

**ACCESS AND ACCOUNTABILITY: EXAMINING OB-
STACLES TO HIGH-QUALITY PATIENT CARE IN
LOUISIANA**

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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MONDAY, JUNE 20, 2016

**FIELD HEARING HELD IN
PINEVILLE, LOUISIANA**

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ACCESS AND ACCOUNTABILITY: EXAMINING OBSTACLES TO HIGH-QUALITY PATIENT CARE IN LOUISIANA

Monday, June 20, 2016

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

The Subcommittee met, pursuant to notice, at 3:00 p.m., in Pineville City Council Chambers at Pineville City Hall, 910 Main Street, Pineville, Louisiana, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek and Abraham.

Also Present: Representative Fleming.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. Hello? Can you hear me now? The Subcommittee will come to order.

Before I begin, I would like to take care of one minor procedural detail, and that is, I ask unanimous consent for Congressman John Fleming to sit at the dais and participate in today's proceedings. So, without objection, so ordered.

With that out of the way, thank you all for joining us today. I am Dr. Dan Benishek, and I am the Chairman of the Subcommittee on Health for the Committee of Veterans' Affairs of the United States House of Representatives.

And I also represent the Michigan's First District. That is the northern half of Michigan. It is half the State of Michigan. It is a very rural district, very much like this district in Louisiana. You have got a bigger challenge in your district than I have in mine, but the problem of rural veterans living far away from a major medical center is very near and dear to my heart. So I understand what is going on.

I also worked at the VA for 20 years as a consultant. I am a general surgeon, and I took care of veterans there for a long time. I am not a veteran myself. My daughter is a 5-year veteran of the Teddy Roosevelt, served two war cruises.

I am here today, joined by your congressman, Dr. Ralph Abraham. Of course, you know Dr. Abraham. He is sort of a jack of all trades. He is a veteran, a doctor, a veterinarian, a pilot, and lucky for us, a Member of the Subcommittee on Health, where his experience and input is vital to the work that we do to improve the care that veterans receive here in Pineville and across the country.

Dr. Abraham, thank you so much for inviting me to Louisiana today—

Mr. ABRAHAM. You are welcome.

Mr. BENISHEK [continued].—and for all the work that you do.

I want to thank Dr. John Fleming for joining us this afternoon. Dr. Fleming is also a veteran and a doctor, and I am grateful for his service and his attendance here this afternoon.

Before I go any further, I would ask that all veterans in our audience today please stand, if you are able, or raise your hand and be recognized.

[Audience response.]

[Applause.]

Mr. BENISHEK. Thank you so much for your service.

Ensuring that you and your veteran family, friends, neighbors, and colleagues, both near and far, have timely access to high-quality health care through the Department of Veterans Affairs is the sole mission of the Subcommittee on Health. And while we have certainly made progress on that mission, we have a long way to go.

During today's hearing, we will discuss the care that is provided to Louisiana's veterans through the Alexandria VA Health Care System. Prior to running for Congress, as I said, I was a physician there, and I know firsthand the challenges that involved working for the VA, the Nation's second-largest Government bureaucracy.

I am sure the vast majority of the employees at the Alexandria VA Medical Center come to work every day and do their very best for their patients, and for that, I thank them. However, the testimony that will be provided by the veterans, family members, and other advocates this afternoon clearly illustrate a facility in need of improvement.

Perhaps nowhere is that more clear than in the devastating testimony of Mr. Gordon Ryder. Mr. Ryder's testimony details the final year in his son Gerrit's life, and show instance after instance where VA fell tragically short of its mission. His statement concludes by noting that, "We have seen all too often, at best, the VA moves at a snail's pace. The rest of the world is watching DVDs, and they are stuck on cassette tapes."

Mr. Ryder, please accept, on behalf of all of us, our heartfelt condolences on the loss of your son.

Mr. RYDER. Thank you.

Mr. BENISHEK. Thank you for being here today to share his story, for helping us improve the system that so badly failed him.

This afternoon, we will also discuss the 2013 case of an Alexandria VA Health Care System employee who was involved in a physical altercation with a veteran patient who later died. Though the VA's internal investigation found no wrongdoing, that employee was arrested for manslaughter in December of 2013 and spent the next 2 years on administrative leave.

That means that for 2 years, this employee continued to collect a taxpayer-funded paycheck without once reporting to work or providing any benefit to our veterans. That would never happen in the private sector, and it shouldn't happen in the VA either.

The Committee continues to fight for increased accountability within the VA system, and stories like this one underscore just how important that fight is. The Committee has also worked to stream-

line and improve VA's community care program so that veterans have access to care when and where they need it most, whether that is in a VA medical facility or a community hospital.

It is important to remember that the effects of VA's inefficiencies and lack of accountability are felt beyond the walls of a medical facility. Non-VA health care providers who try to serve veteran patients often wait exorbitant amounts of time before they are reimbursed by the VA, if they are reimbursed at all. That is not an appropriate or respectful way for Government to do business, and it often results in decreased access to care for veteran patients who need it.

I look forward to our discussion this afternoon, and taking your thoughts and ideas back to Washington when we leave.

Thank you all for being here this afternoon, and with that, I will recognize Representative Abraham for a brief statement.

OPENING STATEMENT OF HONORABLE RALPH ABRAHAM

Mr. ABRAHAM. Thank you, Dr. Benishek.

Just a quick note to everyone in the audience, thanks for being here. I know you took time and treasure in some cases to be here at this particular time. So much appreciated, and I assure you something good will come out of this hearing for sure.

Dr. Benishek has come down from Michigan, Dr. Fleming. Both of these gentlemen are my friends. They have been my mentors, and their presence here just raises this to a whole higher level, in my opinion. So good people on my left and right. Good people in the audience.

So, Dr. Fleming, Dr. Benishek, thank you so much. I yield back.

Mr. BENISHEK. Thank you.

Dr. Fleming, you are recognized.

OPENING STATEMENT OF HONORABLE JOHN CALVIN FLEMING

Mr. FLEMING. Thank you, Mr. Chairman, for recognizing me, and it is great to see you all this afternoon.

We have all lived through the many, many reports throughout the last 3 or so years of veterans who have been denied access to care, a long list that turns out were not lists at all because many veterans weren't even on a list, only to find out that some of them pass away, leave us without even the first opportunity to get treatment. So we are saddened by that.

We have sent money to bolster the VA, the VA hospital system to try to improve care. And to be honest with you, we have not seen much in the way of results. We passed a bill of accountability from the House. It has not been taken up or passed from the Senate, and the President doesn't seem to be interested in signing it into law.

So having said all of these things, we will continue working daily to make the VA accountable, to be sure that people who are not doing their job should be fired, people who are breaking the law should be prosecuted, and we will continue that endeavor.

And I very much thank my friends and colleagues here today for holding this very valuable field hearing, and I look forward to our discussion.

Thank you, and I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Mr. Fleming.

We will begin today's hearing with our first panel of witnesses, who are already seated at the table. I am going to yield to Congressman Abraham to introduce our witnesses, but first, I want to thank them all for their presence and participation here this afternoon and for the work that they do for our veterans.

I would also like to gently remind all of today's witnesses to be mindful of the 5-minute time limit for your testimony and the question-and-answer period that will follow. The light here—this is something we live with in Congress—is that is green for a while, then it turns yellow. And then when it turns red, that means the time has expired.

So we try not to be too strict, but in order to give everybody an opportunity and chance to speak, time goes by really fast. So we are going to try to be good with it. But thank you in advance for that consideration.

And now, Dr. Abraham, can you introduce our panel for us?

Mr. ABRAHAM. Yes, thank you, Mr. Chairman.

Starting from my left, moving to my right, Mr. Charles Hunter, joined by his wife, Glenda. Is that right? Okay.

Mr. Gordon Ryder, joined by his wife, Brenda, father of Gerrit Paul Ryder, deceased, as you have heard.

Carroll Knott, who is a member and former State commander, Veterans of Foreign Wars of the United States. Thank you, sir, for being here.

Asbel Montes, vice president, reimbursement and government affairs for Acadian Ambulance Service. Good to see you again.

Mr. Chairman, I yield back.

Mr. BENISHEK. Thank you, Dr. Abraham.

Mr. Hunter, we will begin with you. You are recognized for 5 minutes.

STATEMENT OF CHARLES HUNTER

Mr. HUNTER. Yes, sir. May I have permission to let my wife speak for me? Because I would get up there and get to stuttering.

Mr. BENISHEK. Say what?

Mr. HUNTER. I will get to stuttering, and I can't put it out.

Mr. BENISHEK. Oh, yes. Do you want to do the testimony, Mrs. Hunter? That is fine.

Mrs. HUNTER. We wrote it all down, sir.

Mr. BENISHEK. All right.

Mrs. HUNTER. Okay. I am going to real quickly.

Mr. BENISHEK. No, no problem.

Mrs. HUNTER. In 2014, Charles went to the ER in Alexandria because of a callus on the great toe of his left foot. He was seen by the ER podiatrist. The doctor decided to do surgery on the toe. After the procedure, we returned the next week and for 7 consecutive weeks.

Each time, the doctor did surgery on the toe. Finally, the doctor decided the toe was not going to heal, and Charles subsequently developed gangrene. The doctor told us he was going to have to amputate. He said the toe, maybe the foot, and possibly the whole leg.

I immediately asked for a second opinion because I felt this was pretty drastic.

We were sent to Shreveport. The vascular surgeon was concerned because no test for circulation was done on Charles in Alexandria before any surgery. The next day, the surgeon tried to put in stents in Charles' abdomen without success because of poor circulation.

He was shipped off to Houston, where two stents were put in, and his left leg was amputated because of the gangrene, above the knee. We were then turned over to Dr. Ferreras in Alexandria for wound care, where we received excellent care. Dr. Ferreras was very caring, a professional, and concerned for Charles. He was treated for several months by Dr. Ferreras and improved. Thank God for Dr. Ferreras.

In 2015, Charles hit his toe on the other foot on a piece of furniture. We went to Dr. Ferreras. The toe became infected. The doctor treated the toe and immediately sent us to a vascular surgeon in Alexandria for additional stents in his right leg to try and save the toe.

Unfortunately, this did not help, and once again, we had a gangrene issue set in. Dr. Ferreras was very concerned about the gangrene and said the toe had to be amputated immediately. However, it took us 3 weeks and many, many calls begging for admittance to the hospital. Finally, we contacted Congressman Abraham's office, and an angel there by the name of Donna intervened and helped us and got us approval.

We were then told to go to our local emergency room at Opelousas General Hospital. They wouldn't even return our calls. It was just terrible. We saw Dr. Hargrove in the emergency room, and he immediately admitted Charles. Dr. Thibodeaux was called in to perform the surgery. He had to take Charles' entire foot, and then we spent 7 months in Opelousas' LTAC unit.

Charles had a total of 7 surgeries and 70 hyperbaric treatments, which resulted in eardrum rupture. Unfortunately, the doctor had to amputate this leg above the knee.

It is truly unthinkable that a 100 percent service-connected disabled vet would receive such poor treatment. If Charles would have been admitted when Dr. Ferreras had requested immediate surgery, then he may not have lost his second leg. Dr. Thibodeaux put in two more stents. Charles could very well have lost his life, as well as both of his legs because of the gangrene and waiting 3 weeks, which is unthinkable.

Charles had two emergency room visits to Memorial Hospital in Mississippi in the middle of the night because we thought he was having a heart attack. The cardiac surgeon admitted him through the emergency room, and the next day, two more stents were put in behind his heart. Unfortunately, we are now getting bills from the private doctors that the VA refuses to pay, and now we are in collection agencies, which is ridiculous for especially the 100 percent service-connected vet.

Something needs to be done to help our veterans. We are still waiting for a consult to a retina specialist because of Charles' severe diabetes due to Agent Orange from Vietnam.

Charles Hunter gave 16 years of service to his country and returned home as a disabled vet. I firmly believe he deserves and has

earned the medical care he needs. We would appreciate your help with getting these bills paid and give us a guarantee that Charles will continue to receive the proper medical care he needs.

In the past, Charles did receive good care from the VA, but the above incidents listed are unbelievable and unacceptable as far as we are concerned.

Thank you for your assistance, and may God continue to bless America.

[THE PREPARED STATEMENT OF CHARLES HUNTER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. and Mrs. Hunter. Thank you for your service.

[Applause.]

Mr. BENISHEK. And thank you for the courage to be here talking about it.

Mrs. HUNTER. Thank you.

Mr. BENISHEK. Mr. Ryder—

Mr. RYDER. Yes, sir.

Mr. BENISHEK [continued].—you are now recognized for 5 minutes.

STATEMENT OF GORDON RYDER

Mr. RYDER. Well, I will try to condense this and go along to tell our story. It started in May of 2015. Our son felt a lump in his abdomen, and he was a fitness nut. It was getting in the way of his training.

So I told him, “Why don’t you try to get an appointment with the VA?” And he says, “Well, you know, it is kind of hard to get in. I do have a check-up coming July 1st.” He says, “I will wait until then. I am going to go to a chiropractor. I will put heat on it. I will put ice on it. I will see what I can do.”

He still had problems through June, and I was after him for that appointment. But he said, “It is right around the corner. I will go July 1st.”

July 1st, he went to the Lafayette VA, and the doctor was sick. So they sent him home, and they said you can either come back around August 15th, or you can come tomorrow and wait. So that night, when I got home about 8:30, we found him doubled up on the floor in pain. We went immediately to the ER at Opelousas General, where a scan showed he had a mass in his abdomen.

The ER doc there, it wasn’t no young doctor. He was old, knew what he was looking at, says, “This is lymphoma. I am pretty sure. I am sorry.”

We have a close relative who is an internist in Opelousas. The next day, we went to see him, and he said we got to get a game plan going. So we started with that. I made some calls. His physician, who I can’t say enough about, his primary care physician in Lafayette, Dr. St. Cyr, when you could get to him, was excellent.

I pulled some strings. I knew another doctor in Lafayette who knew Dr. St. Cyr, who, even though he was convalescing, got himself driven to the VA clinic to talk to Dr. St. Cyr to see my son. He saw him the next day.

Let us see, that would be about—he saw him. I wasn't with him. He lined up out of network—he said, "I stuck my neck out a little bit." He lined up a PET scan at Our Lady of Lourdes.

So for the follow-up on that, I went with him, and Dr. St. Cyr was very concerned. He said, "Your son needs care." He said, "I am not seeing him because Dr. Brent Prather came to see me. I am seeing him because he needs help. He looks good now," and he said, "I assure you a month from now, he will be in greater pain."

So that was when he says, "I must contact the Alexandria VA. We saw some things in the PET scan that we need to look at." And he called. Immediately, they lined up for the next day an appointment to see about an upper and a lower GI.

I rode with him that next day. The lady up there was extremely nice, worked us up. And I thought it unusual, about midway, she stopped, and she says, "You know, pardon me, but we don't usually see somebody in the shape you are in." She said, "It is refreshing to have somebody that is taking care of themselves, in good shape," you know? "You don't smoke. You don't drink. You work out. I am sorry you are going through this."

So we lined up the upper and the lower GI. They wanted to make sure nothing was in the bowel, in the esophagus, and we prepped for that. We showed up at Alexandria, and he started his tests.

Pretty soon, the surgeon came in. I think he was Dr. Dorval, came in, and he said, "Listen." He said, "There is nothing in the intestines. There is nothing in the esophagus. It looks good."

He said, "Come back in 2 weeks. We are going to do an ultrasound." He said it might be benign. I said, "Well, Dr. St. Cyr talked about maybe having a biopsy?"

"Oh, no, no." He said, "I am in charge now." He said, "Probably benign. Come back in 2 weeks, an ultrasound," and left. So my son came back. He was recovering.

We started our hour trip back to Opelousas, and he was agitated. He says, "I tried to talk to this guy, tell him my symptoms," you know? We got three doctors saying it is lymphoma, but it is benign. Come back in 2 weeks, when we didn't think we had the time. Time was of an essence here.

So before we could get back, I think Dr. St. Cyr looked, saw what was going on. About a half hour into the drive, we got a call and said, "Listen, you will get a call. We are going to try to do a needle biopsy at Our Lady of Lourdes soon."

