VBA AND VHA INTERACTIONS: ORDERING AND CONDUCTING MEDICAL EXAMINATIONS

HEARING

BEFORE THE

OF THE

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

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VBA AND VHA INTERACTIONS: ORDERING AND CONDUCTING MEDICAL

Wednesday, June 25, 2014

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

The committee met, pursuant to notice, at 9:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the House Committee on Veterans' Affairs] presiding.

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

The *Chairman.* Good morning, everybody. During this morning's full committee hearing entitled VBA and VHA Interactions: Ordering and Conducting Medical Examinations, we are going to examine the relationship that exists between VHA and VBA as to their respective efforts to conduct medical examinations on veterans' claims for disability benefits known as C&P exams. There will be several reasons that we are going to focus on today and the reason that we are focusing on it is medical but non-treatment related VA functions that they perform.

The first is based on that fact that VHA has failed. It has failed in its paramount mission and I quote, "to honor America's veterans by providing exceptional healthcare that improves their health and their well-being." The rampant corruption, dishonesty, and cowardice that has been brought to light by this committee shocks the very conscience of everyone in this room and certainly of the United States of America. This week's newest whistleblower allegation regarding the falsification of deceased veteran records yet again underscores the bureaucratic arrogance that exists within this department.

The consequences of VA's failures did not fall on the unscrupulous or the willfully ignorant facility leadership. Instead the consequences fell squarely on the shoulders of those individuals who stood up and swore commitments to this nation. Commitments that center on fidelity, on honor, and on duty. And veterans have died.

Over the course of recent weeks this committee has held many hearing, targeted to address comprehensive VA reform and there are going to be more hearings to come. I still believe that the majority of VA's workforce, the doctors, the nurses, the claims processes, and the veterans service representatives truly do endeavor to provide quality service to our veterans. But VA's epidemic lack of accountability, and mission focus requires a wholesale, systematic reform of the Department. A massive, massive cultural shift is in fact necessary.

I have listened to VA's responses to this committee's questions in recent weeks and what I hear are frequently institution-centered answers, not veteran-centered responses. In setting the tone for this hearing and future hearings, let me begin by cautioning that any equivocation, any excuse provided by VA that seeks to protect the establishment to the detriment of the veteran is going to fall on deaf ears. The time for excuses has long passed.

Today's hearing will explore the current division of labor between VBA and VHA on provision of C&P exams for disability adjudications, as well as the various contract tools that each administration uses. Given the recent VHA failures and issues raised by VHA to include space limitations and staff shortages, I want to hear your thoughts on whether the thousands of VHA employees assigned to performing C&P exams could be better used to treat veterans. VHA currently has nearly 8,200 registered and certified C&P examiners, which include physicians, nurse practitioners, physician assistants, and psychologists, as well as additional administrative support staff necessary to administer this function, many of whom work with VBA solely to perform C&P disability exams. Transferring some or all of the VHA C&P staff to treatment jobs would significantly increase the number of appointments available to veterans.

I am aware that VHA has voiced some initial resistance to this concept and has objected on the basis that many C&P exam providers at VHA have either not maintained the necessary credentials to transition into patient treatment roles or that some prefer to work on a part-time schedule and thus must remain with a C&P examiner capacity at VHA.

I would point out that this is a prime opportunity to demonstrate that culture shift that I have spoken about. The mission is to provide quality and timely healthcare to veterans, not to accommodate the status quo. And in any event, I am curious as to why VA does not require more than their healthcare providers to maintain their qualifications. Based on the high level of satisfaction with the contractors who perform medical disability examinations for purposes of adjudicating disability claims, VA has supported expansion of its contract authority in the past. However, we are also aware that VBA and VHA do not award or administer contracts uniformly. The ordering processes are different, the scheduling systems are different, the work flow processes are different, and the billing and collection processes are different. Accordingly, today we are going to take a detailed look at the big picture. We will look for sensible solutions and best practices to achieve both the most effective access to medical treatment as well as assurance of timely, high quality C&P exams for disability adjudication.

STATEMENT OF JEFF MILLIER, Chairman

During this morning's full committee hearing entitled, "VBA and VHA interactions: ordering and conducting medical examinations" we will examine the relationship that exists between VHA and VBA as to their respective efforts to conduct medical examinations on veterans' claims for disability benefits, known as "C&P exams."

And there are several reasons that we will focus on this specific medical, but non-treatment related, VA function.

The first is based upon the fact that VHA has failed ... it has failed its paramount mission, I quote, "to honor America's veterans by providing exceptional health care that improves their health and well-being."

The rampant corruption, dishonesty, and cowardice brought to light by this committee shocks the conscience of everyone in this room, and of this Nation.

This week's newest whistle-blower allegation, regarding the falsification of deceased veterans' records, yet again underscores the bureaucratic arrogance that subsists within this department.

The consequences of VA's failures did not fall on the unscrupulous manager, or the willfully ignorant facility leadership; instead, the consequences fell squarely on the shoulders of those individuals who stood up and swore commitments to this nation ... commitments that center on fidelity, honor, and duty.

And, veterans died.

Over the course of recent weeks, this committee has held many hearings targeted to address comprehensive VA reform, and there will be more hearings to come.

I still believe that the majority of VA's workforce - the doctors, nurses, claims processors, and veteran service representatives - truly do endeavor to provide quality service to veterans. But, VA's epidemic lack of accountability —- lack of mission focus—- requires a wholesale systematic reform of the department ... a massive, massive, cultural shift is necessary.

I have listened to VA's responses to this committee's questions in recent weeks ... and what I hear are frequently institution-centered, not veteran-centered, responses. And so, in setting the tone for this hearing, and future hearings, let me begin by cautioning that any equivocation —- any excuse —- provided by VA that seeks to protect the establishment, to the detriment of the veteran, will fall on deaf ears. The time for excuses is long past.

Today's hearing will explore the current division of labor between VBA and VHA on provision of C&P exams for disability adjudications, as well as the various contract tools that each administration maintains.

Given the recent VHA failures, and issues raised by VHA to include space limitations, and staff shortages, I would like to hear your thoughts on whether the thousands of VHA employees assigned to performing C&P examinations could be better used to treat veterans.

VHA currently has nearly eight thousand two hundred registered and certified C&P examiners, which include physicians, nurse practitioners, physician assistants, and psychologists, as well as additional administrative support staff necessary to administer this

function, many who work closely with VBA solely to perform C&P disability examinations.

Transferring some or all of the VHA C&P staff to treatment jobs would significantly increase the number of appointments available to veterans.

Now, I am aware that VA has voiced some initial resistance to this concept, and has objected on the basis that many C&P exam providers at VHA have either not maintained the necessary credentials to transition into patient treatment roles, or that some prefer to work on a part-time schedule, and thus must remain within a C&P examiner capacity at VHA. I would point out that this is a prime opportunity to demonstrate that culture shift I spoke about:

The mission is to provide quality and timely healthcare to veterans, not to accommodate the status- quo. And, in any event, I am curious why VA does not require more of their healthcare providers to maintain their qualifications.

Based on the high level of satisfaction with the contractors who perform medical disability examinations for purposes of adjudicating disability claims, VA has supported expansion of its contract authority in the past.

However, we are also aware that VBA and VHA do not award or administer contracts uniformly; the ordering processes are different, the scheduling systems are different, the workflow processes are different, and the billing and collection processes are different.

Accordingly, today we are going to take a detailed look at the big picture.

We will look for sensible solutions, and best practices, to achieve both the most effective access to medical treatment, as well as assurance of timely, high-quality C&P exams for disability adjudication.

With that, I want to recognize the Ranking Member Mr. Michaud for his opening statement.

OPENING STATEMENT OF MIKE MICHAUD, RANKING MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman, for holding this hearing today on behalf of our nation's veterans. Mr. Chairman, I appreciate your taking the time during our extensive oversight of the VA to focus on something that the VA is improving upon, processing claims.

As of today the VA has reduced the backlog by more than 50 percent from the highest point in March of 2013. We are not even close to the finish line but we are starting to see increase in productivity as a result of VBA's long overdue shift from paper to an electronic processing system. All 56 offices have moved into this electronic processing system and into a new organizational model that appears to be showing positive results. Some of our high performing regional offices are nearing the point at which the backlog will be eliminated.

While we have heard of the scheduling challenges that the veterans face in receiving clinical appointments, I am happy to hear that VA has been providing timely medical examinations to determine a veteran's entitlement for VA benefits. Currently VA's national average for medical examinations for benefits purposes is 24

days, which is six days better than their goal of 30 days. VA seems to believe that they have a solid handle on their mix of contract versus non-contract examination. We have heard VA suggest that in an ideal world they would prefer non-contract examinations over contract examinations because they believe it will provide a better continuum of care for our veterans. We have generally heard the same things from veterans, who suggest that when they have access VA quality of care is second to none.

However, with regards to contract examination it seems that the logical way forward continues to be a mix based on clear standards as to when and where they should or should not be used. That said, I have some overarching concerns with VBA's transformation efforts. Foremost, the all in focus on the backlog is starting to come at the cost of increased delays from other benefits. Management by crisis is not a long term viable solution. We cannot afford to solve one critical issue by taking our attention off another.

I urge VA to reallocate resources to process non-rating claims and appeals in a timely fashion. Appeals in non-rating claims are also part of the backlog and deserve to be adequately resourced to provide timely and accurate decisions to our veterans.

There will be no victory laps until VBA has eliminated their entire overdue inventory. If we have learned anything from this healthcare debacle it should be that serving veterans, not performing metrics, is a way to do business. Along these lines I would encourage VBA to ask itself are we oriented towards a specific set of performance metrics at the expense of identifying how to best serve our veterans? These are the types of questions we must answer as we move forward and I hope to hear them discussed in today's hearing in more detail.

I want to thank all of you for coming here today, joining us, and look forward to the hearing, your testimony, as well. With that, Mr. Chairman, I yield back.

STATEMENT OF MIKE MICHAUD, Ranking Member

Thank you, Mr. Chairman for holding this hearing today on behalf of our nation's veterans.

Mr. Chairman, I appreciate you taking the time during our extensive oversight of the VA to focus on something that the VA is improving upon: processing claims.

As of today, the VA has reduced the backlog by more than 50 percent from its highest point in March of 2013.

We are not even close to the finish line, but we are starting to see increases in productivity as a result of VBA's long overdue shift from paper to an electronic processing system.

All 56 offices have moved into this electronic processing system and into a new organizational model that appears to be showing positive results.

Some of our high-performing regional offices are nearing the point at which the backlog will be eliminated.

While we have heard of the scheduling challenges that veterans face in receiving clinical appointments, I am happy to hear that VA has been providing timely medical examinations to determine a veteran's entitlement for VA benefits.

Currently VA's national average for medical examinations for benefits purposes is 24 days, which is six days better than their goal of 30 days.

VA seems to believe that they have a solid handle on their mix of contract versus non-contract examinations.

We have heard VA suggest that in an ideal world they would prefer non-contract examinations over contract examinations because they believe it provides a better continuum of care for veterans.

We have generally heard the same thing from veterans, who suggest that when they have access, VA quality of care is second to none.

However, with regards to contract examinations, it seems that the logical way forward continues to be a mix based on clear standards as to when and where they should or should not be used.

That said, I have some overarching concerns with VBA's transformation efforts.

Foremost, the "all-in" focus on the backlog is starting to come at the cost of increased delays for other benefits.

Management-by-crisis is not a long-term viable solution - We cannot afford to solve one critical issue by taking our attention off another.

I urge VA to reallocate resources to process non-rating claims and appeals in a timely fashion.

Appeals and non-rating claims are also part of the backlog and deserve to be adequately resourced to provide timely and accurate decisions to our veterans.

There will be no victory laps here until VBA has eliminated their entire overdue inventory.

If we have learned anything from this healthcare debacle, it should be that serving veterans, not performance metrics, is the way to do business.

Along these lines, I would encourage VBA to ask itself, are we oriented toward a specific set of performance metrics at the expense of identifying how to best serve our veterans?

These are the types of questions we must answer as we move forward, and I hope to hear them discussed in today's hearing in a bit more detail.

The *Chairman.* Thank you very much, Mr. Michaud. And if you have a telephone on in this room, turn it off. Thank you very much. I would ask all members to waive their opening statement as per the Committee's custom. Thank you for appearing before us today as witnesses. We are going to hear from Mr. Tom Murphy, Director of Compensation, Veterans Benefits Administration, Department of Veterans Affairs. He is accompanied by Ms. Beth McCoy, Acting Deputy Under Secretary for Field Operations, Veterans Benefits Administration, Department of Veterans Affairs; Dr. Gerald Cross, Chief of the Office of Disability and Medical Assessment, Veterans Health Administration, Department of Veterans Affairs; and Ms. Patricia D. Murray, Director of Clinical Programs and Administrative Operations, Veterans Health Administration, Department of Veterans Affairs. And we also will hear from Mr. George Turek, Founder, Owner, Chairman, and Chief Executive Officer for Vet-

erans Evaluation Services. I ask all the witnesses now if you would please rise and raise your right hand?

STATEMENT OF THE HON. ANN KIRKPATRICK

Veterans are waiting too long—for medical appointments and for their disability claims to be processed. This week, the VA claims backlog stands at 562,968. This number only reflects the number of claims that have been filed and have been pending for longer than 125 days. If veterans are waiting just to get that examination to file a claim, this adds to the wait time.

Appointment scheduling and wait time data for compensation and pension examinations should be carefully scrutinized in light of report after report of VA medical facilities covering up long patient wait times. Any additional reviews of appointment scheduling should include an examination of patient wait times for these exams as well. It is imperative that accurate data be reported so that the VA is able to serve the growing number of veterans that are seeking care.

Major reforms in the VA are sorely needed. The VA and Congress must work together to strip away the layers of bureaucracy and cut through the red tape so that the VA is able to efficiently meet the needs of our veterans. While contracting out compensation and pension examinations gives VA primary care doctors more time to see patients, we cannot sacrifice quality for efficiency. We have received several reports of compensation and pension exams being performed by contract doctors that do not have the licenses or credentials to perform these exams—which can lead to wrongfully denied claims, and the growing backlog of appealed claims.

[Witnesses sworn.]

The *Chairman.* Thank you very much. Please be seated. Each of your written statements will be entered into the record and Mr. Murphy, you are now recognized for five minutes.

STATEMENT OF THOMAS MURPHY

Mr. MURPHY. Chairman Miller, Ranking Member Michaud, and committee members, thank you for providing me the opportunity to discuss the VA's C&P examination process.

The Department of Veterans Affairs is committed to providing timely, high quality healthcare and other benefits that veterans deserve and have earned through their service. An important part of accurately determining those healthcare and other benefits for which a veteran is eligible is through a C&P examination. For this reason it is important that C&P exams are performed under stringent clinical requirements and credentialing criteria for both the elements of the exam as well as the clinicians who perform them.

These requirements are the same whether the exam is conducted by a VA provider or a VA contracted community health provider. A case has been identified where 51 veterans were previously examined by a VA contractor need to be reexamined by VA to ensure the required standard was upheld. These 51 veterans are being contacted individually and their appointments scheduled at their earliest convenience. VA benefits staff members are standing by to

expedite processing of these C&P exams and inform veterans of their benefits for which they may be eligible.

VA is working with the contractor to rectify the current situation and prevent any recurrences. In addition, VA contacted all DEM vendors and reviewed requirements for training and certifying providers that conduct C&P exams. VA required that all DEM vendors verify they are following these requirements.

VHA conducts disability exams at the request of VBA. A medical exam or opinion is required in claims when, after the development of all other relevant evidence, there is not sufficient medical evidence to make a rating decision on the claim. To trigger the requirement for the examination there must be evidence of a current disability, evidence of an event, injury, or disease in service, and a nexus between the two.

VBA and VHA have instituted several initiatives to improve the timeliness and accuracy of claims processing based on medical evidence. For example, DBQs are designed to efficiently gather medical evidence by capturing all information needed to rate a claim for a specific condition. A total of 81 DBQs are available for VHA clinicians, including 71 DBQs that can be completed by private doctors. Similarly, in the ACE VHA initiative, clinicians review existing medical evidence and determine whether that evidence can be used to complete a DBQ. For many veterans this means they no longer need to travel and take time off to complete an examination.

VHA is providing certified C&P clinicians at all 56 VBA regional offices and two DRAS sites. The clinicians provide medical opinions, answer staff questions, correct insufficient examinations, and serve as a key communication link between VBA and VHA. No examinations are conducted at the regional offices.

VHA and VBA joint analytics team work closely together to track C&P examination metrics as well as to analyze data to be able to identify trends, strengths, and weaknesses and project future workload.

VHA's DMA is a national office that facilitates the disability examination process to support field C&P clinics. Nearly 8,200 VHA registered and certified V&P examiners, which included full-time and part-time VHA employees, residents, fee for service examiners, VHA contract vendors, locum tenens, and specialty providers.

In 2011 VHA established a nationwide medical examination contract with additional overseas capability. The contract is held by four vendors who provide their services to meet VHA standards.

In addition to DEM contract services, VHA provided VA medical centers a number of tools. Examples of these tools include hiring staff, fee basis support, the locum tenens program, and additional funding.

The national standard for completing C&P disability exams is 30 days, or 45 days for IDES. This is measured from the day VBA electronically submits an exam request to the day VHA electronically returns the report. For fiscal year 2014 the average time was 24 days and 32 days for IDES. The total number of disability exams and medical opinions completed by VHA and its contractors was 1.85 million for fiscal year 2012, 2.17 million in fiscal year 2013, and 1.58 million in fiscal year 2014 to date.

In addition to examinations completed by VHA, VBA contracts with three vendors. They provide examinations to 18 regional offices. VBA is able to conduct contract examinations using both mandatory and discretionary funds. VA's authority to use discretionary funds for contract exams expires this December and VA supports extension of this authority. VBA's authority to use mandatory funds for contract exams is limited to ten regional offices. The authority to contract disability exams is essential to VBA's goal to eliminate the claims backlog.

