 with a responsible, staged implementation focused on delivering the best Veteran experience.

We remain concerned, however, about the potential fragmentation of care and our ability to ensure Veterans receive appropriate preventive health and screening. As you are aware, the average enrolled Veteran is older, sicker, and poorer than the general population. We have made significant investments to ensure that our patients have access to mental health services in the Patient Aligned Care Team clinic. Community mental health resources are often not readily available, particularly in rural areas, and are rarely integrated into a private-sector primary care-experience. As

one-third of Veterans receiving VA care have a mental health diagnosis, coordinating care and providing timely access to high-quality mental healthcare is of the highest importance to us.

Additionally, the success of interoperability depends on the integration of records from non-VA providers into the VA's electronic medical record and clinician's workflow at the point of care. The current state of national health information exchange continues to evolve in response to known challenges. In order to ensure sufficient continuity of care for Veterans who are treated in both VA and non-VA settings, we will continue to work at finding solutions to deliver the greatest healthcare outcomes for our Veterans.

Pursuant to the Act, we successfully re-defined and published a new wait-time standard for appointments. The new wait-time standard is 30-days from either the date that an appointment is deemed clinically appropriate by a VA healthcare provider, or if no such clinical determination has been made, the date the Veteran prefers to be seen. While this standard will help ensure that Veterans receive timely access to the benefits of the Choice Program, it is not a clinical standard for timely care. As we have long maintained, for the Veteran who needs care today, VA's goal will always be to provide timely, clinically appropriate access to care in every case possible.

Conclusion

VA is committed to providing Veterans with the best possible care-experience by implementing this legislation effectively to deliver timely access to high-quality care for Veterans. We are grateful for the close working relationship with Congress to ensure that we are making forward progress." Congress can be assured VA's staged implementation of the Act will ensure the Veteran's best possible experience.

To the extent that there are significant challenges, we are working to overcome the challenges while meeting the intent and requirements set forth in the Act. We will continue to share with the Committee any issues to ensure we have a common understanding of the implications of the Act.

Lastly, I thank the Committee again for your support and assistance in fine-tuning the Act as we work to implement this vital legislation, and we look forward to working with you in making things better for all of America's Veterans.

This concludes my testimony. Dr. Tuchsmidt, Mr. Giddens, and I are prepared to answer any questions you or the other Members of the Committee may have.

FOR THE RECORD

STORY BY JEREMY SCHWARTZ, AMERICAN-STATESMAN STAFF ON SEPT. 7, 2014

On the morning of July 1, 2008, Department of Veterans Affairs officials gathered to unveil a state-of-the-art brain scanner they predicted would help revolutionize the understanding of traumatic brain injury and post-traumatic stress disorder in combat veterans.

The timing, and location, seemed perfect. One of the first studies would scan nearby Fort Hood soldiers before and after they deployed to war in Iraq or Afghanistan—a unique opportunity to study physical changes in soldiers' brains due to combat.

Six years later, the \$3.6 million machine sits unused in an out-of-the way corner at the Olin E. Teague Veterans Medical Center in Temple.

Not a single study based on the machine's scans has been published.

Not a single veteran has received improved treatment because of advances ushered in by the scanner.

The machine has sat dormant for the past three years, plagued by a series of delays caused by mismanagement, mechanical failures and bureaucratic roadblocks. Officials at the Waco Center of Excellence for Research on Returning War Veterans, which oversees the program, aborted the scanner's first and only brain study in 2011 when they declared its image quality too poor to use.

In a grim internal assessment, the center's associate research Director, Dena Davidson, wrote in March 2013: "I think there should be serious consideration of returning the MRI from where it came because we do not have the expertise to use it or care for it."

The scanner idles 24 hours a day because it's more expensive to turn an MRI machine off and on than to keep it running. A full-time technician diligently performs daily maintenance checks on the unit.

By early 2014, VA staffers were seeking alternative purposes for what was once envisioned as support space for the multimillion-dollar scanner.

One idea: housing for lab rats.

"Can I store my 14 rodent housing racks (2'x6'x7') in there?" one VA employee asked colleagues in a January email. "This is not a joke."

It was an inglorious decline for a machine once hailed by VA leaders as the most powerful mobile MRI on the planet. The scanner, housed in a semi-truck trailer, was supposed to travel between Fort Hood, the nation's busiest deployment hub for war-bound soldiers, and the VA hospitals in Temple and Waco.

Internal VA emails, reports and documents detail a program that was bungled almost from the start. Yet the story of how one of the agency's most powerful diagnostic tools devolved into a ghost machine also stands as a stark symbol of the VA's shortcomings in responding to the specialized needs of soldiers returning from the longest-running conflicts in the country's history.