The next day he got a call. The needle biopsy was scheduled for the Friday. He went and had that done. We went back to Dr. St. Cyr after that, and he said, okay, we will schedule you with oncology in Alexandria, in Pineville. That is Dr. John Clement, very fine. I can't say good enough about the care you get when you get to the pure medical side of the house, you know?

When you get through the red tape, which there is a lot of it, but the medical side of the house, they are caring and engaged people in the health care. You have a few dim bulbs in there, but by and large, they are bright lights in the VA system.

Dr. St. Cyr mapped out a plan, and he said, "Well, you have a 75 percent cure rate and a 95 percent remission rate." And he says, "We will start in —" I think it is R-CHOP at that time. "We will start a chemo."

Now he is getting weaker all the time. He is starting to get—to feel bad, in a lot of pain, and we lined it up finally, I think it was on the 17th maybe? No, I am sorry. This was in August.

Mrs. RYDER. August the 3rd.

Mr. RYDER. August the 3rd, we went up to Alexandria to start the chemo, and he was getting very weak by then. We got there, I think almost immediately they gave him two units of blood. Well, we left him. We went home. We stayed in contact by phone.

On his own, he tried to get himself off of some of the pain meds. He didn't know the pain meds caused such severe constipation. He started having a lot of bleeding because of this. Therefore, he was losing blood, plus the cancer. So on his own, he kind of weaned off of that, and he said he had several very bad nights there. But it was like he said, "I am put on hold. They will come do a test. I don't see anybody for a day. They will come around and check on me."

But they gave him the blood. They installed a port. They did a scan and said, okay, we are going to start chemo tomorrow. We need some approval from, I think it was Little Rock. Well, the approval was late in coming because apparently somebody's car broke down, didn't go to work.

But it finally came, and by the week's end, we started the chemo. He had a very bad week the next week. We went in for a check-up. They gave him three units of blood because he was down. That kind of picked him up.

This went on for approximately four cycles. It appeared the chemo was working. When he went in for the fifth cycle, his blood was not good enough. So Dr. Clement said come back in a week. We came back in the week. He said still not good enough. Come back Monday. We are going to give you more blood. We are going to do a scan, and we will try to get to the bottom of this. Maybe a bone marrow biopsy.

Well, he got the blood, four units this time. I went back. He called me. He says, "They are not going to do the biopsy. They did a scan. I have more tumors. What I have is, some have shrunk. Some is growing."

From that point, he said I have to refer you either to MD Anderson or to Michael DeBakey in Houston, whoever we can get to first. And fortunately, within 2 days, Houston VA called and said can you be here the Monday after Christmas?

We were there. We got excellent care there. There, one thing that stood out in my mind was as they processed him, and I won't rehash all of this. It is all written down, and I am sure you have all read it.

This is a chemo-resistant lymphoma. He said, "We will try to work with it. We have a lot of things we can do," and I remember the doctor pointing to the skyline. "If we can't, MD Anderson is over there. I will send him there."

We started the different work-ups and the doctor says, "I want to do a test. It is a genetic test." He says, "It is only done in San Francisco." He says, "It is kind of expensive, but I think they will approve it."

Well, that is the last I heard of it. I don't know what happened with that. We started a salvage chemo, where he went through one

cycle of that. And upon returning, 28 days later, things still went downhill. He said I will immediately try to get you into MD Anderson, and there is where things kind of went awry. Trying to get this approval was like pulling teeth.

We brought him home. There were numerous physical problems. We were at the ER several times. We would have to get fluid removed from his abdomen. I would call. I got to know a lady at MD Anderson very well. I said, "Do you have any information on Gerrit Ryder?" "No, we need such and such approval, a Form 7." I don't remember what it was.

So I called back the next day. I called Dr. Abraham's office, which I think I called several times for help with some of this approval. And they called back and said this approval is forthcoming. Never got it.

Through a contact, I think it was in Pineville, I got the number of TRICARE. That is an outfit in North Carolina that approves a lot of these out of network services. I called and, "No, it is going through the process. We will get this paperwork to you, 5 to 7 days." I said, "Can you fax it? I have medical power of attorney."

"Well, no, we can't do that. We can send it to you." So I got a little ugly on the phone, I think. But the next day, I received a call from a supervisor over there. Apparently, the calls are monitored, and she said, "I assure you we will get this out today." A span of about a week, maybe longer, I don't know, things just kind of melted together on this rollercoaster ride we were on. We never got that approval that I know of, you know? I think it came in after we came back from MD Anderson.

He went back into the ER. The doctors there said, look, it is not good. What about this approval? You have to get to MD Anderson. He said, "I will try to approve you." Her cousin is the internist. He said, "I will do a hospital-to-hospital transfer." They weren't taking transfers because they were full.

We went back to the ER, and I said, "Listen, I am going to wait until next Wednesday, and then I will get him over here." He says, "You might not have until next Wednesday." So I said, "Okay, we will leave tomorrow." And Gerrit says, "Dad, give me a day to rest." He says, "I am beat down."

So we rested on Sunday. Monday morning, I guess it was the scariest thing I ever did. I loaded him up in the car, and we drove 4 hours to the MD Anderson ER. Now I had given them all the information. They knew who we were.

So I said here we are. Within 45 minutes, we were admitted. When you get to the pure medical side of the house anywhere, you know, it is great. You know, you guys all took an oath, you know? Do no harm. Treat. Care.

We got there. If I would have waited, I would have never got there. They treated him for 8 days. By then, I am sure it was too late. Maybe if we would have had this genetic test, we would have found out earlier on. They said something about it was Burkitt's syndrome, double-hit. Never heard that, you know?

When I got back, Dr. Brent Prather, he was the doctor who got out of his sickbed to go over and talk to St. Cyr. I called him to tell him Gerrit had passed away, and I mentioned Burkitt's, dou-

ble-hit. He said, "Oh, did he have mononucleosis?" I said, "Yes, he did in the Navy."

He said, "People with mononucleosis are more prone to Burkitt's or some of the severe lymphomas." Well, that was the first time I heard that, and that came from a pediatrician who does allergy.

But it is harder than it should be. As I stated, you know, you have got a DVD, you give to them, and they are shoving it in a cassette player. There is one side speaking English. One side speaking German. There is no continuity.

It can be better. I don't know what else to say. It was like pulling teeth.

Medical records. I had to put on my backpack, leave MD Anderson, walk a mile and a half over to Michael DeBakey to get his slides. The oncologist at MD Anderson asked me, he said, "I need to see the slides that they have before I can start this emergency chemo. Maybe we can give him some time."

So I called Dr. Clement, tried. I called, and he would answer his phone over here. He would pick up usually on the first time. He said, "I will see what I can do."

So, finally, about 3:00 one afternoon, I put on my backpack, and I walked to the pathology department at Michael DeBakey. And I walked up to this nice lady, and I says, "I am trying to get my son's medical records. Can you help me?"

She looked at the paper in her hand. She said, "Gerrit Ryder?" I said yes. She said, "I have been trying to find him. I got them here. I will get them for you. If you go back, I will overnight them."

I said, "Well, if you don't mind, he is dying of cancer over there. I will just hand carry it," you know? So after about an hour, they packaged it up. I got them no problem. I walked it back.

It is harder than it should be. When we left Michael DeBakey on the 28th of January, we signed everything to get transferred, to get medical records transferred, and this was the 10th of February, you know, and the records were still languishing somewhere.

[THE PREPARED STATEMENT OF GORDON RYDER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Well, I think we get the idea, Mr. Ryder.

Mr. RYDER. Okay.

Mr. BENISHEK. I really appreciate your testimony.

Mr. RYDER. I have taken a lot longer than I should, you know?

Mr. BENISHEK. And I really appreciate you both being here today.

Mr. RYDER. And I am not going to beat up on you guys. I did write in my statement that if you would fold the VA system in the health care that you three guys got, it would be solved, you know?

Mr. BENISHEK. Thank you. Thank you very much. Truly appreciate you being here.

Mr. RYDER. Thank you, Mr. Chairman.

Mr. BENISHEK. Mr. Knott, you are recognized.

STATEMENT OF CARROLL KNOTT

Mr. KNOTT. Ladies and gentlemen, good afternoon.

What I am going to be talking about is stuff that happened just 3 or 4 weeks ago. We have a very serious problem in our psy-

chology department. We brought a young man over here who is psychotic. He is on crack, he is on methamphetamines, and he is an alcoholic.

They kept him 5 to 6 days, and they wanted to kick him out, send him elsewhere. I got with Harvey Norris, who is a crisis intervention person, and he helped me extend that stay. So we kept him in for about 10 days, but they still want him to go to this SUDS program, which, what that is, is you go to your deal at the VA, but then you sleep at the Salvation Army.

Ladies and gentlemen, there is more drugs at the Salvation Army than there is candy in a candy store. It is terrible.

I have a problem. When a veteran calls and he is in distress and he asks to speak to somebody, a counselor or whatever, and the clerk tells him that it will be 30 days before they can get to him, this man goes kind of berserk, I guess you could say. He makes the statement, "Well, I guess I will have to go to the park and start shooting people before you all will see me."

Well, needless to say, pardon my French, all hell broke loose. I was just about to my office when Harvey Norris called me again and said, "Carroll, please, please help us."

Well, I got my guys all together. We got things going. We got him to come meet us. And I am going to tell you something. When that boy got out of that pickup truck, he rolled out for about 2 minutes, about 6'8", 300 pounds of muscle.

And he was in a combat position. He was ready to fight. He thought we were going to arrest him. I said, "No, we are not here to arrest you. We are here to help you." And we were able to calm him down and get the problem under control. But when a clerk can cause that to happen to a veteran, we have got a serious problem.

I know of a past State commander who went to the Lafayette VA and went to the Alexandria VA, and felt that he was treated like a stepchild. So a friend of his says, "Hey, why won't you go to Lubbock, Texas? They treat us real well over there."

He did. He drives 250 miles one way to go to Lubbock, and they don't pay for his mileage. But the care and everything is so good, he will drive that 500 miles back and forth. I think we got a problem with that.

I have got a veteran who had a foot problem. They put a screw in his foot. A year later, he lost his leg, right here in Alexandria.

Now I am going to go over—I am running out of time just about. I am going to go to the union. My understanding is that the union has a very large part to do with who is hired in Alexandria. Ladies and gentlemen, we have got some people here that don't—they are lazy. There is no other way to put it. They are lazy.

I hope that the clinic in Lafayette works like we want to. They put it in an area where there is heavy, heavy traffic, which I think could create a problem. One of the things we would like to know about our Lafayette clinic and our Lake Charles clinic is how much permanent staff are we going to have in Lafayette? How much are we going to have in Lake Charles? And is it going to be people that are going to be running from Alexandria to Lafayette or Alexandria to Lake Charles? That will be a problem, serious.

Coming back to the union, more than 94 percent of the VA employees are union. I have been told that the union pretty much dic-

tates who is hired and who is fired. It is true or not, I don't know. But I got it from pretty reliable source.

Well, another problem that we have. It seems to me like here in Alexandria in the past 7 years, we have swapped directors, I mean like playing marbles. In the last 2 years, we have had four people. We had a director. He was transferred. Then we had three that were interim. They were transferred.

I think Mr. Dancy is going to do a good job for us. I am hoping that they give him enough time to do a job. Because if you give him 6 months and then you move him away, you haven't accomplished anything.

My next serious part is the telephone. I get a lot of questions, "Why can't I call Lafayette VA?" They have an 800 number. They have a 337 number. The phone rings, and this lady comes on, you know, "Your call is very important to us. Please hold on." And a few minutes later, a little old man comes up and he says it in French, same thing.

It takes 45 minutes, and then the man hangs up. And then the veteran is upset. So I don't know what the phone problems are. But let me tell you, they are serious. They are very, very serious.

And you know, I don't have any problems with the VA. I really don't. They have taken very good care of me. And I want to thank you, Dr. Abraham, for everything that you do for veterans. I cannot complain about the VA, but boy, I get a lot of, lot of, lot of complaints.

So what causes that, I don't know. I see I am over my time.

[THE PREPARED STATEMENT OF CARROLL KNOTT APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Knott. Appreciate your testimony today.

Mr. Montes, you are recognized for 5 minutes.

STATEMENT OF ASBEL MONTES

Mr. MONTES. I will keep to my 5 minutes, I promise.

Mr. Chairman, Dr. Abraham, Dr. Fleming, I am the vice president of reimbursement and governmental affairs for Acadian Ambulance Service. Our chairman and CEO, Richard Zuschlag, founded the ambulance service in 1971 with eight Vietnam veterans. Today, we now have over 4,400 employee-owners and 400 of them being military veterans.

Since the last hearing on June 3rd of 2015, where we provided information on this issue, our company, along with American Medical Response, the largest ambulance provider in the Nation, and the American Ambulance Association have worked diligently with our congressional delegation, including Congressmen Abraham, Boustany, and Coffman and other health care stakeholders, the Veterans Integrated Network Services, as well as the national leadership at the VA, to assist, recommend, and frankly, demand that the VA expedite the updating of their internal processes to promptly pay for emergency treatment that our Nation's finest receive by non-VA health care partners.

Due to these continued efforts, we have seen significant progress made within VISN 16 and attribute these gains to the hearing con-

ducted last year. However, there is still significant work to be done, and my colleagues within the ambulance industry nationwide are still experiencing extraordinary delays in processing and payment of other VISNs.

For a real-life look at the progress made by the VA and the issues still prevalent, I would like to include two specific examples. In the first quarter of 2014, it was taking the VA in Alexandria approximately 138 days to pay for an emergency ambulance transport. Thanks to the efforts of Congressman Abraham and this Subcommittee, we are now receiving payments for approved care within 40 days through electronic submission.

However, on the flip side, the Flowood, Mississippi office, and the Houston office in VISN 16 are still struggling to improve prompt payment efficiencies. For example, Flowood still requires that we send all claims and medical record via paper.

In addition, claims are being underpaid now due to a new unregulated process that requires us to add the zip-plus-four to every claim. No other Federal or State payer or other VISN office requires this that we are aware of. It should also be noted that no one was ever notified of this requirement prior to the complaints being made as a result of the underpayments.

In November of this past year, we had to engage the assistance of Congressman McCaul's office to address severe payment and processing—claim processing delays in VISN 17. This work is still ongoing, and our efforts are being coordinated with the Chief Business Office in Denver, Colorado, under the direction of Mr. Steven Gillespie. Our current aging receivables over 180 days are in excess of \$600,000 still awaiting payment and denial.

There are many more examples just like this one that can be given by providers and veterans alike across the Nation. This problem is especially acute for the majority of ambulance services, providers that serve as the local 911 responders in their communities who are prohibited from refusing emergency treatment for any patient, regardless of payer source or ability to pay.

This failure to pay providers in a timely and accurate manner puts providers in the difficult position of having to shut their doors and eliminate access to care or to bill the veteran for emergency treatment, placing an unfair financial burden on the veteran due to the lack of response, invalid denial, or payment by the VA. Ultimately, it is the veteran who suffers for the lack of coordination, inefficiency of the internal systems at the VA.

While the Chief Business Office has been very responsive to our company over the past 9 months, there is still an inefficiency in system design regarding prompt payment and processing of provider claims. As of 3 weeks ago, one facility in VISN 17 requested that we submit everything via paper until they could resolve our issues on why claims were not processing through their electronic system. This only continues to exacerbate the administrative and financial burden for providers who serve our Nation's finest.

The Federal Government has a responsibility to ensure that our veterans receive the best health care we can provide. It also has a responsibility to ensure that they are not required to bear an unjustified financial burden as a result of the VA's failure to pay for non-VA providers in a timely and accurate manner.

As stated in my previous testimony last year and subsequently introduced via legislation by Congressman Boustany in H.R. 4689, it is our recommendation that Congress remove all claims processing for non-VA providers from the Department of the VA, and place it with a single fiscal intermediary. Congressman Coffman has also introduced H.R. 5149 that will provide clarification on how the VA will reimburse emergency ambulance providers for the care provided to our veterans who meet the prudent layperson's definition of an emergency, to ensure our veterans are not financially burdened solely as a result of the VA's subjective and adverse treatment of these claims.