In fiscal year 2013 VBA contractors completed over 225,000 examinations in addition to the 2 million exams conducted by VHA and its contractors. In fiscal year 2014 exams conducted using mandatory appropriations were completed on an average of 29 days and exams conducted using the discretionary funding were completed in an average of 17 days.

VBA and VHA have worked to expand capacity for disability examinations provided internally and through contract resources. This collaboration has helped improve the timeliness and accuracy of examinations and ultimately improved the delivery of benefits to disabled veterans.

This concludes my testimony, Mr. Chairman. I would be happy to address any questions you or other members of the committee may have.

STATEMENT OF
THOMAS MURPHY,
DIRECTOR, COMPENSATION SERVICE
VETERANS BENEFITS ADMINISTRATION
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
JUNE 25, 2014

Chairman Miller, Ranking Member Michaud, and Committee Members, thank you for providing me the opportunity to discuss the Department of Veterans Affairs' (VA) Compensation and Pension (C&P) examination process. I am accompanied today by Beth McCoy, Acting Deputy Under Secretary for the Veterans Benefits Administation (VBA) Field Operations, and from the Veterans Health Administration's (VHA) Office of Disability and Medical Assessment (DMA), Dr. Gerald M. Cross, Chief Officer, and Patricia D. Murray, Director Clinical Programs and Administrative Operations. The Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) work closely together and are committed to providing quality medical examinations in a timely manner in support of our disability claims evaluation process. These medical examinations ensure proper benefits are provided to Veterans, and providing these examinations in a timely manner is critical to VBA's goal of eliminating the claims backlog with 98-percent rating accuracy in 2015.

VHA Involvement in the Disability Claims Process

VHA conducts these medical examinations at the request of VBA for a number of purposes in the disability claims evaluation process. A medical examination may be necessary to diagnose a claimed condition for a disability determination or to determine the severity of a disability and the impairment that it causes. Medical examinations are also necessary to determine the cause of specific disabilities. VBA may also request medical opinions to consider whether a disability originated in military service or results from another disability that is due to service.

A medical examination or opinion is required in claims when, after the development of all other relevant evidence, there is not sufficient medical evidence to make a rating decision on the claim. To trigger the requirement for the examination, there must be evidence of a current disability; evidence of an event, injury, or disease in service; and evidence that the current disability may be related to the event, injury, or disease in service. These medical examinations and opinions are vital in the process of determining whether a disability is caused by military service and assigning an appropriate percentage of disability. VBA may request medical examinations from VHA or from its own contractors. In addition, a Veteran may submit medical evidence from a private or VHA provider.

VBA and VHA have instituted several initiatives to improve the timeliness and accuracy of claims processing based on medical evidence. For example, Disability Benefits Questionnaires (DBQs) are designed to more efficiently gather medical evidence from VHA clinicians and private physicians by capturing all the medical information needed to process a claim for a specific condition at once and up front. A total of 81 DBQs are available to VHA clinicians, including 71 DBQs that can also be completed by private physicians The terminology in the DBQs is built around the specialized requirements needed to make forensic determinations regarding a disability and gather the information needed to rate a disability claim. DBQs were designed for use by raters and may not follow the usual clinical workflow or thought process.. The timeliness measure of 30 days and the Audit Quality Review for consistency and sufficiency are DBQ metrics used by VHA.

Similarly, in the Acceptable Clinical Evidence (ACE) process, VHA clinicians review existing medical evidence and determine whether that evidence can be used to complete a DBQ without requiring the Veteran to report for an in-person examination. For many Veterans, this means they no longer need to travel and take time off for an examination, which can be a significant burden. In addition, VHA demonstrated success conducting mental health examinations using Telehealth technology. Clinicians also have the option to supplement medical evidence with telephone interviews with the Veteran, or to conduct an in-person examination if determined necessary.

VHA is providing certified C&P clinicians at all 56 VBA regional offices (RO) and the Providence, RI and Seattle, WA Disability Rating Activity Service (DRAS) offices. The clinicians provide medical opinions, answer staff questions, correct insufficient examinations, and serve as a key communication link between VBA and VHA This assistance reduces the need for Veterans to schedule in-person examinations; however, no examinations are conducted at the ROs.

VHA and VBA joint analytics teams work closely together to better understand the overall claims process. The team looks for creative ways to track C&P examination metrics as well as to analyze data to be able to identify trends, strengths, and weaknesses. VHA's quality assurance program was developed and integrated with VBA's quality assurance review process to more accurately measure examination request and quality. In addition, the team works to develop long-term strategies to enhance the claims process.

Along with communication at the local level, VHA and VBA host weekly meetings to discuss the disability claim examination process. These meetings are data-driven and allow senior leaders in both organizations to provide guidance. Both organizations have established mailboxes for any questions employees may have about the process and participate in weekly calls to discuss claims initiatives and any other issues impacting the disability examination process. VBA and VHA also collaborate on training programs and development of national policy and procedures to ensure consistency and quality.

Examinations Conducted by VHA

VHA's DMA is a national office that facilitates the disability examination process to support field C&P clinics conducting disability examinations. Nearly 8,200 VHA registered and certified C&P examiners , which includes physicians, nurse practitioners, physician assistants, and psychologists, work closely with VBA to perform C&P disability examinations. They include full-time VHA employees, part-time VHA employees, Residents, Fee-for-Service examiners, VHA contract vendors, Locum Tenens and speciality providers.

VHA supplements these C&P clinics' capabilities, as necessary, using contracted disability examination services. These contractors support the performance of required disability examinations during surges in claims processing, for periods of staffing vacancies, or for times when specialists are required. VHA may also use these services for Veterans who do not live near a VHA medical facility. The use of these "on demand" services allows VHA to maintain examination timeliness and quality to support VA's goals for processing disability claims. VHA medical facilities can use locally contracted services through an individual facility or utilize the centralized, national VHA Disability Examination Management (DEM) contract.

In 2011, VHA established a nationwide medical examination contract with additional overseas capabilities. The contract is held by four vendors who provide their services to meet VHA standards. VHA has also established a contract oversight board to provide the field an opportunity to oversee VHA contract performance. Included in the contract is the requirement to conduct quality reviews.

In addition to contract services, VHA has provided VA medical centers a number of tools to manage increases in disability examination workload. Examples of these tools include hiring staff, fee-basis support, the locum tenens program (ability to rapidly replace credentialed and privileged certified C&P providers during periods of absence or to enhance surge capabilities), and additional funding.

The national standard for completing C&P disability examinations is 30 days, or 45 days for Integrated Disability Evaluation System (IDES). This measures from the day VBA electronically submits an examination request to VHA to the day VHA electronically returns examination reports to VBA For fiscal year (FY) 2014, as of June 16, 2014, the average time to complete disability examination requests by VHA and VHA contract examinations for C&P was 24 days and 32 days for IDES. The total number of disability examinations and medical opinions completed by VHA and VHA contractors for FY 2012 - 1,850,386; FY 2013 - 2,176,651; and FY 2014 through June -1,584,545. The foundation for the improvement is the improved relationship between VHA and VBA. That created the foundation for data sharing and cooperation.

VHA Disability Examination Program	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total Examinations Completed by VHA Clinicians	1,152,139	1,295,700	1,850,386	2,176,651	1,584,535
Total Examinations Completed by VHA DEM Contractors	N/A	N/A	59,194*	178,406	170,499
Total Veterans served by VHA	631,888	694,597	797,935	821,440	595,713
Total served by VHA using Contractors	N/A	N/A	14,662	54,364	45,655

* First year reporting was based on examination requests versus completed examinations.

VHA has successfully met and exceeded the required timeframes for timeliness of completion of examination requests. Collaboration with VBA has been critical to this success. Weekly War Room discussions, the use of VHA clinicians at the ROs, innovative use of ACE evaluations, and providing medical evidence for opinions and in support of those claims needing additional information have contributed to improvement. Initiating the "No Wrong Door" approach has resulted in accommodating any examination request, regardless of jurisdiction. The focus on C&P as the transition from active duty to Veteran status has improved the access to Department of Defense medical information, thereby reducing the amount of time needed to complete an examination request. Site visits, focused weekly training for clinicians and clerical staff, and closely working with Veterans Integrated Service Network and facility leadership to forecast workload has optimized resource use and improved timeliness.

Use of Contract Examinations by VBA

In addition to examinations completed by VHA, VBA contracts with three vendors to conduct C&P examinations. These contractors provide examinations to

18 Regional Offices: Atlanta, Cleveland, Denver, Des Moines, Honolulu, Houston, Indianapolis, Lincoln, Los Angeles, Muskogee, Providence, Roanoke, Salt Lake City, San Diego, Seattle, St. Louis, Waco, and Winston-Salem. Additionally, the contractors provide examinations in support of VBA Special Missions, such as Integrated Disability Evaluation System (IDES) and the Benefits Delivery at Discharge Program (BDD). Veterans report high levels of satisfaction with the contractors who currently perform these examinations.

VBA is able to conduct these contract examinations using both mandatory and discretionary funds. VA's authority to use discretionary funds for contract exams will expire on December 31, 2014. VA supports extension of this authority and proposed this extension in the FY 2015 budget request. VBA's authority to use mandatory funds for contract exams is limited to 10 ROs. The authority to contract disability exams is essential to VBA and achievement of our goal to eliminate the claims backlog. The demand for disability examinations increased significantly in recent years, primarily due to an increase in access to and utilization of benefits. The increase in disability examinations can also be attributed to the increasing complexity of disability claims, an increase in the number of disabilities Veterans claim, and changes in eligibility requirements for disability benefits. In FY 2013, VBA contractors completed over 225,000 examinations, in addition to the over two million examinations conducted by VHA and its contractors.

VHA and VBA examination contracts were competed and awarded separately and contain different timeliness standards. In addition, VBA's disability examination contracts have different timeliness standards, as the contracts are independent from each other. The VBA contracts reimbursed from the mandatory appropriation will be recompeted in the first quarter of FY 2015 and will align timeliness standards closer to VHA's contract standards. In FY 2014 through June 16, examinations conducted using funding reimbursed from the mandatory appropriation were completed in an average of 29 days and examinations conducted using discretionary funding were completed in an average of 17 days (timeliness standard of 20 days).

The ability to conduct contract examinations has contributed to the completion of more than one million claims each year for the last four years.

Conclusion

VBA and VHA have worked to expand capacity for disability examinations provided internally and through contract resources. This collaboration has helped improve the timeliness and accuracy of examinations and ultimately improved the delivery of benefits to disabled Veterans. We will continue to assess our processes to ensure Veterans' medical information is efficiently gathered to expedite the claims process.

This concludes my testimony, Mr. Chairman. I would be happy to address any questions you or the other Members of the Subcommittee may have.

The *Chairman.* Thank you very much, Mr. Murphy. Mr. Turek, you are recognized for five minutes.

STATEMENT OF GEORGE C. TUREK

Mr. TUREK. Thank you, Mr. Chairman, Mr. Ranking Member, and the committee members for providing me the opportunity to testify today. My name is George Turek. I am a veteran. My wife and I and four dogs and five cats, all rescue, live in Houston, Texas.

I have been in the independent medical evaluation business for 36 years, having established the first fee standing IME facility in the U.S. in Detroit, Michigan in 1978. We formed Veterans Evaluation Services in 2007 to provide outsourced medical disability examinations, or MDEs, to the VA. We became involved because we are highly committed to our veterans.

Currently VES has two contracts with the VA for outsourced MDEs, one with the VBA and the other with the VHA. Our VBA contract is a single source discretionary funded contract and we serve in seven and a half regions. Our VHA contract is indefinite quantity for overflow cases from VAMCs across the world and we compete with compete with four other contractors on this contract. We thoroughly enjoy working with both the VBA and the VHA and their respective staffs are top notch.

There are challenges, however, adhering to each agency's divergent processing and work flow requirements. The differences in work flow processes between the VBA and VHA are notable. One, VBA outsourced MDE allotments are controlled by senior staff in Washington, D.C., while the allotments of MDEs from the VHA are determined by each individual VAMC. Number two, although they use the same computer system to process MDEs, VBA and VHA use totally different scheduling systems. The VBA uses CAATS, which is highly automated and efficient, while VHA uses DemTRAN, which essentially consists of encrypted emails that have to be manually entered into our system each and every referral. And number three, the VBA and VHA have two entirely different work flow processes for the same exact MDE. An MDE referred from the VHA requires over twice as many steps to process as the same one referred from the VBA. Number four, monthly billing is a one-step process with the VBA while it is a 12-step process with the VHA. With the VBA we simply prepare one bulk bill for all the MDEs performed in the past month. But with the VHA each MDE is billed separately and sent to each referring VAMC. Based on our experience of working with both agencies, it is our opinion that the VBA method of outsourcing MDEs is far more time efficient and cost effective.

Now I would like to comment on two pressing issues. This committee, the Senate Veterans' Affairs Committee, and the VA have been struggling for years with the backlog of veterans disability claims. Now in addition you are forced to deal with the backlog of veterans seeking timely treatment appointments at VAMCs. I am convinced that we have at least a partial solution for both frustrating problems. Our recommendation is that VAMC medical providers perform medical treatment only, no MDEs, allowing them to

focus 100 percent of their time on treating veterans. With 80 percent of all MDEs currently conducted by VAMC medical providers, this would free up hundreds of thousands of man hours for VAMC medical providers and their support staff to treat veterans. Concurrently, the VA should outsource all MDEs to community based medical providers. Private contractors have access to trained and experienced medical providers as well as the necessary support staff to allow them to timely and cost effectively process all MDEs.

The simple, reallocation of existing assets would go a long way to resolve the backlog of both treatment cases and C&P claims. This can be done quickly, much more quickly than building new hospitals and clinics and then hiring and training staff. This method of handling MDEs is consistent with how independent medical examinations, the commercial equivalent of MDEs, are processed in all other delivery systems, where they are part of the claims management process, not the healthcare delivery system. This is a crucial point and one which the members of this committee who are themselves physicians should well understand. This protocol is tried and true and has worked extremely well in the commercial world for years. We believe that it would likewise work well for the VA. We are simply suggesting that with regard to MDEs, the VA should adopt the commercial market method for processing claims.

The mission of the VHA should be to treat veterans, period. On the other hand, the VBA should function as the claims administrator for MDEs by ordering and scheduling them with independent community based medical providers as part of the C&P benefits delivery process.

Lastly, with regard to pending legislation, House Bill 2189 and Senate Bill 2091 are commendable but we believe they do not go far enough. All VA regional offices should be allowed to outsource MDEs under mandatory funded contracts with private contractors. This would dramatically increase the resources available to the VA to reduce the backlog of C&P claims as well as reduce the treatment backlog at VAMCs.

Mr. Chairman, that concludes my statement. I would be pleased to answer any questions that committee members may have.

GEORGE C. TUREK
Written Statement
House Committee on Veterans' Affairs
VBA and VHA Interactions: Ordering and Conducting Medical Examinations
June 25, 2014

Chairman Miller, Ranking Member Michaud and Committee Members. Thank you for the opportunity to discuss the interactions between the VBA and VHA in the ordering and conducting of Compensation and Pension ("C&P") Medical Disability Examinations ("MDEs"), as well as my recommendations to streamline the process and maximize staff resources to best benefit our veterans.

By way of introduction, my name is George Turek and I am the majority shareholder of Veterans Evaluation Services ("VES"), a veteran-owned company which provides outsourced C&P MDE services to both the VBA and VHA through two contracts. VES was founded in 2007 as a wholly-owned subsidiary of MES Solutions ("MES"), which was established in 1978 to provide Independent Medical Examination ("IME") services to the commercial insurance and legal communities. MES was sold to a New York Stock Exchange listed company in 2011, at which point MES had the distinction of being the oldest and largest free-standing commercial IME facility in the United States. In 1978, as a young man, I sold my house and with a $5,000.00 profit, I founded MES. (Please see attached Exhibit # 1.) I thought I had started a business. Three-and-a-half decades later, I realize now that I had started an industry. When MES sold in 2011, VES was not part of the sale. We retained ownership of VES because we have a deep commitment to our veterans and were convinced that keeping VES family- and employee-owned would assure our veterans and the VA the very best in MDE services.

I have been asked to comment on several topics, one of them being comparing and contrasting the VBA and VHA MDE outsourcing processes. As noted above, VES holds two MDE contracts with the VA. (Please see attached Exhibit # 2.) One contract is with the VBA and is a single-source discretionary-funded contract. VES has held this seven-and-a-half region contract since 2008. The other contract is with the VHA, and VES has held this contract since 2011. In this contract, VES competes with four other contractors for overflow MDE work from VA Medical Centers ("VAMCs") located throughout the world. As a result, VES as a contractor works daily with both the VBA and VHA, adhering to each agency's differing requirements for the intake, scheduling, examination, diagnostic testing, processing, quality control, report delivery and invoicing associated with MDE services.

The differences are many between the VBA and VHA when it comes to processing MDEs. Below are some examples:

1. Although VBA regional offices send the actual MDE request, it is the VBA senior staff and the contracting officer in Washington, D.C., who set the monthly allotments. In contrast, the VHA Office of Disability and Medical Assessment ("DMA") staff located

in St. Petersburg, Florida, administers the VHA contract, but they do not dictate the number of MDE requests emanating each day or month from the individual VAMCs; that responsibility rests with each individual VAMC.

2. Although the VBA and VHA use the same computer system, CAPRI, they use entirely different appointment systems to request MDEs. The VBA uses CAATS to request MDE appointments. CAATS is highly automated and works seamlessly with VES' computer operating system, with very little human intervention necessary. On the other hand, the VHA uses DemTRAN, which is very labor-intensive and in essence is nothing more than encrypted e-mails and requires the contractor to receive and manually enter, one-by-one, each individual MDE referral.

3. The VBA and VHA have two vastly different workflow processes to which contractors must adhere. The VBA workflow has some 15 steps, while the VHA workflow has 33 steps. This obviously complicates and adds additional cost and man hours to the processing of MDEs. By way of example, VES had to establish a designated team just to individually enter VHA referrals by hand. (Please see attached Exhibit # 3.)

