

# CONSOLIDATING NON-VA CARE PROGRAMS

---

---

## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

---

DECEMBER 2, 2015

---

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.fdsys.gov>

---

U.S. GOVERNMENT PUBLISHING OFFICE

98-066 PDF

WASHINGTON : 2016

---

For sale by the Superintendent of Documents, U.S. Government Publishing Office  
Internet: [bookstore.gpo.gov](http://bookstore.gpo.gov) Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON VETERANS' AFFAIRS

JOHNNY ISAKSON, Georgia, *Chairman*

JERRY MORAN, Kansas

JOHN BOOZMAN, Arkansas

DEAN HELLER, Nevada

BILL CASSIDY, Louisiana

MIKE ROUNDS, South Dakota

THOM TILLIS, North Carolina

DAN SULLIVAN, Alaska

RICHARD BLUMENTHAL, Connecticut, *Ranking  
Member*

PATY MURRAY, Washington

BERNARD SANDERS, (I) Vermont

SHERROD BROWN, Ohio

JON TESTER, Montana

MAZIE K. HIRONO, Hawaii

JOE MANCHIN III, West Virginia

TOM BOWMAN, *Staff Director*

JOHN KRUSE, *Democratic Staff Director*

# C O N T E N T S

DECEMBER 2, 2015

## SENATORS

|   | Page |
|---|------|
| Isakson, Hon. Johnny, Chairman, U.S. Senator from Georgia .....             | 1    |
| Blumenthal, Hon. Richard, Ranking Member, U.S. Senator from Connecticut ... | 2    |
| Moran, Hon. Jerry, U.S. Senator from Kansas .....                           | 13   |
| Hirono, Hon. Mazie K., U.S. Senator from Hawaii .....                       | 18   |
| Rounds, Hon. Mike, U.S. Senator from South Dakota .....                     | 20   |
| Murray, Hon. Patty, Chairman, U.S. Senator from Washington .....            | 23   |
| Prepared statement .....  | 25   |
| Cassidy, Hon. Bill, U.S. Senator from Louisiana .....                       | 26   |
| Manchin, Hon. Joe, U.S. Senator from West Virginia .....                    | 28   |
| Sullivan, Hon. Dan, U.S. Senator from Alaska .....                          | 31   |
| Tester, Hon. Jon, U.S. Senator from Montana .....                           | 34   |
| Tillis, Hon. Thom, U.S. Senator from North Carolina .....                   | 37   |

## WITNESSES

|   |    |
|---|----|
| Gibson, Hon. Sloan, Deputy Secretary, U.S. Department of Veterans Affairs;<br>accompanied by David J. Shulkin, M.D., Under Secretary for Health; Baligh<br>Yehia, Assistant Deputy Under Secretary for Health for Community Care,<br>Veterans Health Administration; and Joe Dalpiaz, Network Director, Heart<br>of Texas Health Care Network (VISN 17), Veterans Health Administration ... | 3  |
| Prepared statement .....  | 5  |
| Response to posthearing questions submitted by:   |    |
| Hon. Johnny Isakson .....   | 45 |
| Hon. Richard Blumenthal .....   | 52 |
| Hon. Dean Heller .....  | 54 |
| Hon. Sherrod Brown .....  | 55 |
| Hon. Steve Daines .....   | 56 |
| Butler, Roscoe G., Deputy Director, National Veterans Affairs and Rehabilita-<br>tion Division, The American Legion .....   | 57 |
| Prepared statement .....  | 59 |
| Selnick, Darin, Senior Veterans Affairs Advisor, Concerned Veterans for<br>America .....  | 61 |
| Prepared statement .....  | 63 |
| Response to posthearing questions submitted by Hon. Steve Daines .....  | 87 |
| Rausch, Bill, Political Director, Iraq and Afghanistan Veterans of America .....  | 65 |
| Prepared statement .....  | 68 |

## INDEPENDENT BUDGET REPRESENTATIVES

|   |    |
|---|----|
| Kelley, Raymond C., Director, National Legislative Service, Veterans of For-<br>eign Wars of the United States; accompanied by Joy J. Ilem, National<br>Legislative Director, Disabled American Veterans; and Carl Blake, Asso-<br>ciate Executive Director, Government Relations, Paralyzed Veterans of<br>America ..... | 69 |
| Prepared statement .....  | 71 |
| Attachment: A Framework for Veterans Health Care Reform .....   | 77 |



## **CONSOLIDATING NON-VA CARE PROGRAMS**

**WEDNESDAY, DECEMBER 2, 2015**

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

The Committee met, pursuant to notice, at 2:31 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

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

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

Chairman ISAKSON. I call this hearing of the Senate Veterans' Affairs Committee to order and welcome everybody. I hope you all had a great Thanksgiving and hope everybody has a wonderful holiday season coming up.

This is a very important hearing for the Veterans' Affairs Committee of the U.S. Senate. On November 4, if my memory is correct, we had a meeting at the VA when we had a stand-up with Secretary McDonald and Sloan Gibson and Dr. Shulkin and some of the others that are in the room, talking about the vision for the future in terms of VA health services delivery to our veterans, about Veterans Choice, about consolidating programs, simplifying the reimbursement rates so there were no preferences one over the other, and seeing to it that coordinated care for our veterans could be a reality in our lifetime and in their lifetime.

With that will come a number of decisions. This will not be the first time I heard most of this information, as we had that meeting before, but it will be the first time a lot of people have heard it. There are a critical number of decisions that we will have to make to make the MyVA work, the new Veterans Choice work, and make sure that VA does what it does best, but does not get itself into things that it has proven in the past it does not do very well.

There are certain issues about information technology and network building that I specifically want to ask, because as someone who ran a company, I know every time you start talking about information technology or you start talking about building networks, you talk about infrastructure and cost. You talk about increasing the number of employees and management people. If you take an agency that already has 314,000, and if you grow that some more, you are probably making a big mistake. So, I am going to be very

interested in the testimony, what all of you have to say on those particular points.

We are delighted with the progress that we have made at the VA. I am stopped all the time back in Georgia and folks say, well, you are Chairman of the VA Committee. Are you not frustrated with how screwed up the VA is? I say, well, you know, the problem is that we see every day the successes that are being made, where we are fixing the problems that we have had in the past, and we have got a good Secretary. We have a good team. We are making some good progress on Veterans Choice. For all the bad stories you hear about, they are mostly stories of things that happened in the past that we are trying to correct, not things that are happening today.

I want to start this hearing out by saying that this—what we are going to talk about today is an approach to address a number of previous shortcomings of the VA health care system to improve it for the veteran in terms of their access and the coordination of their care and the VA in terms of the delivery of the system, but to ensure that we magnify choice and not minimize choice so that we can deal with the challenges of the 21st century for the veterans of the 21st century.

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

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

Senator BLUMENTHAL. Thank you. Welcome to our witnesses and thank you for being here and for your good work on behalf of our Nation.

This task of consolidating and reorganizing community care and the patchwork of programs we have now is certainly an urgent one and apparently a very expensive one. One-point-nine billion dollars is a lot of money to spend on an organization. I want to know how that money is necessary and what specifically it will be used to do. I also will want to know about consumer rights, how do we protect consumer rights and educate both providers and individual patients, your consumers, as to their rights and responsibilities. I want to make sure that this plan for care in the community is implemented as well as possible. I know that is your goal, too, and thank you for being here.

Chairman ISAKSON. We have two panels today, and our first panel will be made up of the Honorable Sloan Gibson, the Deputy Secretary of the Department of Veterans Affairs, with whom we have worked diligently for the last year on a number of projects and look forward to this one.

He is accompanied by Dr. David Shulkin, who I want to commend this Committee on the rapid approval of his confirmation to take over a job that is critical to being able to deliver health care services to our veterans. I appreciate, A, his willingness to do it and, B, the Committee's willingness to act quickly and expeditiously to see to it that we do.

I am going to pronounce these names and I do not want to mess up. No, no, do not cheat. Dr. Baligh Yehia, for South Georgia, that is pretty good. [Laughter.]

Dr. Joe Dalpiaz. Is that pretty good?

Mr. DALPIAZ. Yes—

Chairman ISAKSON. You all can correct me. I beg your pardon?

Mr. DALPIAZ. I am no “doctor,” thank you.

Chairman ISAKSON. No doctor? Take it if you can get it.

[Laughter.]

With that, we will introduce your testimony. Keep it within 5 minutes, if you can. If you go a little bit over, as long as it is factual and important and relevant, we are happy to hear from you.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. Deputy Secretary Gibson, thank you for being here today. The program is yours.

**STATEMENT OF SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH; BALIGH YEHIA, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION; AND JOE DALPIAZ, NETWORK DIRECTOR, HEART OF TEXAS HEALTH CARE NETWORK (VISN 17), VETERANS HEALTH ADMINISTRATION**

Mr. GIBSON. Yes, sir. Thank you, Mr. Chairman. I will offer a bit more elaborate introduction of these three.

David is our Under Secretary for Health. He has been at VA now for all of 4 months. He comes to us from a career in the private sector managing large health care organizations.

Dr. Yehia has been with VA for all of 18 months. He has years of clinical experience and he continues to see patients inside VA, a brilliant young infectious disease doctor.

Joe is the Network Director for VISN 17 down in Texas. He has been with VA for over 30 years, much of it as a medical center director. He has spent most of the past several months working with this team on this report and addressing community care issues.

Mr. Chairman, we are facing an historic opportunity to make a major advance in health care for veterans by consolidating and streamlining VA’s various means of providing care in the community so veterans get the best possible care no matter where they receive it. We are determined to seize that opportunity and make the most of it. We are grateful to the Committee for responding to our need for consolidation.

VA is already in the midst of an enterprise-wide transformation called MyVA—you alluded to it, Mr. Chairman—which will modernize VA’s culture, processes, and capabilities. Our proposal to consolidate Community Care Programs is a part of that overall effort.

Care in the community has been and will always be a vital component of health care for veterans when they live too far from a VA facility, when they need care available only in the community, and when increasing demand for care exceeds existing capacity, as we have seen in recent years.

We are referring veterans to community care more than ever before, but we are saddled with a confusing array of programs, authorities, and mechanisms that greatly complicate the task of ensuring veterans get the care they need when and how they need

it. These different programs include Project ARCH, PC3, Choice, two different plans for emergency care, affiliations with other Federal agencies and academic partners, and numerous individual authorities. Each has its own requirements, different eligibility rules, reimbursement rates, different methods of payment, and different funding routes. It is all too complicated, too complicated for veterans, for community providers, and for VA staff, as well.

Consolidation will improve access and make the process easier for veterans to use. Veterans will have better access to the best care outside VA. Providers will be encouraged to participate and to provide higher quality care, and VA employees will be able to serve both better while also being good stewards of taxpayer resources.

Our report is based on input from veterans, the Independent Assessment, Veterans Service Organizations, VA employees, Federal stakeholders, best practices of the private sector, and we also appreciate the many discussions that we have had with your staff, many of whom are in the room today.

The report focuses on five functional areas. First, veteran eligibility: A single set of eligibility criteria based on distance from a VA provider, wait time for VA care, and the availability of services at VA, with expanded access to emergency and urgent care.

Second, ease of access: Streamlined business rules to speed up and simplify the referral and authorization process.

Third, high-performing network: Partnering with Federal, academic, and community providers to offer a tiered provider network which will enable VA to better manage supply and demand and monitor health care quality and utilization.

Fourth, better coordination of care: Making health information easier to exchange and helping veterans make the best choices among community care providers.

And, fifth, prompt payment: Improving billing, claims, and reimbursement processes to allow auto-adjudication of most claims and faster, more accurate payment.

These efforts will not just improve the way we do community care. They will make community care a part of the fabric of VA care, making VA truly an integrated health care system.

Getting there will take time, but even as we work toward the longer term, we are improving the veteran's experience of care in the community. In the near term, we have expanded the provider base by including providers already participating in Medicaid. We have added urgent consult scheduling to get veterans seen in two business days, when necessary. And we have eliminated enrollment date and combat eligibility indicators as factor limiting Choice eligibility.

Just yesterday, we announced several new changes to the Choice Program that are products of our collaboration with this Committee and your House counterparts, for which we are very appreciative. First, veterans are now eligible if there is not a VA facility with a full-time primary care physician within 40 miles.

Second, when qualifying veterans for the Choice Program, we are now taking into consideration the nature of the care they need, how often they need it, and whether they need someone to accompany them. If a veteran just needs a flu shot or if they need a round of chemotherapy every 2 weeks or so, they may now qualify



for Choice no matter where they live. Those are just a few ways we are making community care more accessible to veterans even while working toward the longer-term goal of consolidation.

In the coming months, we expect to accomplish a number of close-in consolidation objectives: The streamlined referral and authorization process; standardization of our partnerships with DOD and our academic affiliates; critical make versus buy decisions on information technology and contractor support; successful application of MyVA customer service systems to community care coordination. These objectives will be the work of an enterprise-level community care team dedicated full-time to improving and consolidating community care and led by a new Deputy Under Secretary of Health for Community Care.

We are eager to move forward with consolidation, but it must be a collaborative effort with Congress. This consolidation, like many of the improvements we have already made, is only possible with your support. We need Congress to provide the necessary legislation to support change and the required funding to implement and execute the consolidation program.

I know costs are an issue, but the critical cost issue right now is the \$421 million we expect to spend this fiscal year on systems redesign and business solutions. These are one-time improvements that are absolutely essential if we are to move forward with consolidation and improving the veterans community care experience.

Later, Congress and VA may need to consider additional costs to cover other possible aspects of consolidation, such as increased demand and expanding emergency and urgent care. We also expect some cost savings from consolidation, as well.

We have detailed our specific legislative proposals in the report, briefed their structure to your personal staffs, and we are happy to work with any member on these items.

Finally, Mr. Chairman, a word about provider agreements. We need Congress to act on the proposal we submitted May 1 to end the uncertainty about aspects of purchased care that are outside the Choice Program and that complicate provider participation in our other Community Care Programs. This is especially critical for veterans in long-term care. We are already seeing nursing homes not renew their agreements with us, which means that veterans will have to find new homes.

Thank you for the support you have already shown. We look forward to working with you to fully integrate care in the community into the VA health care system.

[The prepared statement of Mr. Gibson follows:]

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

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) proposal to consolidate VA's care in the community programs to improve access to health care. I am accompanied today by Dr. David Shulkin, Under Secretary for Health; Dr. Baligh Yehia, Assistant Deputy Undersecretary for Health for Community Care; and Mr. Joseph Dalpiaz, Network Director, Veterans Integrated Service Network 17.

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in demand for care, it is essential for VA to partner with providers

in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans and community providers, as well as VA employees.

Acknowledging these issues, VA is taking action as part of an enterprise-wide transformation called *MyVA*. *MyVA* will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. Included in this transformation is a plan for the consolidation of community care programs and business processes, consistent with Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (also known as the VA Budget and Choice Improvement Act) and recommendations set forth in the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (Independent Assessment Report) that was required by Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (The Choice Act).

This document provides a plan for how VA could consolidate all purchased care programs into one New Veterans Choice Program (New VCP). The New VCP will include some aspects of the current Veterans Choice Program (Section 101 of Pub. L. 113-146, as amended) and incorporate additional elements designed to improve the delivery of community care. The 10 elements of this plan, as set forth in law, are listed to the right. With the New VCP as described in this plan, enrolled Veterans will have greater choice and ease of use in access to health care services at VA facilities and in the community.

#### VA BUDGET AND CHOICE IMPROVEMENT ACT LEGISLATIVE ELEMENTS

1. Single Program for Non-Department Care Delivery
2. Patient Eligibility Requirements
3. Authorization
4. Billing and Reimbursement Process
5. Provider Reimbursement Rate
6. Plan to Develop Provider Eligibility Requirements
7. Prompt Payment Compliance
8. Plans to Use Current Non-Department Provider Networks and Infrastructure
9. Medical Records Management
10. Transition Plan

The New VCP will clarify eligibility requirements, build on existing infrastructure to develop a high-performing network, streamline clinical and administrative processes, and implement a continuum of care coordination services. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve Veterans' experience and access to health care. VA's future health care delivery network will address gaps in Veterans' access to health care in a simple, streamlined, effective manner and will continue to support VA's missions of research and education.

VA is continuing to examine how the Veterans Choice Program interacts with other VA health programs, including the delivery of direct care. In addition, VA is evaluating how it will adapt to a rapidly changing health care environment and how it will interact with other health providers and insurers. As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in this plan into an executable, fiscally-sustainable future state. In addition, we plan to receive and potentially incorporate recommendations from the Commission on Care and other stakeholders.

VA anticipates improving the delivery of community care through incremental improvements as outlined in this plan, building on certain provisions of the Veterans Choice Program. The implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing health care costs. VA will work with Congress and the Administration to refine the approach described in this plan, with the goal of improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs.

#### THE PATH FORWARD

The design of the New VCP (Legislative Element 1) is based on feedback from Veterans, Veteran Service Organizations (VSOs), VA employees, Federal stakeholders, and best practices. VA's plan centers on five functional areas. Within each

functional area are key points to enable Veterans to receive timely and high-quality health care.

1. *Veterans We Serve (Eligibility)*—This area addresses overlapping community care eligibility requirements, as directed in Legislative Element 2. Streamlining and consolidating these requirements will allow Veterans to easily understand their eligibility for community care and access community care faster. VA and community providers will have significantly lower administrative burdens, which have often impeded timely delivery of Veterans' care. This area includes the following possible enhancements:

- Establish a single set of eligibility criteria for all community care based on geographic access/distance to a VA primary care provider (PCP), wait-time for care, and availability of services at VA.
- Expand access to emergency treatment and urgent community care.

2. *Access to Community Care (Referral and Authorization)*—This area addresses the complicated process of community care referrals and authorizations, as directed in Legislative Element 3. VA will optimize the referral and authorization systems and supporting processes, enabling more rapid exchange of information to support timely delivery of care. This area includes the following possible enhancements:

- Streamline business rules in referral and authorization to minimize delays in delivering care and eliminate unnecessary administrative burdens.
- Improve VA visibility into health care utilization in the community.

3. *High-Performing Network*—This area leverages components of existing non-Department networks and identifies new community partners to build a high-performing network, as outlined in Legislative Element 8. Addressing issues of provider eligibility requirements and reimbursement rates, as outlined in Legislative Elements 5 and 6, will be key to this approach. This area includes the following possible enhancements:

- Develop a tiered, high-performing provider network to better serve Veterans, consisting of the following categories:
  - *VA Core Network*: Includes existing relationships with high-quality health care assets in the Department of Defense (DOD), Indian Health Service (IHS), Federally Qualified Health Centers (FQHC), Tribal Health Programs (THP), and academic teaching affiliates.
  - *External Network*: Includes commercial community providers and distinguishes Preferred providers based on quality and performance criteria.
- Move toward value-based payments in alignment with industry trends.
- Implement productivity standards to better manage supply and demand.
- Develop dedicated customer support to improve Veteran and community provider experiences.

4. *Care Coordination*—This area focuses on improving medical records management and strengthening existing care coordination capabilities, as directed by Legislative Element 9. Improving medical records management will support a high-performing network and enable better decisionmaking through analytics. It will also support more effective care coordination and improved Veteran health care outcomes. This area includes the following possible enhancements:

- Offer a continuum of care coordination services to Veterans, tailored to their unique needs.
- Use analytics to improve Veterans' health by guiding them to personalized services and tools (e.g., disease management, case management).
- Enable community providers to easily exchange health information with VA.
- Design customer service systems to help resolve inquiries from Veterans and community providers regarding care coordination.

5. *Provider Payment*—This area focuses on improving billing, claims, and reimbursement processes, as well as Prompt Payment Act (PPA) compliance for purchasing care, as directed by Legislative Elements 4, 5, and 7. This area includes the following possible enhancements:

- Implement a claims solution which is able to auto-adjudicate a high percentage of claims, enabling VA to pay community providers promptly and correctly.
- Move to a standardized regional fee schedule, to the extent practicable, for consistency in reimbursement.

The New VCP will use a system of systems approach to enhance these five functional areas as part of the larger VA health care transformation. This approach stresses the interactive, interdependent, and interoperable nature of external and internal components within VA's health care delivery system. The New VCP in-

cludes enhancements to the following systems, which will have a positive impact on VA and the greater Veterans' health ecosystem:

- *Integrated Customer Service Systems*—Provide a reliable, easy-to-use way for Veterans and community providers to get their questions answered, provide feedback, and submit inquiries.
- *Integrated Care Coordination Systems*—Establish a clear process for Veterans to seamlessly transition between VA and community care, supporting positive health outcomes wherever the Veteran chooses to receive care.
- *Integrated Administrative Systems (Eligibility, Referral, Authorizations, and Billing and Reimbursement)*—Simplify eligibility criteria so Veterans can easily determine their options for community care, streamline the referral and authorization process to enable more timely access to community care, and standardize business processes to minimize administrative burden for community providers and VA staff.
- *High-Performing Network Systems*—Enable the development and maintenance of a high-performing provider network to maximize choice, quality, and value for Veteran health care.
- *Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting)*—Define ownership and management of community care at all levels of VA, local and national, and institute standard metrics to drive high performance and accountability across facilities.

The New VCP plan envisions a three-phased approach to implement these changes to support improved health care delivery, as outlined in the Transition Plan (Legislative Element 10). This will deliver incremental improvements while planning for a future state consistent with evolving health care best practices. The first phase will include development of the implementation plan and will focus on the development of minimum viable systems and processes that can meet critical Veteran needs without major changes to supporting technology or organizations. Phase II will consist of implementing interfaced systems and community care process changes. Finally, Phase III will include the deployment of integrated systems, maintenance and enhancement of the high-performing network, data-driven processes, and quality improvements.

Executing the New VCP will not be possible without approval of requested legislative changes and requested budget. The primary objectives of the legislative proposal recommendations are to make immediate improvements to community care, establish a single program for community care, and implement necessary business process improvements. The budget section of this plan is divided into three parts: (1) System Redesign and Solutions; (2) Hospital Care and Medical Services, including Dentistry; and (3) Expanded Access to Emergency Treatment and Urgent Care. System Redesign and Solutions include enhancements to the referral and authorization process, care coordination, customer service, and claims processing and payment. These changes are expected to improve the Veteran experience with community care. As a result, this may increase Veterans' reliance on VA community care, leading to increased Hospital Care and Medical Services costs. Expanded Access to Emergency Treatment and Urgent Care is important in providing Veterans with appropriate access to these services, but is severable from other aspects of the Program and could be implemented separately.

The incremental costs of the enabling System Redesign and Solutions for the New VCP are estimated to range between \$400 and \$800 million annually during the first three years. VA's community care programs (hospital care, medical services, and long-term services and supports) prior to the enactment of The Choice Act, cost roughly \$7 billion per year. Continuing the Veterans Choice Program, as amended, beyond its current expiration will cost approximately an additional \$6.5 billion per year, assuming no changes are made to its current structure (eligibility, referral and authorization, provider reimbursement, etc.). Improvements to the delivery of community care as described in this plan would require additional annual resources between \$1.5 and \$2.5 billion in the first year and are likely to increase thereafter. The proposed expanded access to emergency treatment and urgent care requires an additional estimated \$2 billion annually. Refer to the estimated costs and budgetary requirements (Section 5) and legislative proposal recommendations (Section 6) for additional information.

The estimated costs reflected in this report represent the funding required to maintain VA's delivery of community care at current levels, as well as incorporating the considerations outlined in this plan. Additional changes or expansion of the program beyond the scope outlined in this report could significantly increase the projected costs.

VA cannot reach the future state alone. Ongoing partnership with Congress will be critical to addressing the budgetary and legislative requirements needed for this

important transformation, including outstanding decisions on aspects related to sustainability and cost-sharing. The support and active participation of Congress, Federal partners, VA employees, VSOs, and other stakeholders are necessary to achieve more efficient, effective, and Veteran-centric health care delivery.

CONCLUSION

Transformation of VA's community care program will address gaps in Veterans' access to health care in a simple, streamlined, and effective manner. This transformation will require a systems approach, taking into account the interdependent nature of external and internal factors involved in VA's health care system. *MyVA* will guide overall improvements to VA's culture, processes, and capabilities and the New VCP will serve as a central component of this transformation. The successful implementation of the New VCP will require new legislative authorities and additional resources and will position VA to improve access to care, expand and strengthen relationships with community providers, operate more efficiently, and improve the Veteran experience.

Thank you. We look forward to your questions.

Chairman ISAKSON. Thank you, Secretary Gibson. We appreciate your testimony.

I want a short answer on this question. You said you made two changes. You announced two changes yesterday regarding the 40-mile rule and the services a veteran needed to expand Choice access, which were steps along the way toward accomplishing the long-term goal of consolidation. I think that is what you said.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. In one sentence, describe what that long-term goal is.

Mr. GIBSON. The long-term goal of consolidation of care is to improve the veterans care experience and deliver that at the best possible value to taxpayers.

Chairman ISAKSON. OK. In that case, when we had the field hearing in Gainesville, GA—I do not think you were there, though Secretary McDonald was kind enough to come—we had the, I cannot remember the name right now, but the Choice provider for the East Coast—

Mr. GIBSON. HealthNet.

Chairman ISAKSON. HealthNet attended, and a discussion ensued about the issue of an eligibility of a veteran to get services outside of VA through Choice. It was an arduous process, which includes file after file going to the third-party provider before they could determine getting the veteran the service. Is that still going on with the third-party provider? One of the things we want to see is easy access for every veteran to care, wherever it comes from—

Mr. GIBSON. Yes—

Chairman ISAKSON [continuing]. Whether it is you or whether it is a private provider. But this eligibility situation, which you used the word "eligibility" in your testimony a lot, is something that evidently is more cumbersome in practice than it is in words. What are you all doing to streamline that process so a veteran knows they are eligible and does not require a Philadelphia lawyer to figure out whether or not they are?

Mr. GIBSON. Let me ask Dr. Yehia to respond to the question, Mr. Chairman, and outline some of the things that we have already done to simplify that process.

Dr. YEHIA. Thank you for that question. I think eligibility and the referral and authorization process, which is the way that a veteran can actually access care in the community, they are two of the

foundational elements of the report. Really, the process of consolidation is to help streamline eligibility so there is not multiple programs, each with different criteria, that a veteran has to meet in order to access community care.

That is kind of what we outline here, is to develop a set of consistent eligibility criteria that is easy for the veteran to understand and easy for our community providers to also be able to administer and for our employees to deliver that care. That is from the eligibility standpoint.

When we talk about referrals and authorization, right now, that process is very cumbersome, just as you described, Mr. Chairman. There is a number of steps that our employees have to go through in terms of transposing information, uploading information, sending that over to our third-party contractor, steps that they go through before we can actually make an appointment for the veteran. That is too long, and what we are proposing here in the plan is to streamline that so that there is less redundancy, we are more automated and less manual process to actually accomplish that.

Mr. GIBSON. What we have done in the meantime, Mr. Chairman, is we have modified the contract with both of the third-party administrators, which now allows us to almost immediately send an authorization document to the third-party administrator that triggers a call from the administrator to the veteran. Instead of the veteran having to call the administrator, waiting several days before doing that and getting bounced back and forth between VA and the third-party administrator, the burden falls on the third-party administrator to reach out and make contact with the veteran to get the appointment scheduled, designed to simplify the experience and streamline the experience from the veteran's perspective.

Chairman ISAKSON. All right. I am going to try and phrase this question properly so I am expressing it properly. My ultimate vision for Choice was that a veteran had a choice to go to a doctor who could provide that veteran with the service they need whether they are a VA hospital facility or a private provider in the community. When you refer in here to consolidating your private providers in the community, are you talking about building a network within the community where you have a network of doctors that the VA has approved that the veteran can go to?

Dr. SHULKIN. Mr. Chairman, I think the name "Choice" was deliberate on your part. That is the way that we intend to do this. The first issue in this plan is to build a network of providers in the community, as you said, based upon high-quality criteria, to assure that veterans are getting the best care available anywhere in America, and then to allow that information to be transparent, so people have information on quality and metrics to be able to make educated choices. That would be the intent of the program.

This program does not specify that—how we do that, because this year, the first phase of it would be planning and designing how that system works.

Chairman ISAKSON. Well, it is the "how" that is so important, and that is what I am really trying to talk about here, and I am going a little bit over and I apologize and will be generous with time for everybody. I have a health care plan—

Dr. SHULKIN. Yes.

Chairman ISAKSON [continuing]. And I know which doctors in my community are eligible and which are not because they publish a book that says which ones are and which ones are not. I call them up, I make an appointment, and I go. It is a pretty simple process. Is that what you are looking at doing?

Dr. SHULKIN. That is the intent, which is identifying the high-performing network and then allowing veterans to have the choice into which providers they select, because it is not only the specific quality criteria that defines the interaction with a patient and a physician. It is actually the personal interaction, and that is very variable depending on how the veteran experiences the physician. We want to help guide veterans with the right information, let them see it and then allow them to make the choice.

Chairman ISAKSON. The last extension of my time, and I will not ask any more, but do you ultimately envision the third-party conduit they have to go through going away because you have an approved network, list of doctors that they can go to, and the veteran knows they are eligible and they just make the appointment themselves and go and you remove that middleman?

Dr. SHULKIN. What we are trying to do in this planning process, what we call phase one of the contract, is to evaluate how do we simplify the process to allow this to be veteran-centric, something today that I think you suggested we are far away from because there are too many hoops to jump through, and in each one of these design phases, we are going to be doing a “build/buy” decision. What is the best thing for the veteran? What is the best thing for taxpayers?