This step would ensure consistency, efficiency, and expertise in personnel, as well as sufficient dedicated resources to process claims timely. Several other Government programs, including Medicare and TRICARE, utilize this strategy.

Thank you for giving me the opportunity to provide information and to serve those who have sacrificed so much for our Nation. Look forward to answering the questions.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF ASBEL MONTES APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Montes. I appreciate your testimony.

I appreciate all your testimony today.

I am going to yield myself 5 minutes for questions. Then we are going to alternate with the other Members to see if we have any questions for you.

I am going to start with you, Mr. Ryder.

Mr. RYDER. Yes, sir.

Mr. BENISHEK. It sounds like you had a really frustrating time with the VA. I want to ask you this specific question. Did you have an opportunity to work with a patient advocate at the VA, someone to help guide you through this?

Mr. RYDER. I don't remember any here in Pineville. Once we got to Houston, yes. They carried me around. They helped him sign up for different programs, disability. Since he was 8 years in the Navy, we didn't know he was due a pension while he was disabled, and that was in the process. But unfortunately, he didn't last that long.

Mr. BENISHEK. Did the staff at the Alexandria VA Health Care System ever explain to your son or you the authorities that the VA can refer patients outside of the community, including Choice?

Mr. RYDER. He knew a little bit about that, the Choice card, yes. Yes. Well—

Mr. BENISHEK. You are not familiar with it?

Mr. RYDER. I am a little bit familiar with it. I have just gotten my cards not that long ago. I mean, I haven't used them yet. But you know, we were dancing with the partner that brought us there.

We started, like I said, in Lafayette, and the roadblocks that we would face, we see them disappear, and I got to think it was the hand of Dr. St. Cyr in the background. You know, he would do an end run. He did the PET scan. He had the needle biopsy done. He

would go out—he would look and see what was input, I think, and then he would go around—

Mr. BENISHEK. What can you say about how can we improve the customer service at Alexandria?

Mr. RYDER. Contact. You know, it is a mixed bag. You have so many good people there. We ran into several of the oncology nurses, Dr. Clement. Most of them, by and large, were engaged in their patients' treatment. But some of them I get the impression that they were marking time.

VOICE. You got that right.

Mr. BENISHEK. Let me ask Mr. Knott a question now.

Mr. KNOTT. Yes, sir.

Mr. BENISHEK. Mr. Knott, I deal with this phone issue myself in my district. My big complaint in Washington is the fact that in my district for a long time, if you have got the VA, you have got to push 1 for the clinic, push 2 for the pharmacy, press 3 for OR. But if you have a mental health emergency, please hang up and dial 866-778-5791.

That is not very good phone etiquette. You know, to me, that mental health crisis should be the number-one thing. And it took more than 6 months of me complaining in Washington before a national audience before they actually changed that. And it sounds to me that you are having that problem here as well.

So how long has that been going on? Does that happen every day?

Mr. KNOTT. Well, I work with a lot of veterans. I am with the sheriff's office, and he has me kind of take care of the guys because, I mean, there is a lot of things out there that these people have no idea—

Mr. BENISHEK. When you call, is it a long time?

Mr. KNOTT. I am sorry, sir?

Mr. BENISHEK. When you call the VA, does it take a long time to get through?

Mr. KNOTT. Oh, yes, sir. Oh, yes. As a matter of fact, I did it just the other day, just to test before I said anything over here. Forty-five minutes, I hung up. I mean, it is like it goes in circles.

And the lady keeps coming on, and then the little man comes on, and it just—I mean, it is just in circles. So you hang up. Now the 706 number, if you happen to have it, a lot of times you would get right on through.

Dr. Kinchen was my doctor. His nurse will answer pretty much on the money. And I will be honest with you, I don't know how he does everything he does. He has called me at 10:30 at night, he is still working. So, basically, he is overworked.

Mr. BENISHEK. All right. Thank you.

Mr. Hunter, it doesn't sound like they did a vascular—I am a doctor. So, and I used to do vascular surgery, too. So it seems to me that usually if you have got a problem with your toe, that they usually do a vascular evaluation before they start operating on the toe, in my experience, unless there is pus right then and there. You have got to drain the pus right then and there.

But it seemed like it took you a long time to get treatment.

Mr. HUNTER. Very long time.

Mr. BENISHEK. Can you explain to me, did they give you any reason for that?

Mr. HUNTER. No. They just kept saying, well, we are going to get you fitted. Dr. Ferreras is the one that started this.

Mr. BENISHEK. Fitted?

Mrs. HUNTER. Admitted.

Mr. BENISHEK. Admitted.

Mrs. HUNTER. Dr. Ferreras was the one that actually—

Mr. BENISHEK. He is in the VA, Dr. Ferreras?

Mrs. HUNTER [continued]. Yes, sir. He is here in Alexandria. He is excellent. He is in wound care, and he is the one that actually started getting the stents and—

Mr. BENISHEK. But it took several weeks before you ended up seeing him, and then things started to move?

Mrs. HUNTER. Yes. Yes.

Mr. BENISHEK. So I take it, you are diabetic then?

Mrs. HUNTER. Yes. But also I forgot to mention that the doctor, the orthopedic doctor in Mississippi has refused to give Charles a prosthetic leg because of his age.

Mr. HUNTER. He said I wouldn't walk again.

Mrs. HUNTER. He said he won't walk. So there is no point in giving it to him. Because he is 75, there is no point in giving him a prosthetic leg.

Mr. BENISHEK. Yes, well, I am not going to try to figure that out. I am not an orthopod.

Thank you. I am over time.

Let us go with Dr. Fleming. We will give him the first run. Dr. Fleming, you are recognized.

Mr. FLEMING. Well, again—okay, thank you, Mr. Chairman.

Panel, this is a general question to everyone here. The second panel today, the VA is going to claim that as early as this month, 90 percent of the veterans who used sign-in kiosks upon entering the Alexandria VA Health Care System were either completely satisfied or satisfied with their ability to receive care when they wanted it.

So that is a 90 percent satisfaction rate. What would you say about their claim? Your experience, not just your own personal experience, but others around you?

Mr. RYDER. I would say it is skewed.

Mrs. RYDER. Quite skewed.

Mr. RYDER. Skewed, that 90 percent is a skew. He would go in and sign in on the kiosk. I mean, we got to a point where he would just go on to oncology or go to blood, check blood, and then just go and sit and wait, an oncology would come, get him. But—

Mr. FLEMING. Okay. Mr. Knott?

Mr. KNOTT. Yes, I am an amputee. And when I hear this man having all these problems that he is having, it is totally absurd. I am 71 years old. I have been wearing a prosthetic since I was 22. This man lost his leg. It doesn't make sense not to give him a prosthetic.

It doesn't make sense for Mississippi to say we are not going to give you a leg because you are too old. Never heard of that before.

Mr. FLEMING. Okay.

Mr. KNOTT. But to answer your question, I guess a lot of times, it is the way we present ourselves. You know, a lot of times we want everything to go perfect. It is not going to go perfect.

It doesn't go perfect in civilian life. When you go to the doctor, you have got to wait. So—

Mr. FLEMING. Yes. Well, I have got some more questions. So let me go ahead and move on, and I will come back to you with this one, Mr. Knott. How often would you say that the veterans attempt to call the Alexandria VA, the health care system number, and they are left waiting for a long period of time, and what impact does that have on one's experience?

I have already heard of you talking about 45 minutes. Is that rare or commonplace?

Mr. RYDER. Average. Average. That is about average.

Mr. FLEMING. That is a typical number?

Mr. RYDER. Thirty to 45 minutes.

Mr. KNOTT. And I will tell you, most of the time, they have to take and go to the clinic and say, "I have been trying to get hold of you all." Or you go through the operator, and you get the same thing.

Mr. FLEMING. Now if Enterprise Rent-A-Car had a 45-minute wait for their customers, how long would Enterprise Rent-A-Car be in business?

Mr. KNOTT. Not very long.

Mr. FLEMING. Okay. All right. Again, Mr. Knott, would you please elaborate on the concerns expressed in your testimony about the mental health department at the VA, the Alexandria VA, and tell us what you think needs to be done to improve the provision of mental health care to veterans in need, particularly those who are at-risk homeless?

Mr. KNOTT. I guess it is a situation where I just brought this young man over there about 3 weeks ago, and as I said, they were going to cut him loose in 4 days, 5 days—4 days unless he went to the SUDS program. He didn't want to go to that program because of the fact that he used everything that was going on over there.

I hate to say it, but I am going to say it anyway. I just can't see the social workers not spending any time at all with the veterans. Or I can't see a social worker telling a veteran you need to leave your wife and go on your own, and that was done. That is absurd, you know?

How do you deal with that?

Mr. FLEMING. Okay. I have got a little bit less than a minute left. Any other comments or reactions to questions or comments that I have made?

Mr. MONTES. The only statement that I would make to your first comment would be I would suspect the integrity of the data. And for example, that would be related to, if you have an issue with satisfaction scores where they are quoting it is at 90 percent, I would immediately, the first thing that rang to my mind was suspecting it from a payment standpoint.

Because everything was, actually, they found cases of claims that not just within Alexandria, but within the VISN 16 system that

weren't actually recorded into their system. So when they started to come back with this, payments were being made promptly.

So I would suspect that from an integrity of the data standpoint, is that maybe not everything is inputted at that point, and so maybe it is skewed.

Mr. HUNTER. One more thing about the Alexandria, the emergency room there. I went in there to the emergency room and stayed a whole day waiting to see a doctor.

Mr. FLEMING. Well, I see my time is up. I would just say in closing that waiting 45 minutes for a response for a health care facility even one time is a disgrace.

And I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, my friend.

Dr. Abraham?

Mr. ABRAHAM. Thank you, Mr. Chairman.

You just have to shake your head hearing these stories. For your loss, we are all truly sorry, Mr. Ryder.

I am having staff tell me that they stopped by the VA on the way up here, and there is a sign—and I will address this with Mr. Dancy on our second panel—that says the average wait time for a phone call in April was 90 seconds.

[Laughter.]

Mr. RYDER. Ninety seconds. Yes, before you get put on automatic—

Mr. ABRAHAM. So I see there is somewhat of a disparity, to say the least—

VOICE. That is a blatant lie.

Mr. ABRAHAM [continued].—in what we are told by one, by the VA and what we actually hear from you, our witness. So we appreciate the information.

On Acadia, let us start with you, Asbel. Thanks for Acadia being such a provider for our veterans. Can you explain to us—I think you and I know, we have had discussions on this before—how our veterans are impacted negatively when the VA just doesn't pay them, when they are deadbeats?

Mr. MONTES. So this issue came about, about 4 years ago back in 2011. At the time, we didn't really have a process when we were transporting patients that called 911 and they were going to non-VA related care. So a veteran would call us. They are having a heart attack, or they are having severe abdominal pain. We are taking them to one of the local hospitals, whether it is Christus here or it is Lafayette General.

And we were—we didn't know they were a veteran at the time. We would either bill, then they would tell us, "Hey, I have got the VA." We would bill the VA. There would be no payment for 90 days, and so the bill would roll to the veteran. They would go to collections, unfortunately.

And at one time, we found out that if—the collection agency said, you know what, if you hand hold this through the process, you can eventually get paid in about a year to 18 months. They may ask for all this information. So we immediately brought it back in, in house.

So at that time, it was taking anywhere from 18 months to 2 years, and there is a whole disconnected piece where the emer-

gency room would have to provide emergency records for them to pay for the emergency room. And we eventually started to work that process through.

The issue is, is not one department is responsible for it. Now since, the Chief Business Office has kind of taken over that. But for our veterans here, prior to us putting that process in place, they were going to collections. They were getting calls from the collection agencies. It was going on their credit files.

We as a company—now not all ambulance services can do that because 80 percent of the ambulance providers in the Nation are very small ambulance services. Our company has made the decision that until we can get a response from the VA whether they are going to pay for it or not, we are no longer going to bill the veteran for that.

So it stays, when I said that it stays within our aging at Acadia Ambulance Service, that we have over \$600,000 over 180 days across the VISNs. That is just not here locally to Alexandria, and that is the reason why. But most ambulance services, actually, the veterans are just getting billed for it.

Mr. ABRAHAM. Thank you.

Mr. Hunter, I think it was you that alluded to the fact that we have here in Alexandria a very high turnover rate of personnel, and I will ask this to everybody on the panel. Certainly our first three, start with Mr. Knott. How is that impacting our veterans when you don't have that continuity to go back and see the face that you—Mr. Knott, you are nodding. I will take you.

Mr. KNOTT. Yes, it—I don't think I understood the question.

Mr. ABRAHAM. Well, this VA here has had several directors in a very short period of time.

Mr. KNOTT. Right.

Mr. ABRAHAM. Some have been temporary. Some have been into a permanent position. The question is, is that, in your opinion, affecting veterans' care?

Mr. KNOTT. I personally think it is. Because we don't get a chance to get to know a director before he has been shipped out. I mean, this has been going on for 7 years, Dr. Abraham, 7 years that we have been swapping people out and—

Mr. ABRAHAM. Mr. Hunter, do you have a comment? Mrs. Hunter?

Mrs. HUNTER. I feel the same way. You know, you start to get a rapport with someone, and you know, a month later or 2 months later, they are gone. You start all over again, and you are just not getting the proper care that you need.

Mr. ABRAHAM. Well, the thing that, you know, every one of us on this panel will tell you, that the problems that we are hearing today, unfortunately, are across the Nation. Every veteran seems to have a story, and it is not a good one.

It is like you said, Mr. Ryder, you know, once you get on the medical side—

Mr. RYDER. It is fine.

Mr. ABRAHAM [continued].—things get good in most cases. It is just getting from that point A to that point B is sometimes like a Grand Canyon.

So, anyway, thank you so much for your testimony. I see my time is up. Mr. Chairman, I yield back.

Mr. BENISHEK. Thank you, Dr. Abraham.

I want to thank—Mr. Knott, you want to add something? Just a moment, though. We have got to move along.

Mr. KNOTT. Yes. I have one important thing. Can I submit—on the psychology part of it, I would like to submit a deal written by the young man's wife, and I would like to have that put in the record.

Mr. BENISHEK. Without objection, so ordered.

Mr. BENISHEK. All right. Thank you. Thank you all for being with us here this afternoon, and thank you for your compelling testimony. We appreciate your courage for being here.

You are excused from the panel. So you can take your seats. We are going to have our second panel of witnesses for the witness table. So you can make your moves.

[Pause.]

Mr. BENISHEK. All right. We are having a second panel. We have got to keep moving here. We have got another panel of witnesses. I would like to get to their questions. So please, please come to order.

VOICE. Mr. Chairman, before you all get started, I would just like to ask you a question. Does the Veterans Affairs still distribute all their bonuses yearly to the employees?

Mr. BENISHEK. Well, I am not exactly sure what is happening, but they are supposed to have put a hold on all bonuses.

VOICE. Well, I would just like to say that as a veteran—

Mr. BENISHEK. We will ask that—

VOICE [continued].—who hasn't received any bonuses for going to war—

Mr. BENISHEK. All right. All right. That is good. Thank you very much for your comment, sir.

VOICE. Thank you.

Mr. BENISHEK. I would like to yield to Congressman Abraham to introduce the second panel of witnesses.

Dr. Abraham, you are recognized.

Mr. ABRAHAM. Yes, sir. Thank you, Mr. Chairman.

We have got Mr. Homer Rodgers, Under Secretary, Department of Veterans Affairs, State of Louisiana; Janet Henderson, M.D., Chief Medical Officer, South Central VA Health Care Network, VISN 16, Veterans Health Administration. And she is accompanied by Shannon Novotny, Acting Deputy Network Director of South Central VA Health Care Center, VISN 16, and Mr. Peter Dancy, Medical Center Director, Alexandria VA Health Care Center, South Central VA Health Care Network, VISN 16.

I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Doctor.

Mr. Rodgers, you are recognized for 5 minutes. Please begin your testimony.

STATEMENT OF HOMER RODGERS

Mr. RODGERS. Thank you, Congressman Benishek. I don't think this will take—I don't believe that it will take 5 minutes because

most of the first panel had discussed our advocacy for the veterans that we had spoke to before.