4. Monthly billing is a computerized, one-step process with the VBA. One monthly bulk invoice is created on a spreadsheet and e-mailed to the VBA for all MDEs performed during the month. Payment is made by wire transfer within 20 days. On the other hand, with the VHA each case is billed separately and paid separately by each VAMC. What is a one-step process with the VBA is a 12-step process with the VHA, which results in significantly slower payments, mistakes, underpayments and overpayments, and can be extremely labor-intensive and time-consuming for the VAMCs.

Currently VES' timeliness for a VBA case is 18 days, while our timeliness for a VHA case is 26 days, with much of the difference being directly attributable to the difference in workflow processes. The same agency – the VA – but with two completely different processes, one of which is highly inefficient. In our opinion, the VBA workflow process for an outsourced MDE is significantly more time-efficient and cost-effective than the VHA workflow process for the exact same case. At the end of the day, the more efficient the process, the more veterans that can be evaluated and ultimately receive their much deserved C&P benefits.

Although not an issue of processing, another issue the Committee should consider is the method of funding for outsourced MDE contracts. As noted above, VES' contract with the VBA is discretionary-funded, whereas other outsourced MDE contracts are mandatory-funded. The reason this is significant is that a discretionary-funded contract (or an indefinite quantity contract) for MDE services makes it extremely difficult and costly for a contractor such as VES to develop and maintain a network of fully credentialed medical providers who are readily available, trained and experienced in conducting MDEs.

As a representative example, below is a chart of the MDE referrals VES received in 2013 from two different VAMCs, in two completely different geographical regions:

Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
10	24	125	364	8	5	0	39	0	2	0	0
0	0	0	0	0	0	352	697	775	17	14	48

For those Committee members who have run a business, you can easily see how difficult it becomes to plan, budget and staff for MDE services with such a widely fluctuating referral volume. Absent a reliable allocation of resources from Congress to fund these contracts, such as is the case with a discretionary-funded contract, the VA cannot establish a consistent flow of referrals to contractors providing MDE services. If contractors cannot count on a consistent flow of referrals during the term of a contract, it makes it very difficult, if not impossible, for the typical privately-held contractor to effectively manage and run their business. Ultimately this may dissuade such contractors from bidding on these contracts. The solution is simple: at least while there remains a significant backlog of veterans waiting to receive C&P benefits, Congress should pass legislation making all outsourced MDE contracts mandatory-funded.

I would like to share with the Committee some observations of the current MDE process based on 36 years of industry experience in facilitating Independent Medical Examinations ("IMEs"), which are the commercial equivalent to MDEs. In the commercial world, IMEs are part of the claims process, not the healthcare delivery system. This is a crucial point, which the Committee members who are medical providers should well understand. An IME is ordered by an adjuster in a claims department of an insurance company or third party administrator on an individual who has filed a claim for benefits (workers' compensation, personal injury, long-term disability, etc.). The claimant is sent to an independent third party medical provider for the IME. Somehow and at some point, and I admittedly do not know the history regarding this, the VA decided to use its own medical providers, in its own medical centers, to render third party independent medical opinions. This practice is completely at odds with the standard in the commercial claims world. In fact, this practice is contrary to what all other local, municipal, state and federal agencies, such as the Social Security Administration, the Department of Labor, and the U.S. Postal Service, do when they are required to obtain an IME. In every instance the claimant is referred to an independent third party medical provider for evaluation. I know of no instance where a claimant would be referred to his own treating medical provider for an IME (other than possibly in a rural area where no other medical provider is available). In fact, in the commercial world, a claimant would not even be referred to a medical provider either associated or affiliated with the claimant's treating medical provider, such as in a group practice or medical clinic. This is simply not considered proper protocol. Only a third party independent medical provider is capable of rendering an unbiased and objective opinion. These observations are based on years of working in the IME industry and having owned an IME company that provided services in all 50 states and numerous countries around the world, in most, if not

all, benefit delivery systems. I have always thought it peculiar that the VA actually conducted MDEs on veterans within their own medical centers where they treat those very same veterans. I find it even more peculiar that both the VBA and VHA not only send veterans to VAMCs for MDEs, but they also send veterans to truly third party independent medical providers using disparate workflow processes. From the perspective of an outsider to the VA, albeit someone who is intimately familiar with the IME industry, this just does not make sense.

With the above in mind, and in light of the crisis facing the VHA right now with regard to providing timely medical treatment to our veterans, I would like to offer some recommendations regarding the C&P MDE process. There has in recent years been a substantial increase in total veteran enrollees for VA healthcare. There has also been a substantial increase in VAMC inpatient admissions and outpatient visits. The VA experienced an 80% increase in outpatient visits over a 10-year period, from 46.5 million in 2002 to 83.6 million in 2012, which begs the question: has the treating medical provider and associated support staff at VAMCs and outpatient clinics increased proportionately to accommodate this dramatic increase in patient population? From the looks of it, and based on what we see in the media, it appears that they have not.

Based on our experience at VES, on average it takes about three hours for a medical provider to review records, interview and examine a veteran, review diagnostic testing, and then enter the appropriate Disability Benefits Questionnaires ("DBQs") into the portal, and it is reasonable to assume that VAMC-employed medical providers are spending a comparable amount of time on each MDE they conduct. Our information is that approximately 80% of all MDEs are conducted by VAMC-employed medical providers. Suffice it to say, therefore, that VAMC-employed medical providers are spending hundreds of thousands of hours each year conducting MDEs. In addition, clerical and other professional staff spend hundreds of thousands more hours to support the VAMC MDE process. Finally, diagnostic testing and laboratory work is often conducted on the veteran as part of the examination process. As a result, VAMC departments such as radiology, audiology, the blood lab, cardiology and ophthalmology are called on to provide diagnostic testing services in association with an MDE, which further strains the VAMC MDE process, as both treating medical providers and MDE medical providers vie for diagnostic testing time slots.

When you consider the fact that IMEs, which are the commercial market equivalent of MDEs, have historically been conducted by independent third party medical providers, and the fact that hundreds of thousands of man hours each year are being devoted by VA-employed medical providers to conducting MDEs, rather than providing much needed medical treatment to our veterans, one simple solution becomes obvious: immediately pass legislation to outsource all MDEs to private contractors utilizing community-based independent medical providers.

This solution serves to address two very serious problems confronting the VA today:

1. Veterans are waiting too long to receive medical treatment appointments at VAMCs; and

2. Veterans are waiting too long to receive C&P benefits because there is a significant backlog of MDEs waiting to be performed.

By outsourcing all MDEs to private contractors, VA-employed medical providers would be free to devote 100% of their valuable time to providing much needed medical treatment to veterans. Moreover, outsourcing of MDEs has been extremely successful, and private contractors have access to trained and experienced community-based medical providers, as well as the necessary support staff, to quickly reduce the large backlog of these cases. Outsourcing all MDEs would solve both problems: it would reduce the long wait time for our veterans to receive appointments for medical treatment at VAMCs by allowing VA medical providers to focus exclusively on providing medical treatment and it would facilitate the timely delivery of C&P benefits to our veterans by significantly reducing the backlog of MDE cases.

This Committee, as well as the Senate Committee on Veterans' Affairs, has been grappling for some years with the long-standing backlog of C&P claims. Now, however, both Committees are confronted with an additional problem: the backlog of veterans seeking timely medical treatment at VAMCs. Ironically, the recommendations set forth above would, if adopted, have a positive impact on greatly reducing both the backlog of C&P claims as well as the backlog of veterans waiting for medical treatment at VAMCs. One of the most appealing aspects of this proposed solution is that it could be adopted and put into effect almost immediately; not in two or three or five years, but right now. The staff and physical assets are already located at the VAMCs in order to handle the additional treatment cases; they just need to be reallocated from MDEs.

In summary, my recommendation is to have the VHA focus on its primary responsibility – providing timely medical treatment to our veterans, and to have the VBA take full responsibility for what is essentially a claims processing function – referring our veterans to independent community-based medical providers for MDEs. Two problems: one simple solution.

I commend both the House and Senate for considering other measures to address the long-standing backlog of C&P claims, and fully endorse both H.R. 2189 and S. 2091, and in particular Sections 201 and 203, respectively. The title of both of these sections is the same: "Improvements to Authority for Performance of Medical Disabilities Examinations by contract physicians." The proposal to expand the scope of the pilot program under the Veterans Benefit Act of 2003 is definitely a step in the right direction; however, I would suggest that it go further: why limit the number of VA regional offices allowed to outsource MDEs to 15 – why not allow all VA regional offices to do so? Allowing all VA regional offices to outsource MDEs to community-based independent medical providers, with mandatory-funded contracts awarded through the competitive bidding process (RFP), would serve to increase the number of resources available to the VA to reduce the backlog of C&P claims.

Similarly, the proposal to allow medical providers licensed in one state to perform MDEs for the VA in any other state would likewise add to the VA's resources and assist in reducing the backlog. We, therefore, support both pieces of legislation, although we would suggest that the pilot program be unlimited in its scope, and we encourage the Congress to adopt such legislation this session.

Thank you for the opportunity to address the Committee and share my thoughts and recommendations on these issues. VES and I stand ready and willing to assist this Committee as well as the VA in whatever measures are adopted to reduce and/or eliminate the long wait times for our veterans to receive much needed medical treatment and the C&P benefits they so justly deserve based on their service to our country.

All hands on deck for treatment and C&P benefits for our veterans!

GEORGE C. TUREK
P.O. BOX 8465
THE WOODLANDS, TEXAS 77387
(832) 333-5912

EMPLOYMENT

MES Group, Inc.
MES Solutions
Medical Evaluation Specialists, Inc. (MES) 1978 – 2011

Founder, Owner, Chairman & CEO

MES was founded in 1978 in Detroit, Michigan, as the first free-standing independent medical examination (IME) company in the United States. MES provided IME and associated services to the commercial insurance claims and legal communities, principally in the workers' compensation, personal injury and long-term disability markets. MES grew rapidly and ultimately expanded from Michigan to California, Massachusetts, Texas and Washington, and eventually all across the country. MES was, in part, employee-owned through an employee stock ownership plan (ESOP) and had in excess of 500 employees and 20,000 contracted healthcare professionals providing IME services throughout the country and internationally. MES was sold to a New York Stock Exchange listed company in February 2011.

Peer Review Services (PRS) 2004 – 2011

Founder, Owner, Chairman & CEO

PRS was a wholly-owned subsidiary of MES and was founded in 2004 in Boston, Massachusetts, as an independent review organization (IRO). PRS provided IRO services to the commercial insurance claims community, principally in the long-term disability market. PRS provided services all across the country, with in excess of 100 employees and 5,000 contracted healthcare professionals. PRS was included in the sale of MES in February 2011.

VES Group, Inc.
Veterans Evaluation Services (VES) 2007 – Present

Founder, Owner, Chairman & CEO

VES was initially a wholly-owned subsidiary of MES and was founded in 2007 in Houston, Texas, for the purpose of providing compensation and pension (C&P) medical disability examination (MDE) services to the Department of Veterans'

Affairs (the VA). VES has been awarded two contracts by the VA to provide C&P MDE services: one through the VBA in 2008, which includes 7½ regions in the central United States, and the other through the VHA in 2011, which includes in excess of 100 VAMCs throughout the world. VES continues to service both contracts, with some 300 employees and thousands of healthcare professionals. VES was excluded from the sale of MES in February 2011, and remains family- and employee-owned.

MILITARY SERVICE

United States Navy 1967 – 1975
Active and Reserve

EDUCATION

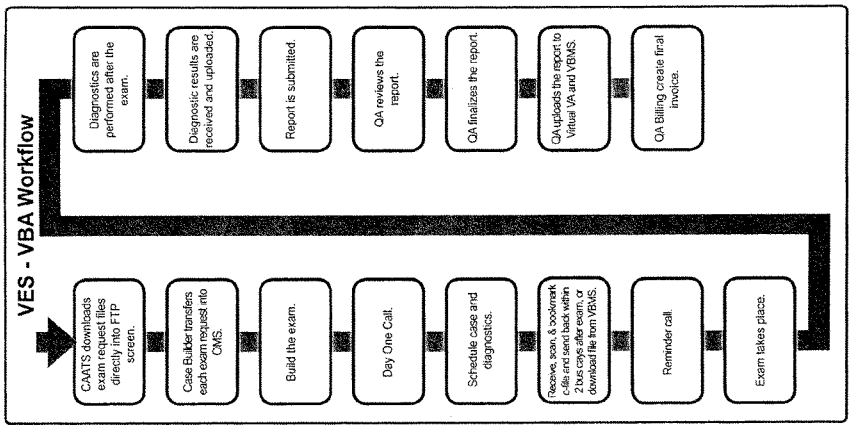
University of Michigan
Ann Arbor, Michigan 1975 – 1976
Degree: Masters of Science, Management

Eastern Michigan University
Ypsilanti, Michigan 1966 – 1970
Degree: Bachelor of Science, Industrial Technology

Catholic Central High School
Detroit, Michigan 1962 – 1966

FEDERAL CONTRACTS HELD BY VES

Fiscal Year	Source	Amount (maximum / minimum)
2014	VBA	$180,000,000 / $1,376,440
2014	VHA	$500,000,000 / $100,000
2013	VBA	$180,000,000 / $1,376,440
2013	VHA	$500,000,000 / $100,000
2012	VBA	$180,000,000 / $1,376,440
2012	VHA	$500,000,000 / $100,000



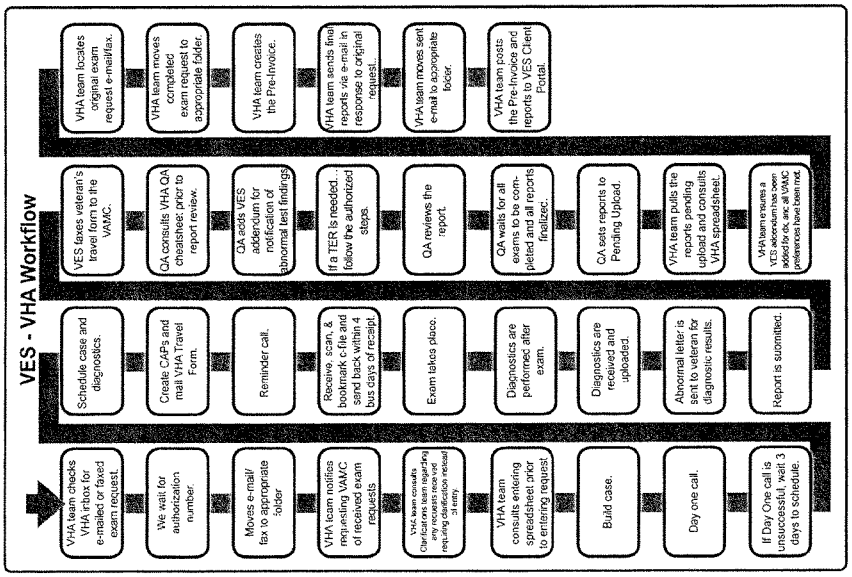


EXHIBIT # 3
George C. Turek
Written Statement

EXECUTIVE SUMMARY

The VA and this Committee are confronted today with two significant issues affecting our nation's veterans:

1. Veterans are waiting too long to receive medical treatment at VAMC's; and

2. Veterans are waiting too long to receive C&P benefits because of the backlog of MDEs waiting to be performed.

A simple, straightforward and easily implemented solution would be to outsource all C&P MDEs to community-based medical providers, thereby allowing VAMC-employed medical providers to focus 100% of their time on providing treatment to our veterans. The VA's mantra should be: all hands on deck for treatment and C&P benefits for our veterans.

Private contractors such as VES already successfully facilitate approximately 20% of all MDEs, with quality ratings equal to or surpassing those of VAMC-employed medical providers. Private contractors have access to trained and experienced community-based medical providers, as well as the support staff, facilities and other resources necessary to process all MDEs.

Outsourcing MDEs is consistent with the long-standing and proven practice in the commercial insurance claims industry of ordering IMEs from independent community-based medical providers. Doing so maintains the integrity of the medical opinion by removing any internal or institutional bias, and allows for a truly independent and objective medical opinion. There is every reason to believe that the VA would experience similar results with MDEs if it adopted the insurance industry's approach to IMEs.

Both the VBA and the VHA currently utilize private contractors to perform MDEs, although the process for ordering and conducting MDEs is divergent depending on which agency is involved: the ordering process is different, the scheduling systems are different, the workflow processes are different and the billing and collection processes are different. The VBA's process, we believe, is more time-efficient, cost-effective and less prone to mistakes than that of the VHA.

Another difference in outsourced MDEs is the type of contractual funding: discretionary vs. mandatory. Discretionary-funded contracts, with inconsistent monthly referral volume, make it difficult for contractors to develop and maintain fully credentialed and readily available medical provider networks, let alone to plan, budget and staff accordingly for the work. At least until the backlog is eradicated, all outsourced MDE contracts should be mandatory-funded.

H.R. 2189 and S. 2091 are commendable, but all VA regional offices should be allowed to outsource MDEs (not just 15) through the open RFP and competitive bidding process. This would dramatically increase the resources available to reduce the backlog of C&P claims.

All hands on deck for treatment and C&P benefits for our veterans!

The *Chairman.* Thank you very much, Mr. Turek. We appreciate all of you being here today. And I am going to start with kind of a lengthy set up to a question, but I think it goes right to the

heart of some of the problems that this committee is having with the Department.