"Everyone involved in this effort felt this was a unique opportunity to help our troops, not just at Fort Hood, but throughout the country," said former U.S. Rep. Chet Edwards, D-Waco, who had worked to bring the center and mobile MRI to Waco. "I had hopes that this project would work at a time when troops were still deploying to Iraq and Afghanistan. I don't understand why that didn't happen. There may be a good reason. I simply do not know."

VA Research Arm Escapes Public Scrutiny

In recent months, a burgeoning national scandal over how long veterans have to wait for medical care has spurred congressional and criminal investigations and toppled the former VA secretary. Lawmakers have also probed the agency's disproportionate use of painkillers, high rate of veteran suicide and massive backlogs of disability claims.

The scrutiny, however, has largely ignored the VA's \$2 billion-a-year research arm. A 10 month American-Statesman investigation suggests that the VA's research arm, charged with developing the military's treatments of the future, also merits close examination.

The newspaper reviewed more than a thousand pages of documents obtained through Freedom of Information Act requests and interviewed six former and current employees of the Center of Excellence, which was to house the mobile MRI and oversee the research.

The documents and interviews show that leaders took charge of the scanner without a clear plan for success and then were unable to recruit enough researchers, as staffing at the center fell to just 15 employees in January despite initial plans for 75. Later, administrators became mired in red tape; internal VA squabbles paralyzed the imaging program after workers appeared close to restarting research in 2012—delays that launched a cascade of new problems. The Waco center lost at least seven federally funded grants for what researchers hoped would be groundbreaking brain injury research.

"They didn't want people to know how much of a failure it was," said one former Center of Excellence employee, who requested anonymity because he feared retaliation from the VA. "Unless someone says something, they will think it's OK to do what they've done and continue to do."

The program's failures came just as it was needed most. Since 2008, more than 150,000 U.S. service members have returned from war with diagnoses of PTSD or TBI. Yet research has yielded few significant advancements in treatment of the two maladies, experts say.

For many vets, "PTSD or TBI are factors in their inability to reintegrate—they come back a changed person, they know it, but they can't identify why," said Steve Hernandez, the McLennan County veterans service officer. "To know we had seven years where we could have helped find breakthroughs in understanding, that's disheartening."

Troubled Beginnings

Waco MRI research project had roots in failed UT program.

Waco resident Timothy Priddy, who suffered a traumatic brain injury when he deployed to Iraq with Fort Hood's 1st Cavalry Division in 2004, wonders if the scanner could have led to advances that might have helped him get better treatment.

"The way they were talking, (the scanner) could see more thoroughly into the brain and better detect brain injuries and everything," Priddy, 35, said. "(The center's failures) were a slap to all veterans that go out there. There's no telling how many Vietnam veterans have TBIs."

The tumult at the Waco Center of Excellence also caps nearly a decade of VA futility in Central Texas when it comes to researching brain injuries. Five years ago, the VA shut down research at a similar program at the University of Texas in Austin—the Brain Injury and Recovery Laboratory, which didn't scan a single veteran before its assets were transferred to Waco. Between them, the two imaging programs cost taxpayers more than \$12 million and squandered almost a decade of opportunity.

Today, VA officials say they are trying to revive the Waco program and find a researcher to take charge of the troubled scanner. They have hired a new center Director, added employees and hope to eventually grow to 50 staffers.

"You know, I can do what I can do," said the center's new Director Michael Russell. "I'll get it going, and I think there's going to be a continuing (operational) tempo of deployments for at least some time. It will be smaller numbers, but there will still be deployers."

The VA did not respond to a request for comment from administrators who oversaw the program during the previous six years.

New Understanding of Brain Function

While the VA is best known for providing healthcare and disability benefits to veterans, it also operates one of the nation's largest research operations. With unique access to millions of veterans and their medical records, the VA in 2014 spent \$586 million on research and prosthetics and oversaw nearly \$2 billion in total research funding.

In 2015, the VA plans to spend about \$35 million—or less than 6 percent of its research budget—on TBI and neurotrauma study nationwide. The most advanced research occurs at specialized mental illness centers such as the Waco Center of Excellence, which opened at a time when increasingly powerful scanning instruments were revolutionizing how the medical profession viewed the brain.

"For much of the last three to four decades, (research) was predicated on the idea that brains can't heal," said Jim Misko, a former board member of the Brain Injury

Association of America. "But in the last 10 years, that's been completely replaced by the data driven, informed view that a lot of damage from concussion or TBI isn't black and white. It's not a question of healthy vs. dead tissue. Most of the damage is in between, in tissue that can be repaired. Now the lid is off with people (wanting) to do research."

He added, "If you have access to the best imaging, you're getting to see damage where we could never see it before."