The role of outside organizations helping us is still uncertain until we go through that process and decide. Is it better to essentially build or eliminate processes, or is it better to seek external help? And one of the things that we have recognized is, is that VA does not always do this internally that well. We are open to the answer being that we need help to do this. But, we want to have the discipline of going through every step and deciding, should we build this or should we buy this?

Chairman ISAKSON. Thank you, and I apologize for going over.

Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

I would like to pursue the question I raised during my opening remarks about protecting consumers and patients. What kinds of mechanisms and standards will be in place to assure that protection?

Dr. YEHIA. I think that is an excellent point. What we are proposing in the plan is the first step to get to consumer protection is to actually have the necessary information on the providers in the network, their performance, so that we can make sure that consumers or patients have the information they need to make important decisions. Right now, that is actually critically missing. We might have local information at the medical center level, but regionally and nationally, we do not have the necessary data to determine the quality of care or the health care utilization—

Senator BLUMENTHAL. Where do you get that data?

Dr. YEHA. That is exactly what we are asking for in some of the \$421 million in phase one, which is to build a network where we can actually gain that sort of information, those analytics.

Senator BLUMENTHAL. Okay. What kinds of mechanisms will you put in place to assure that there is education of those patients, and number 2, that there is a way for them to bring complaints to bear?

Dr. YEHA. I will answer that in two parts. What is articulated in the plan is a robust customer service function, which is we want to make sure that we are able to get complaints or compliments or issues raised not only from veterans, but also from community providers. Most health plans that function very well have a beneficiary arm as well as a provider engagement arm. We want to make sure that there are avenues to be able to communicate two-way between our customers, our patients, as well as our community providers that serve them.

In terms of the specific details, we are starting the process now of developing implementation plans and milestones and really working out those exact details on how to do that—

Senator BLUMENTHAL. Is that the Veterans Experience Office that will be a center point or a core function?

Dr. YEHA. The Veteran Experience Office is Department-wide, part of the MyVA initiative. They are critically part of our team that is rolling this out. Yes, there is a role for that. I think we are welcome and open to discussing with you and your staff other opportunities that we can have to make sure that there are safeguards for our patients in the network.

Senator BLUMENTHAL. I would want to pursue that. A lot of subjects to cover here, so I cannot do it right now, but I do want to pursue that set of issues.

I was struck to learn that VA data shows a loss rate of nearly 9 percent for physicians and 8 percent for nurses in the fiscal years 2014 and 2015. In each of those years, the VA lost about 6,000 physicians and nurses combined. Presumably, many of them would have played a key role in the coordination of care in the community. They are now going to be out in the community, presumably. What can be done to keep those people within the VA so that their care is, in fact, provided by the VA? The majority of the staff losses for physicians and nurses for the two fiscal years 2014 and 2015 were due to staff who quit. I also was struck to learn that the VA has about 336 buildings that are vacant or less than 50 percent occupied.

Given that the VA trains about 70 percent of our physicians nationally, which is an impressive number, 70 percent nationwide, do we not run the risk of not being able to train enough medical professionals to work in both the private sector and the VA?

There are really two related questions. We are losing staff, we are underutilizing buildings. Can we continue to provide quality care within the VA, and can we continue to train?

Dr. SHULKIN. Senator, a lot in those questions, so I will try to be brief in my answers.

Senator BLUMENTHAL. And you can supplement it.

Dr. SHULKIN. Absolutely.



Senator BLUMENTHAL. I recognize this forum is only a kind of introductory means to answering some very profoundly important questions.

Dr. SHULKIN. I appreciate that and we will take you up on that.

Your issue about consumer rights, very important issue, very, very big in health care, and I would just very briefly say, the rest of health care, the private sector is dealing with this by no longer trying to be paternalistic and make choices. You make information available and you let people decide what is best for them, and I think Senator Isakson was also talking about this, as well.

On the issue of losses, the 6,000 physicians and the nurses and other staff that we lose, each one of those people that leave the organization that should not be painful for us and we have to figure out ways to retain people. Morale is lower than we want in the organization and we absolutely have to address it. It is one of my priorities as Under Secretary, to address that issue.

But it is not all bad news. Between August 2014 and October 31 of 2015, this period you are talking about, we had a net increase of 1,692 physicians and a net increase of 3,508 nurses. So, while we are losing and we have to address that, we are actually hiring more and having a net increase which is helping us deliver care.

On the issue of training, the role of education, medical education, nursing education, psychologists, social workers, pharmacists, VA is critical for American medicine. We cannot lose that mission. We cannot lose that role. We have to be able to keep a strong clinical environment to train America's professionals.

We do have vacant space, and part of our plan identifies savings, another issue that you had talked about in your opening statement, the cost. Some of the savings will come from rightsizing some of the space that we do not need, but it is not going to be at the expense of us training America's health care professionals.

Senator BLUMENTHAL. Well, I really appreciate those answers and the answers that you will give in follow-up. I really think this area is critical. Training our Nation's physicians is one of the premier public service functions of our VA system and it is a pillar of American medicine. The talk around here is often of accountability and cracking down on bureaucrats who may be incompetent or corrupt, but we also need to focus on keeping the good people, the good doctors and nurses and pharmacists and clinicians in the VA, because they are going to be critical to American medicine in training but also in caring for our veterans. Thank you for your answers.

Chairman ISAKSON. Senator Moran.

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

Senator MORAN. Mr. Chairman, thank you and Senator Blumenthal for this hearing. Thanks for the panelists for joining us this afternoon.

Under Secretary Shulkin, is it your responsibility to implement the Choice Act? First, welcome to the VA. Thank you and congratulations—

[Laughter.]

Senator MORAN [continuing]. Congratulations on your confirmation. Glad to have somebody rowing the boat. But, Choice Act becomes your responsibility, or is?

Dr. SHULKIN. Yes, it is.

Senator MORAN. Deputy Secretary Sloan Gibson and I have had a history on this topic and I am going to try a fresh face and go at this again. [Laughter.]

I have had a goal of seeing that the Choice Act is, in my view, appropriately implemented, and part of my interest in this certainly comes from the demographics, the geography of Kansas, lots of territory, lots of distances. Choice can be a significant asset of great value to veterans across our State.

My original complaint with the implementation of the Choice Act by the Department of Veterans Affairs was this issue of whether it mattered if the CBOC provided the service that the veteran needed. If it does not, does it count as a facility under the Choice Act? We have had this ongoing discussion.

I offered legislation that passed the Senate that said if the veteran cannot get the service he or she needs at the CBOC, it does not count. That legislation is pending in the House of Representatives, but I was encouraged, perhaps convinced by my colleagues in the House and perhaps here in this Committee that there was another approach, and that was to define what a facility is based upon the full-time nature of the staff there, in particular, a physician.

Legislation now in law says that it requires for a facility to be counted under Choice that there be a full-time physician at that clinic. I was always worried about whether or not the VA would interpret that in some way contrary to what common understanding would be, at least my common understanding. I had assurances from VA personnel and staff, certainly on the House committee, that a physician would be required to be at a facility on a full-time basis, which was 40 hours.

Now, even as recently as 2 weeks ago, I think that was confirmed to me by two of the panelists who were in a meeting with my staff in Senator King's office. Then yesterday, you report different language about what this now means.

What came out yesterday is that the interpretation is completely different than what I was assured it would be and it says multiple physicians, not one, equivalent to 0.9 FTE maxing 36 hours.

I think the language is clear. It does not say "physicians." It is not plural. I would like to hear how we got to the point that we now appear to be and to see if there is something we can do about that.

Let me bring this back to Kansas. Long before Secretary Gibson, we have been trying to recruit a physician to a CBOC in Liberal, KS, the southwest corner of our State, unsuccessfully for years. I appreciate that Secretary Gibson, in his effort to solve that problem, determined in a letter to me in July 2015 that the Liberal CBOC would not count as a facility under the Choice Act and that veterans who were receiving care there could have community services.

This is the issue we continue to face, in part based upon how you define what a full-time physician is, but also, why do the veterans

who live in areas other than Liberal not get the same kind of standard for whether or not the CBOC counts or not?

For example, Emporia, KS—it is a community in the Flint Hills of our State, 25,000 Kansans, several thousand veterans—it is open 1 day a week. It counts as a facility. Seneca is open 1 day a month. It counts, and, in fact, the VISN is now closing Seneca's CBOC so that it no longer counts. The reality is, it should not count in the first place if it is open 1 day per month.

Is this just confusion within the VA or is there a solution so that the veterans who get the benefit of outpatient services at Liberal, it is true regardless of where you live in Kansas or across the country?

Dr. SHULKIN. OK. Well, thank you. Senator, first of all, there should not be a difference between what you want and what the VA wants—

Senator MORAN. Let me first of all say, I do not want you to take away Liberal's benefits to make that come true.

Dr. SHULKIN. No. Right. OK. [Laughter.]

We want the same thing, which is, particularly in rural areas where there is a severe shortage of providers in general, we want to have as much access to care as possible. That is the goal. I think this difference of interpretation—which you learned about just a short time ago, and I, as well—this difference of interpretation is really a well-meaning difference that I believe we can work out.

Our belief is, the way we were interpreting this—or I will speak for myself—is that we want to have a full-time physician, a provider of 0.9 FTEs. In rural areas, in particular, we find that it is sometimes easier to recruit part-time physicians rather than full-time physicians. In our view, two part-time physicians that add up to keeping that office open 36 hours a week is what is in the veteran's best interest.

As you may know now, about 20 percent of physicians in this country work part-time. For women physicians, it is actually higher, up closer to 35 percent. We are trying to staff these clinics in the best way possible, and so that is our intent, which is to provide that—the office open 36 hours in whatever setting.

In terms of the clinics that are open 1 day a week, that should not count. If they are not open with a provider for the 36 hours, the 0.9 FTE, that does not count.

Dr. YEHA. And they do not count, if I may.

Senator MORAN. Yes.

Dr. YEHA. The CBOC, actually, the definition of a CBOC, they have to provide a certain volume of primary care and mental health care. There has to actually be open daily and they have to be able to provide that level of service.

There are a number of categorizations that we use for those clinics that are only open 1 day a month or a couple days of the week, and those are not actually used in the calculation of the 40-mile criteria. I actually have a listing from VISN 15, and Liberal and Seneca and Emporia that you mentioned are not used to judge the 40-mile geographic criteria.

Senator MORAN. My time has expired, but that is interesting, because the CBOC in Seneca is being closed for the stated purpose

of making certain it does not count as a facility under the Choice Act.

Dr. SHULKIN. The Seneca—as this was recently presented to me, because I do not like closing facilities that serve rural areas, I think that that is of concern—the Seneca example is that there was such a small number of veterans, like 100 veterans, that our doctors coming from the larger medical center were actually spending a day traveling there and potentially a day back of which they were not practicing during that time. We felt we could better serve Kansas veterans by actually potentially closing that one clinic and using community providers.

Senator MORAN. I only raise Seneca as the example of where the VA has determined, as I understand it from the folks at home, that it has to be closed so that those veterans can access care within the community.

Under Secretary Dr. Shulkin, your definition—maybe you are right about how we are going to have to attract physicians and they are going to be more likely to be part-time than full time, and to fill that gap, particularly in rural places, that is necessary. But I would again make the point that the law says what it says and the conversations that we have had over a long period of time confirm that. Whether you are right or wrong, whether veterans can get better care by a different definition, I think that is a matter that Congress needs to deal with. It is outside your rulemaking authority to go beyond what the law says. Thank you.

Chairman ISAKSON. This is a very important point, so I am going to follow up with a question on this. You made two changes that you announced yesterday in the Choice Program. Would you read the second one again in your testimony, Sloan? You said you announced two changes of veterans Choice eligibility. [Pause.]

Mr. GIBSON. Second, when qualifying veterans for the Choice Program, we are now taking into consideration the nature of the care they need, how often they need it, and whether they need someone to accompany them. If a veteran just needs a flu shot or if they need a round of chemotherapy every 2 weeks or so, they may now qualify for Choice no matter where they live.

Chairman ISAKSON. Here is my follow-up question on Seneca and Liberal. Seneca is part-time. Liberal is semi-staffed, is that right?

Senator MORAN. No physician.

Chairman ISAKSON. No physician. You have a Kansas veteran who needs health care service and cannot get it at either one of those facilities. Why are they not eligible now to go to a private doctor?

Mr. GIBSON. They are already, from both locations. They already are.

Chairman ISAKSON. So, what am I missing?

Senator MORAN. I think you are missing that—you are not missing anything, Mr. Chairman. Excuse me for suggesting that you are. [Laughter.]

That is not the way it is being implemented.

Chairman ISAKSON. Well, that is what I am referring to. I mean, I am a pretty simple guy, but when you read what you read, it told me if I was a Kansas veteran and I needed chemotherapy or I needed a regularly scheduled 2-week appointment or I needed

whatever, and neither Seneca nor Liberal offered it, I ought to have Choice accessible for me to go to a private doctor in Liberal or in Seneca—

Mr. GIBSON. Here is what I would like to do to get clarification here. What we will do is we will go to the 40-mile roster, the list of veterans that are eligible for care under the 40-mile rule. We will look specifically at Seneca and Liberal and wherever else you want us to look and we will print you the list of the names of the veterans that show up on that 40-mile list, because we know who is eligible for care under 40 miles. We know that already today, now. We will do that and provide it to you, and then we can figure out whether or not those veterans are actually accessing care in the community.

Chairman ISAKSON. I am going to continue on this one more second, because I am slow. In the case we just talked about, 40 miles is irrelevant. I mean, if you are within 40 miles but you cannot get the service that they need, they ought to have Choice. If the clinic is not open or it is not available, they ought to have Choice to go, as well. Period, end of sentence. I thought that is—

Mr. GIBSON. That is the interpretation that we have applied on part-time clinics since we launched Choice. But, we will go print out the list of veterans on the 40-mile list and we will look for those from Seneca and wherever else, whatever communities in Kansas you would like for us to look for and determine who is actually using 40-mile eligibility. That is the way it works today, not tomorrow, but today and yesterday.

Senator MORAN. Mr. Chairman, there are nine CBOCs in Kansas that do not have a full-time physician that are still listed as facilities and veterans are being told that they live too close to a facility to access Choice care.

Chairman ISAKSON. Which is wrong.

Mr. GIBSON. It is wrong, and if that is the case on the ground, we will fix it.

Chairman ISAKSON. Because whether it is Hartford, CT, Macon, GA, or Liberal, KS, if a veteran cannot get the service from the VA and Choice is operable, which it is, they ought to be able to choose a physician that can deliver the service to them in their—

Mr. GIBSON. Absolutely, yes.

Chairman ISAKSON [continuing]. Without having to get a Philadelphia lawyer to negotiate it.

Mr. GIBSON. They do not have to go through anybody to do that. They get their appointments—

Senator MORAN. Mr. Secretary, your letter to me of June or July was very appreciated and it, in fact, reinforced how I thought Choice should be interpreted in the first place.

Mr. GIBSON. Yes.

Senator MORAN. Your ability to do that in Liberal is just what we want to have the ability to do everywhere else. And what you are telling me is that is now the case.

Mr. GIBSON. That is now the case, yes, sir. And if we are not executing that way, shame on us. Bad on us.

Senator MORAN. Thank you.

Chairman ISAKSON. I have taken the additional time because Senator Tester was out of the room and he would have been asking those questions if he had been in the room. [Laughter.]

But I wanted to make sure that people from Kansas and Montana, Connecticut, Georgia, and Washington State, and everybody knew that we believe the intent of Choice was if a veteran could not get service from a VA facility, they got to go to Choice in their area closest to them to get the service, period, end of sentence, without problems with definitions and things like that. If we are talking about consolidation to provide Choice and make it meaningful for our veterans, that ought to be the ultimate goal where we go.

Senator TESTER. Especially the folks in Liberal, KS—  
[Laughter.]

Chairman ISAKSON. Who voted for Jerry Moran.

Senator MORAN. [continuing]. Liberal, KS—

Chairman ISAKSON. Senator Hirono.

#### **HON. MAZIE K. HIRONO, U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you. I thought I was hearing wrong when the Senator talked about Liberal. I was thinking on a political continuum, but, obviously, that is not what we are talking about. [Laughter.]

I am looking at your testimony, Secretary Gibson, and I would like to make sure that I understand your testimony. Looking at page three, you say that this consolidation plan, or the new VCP, will center on five functional areas, and you list the five functional areas. Then, going on to page five of your testimony, you say that—I assume that, again, we are talking about the new VCP—will involve enhancements to the following systems, which you list one, two, three, four, five systems. Are the enhancements to the five systems in alignment somehow with these five functional areas that you identify? Is that how your testimony is to be read?

Dr. YEHA. It is—

Senator HIRONO. It is a little bit confusing, I might say.

Dr. YEHA. Yes. The way that it is presented is in these five foundational areas that really trace the veteran's journey through community care. We start with eligibility, go to referral and authorization, the providers that they see in the network, how they coordinate care, and then kind of the back office function of claims. That really maps a veteran's journey.

Then when we are writing out the way that we should approach implementation and how we should think about system design, we use what is called "a system of systems" approach, where we looked at what the different systems are that touch these five cornerstones, and those are the systems you see there.

One is customer service, which is how do we improve customer service for veterans and community providers.

One is for care coordination: how do we improve coordination of care, including IT systems.

One is administration, so that deals a little bit with eligibility, the referral and authorization process.

The next one is the network, which is how do you actually build a network of providers that can deliver the needed care to veterans.

And then last is kind of how do you operationalize this? How do you implement it? That gets into the governance structure, both nationally and locally. How do you get data so that we can make sure that we are tracking and monitoring things correctly?

They are very related. They do not overlap a hundred percent. One is the foundational building blocks of the plan and the other one is the systems that we need to use to actually implement the plan.

Senator HIRONO. We know that when we are talking about the VA health system, we are talking about a vast system, and it is all very complicated. For the individual veteran to navigate his or her way through the system is really a challenge. While it sounds really good the way it is described, each of these systems that you seek to enhance could take a whole lot of effort to even figure out how to do it.

I am wondering what your timeframe is, because you asked for over \$420 million just to design what you are going to do with these one, two, three, four, five enhancement systems that you are going to look at.

Dr. YEHIA. I think you are accurate that this takes time. This is not something that we can just switch on and be able to implement completely. In fact, there really needs to be close collaboration with this Committee and Congress to be able to get certain legislative relief and resources to do that.

With that said, the way that we are designing implementation and the transition plan to carry out some of this work is not, you know, in 3 years to have some big grand reveal—

Senator HIRONO. Yes.

Dr. YEHIA [continuing]. Of, like, here is the program—

Senator HIRONO. No, we all get that it is going to be quite complicated—

Dr. YEHIA. Yes. It is iterative.

Senator HIRONO [continuing]. One of the aspects that you are really focusing on is the outcomes, and so that is a whole huge system or process that you have to develop to figure out whether we are actually getting the best bang for the buck.

Part of what your testimony, Mr. Gibson, says is that this would not be possible without approval of requested legislative changes, and I was trying to look in your testimony to see if you have some very specific legislative changes that you are requesting. Is it in your testimony, requested legislative changes?

Mr. GIBSON. The legislative changes are not incorporated into the testimony. They are incorporated into the plan document—

Senator HIRONO. OK.

Mr. GIBSON [continuing]. And they have been briefed and discussed with Senate staff.

Senator HIRONO. Because I would hate for us to appropriate \$421 million for you to develop a system and then it cannot ever be implemented because these other legislative changes that you say are integral to the changes you are talking about do not happen, and I want to give an example.

For example, when Secretary Gates and Secretary Shinseki said that they were committed to making sure that the medical records of the active duty and the veterans would become integrated, and

after a billion dollars plus, we still do not have it. That raises in my mind some concerns I have about this undertaking and what kind of resources it is really going to take for us to implement it. Worthy goals, but I think we are going to be working very closely with you all to make sure this happens. I do not know whether this is biting too much—

Dr. YEHA. If I—

Senator HIRONO [continuing]. From the outset. What would your priority be within these areas that you are designating? I am going over, but, Mr. Chairman, you gave us leave, so there we go. [Laughter.]

Chairman ISAKSON. I broke the rule, so go ahead.

Dr. YEHA. Thank you, Senator. I just wanted to clarify. When we were talking about systems, they are not necessarily, like, IT systems or systems that would be built by VA. There may be a combination of improvements to existing systems, enhancements to ones that exist, solutions that we might purchase from the private sector. The word “systems” is just a term to describe, for example, customer service or care coordination. It does not necessarily mean there is a platform.

Senator HIRONO. OK.

Dr. YEHA. It is just the actual area of work.

Dr. SHULKIN. I would just add, to be very specific, Senator, the \$421 million that we are requesting from 802 funds, not new additional monies, would be to fix the problems that currently exist in the Choice Program. This is to make the veteran experience better that we know is not working well for veterans.

The biggest part of that, \$300 million of the \$421 million, is to build what we could call a veteran portal, a place where veterans can go, get the information on their care, have it coordinated with care from the private sector and the VA. Without effective information sharing between the private sector and the VA, this plan cannot work and it will not work for veterans. That is the majority of that money that we are asking—

Senator HIRONO. When you say this plan, are you talking about the Choice plan?

Dr. SHULKIN. The new Choice plan, the plan that we have delivered to you, the new Veterans Choice plan, about how we are going to work better with the private sector, needs to have effective care coordination and information exchange, and that is really the majority of the \$421 million.

Senator HIRONO. I think we just want all of this to actually happen. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Hirono.  
Senator Rounds.

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

Senator ROUNDS. Thank you, Mr. Chairman.

I would like to follow up on what the Senator from Hawaii is speaking about with regard to the portal itself and the plan on how you would implement it. I am curious. Are you planning on using internal resources to accomplish this or will you be using a third party to actually create the enhancements to existing software? How do you plan on doing this?



Dr. SHULKIN. The first part of the plan, Senator, is to identify the systems that we want and then make a build/buy decision. We do not have an answer to this now. I will tell you, though, that our experience, and we are often reminded about this from Members of Congress, about building all these systems ourselves is not always the best. We are going to be very open to, if this exists in the private sector, if we can buy this off the shelf, because time is of the essence and execution is more important, we are going to have the intellectual integrity to make that choice.

Health information exchanges, another word for portals, are very, very robust now. They are out in the community. Many private sector institutions that I have been affiliated with have functional HIEs, health information exchanges. We are certainly going to look at that option.

Senator ROUNDS. I am one of those skeptics, and I guess the reason why I bring up the discussion is that I think there is no reason for the VA to try to reinvent the wheel if it already exists. I would expect that there would be the opportunity within the private sector to find competitive proposals that are out there in terms of quality and cost. So, I think what I am asking today is, is that the primary approach you would use, or is that going to be the fallback position with the intent to look internally first?

Mr. GIBSON. I would tell you, with our new Chief Information Officer, LaVerne Council, who comes to us from Johnson and Johnson, where she had the same position, her bias on every system is to go commercial off the shelf. That is the default position that we take until we have determined that we are unable to do that.

Senator ROUNDS. Very good. How about with regard to the discussion about the providers and the provider networks that are out there right now currently? I believe in your early testimony, Mr. Secretary, you indicated that the providers already included would include, and I believe you said Medicaid, individuals who are eligible for providing services through Medicaid. Is that correct, or—

Mr. GIBSON. One of the changes that Congress passed recently, at our request, was that the original Choice Act required us to only use Medicare-qualified providers, and if you stop and think about it, there are some—say, obstetrics, for example—you are not going to find any Medicare providers in that space.

Senator ROUNDS. Correct.

Mr. GIBSON. We asked to open the aperture on providers to include Medicaid providers to allow us to reach into some of those other specialties.

Senator ROUNDS. Now we would be talking about not only Medicare providers, but also Medicaid providers, to all be currently eligible as qualified providers under your guidelines?

Dr. YEHIA. Those providers, you have to be—if you are a Medicare provider or a Medicaid provider, you meet that standard and then you would have to join the network. A veteran cannot go to any specific Medicare or Medicaid provider right now. They would have to use the network providers, which are made up of those type of doctors.

Senator ROUNDS. I do not mean to cut you off, but I am going to try to keep closer to a timeframe here in deference to the Chairman. If you have an individual who, though, is identified as being

a quality provider through Medicare or Medicaid, the option then becomes theirs to make a decision whether or not to join your network and not a matter of stepping through another hoop provided by the VA for determination of eligibility? It would be the providers' decision?

Dr. YEHA. Let us say there is a doctor that takes Medicare or Medicaid in the community but they are not part of the network. They can actually go to our contractor and say, I want, you know, Dr. Smith, and our contractor will reach out to Dr. Smith, give him a provider agreement to sign, and they would become part of the network and that veteran can go to that doctor.

Senator ROUNDS. Fourteen months ago, there was a concern that you were using outside vendors to provide for those networks. Today, as I understand it, you are looking seriously at doing your own network itself. Why would you now have the expertise to do it yourself if 14 months ago you did not? I am curious.

Dr. SHULKIN. I do not think we have made that decision, Senator. I think this is another example of we are going to look to what is available in the private sector to help us with that and we are going to look whether if we cannot get that, then we would have to look internally, but we have not made that decision.

Senator ROUNDS. Do you intend that the provider networks also include optometrists?

Dr. SHULKIN. Yes.

Senator ROUNDS. That would be a major change, then, over what it is today.

Dr. SHULKIN. We have optometrists in our network.

Senator ROUNDS. I understand, but in many cases, you have licensed optometrists in communities where at this stage of the game, they have not been found eligible until they have been approved by some sort of VA determination up front. I have actually had veterans who have gone in, gone to their own optometrist in a town like Pierre, South Dakota, and then when they go to get their eyeglasses, they are told, I am sorry, but you do not have a qualifying optometrist giving you this information, so we are not going to give you your eyeglasses. What I am curious about is, included in this in the future will be an opportunity for optometrists to be included in this same category of providers?

Dr. SHULKIN. Umm—

Senator ROUNDS. Medicare or Medicaid eligible—

Dr. SHULKIN. I do not know the situation that you are referring to. We would be glad to track that down for you, by the way, but—

Senator ROUNDS. It took this veteran 6 months to get a pair of glasses.

Dr. SHULKIN. Yeah, and that should not happen. We do need to have a contractual relationship with a provider today for us to be able to exchange money with them.

Senator ROUNDS. In this case, they were not asking for any money.

Dr. SHULKIN. OK.

Senator ROUNDS. All they wanted to do were to get glasses through VA—

Dr. SHULKIN. Fill the glasses—

Senator ROUNDS [continuing]. And they would not accept the prescription from that optometrist—

Mr. GIBSON. That is inappropriate.

Senator ROUNDS [continuing]. A qualified optometrist.

Dr. SHULKIN. Yeah.

Senator ROUNDS. We are not going to see—you would see this as going away, if this happens?

Mr. GIBSON. That makes no sense.

Dr. SHULKIN. We are going to have criteria to get into the network, and once you are in the network, once you are accepted into the network, we want all those paperwork authorizations to be minimized.

Mr. GIBSON. But, I think the very simple example here is a veteran has a prescription for his eyeglasses. He wants to come to VA to get his prescription filled. He ought to be able to do that right this minute.

Senator ROUNDS. That is right.

Mr. GIBSON. No reason why that should be happening like that.

Senator ROUNDS. That is the way we saw it, as well.

Mr. GIBSON. Yes.

Senator ROUNDS. In fact, we offered to go and pick up the eyeglasses for the veteran and that would not work, either. I am happy to hear that you are—it sounds like you are on the right track. Hopefully, we will get this resolved.

Mr. GIBSON. Unacceptable.

Senator ROUNDS. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Murray.

#### **HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, thank you very much, Mr. Chairman. Thank you for having this hearing.

Secretary Gibson, I wanted to ask you, some of the proposals out there would have the VA health system provide only some of the so-called VA specialties, like PTSD or TBI treatment, and get the VA out of the business of doing some things like primary care and rely just on the private sector for that type of care. That may be concerning to veterans who want to use the VA facilities, and cutting out that much work, I think could have serious consequences for our VA hospitals and our providers.

I wanted to ask you, can you talk with us about some of the impacts of taking away some of the fundamental lines of care.

Mr. GIBSON. Yes. Ma'am, I would tell you, at the very heart of what we must preserve is primary care. I would tell you there is no other organization that integrates mental health care, large health care organization in America that integrates mental health care into primary care the way VA does. So, I think primary care will always be a mainstay of VA health care.

I think as we get into other situations—we have talked about make versus buy decisions in the context of different administrative parts of running this program. I think over a period of time, we wind up, if we are doing our job, we wind up getting into make versus buy decisions elsewhere. It is interesting that we talked about optometry, for example. You can get eyeglasses anywhere. I mean, there are optometrists anywhere. So, I think at some point

and in some locations, we are going to have to make a decision. Are we better off continuing to use our scarce space and our scarce resources to deliver basic optometry services, or do we refer that into the community where veterans can get a good service at good value that is very convenient for them.

I do not see any of those kinds of core services—spinal cord injury, Traumatic Brain Injury, polytrauma—I have got to tell you, we were in Tampa a couple of months ago and Rich Carmona, Dr. Rich Carmona, the former Surgeon General of the United States who saw what we were doing in polytrauma there said, “Do you realize, this is world class? This is not just best in class in America. There is nobody in the world that is doing what VA is doing in polytrauma.” We are not going to sacrifice that for our veterans.

Senator MURRAY. OK. I also wanted to ask you about emergency care. It is really important that this program reform emergency treatment to be more permissive in allowing our veterans the use of emergency care or urgent care. However, as I look at your plan, it seems to require veterans to pay a copay of up to \$100 no matter what. I am kind of amazed that we would ask our veterans to pay for care for service-connected conditions. That is a major reversal of a fundamental tenet of our care for veterans. Can you comment on that?