To the VA witnesses, you have noted that you have a joint analytics team in place that tracks C&P exam performance metrics. I am curious as to which one of you oversees the office because in preparation for this hearing VA provided three separate documents to this committee, each of which contains different numbers listed in the column total examinations completed by VHA clinicians for fiscal years 2012 and 2013. In June 2014, correspondence between OCLA staff and my staff stated that in fiscal year 2012 never mind 1,789,470 examinations were completed and in 2013 1,996,148 examinations were completed by VHA clinicians. In the answers to the pre-hearing questions that were submitted for today's hearing, the table contained in the answer to pre-hearing questions, number seven, located on page five of eight in the document states that fiscal year 2012, 1,791,192 were completed by VHA clinicians, and in 2013 1,998,886 examinations were completed. And finally, in VA's written testimony today, which was provided at the same time and in the correspondence as the answers to the pre-hearing question, it states that in fiscal year 1,850,386 examinations were completed by VHA clinicians and in 2013 2,176,651 examinations were completed.

As you are all aware VA, and VHA in particular, has been recently exposed for manipulating performance metrics and data. How can we take any of the numbers reported here at face value when you reported three separate numbers for the same metric including two sets of differing numbers that were reported to the committee on the same day?

Dr. CROSS. Sir, I am happy to respond. The Ph.D. level statisticians that helped prepare this report for the VHA component of the numbers are in Florida. I went over with them with the same numbers in preparation for this committee hearing. I said, why are the numbers different? In every case, they had a good answer. For instance, when you look at the numbers on total examinations, in one chart they included medical opinions and in the other chart they did not. Other differences related to the exact point in time when the measurement was started and the measurement was ended. We can go through these with you. I know my staff will go through every one of them with you if you are——

The *Chairman.* If you would deliver it for the record. But it makes it very difficult when you provide conflicting numbers like that to the committee and expect us to be able to decipher how those numbers were arrived at.

Mr. Murphy, why does VBA only award contracts to single, nationwide vendors who can bid on the entire contract, rather than soliciting a regional contract provider in particular geographic areas?

Mr. MURPHY. Mr. Chairman, in years past prior to the contracts that we have in existence today, that was the practice. However, since I have been in the Compensation Service Director position, the three contracts that we do, have awarded have been recompeted. The larger contract on the mandatory funds, we broke the area of the country down into four areas and then we awarded those four areas to the best contractor, the best bid in that process.

So in years past in prior contracts it was one which would cover the entire nation. We have modified that under the existing contract and we are taking a hard look at that for a recompete which is going to be necessary because we are going to be out of option years at the end of 2015.

The *Chairman.* Dr. Cross, do you use a regional method instead of the nationwide? Is that an appropriate way to look at it?

Dr. CROSS. Our contract is nationwide, Sir, with additional contractors. We have four at the moment. We used to have five. And we are happy with that arrangement.

The *Chairman.* And very quickly, and this may take a little more than 30 seconds, but in response to pre-hearing question number nine, I note that despite providing two full paragraphs in response to the question, the answer was not given. So I am going to ask it again. Yes or no, does VHA pay for local C&P exam programs by using money from its general purpose fund?

Dr. CROSS. Funding for the program comes from VERA, which is the overall mechanism that we have for distributing funds to the VISNs.

The *Chairman.* So that does or does not come from the general purpose fund?

Dr. CROSS. That is correct, yes.

The *Chairman.* Okay. Yes or no, is this the same fund from which VA pays for its primary care?

Dr. CROSS. Yes.

The *Chairman.* Yes or no, VHA is suffering from a dearth of providers and long appointment wait times in primary care?

Dr. CROSS. Yes, sir.

The *Chairman.* Yes or no, there is no separate line item in the budget specifically allocated to the C&P examination process alone?

Dr. CROSS. Yes, sir. For Fy 15 there is no separate tie one item for C&P. And may I go back into your previous question——

The *Chairman.* Yes——

Dr. CROSS. —in regard to the shortage of personnel, there are other factors as well related to——

The *Chairman.* Just yes or no. Thank you.

Dr. CROSS. Yes, Sir.

The *Chairman.* Given the recent issues at VHA with primary care in particular, do you think there should be a separate line item?

Dr. CROSS. Sir, I am not sure on that. I think that is something we would have to consider.

The *Chairman.* Okay. Thank you. Mr. Michaud?

Mr. MICHAUD. Thank you very much, Mr. Chairman. As I stated in my opening statement, your efforts to reduce rating claims, otherwise known as the backlog, has been laudable. However, we are starting to see a new backlog of other workloads, such as non-rating workload and appeals. When will the VA adjust their staffing to ensure that these areas are adequately addressed for timely outcomes on behalf of our veterans?

Ms. MCCOY. Sir, I would say yes, we have made substantial progress on serving veterans whose claims have been pending the longest with our oldest claims initiative. Also those priority veterans, such as homeless, terminally ill, financial hardship. That

has been our primary, first focus in reducing the rating claims backlog. We have also continued at the same time to process non-rating claims. Last year 2.4 million non-rating claims, this year on track to complete 2.8 million non-rating claims. There are dedicated staff in the regional offices for that work, as well as the appeals work. They focus on that work during their day hours. On overtime they are helping on the disability rating claims. So we have taken steps to continue working on that as well.

It is of course not going at the pace that any of us are satisfied. We have put other measures in place. Some of those include automation. We have a rules based processing system that is processing dependency claims received online in as little as one day. We also have worked with Compensation Service to put in place a contract to more quickly address the dependency rating claim, non-rating claims that are pending. We have a number of efforts underway. And these have been part of our transformation initiatives from the beginning.

Mr. MICHAUD. But are you seeing an increase in the backlog in the appeals process?

Ms. MCCOY. Part of producing more claims is that there are other side claims that come up. So we have completed more than a million claims for each of the last four years and we are on track to complete 1.3 million claims this year. So some of the secondary effects of that are additional non-rating claims and additional appeals. The appeals rate has stayed steady for about the last 20 years, at about 11 percent. So when we complete more claims, as that appeals rate does continue to stay steady, there is a volume that comes along with that. Last year we did complete more than 76,000 appeals.

Mr. MICHAUD. I see that most of the contractors tend to slightly lag VA in terms of examination timeliness. How do the contractors compare to the VA in terms of quality metrics?

Mr. MURPHY. Sir, are we referring specifically to the VBA contractors on this?

Mr. MICHAUD. Yes.

Mr. MURPHY. Okay. The VBA contractors have two different performance standards based on what year those contracts were awarded. One of the contractors is on a 20-day standard and they are currently performing at 17 days. The other contractors are on a 38-day standard and they are currently delivering in 39 days. And as we recompete these contracts and as we move forward we have lessons learned in improvements and efficiency and we are leveraging that and reducing those times in contracts.

Mr. MICHAUD. Thank you. Mr. Turek, in your testimony you highlight a large disparity in the number of examinations per month and how this is a challenge. Can you explain why there are such significant shifts in the number of medical examinations that are requested per month?

Mr. TUREK. Yes, I can. We have two different contracts. We have the VHA contract, which is a demand contract, and then we have the VBA contract, which is a discretionary contract and we receive so much money per year from Mr. Murphy.

With the VBA contract if we receive X amount of money, we will be given so many cases per month based on the amount of money

that is allocated for the year. That way we do not use it all up in six months and fall on our face, run out of money. With the VHA contract it is purely discretionary demand by the VAMCs themselves. So in essence we have 151 customers with the VHA contract. With the VBA contract we have one customer. And we have to essentially deal with each VAMC and let them know our services are available for overflow and they can choose to use us or not use us. So we never know from one month to the next how many cases we are going to get from any of those 151. Right now we have about 75 that are actively sending us cases around the world. And we do, I believe we are the only contractor that does overseas work for the VHA as well.

So it is tough when you have discretionary funds and on top of that you have another contract where you do not know what you are going to get, you know, from month to month for staffing purposes and dealing with just trying to run a business. It would be much better if we had, you know, a contract that was much more stable and we had some kind of uniform flow coming in. That way we could service the contract better and we could make sure that we had the right doctors in the right places.

Mr. MICHAUD. Okay. Thank you. Thank you, Mr. Chairman.

The *Chairman.* Thank you very much. Mr. Runyan, you are recognized for five minutes.

Mr. RUNYAN. Thank you, Mr. Chairman. And I want to apologize for not being here on Monday but I had the opportunity to have Acting Secretary Gibson up in our Philadelphia health facility. And to go back to the question you had asked Dr. Cross a second ago, it was myself and my colleague, Pat Meehan, an opportunity to sit down with him and talk to him about exactly how Dr. Cross answered your question about why the numbers. And we talked about 15 minutes about standardization, so we can get out in front of these problems from a central office level before we end up in these crises. So that was brought up in that hearing and I just wanted to make you aware of that.

The *Chairman.* Thank you.

Mr. RUNYAN. And to all of our witnesses, I know Mr. Murphy, you previously expressed support of H.R. 2189, which has the language of my bill, which was H.R. 2423, which was cosponsored by my good friend Mr. Walz, and is now sitting over in the Senate. It includes provisions that would expand VA's mandatory funding for contract examinations. Your testimony dated July 25, 2013 states that VA strongly supports this provision to extend VA's authority to contract for C&P examinations. And further stating that this authority is essential to allowing the Veterans Health Administration to focus on providing healthcare to veterans needing it. Given VHA's recent issues providing healthcare to veterans in need, can you further explain your support of this legislation?

Mr. MURPHY. Mr. Runyan, we can state that, WC reinforce the position that we do strongly support the expansion from ten to 15 regional offices, and the additional surge capacity that an expansion brings to us to address the surges as they arise around the country.

Mr. RUNYAN. And I thank you again for that support. Because I think it is another piece of the puzzle, how we are eventually

going to solve this problem. Dr. Cross, with regard to the substance of C&P examinations, what are the most frequently conducted C&P exams?

Dr. CROSS. Probably exams related to musculoskeletal.

Mr. RUNYAN. Okay.

Dr. CROSS. There are about I think nine or 11 DBQs related to that.

Mr. RUNYAN. How many exams are deemed inadequate for rating for purposes by VBA requiring an additional follow up?

Dr. CROSS. Let me ask Ms. Murray to answer that.

Ms. MURRAY. Sure. Thank you, Congressman Runyan, for your question. VHA has monitored the sufficiency of exams for an extended period of time. And right now we have a goal of no more than two percent of those exams being insufficient and we are about around one percent of running insufficient exams. And so we are taking extraordinary measures to ensure that those exams are corrected very quickly. We have providers in the RO that will provide clarifications and get those exams back to the raters to do immediate rating on. So to answer your question, around one percent.

Mr. RUNYAN. Okay. Thank you.

Dr. CROSS. Sir, may I add to that?

Mr. RUNYAN. Yes.

Dr. CROSS. Any insufficiency is not a good thing from our point of view because that means working again to do what we had already done. Putting the clinicians from VHA at the regional office was a huge effort and collaboration between VHA and VBA. It serves a vital purpose in this regard. We can make those corrections on the spot, as soon as the VBA staff point out to us what that is instead of sending it back through the mail or through other means to the VHA. We have cut off many days of processing just by doing that.

Mr. RUNYAN. Thank you. One last question. Have any of you seen any improvement in performance since the implementation of DBQs?

Ms. MURRAY. Since the implementation of DBQs I think we have seen more standardized medical evidence being returned to VBA in a format that is usable and efficient for their use. So we have seen some improvements, and particularly for our raters to be able to more efficiently look at the medical evidence and be able to clearly identify the ratable criteria. So it has organized the information very clearly for the raters. And so we are providing them that information in that format and I think it is effective.

Mr. RUNYAN. All right. I yield back, Chairman.

The *Chairman.* Thank you, Mr. Runyan. Dr. Cross, I think your answer in regards to taking physicians and surging them out of the regional offices or into the field is a good step. But I want to read to you an email that was sent on June 19th. "Good afternoon, and our in house physicians are out of work. All employees currently reviewing and processing claims should be on the outlook for any cases that would be appropriate to refer them to our in-house physicians for medical opinions, consultations, and any possible ACE examinations, etcetera. We need work for them ASAP." How would you respond to that?

Dr. CROSS. One of the things that we want in our contract support is the ability to control it so that it is supplemental as opposed to primary. And I am not sure if that was the case, or where the location was that was from, whether it was a VBA contract or a VHA contract?

The *Chairman.* It is within the VA. It is not a contract. It is in a regional office. So it is your physicians.

Dr. CROSS. I would stick with my comment, sir. We prefer a situation where we go to VHA first for the work that we have to do.

Ms. MCCOY. Mr. Chairman, if I could add, we constantly encourage our regional office personnel to engage with the doctors, the clinicians in the ROs. They do more than fill out disability questionnaires. They do supplemental opinions, as Dr. Cross alluded to. They are also available to answer questions for the raters on medical questions——

The *Chairman.* If I could, Ms. McCoy, if I could interrupt you. But there is a serious crisis out there today with a backlog of people trying to see physicians. And so you have a physician that is just sitting there with nothing to do?

Ms. MCCOY. Sir, we constantly have our folks looking to take best advantage of that resource.

The *Chairman.* But they are looking to take best advantages within VBA and not surging them to VA. Why?

Ms. MCCOY. I understand your concern. It is our concern as well, sir. But having those folks available——

The *Chairman.* Do you think this email is a strange email?

Ms. MCCOY. I do not——

The *Chairman.* Do you think it is normal?

Ms. MCCOY. No, I do not think it is normal, sir.

The *Chairman.* Okay. Does it bother you at all?

Ms. MCCOY. Of course it bothers me.

The *Chairman.* Okay. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman, and I thank the panelists for joining us this morning. Mr. Murphy, I wanted to ask you what your reaction is to some of Mr. Turek's testimony with regard to what he pointed out, the differences between VHA and VBA, and the scheduling systems, the work flow processes. Clearly from what he stated it sounded like one is much more superior than the other and if you could comment on that, please?

Mr. MURPHY. We have done some things recently on the VBA side, the introduction of CAATS, for example, the scheduling system, and upgrade our systems, leverage some of the technology that we had, and the fact that we are moving files back and forth electronically as opposed to the paper that we shipped previously. And because we are dealing with a single contractor we have been able to leverage that a little bit faster. And it is certainly something that we are discussing actively with VHA to roll into all of our facilities.

Dr. CROSS. May I respond to that as well?

Ms. BROWNLEY. Yes.

Dr. CROSS. We really appreciate the work that our contractors do and Mr. Turek, of course. There is an issue here. He described in great detail the additional complexity related to working with the

local customers. And so he identified instead of having one customer, 151. That is exactly why we designed the contract that way. We want local folks to be taking responsibility for this and determine how much contract work they want to do, how much they want to do internally, how much they want to do for fee basis. In my view, from where I sit, that is a success.

Ms. BROWNLEY. Thank you. And Mr. Murphy, do you track the C&P exam wait times across regional offices?

Mr. MURPHY. We track C&P examination times across regional offices, yes. And it is measured, like I said in the testimony, from the time that we order, complete a Form 2507, the ordering of the examination, until the time that it is returned to us electronically. Meaning, I now have that examination in front of me and a rater can then take action. Yes, we track that.

Ms. BROWNLEY. Thank you. So you can provide me with the wait times in the Los Angeles Regional Benefit Office? And we also have an intake site in Port Hueneme. I am from Ventura County in California.

Mr. MURPHY. Yes, we would be happy to provide you that information.

Ms. BROWNLEY. Thank you. And in terms of, we have been talking about standardization, and what is the VBA doing to ensure that all of the exams, whether they are conducted at VHA or by a contractor, are being performed accurately, and that the physicians performing the exams are using the same metrics and criteria for reporting so that veterans are being treated equitably no matter who performs the exam?

Mr. MURPHY. This requires a two-part answer. I can speak specifically to what VBA is doing with our contractors and then there is a whole other side of this that VHA is going to need to discuss. But we have timeliness standards in terms of how much time you need to spend with the veteran as a standard written into the contract. We also have a quality team that samples, measures, monitors. With all of our contractors, they use electronic systems to complete these DBQs and they have built in some quality steps and measures that require the blocks that are necessary to be completed to require the signature, license numbers, etcetera, that the doctors need to complete and provide an adequate DBQ for rating purposes.

In addition to that in the VBA contract there are financial penalties in place that a contractor must meet certain quality standards. So there is an incentive for the contractor to do the right thing, to give an exam that is completed the first time. And I believe VHA would like to expand on that.

Ms. MURRAY. Yes. Thank you, Tom. So the Office of Disability has a quality team that randomly selects exams on a monthly basis, which is our VHA exams as well as our contract exams. And we apply about ten criteria to that to ensure that the information that is being requested on the 2507 and what is being provided by the examiners are consistent with what is needed and to ensure that the information is ratable and it is sufficient for rating.

We also conduct inter rater reliability between our two organizations and we do some sampling nationwide, and we have both of our teams looking at those. And so we ensure that we are looking

at these consistently. And when we identify any outliers we immediately provide education and training. Our benchmark is at 90 percent and we have been maintaining 90 percent across the nation. Our quality managers go out and do individual education and training at our sites. And then we also provide all of our training modules that we do for our clinicians, we provide those also for our vendors.

Ms. BROWNLEY. So do you find discrepancies across the country in terms of regions performing better than others?

Ms. MURRAY. They are pretty consistent with ranging about 90 percent. We do have two measures that we look at that tend to be something that we have to make sure that we stay on top of. And that is sort of, it is not really consistent across any one location but just reminders that we send out to be sure that we pay attention to this. So just whenever we find that there is an outlyer for the month we will immediately send out some reminders, and conduct needed training.

Ms. BROWNLEY. Thank you. And Mr. Murphy, you talked about the VBA contractors, or the contracts that you have, and that you have two metrics, one 20 days, one 38 days. It seems like the 38-day one is performing less than the other. You also talked about lessons learned when you renew these contracts. Can you kind of share lessons learned? Am I over? Oh, I apologize. I yield back.

The *Chairman.* There is a little clock right in front of you. And there is a little red light that comes on. Thank you, Ms. Brownley. Dr. Benishek, you are recognized.

Mr. BENISHEK. Thank you, Mr. Chairman. I guess I am not understanding exactly the numbers that I am looking at here. Because from what I can understand there was about 2 million C&P exams last year. But they talk about 800,000 veterans. So how is it that there is 2 million exams and 800,000 veterans?

