VA FEE BASIS CARE: EXAMINING SOLUTIONS TO A FLAWED SYSTEM

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OF THE

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FRIDAY, SEPTEMBER 14, 2012

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

The Subcommittee met, pursuant to notice, at 9:32 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Roe, Benishek, Runyan, Michaud, and Reyes.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good morning. This hearing will now come to order.

Welcome and thank you all for being here this morning for today's hearing, VA Fee Basis Care: Examining Solutions to a Flawed System.

Recent years have seen tremendous growth in the VA's Fee Care Program, with independent assessments estimating growth of close to 300 percent from fiscal year 2005 to today. Unfortunately, however, as the program has continued to grow, so have the management and oversight problems that have plagued the system through which the Department of Veterans Affairs provides care to veterans outside the walls of a VA facility. It is seriously flawed, if not altogether broken.

In the last 3 years alone, the VA Inspector General has issued no less than seven separate reports detailing in-depth the serious deficiencies and challenges the Fee Care Program faces, including inadequate fiscal controls that have resulted in hundreds of millions of dollars in improper payments.

Further, last September, the National Academy of Public Administration issued a white paper on VA's Fee Care Program that drew alarming conclusions about the VA's ability to effectively manage and oversee care and services under this program.

According to NAPA, VA's Chief Business Office has exercised limited and ineffective oversight of the Fee Care Program; The program itself lacks operational objectives, performance goals, or a clearly defined strategy for managing expenditures; and VA doesn't understand what services are being procured through the fee program and at what cost.

There have been some bright spots. Congressionally mandated pilot programs Project HERO and Project ARCH have shown prom-

ising results in achieving a more patient-centered, coordinated, cost-effective delivery model for fee care. These are small pockets of success, despite the VA's reluctance to implement and utilize these programs to the fullest intent of Congress.

Recognizing the substantial deficiencies with the Fee program, VA has begun implementing two new initiatives, the Patient-Centered Community Care—PCCC—Program and the Non-VA Care Coordination—NVCC—Program. The Department this morning is going to testify that these two initiatives will address all of the challenges the Fee program faces and ensure our veterans receive effective and efficient non-VA care in a seamless manner.

I honestly wish that I could believe that was true. However, given the history of failure we have seen already, I have serious reservations that the actions VA is taking now will address the core challenges that the VA faces and not simply lead to yet further fragmented care and an inability to deliver quality care, especially in our rural communities.

Most notably, the VA lacks the information technology and administrative services solutions essential to establishing in-house the clinical information sharing and electronic claims processing so very vital to a successful care-coordinated and veteran-centric program.

The VA has spent approximately $4.6 billion to purchase care in the community for veteran patients in the last fiscal year. That is billion with a "b".

We cannot afford to allow the VA to continue to flail and struggle to test new programs in an inherently flawed system. We cannot rely on the promises from the VA that they can finally get it right.

Our veterans are everywhere, and VA cannot be. And at the end of the day what fee care is about is effective, efficient delivery of care to veterans, where they need it and when they need it.

Getting it right is about honoring their preferences, their choices, and their daily lives as well as their service to our Nation.

Getting it right is telling a Vietnam- or Korean-era veteran that he doesn't have to travel 4 hours to the nearest VA medical facility for his cancer treatments. He can go to a hospital closer to his home and spend the time he would have spent on the road getting better.

Getting it right is telling a Gulf War veteran that she doesn't have to take a day off from work to drive a VA clinic two towns over for a physical examination. She can go to the doctor down the street if she would prefer and get to work on time.

Getting it right is telling a young veteran, recently home from Iraq or Afghanistan, that he doesn't have to sit and wait all day in a waiting room to see his doctor. He can choose another provider who can see him now and spend the afternoon with the people he missed while he was overseas.

This is what we are talking about today; and these stories, -stories that my colleagues and I hear every day from veterans in our community who are fed up, are what I want all of us to keep foremost in our minds this morning as we talk about how we can make this program better and get it right for the veterans and those who have served this Nation so honorably.

I now yield to the Ranking Member, Mr. Michaud, for any opening statement he may have.

[The prepared statement of Chairwoman Buerkle appears on p. 35.]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Madam Chair, for having this very important hearing; and I would like to thank everyone for coming today.

The subject of the hearing today is an important one and one that is fundamental to the ability of the Department of Veterans Affairs to deliver quality, timely, and accessible health care to all our veterans, regardless of where they live.

Congress gave the authority to the VA to purchase hospital care and medical services in non-Department facilities for veterans in order to give the VA flexibility and ensure access to care. Of concern today is the inability of the Department to adequately manage this authority through the existing fee-based program.