I do want to say that about the Choice cards seem to be the major issue that we hear with the Louisiana Department of Veterans Affairs—its use, its approval, and the time, amount of time that it takes for those things to be approved and used by the veterans. We do want to say that we are pleased to hear that the Lafayette clinic, CBOC, is about to open and that the Lake Charles CBOC is finally going to be breaking ground soon for our veterans in the southwest part of the State.

And that is pretty much my testimony.

[THE PREPARED STATEMENT OF HOMER RODGERS APPEARS IN THE APPENDIX]

Mr. BENISHEK. All right. Thank you, Mr. Rodgers.

Mr. RODGERS. Thank you, sir.

Mr. BENISHEK. Appreciate your testimony.

Dr. Henderson, the floor is yours for 5 minute.

STATEMENT OF JANET L. HENDERSON, M.D.

Dr. HENDERSON. Good afternoon, Mr. Chairman, Congressman Abraham, and Congressman Fleming.

Thank you for the opportunity to discuss the efforts that VA has taken to improve access, patient care, accountability, and prompt payment of community providers. VA remains—

Mr. FLEMING. Mr. Chairman? Mr. Chairman? I think some in the room cannot hear. If you would ask the witness to bring the microphone closer?

Mr. BENISHEK. Is it on? Is it on, Dr. Henderson?

Dr. HENDERSON. Yes.

Mr. BENISHEK. Can all of you hear in the room testimony?

Mr. FLEMING. Yes, they are having trouble out there, Mr. Chairman.

Mr. BENISHEK. All right. Just try to speak so the microphone picks you up there, Dr. Henderson.

Mr. FLEMING. Make sure it is close enough and you are speaking into the microphone.

Mr. BENISHEK. We want everyone to hear your testimony.

Dr. HENDERSON. Excuse me. All right.

Mr. BENISHEK. Thank you.

Dr. HENDERSON. VA remains committed to ensuring America's veterans have access to the health care they have earned through their service. Veterans are demanding more services from VA than ever before. There has been a 1.83 percent increase in appointments over the past 12 months in Alexandria.

Even as VA becomes more productive, the demand for benefits and services from veterans of all eras continues to increase. VA's top priority is to improve access to care for every veteran who needs it. Actions like the focused access stand-down events in November of 2015 and February of 2016 have addressed the needs of veterans who require urgent medical care and have significantly reduced the number of veterans waiting for care.

Veterans should be in control of their health care. This means changing our old systems that have been in place for decades at VA

to a system that works for veterans and is focused on contemporary practices and access. That is why Under Secretary Shulkin developed the MyVA access declaration, which is a set of foundational principles for every VA employee to improve and ensure access to care.

The goal for 2016 is when a veteran calls or visits primary care at a VA medical center, their clinical needs will be addressed that day. Alexandria is proud to say that we now provide veterans with this same-day access. Alexandria uses a sign-in kiosk to assess veterans' satisfaction with their ability to get their appointment when they wanted it.

As of June 10th, 92.4 percent of veterans being seen at the facility using the kiosk were completely satisfied or satisfied with their ability to get care when they wanted it. We want to ensure there are no veterans who need care now who are not receiving it. We are not there fully yet, but we are moving in the right direction.

Two of Secretary McDonald's breakthrough priorities focus squarely on health care outcomes, improving access to care and improving care in the community. Alexandria has already implemented a number of actions to address access, quality, and patient satisfaction within the larger transformation of MyVA.

For example, the most recent data available, April 2016, shows that Alexandria completed over 93 percent of appointments within 30 days. Alexandria now offers an extensive community provider network of over 1,000 providers through the Patient-Centered Community Care Choice programs, and more are joining each month.

Alexandria VA is expanding community-based outpatient clinics in Lafayette and Lake Charles, which will provide primary care to over 9,000 veterans. Alexandria also provides telehealth to nearly 4,000 veterans. Telehealth services have been expanded to CBOCs for primary care, mental health, and specialty care services, which are critical to expanding access to VA care.

In April 2016, 50 veterans attended a town hall in Natchitoches, held by the Alexandria director to hear veteran concerns. Town hall meetings like this will continue, with the next being June 29th in Lake Charles, and a follow-up meeting in Natchitoches in July.

In addition to town halls, Alexandria has initiated employee recognition programs based on I CARE values. In partnership with the Office of Patient-Centered Care, the medical center has begun MIL-X training for employees, which provides awareness, insight, and understanding of military culture to help facilitate a healing relationship with the veterans we serve.

During fiscal year 2015, it was discovered that there was a significant backlog of paper-billed ambulance claims at the Alexandria VA. System redesign principles were employed to streamline the process for payments of ambulance claims and to have all ambulance claims submitted electronically.

This new process began in March 2016. Alexandria and staff from the Consolidated Fee Unit began breaching calls and status updates on ambulance claims. As of June 9th, there were 34 ambulance claims on hand, totaling just over \$57,000, and none of those claims were aged greater than 14 days. Not only was the backlog resolved, the process was streamlined and is sustainable.

In conclusion, VA is committed to improving access, patient care, accountability, and prompt payment to better serve our veterans. We realize the significant work that remains ahead. The good news is that moving forward, along with Congress and our VSOs, we have an opportunity to reshape the future and make long-lasting, valuable changes.

We appreciate your support, and look forward to responding to any questions you may have.

[THE PREPARED STATEMENT OF JANET L. HENDERSON, M.D. APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Doctor.

I don't know, Dr. Henderson. This is the kind of answers that I get really frustrated with. I don't know who wrote that, but it sounds as if somebody from Washington wrote that because it is the same kind of testimony we get from the VA every single time we have a hearing, okay?

So it gets pretty frustrating for me to hear you say all that stuff just after we had these veterans here talk about real problems, okay? It would be nicer for me for you to have a personal statement, and I know you probably can't do that because somebody told you to read that. But it is just very frustrating to me here.

I yield myself 5 minutes to ask a few questions myself. I want to focus on some of the things that were brought up here at this meeting because this answer that you gave, somebody wrote that for you as a standard statement that the VA says at every single hearing that we ever hear. So it is just a little frustrating for me to hear you have to go through that, even though somebody told you to do it.

So, Mr. Dancy, I want to talk to you about the phone thing.

Mr. DANCY. Yes, sir.

Mr. BENISHEK. All right? So do I have to call the VA right now and see how long it takes, okay?

Mr. DANCY. Yes.

Mr. BENISHEK. Because I tend to believe these guys, and this 90-second number that somebody said I don't buy. So what are you going to do to fix that?

Mr. DANCY. Well, first, Chairman, I would like to thank you for the opportunity to speak before the Committee. And as an Army veteran, I feel I am—

Mr. BENISHEK. That is great, Mr. Dancy. But unfortunately, I have only got 5 minutes.

Mr. DANCY. Yes, sir.

Mr. BENISHEK. So I wanted—what are you going to do to fix the phone problem?

Mr. DANCY. With regard to the phone system specifically, I know it was reported that there was 90 seconds. Obviously, that is not the case. I have heard veterans that are waiting 30, 45 minutes. Bottom line, sir, unacceptable. And that is an area that I am going to look into.

Mr. BENISHEK. So when can we have that answer, Mr. Dancy? Is it by the end of the week or next week, are you going to have the solution to this problem so that when I call one of these people

that just testified, Mr. Knott, for example, he can call and expect 90 seconds?

Mr. DANCY. Sir, I can't guarantee that we will have it by the end of the week, but I think we will have a solution—

Mr. BENISHEK. Have a plan for me by next week maybe, how is that? Not to have it done, but then maybe by the end of the month, the end of next month we can have it done.

I want to come over here to you, Mr. Novotny, because I want to ask you another question. I will leave the phone thing with Mr. Dancy. But, and I mentioned this to you earlier before the hearing that one of my pet peeves is the problem of the directors of a medical center not having enough time in that medical center to actually make a difference or know where the bathroom is or, you know, be able to solve the problem, and then they are whisked off to another assignment.

Now what is the story here in your VISN about the tenure of the director of a medical center? What is the typical tenure of a director of a medical center?

Mr. NOVOTNY. Those tenures are really evolved from medical center to medical center. What is significant to note about the leadership vacancies, you know, first and foremost, we do realize that leadership matters. Leadership does make a huge difference.

When a director vacates one of these facilities, in a perfect world, and that is if the system works, everything works correctly, it is a 6- to 9-month process in order to identify, go through the selection process, the vetting process to bring another director on. And that is excluding if they have been a sitting director before.

An individual who has never been a director before has to go through the SES certification process—

Mr. BENISHEK. Why does it take 6 to 9 months to hire that person?

Mr. NOVOTNY. Okay. That is because there is a specific period of announcement. There is a specific period of reviewing of the applications, and then there is a vetting process that occurs in central office.

Mr. BENISHEK. Okay. So once somebody gets in there, then how long do they typically stay at a VA? We have heard testimony that there has been like some interim directors. Is it really hard to find individuals to be a director?

Mr. NOVOTNY. In Alexandria's case, it has been a challenge. I mean, you know, history indicates that it has been a challenge. Over the past 5 years—

Mr. BENISHEK. Why is that?

Mr. NOVOTNY. There are several reasons. Alexandria, like many hospitals across the country, is a highly rural location. And although I grew up in the South, I love the South, it is not considered a destination location to some individuals.

Alexandria also is what is called a Level 3 hospital. And so sometimes directors will go to Level 3 hospitals to prepare for assignments of greater responsibility.

Mr. BENISHEK. So someone can't advance if they stay here?

Mr. NOVOTNY. I am not following.

Mr. BENISHEK. Well, you know, that is what my frustration is about—one of the things about the VA is they plan for the director

to only be there for 2 years because he can't get a raise or an advancement within the VA unless he moves somewhere else. So the whole system is rigged so that Mr. Dancy here, although he may want to stay here, if he wants to go anywhere with his career, he has got to move somewhere else.

So you know that in 2 years, 6 to 9 months are going to be taken to hire a new guy. But that doesn't allow for continuity within the hospital, right? I mean, I was able to change that in my district. We were able to get a director who was actually from the area. He has been there like 5 or 6 years now.

And you know, he has actually made some improvements. It is hard to make an improvement in the local hospital and then, you know, he leaves and then somebody else comes, "Well, I got a different idea for improvement." So nothing ever makes any progress.

Do you understand what I am saying? And I think that the upper levels of the VA need to have a better recognition of this problem.

And somebody mentioned that is the way the military does it. Well, I am not sure that is the best thing for the military base either. It may be good for the commander, who gets a broad experience, but it is not good for the base.

Well, I am out of time, and I know I talked too much and didn't ask enough questions. But I have to yield now to Dr. Abraham.

Mr. ABRAHAM. Thank you, Mr. Chairman.

And everybody in this room, especially the panel members, you can feel the palpable frustration level up here, and certainly in the back of the room because, like Dr. Benishek says, Dr. Henderson, your speech, I mean, your opening statement, you could have—we have heard that exact statement 20 or 30 times on these hearings.

The MyVA, it is a wonderful concept. When Secretary McDonald, he brought us a pin that said MyVA, and Under Secretary Sloan Gibson. They wear their pins, but we are finding that is all it is. It is just a pin. There is no substance to it.

I want to ask you, Dr. Henderson, you said—and please correct me if I misstate your statement here—but do you now at the VA center have same-day access?

Dr. HENDERSON. Yes, sir. In Alexandria, there is same-day access. Now same-day access means that if you present to a clinic, you have a medical issue. The issue will be addressed. It doesn't necessarily mean you will see a physician that day.

Mr. ABRAHAM. Ah, see, there is a difference, but—

Dr. HENDERSON. But if you need to—

Mr. ABRAHAM [continued].—let me interrupt you.

Dr. HENDERSON. Okay.

Mr. ABRAHAM. You are a physician, and you got three here.

Dr. HENDERSON. Yes. Yes, sir.

Mr. ABRAHAM. And we know if a patient comes to a medical facility, and if that patient feels that they have a condition that they need to see a doctor that day, that is why they show up that day. So let us peel the onion, so to speak.

So let us say somebody comes with a diabetic foot ulcer, and who are they assessed by? Let us get into the logistics. Walk me through it.

Dr. HENDERSON. Okay. And I would say that this would apply across VA, no matter which facility that you presented to. If you present to your primary care provider with a diabetic ulcer—

Mr. ABRAHAM. But you have got to get to him, and you are telling me they may not see that provider that day.

Dr. HENDERSON. Well, I said they may not see their primary care provider, but if the primary care provider was unable to see them, the VA has emergency departments. Alexandria has an urgent care department.

Mr. ABRAHAM. Do you all track those patients that come in? For same-day access, do you all have tracking—Mr. Dancy, I will ask you—that tells the outcome of that particular patient, if they actually saw a physician, a nurse practitioner, or a health care provider? Or if they were given an appointment? Are those tracked on a daily basis?

Mr. DANCY. I can't say for sure that those are tracked. I don't know, Congressman.

Mr. ABRAHAM. Okay. I think that is important—

Mr. DANCY. Yes, sir.

Mr. ABRAHAM [continued].—for metrics to know where if you need to go—if we are doing any good. So if you could maybe look at that, I would appreciate that.

Mr. DANCY. Yes, sir.

Mr. ABRAHAM. And Mr. Dancy, I will come back to you. You and I met before. We have had this discussion. Where does the VA rank, or do you know, as far as in national turnover rates of directors and of personnel, per se?

Mr. DANCY. I don't know about directors, but I can speak, Congressman, to—in terms of personnel, and I will talk about providers specifically. Two locations that I will speak to specifically are our Natchitoches clinic CBOC, and also our Lafayette clinic, for example.

In Natchitoches, it is a one provider, one PAC team facility. We recently lost a provider, a primary care provider, probably a couple of months ago, unexpected loss. And I don't recall—

Mr. ABRAHAM. Did they die?

Mr. DANCY. No, no. He left.

Mr. ABRAHAM. Okay.

Mr. DANCY. He left.

Mr. ABRAHAM. Well, I mean, why would you—they just picked up stakes and left that day?

Mr. DANCY. Well, he gave his—the individual gave a notice that he was going to be leaving unexpectedly. From that standpoint, we basically had a gap in terms of a provider.

Mr. ABRAHAM. And how about here—I see my time is running out. How about at the VA? Let us not talk about Natchitoches or Lafayette. What about right here in Pineville?

Mr. DANCY. In terms of—

Mr. ABRAHAM. Turnover. How does it rank?

Mr. DANCY. I don't know where we rank, but typically, we have normally about a 10 percent vacancy rate, 10 to 15 percent vacancy rate.

Mr. ABRAHAM. And how does that compare with the Nation?

Mr. DANCY. Sir, I don't know, but I can—

Mr. ABRAHAM. If you would, I would appreciate that.

Mr. DANCY. Yes, sir.

Mr. ABRAHAM. I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Doctor.

Dr. Fleming, you are recognized for 5 minutes.

Mr. FLEMING. Okay. Thank you, Mr. Chairman.

I would like to ask the panel, given the disasters that we have learned about since Phoenix, egregious circumstances, veterans dying waiting for care on a waiting list that actually didn't exist. In all that time, how many people at the Veterans Administration hospital system have actually been fired?

Mr. DANCY. I can speak locally. Over the last—since I have been as a director, and this has been January, there have been two people under my watch.

Mr. FLEMING. Related to these types of circumstances?

Mr. DANCY. No, sir. These are related to just disciplinary action, but not related to wait times.

Mr. FLEMING. Well, no. I am talking about—I am talking about the inadequate response, not caring for veterans.

Mr. DANCY. Oh, my apologies. That has not been the case.

Mr. FLEMING. So we don't know of anybody in this—I guess it has been 3 years since Phoenix. Am I correct about that? So with all of the veterans who have died—or perhaps 2 years has been suggested that we have had a number of cases, egregious cases where people simply never got care, and they ended up dying or losing limbs. And we heard this terrible situation with the Ryders' son.

So my question again is, how many staff have been fired related to these types of delay in care in the whole system?

[No response.]

Mr. FLEMING. I assume by your—

Mr. DANCY. I don't know, sir.