Dr. CROSS. Sir, that is one that is fairly easy for me to answer. I appreciate that. The exams are multiple for veteran quite often. The reason for instance that the standard for C&P in general is 30 days and the standard for IDES, which is on active duty military, is 45 days is because of the increased complexity of those exams. So they require typically even more exams, more——

Mr. BENISHEK. But I thought you said earlier that only one percent of the exams were not complete?

Dr. CROSS. I——

Mr. BENISHEK. I mean, did not Ms. Murray——

Ms. MURRAY. So——

Mr. BENISHEK. —did you not just say that only one percent of your exams did not have the complete information?

Ms. MURRAY. So we were asked about the sufficiency for rating, and our target is two percent.

Mr. BENISHEK. But there is twice as many exams as there are patients.

Ms. MURRAY. And so what I would say, Congressman, is that many of our exam requests contain anywhere from one condition up to 60 conditions. And so depending on how many issues are claimed, we are doing multiple exams on any given——

Mr. BENISHEK. But that is not the same, you are talking about the same thing. You are telling me there more than two exams per

patient. Then you previously told me that only one percent of the exams do not comply with all the stuff.

Dr. CROSS. The percentage——

Mr. BENISHEK. That is inconsistent.

Dr. CROSS. Sir, no, that is quite explainable. The percentage for insufficiencies applies across the board, no matter how many exams there are. We look at those for quality. We have to survey the entire package. What we wanted to convey to you is that the complexity of this is multiple DBQs, similar to multiple exams, for many of these individual patients that come in. We may have a patient come in and says I have a neurological problem, another one, and at the same time an orthopaedic problem, and other things. And so they are going to have different exams for those conditions. They will have different DBQs.

Mr. BENISHEK. But they do not, the person that does the exam is not the same person, then?

Dr. CROSS. In many cases it is the generalist. We try and do as much as this by primary, general type medical skills as we can. If it requires a specialist examination, such as say for audiology, they have to go see the audiologist. If we are going to do a new diagnosis for PTSD, we want to go find a specialist who is highly skilled in that area to do that assessment.

Mr. BENISHEK. Well I guess I can understand that. It is just that it is kind of disconcerting when there is twice as many exams as there are patients. It seems like you would try to get most things done and I guess I understand that, you know, I am not going to do an audiology study as a surgeon. But what, you are saying that the rate of people getting, not getting their rating, a sufficient exam is only one percent, and that they go back for the same thing twice does not occur, basically?

Dr. CROSS. No, sir. They do not generally come back for an exam——

Mr. BENISHEK. All right. Okay.

Dr. CROSS. We do not correct the exam.

Mr. BENISHEK. I guess that answers the question. Mr. Murphy, I am kind of concerned about this process and Dr. Cross kind of touched on it a little bit. But, you know, Mr. Turek seems to think that it is much more efficient to, the VBA's method of contracting is easier than the VHA's method. And Dr. Cross may have touched on it a little bit but I still do not quite understand the answer, why it takes 12 steps to pay somebody through the VHA process versus the VBA process.

Mr. MURPHY. I cannot answer for the VHA in terms of the steps that they have to go through. But one aspect of this is I order the exam directly from that contractor, where if it is VHA I go to VHA first, and VHA uses that as a surge or overflow to order that examination. So there are some additional steps in there as that examination goes from us, to VHA, to VHA's contractor.

Mr. BENISHEK. I mean, it seems like the 12-step makes it a longer timeline.

Mr. MURPHY. Again, sir, I have to defer to Dr. Cross on this one.

Dr. CROSS. Sir, let me provide some more information. Those exams are controlled by the local medical center in terms of the volume that we want to use, how much we want to pay. That is

where we want the control, right there, so that they can maximize the use of their internal staff. I do not want them having emails like the chairman pointed out, ever.

Secondly we provide some value added in the course of those steps, such as trying to enroll the individual in VA healthcare as early as possible, and tying into the famous electronic record that we have in the VA so that those things link up.

But to be fair, it is complex. And while it serves our needs we would like to streamline that. So we have a program called DEAP that our IT folks are working on which will help replace at least a portion of the legacy program, which was called CAPRI. So we are working on a solution to add more efficiency. But I want to tell you that some of that is built in legitimately.

Mr. BENISHEK. I am out of time.

The *Chairman.* Thank you very much. Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you very much, Mr. Chair. And thank you to our panel for being with us today. I wanted to focus in on a different area of concern. This is with regard to a June 20th letter that 32 members of Congress sent to Acting Secretary Mr. Gibson. And it relates to the GAO report on VA's disability claims process for survivors of military sexual trauma. In the report we found, we learned, that the current regulation for MST claims discriminates against survivors of sexual assault and should be simplified and improved. And it appears that it is due to the fact that despite a change, and I believe this was a court ordered change, in 2002, the VA changed the regulation to allow veterans to submit circumstantial evidence, sometimes referred to as markers, because often there is not an official record of the assault, typically because the victim was not in a position to report the assault that may have been perpetrated by a commanding officer. But it seems there is wide variation among the claims in these medical examinations and in this process. And this GAO analysis found that granting the claims ranged across the various states from 14 to 88 percent in terms of whether the claims were granted. And I think you will agree that is a pretty broad range.

What I am wondering is what is the process for training and updating and informing these people that are making these evaluations? And then I would also love to hear a comment on the number of claims that were denied. This comes from a June 25th Huffington Post did a very lengthy article about the GAO report, noting that it really was more a function of where the evaluation was conducted rather than whether or not the assault occurred as to whether or not the claims would be granted. And so what has happened in terms of those that were denied, how have we reached out due to the high rate of failure to identify and grant these claims? So if you could address those two points, and perhaps Mr. Murphy we will start with you and go from there.

Mr. MURPHY. Let me start with the GAO report. Over the last 18 months, year to 18 months, we have spent a significant amount of time and effort on MST in particular. As a result of GAO and other attention around military sexual trauma we made the decision, and we saw the inconsistencies that you are describing early on. So we went back in and said the way we are going to handle

this is we are going to identify specific individuals, train them to the standard of this is how you properly identify markers which lead to the conduct of the C&P examination, which allows the rating. So what we did not want to do was improperly deny somebody even the benefit of coming in and having the C&P examination to determine if there is some compensation due to the individual.

So we went back in and targeted in each regional office specifically trained individuals and said those people and only those people are the ones that will touch MST cases. And the results of that, which are not reflected in the GAO report because the GAO report looks at a large set of data that is early on in that 18 months and before the process that I described to you. So what I am saying is the process that they describe versus the process happening right now in the regional offices, we are seeing different results from them and it is much better results. The rates that we are seeing on grant rate for MST are more in line with all of the other situations around PTSD.

Ms. KUSTER. And could you ask the Acting Secretary, or in your office could you report back to, not just the 32 members of Congress that sent this letter, but to this committee and others that may be interested on progress beyond the date of the GAO report? Because these are troublesome findings.

Mr. MURPHY. Yes.

Ms. KUSTER. And if there is progress being made, we would very much like, the American people would love to hear progress being made right now at the VA.

Mr. MURPHY. We would be happy to take that for the record and provide updated information to the committee.

Ms. KUSTER. Thank you so much. My time is up. Thank you.

The *Chairman.* Thank you, Ms. Kuster.

Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Mr. Turek, in your testimony, you propose outsourcing all medical disability examinations to private contractors so that VA employed medical providers would be free to devote a hundred percent of their time to treating veterans.

However, in a recent conversation with VA staff, staff was informed that such a changeover was not feasible because many C&P physicians have not treated veterans in many years and are lacking in the proper certifications or because many of them choose to work part time.

As anyone who works in the private sector knows, if your organization's needs evolve and certain employees cannot evolve to keep up with current needs, those employees are terminated.

Mr. Turek, what are your thoughts on VA's response?

Mr. TUREK. Well, my response would be that if those physicians are not credentialed, that they should get credentialed. And if they don't want to get credentialed to treat, that they should go back into the community or retire and be replaced with active treaters. That is my response.

Mr. COFFMAN. Okay. To the VA witnesses at the panel testifying today, please tell me why your responses are more focused on—it seems to be more focused on protecting employees than meeting veterans' healthcare needs.

Can you respond to that?

Dr. CROSS. Exactly, sir. As my opening statement was, let's do what is best for our veterans in this issue. So let's look at some of this.

We looked at the number, preliminary numbers just to get a ballpark figure. And I want to be very careful with this because I would like to go through and look at these numbers more closely.

So we started off with the number of 8,000 individuals. What does that mean? That means that these individuals have taken the course and passed the certification exam. I am one of them. That doesn't mean I am seeing patients routinely.

Most of these individuals in that 8,000 I would expect are already seeing patients because they see these C&P exams only on occasion when they are referred a case such as an ENT doctor. And that explains part of that.

I think the magnitude of this is that roughly a little bit less than a thousand of our docs and nurse practitioners and PAs and so forth are full time, a little bit less than a thousand. But, again, preliminary numbers that we worked up just this week.

About 1,100 plus, maybe 1,200, in that ballpark, are part time. Six hundred and sixty some of them, roughly again, have some primary care experience somewhere in their past.

But then there is something that I think we can use right away, if we can, is about a hundred of them are currently working in primary care and C&P. So obviously that would be the first place we would start as a constructive response to the situation that we are facing.

Mr. COFFMAN. Dr. Cross, you said that is the first place, I think if I remember your comment, that we should start. How about will start? Tell me what the solution is here to move forward.

Dr. CROSS. You say will we or we won't? I say there is no choice. We are in a situation that, you know, to me it is heartbreaking in that we have worked on this. So many of us have worked so hard on the system.

These are veterans that we are taking care of. We have to do better. We have to do better. And so we are going to have to look at each of these options with our leadership and use as many of them as we have to.

Mr. COFFMAN. Thank you, Dr. Cross. Really I appreciate your response.

I think there are so many times before this committee where it seems as if there is a defense of the status quo with no hope to those veterans seeking treatment or in this case, seeking some type of outcome in terms of a claim. And so I appreciate your response.

Mr. Chairman, I yield back.

The *Chairman.* Thank you, Mr. Coffman.

Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke.* Thank you, Mr. Chairman.

Mr. Chairman, I would like to begin by first of all thanking the VA. As our ranking member, Mr. Michaud, said, we are very focused on the access to healthcare crisis right now, but we can't lose sight of other important issues within the VA and our responsibilities to the veterans we serve including those carried out by the VBA.

The director for the Waco regional office which serves the veterans in El Paso, Mr. John Limpose, is coming out to our veterans' town hall this Saturday. And it is really hard for us to and veterans in El Paso to directly hold VBA accountable at that regional office. It is a nine-hour drive from El Paso to Waco one way.

So, you know, his coming out to El Paso, I think, helps us to hold the VBA accountable for him to hear directly from veterans. So I just through you want to thank VBA leadership for this level of responsiveness and accountability.

I would like to ask a question based on a comment Dr. Cross made about the Integrated Disability Evaluation System or IDES which is a process by which we transition wounded active servicemembers out.

And that process is supposed to take 295 days, but because of delays within the VBA, in the examination and the rating process, we were adding another 185 days to that wait. So those servicemembers at the warrior transition unit in Fort Bliss in El Paso were literally languishing an additional 200 plus days in some cases before they could transition out.

Mr. Runyan held a great hearing last month where we learned that when it comes to the benefits part of this, we are now—we no longer have a delay as of March and that on the rating side of this, we are supposed to end the backlog by October of this year.

So I want to compliment you on achieving those goals, but I want to ask you how you did it and how that might apply to the situation that we are discussing today.

Ms. McCoy. Thank you for your question, Congressman.

Part of it was sharing resources between the DRAS sites focusing on partnership with VHA in getting the examinations completed.

One of the lessons learned from our oldest case initiative, two-year-old cases focus, one-year-old case focus was the goodness from more hands across the country touching those oldest cases to serve those veterans with the longest pending claims.

As we move forward toward our national work queue in VBA, where 90 percent of our claims are electronic in the Veterans Benefits Management System, that gives us agility that we haven't had before. We will be able to move that work around by priority and be able to utilize the full resources across the country to do that work and all of our work.

So we are looking forward beginning of next calendar year to having more agility with the national work queue.

Mr. *O'Rourke.* Yeah. If these numbers hold up under scrutiny, that is a remarkable turnaround. I would love to see that same initiative applied to the problems that we are hearing today.

Dr. Cross, did you have a comment?

Dr. Cross. Yes, indeed, in terms of the numbers. IDES is overseen by the Department of Defense, VA, VHA, VBA, many, many different eyes looking at this along each step of the way.

So I think in terms of confidence, this is one of those sets of numbers I have the greatest confidence in and it has been working now for many years.

And I wanted to remind you one part of this that has been successful for some time now is the—it is always on time for the exam part.

Mr. *O'Rourke.* Switching gears, you know, Mr. Turek makes a great argument and Mr. Murphy brings up some wonderful points about where core competencies should be and how we most effectively and efficiently serve the veterans for whom we have a responsibility.

And I am wondering, is there to kind of resolve some of the differences that—between the arguments that you brought up, is there—has there been some kind of independent analysis or accounting that looks at, you know, timeliness, cost, accuracy, overall effectiveness for the veteran either by the GAO, a veteran service organization, or some other outside party?

Mr. Turek, are you aware of any study to do so?

Mr. TUREK. No, sir.

Mr. *O'Rourke.* Mr. Murphy, do you know?

Mr. MURPHY. I am unaware of a GAO or IG report.

Mr. *O'Rourke.* Yeah. I will yield back to the chairman and just ask that we pursue a GAO analysis if it is different so that we have the facts to make the best policy decisions going forward. I yield back.

The *Chairman.* There was an IG report from 2010, but it has not, to my knowledge, been updated——

Mr. *O'Rourke.* Thank you.

The *Chairman.* —since that time.

Dr. Wenstrup, you are recognized for five minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman.

I am going to ask some questions just to get some clarity for me of how the system is operating right now, especially between DoD and VA.

I was stationed at Fort Lewis and Madigan last summer, spent some time in IDES, the Integrated Disability Evaluation System.

So my first question is, you know, within the VA, you have MEB and a PEB, correct, Physical Evaluation Board, just in DoD?

Ms. MURRAY. That is correct, just in DoD.

Mr. WENSTRUP. Okay. So when you are doing your disability ratings, there are standards of measures that you use and, you know, I've seen the books to determine disability, you know, how you come up with the numbers.

And so there are standards there and the DoD, the army does have their board. And they come up with a disability evaluation as well.

Is that rating that is done while the soldier is in uniform able to carry right over to the VA or do they start all over again?

Dr. CROSS. I will ask my VBA colleagues to add into this, but we do one rating and it is based on the claimed conditions and on the referred conditions. But the referred conditions are those that were found unfitting, those conditions that caused the individual to be put into the program in the first place. Why? He would be nondeployable and so forth.

The claimed conditions are the whole person exam that we do looking at everything else. For instance, some high blood pressure might not make you unfit for duty, but it is still a condition that we can help that veteran with going forward.

Can I ask my VBA folks if they would like to answer?

Mr. MURPHY. Dr. Cross is spot on. From the VBA perspective, we make a rating decision based on all claimed conditions. The Department of Defense uses a subset of that to the conditions which are unfitting to continue your military service.

And the decision that we make that is used to make that decision by DoD is the one that carries forward after the veteran leaves service.

Mr. WENSTRUP. I guess what I am trying to do is cut out redundancy here. And that is the impression I got when I spent time in that department that they were saying as a test model, they were bringing the VA into that component. Now, I don't know if that is nationwide or if it is just at Madigan right now.

So if you could help me out.

Ms. MURRAY. So if I could add, the IDES is the Integrated Disability Evaluation System, meaning that we have integrated the DoD side of the program with the VA side of the program. And so VA for the most part is doing all of the exams so the servicemember goes through the process one time.

Mr. WENSTRUP. So we are tearing down that wall.

Now, I got the impression last year that it was just being done sort of as a test at Madigan. Is it throughout the military, throughout the army?

Ms. MURRAY. It is throughout the entire IDES system including all services.

Mr. WENSTRUP. All branches. Okay. So, in essence, it is a one-stop shop then for the servicemember. Now, obviously someone who has something develop later such as a result of Agent Orange, then that is all through the VA side, correct——

Ms. MURRAY. Yes.

Mr. WENSTRUP. —because it is so much later? Thank you. That answers my question.

I yield back.

The *Chairman.* Thank you.

Mr. Walz, you are recognized for five minutes.

Mr. WALZ. Thank you, Chairman.

And thank you, each, for coming here today.

And, Dr. Cross, you are right. I said the heartbreaking nature of this and it is so frustrating. I am appreciative, though, that we are trying to diagnose and then we are trying to come up with some prescriptions on this.

The thing I would say that may be most frustrating for us, and, again, I think the specifics of this are going to be important, but I am going to take it back up to that 40,000 foot, this cultural issue that we keep coming back to.

And the reason I say this is is that one of the questions I get asked by veterans and folks when I am back home is how could what happened in Phoenix and other things, how could it possibly happen, how could no one have understood this. And that is unfair because I would make the argument that people like Mr. Runyan knew it was going to happen.

And in 2012, I traveled with him when we came up with this idea and heard from veterans and heard from providers that there was a shortage and the C&P exams were taking people away from

seeing patients to cover that and that there was opportunity in the private sector to make up that difference.

So what we did was work with people, crafted a bill, and Mr. Runyan put a bill together. There is a Senate companion. Senator Franken has a bill over there on this very issue.

And I would come back to this. It seemed to me, though, every step of the way when we would try and ask and try and be seen as collaborators and partners in this, I got the thing, we got it. It is under control, we got it.

And there was no sense of urgency because I clearly remember up in New Jersey a veteran coming and saying I am convinced that they are spending all their time on these C&P exams and that is why it takes me so long to get an appointment. How prophetic was that, of coming up, of saying that?