Dr. YEHIA. Sure. Thank you for that question. We agree with you that there needs to be fundamental reforms to the ER system right now. Because of various rules and regulations and laws, we deny about a third of ER claims. Today, when a veteran goes to the ER, if they were not able to get preapproved by VA or they bypassed a VA, they could end up getting stuck with a bill that is way more than \$100, on the order of thousands of dollars. As a result of that behavior, right now a lot of veterans end up deferring ER care, and so they end up driving to the VA or waiting for our doors to open to be seen and that is really creating the perverse incentive.

What we were trying to do here is to be able to responsibly address the management of ER care. What we propose is removing all those different restrictions so that a veteran can feel comfortable that when they go to the ER, they will get seen and VA will be able to pay the bill.

The idea of cost shares is really modeled off of health plans in the private sector and TRICARE, which is we do not necessarily want everyone to go to the ER for, you know, the sniffles or if they have a paper cut. We want them to be able to call their primary care doctor, have that dialog, and hopefully be seen—

Senator MURRAY. Even for service-connected, though?

Dr. YEHIA. Regardless of service-connected or non-service-connected, those are the same issues. If you only have a little cold and need to be seen by your primary care doctor, we want to expedite that so you get seen in the VA or by your primary care physician in the community rather than going to the ER.

There are many different ways that we can do it. If we remove that cost share, that is something that, I think, is up for discussion. I just would say that the actual cost of that program would be well more than what we outlined in this plan.

Senator MURRAY. OK. Well, I think we have always told our veterans we would care for them for service-connected issues. This

would be a major reversal of policy if we are all of a sudden charging them a copay for emergency visits.

Dr. YEHLA. I think part of the problem—

Senator MURRAY. Service-connected.

Dr. YEHLA. We have a third of claims that are denied even for service-connected claims. Even the system, the way that it works today is if you do not follow all these different rules and regulations that are in place, even for a service-connected condition, they get stuck with a very large bill and ambulance bills. We were trying to find a way to be able to sustainably be able to manage and address that issue.

Senator MURRAY. OK. I am out of time, but I did want to ask you, Secretary Gibson, how are you going to make sure that the care veterans receive in the private sector is high quality, timely, and coordinated? How do you do oversight of that?

Mr. GIBSON. This is where we are going to have a comprehensive set of quality measures, of metrics, both outcome metrics and process metrics to be able to measure, and the advances in outcomes measurement and quality measurement, actually my area of training, has become so sophisticated that VA has data sets that really are unparalleled by any health system in the country that we can produce this type of data.

Senator MURRAY. I am sorry, I am out of time, so I will follow up with you separately.

PREPARED STATEMENT OF HON. PATTY MURRAY

Thank you, Mr. Chairman, for holding this hearing and thank you to the witnesses for appearing here today.

I think everyone in this room agrees that our country has a duty to do everything it can to care for its veterans.

Unfortunately it is clear that our Nation is falling far short of its duty to honor our veterans when it comes to providing timely, high-quality VA health care.

A year ago we passed sweeping legislation, which in addition to creating the Choice Program, was intended to tackle the most pressing problems and give the VA new tools to address some of its longstanding challenges.

Unfortunately, despite these efforts I continue to hear from veterans across my home state of Washington that they have to wait too long for care. And when they do receive the care they need, it's often inconsistent or unclear what they should do next.

As the daughter of a World War II veteran, I refuse to let substandard care be the status quo.

VA is operating many different programs so veterans can receive care outside of the system. But none of them are coordinated or consistent. It's a mess that is impossible for VA to administer, much less for veterans to understand and use.

After hearing from so many veterans in my home state, I knew this problem could not be ignored. So more than one month ago, I spoke on the Senate floor to urge the VA to create a new plan for non-VA care for the future.

I called on my colleagues to help me help the VA build a program that is veteran-centered and one that would address growing bureaucracy—and tackle problems with leadership, staffing, and massive capital costs.

I also urged the VA to ensure that any new plan is easy for veterans to understand and access. That means it must have clear eligibility, as too many veterans have been unsure what they qualify for and when they can be referred to the community for care.

It is essential that any final plan to consolidate care ensure that there are simple and consistent procedures for providers to deliver care and get reimbursed quickly.

The new plan must also ensure high quality care for veterans. This includes oversight and coordination of care.

A new system must be flexible enough to meet local needs and use non-VA providers to fill in the gaps that VA can't meet.

And the new system must be cost effective and fully resourced. VA nearly ran out of money and would have had to shut down the entire health care system earlier this year. That can never happen.

So VA's plan that we are discussing today asks many of the right questions, and recognizes the importance of each of those criteria I outlined. But I have some concerns, and we're going to need to make changes.

And, as VA looks to implement their new proposal, it must be clear with Congress about what it needs to effectively implement the new non-VA care system and ensure our veterans are getting care.

Veterans deserve a system that works, not one that is torn apart and weakened over time. So, the answer isn't just to dismantle the VA and leave veterans to fend for themselves, as some proposals would do.

It's important that we are having this conversation today—about what is going on at the VA and what the problems are. But it needs to be followed by a plan that pursues an “all of the above” approach.

So we have a lot of work ahead of us as we evaluate VA's new plan to make sure it meets all of those criteria. With the demand on the VA only continuing to grow, this is a pivotal moment in deciding how we provide care for veterans.

We need to get this right. And I look forward to working with all of you on this important task.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Cassidy.

**HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA**

Senator CASSIDY. Thank you, Mr. Chairman.

The data sets the VA has look at quality measurements. Those are for VA physicians. But Senator Murray asked about your outpatient. Are you going to construct that same data set for outpatients?

Dr. SHULKIN. Yes, you would have to. If you want to have an integrated system of care and seamless between private sector and VA, you have to collect those measurements. Part of the high-performance network—

Senator CASSIDY. I accept that.

Dr. SHULKIN. OK, fine.

Senator CASSIDY. And limited time.

When the Chair asked you earlier, I think it was he. He spoke so long, it could have been he almost certainly—

[Laughter.]

Senator CASSIDY [continuing]. In regards to the metrics, you mentioned, as well, some qualitative measure of how the patient interacts with the physician. That is not defined currently by anyone, so you are apparently going to do surveys of the patient to see their satisfaction with a particular provider.

Dr. SHULKIN. Well, we do surveys. That is part of outcome measurement systems. But, what I was referring to the Chairman is this is like dating. You know, you do not know what that attraction and that magic is—

Senator CASSIDY. I accept that. So, you need a certain in—

Dr. SHULKIN. Right.

Senator CASSIDY [continuing]. It is going to have to be a robust data set.

Dr. SHULKIN. Yes.

Senator CASSIDY. Now, at the risk of just sounding like a sour lemon, I have asked for data before from the VA on data that was specific to the New Orleans VA and I was told that you could not segregate it from the aggregate.

Dr. SHULKIN. Not true, and I apologize. We will get you whatever data you need. We can absolutely segregate it for that VA and we have robust metrics.

Senator CASSIDY. Second, I went recently to a very well run, basically cross between a staff model HMO (health maintenance organization) and an IPA (independent practice association), which is what you are aspiring to, but much smaller and much more able to bring every physician in and counsel her or him. They found their data systems very difficult to—they are very successful, but they are nowhere approaching the goals that you are putting.

Now, it gives me pause when you suggest to us that you can achieve that when a much smaller organization has been unable to do so with a more homogeneous set of providers. Any comments on that?

Dr. SHULKIN. First of all, I would very much appreciate being put in touch with them so we could see what they are doing and learning. But, as you know, my experience is from the private sector where I have built these systems. I have done this before, where we do have metrics. These are not perfect metrics; I am not suggesting that they are. They get better every year and they will continue to get better. I believe VA has the capabilities to actually lead in this in American medicine.

Senator CASSIDY. But, for the data to be worth anything, the physician who is seeing the patient will have to spend a significant amount of time interacting with the metrics, which means that a certain bulk of their patients would have to be VA patients in order to make it worth their while. You see where I am going with this. Which means that your ambition and the money that we are going to apparently provide for this ambition, I am not quite sure I see it as being a realistic ambition.

Dr. SHULKIN. Yeah. If you involve your clinicians in data gathering and metrics, it is going to fail. I absolutely understand your warning. That is not what our intent is. The advances in outcomes measurement have come off of administrative systems merging with the clinical record. As you know, VA has the longest experience with an integrated electronic record. We have more clinical data we can extract, and then you combine it with administrative claims data and this is what we are talking about doing. We are not talking about turning doctors into data collectors.

Senator CASSIDY. Then let me ask this. Just because we are here, as Secretary Gibson once said, about the veteran. I was in a conversation with a very high-profile medical system director. If I mentioned his name, we would all know who he is. He had a very dim view of quality in the VA, pointing out that more people in the VA lose limbs from diabetic foot ulcers, which is really a failure of management, than do from trauma, and strongly saying that any well run private ACO (accountable care organization) or system which had the same outcomes as VA would probably lose their license.

I am just channeling right now. I am sure there are statistics that could prove or disprove this contention. But the point is, if the VA has so far to go in quality but they are passing judgment on other systems that quite likely will provide statistically, according to this gentleman, superior care to that rendered within the VA,

again, it seems a little bit like the judge is guilty. Any thoughts on that?

Dr. SHULKIN. Yes. Yes. First of all, I would love to talk to this person, and I would love to show him that since this is not an argument between difference of opinions, there is data on this. The data actually show that VA does as well or better in almost every quality metric study done. I have just reviewed nine additional studies showing VA's quality is better.

Now, no system is better in everything. I am not suggesting the VA is better in every metric. But when you take a look at screening, adherence to well accepted evidence-based protocols, risk-adjusted mortality, risk-adjusted length of stay, the VA performs better than the private sector and certainly as well in these studies. I would be glad to share that with you. Just came from it an hour before the hearing, a meeting with all of our health services researchers who do this type of work and have the data to prove that.

Senator CASSIDY. OK. I yield back. Thank you.

Chairman ISAKSON. Senator Manchin.

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

Senator MANCHIN. Thank you very much, and thank all of you for your work you do.

We all have the concerns over VA and we want to make sure they get the best service possible, and CBOCs right now count within that 40-mile. That seems to be our problem in rural West Virginia and I know in rural America, and when that situation happens, we do not have the expertise, as you could imagine. Then, there is a time elapse that goes on before they can get the proper care they need.

I know you all wanted to move in that direction. Do you believe that steps in the direction you are going right now is going to relieve that veteran who cannot get the expertise service, that he or she will not have to petition and wait and go through a period of time before they can get the services they need? You can understand the frustration, right?

Mr. GIBSON. That is precisely the objective, and when we describe the existing system as being broken, what you are describing is the broken—

Senator MANCHIN. That is—

Mr. GIBSON. Yes.

Senator MANCHIN. And I think we all have it, do we not?

Mr. GIBSON. Yes. Yes.

Senator MANCHIN. All of us have it. And, this takes effect when?

Mr. GIBSON. I am sorry?

Senator MANCHIN. The new plan. When—

Mr. GIBSON. What you see in the plan here, as Dr. Yehia has been describing, is an iterative process. What we do is we start going through and improving the veterans care experience as we have the capability to be able to do that.

Senator MANCHIN. I would say in rural America, especially in rural West Virginia, if you want to start and find out if it works or not, that would be the place to come, because that is where our greatest challenges are. We do not have these large areas where



you have trauma centers and all that going on. That is the thing that we are running into, and how we can alleviate this.

The frustration that I think that Senator Cassidy and everybody, you know, they deserve the best. They really do. And they might have a family member that is able to go and get top-notch expert. They do not have that opportunity, and that is just not right. It is just not fair. I know that is what you want. We do not have to re-invent the wheel here.

Mr. GIBSON. So——

Senator MANCHIN. Tell us how we can help you from this end of the table simplify the process that we all want.

Mr. GIBSON. Well, that is what this plan accomplishes, and there are explicit legislative requests that are part of this that will help us do that.

Two quick comments. I really bristle at the characterization that VA care is bad. That is not an accurate characterization of VA care, period. I will tell you that there is variability within the VA system, variability of health care outcomes, variability of access. Part of our challenge is to diminish that variability. I would tell you, go out and look in the private sector. In fact, there are references in the Independent Assessment to the fact that you actually find, even in well regarded HMOs, wider variability in health care outcomes than you find in the VA system.

Senator MANCHIN. Mm-hmm.

Mr. GIBSON. That is point number 1.

Point number 2, as I mentioned in my testimony, care in the community is going to be there for VA for the long haul. It is either a specialized service that we need to rely on the community to be able to deliver because we do not have the critical mass to do it——

Senator MANCHIN. True.

Mr. GIBSON [continuing]. Or it is because of geography, extraordinary geography, or it is because of extraordinary demand, those three circumstances. The challenge we have right now is we have seven different programs out there. They are confusing to veterans. They are confusing to providers. And they are confusing, quite frankly, to VA staff. If we do not streamline and simplify all that so that we can make it—Baligh and I were in——

Dr. YEHIA. Charleston.

Mr. GIBSON. Charleston——

Senator MANCHIN. Is that West Virginia or——

Mr. GIBSON. No, South Carolina. Sorry. Two weeks ago, we sat and we watched what our staff was going through in order to set up a Choice referral. It would dumbfound you.

What we have here is we have this patchwork quilt and we have got to go through and streamline this. We have to lean it all and make sure that it is working for the veteran, make sure it is working for the taxpayer, and make sure that it is working for the community provider, as well. That is where you get the kind of seamless care that we are talking about delivering here.

Senator MANCHIN. What are you able to do without us? What are you able to do and you believe that you have the authority to do without us?

Dr. YEHIA. Yes——

Senator MANCHIN. Because if you are counting on us to get something done quickly, it does not work that way here. [Laughter.]

Dr. YEHIA. There are certain things that are outlined in the plan that we are executing now. As the Deputy described in the beginning, there are iterations of Choice. The Choice of today is very different than the Choice of a year ago—

Senator MANCHIN. Right.

Dr. YEHIA [continuing]. And that really is because of this partnership with this Committee and the Hill, and we are continuing to build on that. There are a couple teams, or a couple items that we have actually outlined that are within the control of VA that we want to start working on now, and we are actually calling these our quick wins. We want to be able to get those done in the next couple months, and that is to, one, tackle this referral and authorization process. There are certain things that we can lean up and make it a little bit smoother. We want to really leverage the MyVA customer service training for our folks in the community so that when a veteran calls or they have questions about community care, we can answer them.

Then for our core network, those specific relationships that we have with DOD and academic teaching partners that really form the foundation of community care, we want to make sure that the way we partner with them is as streamlined and as simple and principles-based as possible.

Those are just a couple of the things that are within VA's control that we are working to execute now.

Senator MANCHIN. Well, again, I will just finish up very quickly. My time is running out. I would say that in a State such as West Virginia, which the population is less than two million people, disproportionately high VA population because a very patriotic State and they have served in every conflict. We look for any type of way that we can fight somebody—

[Laughter.]

Senator MANCHIN [continuing]. Especially anybody trying to attack America. But, with that being said, you are going to find in these small rural States a disproportionate number of veterans. I would encourage you, if you are looking if something would work, and trying to come into some of our rural areas, we can get you feedback immediately. You can find out without going through another year or two study very quickly if it is going to serve those people or not. I would encourage you to come to Charleston, West, by God, Virginia, which is different than the other Charleston or the other Virginia, OK? [Laughter.]

Senator MANCHIN. Thank you.

Chairman ISAKSON. Senator Tillis.

Senator TILLIS. Mr. Chair, I am going to ask that you defer to Senator Sullivan. The truth is, the only reason I got in the door first was he was gentleman enough to keep the elevator open for me, so—

[Laughter.]

Chairman ISAKSON. Senator Sullivan.

**HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA**

Senator SULLIVAN. Oh, OK. Thank you, Mr. Chairman. Thank you, Senator Tillis. Very kind of you.

Well, look, Dr. Shulkin, Mr. Secretary, I think you guys probably know where I am coming from on this. I am a big fan of yours. I really appreciate you coming up to Alaska. Senator Manchin talked about going to rural communities and seeing what the frustrations are. You got a heavy dose of it in my State when you agreed to come up in August.

Dr. Yehia, you are talking about quick wins. I thought we were going to have a quick win in Alaska, and you laid out a plan. One of the things that I emphasized when you came up there to the veterans was, hey, I know you guys are frustrated, but please be calm. You did not create the problem. You are here to fix the problem. But, I need to tell you that now I am the one getting frustrated, because it has been 100 days since you guys were up there. You talked about your six points, which I still have here. I appreciated it. Here they are, on the Alaska pilot program. I am getting hit every day in my State.

I was on a plane coming down here 2 weeks ago. Three veterans within a circle of two rows on the airplane were complaining to me, and I was telling them, hey, do not worry. We are on it. The VA has got a pilot program. It is going to have a win, a quick win in Alaska. Then, my staff gets told today that a lot of what you told me and committed to me—and I am telling veterans this in my State—is now not going to happen.

We were told this is going to happen in November, mid-November, and now we are told maybe not. Maybe indefinitely it is not going to happen. No Alaska pilot program. You guys are asking for \$13, \$14 billion to fix the Choice Act and you cannot even fix it in my State, where you know, Dr. Shulkin, it is a frickin' disaster.

I am a little bit upset, and I have been very measured. I have been trying to be measured here for months. You saw the way we operated up there in Alaska. You saw the problems. We are not making this up. This is a nightmare. And my veterans—who, by the way, more veterans per capita in my State than any State in the Union—it is not funny. They are not being served right. You guys are making promises that now I am learning that your staff is walking all this stuff back, all your six points.

When are you going to fix the problem in Alaska like you committed to when you were there in August, and why are you walking back commitments that you made to me publicly, that was made here on October 7 publicly about an Alaska plan? All being walked back, and I just do not understand. On behalf of my veterans, I am pissed.

Dr. SHULKIN. Yeah. Yeah.

Senator SULLIVAN. What the hell is going on?

Dr. SHULKIN. OK, Senator. First of all, you have been consistent from prior to my confirmation through now that you—

Senator SULLIVAN. Even when we saw each other on Veterans Day.

Dr. SHULKIN. A hundred percent consistent that the situation was not acceptable to you. You asked me to come up there. You

were absolutely correct about how the veterans felt in Alaska. I understood that, and——

Senator SULLIVAN. But you saw the problems yourself.

Dr. SHULKIN. I did, and you have been a tireless advocate for veterans, and I am not walking back on this——

Senator SULLIVAN. But your staff was walking back——

Dr. SHULKIN. My staff, who I bet is watching this right now, is listening to me as I say we are not walking back on this. I made a commitment to you and to the veterans and we are going to see this through.

Senator SULLIVAN. OK. When?

Dr. SHULKIN. Here is what has been done, OK. Number 1, a virtual call center was established, staffed by 25 people who do nothing but answer the phone for Choice.

Senator SULLIVAN. Well, remember, you said you were going to get people——

Dr. SHULKIN. OK——

Senator SULLIVAN [continuing]. In Alaska.

Dr. SHULKIN. So——

Senator SULLIVAN. One of the biggest problems that you saw was people down in wherever the heck it was——

Dr. SHULKIN. Absolutely. So——

Senator SULLIVAN [continuing]. Scheduling for Alaska. They did not even know the——

Dr. SHULKIN. We have through TriWest a virtual call center only answering for Alaska. I said to you I want people in Alaska scheduling and——

Senator SULLIVAN. My team was told you guys are not doing that.

Dr. SHULKIN. We are doing it, but it required a contract modification to a Federal contract, which is a bigger deal than I knew when I came into the government. We are committed to doing that. That is going to be in place. The contract modification happened November 2, which is to embed staff in Alaska. That happened November 2. TriWest is now, now that that contract modification happened, hiring staff. They believe they will be in place in 6 weeks.

Second, the VA Alaska staff have taken their own people and now assigned them to be Choice people in Kenai, in Anchorage, and in Fairbanks. They have VA Alaska staff that are there helping veterans every day get through the Choice Program. This is the band-aids, but it is being done now to help veterans. We are not walking back on this plan. It is taking longer than you or I want, and you are right to be impatient.

Senator SULLIVAN. Mr. Chairman, if I may, I think the Alaska plan, what you are trying to do, has implications not only, of course, for my State, but nationally——

Dr. SHULKIN. Yes.

Senator SULLIVAN. I think that you saw the problems. You came up with a plan, supposedly, to fix it. Now we are being told by your staff that they are going to work on the national issues before they get to Alaska. The whole point, according to our 3 days spent together——

Dr. SHULKIN. Yeah.

Senator SULLIVAN [continuing]. Going throughout the State was to fix this, look at it as a template—many of the Choice Act changes were templates from Alaska anyway—and then try to use the lessons that you do fixing the Choice Act in Alaska for the national approach. Now you are talking national—

Dr. SHULKIN. Yeah.

Senator SULLIVAN [continuing]. And you are telling me, wait—your staff is—wait for the national to be fixed and then we will get to Alaska. That is exactly the opposite of what you committed to me on.

Dr. SHULKIN. No. No. I do not want any of my staff to believe that Alaska is not a priority and that we are not going to do it. We have embedded staff one place prior to Alaska, and it is already happening in New Orleans, but it was because you started it in Alaska. It got implemented sooner in New Orleans. We are waiting to hire the staff now that the contract mod is done and it will be in place.

We are going to do this in Alaska, and you are right, other places around the country have said, we want that, and we have started the discussions in other places. But the only one that is actually ahead of you is New Orleans right now.

Senator SULLIVAN. Well, Mr. Chairman, if I can get a commitment from you, you, Mr. Secretary, on continuing to work with my team to implement what you have already committed to me—we cannot wait—

Dr. SHULKIN. Absolutely.

Senator SULLIVAN [continuing]. The idea of you guys pushing this back—remember, the commitment was right here—

Dr. SHULKIN. Absolutely.

Senator SULLIVAN [continuing]. In November, it was all going to be done. It is not done.

Dr. SHULKIN. Yes. I know the Deputy Secretary and I have spoken about this. He is committed to it. The Secretary is committed to it. He was also in Alaska, as you remember. He absolutely understands what you are talking about. You have never deviated from this. We are not deviating from it. It is taking longer, but that is why our staff in Alaska are doing what they can to help veterans right now. It is not enough and we are still hearing the comments and we are going to stick with it. I do not want to be giving excuses. I only want to fix the problem in Alaska and we are going to stick at it.

Senator SULLIVAN. OK. All right. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. I just want to observe that this kind of dialog is exactly what this Committee is for, for us to work with the administration and with the Department to come together and solve solutions in Alaska, Montana, Georgia, and Washington State. I appreciate your active engagement and I appreciate your attention to it. I think we had it on the Kansas issue earlier and the Alaska issue now. I think we found some meaningful common ground on what we need to do better and we want to help you be able to do that.

I am going to recognize Senator Tester in 1 second and then Senator Tillis, but I am going to have to leave for about 20 minutes.

I am going to relinquish the gavel to the Senator from Kansas, Senator Moran, and then I will return later on. I just want to make you aware of that.

Senator Tester.

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

Senator TESTER. Thank you, Mr. Chairman, and I want to thank all of you for being here today.

The proposal gets implemented, and this, I guess, is for you, Deputy Secretary Gibson. Do you see an increase in the overall ratio of veterans being referred to non-VA care?

Mr. GIBSON. I think it is highly likely that there will be. I think we are going to see, from looking at where we are right this instant, you know, we saw a disproportionate increase in care in the community in 2015—

Senator TESTER. OK.

Mr. GIBSON [continuing]. And I think we are going to see a disproportionate increase during 2016, as well.

Senator TESTER. Do you anticipate this is going to, because we do not talk about money enough, I do not think, in this Committee, but do you think this is going to end up costing more than if the VA provided it?

Mr. GIBSON. That is where I was alluding earlier to, to another context for make versus buy decisions. I think we have to get to the point where we are looking with a business eye about those make versus buy decisions for care in different markets and different situations. We need to look for where we can buy it, where we can get quality care at better value. Then we need to look really hard at buying it in the community as opposed to delivering it ourselves, make more efficient use of the space and the resources to deliver care that we cannot buy in the marketplace.

Senator TESTER. I will ask it this way. Overall, once the program is implemented, do you anticipate it costing, after you do your metrics, do you anticipate it costing more money for the veterans you serve per veteran, or the same, or less?

Mr. GIBSON. I would like to think that it would be less per veteran.

Senator TESTER. Is that the way it is today?

Mr. GIBSON. I need to rephrase that—

Senator TESTER. Yeah.

Mr. GIBSON [continuing]. Because part of what we are already seeing as we improve access to care and make the care experience better is more veterans are coming to us for more care.

Senator TESTER. Yes.

Mr. GIBSON. The bigger part of that is veterans that were already coming to us for care are using us for more care.

Senator TESTER. Yes. Right.

Mr. GIBSON. I cannot really say that per veteran, but I get the point that you are making.

Senator TESTER. Yeah.

Mr. GIBSON. If we do not become more productive—

Senator TESTER. Yes.

Mr. GIBSON [continuing]. Through all of this, then I would say that we have not succeeded.

Senator TESTER. I am going to go to another point, and I have a very similar circumstance as Senator Moran talked about in Kansas, where we have got CBOCs with no doctors. I think that what appealed to me about Choice is in those areas where they did not have access to VA health care, they could get access. It could actually save the VA some money because of the mileage difference.

All that being said, I am a big fan of VA health care. I think that what I hear from veterans in Montana regularly under your guys' watch, and it faltered for a while, but under your guys' watch, is you do a pretty damn good job.

The question I have for you is that we are building capacity in the private sector. Are we going to continue to build capacity within the VA, and how are you going to make those determinations of where capacity needs to be built in the VA and where you are just going to outsource it to the private sector?

Mr. GIBSON. I think a big part of that has to do with where we have critical mass. Where we have a critical mass of veterans to serve—

Senator TESTER. Yes.

Mr. GIBSON [continuing]. Our analysis shows that we can deliver better care at better value—

Senator TESTER. Yes.

Mr. GIBSON [continuing]. Then we should be building infrastructure to deliver that care. Where we cannot justify—

Senator TESTER. Within the VA?

Mr. GIBSON. Within the VA. But where we cannot justify that business decision, we need to be outsourcing.

Senator TESTER. That is solid. Just one more thing that follows up with that. In another year, you guys are going to probably be gone. It will be a new administration. I hope not. I hope you all stay, but you are probably going to be gone. Are you laying out a process so that whoever takes your place, assuming that you are not brought back, that the transition would be seamless and the justification—keep going.

Mr. GIBSON. We are absolutely looking at ways that we can institutionalize what we are talking about doing here—

Senator TESTER. That is a good word.

Mr. GIBSON [continuing]. And I would say that one of the important roles that this Committee can play—

Senator TESTER. Yeah.

Mr. GIBSON [continuing]. Is to be a source of continuity about some of these operational concepts—

Senator TESTER. I think you are right.

Mr. GIBSON [continuing]. As we bridge across administrations.

Senator TESTER. You have six or seven different outsourcing programs out there. One of them is Project ARCH, which has been pretty successful in Montana; had a few hiccups, but not bad. Can you just give me a quick word on how that transitions for those folks once this plan is in place?

Dr. YEHIA. You are right. Project ARCH has been very successful. In fact, we took a lot of lessons from Project ARCH as we built this plan.

Senator TESTER. Sure.

Dr. YEHA. There are a lot of lessons about preserving veterans' choice. The whole episode of care came from ARCH. A lot of lessons learned about how to work with community providers, how to make sure there is a direct connection between VA and community providers, and then also from the business side—

Senator TESTER. Yes.

Dr. YEHA [continuing]. Of really having one pot of money for care.

Senator TESTER. Sure.

Dr. YEHA. I think what we tried to do in the plan is create these eligibility criteria that focus into these three big buckets. One is geography, one is wait time, and one is availability of services.

Senator TESTER. Yes.

Dr. YEHA. For the most part, a lot of the veterans that are currently using Project ARCH will be able to continue to use community care through one of those three mechanisms. There may be some folks that would have to change providers. In those circumstances, we want to create a transition plan so we can make sure that there is a warm handoff as needed.

Senator TESTER. OK. That is good. What I just want to point out is actually the Kansas example, and that is if you do not have people on the ground that know what you guys want, it is not going to happen. I hope that communication filters all the way through middle management to the ground, because you have some great folks on the ground.

The last thing, if I might, Mr. Chairman, the last thing I am going to say is that we had a scheduling hearing here a month or two ago, on scheduling within the VA. They said they are working on it. They said the VA is working on a new scheduling program, is that correct?

Mr. GIBSON. Yes, we are.

Senator TESTER. How much is that baby going to cost?

Mr. GIBSON. In fact, there are two or three efforts underway. There are some apps. We are actually going to be able, within about 6 months, maybe less, we are going to be able to provide veterans the ability to schedule an appointment for primary care, mental health care.

Senator TESTER. OK. And that was an off-the-shelf program?

Mr. GIBSON. Through a mobile app. This one was developed inside VA.

Senator TESTER. OK.

Mr. GIBSON. The other thing—the second leg of this effort is what we call VSE, Vista Scheduling Enhancement—

Senator TESTER. Yeah.

Mr. GIBSON [continuing]. Where we have taken and modified—they actually put a graphical user interface on top of—

Senator TESTER. Right.

Mr. GIBSON [continuing]. The old 1980s-era scheduling system—

Senator TESTER. Yeah.