There have been many studies done in the fee program, and most of them have not been positive. The Veterans Affairs Office of Inspector General has conducted several audits over the past few years and has found a lack of education in the fee staff and the processing of claims, a lack of comprehensive fee policies and procedures from Veterans Health Administration, a lack of clear oversight responsibility, and an overall lack of management oversight and involvement. All of these lead to mismanagement of payment and billing and a whole host of other issues.

And on the heels of the Inspector General report that documented the chaos and mismanagement within the fee program is a National Academy of Public Administration report that finds more of the same, and I am looking forward to testimony today. Quite frankly, because I see no improvement in any of these identified issues, it looks to me that the Inspector General's recommendations have been ignored; and I hope that the VA will take this new report seriously and will proceed with the recommendations to change some of the policies at VA.

And, finally, I look forward to hearing from Dr. Petzel regarding VISN 1 and the veterans who reside in Martha's Vineyard. It is my understanding from testimony submitted by the American Legion that a contract with a private hospital in Martha's Vineyard was allowed to lapse in 2004, and 4 years passed before the gap in care was discovered, and there is still no contract. In the meantime, these veterans have to take a ferry, then drive 2 hours to Providence VA Medical Center. We know we can do better than that for our veterans, we must do better than that.

So I want to thank all the panelists for coming today, I look forward to hearing testimony, and I look forward to having an open dialogue on how we can improve the VA as it delivers the services to our veterans.

Thank you very much. I yield back, Madam Chair.

[The prepared statement of Congressman Michaud appears on p. 3.]

Ms. BUERKLE. Thank you very much.

I will now introduce our first panel this morning.

Joining us from the veterans service organization community is Mr. Adrian Atizado, the Assistant National Legislative Director for the Disabled American Veterans; Mr. Shane Barker, Legislative Associate for the Veterans of Foreign Wars of the United States; and Mr. Jacob B. Gadd, the Deputy Director for Health Care for the National Veterans Affairs and Rehabilitation Division of the American Legion.

Thank you all for joining us this morning, I am eager to hear your views. Please have a seat at the table. Thank you very much.

Mr. Atizado, we will begin with you. Thank you.

STATEMENTS OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; SHANE BARKER, SENIOR LEGISLATIVE ASSOCIATE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND JACOB B. GADD, DEPUTY DIRECTOR FOR HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee, good morning.

I would like to thank you for inviting the DAV to testify at this important hearing. We appreciate the Subcommittee's leadership in overseeing VA's contract and purchased care programs, including fee and contract medical care on which many service-connected disabled veterans rely. The DAV does recognize the care VA buys from the community is essential in providing access to better health care to veterans, but, as noted, significant improvements are indeed needed.

The delegates to DAV's most recent national convention passed a resolution regarding VA's purchased care program. Among other things, this resolution urges VA to integrate and promote care coordination with all non-VA purchased care programs and services. With the exception of the ongoing Project HERO pilot program, today's care bought by VA does not exhibit the kind of care coordination discussed in our national resolution, nor health care as provided within the VA health care system.

The focus of today's hearing, fee care, allows for individual authorizations by VA when demand is for only infrequent use. Yet, over the past several years, expenditures for fee care have been rising dramatically, greatly outpacing the number of veterans served by fee.

Unfortunately, fee care has not received sufficient attention and resources to ensure its integrity, efficiency, and integration with the Department's health care system. Service-connected veterans were first to experience the ill effects of this neglect.

When service-connected veterans were authorized under fee care to seek care in the community, there was a palpable disconnect from the continuity of care that the VA is known to provide. Veterans complained that they were required to identify community providers themselves, not knowing the quality of care that they would receive. They often are required to negotiate prepayment of

care or pay for part of that care. They also have to serve as a health care linkage between the fee care provider and VA.

All of these things encumber veterans when they are asked to step outside the VA health care system and receive care in the private community. In essence, as a health care delivery model, fee care is not optimal from the patient's perspective.

The DAV does applaud VA for taking steps in the right direction to meet the goals of our resolution to provide proper care coordination and fee care and make care coordination a standard business practice. However, because non-VA care coordination, NVCC, is built upon the current fee care information technology system and infrastructure, we are concerned that its success will be limited.

Fee care uses VistA Fee, which was developed over 20 years ago. There is a concurrent claims processing software called the Fee Basis Claims System which fee staff has to toggle, they have to use both systems, in order to do their job. It is very cumbersome and labor intensive. Both do not properly support the volume and complexity of fee care now being processed by VA.