So, Mr. Turek, I am going to ask you on this. I have got a gentleman out in my district that, again, over three years ago. His name is Don Weber. He has LHI that I think does basically what you do. And Don made this very same thing. He told me he has 2,100 physicians, but he is always meant to feel like there is another hoop, there is another to get to, and that his physicians aren't as prepared.

This is a subjective question to you. Is that a fair assessment that is seems like it is always one more thing or that it is not an equal ability here because all I care about for you is to provide the best care to veterans just like you do?

And I think there are folks out there that were willing to do it, to take away some of that pressure to make it easy as possible. We were convinced and I am convinced here is there was no real desire to help us move this bill. There was no real desire to make it easier for Mr. Turek.

And I am trying to get at your take on this. Is that true?

Mr. TUREK. Could you rephrase it, Congressman? I am not sure exactly what you are asking.

Mr. WALZ. What I am saying is that is there a willingness to reach out from the VA to say we need your help, let's get this done as easily as possible, and let's see these veterans and move on?

Mr. TUREK. Okay. I think that the VBA and we work real well together. There is a business partner relationship. I don't think that we have reached that level with the VHA. I will be real frank with you. Although we try desperately to partner, you get that feeling that there is, you know, some push back. Okay? And I am just being as honest as I possibly can.

Mr. WALZ. Oh, I am grateful for that because I am being honest, too, as I get the same feeling. And I feel like I am one of the offending partners to try and make this work. And I always feel like I get resistance. And I understand there are metrics. I understand that there has got to be standards that are kept and all that.

But these folks we are getting there, and I didn't come to this conclusion because I thought this was something to do. I came to the conclusion that I thought what Mr. Runyan was proposing and what we talked about would have made it easier. I wanted to see you get your folks in there, get these C&P exams, and move the process forward.

Mr. TUREK. Well, there is no doubt that given the opportunity, we can spool up very quickly and take on a lot more work.

I mean, I had another company, a commercial IME company which we sold three or four years ago to a New York Stock Exchange company. I on purpose kept Veteran Evaluation Services because I didn't want anyone to touch it other than us. And at that time, we were doing a quarter of a million exams a year, fully integrated.

We have been doing it for 36 years. We really know what we are doing. We did it in all 50 states, across the world, different benefit delivery systems that had different resources and demands. We could spool up very, very quickly.

Mr. WALZ. Well, for your time.

And, Dr. Cross, again, I come to this because here is the thing. Perceived reality is reality. And at this point in time, the VA gets no benefit of the doubt on anything. And I am telling you as someone who has been around this, has worked, has tried to do this is I feel the resistance.

Mr. Turek and others, Mr. Weber and others have felt resistance. Use us as a resource to help. Use this committee, use these providers. Just help us change the attitude.

Dr. CROSS. Could I respond?

Mr. WALZ. It is the chairman's time. I am going to have to yield back.

The *Chairman.* Yes, you may.

Mr. WALZ. Thank you.

Dr. CROSS. Sir, there was a period of time in the past months where what you said was precisely correct in my view. It was all hands on deck. We were dealing with our colleagues in VBA on the one-year-old claims, very large number of individuals, tremendous desire on everyone's part including, I think, this committee's to lower the backlog and to do everything we could. It was hands on deck.

And to some degree, that impacted on the primary care folks. We are past that and we work with our primary care community to say do what you can. Some of your veteran patients, your patients want your input into their condition, but still you have the option of sending them to the C&P clinic and so forth.

So many things have taken place and so many accomplishments, but, yes, I have to admit that there was a period of time where that was happening.

Mr. WALZ. Thank you, Mr. Chairman.

The *Chairman.* Mr. Bilirakis, you are recognized for five minutes.

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

What procedures are in place to hold these C&P examiners accountable? Can you elaborate on that? Can you, please, to follow-up Mr. Walz?

Dr. CROSS. Perhaps Ms. Murray can help me on this, but the oversight from the quality folks, the oversight in terms of their performance is relayed through the entire system and reviewed repeatedly. We look for outliers and we are very aggressive when we find outliers. We want to go hold them accountable, but really what that means to me in most situations is they are working very hard.

They need some help. It may be that it is not their fault, that they have fallen behind in some way.

So we go in, educate them, tell them how to use the fee basis system, how to use the contract system. We sometimes even send people in from my office to actually do exams. We development a locum tenens program so that we can air assault individuals directly into that program who are qualified when we lose someone who is unexpected.

Mr. BILIRAKIS. Thank you.

Mr. Murphy, regarding the number of examinations by the VHA clinicians, what are the cancellation and no-show percentages for fiscal year 2012 and 2013?

Mr. MURPHY. I don't have those numbers in front of me. Perhaps Ms. Murray does.

Ms. MURRAY. Sure. The cancellation rates when our office stood up was about 18 percent and have been holding at about 18 percent for many years. Since we have jointly began to look at the flow of the work between the VHA and VBA, we have reduced the cancellation rate down to 14 percent. We have revised our policies to clarify guidance.

And any cancellation rate that peaks or is out of the norm, we immediately contact the facility, take immediate actions. And if anything comes to our attention through anything outside of our data, we immediately take actions to assess what the issue is and implement corrective actions.

Mr. BILIRAKIS. Is it common practice to call the veteran to remind the veteran that an appointment will take place?

Ms. MURRAY. So our——

Mr. BILIRAKIS. Is that a common practice within the VA?

Ms. MURRAY. So for C&P, our process is that when the 2507 exam request is received at our medical center, there is a requirement to contact the veteran by phone.

Mr. BILIRAKIS. Okay. If there is a no show or cancellation, is that included in the veteran serve category?

Ms. MURRAY. Can you repeat the question, sir?

Mr. BILIRAKIS. Well, if there is a no show, let's say a no show, is that included in the veteran serve category? First of all, why don't you answer this question. What does constitute as a veteran being served by VHA clinicians, i.e. attempted to contact the veteran, made contact with the veteran, appointment scheduled, appointment completed? What is the definition——

Ms. MURRAY. Yes.

Mr. BILIRAKIS. —of a veteran being served?

Ms. MURRAY. Sure. That represents the 2507 exam requests that has come over from VBA and the exams completed and closed out in the CAPRI System and returned back to VBA. That is what that number represents, everything that has been completed.

Mr. BILIRAKIS. Okay. Mr. Murphy, VBA is now tracking the difference between the electronic date stamp from when the request is submitted by VBA and when it is returned to VBA as complete.

Is anyone from VA using this information to track the overall number of days from when the veteran submitted the claim?

Mr. MURPHY. Yes. VBA's clock never stops from the time I identify there is a need until the rating is done. Our clock on the timeli-

ness for the exam doesn't stop. We talked about cancellations. If there is a cancellation or a delayed appointment or any of the other things that happen, I still have a claim that has to be done in less than 125 days.

So in order to drive that process, we sit down with VHA every Friday and we dig deep and sometimes the conversations aren't so pleasant, but that is exactly how it needs to be. We, the VA, have a mission. We have to deliver on it. And we have candid, frank conversations based on the numbers to drive the performance of the whole organization.

Mr. BILIRAKIS. So you are saying that when the veteran submits the claim, there is tracking between when the veteran submits the claim and when the claim is completed, not just when it is stamped by the VA?

Mr. MURPHY. Correct. In years past, there were people involved in the process. There has been steps put in place now where it is done by triggering events in the system. So we have taken the ability away from the individual to date stamp and do things. The system tracks it.

When the 2507 request for examination is completed and we hit the enter button, that gives me the ability without the individual's ability to influence to look at that and tell when exactly that examination started.

On the other side, VHA completes the examinations required, returns them to me. And when they show up back in my box, there is another trigger that is electronic and we can go back and we do go back and measure the spread between those two dates. That is the 24-day number average that you are hearing.

Mr. BILIRAKIS. All right. Thank you.

My time is expired. I yield back.

The *Chairman.* Dr. Ruiz, you are recognized for five minutes.

Mr. RUIZ. Thank you, Mr. Chairman. I appreciate that we must leave no stone unturned as we identify ways the VA can expedite quality care for our veterans.

My question is, what measurements does the VA have in place for a compensation in pension and medical examination that demonstrate the VA is conducting quality exams that further a veteran-centered mission? Specifically, do you have a system in place where a veteran can provide feedback on the quality of the medical assessment?

Ms. MURRAY. So, I thank you for your question, Congressman. For our military service members that are going through the process, that process is in place. They are surveyed and we get their feedback on their experience with our examiners. And on the C&P side, it is not quite as formal but we are developing tools to be able to put that in place more specifically for our C&P.

Mr. RUIZ. Okay. So it is not there yet, but you are going to do it?

Ms. MURRAY. That is correct.

Mr. RUIZ. And you are going to do surveys?

Ms. MURRAY. We have looked at having some kiosks at the medical centers where when a veteran completes his or her appointment, they can go to a kiosk and give us some feedback on ——

Mr. RUIZ. In person, or on-line, or a survey? Because, you know, as you know, being a scientist, the methodology is everything. And you have to match the methodology with the culture of the veterans and what they have access to. So I just encourage you to make sure that it is something that they can respond to in a timely manner.

My next question is, if they disagree with the medical assessment in the ratings, what do they need to do and how long do they have for it to be corrected?

Mr. MURPHY. There is an avenue for a veteran to not agree with what is found in the medical examination process and after they receive their rating decision they have one year to file an appeal and run through the appeals process.

Mr. RUIZ. Okay. How can you expedite that so that they do not have to jump through so many loops and bureaucratic red tapes so that at the moment that they receive it, there is a discretion and then they can maybe have that second exam with a different examiner.

Dr. CROSS. Let me add to that, please. Sitting in the room with the patient, in the examining room, and you are doing the exam, what I have witnessed is the patient becomes part of that process. And if you make a mistake as you are typing it in, you are talking to the patient and you are talking about what you are entering. That is the first chance right there to make a correction or engage the patient.

There is something else that I want to tell you about. There is a lot of stress for a veteran coming in to that examining room, and I talked to them about this, and we want to try and find ways to lower that stress. This is such an important event for them. This means so much to them and to their family potentially, and we are looking at every way that we can to make that experience as more

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Mr. RUIZ. That is wonderful and I want to expedite the appeal process because they cannot get the care that they need, the resources that they need unless they get conclusion with that.

The other thing I want to note here is that oftentimes certain mental health illnesses or physical disabilities do not present themself on their exit interview from the Department of Defense.

So to clearly delineate that a veteran does not have a certain illness, and that becomes your gold standard. That becomes what then in the future you might want to refer back to and say, well, but your disability was on this when you left the Army, so clearly you did not get this illness—this mental health illness, because when you left your exam showed this.

We do know that Post Traumatic Stress Disorders, other mental health illnesses that are derived from very high stress scenarios develop over time, including pulmonary illnesses from exposures to certain chemicals. So I think that we have to reevaluate how definitive we make that exam when they leave the Department of Defense and recognize that illnesses change.

Dr. CROSS. One thing that we have not talked about and I have not heard in the Committee is something that we are starting new is separation health assessment. This is an agreement that we

have now worked out with DoD. Both sides have signed it to do a standard examination at the time of departure.

One of the things we will look at, of course, is hearing and see where the baseline was at the time that the individual was leaving the military as opposed to what it was at some future point when a claim was made.

Mr. RUIZ. Okay. You know, these questions are once again aimed at changing the focus and using a veteran-centered lenses from the eyes of our veterans, and not from the eyes of the institution. Okay?

Thank you. I yield back my time.

The *Chairman.* Thank you. Mr. Huelskamp, you are recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate particularly your opening questions. I want to follow up on a few of those, particularly the concern about different data being submitted to the Committee about actual number of exams actually conducted.

But first of all I wanted to hear an explanation a little bit more on CAPRI. It is a Legacy system. How old is that system again? Who would answer that question? How old is old? Is it a DOS based system?

Dr. CROSS. I do not know precisely how old it is.

Mr. HUELSKAMP. Anybody have any guess? Is it contained wholly within the VISTA system, or is it separate? Can you describe the architecture of how these two systems work together, or part of the same system?

Dr. CROSS. Sir, if you are asking me to start describing IT stuff, we are in trouble, I think. So I will get you that answer if that is what you want.

Mr. HUELSKAMP. I would like to see that as well, and it is troubling to have obviously three separate sets of data submitted. That needs to be answered, I think. You have offered to answer that separately.

So do you have any staff here that can answer that question, how old is this system? Because as you know that is something that I think the American people have been most upset about, is for years this Committee has been told things are fine and then whistle blowers say, well, no, because somebody was gaming the system. As of today there are 70 different investigative teams looking into criminal allegations across the country.

So do you have any staff available?

Dr. CROSS. There are staff members watching this program on TV, and their job is to go find the questions that I cannot answer.

Mr. HUELSKAMP. Okay. All right. Well, thank you. I will follow up with that. Are there any bonuses tied to performance in the numbers of the exams conducted and completed?

Dr. CROSS. Yes. The bonuses in this case are part of a large package of performance measures. Certainly just one small part of that overall package of performance that the individual is held accountable for.

Mr. HUELSKAMP. And that would be for SES employees and/or the examiners?

Ms. MURRAY. We could probably come back to you on that, but we would, you know, we do roll down our measures through the or-

ganization. So, you know, those measures are—in my performance plan. They are probably at the VISN level and I would venture to say that they are being held accountable at the medical center level, as well.

Dr. CROSS. For clarification, none of those are the 14 day issue in regard to C&P, which is irrelevant to C&P. We do not measure wait time because we do not have wait time, and as such we have process time.

Let me explain. You have 30 days to get this job done. Whether we get the person in on the second day of that period or the tenth day of that period, we have still got to wrap it up in 30 days.

Mr. HUELSKAMP. And what happens if you do not? Again, remind me what happens, Doctor.

Dr. CROSS. Then you are out of standard and they will receive our personal attention.

Mr. HUELSKAMP. Okay. Do they lose their bonuses?

Dr. CROSS. What we try and start with usually is education and trying to figure out why they fell out of standard and help them. But, yes, ultimately it could have negative consequences.

Mr. HUELSKAMP. Well, yeah, I appreciate that, Doctor. I would like to see from you then how these bonuses are tied to whether it is the member exams or the wait time, I would—you have a different term. I would call it the wait time, especially if they are waiting as long as some of my constituents have been waiting to get through the process. Thirty days would seem fairly miraculous to many of them based on their situation, and can you provide that back to me, a description of how that would ruin the bonuses?

Dr. CROSS. Sir, I will do my best on that. I am happy to show you mine.

Mr. HUELSKAMP. Are any of the folks here are SES level? Are you, Doctor?

Dr. CROSS. I am a physician so we fall in a different category, but they call it SES equivalent.

Mr. HUELSKAMP. I though the Administration announced SES employee bonuses for VBA had been cancelled for 2012; is that correct or am I missing that? So they still come out. Dr. Cross, you did get a bonus then, or not?

Dr. CROSS. Last year?

Mr. HUELSKAMP. Yes.

Dr. CROSS. Yes.

Mr. HUELSKAMP. Okay. How much was your bonus?

Dr. CROSS. I have got here the past three years. Would you like them all?

Mr. HUELSKAMP. If you provide them to the Committee, however you would like to do that, so.

Dr. CROSS. Do you want me to provide them separately?

Mr. HUELSKAMP. Let's just provide them separately. It would have to make it—I am just curious about that and look forward to a description of how that is signed together, sir. Just understand my concern. I want to make certain that the data is accurate and how it might be tied to bonuses, because on the VA health side, that has been the excuse, that we had a system that encouraged folks to do bad things, which is meet standards and got bonuses as a result.

So with that, Mr. Chairman, I yield back.

Dr. CROSS. We understand quite specifically.

The *Chairman.* Yes, as I understand bonuses for VBA were suspended for last year and for VHA this year. And Dr. Cross, you are with VHA, correct?

Dr. CROSS. Yes, sir.

The *Chairman.* Okay. Thank you. Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman. Thank you, Mr. Murphy, for being here. As you know, as a Ranking Member of the Disability Subcommittee, we pay a lot of attention to this issue. Chairman Runyan and I have heard a lot about this over the last 18 months, so these issues are not really new to us.

Maybe you could tell me how many veterans though in Nevada have had these C&P exams from contracted positions outside of the system. Do you all have numbers like that?

Mr. MURPHY. I do not have those off the top of my head. I have to take that one for the record.

Ms. TITUS. Okay. Well, thank you if you will get that back to me. And speaking of Nevada, I will take this opportunity to raise some issues with you that I have done in the past. A claim that is completed today in Reno for Las Vegas, the District I represent where most of the veterans in the State are, closes at 300 days. And it was the fifth worst in the country. The average was 500 and something days. So you are getting that down, but I would point out that half of the cases there were brokerage somewhere else. So if you had not brokered them, I do not think you would have been making very much progress in the 18 months that I have been there.

Also the VA's Inspector General released a report that VERA was very critical of the leadership of the Reno Office, called in, in fact, a leadership vacuum. So I would ask again because I have heard from many members of the staff that they have no confidence in the leadership if any of the members of that leadership team received any bonuses.

I hope that you are looking into that and that you will make a leadership change at that Reno Office. Now you recently doubled VBA staff in Las Vegas and I appreciate that. We certainly needed it. But the fact remains that two-thirds of the staff is still in Reno. The folks in Las Vegas are being monitored over the phone by this leadership vacuum that is in Reno. You obviously can not recruit people to Reno, but it is very easy to recruit people to Las Vegas. That is what you told me—it was hard to recruit people.

So I am wondering, isn't it time to move that office to Las Vegas? I mean, you are running out of excuses so let me just make that case one more time as I will every time I see you.

Now I would like to get to my question. I have been very supportive of your efforts to bring down that backlog. We have been trying to help. You have been doing a good job. I compliment you when you do that. But that 2015 deadline is coming. You are going to be under more scrutiny from this Committee, from the public, from our veterans, from the media. They are going to be looking at those metrics. There is going to be a lot of pressure.