Mr. GIBSON [continuing]. So that it actually looks like a 21st century app and works like one—

Senator TESTER. OK. So—



Mr. GIBSON [continuing]. And that is happening within the next 6 months or so. The longer-term scheduling process is this comprehensive replacement, and we are going to do that in a very deliberate kind of way, because we are about to deliver the field a substantial improvement in scheduling functionality. Folks in the field that have seen this thing working are awestruck. They cannot believe that we have something like that coming that soon.

Senator TESTER. That is the comprehensive one.

Mr. GIBSON. No, this is Vista Scheduling Enhancement—

Senator TESTER. OK. So—

Mr. GIBSON [continuing]. With the graphical user interface.

Senator TESTER. Let me just ask you this—

Mr. GIBSON. Sure.

Senator TESTER [continuing]. Because the last—and good people at the panel, but did not give me much hope—they said that if I am a veteran and I schedule at the VA and it is the first of December and I schedule on the 20th and I get in on the 20th, there is no wait time. But, if that appointment was delayed until the 25th of December, that is a 5-day wait time. That is how it is valued. Is that going to change, because that is not real.

Mr. GIBSON. Let me tell you what is real. We want appointment scheduling to be either clinically relevant or we want it relevant to the desires of the veteran. When you measure from what you are describing as the create date—

Senator TESTER. Yeah.

Mr. GIBSON. If I am seeing my doctor for a chronic condition and he says, I want to see you back in 90 days—

Senator TESTER. Yeah.

Mr. GIBSON [continuing]. And we schedule an appointment in 90 days, did I wait 90 days for that appointment? It was scheduled coincident with the clinically indicated date. If I call in and I say, I need to come see the doctor, see the dermatologist, but I am going to be traveling for the next 3 weeks, when can I get in after that, and we schedule that veteran in 24 days, what is my wait time? Did I wait 24 days for that appointment?

What we are trying to do here is make it either clinically relevant or relevant to when the veteran wanted to be seen. That is where we measure the wait time gap from. There is no relevance versus the create date. The large majority of our appointments are “return to clinic” appointments, and if you were looking at wait time data, you would see all kinds of examples of people waiting 120 days, or people waiting 60 days, or people waiting 6 months, 180 days, for an appointment, when, in fact, that is exactly when they were supposed to come in and be seen.

Senator TESTER. You are right, except for the fact that—I am sorry, Mr. Chairman, I went down this road—but how the hell do we measure wait times, because if I am a veteran—look—

Mr. GIBSON. When do you want to be seen?

Senator TESTER. I took my granddaughter to the emergency room the other day. Everything worked out fine. I spent 5 hours in that emergency room. They looked at her for maybe 20 minutes of that 5 hours. I still spent 5 hours in the emergency room.

Mr. GIBSON. Right.

Senator TESTER. When that person sets up an appointment, how are we to know which is which? That person has a pain in his heart and needs to get in today and was put off for 3 days, you are right, it is more critical. But how are we going to know as an oversight committee what is going on, because, quite frankly, why this is important, and I do not mean to be critical, but why this is important is we had a real bad hearing here on Phoenix VA a few years ago. It was a horrible hearing. So, how are we going to know the metrics? That is all. You can get back to me on that, because Senator Tillis wants to ask some questions, too. But, the question becomes, how do we do any oversight? I hear you. I understand. How do you get oversight on that?

Mr. GIBSON. We publish that data. We publish that data every 2 weeks.

Senator TESTER. We will take this up offline. I mean, the truth is that it does not work so well. Thanks.

Thank you, Mr. Chairman. I appreciate the flexibility.

Senator MORAN [presiding]. Thank you, Senator Tester.  
Senator Tillis.

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

Senator TILLIS. Senator Tester, I never get tired of hearing your questions.

Senator MORAN. You have not been here long enough.  
[Laughter.]

Senator TILLIS. I want to shift gears to get back to and really tap on what Senator Tester was getting at earlier in terms of institutionalizing this so that we are not all of a sudden restarting in 2017. You all have said a couple of things that give me hope and a couple of things that give me concern, and I am coming at this from the perspective of a systems person that has helped large companies de-complex their environment.

I like the idea of a graphic user. I use this as an example of where, on the one hand, it is a good short-term fix. On the other hand, it adds another layer of complexity. I have implemented those systems. We used to call them lipstick on a pig. What you have done is you have implemented something that makes it easier. In the process of doing that, you probably not only aggregated data from other systems, you probably added data, which adds another layer of complexity when you finally get to the ultimate task of replacing it. We have to be very careful not to go after some short-term priorities that may be voiced from us or others at the expense of creating a long-term, sustainable, economically viable fix. I would think that you all would agree with that. I would be fascinated if any of you did not.

Mr. GIBSON. We agree wholeheartedly with you.

Senator TILLIS. Yes. Now, one thing that I think we need to do, I sometimes think that we need to have hearings here where the only thing that is at the witness stand is a really big plate glass mirror, because a part of what you need to do—the CIO, Ms. Council, is top notch. She has great experience, great relevant experience with the job that she has been assigned.

What you need to do as you go through these buy-versus-build decisions is make absolutely certain that you are buying what creates a best practice and not necessarily creating a “frankensystem,” where you start out with a buy, it looks great, but then you will say, this Congressional mandate requires this sort of reporting or this other analytics capture. This Congressional mandate or this special project as requested by some Senator requires so many variants that by the time you get finished, what you bought bears no resemblance to the baseline project that you want to maintain.

Mr. GIBSON. That is right.

Senator TILLIS. We had a hearing here a couple of months ago where Senator Brown and I have moved a bill that is going to provide a benefit—I think, Deputy Secretary Gibson, you were at that hearing, where I said it is a shame that a benefit that over 10 years will equate to about \$6.2 million is going to require \$5.1 million in systems changes before you can start providing the benefit.

Sooner or later, we need to make sure that you all can come back. I want to associate myself with the comments made by most of the Members, and I share the frustration of Senator Sullivan. I am not going to get into the episodic issues with Fayetteville or anything else in this hearing. That is why we will have conversations outside of the hearing. But at some point, there needs to be a cost associated with a shift of priorities—

Mr. GIBSON. Yes.

Senator TILLIS [continuing]. That comes from the directions you are receiving from this Committee. I will take at face value that the value provided to the States that you are prioritizing, like Senator Sullivan’s, is worth it over the distraction and diversion of resources. But we have to start getting very serious and have everyone understand what the distraction possibly costs us in terms of shortening the time to benefit for the overall transformation.

We also need you all very quickly to be able to articulate in a way that we can understand with the time limits that we have in the VA Committee why what I may be asking you to do may move us further to the right in getting the transformation done. The way you are going to do that is to create a plan that we can communicate before this Committee on a state-by-state basis what the footprint looks like, what is the mix of VA/non-VA Choice, what is the timeline to benefit, what are the things that we can expect on a fairly immediate basis, so that each one of us can feel like we have that information and then we can determine whether or not it needs to be juggled or whether or not it is appropriate. We have not had that, and I think that is one of the reasons why we get more to the episodic discussions that we have in a lot of these hearings.

I would encourage you very quickly, the list of legislative changes that you mentioned for the \$400 million program, to me, it is a bit disturbing that we are going to have to spend \$300 million on a portal because these portals are fairly well established. I know that we have got a hairball of systems that we have to connect them to, and that is where most of the costs come from. It is not the Web site. I get that.

Mr. GIBSON. It is. It is.

Senator TILLIS. It is disturbing to me that, again, if we do these short-term things, we are adding complexity and time to the long-term integrated solution. We have to reach a point to where, like all large-scale transformations, there has to be a freeze except for emergencies so that you can start getting to work on what we are all wanting here sooner rather than later.

I think you need to go back and you need to take a more critical look at the things that you are having to accept as a given that Congress has mandated that you believe no longer have a place in the transformed VA, and it needs to go far beyond what you have probably thought about in terms of the enabling legislation for this particular program. If you do not do that, then you are building the transformed system on outdated policies that may or may not have ever been appropriate. They just happened to get through Congress and you happen to have to live up to them because they have been mandated to you.

I am not going to get into a lot of questions except to say the reason that I continue to have this sort of flavor to my discussion is that I want to help you establish a plan that transcends your tenure and your positions, that continues to show progress as we get another President. I want to be an advocate for that. But it has to be articulated, and then we have to have people in the VA that will put the mirror back on us and say, you are asking me to do something that is shifting me away from the other thing you have asked me to do.

Now, if we do that and you put the mirror in, it is our problem. If we make a request and you do not reflect back on us, it is your problem. And I want to make this our problem so that we can help facilitate the transformation.

The last things that I will just mention, and we can speak, first off, I appreciate the Secretary and his staff for the update on Camp Lejeune. I am looking forward to getting the additional information I requested in a letter today, but thank you for that progress. It is important.

I also want to reinforce what Senator Murray said. Any time I have heard it brought up—I have spoken with hundreds—probably at this point been in the presence of thousands of veterans over the last 11 months since I have been Senator. I have yet to hear a single veteran who has received care from the VA say that they want purely a private choice. They want the optimum mix. They want veterans serving veterans. We want the best possible health care. We know we have world class practices out there. We want to make sure that the people who come to us and say, privatize it all, they almost all have one thing in common. They are not a veteran.

I want to listen to the veterans' voices and make sure that we do a better job of providing the best care for them, which includes Choice, it includes non-VA, and it includes it in different proportions based on the State. There are seven States who have one of the highest per capita ratios of veterans per population. I have a State that has more veterans than those seven States have total people. We all have unique needs and we need to solve them.

I hope that you all will go back and come back with a longer list of things, saying a part of the complexity in making the buy decision is because you have told me to do things that are not best

practice and are not necessary for me to produce the best clinical outcomes. Please, relieve me of this burden. If you start doing that, your job is going to be a lot simpler and what we do for the veterans is going to be a lot better.

Thank you.

Mr. GIBSON. If I may, just 15 seconds—

Senator MORAN. Mr. Secretary.

Mr. GIBSON. I cannot tell you how much I appreciate that perspective, the willingness. I like to think that Secretary McDonald and I have done more of that kind of challenging over the last year and one-half or so than has been done in a long time, but what you are describing is a real paradigm shift for the Department, which is an extraordinary opportunity. We will do our best to seize it.

Senator MORAN. Senator Tillis, thank you for your commentary and analysis, very valuable.

In the absence of the Chairman, there is no second round, but I have a question, and it is a question that follows, in fact, a question that you asked, I think, Secretary Gibson, of me. As I understand it, my take-away from this hearing as far as the Choice Act is that it no longer matters if you live within 40 miles of a facility that does not provide the service that you need. You qualify to have services at home.

Mr. GIBSON. No.

Dr. SHULKIN. No.

Senator MORAN. No? I thought that is what you said in response to Chairman Isakson.

Mr. GIBSON. No.

Senator MORAN. If you live within 25 miles of a CBOC, it does not provide the service you need, what happens?

Dr. YEHA. OK, it has to be 25 miles from a facility or a CBOC that actually has a primary that provides primary care and mental health care, so not the one-off facility that only has one doctor or 1 day a week or something. If it is 25 miles from that, you do not qualify under the geography criteria to access care in the community. However, you might have a wait time for cardiology and you can access community care that way, or that CBOC may not refer folks to the local medical center for neurosurgery or CT surgery and all those services are provided in the community.

I think a lot of times people get fixated on the geography. There is more than one way that people can access community care, and some of that is through wait times and some of that is through they just do not offer that service at that local referral pattern for the medical center and the CBOC and it is always provided in the community.

Senator MORAN. Veterans who live closer than 40 miles to a CBOC that has a full-time physician have a different standard than those who live further than 40 miles, is that true?

Mr. GIBSON. That is correct.

Senator MORAN. All right. The veteran who lives 25 miles from the CBOC that has a full-time physician, who needs his eyeglasses adjusted, needs to see an optometrist, there is no optics available at the CBOC, would be told to travel the 200 miles to Wichita?

Mr. GIBSON. That is what we have described in here as the nature of the service, what I read to the Chairman. You know, that

in the past, I think that is exactly what would oftentimes happen, and what we are saying is we do not want that to happen. It makes absolutely no sense for us to have a veteran go drive 200 miles to get his eyes checked. That is the kind of care that we should be referring into the community under Choice.

But, to be very clear, and I think you realize this, if the aperture is open all the way to 40 miles from where you can get the care, the cost goes through the roof and we simply do not have the resources to be able to deliver that. So, that is why we are trying to do this in a very deliberate kind of fashion.

Senator MORAN. Your plan described to us today is intended to resolve those kind of issues, no?

Dr. YEHA. The way that it resolves those issues is that it allows a local provider, physician, and the veteran to make that determination. We have the national criteria of geography, wait time, and availability of services, but there is this one thing that was passed by the Hill, the unusual and excess burden that allows nuance, which is what we need. When I see patients and I determine that physical therapy is needed, you should not be driving 200 miles to get PT after you just had a knee replacement, we can actually make that decision together and they can access community care.

Senator MORAN. Do you make that decision in the—

Dr. YEHA. In the office.

Senator MORAN [continuing]. Together today, regardless of what happens with your plan for the future? That is already available to that veteran—

Mr. GIBSON. It is now, based upon what we put in place effective yesterday.

Dr. YEHA. Yesterday.

Senator MORAN. Yesterday, OK. Today is a new day.

Mr. GIBSON. It is a new day, yes.

Dr. YEHA. It is.

Senator MORAN. Many of the concerns and complaints that I have raised over a long period of time, in your view, are resolved by what happened yesterday at the VA? You asked me where do I get my concern. Emporia should not qualify, but it does. My concern comes from casework. What you heard around the table is people bringing us issues, including the veteran who lives 25 miles from the CBOC who cannot get his eyeglasses adjusted because they do not do that, was told to go 200 miles to Wichita, which is kind of the norm of how we relate to veterans.

I checked with my staff. Just this week, we have had ten new cases in Kansas related to the Choice Act and the distance necessary to travel. It is an ongoing—

Mr. GIBSON. Would you share those with us so that we can do a deep dive to understand where we can help identify the defects in the system, to understand where things are not working—

Senator MORAN. Great.

Mr. GIBSON. That would be hugely helpful.

Dr. YEHA. If I can add one other thing please? Some of the \$421 million that we are requesting has to do with communication, education, and training. There is a big chunk of that—we did not talk about that today. But, I think what you are experiencing and what

we are getting to is that if that information flow does not occur at every level in the organization, there is a problem. So, that is some of the costs associated with the plan, to improve those communication channels.

Senator MORAN. Thank you very much. My understanding, which I have asked for this kind of information previously, and have learned it now exists; there is something called an abandonment rate, that was described to me as those who apply for Choice and conclude it is not worth it. Those you perhaps reached out to who actually make a request to use Choice and conclude to walk away. That could be a good thing, because they want to use the VA in its traditional ways. It could be a bad thing, because they hit the brick wall, they hit the bureaucracy. I would like to know the abandonment rate. I understand that is a number you keep.

I have no standing to deny, Senator, another question.

Senator BLUMENTHAL. Thank you, Chairman Moran.

The care in community and generally non-VA medical services involve payments and there have been various efforts over the years to make sure that those payments are validly made. The VA authorized a Recovery Audit Program in the 112th Congress, I believe, and the Inspector General, as you well know, recently found, I believe, \$311 million for fiscal year 2014 in, in quotes, "improper payments" for the Non-VA Medical Care Program. I would like to know what progress there has been made in the Audit Program, the Recovery Audit Program. My understanding is there is a request for proposal or that the program is in the works. Could you update me?

Mr. GIBSON. This Recovery Audit Program, I am not immediately familiar with. I am familiar with the efforts that we are doing to expedite and improve the processes around prompt payment. I know that some of the payments that were identified as improper payments associated with care in the community had to do with the fact that they were done under individual authorizations instead of being done under provider agreements, which is one of the reasons we are anxious to have provider agreement authority.

We will get you some information on the recovery effort, because I am not conversant on that at all.

Senator BLUMENTHAL. I would appreciate if you gave me whatever information that you can, hopefully in the next very near future.

Mr. GIBSON. We will do that. Yes, sir.

Senator BLUMENTHAL. Thank you.

Senator MORAN. Senator Tillis.

Senator TILLIS. This time, I will not give a speech. It has actually gone from 50,000-foot to the ground level. Dr. Yehia, you mentioned when we were talking about for doctors who may go into the Choice Program that if they are already certified to provide Medicare or Medicaid coverage, that you provide that doctor a provider agreement to allow them to actually provide VA care. What is that provider agreement like?

Dr. YEHIA. The way that it works right now is we have these contractors, HealthNet and TriWest. They are the ones that actually contract or work with the providers. The provider agreement is, like, two pages. It is actually a very simple process. So, if a veteran

wants to, like I was describing, see someone in Fayetteville, NC, and they are not part of the network, it is the responsibility of our contractor to reach out to that provider, give him that agreement, have him sign it, and then join the network.

Senator TILLIS. It is not a 2-page agreement with 75 attachments?

Dr. YEHA. No.

Senator TILLIS. It is a 2-page agreement.

Dr. YEHA. Yeah. It is a simple agreement that has issues that relate to credentialing, et cetera, the ability to share medical information, things like that.

Senator TILLIS. Do you have any idea what the acceptance or rejection rates are on these provider agreements?

Dr. YEHA. I do not know.

Dr. SHULKIN. Very low.

Senator TILLIS. Very low?

Dr. SHULKIN. Yeah.

Senator TILLIS. OK. Do you have any information on how well we are doing with reimbursements for people who come under that versus a Medicare or Medicaid provider in terms of timeline to reimbursement, those sorts of things?

Dr. SHULKIN. Yes. In the Choice Program, through our contractors, they are close to 100 percent payment within 30 days. In the direct payment from VA, not through our TPAs, we are at 79 percent payment within 30 days, working on an upward trend to get that much better.

Senator TILLIS. OK. Then, the real question is, is the 79 percent relatively simple care versus more complex care so that you get an idea of the dollars outstanding, not just the—

Dr. SHULKIN. No. Our care in the community can be very complex care, as well, and—

Senator TILLIS. That is what I was referring to.

Dr. SHULKIN. Yeah.

Senator TILLIS. Is there any potential 80/20 rule, where 80 percent of the—or the 21 percent that is outstanding more than 30 days is 80 percent of all the dollars outstanding? I am just curious.

Dr. YEHA. The common metric that is used is they differentiate claims into what is called clean claims, claims that have all the information there, and then claims that are not clean claims. They do not really distinguish them by clinical criteria—

Senator TILLIS. OK.

Dr. YEHA [continuing]. Like whether they were more complex or not.

Senator TILLIS. For the most part, if I go out and talk to providers who are getting into Choice, they are no longer telling me it is very, very difficult to do and they are not getting paid on a timely basis.

Dr. SHULKIN. Providers sometimes do not differentiate choice from VA, so you are going to hear both things. They should be getting their payments 100 percent of the time within 30 days through Choice—

Senator TILLIS. OK, and that is because—

Dr. SHULKIN [continuing]. But—



Senator TILLIS [continuing]. It could be a non-VA provider by contract and a Choice provider by episode.

Dr. SHULKIN. Right.

Senator TILLIS. I got you.

Dr. YEHIA. Exactly.

Senator TILLIS. OK. Thank you, Mr. Chair.

Senator MORAN. You are welcome.

Gentlemen, thank you very much. Secretary Gibson and Secretary Shulkin, Doctor, Mr. Dalpiaz, thank you.

I ask the next panel to join us at the table. We should be joined by Mr. Roscoe Butler, the Deputy Director of the National Veterans Affairs and Rehabilitation Division of The American Legion; Mr. Darin Selnick, Senior Veterans Affairs Advisor for Concerned Veterans of America; Mr. Bill Rausch, Political Director for Iraq and Afghanistan Veterans of America; Mr. Raymond Kelley, Director of National Legislative Services of the Veterans of Foreign Wars.

Senator BLUMENTHAL. While you are taking your seats, I want to apologize that I have another commitment. I did not realize that this hearing would last as long as it has, and so I may have to depart before you are done with your testimony. If that happens, I apologize and I will leave the hearing in your hands, Mr. Chairman.

Senator MORAN. You have no alternative. Thank you, Senator Blumenthal.

We will now welcome the second panel.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO  
THE U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* In the plan you drafted, the Veterans Health Administration (VHA) would create a tiered network of providers with the Core Network comprised of VHA's Federal partners and academic affiliates. As it is structured, if VHA can't provide the care or if the veteran is 40 miles from their primary care provider, veterans would be sent to the core network first and the preferred private sector providers would comprise the second tier of care. Currently, the care provided by VHA's Federal partners and academic affiliates is not for all types of care.

a. Would the Core Network be used for both primary and specialty care?

Response. Yes, the Core Network would be used for both primary and specialty care. These relationships with Core partners align with VA's mission, vision, and strategies, as well as those of VA's Federal partners.

b. Would veterans first and only choice to receive care be from the Core Network and only be referred to the Preferred Provider Network in limited circumstances?

Response. The Core Network is critical to VA's mission, vision, and strategies; therefore, the role of the Core Network providers will be similar to its role now. The Core Network providers will be utilized first. If there is not an available provider within the Core Network based on eligibility criteria (e.g., location and wait-times), Veterans will be able to choose a provider from the external network. By establishing the tiered networks, Veterans will have a greater understanding of available community providers, allowing Veterans to make informed decisions based on public information.

c. Did you consider creating two choices for care in the community, as originally intended by the original Veterans Choice Program, within which veterans could choose VA's Federal partners and academic affiliates or private sector providers?

Response. VA's ultimate goal is to develop a consolidated community care program with an established single set of eligibility criteria and streamlined business processes to reduce confusion and improve the experience of Veterans, community providers, and VA employees. Creating two choices would not align with the overall intent to establish a consolidated community care program with a single set of eligibility criteria.

d. Did you consider using the Department of Defense's TRICARE contract to provide care in the community to veterans? If so, please provide a detailed explanation as to why using TRICARE contract was dismissed.

Response. Yes, VA did consider using the Department of Defense's (DOD) TRICARE contract; however, the current TRICARE network is not robust enough to meet the demand. The current contract is focused only in 60+ geographic locations, which would not provide adequate coverage in rural areas and other locations across the country. As VA conducts critical analyses for developing a high-performing network, VA will continue to engage DOD to discuss potential areas of opportunity to extend VA's reach by leveraging the TRICARE network.

*Question 2.* Currently, VHA has a number of local agreements with the Department of Defense medical treatment facilities (MTF) to provide care to veterans. VHA has indicated that the VHA intends standardize care for veterans at MTFs through a national agreement or memorandum of understanding with DOD. Core Team Currently, VHA has a number of local agreements with the Department of Defense medical treatment facilities (MTF) to provide care to veterans. VHA has indicated that the VHA intends standardize care for veterans at MTFs through a national agreement or memorandum of understanding with DOD.

a. Is the intention of a national MOU to provide both primary care and specialty care at MTFs?

Response. Yes, the current intent is to develop a national sharing agreement or Memorandum of Understanding (MOU) with DOD to provide both primary care and specialty care. By developing a standard sharing agreement or MOU, VA will increase visibility into provider locations and improve VA's understanding of supply and demand imbalances.

b. In providing care at MTF's, how will the national agreement ensure that the MTF's can handle the increased patient workload?

Response. By establishing a national sharing agreement or MOU with DOD, VA will increase visibility into supply and demand at DOD facilities. By establishing provider networks, VA will be able to identify and address patient workload, capacity needs, and changes in demand more quickly through robust network analytics.

*Question 3.* Currently, the Non-VA Care Coordination Office handles referrals to community providers and a large part of the plan discusses care coordination. In discussing alignment with MyVA, the plan states that "the five priorities of MyVA align directly with the components of the new VCP." In addition, the plan also refers to a referral coordinator position to assist veterans access community care and dedicated customer service representatives.

a. What specific role will the non-VA Care Coordination Office have under this new plan?

Response. Care coordination is essential to a high performing network. As the plan becomes more defined, the specific activities of the care coordination office will be identified. However, the role is expected to be similar to its current role of coordinating care in the community for Veterans.

b. What role will MyVA have in this plan?

Response. The five priorities of MyVA align directly with the components of the New Veteran Choice Program (VCP). As outlined in the report, VA plans to improve the Veteran's experience by empowering employees to deliver excellent customer service through establishing a single, consolidated community care program and streamlining current processes.

c. Will the dedicated customer service representatives and referral coordinators be new Full-time Employees (FTE) or a shift of existing FTE to new positions?

Response. VA plans to shift existing FTE into the dedicated customer service representative and referral coordinator positions where skill-sets align with the job descriptions and requirements. However, in circumstances where the skill-sets, job descriptions, and requirements do not align, VA may repurpose existing vacancies through attrition to these specific positions or there may be a need for additional FTE.

d. Please describe in detail the duties of the referral coordinators and the customer service representatives.

Response. VA is currently developing referral coordinator and customer service representative job descriptions and duties.

*Question 4.* VA has had numerous issues implementing Information Technology systems over the years and continues to struggle with interoperability of electronic health records with the Department of Defense. The plan calls for the creation of a "portal" that will need to be interoperable with community providers. As VA eval-

uates whether to make or buy this technology can you describe how you will engage with industry and experts in software development to make this critical decision?

a. There will be other information technology issues in implementing the plan that many would argue fall outside of the VA's core competencies, call centers, claims and payment systems, and information technology. What is VA's plan for outsourcing areas where outside resources and expertise can be utilized?

Response. During Phase 1 of the implementation plan, VA will conduct make/buy analyses to determine where it makes sense for VA to utilize outside resources. VA's plan to outsource any IT services will be determined by the results of these assessments.

b. Do you believe you have the necessary expertise to do the necessary make/buy analyses?

Response. Yes, VA believes that through its own competencies and the expertise of external consultants, VA will be capable of conducting these make/buy analyses.

**Question 5.** The independent integrated assessment of the Veterans Health Administration required by Section 201 of the Veterans Access, Choice and Accountability Act of 2014 made four main recommendations regarding contract care. It recommended VA develop a stronger management structure for purchased care; that VA establish an ongoing process for evaluating third-party administrator performance; and develop clear and consistent guidance on VHA authority to purchase care. It also recommended that VA ensure contract care includes appropriate requirements for data sharing, quality of life care reporting, and care coordination. However, it appears that your plan, rather than address these recommendations, simply builds architecture to bring more care inside VA where there has been difficulties in meeting Veteran needs.

a. Please explain how your plan addresses the recommendations in the independent assessment.