Mr. FLEMING. I must assume by your silence that is zero. Am I correct? Do you have a statement?

Mr. NOVOTNY. I have data on separation and removal for VISN 16. I am prepared to speak to numbers for the system as a whole.

Mr. FLEMING. Okay. Well, the reason why I bring that up, I believe it was Mr. Knott who brought up the fact that he is told by folks who are in the know, and I would like to hear your response that, look, if the union says you get hired, you get hired. If the union says you get fired or you don't get fired, you don't get fired.

So what is the role of the union for employees for the VA system, and what control do they have over disciplinary actions?

Mr. DANCY. I would be happy to address that, sir. From the hiring perspective, a supervisor has—can hire based on a list of qualified applicants.

Mr. FLEMING. Well, I am actually interested in firing. I don't care about the hiring, okay?

Mr. DANCY. Okay. Sure, sure.

Mr. FLEMING. So it is the firing.

Mr. DANCY. From the union's perspective, in terms of firing, if an employee is a bargaining union employee, then that union can represent that employee in those proceedings. So the union is a representative.

Mr. FLEMING. So if—if a VA employee mistreats a veteran, then the power of the union itself comes down on their side to protect the employee against being held accountable for the actions they took or didn't take that led to the death or severe illness of the patient?

Mr. DANCY. I can't speak, sir, in terms of what the union's position would be regarding representing—

Mr. FLEMING. But they are an advocate for the employee, not for the patient? I think that is fair in saying that.

Mr. DANCY. Yes, sir.

Mr. FLEMING. Now, look, I have been in hospital systems for 40 years, including the U.S. Navy, private hospitals, even a little bit in VA hospitals back, way back to the day. I have never heard of a system that advocates for the employee over the patient.

Now I think that is a huge problem here. We passed a bill out of the House that would have created some accountability, and it was never taken up in the Senate, and the President said he wouldn't sign it. So isn't the problem, in fact, it doesn't matter how much money you throw at, it doesn't matter who you put in charge, if you don't hold people accountable for their actions or lack of actions, you are never going to get good results.

So we are talking—you are saying the calls are 90 percent, I mean, I am sure on paper your statistics are excellent. But we hear testimony from good people, veterans. They are not here to lie. They just want to get good care.

And in fact, when it is good, they say so. They say when we actually get in the system, we get good care. So they have absolutely no investment in saying otherwise.

So the point being here that there is just simply a lack of accountability, and the union works on behalf of the employee against the interest of the patient. And ladies and gentlemen, we are never going to fix this problem until we fix that.

Mr. Chairman, I yield back.

Mr. BENISHEK. Thank you.

I am going to ask a few more questions. I am not going to use my whole 5 minutes, but I've time to take a few more questions, if you don't mind.

Dr. Henderson, this is compelling testimony from Mr. Ryder about his son, all right? And so I am wondering, what would somebody in Mr. Ryder's position, a family member or a veteran who is grievously ill and in need of immediately treatment to save or extend his life, but is waiting for community care authorization, what should that person do if it seems to be taking a long time?

Dr. HENDERSON. Well, I can say in our facilities that we have nurse navigators within the community care departments, and their role is to help the patient navigate through that system. I heard when you asked Mr. Ryder if at any time he had had contact with a patient advocate at Alexandria, and he said that he had not.

Mr. BENISHEK. I mean, aren't you sort of appalled by what happened in that case?

Dr. HENDERSON. It is a heartbreaking story. There is no question about that.

Mr. BENISHEK. That shouldn't happen to anybody, right, Doctor?

Dr. HENDERSON. It should not happen. No, you are correct.

Mr. BENISHEK. So, we don't want to see that happen again, do we?

Dr. HENDERSON. It would be my desire that it would never happen again.

Mr. BENISHEK. So, how does that person, when they are frustrated at the system there, they come in and rather than threatening to go off on a deep end, which is another story we heard about a different patient, what do they do? Who do they call? You understand the frustration of the people that testified here today? What do we do? Do you have any input on any of that?

Dr. HENDERSON. Well—

Mr. BENISHEK. I mean, you are the Chief Medical Officer for the VISN, right?

Dr. HENDERSON. That is true.

Mr. BENISHEK. One of my complaints, to tell you the truth, Doctor, is the fact that the doctors have very little say in how the VA works. When I worked there, it would seem to be the nurses and the bureaucrats that were running the show, and what I wanted didn't really matter because I was just a doctor.

You know what I mean? So when I wanted to have two nurses in my clinic so I could move patients through quickly, well, that is not your job, Doctor, to decide how many nurses belong in the clinic, even though I could see twice as many patients in the same period of time because I am sitting around twiddling my thumbs between patients because there is not enough people to move the patients in and out.

So do you feel as—you probably can't tell me. But do you feel as if that you don't have enough input in the way things are done in this kind of a situation?

Dr. HENDERSON. I think that throughout health care, not just VA health care, but I mean, I think that we need to improve our process. I have been here since May 1st. I am aware of—

Mr. BENISHEK. Do you have any input in that process, Doctor?

Dr. HENDERSON. I have a seat at the table. I do. I am still getting familiar with the various facilities that we have within our VISN.

Mr. BENISHEK. How long have you been with the VA, Dr. Henderson?

Dr. HENDERSON. I have been with the VA total since—almost 10 years this August I will have been with the VA. I have been in VISN 16 since May 1st.

Mr. BENISHEK. So you are new to the—you are all relatively new to your positions, right? Mr. Dancy has just been since January, as I understand it.

Mr. DANCY. Yes, sir.

Mr. BENISHEK. And you have only been on for how long?

Dr. HENDERSON. I have been in VISN 16 since May 1st.

Mr. BENISHEK. So, and then, Mr. Novotny, are you relatively new to your position, too?

Mr. NOVOTNY. No.

Mr. BENISHEK. Oh, you have been around a long time?

Mr. NOVOTNY. No, I am—no, I have been around a long time.

Mr. BENISHEK. So what do you think of my statement to Dr. Henderson there that, I mean, I feel as if doctors don't have enough input in the way things are run.

Mr. NOVOTNY. So I am married to a physician, and if I didn't support physicians in all things, I would be in a lot of trouble. But that aside, I believe fully that our providers are an integral part of our team, both at the floor and at the midlevel, and at the executive levels, as evidenced by Dr. Henderson being here in this room. That is part of the reason why she is here.

All of our providers are integral members of the medical board. All medical centers have chiefs of staff who are senior leaders on the executive team, and play an essential role in the day-to-day operations of these hospitals.

Mr. BENISHEK. All right. Well, you are convincing me, I guess. But let me ask you this other question that Dr. Henderson didn't answer. What does Mr. Ryder do or somebody like Mr. Ryder do when they are faced with a situation where he thinks his son is dying, which he was, and they can't get a referral? So what do they do?

Dr. HENDERSON. If I can speak to my previous experience at the VA was that before, when we were dealing only with non-VA health care, we identified similar situations with what we called high-risk consults like oncology consults, GI consults—

Mr. BENISHEK. I know you are talking a lot, Dr. Henderson, but you are not answering the question. What do they do? Answer that question. What does that person do?

Dr. HENDERSON. It sounds like what they did, they had a champion at the local VA, and sometimes it takes a person. It takes a person to—

Mr. BENISHEK. Mr. Ryder didn't have a champion.

Dr. HENDERSON. Well, I believe he said whenever he would get in touch with Dr. St. Cyr, things would get done.

Mr. BENISHEK. Yes, okay. I give you that.

Dr. HENDERSON. And unfortunately, sometimes that is what it takes. But we have a system that needs to have some improvements. I am going to say that. That when we have high-risk consults like this, as we did at my facility, we established nurse navigators to help the patient and their family—

Mr. BENISHEK. All right.

Dr. HENDERSON [continued].—get what we considered those critical consults accomplished, and I hope that we can get something in place here.

Mr. BENISHEK. Well, I want you to dedicate your time to making sure that that happens so we don't hear another story like Mr. Ryder.

I am over my time. Dr. Abraham?

Mr. ABRAHAM. Thank you, Mr. Chairman. Just a couple, and I will just continue on this line.

Everybody in this room has been involved in the military. They understand SOP procedures, and you would think a patient like Mr. Ryder—and there are, unfortunately, many patients like Mr. Ryder that have life-threatening conditions every day—would get an approval just like that. Because we know what happens when they don't. They die.

Do you guys have a manual, or is there a timeframe that we are supposed to get an approval? I mean, again, I go back to private practice, and I understand we are dealing with bureaucracy with the VA, and I understand it is a big bureaucracy.

But the most important thing is we are dealing with lives. It is not like dealing with some other entity. These are human beings that die when we don't do our jobs. So I guess the question is, there has got to be something in place that if one doc picks up the phone and another doc, it needs to be those two docs.

Like Dr. Benishek says, I have talked to many doctors in the VA system. And Mr. Novotny, I know you said they are chiefs of staffs and they are places of leadership, but they do not have the autonomy that they need in this VA system to make decisions that private doctors make every day in practice, and that is a problem because people die when you have that delay.

So what are we going to do about that? Do we need to do something as Congress? Do you guys—I mean, where is the disconnect? Because this is unacceptable.

Dr. HENDERSON. And I will agree that it is unacceptable. I think that with—the VA is sort of transitioning when we look at care in the community. And I just need to say this because it is a process. It is a bureaucracy that has been created.

With the traditional non-VA care, it was a little bit easier to get out and get patients appointed. With the Choice Act that we are dealing with, there is another layer in that we are dealing with another health entity—

Mr. ABRAHAM. Doc, let me interrupt.

Dr. HENDERSON. I would say that, if I may just finish this one thing, in terms of, we in VISN 16, since I have been here, because I can only speak to since I have been here. But I can tell you that we are actively looking at stat consults that are going out to Choice that should be appointed within 48 hours to be seen.

We are pulling those back in actively. At our facilities, we are looking at those on a daily basis to actively pull them back in, and if Choice cannot get that, then we are going through our care in the community to try to get these patients seen.

I can tell you that we all are concerned about these delays in care, and these certainly are tragic stories that we have heard today. And they are not stories. They are veterans' lives.

And I say that we have a way to go. I would say that there is an awareness now. We are trying to develop the systems to support being able to tightly follow these consults so that we have the clinical staff, as our nurse navigators, in place to help the veteran to break down these barriers to care.

It is not there yet. But I can tell you that at VISN 16, since I have been here, we know it is a problem. We are actively working towards trying to solve the issues that are coming up. I mean, we actively report up delays of care.

Mr. ABRAHAM. And I understand, Doctor, and I will apologize for interrupting because I am sure I am running out of time, too. And I understand.

But this isn't something that has just come to surface. This has been going on for years, and the VA just doesn't get it. And I will use the analogy that I have used in other Committee hearings, is

that when we allow the VA to try to heal themselves, it is like sending the Hindenburg to rescue the Titanic. It just never works.

So, again, I hope we can continue this dialogue, and we can get to that simple phone call to phone call so that veteran can get immediate care when he or she needs it.

Thank you, Mr. Chairman. I yield back.

Mr. BENISHEK. Thank you, Dr. Abraham.

Well, I think I have had enough questions for you all. Thank you for being here.

And I want to thank all the witnesses for being here today and the audience members for joining us as well. It has been a pleasure for me to be here in Louisiana with you all.

I want to also say that I think all the members of the audience have heard the compelling testimony from both the first panel and the second panel, and you know, these folks here today on the second panel, they sound like pretty reasonable folks, don't they? And yet they are part of a bureaucracy that doesn't seem to change, and so we still have this first panel, people that aren't being heard.

So we want to encourage all you good-hearted people that work within this bureaucracy to you be part of the change. If you don't make it happen, it is not going to happen. And I know how difficult that is. So I encourage you, the three there that are here before us today, to make yourselves felt within your organization, and make the changes that we need to have in this organization. You have to do that.

Thank you.

With that, I will ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

So, without objection, that is ordered.

Mr. BENISHEK. This hearing is hereby adjourned. Thank you.

[Whereupon, at 4:40 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Gordon Ryder

Testimony from Gordon Ryder

Gerrit Paul Ryder 11-9-1976 to 3-6-2016

In May 2015, Gerrit felt a lump in his abdomen, had some traveling pains and had difficulty exercising. He went to a chiropractor a few times thinking he had a pulled muscle or pinched nerve.

On Memorial Day 2015, he still managed to do the "murph" in just over an hour.

In June 2015, still having pains, can't sleep on his back. I told him to make an appointment with the VA. He said it was too difficult to get an appointment and he would wait for his July 1st annual checkup.

In July 1st, the VA doctor was sick and they told him to come back August 15th or he could sit and possibly get an appointment the next day. That night at about 8:30 p.m., we found him doubled up in pain on the floor of our house after a big meal. We went to the Opelousas General Hospital emergency room where a scan showed a mass in his abdomen. The ER doctor said it looked like lymphoma. The next day we went to Dr. Gary Blanchard, a relative, to make a game plan. I also called Dr. Brent Prather, Gerrit's doctor when he was a child. He knew Dr. Mark St. Cyr, the VA doctor, and would talk to him about seeing Gerrit. Gerrit saw Dr. St. Cyr at the VA the next day, 7-3-15. He arranged for a PET scan at Our Lady of Lourdes.

On July 7th, I went with Gerrit to his appointment with Dr. St. Cyr for the follow up of the can. He was very concerned and thought we had no time to waste. He contacted Alexandria VA to schedule an upper and lower GI test for Gerrit. We went to Alexandria for pre-op the next day, July 8th. They were going to schedule it for the following Monday. One of the nurses told us that wasn't enough time, then I showed her Gerrit's CT scan results. After reading it, her whole attitude changed. "Yes," she said, "we must hurry and get these tests done."

On July 13th, I brought him to Alexandria VA for the tests. After the tests, the doctor, Dr. Dorval, came to talk to me, wanting us to come back in two weeks for an ultrasound. I asked about a biopsy Dr. St. Cyr was trying to schedule. He, in no uncertain terms, informed me he was in charge. The tumor was probably benign and to come back in two weeks for an ultrasound! On the ride home, Gerrit was very aggravated, told me that the doctor wouldn't let him finish explaining his symptoms and what was going on physically with him. Before we go home, approximately a one hour drive, the Lafayette VA called Gerrit. Dr. St. Cyr saw the Alexandria VA results and would schedule a biopsy at Our Lady of Lourdes in Lafayette out of the VA network. We received a call from Lourdes scheduling a biopsy July 17th. After the biopsy, he received a call from the Alexandria VA to set up an appointment with the oncologist, Dr. John Clement. Dr. Clement told us that with the lymphoma, Gerrit had a seventy-five percent possibility of cure and a ninety-five percent possibility of remission. Chemo was to start August 3rd.

On August 3, 2015, we went to Alexandria, the VA, Gerrit was starting to feel very bad and was having to take a lot of pain medicine. They performed a number of tests, placed a port for chemo treatment on August 4th. We were told chemo would start on August 5th. The night of August 5th, Gerrit told me he had withdrawals from the pain meds, which he quit using because of the constipation it caused. This, in turn, caused very heavy rectal bleeding. Chemo did not start because approval from Little Rock, Arkansas, was needed and treatment could not start because we had not gotten the approval. We are not sure what the hold up in Little Rock was, but we were told it had something to do with somebody having car trouble. Along this time frame, he was given two units of blood. The first cycle of chemo started August 7th. We brought Gerrit home August 8th and he felt bad all week.

We went back August 13th to check the bloodwork and when he checked in, he found out he was mistaken, that his appointment was for the 14th. He was feeling so bad, the doctor worked him into the daily schedule. When his bloodwork was returned, they decided to keep him overnight and give him three units of blood, and he felt much better after receiving the blood.

On August 22, 2015, Gerrit's hair began to fall out.

On September 8th, second round of chemo. He didn't feel too bad, was still going to college at this time, but he does have a high pain threshold.

On October 9th, third round of chemo, everything seemed to be going well.

On November 13th, fourth cycle of chemo. The week before treatment has been getting very painful. He is in much discomfort now.

On December 11th, he went for the fifth cycle, but his blood count was too low and he was told to return December 18th.

On the 18th, his blood count was still too low. Now he was to come back December 21st to receive more blood, have another scan and possibly bone marrow biopsy.