I am wondering, do you have any knowledge, any suspicion, any concern that the VBA employees like we have been hearing about the other employees at the Phoenix Hospital and other places on the other side of this equation have falsified the numbers to make it look like they are having more success. Is that occurring with VBA employees? Tell us something now that we will not hear about from some whistle blowers in the next few months.

Do you have any sense that any of that is happening?

Mr. MURPHY. I do not believe that any of that is happening. There is—and the reason is we are not relying on the actions of individuals to tell us when ratings happen, when notices to veterans go out, when appeals happen. All of this is done by triggering events in our system. So the numbers reported to you are not done by individuals.

They are not going in and—no individual has the ability to go in and change dates, for example. So we are unaware of any manipulation of the system of any kind.

Now on the other side of that, that is the part that I do not sleep at night. I do not want that thing going on, not while I am the Compensation Service Director. It is unacceptable at any time for that kind of thing to happen.

So we are constantly on the look at for where is the next one where we are going to be looked at and under the microscope to somebody say, you know, manipulating the data here. And as we see opportunities—we automate, we lock down as much as we can. We control it so individuals cannot go in and influence their own performance numbers to their own gain, to their own benefit at the detriment of the veteran and the system in general.

Ms. TITUS. And I realize that has much improved with the electronic system because that can be electronically dated. But when something comes in on paper and you can throw it in the desk and wait 30 minutes before you start clocking it, those are the kind of concerns I have.

So you feel like you have some safeguards in place to——

Mr. MURPHY. You are absolutely right that something could be locked in the desk drawer. The problem is, I still own that from the date that it shows up, and when I record it in my system I put it at the date that it shows up and I have to come in here and explain to you why I have claims that are over a certain age.

So it is in our best interest and in the veteran's best interest to drive this the way we are driving it and record it back to the date of claim.

Ms. MCCOY. Congresswoman Titus, if I can add, that is one of the reasons we have also launched a centralized mail initiative so that the mail—it will not be coming to the Regional Offices to be opened in their individual mail rooms. It is going to be rerouted by the Post Office to the vendor and be scanned more immediately.

So we are saving time on moving that paper around. We want to get it into the system as soon as possible, get it under control so that we can see it, and we plan to have that done—that initiative by the end of this fiscal year.

Ms. TITUS. Okay. Thank you. I yield back.

The *Chairman.* Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Murphy, am I correct that VHA performed C&P examinations may be entered seamlessly into the veteran's electronic health record?

Mr. MURPHY. I'm trying to—would you mind repeating that, sir?

Mr. TAKANO. Yeah. Am I correct in my understanding that VHA performed C&P examinations can be entered seamlessly into the veteran's electronic health record?

Mr. MURPHY. I have got to answer that in two parts, and I will talk about it first from the VBA aspect where VBA does directly place that into our VBMS system for the rater to have direct access to. But there is another part of that where you are asking about the electronic health record, and that has implications on the VHA side that I need to defer to VHA. Yes, Dr. Cross?

Dr. CROSS. This is an important question because this is information that although administrative at the moment, serves a purpose down the road that is clinical.

The testing results, the X-rays, all of those kind of things are integrated fully as I understand it into the electronic health record. Let me make this distinction. Because it is integrated fully, my understanding is that if there is an abnormality, it gets flagged. If the doctor wants to do a graph of all of the blood pressures that they have had over the past six months, it becomes part of those graph of information.

But because it is flagged, that information—particularly if it is abnormal, is brought right forward to the doctor. It is not a .pdf file stuck off in the system somewhere that you have to go looking for.

Mr. TAKANO. Well, Doctor, can you tell me how does the process of this record—being able to enter, say the physical examination results into the record, how does that work when they are contracted out to non-VA providers?

Dr. CROSS. I think this applies on the side of our VHA contract as probably as well as our VBA contract. They do get information back to us, but again, it is in a different fashion than full integration as I understand it. I will ask Tom to comment, or Beth.

Mr. MURPHY. Are we talking about the exam results from a VBA contractor?

Mr. TAKANO. Yes.

Mr. MURPHY. Being fed back into our file. Our contractors provide currently into——

Mr. TAKANO. Yeah. Into the electronic health record.

Mr. MURPHY. Okay. Now they are fed into our virtual VA system.

Mr. TAKANO. Okay.

Mr. MURPHY. They are not fed into the electronic health record. But examinations that are done in-house are.

Ms. MURRAY. That is correct.

Mr. TAKANO. Would it be beneficial if there was an ability for our contractors who do the health examinations to be able to do that directly?

Mr. MURPHY. Yes. Yes, of course.

Mr. TAKANO. It would be extremely helpful, right? I mean, it is—you lay out an example of why it would be important. Mr. Turek, does VES use electronic health records and is your system interoperable with VISTA?

Mr. TUREK. I am sorry, Congressman. Could you repeat that?

Mr. TAKANO. Does your company use electronic health records and is your electronic system interoperable with VISTA?

Mr. TUREK. I wish I had my team IT here. Yes, we do interact with the VBA much more electronically than we do with the VHA, okay? We would like to see—and I am going to go off course here a little bit, but I could see even more beneficial things happening down the line to speed up the whole process because what we have talked about in the past is taking the data that is gleamed from each DBQ and feeding that into—and turning it into XML computable data.

Mr. TAKANO. But currently you are not completely interoperable in the way that VBA is with or VHA is?

Mr. TUREK. We are not completely.

Mr. TAKANO. And that is a pretty significant difference, because it has huge health implications for the ability of for the integrated health system to work.

And so, in my view, it is a major problem in terms of your argument to contract out the entire examination process.

Mr. TUREK. Can you talk on that, Tom? Okay, me either. We can do anything—we have a full computer staff. We can do anything that the VA wants us to do as far as hooking up with the VA.

Mr. TAKANO. Well, if you could give me an answer to the question whether or not how much it would cost for you to ramp up on whether your company can make that kind of investment?

Mr. TUREK. I cannot do that.

Mr. TAKANO. Okay. Well, it does not have to be now. You can get the answer to me later.

Mr. TUREK. Yeah. We could.

Mr. TAKANO. Thank you.

Mr. TUREK. Sure.

The *Chairman.* Thank you very much. Ms. Brown, you are recognized for as much time as you need, because of that fine coat you have on today.

Ms. BROWN. Thank you, Mr. Chairman, and before I begin, let me just thank you for your leadership and how you conduct the Committee. I was not on the Hill Monday night and a news flashing came on about another Committee. And the way that the Chairman conducted himself with the witnesses was an embarrassment to the House of Representatives.

So there are some things that you learn before you come to the House of Representatives, and it is how you treat the witnesses, and I want to thank you for your leadership in that manner.

The *Chairman.* Thank you very much.

Ms. BROWN. Now, after saying that, let me just say that there is a lot of doctors on this Committee, and there is a lot of doctors on the conference committee. And they talk a great deal about the private system. Let us be clear. I am a part of the private system and, in fact, I have one of the best. I am a Mayo person. And my doctor, Dr. Willis, controls all of the tests that I do, even when I have tests here they refer it to them. So it is a real coordinated system.

And I am not going to sit up here and be on this Committee and be involved in dismantling VA or privatizing VA, and you have

members, they say, well, we want a certain—I want a system in my area and I want all of the doctors to be in my area—all of the clinics in my area.

But the point is we build clinics based on a formula-driven, my understanding, by the number of veterans in the area. Can you correct me with that? Is that correct?

For example, if my clinic is in Las Vegas, which is where I want to be, and I live in one of those little outlying areas—based on how many veterans in that area is whether or not you have the claims there.

And then I heard other members talking about, well, we do not have a hospital in our area. Well, maybe you do not have that many veterans in that area. That is why you do not have a clinic in that area, and maybe we need to come up with some innovative ways to get to those veterans. Clear that up for me.

Ms. MURRAY. So, ma'am, thank you for your question, and I would hopefully be able to provide you more information on that. But I think when VHA looks at setting up a clinic in a location there are a number of criteria that they look at to do that, and I do not know the full details of that. But I would imagine that the number of veterans would be one of those criteria, but I can certainly find out more information about that.

Ms. BROWN. Probably I know a little bit more than you then, because I have been on this Committee for 22 years and my understanding is we come up with clinics and hospitals and cemeteries based on the number of veterans in that area. No one has the answer?

Dr. CROSS. Yes.

Ms. BROWN. Is that correct?

Dr. CROSS. To the best of my knowledge, that is correct.

Ms. BROWN. It is a problem when I am the institutional memory in the room. I think VA does an excellent job and the feedback that I get is that they are satisfied, but we do have a problem.

And so, I would like for each one of you—how do you think is the best way to address the wait time? And one of the things, like in the Gainesville area, I know we have a good hospital there, and the information was not put into the system because the computer system was outdated. Not that anybody was trying to whatever they think that you are doing. They were making sure that the veterans were getting the services. I know about my area.

Dr. CROSS. Would you like me——

Ms. BROWN. Yes, please. I would like a response.

Dr. CROSS. This is so very important. The confidence is not there, as has been pointed out many times. I would judge the wait time and so forth by what I experience when I go there. I am a veteran. I go to the hospital, at the VA, of course. So I think, you know, what you experienced is a starting point to gain that confidence back, to make it a reality.

Ms. BROWN. Well, one of the things that came up in the conference was women veterans, which is the fastest growing group in providing services. Well, one of the things that I get when we did the clinic in Jacksonville was that we made sure that the doctors—and we had the input from the veterans—so that the women say, well, we don't want cat calls when we walk in. How do we control

cat calls? The way you control it is the women have a separate entrance.

And so I think it is very important as we move forward that we do not just talk to the veterans, but we talk to the VA physicians so that they can make input as to how we can improve the system.

Dr. CROSS. An excellent idea, and I concur.

Ms. BROWN. Mr. Chairman, I want to thank you so much for your kindness in extending a couple of minutes to me. I yield back the balance of my time.

The *Chairman.* Thank you very much, Ms. Brown. Are there any further questions that the members may have?

I have one, Mr. Murphy. What happens if a claim is just found somewhere within the system. Somebody has lost it. Paper file sitting somewhere for two years. Now I am not saying that I have one in mind, but I am interested in where the start date begins. Does it begin when that claim arrived or does it begin when the claim—somebody discovers that the claim was found?

Mr. MURPHY. It depends on the circumstances surrounding that case, but the majority of the time, the overwhelming majority of the time, it goes back to the date we received that piece of paper.

If there is a date stamp on it and we received it four years ago and it is sitting in a desk drawer somewhere, it goes into the system as four years old.

The *Chairman.* What if it is not date stamped?

Mr. MURPHY. Then we have to figure out how it is that we established the receipt of that. Is the envelope still there and is a postal stamp on it?

And then we have some cases where we can identify that is a communication that came in with a certain claim, and we give the veteran the most liberal date that we can assign to that case.

The *Chairman.* So the veteran does get the benefit?

Mr. MURPHY. Absolutely. The veteran is entitled to the first time we see the evidence as an effective date.

The *Chairman.* Well, the first time you see it, that is the question. I mean, if it came in somewhere and it got misfiled in somebody else's file and you do not discover it for two years, when does that veteran—when does it start? When you find it, you see it, or when the veteran says they sent it in?

Mr. MURPHY. The date of claim on that goes back to the date that we can identify that we received that piece of paper. Not that—I said a moment ago "found." It is not found. It is we are obligated—the VA is obligated from the date that the VA receives that evidence, and the veteran is entitled to compensation from that date.

Ms. BROWN. Mr. Chairman, on that point.

The *Chairman.* Yes, ma'am?

Ms. BROWN. Mr. Chairman, I think we have to encourage our veterans to be proactive, also. If my doctor, you know, waits two years, I'm not going to wait for any appointment. And so it is important that they also, and the families or the support system, contact the system. I mean, it is going to take a team effort. The Army motto is, "One team, one fight," so we have got to make sure that we are not just relying on the VA but the stakeholders involved

working with the VA, and the family. It is not just the veteran, it is the family, it is the support system.

Certainly it is the responsibility of the VA, but like you say, two years—that is ludicrous. If they had not contacted me in a certain amount of time, then I am going to contact them. I am going to go to the office, or I am going to the emergency room. And so we have got to encourage them to be proactive, also.

The *Chairman.* Thank you, Ms. Brown, very much. Thank you everybody for being here. We thank the witnesses. I would ask unanimous consent that all members would have five legislative days for which to revise and extend their remarks.

Without objection, with that, this hearing is adjourned.

(Whereupon, at 12:01 p.m. the meeting of this subcommittee was adjourned)

APPENDIX

STATEMENT FOR THE RECORD

STATEMENT OF JEFF SCARPIELLO TO

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

VBA and VHA Interactions: Ordering and Conducting Medical Examinations

Chairman Miller, Ranking Member Michaud, and distinguished members of the Committee, I appreciate the challenges facing you as you study the important role that VBA and VHA have in effectively ordering and conducting medical disability examinations (MDE) in support of benefits that America provides in law to care for our veterans.

As background, I am a service-connected disabled veteran who has underwent several compensation and pension (C&P) exams, so I understand the process and can speak from a recipient's viewpoint. I have also worked for Disabled American Veterans and Paralyzed Veterans of America at the busiest Regional Office (RO) in the country in St. Petersburg, FL and am familiar with the disability exam process from an advocacy perspective. I have also worked for US Senator Bill Nelson for 8 years handling veterans and military issues and can speak directly to the impact of the backlog and veterans not being able to get timely benefits and healthcare. In 2008, I went to work for the Department of Veterans Affairs, Veterans Health Administration (VHA) as a Legislative Health Specialist and have investigated complaints regarding the C&P exam process at several locations throughout the country and provided written responses with the findings back to members of Congress. In 2010–2011, I was the Deputy Director of the Disability Examination Management Office (DEMO), now known as the Office of Disability and Medical Assessment (DMA) led by Dr. Gerald M. Cross who is providing testimony before you today. Among my many responsibilities running the DEMO was to help draft, select and award the Disability Examination Management contract to vendors and implement the contract nationally. I have also drafted all existing policies, directives and guidance currently in effect to govern the current VHA C&P exam process. I am currently the Director of Business Development for Medical Support Los Angeles (MSLA), a Medical Company. MSLA has an indefinite delivery, indefinite quantity contract with the VHA to conduct medical disability examinations for veterans in Region 10 (California, Nevada, Hawaii and Guam) under the Disability Examination (DEM) contract.

I have just a few observations and recommendations to share with you, but first, want to explain several reasons why veterans are not getting timely access to health care from the Veteran Health Administration that may be a result of the disability exam process. As a result of the system-wide delays in processing rating claims Veterans Benefits Administration implemented an initiative to eliminate the 1-year and 2-year old claims backlog by accelerating the claims rating process. At some locations, VHA primary care providers were asked to augment /assist the C&P exams clinics. In addition, VBA's fully developed claim (FDC) initiative, put additional stress on the VHA health care system as veterans began making appointments with their primary care/treating providers at the urging of Veterans Service Organization's (VSO) to have Disability Benefit Questionnaire's (DBQ) completed in support of their disability claims. The Office of Disability and Medical Assessment (DMA) attempted to explain that by allowing primary care providers to complete DBQ's could be problematic. However, the VSO's urged the Secretary and Under Secretary of Health to do more to help veterans get their DBQs completed upon request. DMA then instituted a "no-wrong door" policy and VHA primary care providers were informed they should do everything they can to complete DBQs when requested by the veteran. Subsequently, DMA learned that despite the urging of the Secretary and Under Secretary of Health, many primary care providers who were not familiar with DBQs continued to refuse to complete them.

As a result of primary care providers refusing to complete DBQs, VHA DMA implemented DBQ referral clinic (walk-in) guidance instructing primary care providers who could not complete DBQs to provide a "warm-hand off" of the veteran to the C&P clinic for assistance. Many of the larger C&P clinics are so busy with scheduled appointments that this hand-off typically results in the veteran having to have an appointment scheduled to return to the C&P clinic to have the DBQ completed.

In 1996, when Congress gave VBA the authority to contract MDE's at 10 locations and now with capability that VHA has developed with the DEM contract; the full

utilization of these contract vehicles could free up to 7,000–10,000 C&P examiners and hundreds of administrative support staff to provide medical care/treatment services that would help to resolve the current health care scheduling, access and wait time issues plaguing VA.

It is important to note, as I'm sure Ms. Murray & Dr. Cross will attest to in their testimony that VHA's C&P program is a success. In 2010/11 when I ran the Disability Examination Management Office, C&P exams were averaging over 40 days nationally and in some locations 90 days or longer. The implementation of the DEM contract has played a critical role in exams now being completed in 22–26 days; besting the 30 day or less national requirement/standard for completion of exams. However, there is no established national customer service survey that drives performance improvement or to help identify problems from a user/veterans perspective. There is no centralized control of the C&P clinics within VHA, as C&P is not recognized as its own separate service line and at each location within VHA, the C&P structure varies which makes it difficult for VHA C&P clinics to get on-board nationally when new initiatives are rolled-out. Most importantly, C&P facilities do not receive separate funding and if they utilize the DEM contract services they must pay for it the local level, unlike the centrally funded VBA contracts.

I have identified several issues with the VBA contract that should be of concern to the Committee:

* VBA does not manage its contract exams as completely as the VHA DEM contract and has been reliant upon VHA to provide them with accurate C&P data.

* VBA has no governance board and has not allowed any VHA input into the clinical aspects of the exam process.

* The Compensation Service Director can make unilateral contract decisions that involve hundreds of millions of dollars which can give the appearance of impropriety if the same vendor continues to receive the contract award.

* The fact that VBA only awards contracts to single vendors who can bid on the entire contract vastly diminishes the ability of other contract providers to participate in providing exam services in geographic areas where they can compete.

* VBA allows contractors to provide their own quality assurance and has no real mechanisms in place like VHA's quality review specialists to monitor the quality of the exams'

* Under VBA's existing contract, exams that are reworked can be double billed

* No additional authorization is required for additional testing or exams.

* Payments for exams are more expensive in some cases than VHA DEM contract, although they are listed in VBA's contract as a flat fee.