But few brain injury studies in recent years have scanned soldiers before and after deployments. Such a comparison would allow researchers to observe changes in individual soldiers' brains as the result of exposure to war.

"It's a perfect study design," said Martha Shenton, Director of the Psychiatry Neuroimaging Laboratory at Harvard University and scientist at the VA Boston Healthcare System. "The gold standard is the pre-deployed brain."

Waco's research plans represented more than just a better understanding of PTSD and TBI; they were part of an effort to resuscitate the sprawling, 75-year-old Waco VA complex, which officials had targeted for closure in 2003. Thanks to local veterans advocates and lawmakers, a federal panel recommended in 2005 that the red brick buildings in Waco not only be kept open, but expanded. At the 2008 ceremony, Edwards declared: "This is like the phoenix rising from the ashes."

The centerpiece of the rebirth was the Philips Achieva Quasar mobile MRI unit. The VA hailed the unit as "the world's most powerful research (mobile) magnetic resonance imaging (MRI) machine." It featured a magnet twice as strong as nearly every other mobile unit at the time, which should have given researchers greater speed and image detail.

"They were swinging for the fences," said Russell. "There's only half a dozen of those ever built. So this was like pushing the limits of science, right?"

Trouble From the Beginning

In 2009, the VA signed an agreement with Fort Hood to study soldiers before and after they deployed to war. An early contract called for the scanner to make up to 100 trips per year to scan veterans and soldiers.

Yet moving the scanner, giving researchers access to more subjects, proved problematic.

Technical problems surfaced almost immediately. Images suffered from "artifacts" or lines and spots caused by vibrations and other disruptions in the scanner's magnetic field.

In a statement to the Statesman, Philips said the scanner suffered from "out-of-specification environmental conditions at the site that affected system performance," but wouldn't elaborate. The OshKosh Corp., which manufactured the trailer, didn't respond to a request for comment.

"You have to recalibrate it, anything in the environment has to be factored, it has to be shimmed," Russell said, adding that it costs thousands of dollars each time it is moved. "So you don't move it that often," he said.

Gaps in Research

Waco research center was to play a big role in government brain studies on soldiers before and after deployment.

At the same time, the Center of Excellence was struggling to find a Neuroimaging Director and recruiting imaging researchers.

"They ventured into MRI research projects without having anyone on board who knew what they were doing," said another former center employee, who asked for anonymity because he feared retaliation for speaking out. "They threw money at it, but didn't have anyone in place to get it going. Waco was a tough draw, but a congressman pushed for it in Waco, and so that forced the VA to try and bring people there. It's hard to build a program from scratch."

The employee added that the imaging problems came after the VA failed to conduct proper acceptance testing, which is routinely done to determine if a new research scanner is working as the manufacturer claims.

"It's all good intentions," Russell said. But "by the time we actually had somebody on board who could do those studies, a period of time had already passed. But that's the difference between being a startup organization and purchasing something for an existing institution."

Shut it Down

The scanner's first project was a study seeking to determine the genetic and physical root causes of PTSD, conducted by Keith Young, who served as Acting Director of the Neuroimaging Program, even though, colleagues said, he had little imaging experience. By early 2011, Young had scanned more than 200 veterans with the machine, according to VA documents.

After leaving the Waco Center of Excellence, former center Director Suzy Gulliver, former imaging Director Deborah Little and Baylor University researcher Lea Steele joined forces at Scott and White's Warrior Research Institute to study traumatic experiences, brain injury, and toxic exposure. The trio is pictured here in the April edition of *The Catalyst*, the magazine of the Scott and White Healthcare Foundation.

But the image quality was so concerning that in March 2011 the VA brought in an outside expert, Deborah Little, the Director of MRI research at the University of Illinois-Chicago, to investigate, according to documents.

Little's verdict was devastating: The scanner wasn't capable of conducting the research it had been purchased to do and needed massive repair. The center's then-Director, Suzy Gulliver, immediately shut down the PTSD study and suspended research on the scanner. (Greg Harrington, an MRI physicist and former researcher at the center, disputed Little's assessment, saying that when he left the VA in May 2011, the scanner was "fully capable" of performing most research.)

In July 2011, the scanner suffered a massive failure called a quench, in which the liquid helium used to cool the powerful magnet was released as a gas after the scanner's cooling system failed. Unplanned quenches can permanently damage magnets or lead to repeated quenching, and in this case it required several weeks of repair.

The next month, Little joined the VA to permanently oversee the machine and imaging program. A press release announcing her hiring made no mention of the dire situation facing the center's signature piece of equipment.

For much of the next year, Philips repaired and redesigned the scanner, at no cost to the VA. The machine was finally returned to the VA at the end of 2012.