Response. The following table was provided in section 8.3 of the report.

| Independent Assessment Recommendation   | Description of Alignment to New VCP  |
|---|--|
| <b>Recommendation 1 GOVERNANCE:</b> Align demand, resources, and authorities  |  |
| Clarify and simplify the rules for purchased care to provide the best value for patients.   | <ul style="list-style-type: none"> <li>The plan will consolidate existing authorities and mechanisms for delivering community care into a single program, the New VCP, simplifying the process for Veterans, providers, and VA staff (<i>Element 1: Single Program for non-Department Care Delivery and Element 2: Patient Eligibility Requirements</i>).</li> </ul>   |
| <b>Recommendation 2 OPERATIONS:</b> Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care |  |
| Fix substandard processes that impede the quality of care provided to the Veteran.  | <ul style="list-style-type: none"> <li>The New VCP proposes revised processes for Authorizations (<i>Element 3</i>), Claims Management (<i>Element 5</i>), and Medical Records Management (<i>Chapter 9</i>).</li> <li>Care coordination should improve health outcomes, prevent gaps caused by transition of setting or time, and support a positive and engaging patient experience (<i>Introduction: Care Coordination</i>).</li> </ul> |
| <b>Recommendation 3 DATA and TOOLS:</b> Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decision                                    |  |
| Implement a single, integrated set of system-wide tools centered on a common EHR that is interoperable across VHA and with DOD and community provider systems.  | <ul style="list-style-type: none"> <li>The New VCP proposes medical records management to increase electronic transfer of relevant medical records between VA, Core Network, including DOD, and community providers, improving the consistency, simplicity, and timeliness of the information exchange (<i>Element 9: Medical Records Management</i>).</li> </ul>  |

| Independent Assessment Recommendation   | Description of Alignment to New VCP  |
|---|--|
| <b>Assessment A. Demographics</b>   |  |
| Prepare for a changing Veteran landscape.   | <ul style="list-style-type: none"> <li>The New VCP proposes approaches for High-Performing Network Development, including analytics, that are adaptable over time and can adjust to meet the needs of a changing Veteran population, providing them with access to a tiered network (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>   |
| Anticipate potential shifts in the geographic distribution of Veterans, and align VA facilities and services to meet these needs. | <ul style="list-style-type: none"> <li>The New VCP will develop a high-performing network nimble enough to adjust to shifts in the geographic distribution of Veterans (<i>Chapter 6: Plan to Develop Provider Eligibility Requirements and Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>   |
| Improve collection of data on Veteran health care utilization and reliance.   | <ul style="list-style-type: none"> <li>The authorization, medical records management, and claims processes outlined in the New VCP support increased transparency of data on health care utilization in the community (<i>Element 3: Authorizations, Element 5: Provider Reimbursement Rate, and Element 9: Medical Records Management</i>).</li> <li>Data analytics will be used to improve health care outcomes and personalize care delivery.</li> </ul>  |
| <b>Assessment B. Health Care Capabilities</b>   |  |
| Consider alternative standards of timely access to care.  | <ul style="list-style-type: none"> <li>Shifting to a single community care program will give VA greater flexibility in identifying and responding to access issues (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> <li>VA proposes to identify core competencies and develop a high-performing network in the future, which allows flexibility to determine excessive burden and account for clinical conditions (<i>Introduction: The Future of VA Health Care</i>).</li> </ul> |
| Develop and implement more sensitive standards of geographic access to care.  | <ul style="list-style-type: none"> <li>The development of a high-performing network for the New VCP will allow VA to determine excessive burden for the ill and elderly and establish more sensitive standards for geographic access to care while having confidence that those standards can be met by the VA community network (<i>Element 1: Single Program for non Department Care Delivery</i>).</li> </ul>   |
| Take significant steps to improve access to VA care.  | <ul style="list-style-type: none"> <li>By establishing a single set of eligibility requirements, a high-performing network, and a streamlined authorization process, the New VCP aims to improve Veterans' access to care (<i>Element 6: Provider Eligibility and Element 8: Infrastructure</i>).</li> </ul>   |
| Streamline programs for providing access to purchased care and use them strategically to maximize access.                         | <ul style="list-style-type: none"> <li>The New VCP will consolidate existing purchased care mechanisms into a single program and set of processes that will reduce confusion and improve access to care (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>  |

| Independent Assessment Recommendation  | Description of Alignment to New VCP   |
|--|---|
| Systematically study opportunities to improve access to high-quality care through use of purchased care.   | <ul style="list-style-type: none"> <li>The New VCP will be designed using industry best practices and will evolve over time to support access to high-quality care provided at VA or in the community (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> <li>A tiered network will be developed to better serve Veterans, support adequate coverage, and provide access to high-quality care (<i>Element 8: Plans to Use Current Non Department Provider Networks and Infrastructure</i>).</li> </ul>                                |
| Establish VA as a leader and innovator in health care redesign.  | <ul style="list-style-type: none"> <li>The New VCP will be designed using leading practices from industry and will evolve to incorporate innovative delivery and payment models (<i>Chapter 1: Single Program for non-Department Care Delivery</i>).</li> <li>The New VCP will be implemented using a system of systems approach that considers the interactive and interdependent nature of internal and external factors to optimize outcomes and experience for Veterans (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul> |
| <b>Assessment C. Care Authorities</b>  |   |
| VA and Congress should articulate a clear strategy governing the use of purchased care.  | <ul style="list-style-type: none"> <li>This report provides Congress with VA's proposal for a clear strategy and direction for community care, including required legislative authorities (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>   |
| VA should collect better data to accurately estimate the demand for and use of purchased care.   | <ul style="list-style-type: none"> <li>The New VCP proposes approaches for High-Performing Network Development, including analytics, that are adaptable over time and can adjust to meet the needs of a changing Veteran population, providing them with access to a tiered network (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>  |
| VA should develop a stronger program management structure for purchased care and allocate responsibility and authority to the most appropriate levels. | <ul style="list-style-type: none"> <li>VA will designate a new DUSH to establish national management of and accountability for community care and integration with VA provided care (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> <li>Similarly, at the local level, the New VCP will also standardize community care within facilities to support consistent management (<i>Element 1: Single Program for non Department Care Delivery</i>).</li> </ul>  |
| VA should develop clear, consistent guidance and training on its authority to purchase care.   | <ul style="list-style-type: none"> <li>This report includes a transition plan with change management and training necessary to streamline existing programs and implement improved processes (<i>Element 10: Transition Plan</i>).</li> </ul>   |
| VA purchased care contracts should include requirements for data sharing, quality monitoring, and care coordination.                                   | <ul style="list-style-type: none"> <li>By developing a High-Performance Network, VA plans to implement standards that improve data sharing, monitoring, and care coordination (<i>Chapter 6: Plan to Develop Provider Eligibility Requirements and Element 9 Medical Records Management</i>).</li> <li>VA will identify top performers, measure provider productivity, and develop incentives such as value-based payments (<i>Element 6: Plan to Develop Provider Eligibility Requirements and Element 9 Medical Records Management</i>).</li> </ul>       |

| Independent Assessment Recommendation  | Description of Alignment to New VCP  |
|--|--|
| VA and Congress should adopt a consistent strategy for setting reimbursement rates across purchased care initiatives.  | <ul style="list-style-type: none"> <li>The New VCP proposes consistent reimbursement rates tied to regional Medicare. Rates recommendations include exceptions for specific underserved geographic areas (e.g., Alaska, Hawaii, Guam, Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands); negotiated rates for services not covered by Medicare rather than VA paying billed charges (<i>Element 5: Provider Reimbursement Rates</i>).</li> <li>The New VCP will strengthen existing relationships with DOD, IHS, Tribal, and FQHC partners (<i>Element 5: Provider Reimbursement Rates</i>).</li> </ul> |
| VA should consider adopting innovative, but tested, ways to purchase care.   | <ul style="list-style-type: none"> <li>Over time, the New VCP will evolve to include innovative practices from industry for purchasing care, such as shifts to bundled or value-based payments (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>   |
| VA and Congress should eliminate inconsistencies in current authorities and provide VHA with more flexibility to implement a purchased care strategy.  | <ul style="list-style-type: none"> <li>The New VCP proposes to eliminate inconsistencies between various purchased care mechanisms by establishment of a single program (<i>Element 1: Single Program for non Department Care Delivery</i>).</li> </ul>  |
| <b>Assessment D. Access Standards</b>  |  |
| Care delivery sites should continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet the demand, including the use of alternate supply options, such as alternate clinicians, telemedicine consults, patient portals, and web-based information services and protocols. | <ul style="list-style-type: none"> <li>The New VCP will be flexible to provide access to care through a high-performing network as demand changes (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> <li>Services provided in the network will be complementary to internal VA health care delivery (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>   |
| <b>Assessment H. Health Information Technology</b>   |  |
| VA should explicitly identify mobile applications as a strategic enabler to increase Veteran access and satisfaction and help VHA transition to a data-driven health system.   | <ul style="list-style-type: none"> <li>Enhancing the mobile apps portfolio to support the future state continuum of care coordination, including aspects of patient navigation, secure messaging and mobile Blue Button (<i>Introduction: Care Coordination</i>).</li> </ul>   |
| <b>Assessment I. Business Processes</b>  |  |
| VHA: Develop a long-term comprehensive plan for provision of and payment for non-VA health care services..   | <ul style="list-style-type: none"> <li>VA will pursue a claims solution and simplified processes as it evolves to achieve parity with best practices, working toward consistent, timely payment (<i>Element 4: Billing and Reimbursement</i>).</li> <li>The New VCP develops a single, streamlined billing and reimbursement process to support the program (<i>Chapter 1: Single Program for non-Department Care Delivery</i>).</li> </ul>  |

| Independent Assessment Recommendation   | Description of Alignment to New VCP  |
|---|--|
| VHA: Standardize policies and procedures for execution of non-VA Care, particularly <i>The Choice Act</i> , and communicate those policies and procedures to Veterans, VHA staff, VHA providers, and non-VA providers.. | <ul style="list-style-type: none"> <li>• VA will standardize business rules and processes under a uniform system (<i>Element 10: Transition Plan</i>).</li> <li>• The transition plan lays out the key elements of the change management plan necessary to communicate changes in community care programs and processes to all stakeholders (<i>Element 10: Transition Plan</i>).</li> </ul>   |
| VHA: Employ industry standard automated solutions to bill claims for VHA medical care (revenue) and pay claims for non-VA Care (payment) to increase collections to improve payment timeliness and accuracy..           | <ul style="list-style-type: none"> <li>• Under the New VCP, VA will pursue a claims system that employs best practices, standardized business rules, and auto adjudication, that will help it ensure compliance with the Prompt Payment Act (<i>Element 4: Billing and Reimbursement and Chapter 7: Prompt Pay Compliance</i>).</li> </ul>   |
| VHA: Align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector..  | <ul style="list-style-type: none"> <li>• VA will adopt clinical and administrative best practices under the New VCP using data on Veterans' needs and the quality of providers that will allow for parity inside and outside of VA (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>   |
| VHA: Simplify the rules, policies, and regulations governing revenue, non-VA Care, eligibility, priority groups, and service connections, educate all stakeholders, and institute effective change management..         | <ul style="list-style-type: none"> <li>• The New VCP defines a single set of eligibility requirements for the circumstances under which Veterans may choose to receive health benefits from community providers, enabling timely and convenient access to care in alignment with best practices (<i>Element 2: Patient Eligibility Requirements</i>).</li> <li>• The New VCP will also include plans to communicate these changes to stakeholders (<i>Element 2: Patient Eligibility Requirements</i>).</li> </ul> |

b. Given that VA has spent the past year implementing the current VA Choice Program, at taxpayers' expense, why isn't VA considering modifying this existing program to incorporate the proposed changes proposed in your plan based?

Response. In developing the plan, VA worked with critical stakeholders (e.g., Veterans Service Organization, VA staff and clinicians, Federal partners, and Health Care Industry Leaders) to determine what is working well and the challenges with the current VA Choice Program. VA plans to build on what is working well and make changes to address the challenges that face Veterans, community providers, and VA employees.

c. Would starting over create a transition risk which ultimately could further frustrate and confuse veterans seeking care through VA?

Response. VA will preserve what is working well in the current program and develop plans to transition what is not working well. To minimize potential transition risk, VA plans to implement an agile methodology approach and project management techniques. The agile methodology approach allows VA to fix the most pressing issues with community care today, while making continuous updates to promote a learning health system that evolves with the needs of the Veteran population. For any potential changes, VA will communicate with impacted stakeholders to reduce confusion. Furthermore, by creating a single set of eligibility criteria, VA hopes to reduce confusion among Veterans regarding community care.

*Question 6.* How does VA plan to provide effective oversight and project management support throughout the implementation process? What additional resources will be required? Does VA have the personnel with the necessary skills to successfully implement these changes? If not, where do you intend to get the requisite expertise?

Response. VA has developed a governance structure that will oversee the transition to the New VCP. Using a systems of systems approach will allow VA to execute changes through rapid cycle deployment using an agile approach that supports quick improvements that lead to the longer term changes. VA has established seven Portfolio teams that will oversee projects within their areas. Each team will consist of program office and field subject matter experts and be required to implement project management support including the development of project plans, timelines, and milestones. VA will also work with external consultants with health plan management expertise to assist throughout the implementation process.

---

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL  
TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* The testimonies of the Panel II witnesses—Mr. Butler of The American Legion, Mr. Selnick of Concerned Veterans of America, Mr. Rausch of the Iraq and Afghanistan Veterans of America, and Mr. Kelley representing *The Independent Budget* group—included several specific recommendations regarding VA’s consolidation plan. Please provide VA’s response to those recommendations.

Response. The Department of Veterans Affairs (VA) appreciates the feedback received from Mr. Butler of The American Legion, Mr. Selnick of Concerned Veterans of America, Mr. Rausch of the Iraq and Afghanistan Veterans of America, and Mr. Kelly representing *The Independent Budget* group, and has taken into consideration the specific recommendations made. VA will incorporate all applicable feedback in continuing to direct the consolidation of community care programs when it is in the best interest of the Veteran and tax payers.

*Question 2.* As we think about how to consolidate VA’s care in the community, the cost of such an undertaking will be a key aspect. Members of this Committee will need to consider as stewards of taxpayer’s money. You have estimated the total one-off costs for systems redesigns over the three phases to be nearly \$1.9 billion.

a. During the House’s hearing, I understand VA indicated it would like to take \$421 million from the \$10 billion pot of funds for the Choice Program to pay for Phase I of the systems redesign. Do you intend to take the other money needed for phase II and III system redesigns from that pot as well?

Response. No, VA does not intend to use Choice funds for Phase II and Phase III.

b. Based on what VA currently spends on care in the community, what it expects to spend on the Veterans Choice Program as amended, in addition to further improvements to delivery of care in the community which will increase reliance and your desire to expand access to emergency treatment and urgent care, please confirm or correct that we are looking at an annual cost of roughly \$18 billion for the New Veterans Choice Program.

Response. VA estimated that the cost for expanded emergency treatment and urgent care, and increased reliance for Phase II to be \$3.26 billion, and for year one of Phase III to be \$3.64 billion. VA would need legislative authority to amend the Veterans Choice Program (VCP) and expand emergency treatment and urgent care. Without the expansion of emergency treatment and urgent care and the implementation of the new VCP, VA anticipates the existing community care program would cost \$13.5 billion. This total includes approximately \$7 billion a year that is already built into the base discretionary budget for historical costs of hospital care, medical services, and Long-Term Care Services and Supports (LTSS). In addition, this total also assumes the continuation of the existing Veterans Choice Program with no modification at a cost of approximately \$6.5 billion estimated annual cost. This cost is currently being offset by the initial \$10 billion in mandatory appropriations provided in conjunction with the original authorization of the Veterans Choice Act. Following expiration of these funds and/or the initial program’s authorization (anticipated August, 2017), VA will need additional legislative authority and funding to continue the current VCP even without the Plan’s proposed modifications.

c. Given that approximately \$4 billion has been spent from the Choice Fund to date and the projected burn rate in the coming months and year, will VA be able to stand up a new ambitious program before the \$10 billion supplemental pot of funding runs out?

Response. VA does not intend to use Choice funds to implement the entire new VCP. VA plans to use Choice funds to pay for Phase I, and for additional Phases and years VA will request funding through the annual budget process for the remaining needs. To establish the new VCP, VA will need additional legislative authority and an identified funding stream to cover the Veterans Choice Program costs after the exhaustion of the initial appropriation of \$10 billion. Without these au-



thorities and offsets, VA will not be able to implement a consolidated community care program.

*Question 3.* The VA Consolidation Plan emphasizes the need for enhanced staffing to manage the increase in care coordination that will follow from the expansion of care in the community. However, as has been reported widely and discussed in other hearings this year, VA is suffering from staffing shortages among several key clinical positions including those who are central to the Patient-Aligned Care Teams involved in care coordination. For example, VA data shows a loss rate of nearly 9% for physicians and 8% for nurses in fiscal years 2014 and 2015. In each of these years, VA lost over 6,000 physicians and nurses combined—presumably, many of whom would need to play a key role in the coordination of care for veterans seeking care in the community.

a. The majority of the staff losses for physicians and nurses for fiscal years 2014 and 2015 were due to staff who quit. What is VA doing to learn from these employee exits that will enable the Department to better retain staff—especially in these key shortage positions?

Response. The Under Secretary for Health (USH) has outlined five strategic priorities for the Veterans Health Administration (VHA), one of which is Employee Engagement. VHA is working to create a work environment where employees are valued, supported, and encouraged to do their best for Veterans. This includes making VA a place where all employees and providers feel supported and able to serve our Veterans. This priority is in alignment with the Secretary's *MyVA* strategic initiative to improve the Employee Experience by focusing on people and culture.

VHA is developing a program to provide newly hired physicians with the necessary orientation, relationships, and experiences to succeed as a VA physician. The program is based on a series of seven modules, accomplished over a 2-year period that builds upon a foundation and provides challenging learning to engage, develop, and ultimately retain physicians. A workgroup is currently tasked with developing the content for the modules, and a pilot program will commence upon completion of the curriculum.

In addition, the Education Debt Reduction Program (EDRP) and development programs such as scholarships are targeted toward the top five shortage occupations. In the fiscal year (FY) 2015 award cycle, 82 percent of new EDRP awards recipients were individuals in the top five shortage occupations and 84.2 percent of scholarships were awarded to nurses.

b. Does VA conduct exit interviews with staff who quit? If so, does VA track the reasons for employee's who quit and are there any trends among those leaving shortage positions that could inform future retention efforts?

Response. VHA utilizes the electronic VA Exit Survey per VA Directive 5004, which states that the purpose of the exit survey is to provide voluntarily separating employees the opportunity to communicate their reasons for leaving. The information provided is shared with VA supervisors, managers, leadership, and human resources professionals to assist them in identifying methods to improve employee retention and morale at the local and national levels. Improved retention and morale will improve productivity and save VA organizations money that would otherwise be spent on recruitment and staffing.

The overall response rate to the VA Exit Survey is approximately 30 percent annually, which is considered a typical response rate for an exit survey. The survey is offered to employees who are leaving the VHA system voluntarily and is not offered to individuals who are transferring to another facility or administration within VA. For FY 2015, response rates for the top five shortage occupations ranged from 24 percent for physicians (465 surveys) to 96 percent for physical therapists (88 surveys). Psychologists had an 84 percent response rate (254 surveys), nurses had a 35 percent response rate (1,614 surveys), and physician's assistants had a 34 percent response rate (56 surveys). It is important to note that low response rates may influence the generalizability of the data. To improve response rates, VHA is exploring the option of making the VA Exit Survey mandatory. Responses to the survey indicate that advancement for a unique opportunity elsewhere, normal retirement, relocation with a spouse, and family matters, such as marriage and pregnancy, are the most common reasons for leaving VHA.

*Question 4.* I have heard from some providers in Connecticut that delays in the billing and payment processes have created a disincentive for some providers to work with the VA to provide care in the community. Are there actions VA can take now to address current delays in billing and payment to providers offering care in the community?

Response. VA Connecticut had scanning issues due to staffing shortages as well as problems with scanning equipment. In Veterans Integrated Service Network

(VISN) 1, the scanning process is the responsibility of the local stations; the function did not transfer over to Chief Business Office Purchased Care (CBOPC). The normal process for scanning is to scan everything within 3–5 days in VISN 1. However, due to the staffing and scanning issues, VA Connecticut was unable to scan for several days and fell behind. Normally, 300–500 claims are scanned each day. On two separate days, VA Connecticut staff scanned close to 4000 claims, combined. This resulted in a new backlog being created and VA Connecticut was no longer meeting the measures set by CBOPC. Those measures are defined as: 80 percent of all authorized claims will not age greater than 30 days and unauthorized claims will not age greater than 45 days. However, as of this writing the metrics for VA Connecticut have improved and we are back at the goals set by CBOPC. As of December 17, VA Connecticut is 93 percent current with authorized claims and 84 percent current with unauthorized claims.

*Question 5.* The VA proposal includes plans to provide veterans access to a tiered network of providers in to promote veteran choice and access to care in the community. The VA indicates that it will apply industry-leading health plan practices for the tiered network design and that providers must “demonstrate high-value care” in order to be considered in the Preferred tier and to receive higher payment.

a. Please provide clarification as to how VA will determine whether a provider is offering “high-value care.”

Response. VA will use industry standards and Medicare metrics to determine high-value care. VA will conduct critical analyses to determine which quality metrics best align to its mission, vision, and strategies. VA will continue to work with industry and Federal health leaders as it examines these quality metrics.

b. I have heard from the American Medical Association and the Connecticut State Medical Society that there is concern among providers regarding the tiered network approach. Specifically, that by tiering or narrowing the network, the New Veterans Choice Program may leave patients unable to find specialists or physicians in the top tiers in their areas. With many veterans requiring specialized services, how will you ensure that veterans have access to the top tier and specialist care, regardless of their location?

Response. The Preferred network will include community providers that meet minimum credentialing requirements, in addition to performing highly against quality metrics, demonstrating high-value care, and signing a pledge to serve U.S. Veterans. The Standard network will consist of VA community providers that meet minimum credentialing requirements. The intent of the tiered network is not to narrow the network but reduce administrative burdens for community provider. One of the goals of the network is to reward providers for delivering high-quality care, while promoting Veteran choice and access. VA recognizes the significant challenges in delivering care to Veterans due to geographic limitations and the unique needs of the Veteran population. VA understands the need to establish a broad and flexible network providing convenient care near to where Veterans live. Therefore, VA anticipates in these circumstances that it may have to use provider agreements for certain services.

c. While a tiered approach may be beneficial in locations where there are numerous providers participating in the program, rural areas or locations where provider participation is low may make this approach less effective. Please discuss the VA’s strategy for ensuring a threshold of providers to support a tiered network.

Response. As described in the report, VA faces significant access challenges in delivering care to Veterans due to geographic limitations and the unique needs of the Veteran population. To address these challenges, VA plans to establish a broad and flexible network providing convenient care near to where Veterans live. VA will work with local VA medical facilities in rural communities to enhance partnerships with community providers to meet the local needs of Veterans. By establishing a network, VA will increase visibility into the community capacities and the services Veterans need, and make necessary changes as these trends evolve.

---

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

*Question 1.* When considering the eligibility requirements for this new program, do you plan to revise the 40-mile rule so that it applies to 40 miles to the nearest VA facility that offers the specific service the veteran seeks?

Response. The 40 mile rule will apply to a Veteran’s distance from a primary care provider (PCP) because this is the most critical relationship. From that point, the

Veteran's PCP is responsible for coordinating care for specific services that extend beyond primary care.

*Question 2.* For all the different processes—billing, managing the provider network, authorizations—will you be using a third party network?

Response. It has not yet been decided whether or not the Department of Veterans Affairs (VA) will use a third-party network for these processes. VA is currently conducting analyses to determine how best to implement the program.

*Question 3.* What is your assessment of the current contractors' performance for the existing Choice Program? Will you be taking this into consideration when determining whether to use a third party network?

Response. VA understands the time constraints related to implementing the program may have caused some unintended consequences. Going forward, VA plans to use lessons learned to improve the use of third-party networks in the future. VA is currently in the processes of taking the necessary steps to make these assessments.

*Question 4.* Why does this plan put Federal providers first instead of allowing veterans to choose the private sector if they want?

Response. The Core Network, which includes VA's Federal partners, is critical to VA's mission, vision, and strategies.

*Question 5.* Have you considered some of the consequences or downfall to completely centralizing the system—all the way from reimbursement to authorizations to provider eligibility—rather than still allowing local VA facilities to have some control over the process?

Response. VA has spoken with numerous stakeholders, including local VA facilities, in developing this plan and has aligned the plan with standard operational models and what will best serve Veterans and VA employees. Centralizing systems and processes will reduce variabilities and standardize care. Currently, VA is considering what level of control should be delegated to local facilities and is having ongoing discussions about how to balance decisions that need to be made locally and regionally versus national.

*Question 6.* If Congress gives VA the authority it needs to implement this new plan, what specifically will VA be doing to ensure its employees and veterans understand how this new program works?

Response. VA will implement a comprehensive plan to strategically communicate all aspects of this new program to stakeholders. This program was designed to be less complex than previous community care programs, and thus VA is confident that it will be successful in communicating the new plan to employees and Veterans. The plan has already begun to be socialized internally within VA.

---

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO  
THE U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* I am pleased to see the plan put forth by the VA to consolidate its non-VA care programs, I am concerned about the phasing, and implementation of the plan and whether it will be seamless for our veterans.

Two issues that are of greatest concern relates to electronic medical records and whether providers outside of VHA will be trained to understand the military culture.

a. Explain what effect that understanding the military culture poses to proper care delivery?

Response. It is important that community providers understand the unique health challenges faced by Veterans when providing them with care. The Department of Veterans Affairs (VA) health care providers are accustomed to interacting with Veterans and are trained to understand the intricacies of certain conditions that are unique to Veterans. VA shares information on military cultural awareness with community providers to assist them in gaining the same understanding.

b. What specific steps will the VA take to address these two concerns?

Response. The future state will focus on Health Information Exchanges and care coordination. In addition, preferred network vendors will be required to receive training in military awareness. These efforts will ensure that Veterans experience high quality, consistent care whether that is in a VA facility or in the community.

*Question 2.* How can the VA do additional outreach, to ensure that all veterans, particularly lower-income veterans are properly served by the VA as it transitions into a new phase of services?

Response. VA is committed to providing high quality care to all Veterans. Through this program Veterans will have better access to care, and VA will take the necessary steps to make sure this extends to all Veterans that are eligible. It will certainly provide Veterans in underserved communities more options and better access to care.

---

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON FOR  
HON. STEVE DAINES TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* Prior to the Choice Act being signed into law, there were several existing programs to provide for fee-based care to veterans by outside providers, some of which allowed for non-Medicare providers to administer care. The Choice Program, on the other hand, requires every provider in the program to be a Medicare provider.

a. As we consider ways to consolidate and improve the programs that provide care for our veterans, would allowing non-Medicare providers, including psychologists, to administer care or increased flexibility for reimbursement rates result in more timely care for veterans in Montana and across the country?

Response. The Department of Veterans Affairs (VA) does not plan to limit the external network to only Medicare providers. VA recognizes establishing a robust network of providers will also include non-Medicare providers. This is similar to recent changes in the existing program as a result of Public Law 114–41. As VA considers ways to do this while still maintaining high standards for the quality of care Veterans receive, it will be important to develop strong credentialing processes for non-Medicare providers that only allow high-quality providers into the network.

b. If so, what alternative reimbursement rates or standards would be most effective for providing care for veterans?

Response. As described in the report, VA plans to move toward regional Medicare rates. However, due to geographic limitations in certain locations, VA understands the importance of developing a flexible network to meet local Veterans needs. Additionally, as new models mature, VA will look toward CMS as they begin to pilot new payment models, including value-based payments and bundled payments.

*Question 2.* When the Choice Program was signed into law, it required that the program be implemented within a 90 day period of time. It is my understanding that this strict timeline played a significant role in reducing the number of third party administrators (TPAs) willing to bid for the contract, and resulted in two TPAs with existing customer service issues facilitating non-Department of Veterans Affairs (VA) care obtaining the contract. I have heard from thousands of Montana veterans expressing frustration and anger with the quality of service provided by existing TPAs.

a. How is the VA holding the TPAs accountable?

Response. Within the existing contract, VA established deliverable objectives that address how the contractor shall provide all health care necessary to accomplish the contract requirements, as well as applied a Quality Assurance Surveillance Plan (QASP) that measures the desired outcomes.

Contract deliverables stipulate the frequency, methodology; contractor timeliness, acceptance period of reports, implementation plans, and structuring of administrative fee data. QASP measures pre-determined performance thresholds linked to the VA's goal of providing immediate access to high-quality medical care in the community when unable to do so through VA facilities.

Contracting Officer Representatives (COR) review contract deliverables monitoring compliance and adherence to the specified frequency, nature, and completeness of deliverable articles. CORs also provide technical assistance reviewing reports, document contract performance related to defined standards, and review administrative incentives and disincentives related to performance results.

The Contracting Officer serves as the primary authority ensuring contractor compliance and administering findings and determinations. In the event corrective action is required, the Contracting Officer provides the necessary communication addressing performance, quality standards and medical documentation. The CORs are primarily responsible for technical administration of the contract and ensure proper surveillance of the contractor's performance, cataloging, and reporting deficiencies, and accepting and or rejecting deliverables. On September 24, 2015, the Contracting Officer issued Letters of Correction addressing the Contractors' performance, requesting immediate improvement in the following areas: medical documentation return; timeliness of appointment scheduling; timeliness of appointment completion, and network insufficiency. The Contractors have provided corrective action plans addressing the issues identified. Expectation is for the Contractors to improve per-

formance next quarter (2nd quarter) or further action will be taken. VA has also established joint Program Management Review meetings with the Contractors and Contract Officer providing an opportunity to discuss PWS and QASP current state, as well as, review and monitor performance.

b. What performance metrics are being measured?

VA Response.

- Timeliness of authorization to Veteran appointment
- Timeliness of Veteran clinically indicated date to Veteran appointment date
- Timeliness of critical and urgent findings reported
- Veteran commute times
- Timeliness of Veteran Safety Event Reports
- Timeliness of Medical Documentation Return
- Timeliness of Patient Complaints/Grievances

c. Moving forward, what can be done to ensure that there is a thorough bidding process and robust competition amongst TPAs to obtain VA contracts?

Response. VA employs government contracting officials whose procedures conform to the Federal Acquisition Regulation. Acquisitions are accomplished by sealed bidding, negotiation, or simplified acquisition procedures. Each of these methods is designed to promote full and open competition to the maximum extent possible, which in turn allows all responsible bidders/offers an opportunity to compete. The most suitable, efficient, and economical procedure will be used, taking into consideration the circumstances of each acquisition. To ensure VA chooses the most competent contractor/s, additional time over 90 days would be extremely beneficial for the process.

Senator MORAN. Gentlemen and ma'am, thank you for joining us. I cannot see the name plate, but I think it is Mr. Butler. Please proceed.

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

Mr. BUTLER. Thank you, Acting Chairman Moran, Ranking Member Blumenthal, and Members of the Committee.

The American Legion believes in a strong, robust veterans health care system designed to treat the unique needs of those who have worn the uniform. However, in the best of circumstances, there are situations where the system cannot meet the needs of the veteran and the veteran must seek community—care in the community.

I am privileged to be here today and to speak on behalf of The American Legion, our National Commander, Dale Barnett, and more than two million members in over 14,000 posts across the country that make up the backbone of the Nation's largest wartime Veterans Service Organization.

The American Legion recognizes that the Choice Program was an emergency measure to make health care accessible to veterans where VA was struggling to deliver such care. In recognition of the needs of an integrated system to deliver non-VA health care when needed, The American Legion believes VA needs to develop a well defined and consistent non-VA care coordination program with appropriate policies and procedures that include a patient-centered strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into consideration.

The VA Purchased Care Program dates back to 1945, when General Paul R. Hawley, Chief Medical Director of the Veterans Administration, implemented VA's hometown program. General Hawley recognized that many hospital admissions of World War II veterans could be avoided by treating them before they needed hospitalization. As a result, General Hawley instituted a program for

hometown medical and dental care at government expense for veterans with service-connected ailments. Under the hometown program, eligible veterans could be treated in their community by a doctor or dentist of their choice.

Fast forward 70 years. VA has implemented a number of programs to manage non-VA community health care programs at the request of Congress. Programs like fee-basis, Project ARCH, Patient-Centered Community Care, and the Veterans Choice program were implemented to ensure eligible veterans could be referred outside the VA for health care if needed. VA states that their Community Care Program would streamline the above programs by transitioning them into a single community health care program that is seamless and transparent to veterans.