On December 21st, received four units of blood and had a scan.

On December 22nd, Gerrit called me in the morning, telling me to come pick him up. The scan showed the tumor was growing. Dr. Clement wanted him to go to Houston, either M.D. Anderson or Houston VA, whoever could see him first because the chemo was not working.

He received a call December 23rd from Houston VA, giving him an appointment on December 28th. We drove him to Houston VA December 28th, approximately a four hour drive from our home, had bloodwork at 11:00 and saw the doctor at 1:30. The doctor was very concerned and told us the Houston VA would try to help him and said if they couldn't help him, they would refer him to M.D. Anderson. He was immediately admitted and assigned a team of doctors to treat him.

From December 28th to January 5th, there were a lot of tests, biopsies, scans, ultrasounds, many tests. Because this cancer is so aggressive, we were told about a special test that is only done in San Francisco. The doctor said it was very expensive but he thought they would approve it. We never heard any more about this test. They decided to give him what was called "salvage chemo." We could see the strength draining out of him. We returned home January 5th and were told to go back for the second cycle on January 28th.

The week before January 28th, Gerrit was getting more and more uncomfortable, He doesn't complain much, but I know he is hurting.

Drove to Houston the 27th of January. He had a very bad night that night. Upon examining him January 28th, they found more tumors. This chemo failed also. They would immediately try to refer him to M.D. Anderson. Drove home the 28th and at 8:30 that night, he collapsed in pain again, and we had to go to the Opelousas General emergency room. There, they drained four liters of fluid off of his swollen abdomen.

Started called M.D. Anderson on February 1st, but they had no record of Gerrit at that point, I started a referral and gave them all the medical information I had. We were waiting for the VA approval of out-of-network medical care. Called Congressman Abraham's office for help with approval. His office told us the office in North Carolina was the approver and it was forthcoming. Called North Carolina and could not get any answers. Received a call the next day from the North Carolina office because the previous call was monitored. They assured me they would hurry with the approval.

February 5th, back to OGH ER to drain abdomen because of discomfort and hard to breathe. Called M.D. Anderson, still nothing from the VA. I was told no appointment would be scheduled until they got the VA approval. While in Opelousas General Hospital, I told Dr. Gary Blanchard I would wait until the next Wednesday for the approval. He said Gerrit might not have until then. I let him rest the next day, and February 8th, we got in the care and drove four hours to the M.D. Anderson ER, where they promptly admitted him. The physicians there told us of an experimental treatment but at this time, his blood counts were too low to qualify and they would try some of the previous chemo to see if they could shrink the tumors to give him time for his blood to improve so he would qualify for the experimental treatment. M.D. Anderson installed a chest drain to receive the pressure in his abdomen. The doctor kept asking for the pathology reports and lab slides from the Houston VA. He needed to see the reports before he could start Gerrit's chemo. We had sent permission to Houston VA on January 28th to release all medical records. I called and could not get a good answer as to why the records have not been sent yet. Of course, VA approval for treatment had not been sent either. I talked to Dr. Clement at Alexandria VA several times. He was also trying to find where the records were and why they weren't sent. I walked from M.D. Anderson to the Houston VA, approximately a mile and half, went to the pathology department, tracked down the

correct person to get the records from, sat with her until she got them together, and hand carried them back to M.D. Anderson. She told me she could send them over the next day. I told her if it was all the same, my son was dying of cancer at M.D. Anderson and I would just as soon take them myself. All this time, I am watching him get weaker and weaker.

He had the chemo and we returned home February 16th from M.D. Anderson. His mother commented, when he returned home February 16th from M.D. Anderson, he looked worse than when he left.

We went to Alexandria VA to have his blood checked on either 23rd or 25th of February. It's getting hard for him to walk now, and the fluid is seeping through the skin on his leg and feet. Still no appointment from M.D. Anderson. We keep checking.

On February 27th, Dr. Gary Blanchard checked him at home and told us to bring him to the ER at Opelousas General because he was dehydrated.

On March 1st, I left for a short trip. Gerrit got progressively worse.

I was called home March 4th.

Gerrit passed away in the hospital March 6, 2016, at 2:53 a.m.

I wonder if we had been referred earlier to Houston VA or M.D. Anderson if it would have saved Gerrit. Through this whole process, I got the feeling that veterans are given crumbs, secondhand services, leftovers. At best, the VA moves at a snail's pace; the rest of the world is watching DVD's and they're stuck on cassettes. They like to say, "We'll get back to you in five to seven business days," or "Call back Monday," but cancer and other diseases grow on the weekend and twenty-four hours a day during the week, too. We had a lot of people truly engaged in Gerrit's treatment. I could see the frustration in a lot of them because they weren't given what they were needed to provide for their patients. I wonder if Joe Biden had this much trouble when his son fought cancer. I am a veteran of the U.S. Air Force, Gerrit served eight years in the U.S. Navy, I have another son who was a U.S. Marine. Why can't we and the other veterans get health benefits equal to you people in the U.S. Congress? We served our country, but it is the opinion of a lot of people that all you do is receive from our country.

Prepared Statement of Carroll Knott

Veteran Derek Johnson; submitted by his wife

Social worker, Sharon Deluche, advised me Derek's team meeting would be at 3pm. I arrived at 2pm: they had seen Derek already. Gave Sharon copy of messages where Derek threatened to commit suicide. Sharon left them on her desk and went on vacation. Psychologist told both Derek and I that nothing was wrong mentally with Derek; he just had a drug problem.

When I left I called the crisis hotline because I felt Derek's treatment team was not doing anything. I was advised the Derek could request to be sent to a different VA, which he told them several times he wanted to go to Biloxi and they ignored him. I was also told by his psychologist, Dr. Mollanor, to get a restraining order against Derek.

Sharon Deluche insisted on Derek going to SUDS program in Alexandria and living at the Salvation Army homeless shelter. This was the ONLY option she gave my husband because she did not believe him when he said he wanted help. Sharon refused to put a consult to Biloxi for Derek to do the impatient substance abuse program there.

I called her boss, Harvey Norris, and he is the one who actually helped us. He sent the consultation to Biloxi for us. He also wrote a letter stating Derek was not ready to be discharged because of the suicide threats. Derek's social worker, Sharon, did not do any of this for us.

Sharon never contacted me to let me know when any of his team meetings would be. She never called me to give me updates either. The nurses would not help me; they would just transfer me to Sharon who would not return my calls.

Sharon advised me to leave Derek alone, to let him go and for myself to seek counseling. She then went told Derek that I did not want him home and that he was still in there because of the letter that Harvey wrote while trying to help us. This made my husband stop talking to me while he was in there.

On Derek's day of discharge, he was discharged with a follow up to the SUPS program, which he told them several times he was not doing. Biloxi called the VA on 6/16 with the time and date for his screening appointment for their impatient program. Sharon NEVER passed this information onto us. I had to call Harvey Norris to find out when we would hear from Biloxi for his consultation. The psychiatrist

put Derek on thorazine 2 days before he was released back to us which does not help an unstable combat veteran deal with civilian life that soon.

Prepared Statement of Asbel Montes

Mr. Chairman and distinguished members of the Subcommittee:

My name is Asbel Montes and I am the Vice President of Reimbursement and Government Affairs for Acadian Ambulance Service, the largest private, employee-owned ambulance service in the nation. The Chairman & CEO of our company, Richard Zuschlag, founded the ambulance service division in 1971 with eight Vietnam veterans. Today, we now have over 4,400 employee owners, with over 400 of those being military veterans.

I am honored to sit before you today to represent not only the industry, but even more so, the veterans we serve.

Background

Since the last hearing on June 3, 2015 where we provided requested information on this issue, our company, along with American Medical Response, the largest public ambulance provider in the nation, and the American Ambulance Association have worked diligently with our Congressional delegations, including Congressman Abraham, Congressman Boustany and Congressman Coffman, other healthcare stakeholders, the Veteran Integrated Network Services (VISNs), as well as the national leadership at the VA to assist, recommend and frankly demand that the VA expedite the updating of their internal processes to promptly pay for the emergency treatment that our nation's finest receive by non-VA healthcare partners.

Due to these continued efforts, we have seen some significant progress made within VISN 16 and attribute these gains to the hearing conducted last year. However, there is still significant work to be done and my colleagues within the ambulance industry nationwide are still experiencing extraordinary delays in claims processing and payment in other VISNs.

For a real life look at the progress made by the VA and the issues still prevalent, I would like to include two specific examples. In the first quarter of 2014, it was taking the VA in Alexandria approximately 138 days to pay for an emergency ambulance transport. Thanks to the efforts of Congressman Abraham and this subcommittee, we are now receiving payments for approved care within 40 days through electronic submission. However, on the flip side, the Flowood, Mississippi office and the Houston office in VISN 16 are still struggling to improve prompt payment efficiencies. For example, Flowood still requires that we send all claims and medical records via paper. In addition, claims are being underpaid due to a new unregulated process that requires us to add the ZIP+4 to every claim. No other Federal or State payer or other VISN office requires this that we are aware of. It should also be noted that no one was ever notified of this requirement prior to complaints being made as a result of the underpayments.

In November of this past year we had to engage the assistance of Congressman McCaul's office to address severe payment and claims processing delays in VISN 17. This work is still ongoing and our efforts are being coordinated with the Chief Business Office in Denver, Colorado under the direction of Mr. Steven Gillespie. Our current aged receivables outstanding over 180 days are in excess of \$600,000 awaiting payment or denial.

There are many more examples just like this one that could be given by providers and veterans alike across the nation. This problem is especially acute for the majority of ambulance service providers that serve as the local 911 responders in their communities, who are prohibited from refusing emergency treatment for any patient, regardless of payer source or ability to pay. This failure to pay providers in a timely and accurate manner puts providers in the difficult position of either having to shut their doors and eliminating access to care due to lack of funds to operate or to bill veterans for emergency treatment, placing an unfair financial burden on the veteran due to the lack of response, invalid denial or payment by the VA.

Ultimately, it is the veteran who suffers due to the lack of coordination and inefficiency of the internal systems at the Veterans Administration. While the Chief Business Office has been very responsive to our company over the past nine months, there is still an inefficiency in system design regarding prompt payment and processing of provider claims. As of three weeks ago, one facility in VISN 17 requested that we submit everything via paper claim until they could resolve our issues on why our claims were not processing through the OB10 system. This only continues

to exacerbate the administrative and financial burden for providers who serve our nation's finest.

Solution

The federal government has a responsibility to ensure that our veterans receive the best healthcare we can provide. It also has a responsibility to ensure they are not required to bear an unjustified financial burden as a result of the VA's failure to pay non-VA providers in a timely and accurate manner. As stated in my previous testimony last year and subsequently introduced via legislation by Congressman Boustany and Congressman Abraham in H.R. 4689, it is our recommendation that Congress remove all claims processing for non-VA providers from the Department of Veterans' Affairs and place it with a single Fiscal Intermediary, providing guidelines and policies to address the issues stated here today. Congressman Coffman has also introduced H.R. 5149 that will provide clarification on how the VA will reimburse emergency ambulance providers for the care provided to our veterans who meet the prudent layperson's definition of an emergency to ensure our veterans are not financially burdened solely as a result of the VA's subjective and adverse treatment of these claims. This step would ensure consistency, efficiency and expertise in personnel as well as sufficient dedicated resources to process claims timely. Several other government programs, including Medicare and Tricare, utilize this strategy successfully.

Thank you for giving me this opportunity to provide information and to serve those who have sacrificed so much for our nation. I look forward to answering the Committee's questions and serving as a resource as the Committee's work continues beyond this hearing.

Prepared Statement of Janet Henderson

Good morning, Mr. Chairman, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the efforts that the Department of Veterans Affairs (VA) has taken to improve access, patient care, and accountability. I am accompanied by Shannon Novotny, Veterans Integrated Service Network (VISN) 16 Acting Deputy Network Director and Peter C. Dancy, Jr., Alexandria VA Health Care System Medical Center Director and a 22-year Army Veteran.

VA remains committed to ensuring that America's Veterans have access to the health care they have earned through their service. Veterans are demanding more services from VA than ever before. From March 1, 2015, through February 29, 2016, Alexandria VAHCS completed more than 244,000 appointments; this represents an increase of 4,407 appointments (1.83 percent) over the same time last year.

Even as VA becomes more productive, the demand for benefits and services from Veterans of all eras continues to increase. VA's top priority is to improve access to care for every Veteran who needs it.

As a whole, VA is working to rebuild trust with Veterans and the American people, improve service delivery, and set the course for long-term VA excellence and reform, while delivering better access to care. This initiative is called MyVA. All of us in the VA health care system are focused on this initiative. The first priority of MyVA is to fix the access issues and continue working to reduce the wait times for Veterans who need our services.

Access

The focused Access Stand Down events in November 2015 and February 2016 have addressed Veterans with urgent needs and significantly reduced the number of Veterans waiting for care. Alexandria VAHCS completed 112 combined Veteran appointments at the Alexandria campus and Lafayette Community-Based Outpatient Clinic (CBOC) during the November 2015 Stand Down. They also completed 134 combined Veteran appointments at the Alexandria campus, Fort Polk CBOC, and Lafayette CBOC during the February 2016 Stand Down.

It is important for Veterans to be in control of their health care. This means changing our old systems that have been in place for decades at VA, to a system that works for Veterans and is focused on contemporary practices in access. That is why the Under Secretary for Health developed the "MyVA Access Declaration," which is a set of foundational principles for every VA employee to improve and ensure access to care. The MyVA Access' goal for 2016 is when a Veteran calls or visits primary care at a VA medical center, their clinical needs will be addressed that day.

This initiative and the MyVA Access Declaration represent VA's pledge to improve access to care for all Veterans seeking VA health services.

Two of Secretary McDonald's Breakthrough Priorities focus squarely on health care outcomes: improving access to care and improving community care. Moving toward long-term transformation, the Alexandria VAHCS has already implemented a number of actions to address access, quality, and patient satisfaction within the larger transformation of MyVA.

- Alexandria VAHCS completed 93.28 percent of appointments in April 2016 within 30 days of the clinically indicated or Veteran's preferred date.
- Alexandria VAHCS increased its total outpatient unduplicated encounters by 1.49 percent from fiscal year (FY) 2014 to FY 2015. This equals roughly 6,165 additional completed encounters for our Veterans.
- Alexandria VAHCS has a 97 percent utilization rate for Care in the Community referrals through the Veterans Choice Program (the Choice Program), authorized by the Veterans Access, Choice, and Accountability Act of 2014. There have been 4,361 consults to VA Community Care via the Choice Program this fiscal year.
- Alexandria VAHCS offers an extensive community provider network of over 1,000 providers through the Patient-Centered Community Care/Choice Program, and more are joining each month.
- Alexandria VAHCS is the health care provider of choice for 31,998 Veterans within our catchment area. Of these, 25,872 Veterans receive Primary Care Services.
- Alexandria VAHCS is activating two new permanent CBOCs: Lafayette, Louisiana CBOC and Lake Charles, Louisiana CBOC.
 - The current Lafayette CBOC provides Primary Care to 7,351 Veterans.
 - The current Lake Charles CBOC provides Primary Care to 1,809 Veterans.
- Alexandria VAHCS provides Telehealth to 3,958 Veterans, or 12.37 percent of our Veteran population. Telehealth services have been expanded to CBOCs for Primary Care, Mental Health, and Specialty Services and these are critical to expanding access to VA care.

Patient Care

The Alexandria VAHCS utilizes sign-in kiosks to assess patient satisfaction in terms of their ability to schedule an appointment when they want it. As of June 3, 2016, 90% of Veterans utilizing the sign-in kiosks at the facility were completely satisfied or satisfied with their ability to receive care when they wanted it. We want to ensure that we can say that there are no Veterans who need care now who are not receiving it. We are not fully there yet, but that is the direction in which we are moving.

The Alexandria VAHCS Director has emphasized to Veterans that he wants the Alexandria VAHCS to be the provider of choice within the community. To that end, below are some of the initiatives that have been put in place to address patient care issues within the community:

Between February 27, 2016, and June 5, 2016, Alexandria VAHCS decreased the amount of appointments at Level 1 clinics (defined as clinical services judged to have higher relative risk and more time sensitivity) from 354 appointments to 63 appointments over 90 days, resulting in an 82.2-percent decrease.