Timeline of the Center of Excellence Scanner

Adversarial at Best

Yet there were more glitches. Little told her superiors she needed a research agreement with Philips, which she said would give her the necessary software codes to properly calibrate the machine for advanced research.

For over a year, Little and her staff haggled over the agreement, with no success. Her biggest obstacle wasn't Philips, but her colleagues: According to internal VA emails, the VA's own contracting officials in Illinois refused to release the documents that Center of Excellence staffers needed to execute the agreement.

"We cannot conduct research on our MRI until we have a research agreement in place," Little wrote to her contracting colleagues in a Jan. 7, 2013, email. "This is a critical issue."

Little, who in an internal memo called her relationship with contracting and legal officials "adversarial at best," said the resulting delays cost half a dozen studies that might otherwise have been done—a malaise that bogged down the program's work even more.

"Because of the events of the last year, there has been no recruitment attempted to fill support positions in the Neuroimaging and Genetics Core," she wrote in a February 2013 report. "As such, the Core is woefully and completely understaffed and no other scientists have been trained on management of the MRI."

A month later, Little resigned, leaving the program in total disarray.

"We are at a complete loss for managing this unit without an expert and as far as I understand, Dr. Little was the only person in the VA who had the knowledge to manage this specialized equipment," the center's interim Director, Mira Brancu, wrote in July 2013.

Potential partners outside the center began to take notice of the internal struggles. Baylor University researchers had been eager to use the scanner as a key part of their investigation into the array of poorly understood symptoms facing Gulf War veterans. But in April 2013, they decided to pull the plug.

"We're hoping to start patient recruitment this summer, and really can't afford additional delays," Baylor's Lea Steele wrote to Davidson, the associate research Director. "I am also very sorry to add something else to the list of bad news that you and everyone there has been dealing with for so long."

Davidson's reply reflected the growing feeling of gloom at the center. "Indeed I suspect it will be many months before we have everything in place to use the MRI," she wrote. "So I think you are making a very wise choice. I only regret if we in any way contributed to the delay of your research."

In fact, without Little, VA officials were soon forced to acknowledge that not only did they not know how to use the sophisticated machine—they had no idea if it was functional at all after its long period of inactivity.

Two months later, the scanner suffered its third quench.

Other Problems at Waco Center

The problems in the imaging program were among wider issues plaguing the Center of Excellence. A \$10 million permanent home for the center was supposed to debut in 2011; three years later it still hasn't opened, leaving staffers in temporary quarters. In early 2013, Gulliver, the center Director who had hired Little, left the VA under a cloud of allegations over dubious financial transactions related to recruiting and outside grants.

A series of VA employees serving as interim Directors took over the troubled center. The first, Brancu, expressed distress upon learning the full extent of problems with the scanner.

"We have been left with a multimillion-dollar unique mobile MRI unit that is not being overseen by an expert and not being utilized for research," she wrote in July 2013. The day before she handed off her interim Directorship to her replacement, Jennifer Runnals, Brancu added: "I think at this point, we are concerned about whether this magnet is in any condition to be used."

For her part, Runnals conceded she knew little about the sophisticated machine she'd inherited. "It became apparent to me that my lack of expertise regarding MRIs would be a significant obstacle," she wrote.

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She contacted the VA's other MRI experts for assistance. But her colleagues were no help: "Despite several emails I received no response or assistance prior to my term," she said in a report.

So Runnals next turned to the University of Texas—where the VA had halted research at the Brain Injury and Recovery Lab three years earlier. "What I am looking for is to run some information by a person who knows how magnets function, their upkeep etc.," she wrote to UT professor Jeff Luci.

Luci's prognosis was grim: "Once a magnet starts quenching, the pattern usually repeats itself," he wrote. "I doubt you've seen the last quench."

The Future

Earlier this year, the VA hired Russell, who had previously overseen the Army's TBI screening program, as a permanent Director for the Center of Excellence. Russell said he has doubled the staff and has found someone to oversee the Neuroimaging program—though he'll start with modest expectations.

"His challenge is going to be to make the machine function properly," Russell said. He conceded that it's still not clear if the vibration problem has been solved or if it can ever be used as originally intended. Russell added the machine might have to be taken out of its trailer and bolted to the ground.

In the meantime, he has suggested using it to conduct simple medical scans on veterans to reduce wait times for patients. "It's available if somebody wants it," Russell said. "It hurts me to see it sitting there, honestly. I wish we could be using it clinically."

So far, however, Central Texas VA leaders have declined.

Russell said he hopes the eventual completion of the Center of Excellence's permanent home will help recruiting.

"It's hard to do that kind of cutting edge science without the right facilities," he said. "We have to give people the infrastructure to be able to do it. . . . I'm pretty comfortable that if we build it right, it'll fly. It's just not ready yet."