While these goals sound positive, The American Legion believes by resolution that a proper plan for non-VA care must include the following elements. Ensure all non-VA community care contract provides complete military cultural awareness and evidence-based training. Provide all non-VA providers with full access to VA's computerized patient records system. Ensure VA continues to improve its non-VA coordination through the Non-VA Care Coordination Program Office. Ensure VA improves collection of non-VA care documentation into the veteran's medical record. Ensure VA develops a national tracking system to avoid national or local purchased care contracts from lapsing. And, an automated claims processing system that fully automates the authorization and payment process.

We are pleased to see that VA's plan incorporates many elements of our resolution. If approved by Congress, the plan will be rolled out using a three-phased approach. The plan will be implemented gradually, much like TRICARE, by developing appropriate provider network streamlining business processes. Additionally, VA plans call for cultivating a provider network to serve veterans utilizing Federal health care providers, academic affiliates, and community providers.

The American Legion believes VA has not yet demonstrated it has the expertise or experience to establish large provider networks. So far this year, it has relied on third-party participants, such as HealthNet and TriWest, to fulfill these requirements. VA plans do not specify whether they will continue using third-party contractors to fulfill this requirement if the plan is approved. Serious thought needs to be given to this question.

VA's plan is clearly a huge undertaking and we have concerns about VA's ability to implement the plan. VA has attempted to roll out or has rolled out numerous projects in past years that required dramatic system, information technology, and policy changes. VA must guarantee Congress, VSOs, and veterans that their community care plan will not result in similar failures like other projects such as Core FLS (Core Financial and Logistics System), scheduling redesign, a veteran's lifetime electronic health record, VA's four major construction projects, or the initial rollout of the Choice Program, to name just a few. Veterans are calling on VA to get it right on their first attempt and not continually waste taxpayers' dollars.

In summary, if VA can address The American Legion's concerns, we are cautiously optimistic that VA plans for moving forward may work and could represent an important step toward a truly integrated model for delivering veterans' health care within VA and the community collectively.

Again, I thank the Committee for their hard work and consideration for this legislation as well as your dedication to finding solutions for problems that stand in the way of delivery of veterans health care, and I am happy to answer any questions.

[The prepared statement of Mr. Butler follows:]

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

The American Legion believes in a strong, robust veterans' healthcare system designed to treat the unique needs of those who have served. However, even in the best of circumstances there are situations where the system cannot meet the needs of the veteran, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion believes the Department of Veterans Affairs (VA) must "develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account."<sup>1</sup>

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising of over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify regarding The American Legion's position on "Consolidating Non-VA Care Programs."

VA has recently rolled out their own proposal to streamline all of the legacy systems for non-VA care and consolidate them into a single program—as they were directed to do by law when Congress authorized the ability to move funds from the Choice program to cover shortfalls in the other non-VA care accounts.<sup>2</sup> As set forth in statute, VA health care falls into one of the following categories: hospital care, outpatient medical care, domiciliary care, rehabilitative services, preventive health services,<sup>3</sup> and extended care services.<sup>4</sup> VA health care is offered to eligible veterans, and in some cases, their spouse and dependents may be eligible for VA health care under the Civilian Health and Medical Program of the VA (CHAMPVA).<sup>5</sup>

The VA purchased care program dates back to 1945, when General Paul R. Hawley, Chief Medical Director, Veterans Administration, implemented VA's hometown program. General Hawley recognized that many hospital admissions of World War II veterans could be avoided by treating them before they needed hospitalization. As a result, General Hawley instituted a plan for "hometown" medical and dental care at government expense for veterans with service-connected ailments. Under the Hometown Program, eligible veterans could be treated in their community by a doctor or dentist of their choice. Since then, VA has implemented a number of programs in order to manage veterans' health care when such care is not available in a VA health care facility, could not be provided in a timely manner, or is more cost effective. Programs like Fee-Basis, Project ARCH (Access Received Closer to Home), Patient-Centered Community Care (PC3), and the Veterans Choice Program (VCP) were implemented by Congress to ensure eligible veterans could be referred outside the VA for needed health care.

VA's Community Care plan would streamline their Fee-Basis, Project ARCH, PC3 and Choice programs by transitioning them into a single community health care program that is seamless and transparent to veterans. VA's stated goals for the plan are to:

- Make access to community health care easier to understand and to meet veteran's overall health care needs;
- Improve the veterans' health care experience across all touch points of care;

<sup>1</sup> Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs

<sup>2</sup> Public Law 114-41: July 31, 2105: Section 4002

<sup>3</sup> Title 38 U.S.C. 1701

<sup>4</sup> Title 38 U.S.C. 1710B

<sup>5</sup> Title 38 U.S.C. 1781:CHAMPVA Program

- Clarify community care for VA staff, and make it easier for community providers to partner with VA;
- Provide seamless connections between VA and community providers;
- Apply leading practices from health plans, health systems, and high performing VA programs, and
- Prepare VA to evolve to meet new and changing demands and support health care trends.

While these goals sound positive, The American Legion believes the VA plans lacks specific details on how the goals would be accomplished to ensure success. The American Legion believes a proper plan for non-VA care should include the following elements:<sup>6</sup>

- Ensure all non-VA care contracted providers complete military culture, awareness, and evidence-based training to ensure veterans receive the same or better quality of care standards that they would if they received this care within VA;
- Provide all non-VA providers with full access to VA's Computer Patient Record System (CPRS) to ensure the contracted community provider can review the patient's full history, allow the provider to meet all the quality of care screening and measures tracked in CPRS, and speed up receipt and documentation from the non-VA provider encounter to ensure it's added to the veteran's medical record;
- Ensure VA continues to improve its non-VA care coordination through the Non-VA Care Coordination (NVCC) program office to improve and standardize their process for referrals to non-VA care;
- Ensure VA improves collection of non-VA care documentation into the veteran's medical record;
- Ensure improved coordination of care between VA and non-VA providers;
- Ensure VA develops a national tracking system to ensure national or local purchased care contracts do not lapse; and
- An automated claims processing system should be implemented that automates the payment process leaving little to no room for human errors.

Additionally, VA's community health care plan does not address how community health care providers will be trained to better understand military culture. VA needs to ensure all non-VA care contracted providers complete military culture awareness training to ensure veterans receive the same standard of care or better than they receive in VA. The American Legion strongly believes that the Department of Veterans Affairs (VA) must develop and ensure that all non-VA health care contracts with non-VA health care providers includes military culture and awareness training in order for the veteran to receive the best health care.<sup>7</sup>

Under VA's current plan, it calls for a seamless connection between VA and community health care providers. Care coordination would help veterans navigate the health care system by providing health care management and coordination that is necessary to achieve positive health care outcomes and enhanced medical records sharing. The VA needs to provide all non-VA providers with full access to VA's Computerized Patient Record System (CPRS) to ensure that community health care providers can review the patient's full medical history for continuity of care purposes. Allowing access to CPRS would allow the provider to meet all the quality of care screening and measures that are tracked in CPRS. It would also speed up receipt and documentation from the non-VA health care encounter to ensure all documentation is added to the veteran's medical record.

The American Legion believes VA's plan to provide Non-VA providers full access to VA's CPRS is a good start, but the plan fails to address a systematic approach of electronic medical record sharing. VA's plan must include electronic medical information sharing between the non-VA providers to include the Department of Defense (DOD), Indian Health Services (IHS), and non-VA community health care providers in order to provide veterans the best health care experiences.

According to VA, if approved by Congress, the plan will be rolled out using a three-phased approach. The plan will be implemented gradually, much like how TRICARE was over the years, by developing appropriate provider networks and streamlining business processes. The American Legion strongly believes VA must standardize its reimbursement rates, but not set the rates too low where providers are discouraged in partnering with the VA in providing needed health care services to veterans outside the VA healthcare system.

Due to continuously receiving concerns from veterans about slow payments and the lack of medical record documentation, The American Legion has concerns about VA's ability to implement the plan. While VA must ensure appropriate medical

<sup>6</sup>Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs

<sup>7</sup>Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs



record documentation is received from the non-VA health care provider to incorporate into the veteran's medical record, the veteran should not be held hostage due to VA and non-VA health care providers inability to implement a process that ensures medical record sharing. These delays have resulted in adversely impacting veteran's credit, and VA must guarantee whatever process is put in place will not result in veteran's being harmed in any way what so ever.

VA's plan would call for cultivating a provider network to serve veterans utilizing Federal health care providers, academic affiliates, and community providers. The American Legion believes VA has not demonstrated it has the expertise or experience to establish large provider networks and has relied on third-party participants i.e. HealthNet and Tri-West to fulfill these requirements. VA plan does not state whether it would continue with utilizing third-party contractors to fulfill this requirement; this must be one of the first things decided before moving forward.

#### CONCLUSION

In summary, if VA can address the issues The American Legion has highlighted above, The American Legion is cautiously optimistic that the framework for moving forward is positive and that this plan could represent an important step moving toward a truly integrated model for delivering veterans' health care at the VA and within the community collectively.

The American Legion thanks this Committee for their diligence and commitment to our Nation's veterans as they struggle to access health care across the country. Questions concerning this testimony can be directed to Warren J. Goldstein, Assistant Director in The American Legion Legislative Division.

Senator MORAN. Thank you very much.

Mr. Selnick.

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

Mr. SELNICK. Thank you, Chairman Moran, Ranking Member Blumenthal, and Members of the Committee. I appreciate the opportunity to testify at today's hearing on the recently released VA plan for consolidating non-VA care programs.

In the interest of full disclosure, I am a Commissioner on the Commission on Care. My testimony today reflects only that of CVA and my own personal observations. In no way does my testimony reflect, nor is it representative of, the Commission, the VA, or the administration.

CVA agrees that there needs to be one new Veterans Choice Program that deals with the root cause problems and is simple, effective, and fiscally responsible, with the veteran in control of how, when, and where they wish to be served. This has been a stated goal of the VA.

Although we laud the VA in coming up with a comprehensive plan for such a program, after careful review, it is our opinion that this plan does not meet the criteria listed above. Instead, it continues the VA status quo, cherry picks the Independent Assessment, and ignores the Commission on Care. The plan will fail, cost the taxpayer billions, and impact negatively on veterans' health care.

Instead of a simple program, VA has developed a grandiose dream concept plan that does not deal with the challenges it faces, nor is it in line with Dr. Shulkin's comments that VA will shift the way it does health care by ceasing to provide services commonly found in the health care industry. VA instead is expanding into areas it does not have expertise in.

We identified five key flaws in the plan. First, implementation requires a high-performing health care organization, such as the

Cleveland Clinic. VHA is a low-performing health care system based on socialized medicine, using an antiquated HMO staff model, focusing on a high degree of control. As the Independent Assessment has stated, solving these problems will demand far reaching and complex changes that, when taken together, amount to no less than a systemwide reworking of VHA.

The number of issues VHA currently faces appears overwhelming. VHA is in the midst of a leadership crisis, and VA health care systems are in danger of becoming obsolete. Last year, VHA made 85 million appointments but only completed 55 million appointments. Recent headlines such as “Lapses in Urology Care at Phoenix VHA Endanger Patients,” and VA IG and GAO reports suggest VHA is not up to the task.

Second, VA has provided a concept plan that proposes some lofty goals and operating principles but is not grounded in the reality of the way veterans access their care. VHA is operating on the false premise that it is the medical home for the veterans it serves while providing only a minority of their health care. As the Independent Assessment states, veteran patients’ reliance on VA ranges from 15 to 34 percent for office-based visits to laboratory services.

Third, VA gives lip service to the Independent Assessment’s recommendations, findings, and systems approach, but cherry picks some recommendations and ignores others. VA is focused on what is best for it instead of embracing the governance, data and tools, operations and leadership reforms needed.

Fourth, veterans want real choice in private health care. According to an October 2015 poll, 91 percent of veterans want more health care choices. Instead, VA takes greater control over veterans’ eligibility and access. Veterans would be eligible if they are more than 40 miles from a VA designated PCP. This is unrealistic because veterans’ PCPs are not designated from VA and most of their needed care is from a specialist. With wait times, VA is gaming the system by having undefined wait time goals for every service and leaving it up to the VA provider to decide the clinically necessary timeframe. Accessing the high-performance network is another example. VA’s undetermined referral process, which could take months for each step. The first hurdle is the VA core network and the preferred and standard tiers, all controlled by VA.

Fifth, the plan is extremely premature, especially in light of the charge Congress gave the Commission on Care to examine how best to organize VHA and deliver health care to veterans. The VA plan could short circuit this existing charge and be in conflict with the Commission on Care recommendations.

To overcome the flaws and challenges, CVA proposes the following three steps. One, VA should focus on the short-term solutions of consolidation. That is phase one in the plan. It should be refined with the addition of implementation evaluation. It should be done in consultation with the Commission on Care.

Two, VA should refine phases two and three of the program, in consultation with the Commission on Care, using an integrated systems approach with proper governance, data and tools, operations and leadership reforms.

Three, VA should finalize phases two and three only after the Commission on Care provides its findings and recommendations to

the President and Congress. Although it is tempting to move too quickly on consolidating the non-VA care programs, you must break the cycle of reform and failure by having the right plan that focuses on the veterans first and not the VA.

As President Theodore Roosevelt said, “A man who is good enough to shed his blood for the country is good enough to be given a square deal afterwards.” Let us make sure our veterans get the square deal they deserve on their health care.

CVA is committed to overcoming any and all obstacles and we look forward to working with the Chairman, Ranking Member, and all Members of this Committee to achieve this shared commitment to veterans.

[The prepared statement of Mr. Selnick follows:]

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

Thank you Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. I appreciate the opportunity to testify at today’s hearing on how to consolidate non-VA care programs to ensure veterans receive the care they need without delay and to review the adequacy of the recently released plan to consolidate seven programs of the Department of Veterans Affairs (VA) into one non-VA care program. Your leadership on this issue is critical to ensure that the plan is well thought out and deals with the root-cause problems, so that veterans truly get a real choice that provides them the timely, convenient and quality health care they deserve.

In the interest of full disclosure, I am a Commissioner on the Commission on Care, but my testimony today reflects Concerned Veterans for America (CVA) and my own personal observations. In no way does my testimony reflect, nor are they representative of, the Commission, the VA, or the Administration. The views I present here today are entirely my own.

CVA agrees that it is very important to consolidate all of the various purchase care programs into one New Veterans Choice Program. This single program needs to be simple, effective, fiscally responsible, practical, and feasible. Just as important is that the new program be veteran-centric and move toward *real* choice so that the Veteran is in control of how, when, and where they wish to be served—a stated goal of the VA in the past.<sup>1</sup>

Although we laud and appreciate the VA in coming up with a comprehensive plan in such a short time, after careful review it is our opinion that this New Veterans Choice Program does not meet the criteria listed above, and instead perpetuates the VA status quo. We feel that the proposal cherry-picks the work and intent of the Independent Assessment while ignoring the Commission on Care that was established by the authority granted in the Veterans Access, Choice, and Accountability Act of 2014. Stated bluntly, we believe that approval and implementation of the plan will lead to certain failure while costing the taxpayer billions and impacting negatively on veterans’ health care.

VA has fallen back onto its old ways and developed a grandiose dream concept plan that does not deal with the reality and challenges it faces to stay afloat with its current day to day operations. Nor is it in line with Dr. Shulkin’s recent comments that VA will shift the way it does health care by “[ceasing to] provid[e] services commonly found in the health care industry.”<sup>2</sup> VA once again is doubling down on its previous failures by trying to over control all aspects of health care provision to veterans and expanding its health care operations into areas it does not have expertise in.

To illustrate our concerns, I will examine five key flaws in the premises and processes in the VA new Veterans Choice Program.

*First*—Implementing VA’s plan would likely require a high-performing health care organization, with the organizational capability and desire carry out the task that VA has set for itself. The Cleveland Clinic is possibly a model for the kind of modern, dynamic and flexible organization that would be able to implement such a plan.

<sup>1</sup>“The Road to Veterans Day 2014 Fact Sheet” [http://www.blogs.va.gov/VAAntage/wp-content/uploads/2014/09/RoadToVeteransDay\\_FactSheet\\_Final.pdf](http://www.blogs.va.gov/VAAntage/wp-content/uploads/2014/09/RoadToVeteransDay_FactSheet_Final.pdf), accessed May 5, 2015.

<sup>2</sup><http://Federalnewsradio.com/management/2015/10/va-pitches-fundamental-shift-veterans-health-care-congress/>, accessed November 24, 2015.

As it stands, VA's Veterans Health Administration (VHA) is a low-performing health care system that is based on socialized medicine, and which uses an antiquated HMO staff model. This state of affairs require broad-based and fundamental reforms to way VHA does business. It requires us to go back to drawing board and not add more layers on top of a crumbling infrastructure. Unfortunately, too many stakeholders are invested in perpetuating a dated and failing model rather than bringing VA into the 21st Century.

As the Independent Assessment has shown, VHA is clearly a broken health care organization that at best is treading water. Some examples from the Assessment include:

- “The Independent Assessment highlighted systemic, critical problems and confirmed the need for change that has been voiced by Veterans and their families, the American public, Congress, and VHA staff. Solving these problems will demand far-reaching and complex changes that, when taken together, amount to no less than a system-wide reworking of VHA.”
- “As the assessment reports reveal, the number of issues VHA currently faces appears overwhelming.”
- “VHA is in the midst of a leadership crisis.”
- “VA/VHA health care systems are in danger of becoming obsolete.”
- These shortfalls should not be viewed as individual anomalies, but rather manifestations of the systemic findings that plague VHA.

A further example from VA operations that highlights the situation is last year VHA made 85 million appointments but only completed 55 million appointments.

Recent headlines such as “Lapses in urology care at Phoenix VA endangered patients”<sup>3</sup> and “Florida Hospitals: VA owes \$134 million in unpaid claims”<sup>4</sup> Does this sound like a health care organization that is up to the task that VA has set for itself?

*Second*—VA has provided a concept plan, not an implementation plan. Although it discusses some lofty goals, enumerates ideal operating principles, and makes great use of buzz words in its 121 pages, it is not grounded in the reality of day-to-day VHA operations nor tied to the way veterans access their care. VHA has a track record of coming up with great sounding plans that are never implemented correctly. The continuous stream of VA IG and GAO reports provides a good sample of VA's past implementation failures. VHA is also operating on the false premise that it is the medical home for the 5.8 million veterans it serves. This is not true. In most cases, VHA provides only the minority of their overall health care. As the Independent Assessment states, veteran patients reliance on VA ranges from “15 percent for all office-based visits to 34 percent for office-based laboratory services.”

*Third*—VA gives lip service to the Independent Assessment's recommendations and its findings. Nonetheless, the plan does not truly incorporate the systems thinking or the four systemic findings approach. Instead, it continues a piecemeal approach that perpetuates its own goals by cherry-picking certain recommendations and ignoring the key supporting recommendations of long-term reforms that better serve the veteran. Once again it seems focused on what is best for VA. It relegates the Independent Assessment's approach of using a true integrated systems approach which would embrace the governance, data and tools, operations and leadership reforms needed to improve for the long term its health care operating model and provide the best value for its veteran patients.

*Fourth*—Veterans want real choice that is easy to use, clear eligibility criteria and access to quality private sector health care that meets their needs. According to an October 2015 Tarrance Group poll, 91% of veterans agree that it is important to give veterans more health care choices even if it means paying a little more out of pocket. The VA plan does not truly give the veteran more choices as it is more complicated and less veteran-centric. Instead it gives VA even greater control over the veteran, especially in the areas of eligibility and access using the proposed High-Performing Network—at the end of the day, VA still controls what the veteran is able to do.

For example, page 42 of the plan recommends that veterans be eligible if they are more than 40 miles from a VA designated primary care physician (PCP). The 40 miles from a VA designated PCP is unrealistic because either the veterans true PCP is not designated from VA and/or their health care service needed is not based on the PCP. We believe a veteran should not have to travel more than 40 miles from

<sup>3</sup> [www.stripes.com/news/veterans/va-ig-lapses-in-urology-care-at-phoenix-va-endangered-patients-1.373536](http://www.stripes.com/news/veterans/va-ig-lapses-in-urology-care-at-phoenix-va-endangered-patients-1.373536), accessed November 24, 2015.

<sup>4</sup> <http://www.miamiherald.com/news/health-care/article45269961.html>, accessed November 24, 2015.

the point of health care serve needed. In terms of wait-times, VA is setting the system in a way that would allow them to further game the system and maintain control by having un-defined wait time goals for every service and leaving it up to the VA provider to decide if those wait-time are clinically necessary. This is a recipe for veterans being denied choice, in continuity with VA's track record.

On page 57 of the plan we see another example of the lack of choice for veterans in accessing the High-Performing Network. According to the plan, if VA can't provide the veteran their health care, then the veteran has a multi-step process with undetermined approval and timeframes which could take months for each step. First, the VA has to search for another Federal Government or academic teaching affiliate in its core network. If that does not work then the preferred tier, then the standard tier. VA controls everything, the tiers, referrals, and the limited number of providers. The veteran becomes just VA's loyal subject. Where is the private sector choice and timeliness with this convoluted process? Furthermore, if you are a private sector provider would you want to deal with this tiered mess?

*Fifth*—The new Veterans Choice Program is extremely premature, especially in light of the charge Congress gave the Commission on Care in the Veterans Access, Choice, and Accountability Act of 2014. That charge included a mandate to “strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period.” No one knows what the Commission on Care may come out with. It could be similar or it could be a whole different set of recommendations that are at cross-purposes with the VA plan. If the VA plan is implemented now in its current form, it could short circuit the existing process and possibly provide conflicting recommendations.

These are but a few examples to the flaws and challenges for the new Veterans Choice Program plan. So how should VHA proceed to consolidate its seven purchase care programs into one non-VA care program? CVA proposes the following three basic steps.

1. VA should focus on the immediate short-term need of consolidating its seven purchase care programs into one non-VA care program. This should be the temporary short-term new Veterans Choice Program solution. We believe VA is on the right path with Phase 1 in the plan. Phase 1 should be refined with the addition of an implementation and evaluation plan. The plan, formulated in conjunction with Congress, should ensure quick and transparent action of systems, process, regulations needed and should be done in consultation with the Commission on Care.

2. VA should refine the other phases of the plan in consultation with the Commission on Care using a true systems approach which embraces proper governance, data and tools, operations and leadership reforms needed.

3. VA should finalize the long-term new Veterans Choice Program only after the Commission on Care provides its finding and recommendations to the President and Congress and they have decided which recommendations are feasible and advisable.

Although it is tempting to move quickly on fixing and consolidating the existing seven programs of the VA into one non-VA care program, we must learn from the past and break the cycle of reform and failure by having the right plan that deals with the root-cause problems and focuses on the veteran first, not the VA. 5.8 million veterans are depending on your leadership for this.

As President Theodore Roosevelt said “A man who is good enough to shed his blood for the country is good enough to be given a square deal afterwards.” Let's make sure our veterans get the square deal they deserve on their health care.

CVA is committed to overcoming any and all obstacles that stand in the way of achieving what is best for veterans. We look forward to working with the chairman, ranking member, and all Members of this Committee to achieve this shared commitment.

Senator MORAN. Mr. Selnick, thank you.  
Mr. Rausch.

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

Mr. RAUSCH. Acting Chairman Moran, Ranking Member Blumenthal, on behalf of Iraq and Afghanistan Veterans of America and our 425,000 members and supporters, thank you for the opportunity to share our views with you today at the hearing, Consolidating Non-VA Care Programs.

IAVA is proud to have previously testified in front of this Committee recommending the need for consolidation of care in the community for veterans enrolled in VA health care, and we applaud Congress for requiring VA to put forward a plan for consolidation. We also want to recognize senior leaders at VA, who are still with us here today, for acknowledging the need for consolidation and providing an approach and process that was inclusive, transparent, and veteran-centric.

Last year, as the much-needed Veterans Access to Choice and Accountability Act was being implemented, it became apparent to our members across the country the new law was confusing and added to a series of preexisting VA programs designed to provide care in the community. According to IAVA's most recent member survey, 43 percent of respondents stated the main reason for not utilizing Choice was simply because they did not know how, while 28 percent of our members who utilized the program said their experience using Choice was extremely negative.

Although necessary to address the access crisis at VA revealed by the scandal in Phoenix, the Choice Program quickly became an example of what was and what was not working for veterans, physicians, and VA employees when it came to providing accessible, timely, and high-quality care in the community.

IAVA has conducted numerous surveys, polls, focus groups, collecting feedback from thousands of our members while working with industry and other stakeholders to understand what was needed in order to have a successful consolidation of care in the community. We have attended over 25 formal meetings with other VSOs and VA staff to share what our members were experiencing at the local level in terms of care in the community and have had dozens of additional informal calls, meetings, and opportunities to provide direct feedback from post-9/11 veterans.

Based on the feedback from our members, IAVA believes any plan to consolidate care in the community must be simple to understand, it must be consistent across the country, and place the needs of veterans above all else. The plan put forward by VA meets the above criteria and should be the framework for legislation in order to consolidate care in the community and provide improved and seamless access to care for veterans.

Despite the progress that has been made by Congress, VA, and veterans across the community, we still have three main concerns. One, Congress drafting and enacting the required legislation to effectively consolidate care. Two, VA's ability to effectively implement the new laws designed to designate and consolidate care. And, three, a continued focus on access without enough emphasis on health care outcomes for veterans, which was talked about earlier in today's hearing, especially, though, as veterans start to see community providers who have not historically served the veteran community.

Congress acted swiftly and put veterans first in the wake of the access crisis by passing the Choice Act, and this Committee has been a strong partner with IAVA as the program was being implemented. Unfortunately, even as Congress mandated that VA provide a consolidation of care plan, some Members of Congress con-

tinue to put forward incomplete one-off plans and legislation that did not include feedback from veterans, VSOs, or VA.

As Congress rightly moves forward to simplify a very confusing process for veterans by drafting legislation to consolidate care in the community, IAVA highly recommends Congress should utilize VA's plan as the framework for legislation and avoid one-off proposals that are misinformed or put politics ahead of veterans. After all, it was Congress who provided the numerous different plans that added to the confusion and inefficiencies which resulted in the need to consolidate care. We believe Congress should be mindful of these lessons learned from them and leverage the plan as the framework for consolidation of care moving forward.

Our second concern centers around VA's ability to effectively implement a plan to consolidate care across the enterprise in a way that avoids many of the mistakes made during the implementation of Choice and truly puts the veteran at the center of every decision. During a recent roundtable discussion right here in Washington, DC, at my VA medical center with post-9/11 veterans and Secretary McDonald, one of our members stated, quote, "There seems to be significant inconsistencies across VA, and although I have had positive experiences at VA, there are too many veterans who have had bad experiences," and I could not agree with him any more.

In order to address these inconsistencies and shortcomings, IAVA recommends VA continue its collaborative effort to involve all stakeholders who share the vision of putting the veteran first and focus on values-based leadership and attempt to change the culture of VA across the country.

Given the serious shortcomings related to training front-line personnel on the implementation of Choice and customer service generally, the VA should also continue its efforts with MyVA and must ensure all VA employees are properly and consistently trained on any new plan to consolidate care.

Finally, IAVA encourages everyone—Congress, VA, VSOs, industry, and other stakeholders—to place an increased importance on the quality of care veterans are receiving, especially as new providers who have not traditionally served veterans join new networks to provide care in the community. We need to pay special attention to the care veterans receive in the community to ensure that the quality of care is consistent with the high quality of care provided by VA and that private providers are educated on how best to treat our veterans.

As community providers are increasingly called upon to serve this population, a recent RAND report suggests community providers might not be well equipped to address the needs of veterans and their families, specifically in understanding high-quality treatments for Post Traumatic Stress and other mental injuries.

In closing, IAVA would again like to thank this Committee for your leadership and continued commitment to our entire community of veterans. It is a privilege to testify in front of this Committee today and we reaffirm our commitment to working with you and all of Congress, VA, and our VSO partners to ensure veterans have the access to the highest quality of care available and our

country fulfills its sacred obligation to care for those who have truly borne the battle.

There have been real challenges and tragedies in the past. We have talked about some of them today. However, we believe there is a real opportunity to transform the VA for today's veterans through a one team, one fight approach.

Thank you, and I would be happy to field any questions.  
[The prepared statement of Mr. Rausch follows:]

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

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee: On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our 425,000 members and supporters, thank you for the opportunity to share our views with you at today's hearing on "Consolidating Non-VA Care Programs."

IAVA is proud to have previously testified in front of this Committee recommending the need for the consolidation of care in the community for veterans enrolled in VA health care, and we applaud Congress for requiring VA to put forward a plan for consolidation. We also want to recognize senior leaders at VA for acknowledging the need for consolidation and providing an approach and process that was inclusive, transparent and veteran centric.

Last year, as the much needed Veterans Access to Choice and Accountability Act (VACAA) was being implemented, it became apparent to our members across the country the new law was confusing and added to a series of pre-existing VA programs designed to provide care in the community. According to IAVA's most recent Member Survey, 43 percent of respondents stated the main reason for not utilizing the VA Choice Card program was simply because they did not know how; while 28 percent of our members who did utilize the program said their experience using the VA Choice Card was extremely negative. Although necessary to address the access crisis at VA caused by the scandal in Phoenix, the Choice Program quickly became an example of what was, and was not, working for veterans, physicians and VA employees when it came to providing accessible, timely and high-quality care in the community.

IAVA has conducted numerous surveys, polls and focus groups collecting feedback from thousands of our members while working with industry and other stakeholders to understand what was needed in order to have a successful consolidation of care in the community. We have attended over 25 formal meetings with other VSOs and VA staff to share what our members were experiencing at the local level in terms of care in the community and have had dozens of additional informal calls, meetings and other opportunities to provide direct feedback from post-9/11 veterans.