VA has partnered with the Veterans Engineering Resource Center for the MyVA Access initiative, which will focus on improving access to care for our Veterans across the Nation. Alexandria VAHCS is scheduled to have their initial site visit with the Veterans Engineering Resource Center the week of June 13–17, 2016.

Alexandria VA HCS has also hired a full-time group practice manager who will provide general oversight for all ambulatory care access at the Alexandria VAHCS.

In April 2016, the Alexandria VAHCS Director held a Veteran town hall meeting in Natchitoches, Louisiana to hear Veteran concerns; Approximately 50 Veterans attended. Town hall meetings will continue, with the next scheduled for June 29, 2016, in Lake Charles, Louisiana. To ensure follow-up on actions on the concerns expressed by Veterans at the April 2016 Town Hall in Natchitoches, Louisiana, the Alexandria VAHCS Director will hold another Town Hall meeting in July 2016.

In partnership with the Office of Patient Centered Care, the Alexandria VAHCS has begun engaging employees in Mil-X training, which is an "experience" that provides awareness, insight, and understanding of Military Culture to help facilitate a healing relationship with the Veterans we serve. The main objectives are to develop a better understanding of basic Military Culture, align Military Culture with VA's Mission and Core Values, and connect effectively with Veterans to improve the

Veterans experience. Since May 2, 2016, 63 employees have attended this interactive training. Trainings will continue until all staff has the opportunity to experience this model.

Accountability

The Alexandria VAHCS Director also has emphasized that he would like the Alexandria VAHCS to be the health care employer of choice. He has held eight employee town hall meetings at the local facility and at CBOCs to hear employee concerns, address rumors, and to share the direction the HCS is headed with a focus on the I-CARE values of Integrity, Commitment, Advocacy, Respect, and Excellence.

He has also initiated recognition of employees who have exhibited I-CARE values through weekly presentations at an executive morning meeting using I-CARE certificates. These certificates give supervisors an opportunity to recognize employees who have demonstrated I-CARE attributes through their work. To date, over 15 certificates have been awarded. Supervisors have taken the initiative to replicate this recognition at their own staff meetings.

Each year during patient safety week, the Alexandria VAHCS Director issues a memorandum to all staff regarding the culture of safety and the importance that each individual makes to the organization by reporting unsafe conditions, adverse events, and near-miss incidents. We are deeply committed to promoting a culture of safety in this organization by emphasizing “how” an event occurred rather than “who” may have made an error. Patient events are discussed in a supportive, non-punitive environment, using open communication to improve processes and prevent a recurrence of the event. We are dedicated to developing strong leaders devoted to fostering a foundation of respect, accountability, and responsibility at every level of the organization.

Conclusion

VA is committed to improving access, patient care, and accountability to better serve our Veterans. We realize the significant work that remains ahead. The good news is that moving forward, along with Congress’ assistance, we have an opportunity to reshape the future and make long-lasting valuable changes. Mr. Chairman, this concludes my testimony. We appreciate your support and look forward to responding to any questions you may have.

Statements For The Record

CONGRESSMAN CHARLES BOUSTANY

Chairman Benishek and Subcommittee Members:

Thank you for providing me the opportunity to submit written testimony today. I am especially grateful to the Subcommittee for traveling to my home State of Louisiana to conduct this critically important field hearing. As you consider legislation to reform the Veterans Choice Program and other Department of Veterans Affairs (VA) policies, I believe it is of vital importance to seek solutions to the problem of delayed payments for veterans’ medical care.

In June 2015, I submitted written testimony to the House Veterans’ Affairs Subcommittee on Health regarding the seriousness of the backlog of non-VA emergency medical care claims within the VA. I detailed the case of one Louisiana veteran, Mr. Al Theriot, who waited over a year for the VA to contact him regarding his emergency care claim. I also provided information from two Louisiana hospitals with a cumulative backlog of over \$5.5 million in unpaid claims from the VA. At the time of my previous testimony, the VA’s own data demonstrated a nationwide backlog of more than \$878 million. Today, almost one year later, the nationwide backlog is still a staggering \$788 million.

While it is disturbing in itself that these figures have only slightly improved, it must also be noted that since the time of my first inquiry for emergency claims data from the VA, the agency has internally changed its timely processing standard from within 30 days to within 45 days. Consequently, the most recent claims reports I have received from the VA reflect that change, making it impossible to accurately measure their progress in this area.

In 2015, I recommended that, should the VA fail to improve its performance on claims processing, lawmakers should consider legislation to direct the VA to contract with a third-party entity to process claims. Therefore, due to the lack of improvement from the VA, I introduced H.R. 4689, the Timely Payment for Veterans Emer-

gency Care Act, in March 2016. My legislation would direct the VA to transfer non-VA emergency care claims processing authority from the VA to a third-party contractor. Medicare and TRICARE currently employ third-party claims processors, and according to testimony of the Government Accountability Office (GAO) to this Subcommittee in February 2016, both programs have much higher success rates for timely processing than the VA.

Additionally, my bill would mandate that the entity selected for the contract must be able to accept electronic medical records. Lost records have unfortunately become a frequent problem, and providers still report to me that they are doing everything in their power to ensure the necessary medical records are received by the VA, including sending medical records via certified mail. Despite this, the VA is still denying many claims by asserting that they never received the necessary medical records, even when providers can produce proof of receipt. Ensuring that providers have the ability to submit records electronically will greatly increase the VA's accountability to providers in this area.

America's veterans should never have to worry that an ambulance ride or a trip to the emergency room will negatively affect their personal finances - they should instead be focused on their health and recovery. As your legislative discussions continue, I urge you to give the utmost consideration to H.R. 4689. I sincerely appreciate the work done by the Subcommittee to support our nation's veterans, and thank you again for allowing my testimony.

AMERICAN MEDICAL RESPONSE

Submitted by
 Debora M. Gault, National Vice President of Federal Reimbursements & Regulatory Affairs

Mr. Chairman and distinguished members of the Subcommittee:

American Medical Response (AMR) is honored to have this opportunity to submit a written statement to the House Committee on Veterans Affairs' Subcommittee on Health for the hearing on June 20, 2016. AMR is the nation's largest single ambulance provider with operations in over 2100 communities in over 40 States. AMR proudly serves our nation's veterans on both an emergency basis, through 911 calls, and a non-emergency basis through contracts with the Department of Veterans Affairs (VA). Like so many other non-VA providers in the country, AMR has had consistent difficulty getting reimbursed by the VA for services we provide to veterans. Despite the fact that AMR has been working diligently with the VA for over 2 years now to try to get the backlog resolved, the current payment backlog at the VA for AMR claims totals approximately \$15.8 million. Unfortunately, there has been very little progress after two years of biweekly conference calls with members of the VA CBO and VISNs. As stated in our initial testimony provided for the Committee's hearing in June, 2015, our work has been useful in obtaining the names of contacts that work directly on medical transportation claims, but very little improvement has occurred in terms of actually resolving the issues we have uncovered or in timely payments received.

Background

AMR has been operating since 1992 and currently provides over 3.3 million transports annually to patients in the communities we serve. Approximately 100,000 of these services are provided to veterans across the nation. AMR has over 19,000 employees nationally and many of them are veterans. We continue to be diligent in our recruiting efforts to attempt to reach and provide employment to as many veterans as possible and have established recruiting and training programs specifically directed to provide a career path within AMR for our military heroes who are returning to civilian life. Our objective is for every veteran who desires a career in the world of Emergency Medical Service to be able to attain their goal.

Each of AMR's operations provides clinical ambulance services to our nation's veterans. As a result, AMR works directly with 20 of the VA's Veteran Integrated Service Networks (VISN) when submitting claims and the required documentation as we attempt to secure reimbursement for our services. Unfortunately, as we stated previously, this is not an easy task. While we do everything possible to ensure that veterans' covered services are paid directly by the VA with as little involvement by the veteran as possible, the VA's current lack of consistent processes, the lack of electronic capability for claims submission and the huge backlog of delinquent payments make this goal extremely difficult, if not impossible.

AMR submitted written testimony to the House Committee for Veteran's Affairs for the hearing on June 3, 2015, entitled "Assessing VA's Ability to Promptly Pay Non-VA Providers." Throughout our testimony, AMR discussed several issues that had been discovered through our work with the VA that were causing delinquent payments. As we discussed in our original testimony, AMR's work with the VA began in May, 2014 when Congressman Coffman facilitated weekly conference calls between AMR and representatives of the VA.

Because another year has passed since the discussion of the issues in our testimony for the June 3, 2015 hearing, AMR would like to take this opportunity to update the Committee on the status of the major issues today.

The VA continues to be Delinquent in Payment for Both Emergency and Non-Emergency Claims

Although the conference calls between the VA Central Business Office (CBO), VISN staff and AMR have occurred on a biweekly basis, payments for both Emergency and Non-Emergency Claims continue to be processed very slowly and the total currently owed to AMR by the VA exceeds \$15 Million. Of that total, \$4.5 Million of all claims (contract and non-contracted fee basis claims) are over 90 days old.

Despite the requirement of prior authorization that is included for contracted services with VA facilities, over \$967,000 of contracted claims remain outstanding over 90 days from the date the service was provided to the veteran and authorized by a VA facility. These claims are subject to the prompt payment rule and should be paid within 30 days. Unfortunately, even though AMR is fulfilling our commitment to the veteran and the VA facility, clearly, the VA is not fulfilling its contractual obligations to AMR. Nor is the VA processing claims within the 30 day prompt payment regulation that they are mandated to comply with through statute.

Claims payments for emergency services to veterans have not improved either. Claims processing continues to be done primarily on a manual basis and processing of these claims is extremely slow once the VA receives the documentation required. In addition, the VA continues to follow what we believe to be a misrepresentation of their own processing requirements as it pertains to emergency ambulance services. We will discuss this and what we are doing to attempt to resolve this problem a bit later in our testimony. Due to the VA's mishandling of emergency claims, the backlog of VA emergency claims only at AMR currently totals over \$11 million. Of this amount, over 27% of these claims have remained outstanding more than 90 days past the date the service was provided to the veteran.

Discussions with the VA have not Resulted in Solutions to Payment Challenges

Although consistent dialog has continued and issues are addressed during every discussion, the VA does not seem to be able to make substantial progress. The total amount due to AMR when we began working directly with the VA staff in May, 2014 was \$10 million. Since our work began, the total due to AMR has been as high as \$18 million and averages from \$13 to \$16 million on a regular basis. No other payer demands as much of AMR's claims processing time and resources, and no other payer's reimbursement methodologies are as cumbersome. Ironically, even with all the additional time and attention expended on VA claims at AMR, the VA remains the most delinquent of all our payers.

The VA was tasked with reviewing the cost/benefit of outsourcing the claims administration portion of their service at the June 3, 2015 hearing. However, we were recently informed that because the agency is implementing Electronic Claims Transmission (ECT) pilot programs to resolve the delinquent payment issues, they do not plan on putting such an analysis together. We will discuss the ECT pilot programs in and AMR's involvement with them in more detail later in this testimony.

Utilizing third party contractors to process Medicare claims works very well for ambulance providers. At a minimum, AMR feels strongly that the VA should follow Congress' instruction and produce the requested cost/benefit analysis to study the pros and cons of utilizing third party contractors for their claims adjudication process so that a sound decision can be made. Additionally, AMR supports and urges the Committee to consider H.R. 4689, "The Timely Payment for Veterans' Emergency Care Act" sponsored by Congressman Boustany.

Several Problems Continue to Contribute to VA's Delinquency in Claims Processing

The following portion of our testimony includes an update on the various problems that were discovered through our work with the VA and discussed in our previous testimony for the June 3, 2015 Committee hearing.

VA Continues to Require External Records from other Health Care Providers before Paying Emergency Claims

The VA is holding emergency ambulance claims prior to processing or payment until medical records are received for the veteran's entire episode of care on the day of the ambulance transport. Even if the veteran meets the additional requirements established within the VA's payment regulations (e.g., whether the incident is service or non-service related, whether the patient has been seen within a specified period of time prior to the current date of service), the VA does not truly utilize the prudent layperson standard to establish payment for emergency medical services. In addition to the ambulance service's documentation, the VA still claims that it also requires documentation from other medical providers that are involved with the patient's care on the date in question before the VA can pay any of the claims received. Putting these criteria in the ambulance service's context, the ambulance provider's claim cannot be reimbursed until all medical records from the hospital and other clinicians that see the veteran on the day of their ambulance transport are received and reviewed by the VA. This means that even though the ambulance service personnel are not even present and the ambulance service has absolutely nothing to do with the care that is rendered once the patient is transferred to the receiving facility, the ambulance provider's claim is delayed until all other claims are received and evaluated to determine whether the entire incident can satisfy the need for medical care on that date.

This retrospective lookback using the facility medical records provides the physician at the VA much more definitive information about the outcome of the veteran's medical encounter than the ambulance provider is aware of during their entire time with the patient. Because the VA regulations state that the Prudent Layperson Standard is the standard by which the VA will reimburse emergency medical services, that is the standard that should be used. Unfortunately, that is not the case.

In April of 2015, Congressman Coffman contacted VA Secretary McDonald about this issue on AMR's behalf. Acadian Ambulance Services also requested that Congressman Boustany submit a request for review of this issue to the VA. The Deputy Secretary of the VA responded and stated that the VA was applying their claims methodology for emergency ambulance services properly. We were informed that if we did not agree with their current practices, we would need to seek a legislative solution.

Because of this response to our inquiry, Congressman Coffman recently introduced H.R. 5149 which would specifically require the VA to reimburse emergency ambulance services based solely upon the Prudent Layperson Standard. The bill was introduced by Congressman Coffman on April 29, 2016 with the bipartisan support of Congresswoman Titus, Congressman Abraham, Congressman Takano and Congressman Boustany as original cosponsors of the legislation. The American Ambulance Association is supportive of H.R. 5149, and we have included a copy of their statement as an addendum to our testimony document. We urge the Committee to include the language from H.R. 5149 in any VA reform legislation that may be developed this year so we can resolve this issue for veterans and ambulance providers once and for all. Enactment of the language in H.R. 5149 would help resolve the VA's current misinterpretation of the emergency ambulance service claims requirements and alleviate much of the emergency claims backlog (up to 30% of emergency claims are currently held or denied because of this one issue). Veterans would no longer be held financially responsible for emergency ambulance claims that the VA should have paid and ambulance services would be reimbursed based upon the true application of the Prudent Layperson Standard, which is the standard that other large payers such as Medicare, Medicaid, Medicare Advantage and Blue Cross/Blue Shield apply to establish medical necessity for emergency ambulance services. Ambulance providers nationally would appreciate the Committee's consideration of H.R. 5149 when VA Reform legislation is discussed this year, and we applaud Congressman Coffman for his leadership on this issue.

Electronic Claims Transmission (ECT) is Still Not Available for Submission of All Ambulance Claims

The VA began conducting an ECT pilot program to provide electronic claims submission for all types of ambulance claims in 2015. The main goal of the ECT pilots were to ease the burden for the provider since no eligibility tool is available and VA program requirements for ambulance service eligibility are extremely complicated. The VA is currently claiming great success of Phase I of their ECT pilot which includes five sites (Atlanta, GA, Alexandria, LA, Minneapolis, MN, Las Vegas, NV and Boston, MA). Although the VA claims the ECT pilot has decreased the time taken to pay claims, this has not been the outcome of the program at AMR.

AMR has participated in two of the five pilot programs and, thus far, we have not seen faster payment turnarounds as an outcome of the process.

AMR has seen some benefits of the ECT programs that have been implemented. Some of these benefits are: reduction of paper, visibility of claims submission, tracking of claims acceptance at the VA, ability of reporting at the VA of claims received and faster processing status for denials which generate a paper response received as correspondence on determination. Unfortunately, the current internal shuffling of claims between the different departments within the VA to determine who is responsible for processing the claim and determining whether all of the eligibility criteria has been met continues to hamper the process from showing as much effectiveness and efficiency as possible.