Suggestions and Recommendations:

* Establish a single office that can focus on medical disability examination management. The current oversight is fragmented as currently exists within VBA/VHA. The new joint office should include a single SES responsible for the oversight of the program and include: contract management staff, clinicians to provide quality assurance of contract exams, administrative support, and VBA adjudicators.

* Establish one VA national medical disability examination contract that is broken up into multiple geographical regions including overseas exams, where multiple contract awards can be given to more than one contract vendor in each region.

* Allowing multiple contract awards will help drive internal competition among contract vendors that will drive performance to provide quality and timely exams that will meet or exceed or contract requirements.

* The DEM contract has a successful contract model in place where the contract is divided up into ten geographic regions and multiple vendors are awarded contracts. This would provide fairness and equity so that smaller companies can bid in geographic areas where they are best positioned to provide services without having to bid on a single large contract.

* The efficiencies created by using these contracts will benefit Veterans' immeasurably by creating more options and accessibility to disability exam services and timely access to healthcare that veterans deserve and need.

* Ensure consistent contract standards, pricing, and timeliness standards within existing contracts by VHA / VBA to eliminate confusion.

* Fast-track any IT system solutions that have been presented that would allow this will eliminate current barriers to why VHA facilities are not utilizing the DEM contract.

A lot of work lies before this Committee. All of us who care about the quality of medical disability exams and the benefits we have promised veterans and their families are hopeful that your work will lay the foundation for reform and improvement of the medical disability exam process that will give truth to the commitment to those who have served this nation

Thank you for your consideration of my observations, suggestions and recommendations for changes. Taking care of veterans – and doing it well- is the right thing to do.

VA Responses to Pre-Hearing Inquiries
House Veterans Affairs Committee Hearing – June 25, 2014
"VBA and VHA Interactions: Ordering and Conducting Medical Examinations"

Question/Response:
1. *What is the total number of VHA employees that perform C&P medical examinations?*

As of June 13, 2014, there are 6,631 clinicians registered and certified to perform compensation and pension (C&P) examinations who are designated as full or part-time Veterans Health Administration (VHA) employees.

***2. In a 2010 VA OIG audit report, it was noted that VBA and VHA managers did not effectively collaborate and share information with one another. What steps have been taken since that time?* OIG stated on p. 10 that "VBA maintains rating claims receipt data on a national and local level; however, management does not share this information with VHA."**

Subsequent to VA OIG report, 09-02135-107, *Audit of VA's Efforts To Provide Timely Compensation and Pension Medical Examinations*, the joint VBA/VHA Compensation and Pension Examination Program (CPEP) office was redesigned and more robustly staffed with VBA claims processors and VHA clinicians and managers. The goal of the effort was to collaboratively improve all aspects of the C&P examination process, but principally the quality and timeliness of C&P examinations.

VHA's Office of Disability and Medical Assessment (DMA) and VBA's Compensation Service committed to full collaboration, cooperation, and communication in this effort as evidenced by the assignment of senior managers and staff experienced and knowledgeable in the adjudication needs from the C&P examination process as well as clinicians with prior C&P examination experience. Many of the VBA and VHA staff involved in this effort work out of a co-located office, committed to full communication of any action, changes, or developments within each administration that might have an impact on the other's ability to meet its goals or impact exam quality or timeliness.

Through this joint effort, VHA and VBA began close collaboration to satisfy many of the recommendations made in the cited VA OIG report. An analytics team was also formed to develop new and better methods to track C&P examination metrics as well as to analyze that data to be able to identify trends, strengths, and weaknesses. The VHA quality assurance program was developed and integrated with the VBA quality assurance review process to more accurately measure examination request as well as examination report quality. Both of these quality assurance programs are based on the capability of producing a work product sufficient for disability rating purposes.
Other areas of collaboration to improve examination quality and timeliness include:

- Joint workgroups to develop future IT improvements and solutions,
- Joint workgroups to develop examination templates,
- Joint staff reviews of medical facility activities,
- Development of the Clinician in Residence Program to reduce numbers of exam requests,
- Biweekly collaboration meetings at the VA Central Office level, and
- Weekly meetings with VBA and VHA field staff.

3. Please describe the IT interface between VBA and VHA technologies necessary for performing C&P medical examinations. When do you expect VBA and VHA technologies to be fully integrated?

The Compensation and Pension Record Interchange (CAPRI) software is a decentralized graphical user interface that allows VBA to request examinations from VHA and to receive the results of those examinations electronically. CAPRI provides VHA staff with a standardized electronic way of recording examination reports. VHA clinicians can use a number of different applications to retrieve clinical information, schedule appointments, and refer examination requests to contract vendors. When C&P examination reports are finalized by VHA, electronic copies of those reports are automatically transmitted into the corresponding Veteran's electronic claim folder (eFolder) in VBMS and Virtual VA. In addition, results of certain examinations are transmitted from CAPRI for automated decision support programs. CAPRI also transmits e-mails to VBA requesters of examinations indicating that examination results are available.

Efforts are currently underway to replace reliance on the decentralized C&P disability exam processing IT systems with more centralized, modern technologies that are easier to integrate and standardize across VA and other eligible users. The dates for completing the integration are dependent on the availability of funding to continue incremental development and deployment of the new IT systems.

4. What performance standards are currently in place to ensure that examinations are completed in a timely manner, and are also adequate for rating purposes?

The national standard for processing C&P disability examinations is 30 days, or 45 days for the Integrated Disability Evaluation System (IDES). Timeliness is a performance measure defined as "a cumulative average processing days of less than or equal to 30 days on a fiscal quarterly and yearly basis." This measure is determined by the difference between the electronic date stamp on the examination request when input by the VBA, and the electronic date stamp on the examination request when returned to the VBA as complete. This timeframe measures from the day VBA electronically submits an examination request to VHA to the day VHA electronically returns examination reports to VBA. For fiscal year (FY) 2014, as of June 16,

2014, VHA's average time to complete C&P disability examination requests was 24 days and 32 days for IDES. VHA uses five contract vendors for C&P and IDES examinations: Veterans Evaluation Services (VES); Logistics Health Incorporated (LHI); Quality Timeliness Customer Service (QTC); Medical Support Los Angeles (MSLA); and Comprehensive Health Services (CHS). Their individual contract timeliness performance for C&P is as follows: VES – 28 days; LHI – 26 days; QTC – 30 days; MSLA – 17 days; and CHS – 29 days. Timeliness performance for IDES: VES – 33 days; LHI – 30 days; QTC – 27 days; MSLA – 17 days; and CHS – 67 days.

VHA used two vendors overseas, VES and CHS. Their examination performance was as follows: VES (October 2013- April 2014) – 54 days; and CHS (October 2013- February 2014) – 67 days. However, the contract with CHS was terminated in February 2014.

VHA's Office of Disability and Medical Assessment (DMA) established several methods of ensuring the quality of examination requests and reports since 2011, and improvement in the quality and timeliness of C&P examinations has been progressive.

Quality fiscal year to date consistently over 95 percent

The Quality Audit Review process by DMA includes a review of both the examination request (VBA) and the examination report (VHA). The goals are to assess for completeness, consistency between the medical evidence and the examination report, and to identify any issue that might render an examination report as "insufficient for rating purposes."

The quality of examination reports is determined by a substantive review of the selected examination package (request + report) to allow for the complete adjudication of each Veteran's claim. This focus provides Regional Office and Veterans Integrated Service Network (VISN) performance and allows identification of opportunities for improvement.

Quality is a currently established VISN Performance Measure defined as "demonstration of an average score of 90% on a fiscal quarterly and yearly basis."

Packages to be reviewed are from a computer-selected stratified random sample of VISN disability examination reports residing in the VA Corporate Data Warehouse completed during the sampling month. These may include examination reports completed by a C&P clinician, a fee-for-service clinician or a VHA contracted clinician.

Reviewers have access to the VHA Disability Examination Management (DEM) contract vendor portals to review a statistically valid number of reports monthly.

The VHA DEM contract contains the following timeliness standards for individual examination requests (i.e., task orders under the DEM contract). General C&P examinations and their associated reports must be completed and returned to the ordering VA medical center requestor not later than 26 calendar days after receipt of order throughout the life of the contract when conducted at the contractor location. Examinations for IDES and their associated reports must be completed and returned to the ordering site not later than 35

calendar days after receipt of order throughout the life of the contract. Overseas examinations and their associated reports must be completed and delivered to the ordering site not later than 45 calendar days after receipt of the order throughout the life of the contract. For each Contractor, VHA DMA monitors the monthly Average Processing Days for completed task orders.

The VHA DEM contract Quality Assurance Surveillance Plan provides the following performance standards for examination timeliness.

Completed Task Orders	Performance Threshold
C&P	90% Completed in 26 days or less
C&P	99% Completed in 60 days or less
IDES	90% Completed in 35 days or less
IDES	99% Completed in 70 days or less
Overseas	90% Completed in 45 days or less
Overseas	99% Completed in 80 days or less

The contract requires that each vendor establish an internal review process to ensure the quality of the examinations provided to VHA and that no more than three percent of examinations can be deemed insufficient due to an examining clinician's action or lack of action.

VHA also participates in the quality review of contract examinations. The VHA C&P clinic requesting the examination is responsible for conducting an additional quality review before releasing the results to VBA. Finally, as mentioned above, the DMA quality reviewers have access to the contract vendor portals in order to review a statistically valid number of reports completed during the month.

5. VHA policy states that upon receipt of a C&P examination request, staff should schedule the examination within 3 days and return completed examinations within 30 days. Is this a reasonable performance metric in light of VHA's recent scheduling and data manipulation issues?

In April 2012, VHA no longer required that examinations be scheduled in 3 days of receipt of the 2507 request. C&P examination scheduling differs significantly from that of acute, specialty, and/or primary care appointments. Veterans do not originate the request for C&P examination or associated appointment. The request is instead initiated via a Standard Form (SF)-2507 submitted electronically by VBA to the C&P clinic.

Upon receipt of a 2507 the scheduling clerk is required to call the Veteran.

If telephone contact is made the clerk will:

- Inform the Veteran a request for a C&P examination has been received
- Verify current address and phone number
- Discuss the number and type of examinations required
- Agree upon the dates and times that allow completion of the report within 30 days
- Send an appointment letter to Veteran's validated address

If telephone contact is not made the clerk will:

- Review the number and type of examinations required
- Select the dates and times that allow completion of the report within 30 days
- Send an appointment letter to Veteran's current address
- Reschedule appointments as needed when/if contacted by Veteran

The attempt to improve the likelihood that the Veteran will report for scheduled appointments resulted in an alternate choice in the scheduling process called RSVP in December 2012. When the scheduler cannot contact the Veteran by telephone, an invitation letter is sent within 2 days, requesting the Veteran to call the VHA facility within 10 days to schedule a mutually agreed upon appointment date and time.

During the 2013 surges VBA & VHA distributed policy guidance that required make every effort to reach the Veteran as well as encouraging the Veteran to accept the appointment invitation, including reaching out to the Veteran's service representative before cancelling the 2507 exam request.

6. Is VA tracking the number and type of medical disability examinations conducted, as opposed to just the number of examination requests? (For example, one examination request may encompass multiple claims/disabilities, therefore requiring numerous different medical examinations).

VHA tracks the number of VBA SF-2507 requests, the number of examinations requested, the number of SF-2507 requests completed, and the number of examination types completed (see table below).

7. What is the total number of examination requests and/or total number of medical disability examinations VBA sent to VHA medical facilities in each of the last three fiscal years?

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014 (Oct - May)
VBA 2507 Requests Sent to VHA	804,459	822,317	987,857	977,033	730,904
# Exams Requested	1,504,013	1,609,969	2,306,943	2,484,117	1,801,925
VBA 2507 Requests Completed by VHA	641,492	709,435	817,227*	840,108*	597,819*
# Exams Completed by VHA clinicians	1,152,139	1,295,700	1,791,192	1,998,886	1,414,036
# Exams Completed through VHA National Contract	N/A	N/A	59,194**	178,406	45,655

*VHA National Disability Examination Management Contract initiated in FY 2012. These numbers include those sent to VHA national contract.
**VHA contract numbers were initially reported based on examination requests in FY 2012. All other years are reported in # of examinations.

a. How many total examination requests and/or medical examinations were performed by national contractors?
(See table above)

b. What is the total national C&P workload?
(See table above)

8. Please provide the applicable resource allocation model used to ensure that veterans receive timely C&P examinations. Do these measures:

a. Adequately capture the total C&P workload?
All workload performed during a C&P is coded and captured by VHA workload capture systems. When the C&P examination is provided by a non-VA source, the billing process captures the Common Procedural Terminology (CPT) codes and costs paid by VHA for services rendered. This purchased care is included in VHA data and is funded by the Veterans Equitable Resource Allocation (VERA) Model.

b. Capture total costs associated with performing C&P examinations, such as costs for ancillary tests and procedures?
All workload is captured.

c. **Measure a particular facility's capacity to perform C&P examinations?** Twice weekly, data is updated centrally for facilities, regional offices and leadership to monitor demand and manage resources. Capacity has been extended with the use of the DEM contract.

9. Please confirm that VHA pays for local C&P examination programs by using money from its general purpose fund, and provide any other details as to how budgetary analysis for this program is performed.

VHA provides C&P examinations for Veterans and non-Veterans, including active military personnel. These examinations are identified in the VHA data systems based on a Purpose of Visit codes that are entered when the examination occurs. All clinical care associated with C&P examinations are captured in VHA's data systems and include all the same data elements as all other patient care. Furthermore, C&P examinations can be provided by non-VA sources. Following the scheduled appointment, non-VA care is billed to VHA for payment of services rendered. The billing process outlines the precise services and costs of the care, which are paid by VHA.

Workload and cost captured for C&P examinations are funded by the VERA Model. The VERA Model is the VHA resource allocation methodology, which distributes General Purpose funds to all VISNs. Historically, at least 90 percent of all funds within the VERA Model are directly attributed to patient care practices that are either provided by or paid for by VHA. Patient care practices are captured in the VERA Model by the VERA Patient Classification System, which is a process that categorizes all patients treated by the VHA into a capitated funding methodology that is used to allocate resources to the 21 VISNs within VHA. When patients present for C&P examinations, the workload associated with the examination is captured by CPT codes that identify the precise care provided as part of the examination. There are different levels of C&P examinations and various clinical providers including physicians, physician assistants, nurse practitioners, mental health clinicians and/or audiologists can be part of the examination. From a VERA Patient Classification perspective, if the Veteran receives clinical services that equate to a primary care visit (specifically a level three evaluation and management examination), the Veteran is considered "vested" and funded in the VERA Model no less than approximately $3,000. Veterans that receive a C&P examination that does not meet the VERA level three requirements are funded at approximately $300 by the VERA Model.

10. Why are VHA management and VBA contractors held to different timeliness standards?

The VHA C&P examination timeliness standard is 30 days. The VHA DEM Contractor timeliness standard is 26 days, 4 days less than the VHA standard. The four-day difference accounts for the VHA administrative handling and clinical review of a contracted examination

request. The 26-day turnaround for VHA Contractors supports the overall VHA 30 day processing goal for disability examination requests. One VBA contract allows 38 days to complete examination reports, while the most recently competed contract allows 20 days. Historically, VHA and VBA independently created the scope of contracts, including timeliness. At the next contract negotiations in late 2015, VBA plans to align closer to VHA's internal and contracted timeliness standards.

George C. Turek
Supplemental Testimony

House Committee on Veterans' Affairs,
VBA and VHA Interactions: Ordering and Conducting Medical Examinations

In response to the following question from Congressman Takano, I would like to supplement my testimony as follows:

Mr. Takano: Mr. Turek, does VES use electronic health records and is your electronic system interoperable with VISTA? Currently you are not completely interoperable in the way VBA is with VHA. That is a pretty significant difference because it has huge health implications for the ability for the integrated health system to work. In my view it's a major problem in terms of your argument to contract out the entire examination process. Could give me an answer to the question of how much would it cost to ramp up and whether your company could make that kind of investment?

Mr. Turek: VES works in an electronic medical records environment. All aspects from scheduling to delivery are done electronically. This includes the work performed by VES medical providers who review medical records and complete DBQs in the VES Secure Provider Portal.

With respect to the work VES does for the VBA, we have access to certain limited components of VISTA, including CAPRI and CAATS (which recently replaced VERIS). We also upload all completed C&P MDE reports and the associated diagnostics directly into VBMS, as required by our contract. VES' captive IT department built this capability at the request of and in cooperation with the VBA. We also post the completed reports to our VES Secure Client Portal.

With respect to the work VES does for the VHA, we do not access VISTA, nor do we upload completed reports into VBMS. Although we have offered to do so, the VHA has declined this offer. We currently send completed MDE reports to the VHA via encrypted e-mail as a secure PDF attachment. We also upload the completed reports to the VES Secure Client Portal.

With that said, as a private contractor, VES certainly does not have the same level of access to or interoperability with VISTA as does the VHA or VBA. Moreover, I highly doubt that the VA would allow any private contractor unlimited and unfettered access to a system with such highly confidential and private information. Nevertheless, to the extent the VA was to allow us such access, our company certainly has the IT capability and financial resources to make the necessary investment to become fully interoperable with VISTA. VES maintains a robust, captive IT department, complete with a team of professional programmers who have previously worked together with VA technical experts on a number of IT-related projects. We are confident we can accommodate any reasonable IT requirements established by the VA going forward. However, absent a more detailed understanding from the VA of the parameters of a project to establish full interoperability, we have no basis upon which to provide you an estimate of how much that might cost.

The point is that we do not need the same level of access to or interoperability with VISTA in order to provide the VA timely and quality medical disability examination services. Not having the same level of interoperability with VISTA as the VHA does not in any way limit or compromise VES' ability to deliver valuable services to the VA. Moreover, it does not detract from our position that our veterans would be better served with the VHA focusing exclusively on treatment, and outsourcing all C&P MDEs to private contractors through the VBA.