Based on feedback from our members, IAVA believes any plan to consolidate care in the community must be simple to understand, consistent across the country and place the needs of the veteran above all else. The plan put forward by VA meets the above criteria and should be the framework for legislation in order to consolidate care in the community and provide improved and seamless access to care for veterans.

Despite the progress made by Congress, the VA and the veteran community, we have three main concerns: (1) Congress drafting and enacting the required legislation to effectively consolidate care in the community; (2) the VA's ability to effectively implement the new laws designed to consolidate care; and (3) the continued focus on access without enough emphasis on healthcare outcomes for veterans, especially as veterans start to see community providers who have not historically served the veteran population.

Congress acted swiftly and put veterans first in the wake of the access crisis by passing the Choice Act and this Committee has been a strong partner with IAVA as the program was being implemented. Unfortunately, even as Congress mandated that VA provide a consolidation of care plan, individual Members of Congress continued to put forward incomplete one-off plans and legislation that did not include feedback from veterans, VSOs or VA.

As Congress rightly moves forward to simplify a very confusing process for veterans by drafting legislation to consolidate care in the community, IAVA highly recommends Congress utilize VA's plan as the framework for legislation and avoid one-off proposals that are misinformed or put politics ahead of veterans. After all, it was Congress who provided the numerous different plans that added to the confusion and inefficiencies which resulted in the need to consolidate care. We believe Con-



gress should be mindful of these lessons, learn from them and leverage the VA's plan as the framework for consolidation of care moving forward.

Our second concern centers around VA's ability to effectively implement a plan to consolidate care across their enterprise in a way that avoids many of the mistakes made during the implementation of Choice and truly puts the veteran at the center of every decision. During a recent roundtable discussion at the Washington, DC VA Medical Center with post-9/11 veterans and Secretary McDonald, one IAVA member stated, "There seems to be significant inconsistencies across VA and, although I've had positive experiences at VA, there are too many veterans who have had bad experiences."

In order to address these inconsistencies and shortcomings, IAVA recommends VA continue its collaborative effort to include all stakeholders who share their vision of putting the veteran first and focus on values based leadership in an attempt to change the culture of VA across the country. Given the serious shortcomings related to training front line personnel on the implementation of Choice and customer service generally, the VA should also continue its efforts with *MyVA* and must ensure all VA employees are properly and consistently trained on any new plan to consolidate care.

Finally, IAVA encourages everyone, Congress, VA, VSOs, industry and other stakeholders, to place an increased importance on the quality of care veterans are receiving, especially as new providers who have not traditionally served veterans join new networks to provide care in the community. We need to pay special attention to the care veterans receive in the community to ensure that the quality of care is consistent with the care provided by VA and private providers are educated on how to best treat our veterans. As community providers are increasingly called upon to serve this population, a recent RAND report suggests community providers might not be well equipped to address the needs of veterans and their families, specifically in understanding high quality treatments for PTSD and other mental health injuries.

In closing, IAVA would again like to thank this Committee for your leadership and continued commitment to our veterans. It is a privilege to testify in front of the Committee today, and we reaffirm our commitment to working with Congress, VA and our VSO partners to ensure veterans have access to the highest quality care available and our country fulfills its sacred obligation to care for those who have borne the battle. There have been real challenges and tragedies in the past; however, we believe there is a real opportunity to transform the VA for today's veterans through a one team, one fight approach. Thank you, and I'd be happy to answer any questions you may have.

Senator MORAN. Mr. Rausch, thank you very much.  
Now, Mr. Kelley.

**STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; ACCOMPANIED BY JOY J. ILEM, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA**

Mr. KELLEY. Mr. Chairman, Ranking Member Blumenthal, on behalf of the *Independent Budget* partners, thank you for the opportunity to testify today.

The *IB* partners strongly believe that veterans have earned and deserve to receive high-quality, comprehensive, accessible, and veteran-centric care. In most instances, VA care is the best and preferred option, but VA cannot provide all services to all veterans in all locations at all times. That is why VA must leverage private sector providers and other public health care systems to expand viable options.

After months of working closely with VA officials and other stakeholders, we are pleased that many aspects of the VA's plan are closely aligned with *IB's* veteran health care reform framework. The *IB* partners support VA's concept of consolidating existing care

in the community programs into a single program that would seamlessly combine the capabilities of the VA health care system with other public and private health care providers in the community wherever necessary.

As part of the consolidation, several Community Care Programs would be allowed to sunset. While allowing these programs to sunset is a natural progression in the development of the consolidated Community Care Program, allowing them to expire without assurances that the new plan has the capability to handle the current workload is unacceptable.

The *IB* partners also support the idea of expanded access to emergency treatment and provide access to urgent care, but we cannot support an across-the-board copayment for these services. The idea of charging veterans who are service-connected for care is unacceptable. In an effort to ensure veterans utilize emergency and urgent care appropriately, the *IB* partners suggest the establishment of a nurse advice line.

While the *IB* partners agree that VA must do a better job of collecting third-party payments, we adamantly opposed withholding health care from veterans if they fail to provide other health insurance information. Rather than punish veterans for not providing private insurance, VA should consider ways to incentivize veterans to provide that information.

The *IB*'s framework builds on VA's progress by addressing areas outside VA's plan's limited scope, which I will discuss now. Our four-pronged approach framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that will restructure the veterans health care delivery system, redesign the systems that facilitate access to health care, realign resources to reflect its mission, and reform VA's culture with workforce initiatives and accountability.

Similar to VA's plan, the *IB* framework would combine the strengths and capabilities of the VA and other public and private providers, but included in our framework would be a veterans managed care program that would provide rural and remote veterans with options to receive veteran-centric and coordinated care regardless of where they live.

We recommend that VA move away from a single arbitrary federally regulated access standard. Under the *IB*'s framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among options developed within the network and schedule appointments that are most convenient to them.

The *IB* calls for significant changes to VA's Strategic Capital Investment Plan, or SCIP, process by including public-private partnership options and blending existing replacement options to better leverage Federal and local resources. We also have called for the establishment of a Quadrennial Veterans Review process, similar to the Quadrennial Defense Review, to align VA's strategic mission with its budget and operational plans and help provide continuity of planning across all administrations.

The *IB* framework would establish a biennial independent audit of VA's budgetary accounts to identify accounts and programs that are susceptible to waste, fraud, and abuse.

In addition, we call for strengthening VA's Veteran Experience Office by combining its capabilities with the Patient Advocate Program. Veteran Experience Officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protected under Title 38 are enforced.

Our plan uses the same public and private resources as proposals provided that provide veterans with vouchers or insurance plans, but our plan makes public and private resources complementary instead of in competition with each other, which will be key to truly providing high-quality care with the most ease of access possible for veterans.

Mr. Chairman, this concludes my testimony, and me and my partners look forward to any questions you may have.

[The prepared statement of Mr. Kelley follows:]

PREPARED STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee: On behalf of the co-authors of *The Independent Budget (IB)*, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW), thank you for the opportunity to offer our thoughts regarding the Department of Veterans Affairs' (VA) plan to consolidate its community care programs into a new choice program, as required by Public Law (P.L.) 114-41.

After months of working closely with VA officials and other stakeholders, we are pleased that many of our key recommendations were incorporated into VA's plan, such as ensuring VA remains accountable for the care veterans receive through seamless care coordination—regardless of where the care is delivered. We are also pleased that other key aspects of VA's plan are closely aligned with the *IB*'s veterans health care reform framework, which is appended to this statement.

The *IB* veterans service organizations (IBVSOs) strongly believe that veterans have earned and deserve to receive high quality, comprehensive, accessible and veteran-centric care. In most instances VA care is the best and preferred option, but the IBVSOs acknowledge that VA cannot provide all services to all veterans in all locations at all times; that is why VA must leverage private sector providers and other public health care system to expand viable options. However, when and where a veteran receives care should not be determined by Federal mandates. For that reason, the IBVSOs support VA's plan to move beyond arbitrary Federal standards regulating veterans' access to care in the community. We believe it is time to move toward a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor—without bureaucrats, regulations or legislation getting in the way.

The IBVSOs strongly support VA's concept of developing high performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community, whenever necessary, resulting in expanded options for veterans to receive high quality care closer to home. This marks a significant shift in the role private health care providers play in the veterans' health care system, and is an important step toward ensuring veterans receive high quality, comprehensive, accessible and veteran-centric health care now and in the future.

VA's plan is particularly sensitive to the importance of ensuring culturally competent providers for veterans. In a recent study entitled "*Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and their Families*," the RAND Corporation found that only 13 percent of private sector mental health care providers were able to deliver culturally competent and evidence-based mental health care to veterans and their families. Similarly, less than 50 percent of private sector mental health providers who were affiliated with VA or the Department of Defense met RAND's readiness criteria.

VA's plan to adapt high performing networks to local communities recognizes that the private sector is not a panacea to health care quality and access. We support VA's plan to identify and empower private sector providers who are ready and able to deliver high quality, comprehensive, and veteran-centric health care. Doing so ensures the quality of care veterans receive from private sector providers is at least equal to or better than the care they are accustomed to receiving from VA. As the Nation's largest trainer of health care professionals, VA is already increasing the number of private sector providers who are able to deliver culturally competent, high quality care to veterans. The IBVSOs support VA's plan to build on existing programs by making military culture training and educational resources available to providers who want to participate in high performing networks. However, education alone is not enough. By leveraging the best capabilities of each community's health care market, VA would also ensure private sector providers who invest in learning how to care for veterans are given the appropriate workload to ensure they retain what they have learned.

The IBVSOs firmly believe that VA's medical home model and experience providing veteran-centric care results in the best health outcomes for veterans and, therefore, VA must remain the primary health care provider for enrolled veterans. However, we recognize that VA lacks the resources and capacity to be everything to every veteran it serves. By establishing high performing networks to fill these gaps, VA can leverage the best capabilities that already exist in each health care market and free up resources to invest in services the community lacks. This type of blended health care delivery model will result in improved health care outcomes for veterans by providing them with more options closer to home and ensuring they receive the best quality care available in their communities.

Other models currently being proposed to reform the way our Nation provides care to veterans fall dramatically short. For example, proposals to turn VA in to a voucher system would leave veterans with two lackluster choices: a VA health care system that would continue to be overburdened and underfunded; or private health care that does not guarantee access and lacks the required specialized care services and cultural competencies uniquely defined by veterans' needs. Meanwhile, proposals to privatize VA health care by establishing a health care exchange for veterans to shop for health care coverage would erode the benefits of VA's medical home model, which provides veterans a full continuum of care that is unmatched in the private sector.

Creating health care exchanges for veterans also ignores findings outlined by the Centers of Medicare and Medicaid Services Alliance to Modernize Healthcare in its report entitled "*Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*" (released on September 1, 2015) that veterans are sicker and higher users of health care than the general population. Furthermore, veterans who turn to VA tend to be the most indigent, disabled, and geographically isolated segment of the veterans population. In order to take on such a high risk portfolio of beneficiaries, insurance companies who participate in a veterans health care exchange will need to charge exorbitant premiums to offset the risk—significantly increasing health care costs for millions of veterans who can least afford it.

Instead of moving toward privatization or pushing veterans out of VA and into government-run insurance plans, the IBVSOs believe that creating integrated networks combining VA with top tier private providers is the best way to expand access, improve quality and achieve better health outcomes for veterans.

VA's consolidation plan has identified 11 legislative recommendations that seemingly must be enacted to ensure VA has the authority to implement planned reforms. Since there are not yet details or legislative language for most of these proposals, we cannot offer final views; however the IBVSOs offer the following initial observations and comments on each legislative recommendation:

1. Improving VA's Partnerships with Community Providers to Increase Access to Care

VA and Congress have been working for months to agree upon legislation that would fulfill this recommendation, and the IBVSOs have supported legislation to authorize VA to purchase care through agreements that are not subject to provisions of law governing Federal contracts. Authorizing VA to enter into non-Federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with community care options when needed.

Provider agreements are a necessary tool to allow VA to meet the wide-ranging and unique health care needs of veterans, particularly veterans with spinal cord injury and dysfunction. This proposal would also protect VA's ability to continue to purchase private medical care when not otherwise available through VA, contracts, or sharing agreements.

The IBVSOs would also like to thank Senator Blumenthal for his inclusion of certain federally recognized providers in the text of S. 2179, the “Veteran Care Agreements Rule Enhancement Act.” These entities serve on the front lines of a partnership between the VA and the Department of Health and Human Services that has served more than 3,400 veterans across 31 States, the District of Columbia and Puerto Rico. These agencies provide severely ill and injured veterans of all ages the opportunity to determine their own support services to live independently at home.

The IBVSOs have heard from veterans who live in contract extended care facilities who they may be required to leave the place they have called home for years because VA does not have the authority to renew provider agreements. We urge this Committee to quickly consider and pass this important legislation to ensure severely disabled veterans are not harmed by VA’s inability to enter into provider agreements.

#### 2. Improving Access to Community Care through Choice Fund Flexibility

This proposal would authorize VA to use the Veterans Choice Fund to pay for compensation and pension exams; any health care services under Chapter 17 of title 38, United States Code (U.S.C.); community care; emergency room and urgent care; and the cost of implementing VA’s consolidation plan. While the IBVSOs support the intent of the proposal, we would need to review the legislative language before taking a position.

The IBVSOs believe it is detrimental to veterans’ health care when VA is unable to access all of the resources provided to accomplish its mission. Unfortunately, Public Law 113–146, the “Veterans Access, Choice and Accountability Act of 2014,” limited expenditure of the Veterans Choice Fund to care provided through the Choice Program. The fund was created to ensure VA has the resources necessary to provide community care when VA care is not readily available. In July, Congress granted VA the authority to transfer more than \$3 billion of Veterans Choice Fund money to offset higher than expected demand on VA community care programs.

The IBVSOs believe that another budget shortfall is a real possibility in fiscal year 2016, and requiring that a funding shortfall exist before VA is able to use this fund for purchasing community care could risk harming veterans. However, the IBVSOs do not support the use of this account as a slush fund to pay for unrelated services outside of its intended purpose. If VA has shortfalls in other accounts that are used to pay for non-health care services, such as compensation and pension exams, VA should request additional funding through the regular budget and appropriations process, including requests for supplemental appropriations.

#### 3. Increasing Accuracy of Funding by Recording Community Care Obligations at Payment

The IBVSOs do not object to the purpose of this proposal, which would authorize VA to obligate funds for community care consults when payment is due instead of using an estimated amount to obligate funds. Such an accounting change could result in a more efficient way to track planned expenditures and obligate necessary funds when an authorization for care in the community takes place. It could also bring clarity to the authorization and obligation process so as to mitigate the possibility of a recurrence of the budget shortfall that occurred earlier this year.

#### 4. Improving Access to Community Care by Establishing the New VCP

As previously stated, the IBVSOs support VA’s concept of consolidating existing care in the community programs into a single program that relies on high performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community whenever necessary. Rather than simply giving veterans a choice card and leaving them on their own to navigate the private health market, this plan would require VA to ensure that sufficient real options exist for veterans to receive care closer to home through the new networks, which is far more likely to result in better health outcomes for veterans. The creation of these seamless and blended networks represents the central concept of the new Veterans Choice Program and we look forward to working with VA and Congress to develop the details required to implement this plan.

While the VA plan starts to move beyond arbitrary Federal standards regulating when and where veterans can access medical care, we believe it should go further to ensure access is not determined by the distance veterans live from a VA medical facility or waiting longer than 30 days for care. The IBVSOs support the consolidation of community care programs, but do not agree with VA’s proposal to define geographic access as 40 miles from a VA primary care provider. We firmly believe that the distance a veteran travels is not as important as determining the severity of his or her health care conditions and allowing the health care provider to decide the most appropriate time and location to received care for those conditions. Further-

more, geographic distance should not be used to determine when a veteran is authorized to seek care in the private sector. Private sector network providers should be considered an extension of VA. Doing so would ensure all veterans are afforded the opportunity to receive veteran-centric and coordinated care when they need it and where it is most appropriate.

5. Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account

The IBVSOs understand the intent of this proposal, which would ensure more accurate and accountable funding for community care programs. Based on recent history of changes in VA's appropriations request structure, it is not clear that VA needs specific legislation to make this change. However, until we see more specific details, particularly about the proposed transfer authority, we are not able to offer support for this legislative proposal.

6. Streamlining Community Care Funding

Similar to our position on the prior legislative proposal (#5 above), we understand the intent of this proposal, but would need to see the specific language to accomplish this change before taking a formal position.

7. Improving Veterans Experience by Consolidating Existing Programs

The IBVSOs cautiously support this proposal, which would sunset the numerous community care programs VA intends to consolidate. The IBVSOs believe that VA's transition to the new choice program must ensure veterans who are currently receiving community care through existing programs are afforded the opportunity to continue their care with the same providers. Before allowing these programs to sunset, VA must ensure the new Veterans Choice Program can handle the workload governed by the existing authorities that provide care to veterans.

Permitting the Assisted Living for Veterans with TBI (AL-TBI) program to sunset without granting VA the authority to continue such services would have negative consequences on the veterans who are currently enrolled in the program. There is no indication that there will be follow-on services under the new Veterans Choice Program that will meet the specific needs of the veterans currently served by the AL-TBI program. In fact, the new program guarantees nothing to this segment of the veterans' population, and yet, these veterans are some of the most vulnerable served by VA. Additionally, we are concerned that VA does not have, nor has it requested, the authority to provide assisted living services to these veterans or other veterans enrolled in the VA health care system in need of extended care. Like the realignment of authorities for emergency and urgent care, assisted living is a service that should be expanded.

8. Improving Veterans Access to Emergency Treatment and Urgent Care

The IBVSOs support the plan to expand emergency treatment and urgent care in the community. However, we oppose the proposal for an across the board \$100 co-payment for emergency care and \$50 for urgent care. This proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. Veterans currently exempted from co-payments should not be required to bear a cost-share for emergency and urgent care services.

As an alternative, VA should consider establishing a national nurse advice line to help reduce overreliance on emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance of emergency room care without having to increase cost-shares for veterans.

Additionally, the IBVSOs have concerns about the requirement that eligible veterans must be "active health care participants in VA" in order to access these benefits. The strict 24-month requirement is problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to appointment wait times, despite their timely, good faith efforts to make appointments following their separation from military service. This barrier has caused undue hardship on veterans who are undergoing the difficult transition from military service back to civilian life, and has resulted in veterans receiving unnecessarily large medical bills through no fault of their own. VA is aware of this problem and has requested the authority to make this exemption, however, the consolidation plan does not specifically address this needed change.

Furthermore, this restriction could negatively impact some healthier veterans who do not need as much health care as others and may go more than two years without accessing VA care. This requirement could encourage veterans to seek unnecessary care from VA in order to remain eligible for VA's emergency and urgent care services.

#### 9. Improving Care Coordination for Veterans through Exchange of Certain Medical Records

The IBVSOs support the intent of this proposal, which would lift a restriction on VA's ability to disclose certain medical information. Proper sharing or exchange of veterans' medical records is imperative if VA is going to responsibly coordinate care. While we understand patient privacy concerns that have been raised in the past, VA must be authorized to make all health information available to community providers who will be integral to the care being provided.

The original intent of precluding VA from disclosing patient information regarding drug abuse, alcoholism, and infection of HIV or sickle cell anemia was to prevent veterans from being discriminated against based on their health care conditions. The IBVSOs believe that Public Law 111-148, the "Patient Protection and Affordable Care Act," prohibition on discrimination based on health care conditions by health care providers renders the current VA restriction unnecessary.

#### 10. Aligning with Best Practices on Collection of Health Insurance Information

This proposal would authorize VA to withhold health care from veterans if they fail to provide other health insurance information (OHI). The IBVSOs support the intent of requiring veterans to report information on other health insurance, however, we oppose the enforcement mechanism used to ensure veterans report their health insurance information. We are concerned that efforts to collect other health insurance information could result in veterans being denied non-emergent care.

Veterans are currently required to inform VA when their insurance information has changed and VA typically asks veterans about any changes to their insurance coverage when they present to a VA medical facility. To preclude veterans from receiving VA health care because they may not have known their insurance status changed or because they did not disclose this information could harm the veterans VA was created to serve.

Additionally, the Government Accountability Office and the Congressional Budget Office have both found that VA's ineffective billing process affects its ability to collect the full cost of non-service-connected VA care delivered to veterans with OHI coverage. The IBVSOs have also heard from veterans that VA has erroneously billed their private health insurance for service-connected care. While we understand VA's need to increase the amount of billing it processes, it is more important that it improve the efficacy of its billing process. Doing so would increase medical care collections without placing an undue burden on veterans.

It is important to remember that VA health care is an earned benefit. This proposal would also diminish veterans' service and sacrifices by relegating this benefit to one that can be negated in order to increase the Federal Government's financial revenue. Rather than punishing veterans, VA should consider other ways to incentivize veterans to provide OHI and increase third party medical care collections.

#### 11. Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers

The IBVSOs support the intent of this proposal, which would formalize a VA Prompt Pay standard.

While the IBVSO's generally believe that most of VA's legislative proposals outlined above are sound and necessary, we cannot offer final judgment without reviewing the legislative text of each these proposals in detail.

Overall, the IBVSOs are glad to see that many aspects of VA's consolidation plan are aligned with the *IB's* veterans health care reform framework. The *IB's* framework builds on VA's progress by addressing barriers that are outside of the VA plan's limited scope. The IBVSOs have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a veterans health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system.

The IBVSO's four-pronged framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans.

#### RESTRUCTURE THE VETERANS HEALTH CARE DELIVERY SYSTEM

The *IB* framework would optimize the strengths and capabilities of VA and combine them with other public and private health care providers by establishing local Veterans-Centered Integrated Health Care Networks. VA would be responsible for

organizing the networks, coordinating care, and in most cases, would remain the principal provider of care for veterans.

Similar to VA's consolidation plan, the *IB* framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the *IB* framework would establish a Veterans Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care wherever they live.

#### REDESIGN THE SYSTEMS AND PROCEDURES THAT FACILITATE ACCESS TO HEALTH CARE

We recommend that VA move away from single, arbitrary federally regulated access standards. Under the *IB*'s framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

We also recommend establishing a nationwide system of urgent care at existing VA clinics, and affording veterans the opportunity to receive urgent care from smaller urgent care clinics around the country to alleviate much of the pressure on VA outpatient clinics.

#### REALIGN THE PROVISION AND ALLOCATION OF VA'S RESOURCES TO REFLECT ITS MISSION

The IBVSOs call for significant change to VA's Strategic Capital Investment Planning (SCIP) process by including public-private partnership options and blending existing replacement options to better leverage Federal and local resources. VA must be required to engage community leaders to develop broader sharing agreements, so it can plan infrastructure in a way that allows communities to share resources and VA can invest in services the community lacks. Furthermore, VA should be required to publicly update and report annually actuarial estimates for maintaining and modernizing adequate infrastructure, so that the real financial need for infrastructure resources is known to Congress, veterans and the public.

Our framework also calls for reforming the congressional appropriations process to ensure VA has the resources it needs and the flexibility to allocate them to provide for the health care and services veterans need, instead of limiting the amount of care VA is able to provide. Finally, we call for the establishment of a Quadrennial Veterans Review process, similar to the Quadrennial Defense Review, to align VA's strategic mission with its budgets and operational plans, and help provide continuity of planning across all administrations.

#### REFORM VA'S CULTURE WITH WORKFORCE INNOVATIONS AND REAL ACCOUNTABILITY

The *IB* framework would establish a biennial independent audit of VA's budgetary accounts to identify accounts and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

In addition, we call for strengthening VA's Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code (U.S.C.), including a veteran's right to seek redress through clinical appeals; claims under section 1151 of title 38, U.S.C.; the Federal Tort Claims Act; and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, including both private and public health care entities.

Congress, the Administration, the IBVSOs, and other key stakeholders in the veterans' community all have an interest in fixing and strengthening the veterans health care system so that it is properly aligned to meet the unique needs of the veterans it serves. Today, the VA is at a crossroads that will determine how it will carry out its mission to America's veterans. This is an historic opportunity to put VA on a path to meet the needs of veterans today and far into the future. The IBVSOs will continue working to ensure that our Nation's veterans receive high



quality, accessible, comprehensive, and veteran-centric health care designed around their needs and preferences.

Thank you for the opportunity to present this testimony to the Committee today. We would be pleased to answer any questions the Committee may have.

#### ATTACHMENT

##### A FRAMEWORK FOR VETERANS HEALTH CARE REFORM

In April 2014, whistleblowers from around the country brought to light instances of fraud and manipulation within the Department of Veterans Affairs (VA) that have since led to changes in executive leadership and a wide array of proposals to overhaul the VA health care system. To *The Independent Budget (IB)*, the fact that veterans were waiting too long for the care they have earned and deserve was no surprise.

The *IB* co-authors—Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have been ringing the alarm on VA health care access problems for more than a decade. In 2002, the *IB* included an article on waiting times for outpatient appointments, in which the *IB* veterans service organizations (IBVSOs) urged the Veterans Health Administration (VHA) to “identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide.”

The transformative effort underway at VA, known as *MyVA*, and recent actions taken by congressional leaders, such as enactment of Public Law 113–146, the “Veterans Access, Choice, and Accountability Act of 2014,” have made progress in addressing the access issues that have plagued VA. While such progress in commendable, access remains the principle problem facing the VA health care system, and this problem will continue to negatively impact the health care veterans receive until the VA health care system is significantly reformed. Organizations, politicians, Members of Congress, VA officials and other stakeholders are advocating for specific reforms. What has been missing from these discussions is a plan that truly represents what veterans want, expect, and need their health care system to be and a comprehensive set of reforms to accomplish that vision.

In order to develop a framework that puts veterans’ needs and preferences first and understand the extent of the health care access problem from a veteran’s perspective, the IBVSOs have sought direct feedback from our members and the veterans’ community as a whole. Their responses have validated what we have long known:

1. Veterans prefer to receive their care from VA.
2. They turn to VA because they like the quality of care they receive.
3. They believe VA health care is an earned benefit and VA is best suited to provide veteran-specific health care.

When asked how they would improve the VA health care system, veterans suggest that VA hire more doctors and extend clinic hours to expand internal capacity, improve customer service, and expand overall access by providing convenient health care options in their local communities.

The IBVSOs have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a veterans’ health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The *IB*’s framework includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high quality, and veteran-centered health care system. The framework would provide high-quality health care closer to home by seamlessly combining the capabilities of the VA health care system with public and private health care providers in the community when and where necessary.

In order to accomplish our long-term vision, veterans’ health care reform must address four fundamental ideas:

1. Restructure the Veterans Health Care Delivery System
2. Redesign the Systems and Procedures that Facilitate Access to Health Care
3. Realign the Provision and Allocation of VA’s Resources to Reflect the Mission
4. Reform VA’s Culture with Workforce Innovations and Real Accountability

We hope that Congress, VA, veterans, and other key stakeholders will consider these ideas as the ongoing efforts to reform veterans health care move forward.

## RESTRUCTURE THE VETERANS HEALTH CARE DELIVERY SYSTEM

In the 1990s, under the leadership of Dr. Kenneth W. Kizer, the VA health care system underwent a dramatic transformation from a hospital based system to an integrated ambulatory care system. While the shift to a holistic approach of providing a full continuum of care has made VA one of the premier health care providers in the world, it has largely ignored one of Dr. Kizer's objectives: "Seek opportunities for sharing activities with private sector entities when doing so would be cost effective and improve service to VA patients." In its plan to consolidate community care programs and authorities entitled "*Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*," (mandated by Public Law 114-41, the "Surface Transportation and Veterans Health Care Choice Improvement Act") VA reports having existing agreements or contracts with more than 200 Federal health care facilities, 700 academic teaching affiliates, 700 federally qualified health centers, and 76,000 locally contracted providers. Such contracts and agreements are generally used as safety valves to augment health care veterans receive from VA medical facilities, rather than integrating them into the health care delivery model.

Traditionally, the relationship between VA and non-academically affiliated private sector providers has been unnecessarily adversarial. Many VA medical center directors have wanted their facilities to be everything for every veteran and have viewed the use of private sector providers as a threat to their ability to provide high quality care to the veterans they serve. In addition, the overall inadequate levels of funding provided to meet veterans needs has resulted in a conflict between fully funding VA services and properly utilizing community care options. As a result, VA medical facilities rarely benefited from leveraging the capacity of private sector medicine to improve its health care delivery model. Far too often, community care was uncoordinated, failed to guarantee sufficient access or quality, and was highly susceptible to improper billing of veteran patients and improper payments by VA. Additionally, with inadequate funding levels for medical services, as the IBVSOs have pointed out regularly, VA has been unable to expand capacity fast enough to keep up with demand for services, continues to rely upon outdated software and processes, and has suffered from inconsistent administration of community care throughout the system. As a result, veterans who have faced barriers accessing VA care are forced to wait longer for community care, placed on waiting lists when they should be given the opportunity to receive community care, or forced to forgo needed health care altogether.

With the implementation of coordinated community care programs like Project Healthcare Effectiveness through Resource Optimization (HERO), Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program supported by reform efforts like Secretary McDonald's MyVA initiative, VA has made significant improvements to the way it purchases health care. Through this work, VA has expanded partnerships with private sector providers, identified and addressed a number of the issues highlighted above, and dramatically increased the use of community care. However, VA's consolidated plan acknowledged that VA's community care programs continue to lack system wide consistency and integration with the larger VA health care system.