DAV believes that meeting fee care IT requirements is well past due. However, we believe our concerns are heightened because VA's Office of Information and Technology's focus and backlog of work will delay identification, development, and implementation of an IT solution.

With regard to the program entitled Patient-Centered Community Care, which is described by VA as a soft approach to contracting care and that it will apply lessons learned from Project HERO, which is now in its fifth and final year, we would like to note that it was first met with skepticism by our community. We are very protective of the VA health care system because it is the only health care system devoted to veterans needs, which are very different than the needs of the private-sector health care and their patients.

The VA has repeatedly assured DAV that the care coordination that patients experience in Project HERO will be part of PCCC. But, as of this date, we are uncertain. We are waiting for confirmation in the form of a draft RFP which will proceed the official RFP due out in November of this year.

While building on the success of Project HERO, it is an untested concept for the VA health care system, one that is not intended for pilot testing for effectiveness. We believe it is a good approach but not the best approach, and we hope that VA will take the opportunity to address its problems in Project HERO as well as the private sector's problems with Project HERO.

Madam Chairwoman, there are a lot more things that I can talk about with regard to fee and contract care, but my time is up, and I will make myself available to any questions you or other members may have.

[The prepared statement of Adrian Atizado appears on p. 36.]

Ms. BUERKLE. Thank you very much.

Mr. Gadd, you may proceed.

STATEMENT OF JACOB B. GADD

Mr. GADD. Chairwoman Buerkle, Members of the Committee, thank you for the opportunity to submit the American Legion's

views on the fee basis program. Typically, VA uses fee basis as a last resort and prefers to treat the veteran within their closest hospital VISN or through a DoD collaboration prior to approving fee basis for our veteran patients. In contrast, however, VA utilizes fee basis programs as the first resort when VA hospitals are short on staffing and need to meet a performance measure.

The question then is, what input does the veteran have on their fee basis decision and policy, particularly if they live in a rural area and have to drive 2 hours to the nearest hospital a couple times per week?

The American Legion testified in a Senate field hearing in Montana and urged the VA to reconsider its policies to allow VAMCs to use their best judgment and discretion so veterans are not forced to drive hours to a facility for several routine and recurring appointments.

In the last 4 years, non-VA purchased care has doubled, from 2.2 billion in 2007 to 4.5 billion in 2011, along with a corresponding increase of 355,000 new fee basis patients. The VA facilities struggle with what services they can provide inhouse or whether they contract out care.

Nowhere is this challenge more evident than with women veterans, gender-specific specialty services. The majority of women services are feed out, but as women veterans are the fastest-growing demographic of veterans enrolling in the VA, VA's ability to hire women providers should be carefully considered.

The American Legion System Worth Saving program conducts site visits to VA medical centers annually, and several concerns were identified during those visits. Number one, there is a lack of training and education program for non-VA providers. The VA has specific screening diagnosis and treatment guidelines which are evidence based and require their providers to be licensed, credentialed, and receive that specific training. Why would we want to refer a veteran to a non-VA provider who does not have those same credentials and training? If non-VA providers had training, it would ensure that they were held to the same quality of care standards and treatments as VA providers.

The second concern is VA's computer system. If the non-VA provider had access to the veteran's medical record, it would help in three ways: Number one, the non-VA provider could review the patient's full record and history in order to make a proper diagnosis and treatment plan. Two, it would help the community provider meet all of the quality of care measures tracked in CPRS as well as promoting mandatory screenings for TBI, PTSD, and other quality of care measures that are currently tracked in CPRS. And, three, it would speed up receipt and documentation from the encounter, instead of VA having to wait weeks or months to receive documentation back from a non-VA provider.

The Martha's Vineyard fee basis contract was the third concern. The American Legion conducted a site visit to Martha's Vineyard last year for our report on rural health care. In 2000, a contract was signed between Providence VA Medical Center and Martha's Vineyard Hospital. The contract lapsed around 2004, which the VA didn't realize until 2008 when the hospital acquired new management. The way veterans treated there found out that this contract

had lapsed was when Martha's Vineyard Hospital sent those veterans collection bill notices for medical expenses previously covered under that existing contract.

Since 2008, these veterans have had to take a ferry from Martha's Vineyard to either a local community based outpatient clinic or drive 2 hours for care to Providence VA Medical Center. While there are only a few veterans that live on the island that were affected by this lapse in contract, this delay illustrates the frustrations that veterans living in rural and isolated locations face with contracting delays and receiving assurances from VA that it will be resolved.

VA officials told us this week that the contract had recently been signed and approved, but in order to prevent situations like this in the future VA must strive to create a tracking database of all non-VA purchased care contracts to ensure those contracts do not lapse and veterans are involved as stakeholders.