Because of the VA's own cumbersome process requirements, the current ECT pilot cannot be as streamlined and successful as it would be if the process regulations were clarified. Currently, the claim is transmitted by the provider and received electronically and the provider receives proof of receipt very quickly. However, because of the VA's own process requirements that must be followed and medical claims from other healthcare providers that must be retrieved and approved for coverage before the ambulance claim can be paid, the ambulance claim is still taking a significantly long time to actually process for payment. Until the specifications included in H.R. 5149 are passed into law, the ECT process that the VA believes will resolve ambulance provider payment problems will not be effective.

We were recently told that the VA was so pleased with the outcome of Phase I of the ECT pilot program that they are moving forward with Phase II. Again, while this may improve the submission of the information of the veteran's episode of care to the VA, it will NOT solve the delinquent payment problems. Until the regulations are clarified and the Prudent Layperson Standard is applied correctly by the VA, the ECT pilot program only allows the claim to arrive at the VA more quickly—the processing time remains the same. The ECT pilot program that the VA has implemented is not, in the true sense of how other payers use ECT, fully capable of processing the claim for payment or denial. All it does is allow the VA to accept the information into its system through electronic means while the rest of the process requirements are still performed manually.

VISNs Claim Lack of Funding

When AMR discusses delinquent claims problems with individual VISNs, we continue to be told that the VA must request additional funding because insufficient dollars were appropriated for ambulance services in their budget. This funding request must then go through the VA's internal approval process and causes a large part of the problem with delinquent payments on facility contracted claims. This continues to occur as early as the first quarter of the year. The CBO has sufficient funds to pay ambulance claims but the internal authorization process that must be followed to obtain the funding to pay ambulance providers at the VA facility level takes a substantial amount of time. This process is especially frustrating because the VA has already agreed that the claim should be paid.

The root cause of this problem remains the same as was discussed in our initial testimony. Rather than work with the ambulance professionals during their budgeting process to ensure that the proper amounts are included in their budgets for clinical ambulance care and transport of veterans in each area, the VA budgets are based upon past volumes on a cash basis. If the VA would work together with the ambulance companies to discuss whether there will be volume fluctuations because of various demographic or other differences, much of this problem could be eliminated and resources could be saved for both the VA and the providers and ultimately decrease the number of delinquent claims. AMR and other ambulance providers have reached out in attempts to work with the VA on this issue but the VA has not reciprocated.

There are Not Enough Resources within the VISNs to Process Ambulance Claims

Another problem that continually is used as the number one reason claims cannot be processed is that there are not enough resources within the VISNs to process ambulance claims. The VISNs have continued to be very honest that this is true. We continue to be told by VA personnel that the reason there is such a backlog of our claims is that they simply do not have enough people working on them. The problem is exacerbated when one of the dedicated personnel at the VA is not working for a period of time, and there is no process to accommodate any backfill of that person's work. So, they leave a backlog when they go on vacation or medical/personal leave and come back to a backlog that is exponentially worse because no one has been processing any of these claims in the meantime. While the VA continues to tell us that they will find a solution to this problem, it is now a year later and after

two years of being told this is the number one hurdle to their successfully adjudicating claims timely, no solution has been forthcoming.

When VA does not Pay Claims, Veterans are Affected

As discussed previously, when the VA does not pay claims that they are responsible for paying, veterans continue to be held financially responsible. AMR is still committed to doing everything possible to hold claims until we receive notification directly from the VA that the claim is either not covered or is paid. Despite the fact that there are claims are over a year old that AMR continues to hold open, hoping we can work through whatever issue is prohibiting the VA from paying the veteran's claim, we feel strongly about not holding the veteran financially responsible if the VA should be covering their service.

As we explained in previous discussions and testimony, larger ambulance providers are able to operate despite the VA's delinquent payments and can hold claims open for longer periods of time as they attempt to retrieve reimbursement from the VA. Smaller ambulance providers are a harder time than ever holding VA claims open without payment for long periods of time. Many small providers have simply stopped serving veterans in non-emergency and contracted scenarios. This has put even more of a burden on large ambulance providers. Since the VA has no emergency ambulance service capability, a non-VA supplier must always provide these services for our veterans. Because small ambulance providers can no longer afford to provide these services to veterans, much of their previous service areas must be covered by larger providers. This may result in increased response times as another company must travel longer distances to treat veterans which ultimately reduces the quality of care provided to our veterans and creates an even higher financial burden on the large providers as they absorb more and more VA services.

In addition, as the VA payment cycle increases, it becomes more common for veterans to be held responsible for paying their ambulance bills. In a recent survey of several members of the American Ambulance Association, over 70% of respondents stated that they had no choice but to hold the veteran responsible for paying their ambulance claim after waiting for VA's payment for over 60 to 90 days. Some smaller providers could only wait for VA to pay their claims 45 days and then held the veteran responsible for payment. As a result, veterans have begun to question whether they should dial 911 for fear of being held responsible for paying ambulance claims - and perhaps their hospital bill as well - if the VA determines that the veteran's ultimate diagnosis could have been treated in another manner. Hind-sight is 20/20 but do we really want our veterans to feel that they should think twice about dialing 911 for help when they truly need it? Once again, H.R. 5149 deals with this issue and would help ensure that the veteran would never have to be held responsible for paying an emergency ambulance claim that the VA should be responsible for paying because of a retrospective lookback using information that was not available when help was truly needed. Veterans should never be afraid to ask for help in an emergency because of the VA's inappropriate application of the Prudent Layperson Standard. The VA should treat emergency ambulance claims in the same manner as other payers have done for well over a decade and use solely the Prudent Layperson Standard to establish coverage of the service.

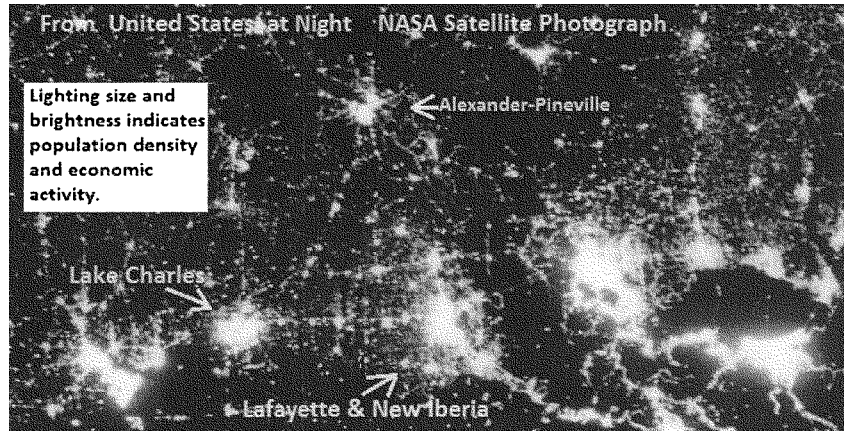
Conclusion

We appreciate the Subcommittee's consideration of these issues. While we were all hopeful that the Veterans Access, Choice and Accountability Act, which was signed into law in 2014, would help resolve critical payment issues, unfortunately it has not. We were hopeful again after the June 3, 2015 hearing that ambulance services' claims payment problems would improve. Unfortunately, that has not been the case either. In fact, the situation has gotten much worse in almost all areas of the country. The VA is already subject to prompt payment laws-laws the agency is not following. Respectfully, we submit that Congress needs to take aggressive action to fix the VA's health care system and ensure that our nation's veterans receive the care they deserve. By supporting the provisions included in H.R. 5149 and H.R. 4689, the Committee would make great strides toward preserving high quality clinical ambulance services for veterans without creating the current level of anxiety about becoming financial liable for medical claims that the VA should be paying and, at the same time, provide a path forward for much fairer treatment for our nation's ambulance service providers.

AMR thanks the Chairman and the Committee for the privilege of submitting this testimony.

VETERAN ACTION COALITION OF SOUTHWEST LOUISIANA (VACSWLA)

The NASA photograph below of the USA at night clearly demonstrates the relative populations and relative economic activity of the Alexandria, Lake Charles and Lafayette, Louisiana areas. The Lafayette and New Iberia Metropolitan Statistical Area (MSA) is now the third largest in Louisiana behind only New Orleans and Baton Rouge. Lafayette, New Iberia and Lake Charles are growing very fast. Alexandria is not.



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1. For more than forty (40) years the VA Staff in Alexandria LA forced veterans in Lake Charles and Lafayette to drive the four-hour plus round trip to Alexandria to receive VA health care which those veterans have earned by their service to our country. The VA Alexandria Staff prevented construction of a VA clinic in Lake Charles prior to 2016. Congress should demand that the VA deliver health care where veterans live. Congress funded two new VA Clinics in Lake Charles and Lafayette that are now under construction. This entire process transpired as The CBOC's in Lafayette and Lake Charles remained tremendously understaffed.

2. There are 35,000 veterans in the thirteen (13) Parishes around Alexandria, LA The Alexandria area has 1,240 VA Staff members that means 28 veterans per VA Staff member. There are 69,500 veterans in the fifteen (15) Parishes around Lafayette and Lake Charles, LA that has eighty (80) VA Staff members or 868 veterans per VA Staff member. The Lafayette and Lake Charles populations are growing RAPIDLY.

3. Veteran population distribution indicate 1,340 VA permanent staff should be as follows: Alexandria clinic 433 staff for 35,000 veterans; Lake Charles clinic 312 staff for 24,000 veterans; the Lafayette clinic 590 staff for 45,500 veterans. The VA Staff in Alexandria will block that distribution unless Congress intervenes.

4. Often veterans arriving in Alexandria were redirected to private specialty physicians in Alexandria - not on the VA Staff - to receive their VA health care. Private specialty physicians were and are available in Lake Charles and Lafayette. Physician "turnover" rate at the Alexandria VA facility is high reflecting the need for more physicians in specialties in Lafayette and Lake Charles, both working in the CBOC's and in the private sector.

5. The Alexander, Lake Charles and Lafayette (28 Parish area) VA Medical Care Expenditures for ten years, FY 05 -14, was \$2,082,676,342.00 More than TWO BILLION Dollars in VA funds have been managed by the VA Alexandria Staff in those ten years. Lake Charles and Lafayette had little to show for that gigantic amount of money. More than THIRTEEN MILLION dollars of construction funds were expended in Alexandria in FY 05-FY 14. NOT ONE PENNY of construction funds were expended in Lake Charles or Lafayette in those ten years. Fortunately that trend is changing.

6. Veterans in the Alexandria area receive many more VA health care dollars "per veteran" than veterans in the Lake Charles and Lafayette areas. "Unique Patients" are veteran patients receiving health care from the VA. There is a much higher percentage of "Unique Patients" in Alexandria when compared to the total veteran population living in that surrounding area than in Lake Charles and Lafayette commu-

nities. Additionally, the Alexandria “Unique Patients” receive many more VA health care dollars than the “Unique Patients” from Lake Charles and Lafayette thus suggesting that Alexandria veterans use VA healthcare at a greater rate because of the lack of travel barriers.

7. Because of Veteran Volunteer groups and our national congressional input, and new leadership in Washington Congress funded new VA clinics in Lafayette and Lake Charles to ensure VA health care is delivered where veterans live. The Lafayette Clinic is under construction with the Lake Charles construction to follow shortly. However, the permanent VA staffing and equipping will determine the success of those two clinics by determining what specialty and primary health care is delivered to veterans at those new clinics.

The facts above merely skim the surface. Many more facts are available on the VA Expenditures web page below:

<http://www.va.gov/vetdata/Expenditures.asp>

Fairness to Veterans under the VA–Union Master Agreements

Apparently, allegedly the five existing VA and union Master Agreements (contracts) are barriers to delivery of timely, quality health care to veterans. The Federal Tort Claims Act is the source of employee immunity from lawsuits for federal workers, not the union master agreement. The act substitutes the federal government for the employee except for certain law enforcement and investigative agencies. However, under the Master Agreements, Union members, after the first year of employment, can be terminated for cause only with great difficulty and after lengthy appeals. One VA staff member in Alexandria, Louisiana remained on the payroll after being charged with manslaughter in the beating death of an Alexandria, Louisiana VA health center patient.

More than 94% of eligible VA employees are union members.

Please see the bottom of page four listing the five unions with which the VA has Master Agreements (contracts). Page four also lists the union members within VA VISN 16 of the south central United States.

VA Secretary McDonald has the opportunity, as the next contracts are being formulated, to fight for veterans, helping to make the future Master Agreements “veteran friendly”, which has not been the case in the past. The current Master Agreements were in place before Secretary McDonnell arrived and appear to place the unions effectively in control of the Department of Veterans Affairs—and in control of delivery of health care to veterans.

When the VA–Union Master Agreements are renegotiated to make them “Veteran Friendly” there will certainly be points of impasse where the Union negotiators will not agree under any conditions. These points of impasse will be resolved by the all-powerful Federal Services Impasses Panel. (See Title 5 United States Code Chapter 71 Article 7119 {two pages}).

All seven members of the Federal Services Impasses Panel are appointed by the US President.

Any member of the Panel may be removed by the US President.

It is recommended that future VA–Union Master Agreements be “Veteran Friendly” by having veteran representation on the VA negotiating boards and on the Federal Services Impasses Panel.

US Department of Veterans Affairs Union Membership Totals among VA Employees in VISN 16 (LA, AR, MS, OK, MO, TX)

Source: <http://www.va.gov/LMR/>

VISN: "Veterans Integrated Service Networks"

VA Station	Facility Name	1272	1276	1613	2039	3537	7777	8888	TOTAL
Number		AFGE	AFGE	IAFF-99	SEIU	NFFE	Eligible, NR	Ineligible	Employees
502	Alexandria VA Health Care System	747	378	0	0	0	72	165	1,362
598	Central Arkansas Veterans Healthcare System Eugene J. Towbin and John McClellan	1,653	1,334	10	0	2	149	429	3,577
586	G.V. (Sonny) Montgomery VA Medical Center	949	1	0	175	814	67	324	2,330
520	Gulf Coast Veterans Health Care System	1,115	832	0	0	0	40	324	2,311
623	Jack C. Montgomery VAMC	633	503	0	0	0	15	165	1,316
580	Michael E. DeBakey VA Medical Center	2,013	1,791	0	0	0	491	489	4,784
635	Oklahoma City VA Medical Center	1,054	834	0	0	1	15	333	2,237
667	Overton Brooks VA Medical Center	730	1	0	0	550	130	249	1,660
629	SE Louisiana Veterans Health Care System	608	2	0	0	526	14	244	1,394
564	Veterans Health Care System of the Ozarks	708	598	0	0	0	35	204	1,545

VISN 16 Unionized Employee TOTALS: 10,210 6,274 10 175 1,893 1,028 2,926 **22,516**

American Federation of Government Employees	AFGE	16,484
(UNKNOWN)	IAFF-99	10
Service Employee International Union	SEIU	175
Nation Association of Government Employees	NAGE	0
National Fereration of Federal Employees	NFFE	1,893
National Nurses United	NNU	0

Alexandria, Louisiana VA Health Care System Totals:
747 + 378 = 1,125 AFGE union members of 1,197 eligible to join the AFGE union. That is 93.98% AFGE union membership in Alexandria, Lafayette, Lake Charles, Jennings and Leesville

VISN 16 Union Membership TOTAL 18,562 of 19,590 eligible is 94.75% union membership

UNION	Master Agreement ?	Signed ?	Status ?	SOURCE: http://www.va.gov/LMR/Agreements.stp
AFGE	YES	328 pages	March 2011	Year-to-year Automatic Renewal in March. See pages 300 and 301
IAFF-99	UNKNOWN			There are only ten (10) IAFF organization members across the entire US VA Department
SEIU	YES	Nine(9) pages	March 2011	Year-to-year Automatic Renewal in March
NAGE	YES	189 pages	Nov 2003	In force for three years. Renewed automatically for three year periods thereafter. Renewed automatically in November 2015 for three years. See page 186.
NFFE	YES	133 pages	July 2012	In effect for three years. Year-to-year automatic renewal in July. See page 116.
NNU	YES	177 pages	Nov 2012	In effect for three years. Year-to-year automatic renewal in Nov. See page 171.