Several ideas for reforming the way VA purchases care have gained national attention in the past year. Many of them fail to put veterans' needs and preferences first and some do not properly account for second or third order effects that would lead to unintended consequences for the health and well-being of our Nation's veterans. For example, proposals that would require VA to compete with private sector providers for veterans' health care dollars perpetuates the adversarial relationship between VA health care and community providers. Rather than force veterans to choose between an overburdened and underfunded system (VA) and one that does not guarantee access and lacks the required specialized care services and cultural competencies uniquely defined by veterans' needs (private sector), veterans deserve a system that integrates the two so that VA's veterans' health care expertise can be complimented with the convenience of private sector providers.

The IBVSOs acknowledge that an exclusively Federal solution is not feasible due to the changing nature of the veterans' population. Moreover, simply making VA a payer of veterans' health care erodes the benefits of VA's patient centered medical home model. That is why the IB's framework takes a logic based approach that optimizes the strengths and capabilities of VA and combines them with other public and private health care providers. Simply put, we recommend establishing local Veterans-Centered Integrated Health Care Networks. These networks would leverage the capabilities and strengths of existing local health care resources (including VA, other public health care systems, and private providers) to meet the needs of vet-

erans in each uniquely different health care market. This includes increasing capacity to deliver urgent care at existing VA medical facilities and developing new capacity through private sector urgent care clinics around the country to create new options between emergency care and primary care.

VA must be responsible for organizing these integrated health care networks, coordinating care, and in most cases, it would remain the principal provider of care for veterans. Similar to VA's proposed consolidation plan, the *IB* framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the *IB* framework recommends creation of a Veterans Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care when they need it and where it is most appropriate.

#### REDESIGN THE SYSTEMS AND PROCEDURES THAT FACILITATE ACCESS TO HEALTH CARE

Over the years, the VA health care system has relied on a number of methods and standards to measure access and timeliness of health care delivery. Prior to the scandal that enveloped the VA health care system in the spring of 2014, the Department's wait-time goal was 14 days from a veterans preferred date for existing patients or 14 days from the date an appointment request was created for new patients. After the health care access crisis exposed that the 14-day goal was unattainable, VA reevaluated its standard and moved to 30 days from a veteran's preferred date. Less than a year later, VA changed its wait-time standard again to facilitate the implementation of the Veterans Choice Program. In an attempt to align its standards with industry best practices, VA elected to base its wait-time goal on clinical need first and rely on a veteran's preference when a clinically indicated date was not identified.

VA has also relied upon a number of geographic based access standards over the years to determine accessibility. Through the Strategic Capital Investment Planning (SCIP) process, dating back to its fiscal year 2008 budget request, VA has used a 60 minute drive-time distance for veterans who live in urban areas and 90 minutes for veterans who live in rural areas as a standard for specialty care. In 2013, VA's long range SCIP process began to include a corporate target of 70 percent of veterans having access to VA primary care within a 30 minute drive time in urban areas and 60 minutes in rural areas.

Additional geographic based standards have accompanied statutory programs, to include 40 miles from a primary care provider (as well as 30 days) for the Veterans Choice Program, or 60 minute drive time from primary care, 120 minutes from acute care, and 240 minutes from tertiary care under Project ARCH. VA has also established geographic based network standards for contracted programs. Under Project HERO, VA required Humana to provide access to required services within 50 miles of a veteran's home. Under PC3, HealthNet and TriWest are required to provide health care options within a 60 minute drive for veterans who live in urban areas, 120 minutes for veterans who live in rural areas, and 240 minutes for veterans who live in highly rural areas, when seeking general care. For veterans who need a higher level of care, the PC3 network must provide them options within 120 minutes for urban areas, 240 minutes for rural areas, and an acceptable community standard for highly rural veterans.

The independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait-times similar to the Veterans Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days-based calculations, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. The IBVSOs strongly agree with IOM's recommendation that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families."<sup>1</sup>

The IBVSOs have reported for years that VA's access standards are not aligned with veterans' perceptions. Moreover, the *IB* firmly believes that federally regulated, arbitrary access standards, such as living 40 miles from a VA clinic or waiting up to 30 days for an appointment, should not inhibit a veteran's access to care. That is why the IBVSOs propose to move away from federally regulated access standards. Under the *IB*'s framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clin-

<sup>1</sup> IOM (Institute of Medicine). 2015. Transforming Health Care Scheduling and Access: Getting to Now. Washington, DC: The National Academies Press

ical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

#### REALIGN THE PROVISION AND ALLOCATION OF VA'S RESOURCES TO REFLECT ITS MISSION

Since it was not required by Public Law 114–41, VA did not address the issue of capital infrastructure in its plan to consolidate its community care programs. However, without proper planning of its current infrastructure responsibilities and needs, VA will face significant challenges in order to effectively deliver quality, timely health care to our veterans.

For more than 100 years, the government's solution to providing facilities to provide health care for our military veterans has been to build, manage and maintain a network of veterans' hospitals themselves. While building these facilities was a necessity, maintaining them and replacing them has saddled the Department with a \$60 billion bill that will need to be paid over the next 10 years in order to properly address the existing access, utilization, and condition and safety gaps to provide veterans with access to the care they have earned and need in a safe and timely manner. Moving forward, VA will need to streamline its procurement and project delivery processes, leverage community resources, realign its footprint to provide appropriately sized facilities in more locations, and ensure VA budget requests for capital infrastructure projects are based on a defined plan to address infrastructure gaps instead of arbitrary lists of needed projects.

Currently, VA takes too long and makes too many changes to construction plans leading up to and during the building phase. We only have to examine the problems experienced in the construction of the new VA medical center in Aurora (Denver), Colorado, to affirm this point. Changes proposed to reform construction management through the inclusion of the Army Corps of Engineers are a necessary reform that must be monitored and assessed going forward.

In addition, VA's infrastructure problems will never be met if they do not find a better way to estimate and request resources through the budget development and appropriations process. Currently, VA's budget requests for construction are unrelated to the actual cost of maintaining their capital infrastructure, as evidenced by the funding gap between SCIP projections and budget requests, a fact verified by the Independent Assessment. In order to resolve this structural problem, VA must base its resource requests for infrastructure on demand capacity assessments and through the development of an actuarial estimate and schedule for maintaining that infrastructure. VA should be required to publicly update and report these actuarial estimates each year concurrent with the budget submission so that the real need for infrastructure resources is known to Congress, veterans and the public.

To better align medical care and services with where veterans need that care, the *IB*'s framework would require VA to reassess all currently proposed and future major construction projects and find ways to leverage community resources to identify private capital for public-private partnerships (P3) as an alternative and more efficient manner to build and maintain VA health care facilities. This would enable VA to invest in services the community lacks, while ensuring it continues to provide specialty care, such as mental health and spinal cord injury/disease care, in state-of-the-art facilities. Future capital infrastructure expansion would be based on need and demand capacity assessments, which would incorporate the availability of local resources.

The *IB* framework would also change VA's SCIP process to include P3 options that would blend existing replacement options to better leverage Federal and local resources. It would also require VA to engage community leaders to develop broader sharing agreements so it can plan infrastructure in a way that allows communities to share resources, while allowing VA to invest in services the community lacks.

The access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system that impact VA's ability to provide direct care. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of veterans' health care demand and utilization measured against VA's staffing, funding, and infrastructure. However, VA's capacity metrics are based on deflated utilization numbers that fail to properly account for the true demand on its system.

For example, a shortage of nurses within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and has forced SCI/D centers to reduce the amount of veterans they admit. This has caused a decrease in the daily average census at some SCI/D centers and implies that there is a lack of demand on the system, when in reality vet-

erans who want to access SCI/D care are turned away because those centers lack the staff to man available beds.

Recognizing that VA's Veterans Equitable Resource Allocation (VERA) model is based on utilization, VA's inadequate staffing ratios cause a downstream impact on funding for capital infrastructure projects and the resources local VA facility leaders are given to meet demand. For this reason, the *IB's* framework recommends establishing staffing models based on population density thresholds, actual medical need, functional level and other critical factors. This model would also need to account for changes in the veteran population and surges in demand as VA health care improves and military downsizing continues. Doing so would ensure VA is able to measure the true capacity of and demand for services at its medical facilities.

Regardless of how well VA reforms staffing and capital infrastructure processes, it will not be able to close access gaps if it does not receive the resources it needs to meet demand. In fact, the CMS Alliance to Modernize Healthcare emphasized in its report "*Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*" (released on September 1, 2015) that VA's ability to meet its promise to veterans is limited by the resources it receives from Congress, and that VA would need increases over the next five years to meet expected demand. The IBVSOs annually conduct a thorough analysis of VA health care utilization and submit detailed recommendations for full and sufficient funding to address current and future utilization and access gaps. Unfortunately, for fiscal year 2015, Congress enacted appropriations that were nearly \$2.0 billion short of the *IB's* fiscal year 2015 recommendations for VA's Medical Services accounts. Less than six months after passage of that bill, VA reported a \$2.6 billion budget shortfall in its Medical Services accounts that could have forced the Department to limit health care to veterans if Congress was unable to provide additional funds. Fortunately, VA was authorized to use the Veterans Choice Fund to address the short fall. The IBVSOs believe that it is likely VA will face another budget shortfall in fiscal year 2016, and this pattern could continue without additional structural changes.

The *IB* agrees with the Independent Assessment's finding that the congressional appropriations process does not provide VA the flexibility it requires to meet the demands on its health care system. With this in mind, the IBVSOs believe that the congressional appropriations process must be reformed to ensure VA has the resources it needs to provide the timely, high quality health care services veterans demand instead of limiting the amount of care VA is able to provide. While the *IB* was at the forefront of efforts to enact advance appropriations to relieve the pressures of a broken appropriations process on the VA health care system, we believe that consideration should be given to new proposals that might optimize the funding process. There have been a number of proposals over the years to address this issue ranging from adopting methods that have worked for other departments (a VA health care fund similar to the Department of Defense's overseas contingency operations fund) to technical changes to the existing appropriations process (authority to transfer advance appropriations to current year budget). The *IB's* framework calls on Congress to evaluate the merits and feasibility of these and other proposals to strengthen the appropriations process to ensure VA has the ability to provide the health care veterans need.

To ensure VA's budget requests are accurate and properly aligned with the health care needs of the veterans population, the IBVSOs would also call for reforming VA's current planning methodology, budget forecasting and resource allocation systems to align them with the changing demographic and health care needs of the veterans population. The *IB* framework recommends the establishment of a Quadrennial Veterans Review (QVR) process, similar to the Quadrennial Defense Review. The QVR would serve as the benchmark for the Future-Year Veterans Program (FYVP) that can take a long view of the prospective resource needs based on demand for health care services within the entire integrated health care network. This would better align VA's strategic mission with its budgets and operational plans, and help provide continuity of planning across all administrations.

While ensuring VA has the resources it needs to meet demand is vitally important, it is also critical that VA continue to serve as a good steward of Federal resources used to provide timely, quality care to veterans. To support this point, the *IB's* framework calls for a biennial independent audit of VA's budgetary accounts to identify line items and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

## REFORM VA'S CULTURE WITH WORKFORCE INNOVATIONS AND REAL ACCOUNTABILITY

Secretary McDonald has made improving veterans experience a main pillar of the *MyVA* transformation. To ensure VA leaders are aware of the issues veterans face when they obtain their earned benefits and health care, the *MyVA* task force has established the Veterans Experience Office, with a Chief Veterans Experience Officer who reports directly to the Office of the Secretary. VA plans to have veterans experience officers throughout the country who collect and disseminate best practices for improving customer service, coordinate community outreach efforts, and serve as subject matter experts on the benefits and services VA provides to veterans.

The IBVSOs have consistently heard from veterans that their patient advocates are ineffective or seek to protect the medical facility's leadership instead of addressing their concerns. The *IB* believes that patient advocates cannot effectively meet their obligations to veterans if their chain of command includes VA medical facility staff that is responsible for the actions and policies they are required to address.

The *IB* framework would strengthen the Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code (U.S.C.), a veteran's right to seek redress through clinical appeals, claims under section 1151 of title 38, U.S.C., the Federal Tort Claims Act, and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, both in the public and private sector.

Finally, any plan to reform the culture of VA must also take into consideration the need to modernize VA's workforce and ensure VA employees serve the interest of the veterans' community. While Congress has focused on firing underperforming employees, the *IB* partners believe that the situation is more complicated and demands a holistic approach to workforce development that allows VA to recruit, train, and retain quality professionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly discipline employees whenever appropriate.

The *IB* partners applaud the *MyVA* task force for acknowledging that employee experience is vital to its transformation efforts. The *MyVA* task force has developed a number of programs and initiatives to engage and empower VA employees. However, Federal hiring still reflects a mismatch between the skills desired and the compensation provided for many of the professionals VA recruits. If Congress is focused on bolstering VA's ability to fire poor-performing employees, Congress must also give VA the leverage to hire employees quickly and offer compensation commensurate with their skill level.

By focusing solely on disciplinary proceedings and failing to properly cultivate a motivated and compassionate workforce, we make VA an unattractive employer to potential recruits. The IBVSOs believe that we must build a framework that makes VA an attractive employment option for the best and brightest who want to care for our veterans.

## CONCLUSION

Congress, the Administration, the IBVSOs, and other key stakeholders in the veterans community have an obligation to ensure that the veterans' health care system is properly aligned to meet the unique needs of the veterans it serves. Meanwhile, the VA is at a crossroads that will determine how it will carry out its mission to America's veterans. The IBVSOs will continue working to ensure that our Nation's veterans receive high-quality, accessible, comprehensive, and veteran-centric health care designed around their needs and preferences.

The *IB*'s four-pronged health care reform framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans. Moving forward, the IBVSOs will use this framework to inform legislative proposals and ensure reforms of the VA health care system focus on veterans experience, service delivery, management, accountability, and budget and planning process changes needed to meet the unique and complex health care demands of the men and women who have served and sacrificed. Only through meaningful reforms can we live up to President Lincoln's promise " \* \* \* to care for him who shall have borne the battle, and his widow and his orphan."

Chairman ISAKSON [presiding]. Senator Blumenthal.

Senator BLUMENTHAL. Thank you. I appreciate your courtesy in allowing me to ask just a couple of brief questions first.

Mr. Selnick, let me ask you, your recommendation is that the VA should finalize its Choice Program, long-term new Veterans Choice Program, only after the Commission on Care provides its findings and recommendations to the President and Congress and they have decided which recommendations are feasible and advisable. Do you have a timeframe as to when those recommendations will be made?

Mr. BUTLER. As of right now, based on the legislation, we are due at the end of February.

Senator BLUMENTHAL. In February?

Mr. BUTLER. That is, as of right now, that is when we are due.

Senator BLUMENTHAL. You would advise waiting until sometime this spring or later when there is feedback from the President and Congress before the VA finalizes its Choice Program?

Mr. BUTLER. Yes. I think the VA's plan has some merits to it, but it has a lot of work that has to be fleshed out. It is not an implementation. It is a constant plan. That can be done. Once again, I am speaking for myself, not for the Commission or anything.

Personally, I feel that can be a more collaborative process, and as part of that collaborative process, let us have a process where we have a really integrated systems approach where we come up with the overall comprehensive solution. The Choice Program is not a solution on its own. It has to be integrated with the rest of this health care system. Coming up with a program on your own that may be in conflict with other recommendations would just cause more confusion.

Senator BLUMENTHAL. Mr. Rausch.

Mr. RAUSCH. Yes. I would just like to add, although we have differing views and opinions about the specific plan, I would challenge anyone to suggest that the process has not been collaborative, in contrast to, say, 2 years ago in working with the VA. I do not believe that this process would have taken place, and based off of a lot of the discussion between Members of this Committee and senior VA officials just a moment ago, it seems that your experiences have also changed with VA.

I would just emphasize that it has been transparent, it has been collaborative, and it has been unprecedented in the Federal Government from our perspective. Thank you.

Senator BLUMENTHAL. Mr. Blake.

Mr. SELNICK. Senator, in full disclosure, I think it would be fair to say that the Commission on Care, we have met with their professional staff, and it is our understanding that they are hoping to extend their charge at least until next summer, which would mean this discussion would presumably be put off until June, July, or August of next summer at the earliest.

I think that would be an unfortunate occurrence for the VA, because as most of us here have testified, this plan that the VA has put forward is a good idea. It is a very good concept for how health care should be delivered. If we just put it off for another potentially 12 months, where will we be now, and will that really solve the problems that we are trying to address?

Senator BLUMENTHAL. I share the concern about timing. I understand Mr. Selnick's point about collaboration, but I am heartened

and encouraged by the feeling that I think is generally shared among this panel that the process has been collaborative, and to that end, I am going to invite, in fact, request that the VA react to some of the excellent ideas that have been suggested by this panel, if they have not done so.

I would ask that the VA, who are still present—let the record show that all of the witnesses on the prior panel are still here and can hear me make this request—I would ask that they react to these proposals because these ideas are very promising and important, and I think collaboration is the key word here.

The VSOs have been extraordinarily and profoundly important in this process and I want to thank all of you gentlemen and lady for the excellent ideas that you have offered today and throughout this process, those who are represented here and others who are not on this panel.

Thank you very much and I will look forward to additional collaboration. I think that is the operative word.

Thank you.

Chairman ISAKSON. Senator Moran.

Senator MORAN. Mr. Chairman, thank you very much.

I think it was Mr. Rausch who had statistics about experiences with the Choice Program, access to care in communities, but let me ask all of you, you are all involved in helping your members, helping veterans access care. What has been the experience with the Choice Act for each of your organizations' members?

Mr. BUTLER. I would say for The American Legion, we have had experiences where veterans have had positive experiences as well as not so positive experiences. It all depends upon the type of relationship the VA has within the community and with the HealthNet and TriWest.

We are still getting calls where, even from veterans where their claims have been turned over to collection because they are not being processed and paid in a timely manner. When we get those type of issues and concerns and we turn them over to our VSO liaison in central office and after they check into that, then we get an affirmative answer as to what was the background and an easy solution to fix it. The question then becomes, why did we get to that point? How come it was not appropriately addressed in the beginning?

Senator MORAN. Thank you.

Mr. SELNICK. For our members it has been mostly a nightmare. The number 1 thing that they say, literally, is—the few that have been able to get Choice is because they have had a Congressman or Senator interfere on their behalf—the common thing they say is, why does it take a Senator or Congressman to get some help? The whole process for our members—you can go online to see the Facebook posts—has just been a continual struggle, a battle.

One of the number 1 questions that we get is, if I am within 20 miles of a VA hospital but the heart surgeon I need is 100 miles, why am I denied the Choice Program? Why can I not get the service within 40 miles of where I live? Why does TRICARE offer a simple system of specialty and primary care and metrics and the VA has this convoluted process?

Senator MORAN. Thank you.



Mr. RAUSCH. Thank you, Senator. Just to repeat those numbers, currently, from our most recent survey: 43 percent of our respondents stated the main reason for not using it was confusion; and 28 percent said they had a negative experience. What we have seen from our polling data—a lot of it are flash polls, social media—we have seen it increase, albeit generally it has still been a negative experience. But, it has increased exponentially.

You mentioned Kansas, and I spent some time in Fort Leavenworth because I was assigned there—by choice—and, so, I know Kansas fairly well, and I was looking at a map recently that TriWest had showed me today, or last month, excuse me, versus a year ago. The providers in the network that they have built in Kansas specifically has been tremendous. What we have seen is not a linear increase, but an exponential increase in number of providers, veterans who understand it better, the VA, who, frankly, were probably the worst performing initially in understanding how to coordinate that care. They even improved significantly.

Although it has been a challenge, we have seen it start to sort of steadily uptick, which is why we also mentioned in our testimony that there are some really positive things and lessons learned from Choice, with some negative things we have learned.

On the broader concept of Choice, as was mentioned earlier about the different plans that have been floated, one of the reasons we support this framework and reject some of the one-off plans because there are certain plans that want to take, as someone mentioned earlier, primary care out of the VA. As someone who actually had my primary care health appointment this morning at the VA, and I have choice because I have private health care, as well, that would be removing choice for me.

There are certain plans out there that actually do not reduce but completely eliminate Choice by pulling some of those resources out of VA, which is, again, why we think this collaborative approach that has been taken is a great and clear path forward.

Senator MORAN. Thank you very much. I appreciate your patience in waiting for the opportunity to testify and be here to answer questions, which gives me the opportunity to also tell the VA how appreciative I am of their patience in staying to listen to the testimony.

Mr. Chairman, thank you.

Chairman ISAKSON. And I apologize for having to go to the floor and make a brief speech, so I missed almost all of your testimony, which I apologize for, but I read through the testimony last night. I have a couple of quick questions, and I know it has been a long time, but I thank you for staying and I thank the VA representatives for staying and listening, as well.

Mr. Selnick, you heard the exchange with Senator Moran, myself, and the VA about the problems in Liberal, Kansas, and the Choice accessibility and the ease or difficulty of that program. You made a comment a minute ago that you were not sure that those providing services at the local level and VA at the Washington level understood how the program is really working or something like that, is that right? Did I hear you right?

Mr. SELNICK. Well, I mentioned a number of different challenges with the program, its staff, its process, and its call center. The whole thing has been a problem.

Chairman ISAKSON. I think you are right, and I do not blame anybody for this, but I think there is a misunderstanding up and down the chain of command in terms of what the intent of Choice was and what some of the changes we have made. I hope as we implement these two changes you all rolled out yesterday, you will make sure the people at the local level, the CBOCs, the hospitals, and medical facilities understand what that really means in terms of the veterans access, because those are two remarkable changes that will make Choice better for every single veteran tomorrow. But if they do not experience it at the local CBOC, it is not going to be any good to them at all.

Mr. Butler, I have two questions for you. One, I want to read this sentence to you. VA needs to provide all non-VA providers with full access to VA's computerized patient records system to ensure that the community health care providers can review the patient's full medical history and continuity of care purposes.

Earlier in your testimony, you referred to the lack of coordination between the non-VA providers and the VA in terms of getting the documentation of services provided so the veteran's health care file is complete, is that right?

Mr. BUTLER. Correct.

Chairman ISAKSON. I agree with you that no system is going to work if you do not have the medical history of the patient and the services they received in one place, easily accessible. Do you think they are capable of doing that?

Mr. BUTLER. The VA has been working on an electronic health record for years now with very little success. Their plan calls for taking the snapshot, the VLJ process, I believe, which is a virtual snapshot of the veteran's record and incorporating that initially as part of the health record and then moving on with a future design of a more coordinated health record.

I think that for any process to work, you are going to have to allow a virtual electronic health record, and that is the whole health care industry is struggling with. But you are going to have to develop a virtual electronic health record that is transportable and sharable between any health care institution. Until we get to that point, you are going to still see the challenges of sharing electronic health information either way, between the VA versus non-VA provider and vice-versa between the non-VA provider and VA.

Chairman ISAKSON. You just hit the nail on the head, because the biggest problem—forget about VA health care for a second. The biggest problem for health care in America has today is the lack of interoperability between data systems. You have Greenway, you have Cerner, you have got Epic. You have these systems that do not talk to each other. It is great to talk about having the information, but if you cannot get them interoperative and talking to each other, you cannot have an ease of file sharing.

Deputy Gibson, if you want to jump in here, say something.

If we are going to make this thing work, and if it is going to work the way you suggested you would be supportive of it working in your conclusion, the first hurdle they are going to have to overcome

is how do we make the systems interoperable between the non-VA providers we use and the VA system to get the information on the veteran in one place, at one time, accessible by the physician and the veteran, as well. Right, Deputy Gibson?

Mr. GIBSON. That is correct, sir.

Chairman ISAKSON. Our new technology leader, Ms. Council, has she figured out how to do that yet?

Mr. GIBSON. That is a big part of what the portal is all about, but a big part of that is what [inaudible]. Some of what is being described is actually available.

Chairman ISAKSON. I think that observation that you made, Mr. Butler, in your testimony is key to maybe this thing really functioning and doing well. I appreciate you bringing that point out.

I appreciate all of you being here to testify today. I appreciate everybody who stayed for the duration of the hearing. I think it was very effective. We look forward to working with the VA and all of the vested parties to see to it that as we roll this plan out and implement it, it works for the person we are here to serve, and that is the veterans of the United States military.

With that said, we stand adjourned.

[Whereupon, at 5:06 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON FOR HON. STEVE DAINES TO DARIN SELNICK, SENIOR VETERANS AFFAIRS ADVISOR, CONCERNED VETERANS FOR AMERICA

*Question 1.* The original for fee-service law, 38 U.S.C. 1703, provided the Department of Veterans Affairs (VA) the authority to reimburse care provided at non-VA facilities if the VA facility did not have the capacity to administer care. What issues or deficiencies did this underlying policy have?

Response. The issues and deficiencies to the policy relates to how VHA implements 38 U.S.C. 1703, using VHA Handbook 1601. The first problem with this policy is that it is not veteran or patient centered. VHA runs as a HMO staff model, which tightly controls all aspects of the veterans' health care. The law and the VHA policy that goes with it makes it very complex on which veterans are eligible and on what hospital and/or outpatient private care they can use and get reimbursed. Official VA policy states "It is VHA policy that admission of any Veteran to a private or public hospital at VA expense will only be authorized when VA health care facilities are not feasibly available" [my emphasis]. This is a tough standard to meet or prove and the VA provides no objective criteria to go by. Below is a list of some specific issues relating to the implementation of 38 U.S.C. 1730:

- Only VA gets to decide the standard for reimbursed care: "When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required." As a practical matter, that is very tightly controlled and used as infrequently as possible. So the end result is that there is a lot of denied outside care which results in long wait times and/or travel for the veteran.

- There is a lack of clear standards for what, exactly defines "not feasibly available." This is an unpredictable judgment call which VA makes in a very opaque manner.

- There is a lack of a clear appeals process for the veteran if the veteran disagrees with VA decision.

- This lack of clarity has resulted in instances of VA staff telling veterans they should use outside private sector care, but the veteran is subsequently denied reimbursement because the veteran did not follow the procedures, which were not explained to them. This has been especially true for emergency care.

- Lack of a proper VA referral and authorization process results in confusion over which veterans are eligible for hospital and outpatient care.

- VA is slow in paying reimbursements to both providers and veterans for their medical claims. However, VA has been quick to bill the veteran for health care services that the veteran thought they were covered for, for example emergency ambulance transportation.

Conclusion: VA uses 38 U.S.C. 1703 as little as possible and standards for use—including authorization and referrals—are vague and arbitrary. The veteran has no say, recourse, or appeal, other than to complain to their Senator or Representative. Improper use of 38 U.S.C. 1703 has resulted in an undue burden on veteran patients and has a negative impact on their overall health care.

*Question 2.* Over time, several additional programs, including the Choice Program, provided specific triggers that mandated the VA reimburse for care at non-VA facilities. In what situations does Choice provide unique value in increasing timely access to non-VA care in ways previous programs were unable?

Response. Private sector health care does not have the sort of triggers for eligibility used by the Choice Program—and the other VA purchase care programs—because these kind of triggers do not provide good health care for the patient. Such triggers are not needed with private sector health care, as in the private sector the patient always has the choice to change providers—for any reason whatsoever.

Unfortunately, the Choice Program has proven to be of very little unique value. The wait time and distance eligibility requirements might have provided value had they been implemented properly. Instead, VA made rules causing it to be very difficult to obtain approval for participation in the Choice Program, all while retaining very strict control over the approval process—the veteran has very little choice at all.

The final wait time rule implemented by VA, as described to inquiring veterans, reads thus: “You are told by your local VA medical facility that you will need to wait more than 30 days for an appointment from the date clinically determined by your physician, or, if not such date is provided, our preferred date.” The phrase “clinically determined by your physician” can be used—and is used—by the VA to ensure the veteran rarely reaches the 30 day threshold.

Regarding distance the VA rule states: “Your residence is more than 40 miles driving distance from the closest VA medical facility.” Even with recent changes aimed at ensuring that every VA medical facility has a PCP, there are still hurdles to veterans wishing to use the Choice Program, as 60% of all VA appointments are for specialists. There would be value if the distance was 40 miles driving distance from the closest VA medical facility that provides the needed health care service for the veteran.

*Question 3.* How can Congress strengthen Choice to better achieve the purposes of the law?

Response. In order to strengthen the Choice Program, Congress has a few options.

a. *Option 1.* Redo the wait time and distance provisions of the Choice program to meet the original intention and known needs of veterans.

- Wait times: You are told by your local VA medical facility that you will need to wait more than 30 days for an appointment from the date that you schedule it.
- Distance: 40 miles driving distance from the closest VA medical facility that provides the needed health care service.

b. *Option 2.* Redo the Choice program so that it follows the proven TRICARE Prime access standards for wait and distance. For example:

- *Routine Care:* Beneficiaries must be offered an appointment to visit an appropriately trained provider within 7 calendar days and within 30 minutes travel time of the beneficiary’s residence.
- *Referrals for Specialty Care Services:* Beneficiaries must be offered an appointment with an appropriately trained provider within 4 weeks (28 calendar days) or sooner, if required, and within 1-hour travel time from the beneficiary’s residence.

c. *Option 3.* Redo the Choice program by restructuring it using the Patient-Centered Community Care (PC3) to run it like TRICARE Prime. If the Choice program implemented PC3 correctly with the same rules, procedures and access standards as TRICARE Prime, you would have a much better program for veterans with a much easier and consistent process of authorization and referrals for the veteran. The VA IG has cited in its report on PC3 that if implemented properly (which would mean it is mandatory for the VA Medical Center to use it) veterans would have better choice with reduced costs for VA.