Secondly, VA should make every effort to hold stakeholder meetings with veterans from those communities, solicit input, and regularly communicate with them on the status of contracts. After all, it is those veterans' health care.

In closing, along with the cost reduction and efficiencies the PCCC program is proposing, it is equally important that quality standards for contracting care must be the same or better than the care otherwise received in the VA. VA is at a crossroads with their legacy traditional fee basis program. Close to one million veterans rely on fee basis programs every day during a given year.

Madam Chairwoman, thank you for allowing the American Legion to testify today; and I would be happy to answer any questions you or the Committee have.

[The prepared statement of Jacob Gadd appears on p. 43.]

Ms. BUERKLE. Thank you.

Mr. Barker, you may proceed.

STATEMENT OF SHANE BARKER

Mr. BARKER. Chairman Buerkle, Ranking Member Michaud, and Members of the Committee, on behalf of the two million members of the Veterans of Foreign Wars and our auxiliaries, I thank you for this opportunity to share our views on the need to improve VA's fee basis care program.

This program has been badly mismanaged for years, if not decades, now. These problems have been well documented, most recently by the NAPA study last fall. For example, while the VA paid out more than 4.5 billion in fee basis health care claims in fiscal year 2011 alone, they have few tools at their disposal to ensure they are getting the most for their money.

Among the serious problems that exist, VA has no way to ensure proper credentialing of those who bill VA, no way to ensure bill procedures actually occurred, and no way to fully integrate the documentation into a veteran's electronic health record. NAPA looked at each of these and other factors, concluding that VA could not determine the value they were getting out of their investment. We appreciate NAPA's attempt to look at the fee program as more than the sum of its parts, and we hope the Committee will also thor-

oughly examine all assets of the program, while not losing focus on the big picture.

One aspect that has to have priority is the lack of a strong IT backbone to complement the work being done by VA employees and their partners in the private sector. It is imperative to employ IT solutions that can integrate the back-end functions between VA facilities in the private sector is obvious, but that doesn't merely apply to business practices such as authorizations, referrals, and claims. The most important factor is the health and well-being of our veterans, and it is being put in jeopardy because health records are not getting back to VA.

Meanwhile, duplicative services are throwing money down the drain, and we can no longer afford the high cost of stagnation in VA's health care IT. The health of our veterans is too important for us not to respond. Like the private sector, VA must try to save time and money using technology so we can provide robust care for the increasing number of veterans, including women veterans and rural veterans who are choosing VA. As Mr. Gadd said, women veterans are the highest growing population of VA, and it is imperative that we respond to that.

Gaining efficiencies and improving coordination between direct care and traditional fee basis care is the purpose behind a new system known as Non-VA Care Coordination, or NVCC. If executed properly, this will standardize business rule, prioritize internal resources and partnerships before authorizing fee services, and ensure clinical notes are sent to VA in timely fashion. It would also regionalize business functions, taking them out of hospitals and moving them to a handful of regional locations. In theory, this would promote care coordination and save time and money.

VA's pilot of NVCC has taken place in one hospital in nearly all of the VISNs, a fact that VA uses to suggest progress. They may well be right, but we are only left to wonder how VA's central office is collaborating with the hospitals, accepting criticism, and incorporating suggestions.

The VA strongly believes in standardization and enhancing productivity for efficiency in savings. However, we do hope the central office is mindful that incorporating advice from the field may improve their efforts, and we hope the Committee explores that topic with VA. We don't want to simply automate and consolidate flawed processes, because flawed processes that are automated cause further problems down the road. We don't think that is appropriate, and we hope that the Committee will ensure that suggestions from the field are being taken into account.

I also want to touch on another topic that we will be discussing today. The RFP for patients under community care known as PCCC, or PC3, will soon go public. This is VA's attempt to replace Project HERO, a 5-year pilot designed to evaluate whether contracting with a network provider would save money over the traditional fee program. Under PC3, VA will enter into multiple contracts with network providers across the country to complement but not to replace the traditional fee program, and we believe that that must succeed. As an aside, we also believe that this must include mental health services in primary care.

Through VA partnership with Humana, Project HERO has met critical needs and saved VA money over traditional fee while also providing relevant customer satisfaction, distance, and access data. A traditional fee program provides no such data. However, VA has lamented the fact that no quality standards were included in Project HERO, and the VFW hopes and expects to see rigorous quality metrics in PC3.

Project HERO is expected to end the same month as PC3 begins. We hope that you can seek assurances from VA that veterans will truly be held harmless from this transition and that the PC3 networks will have the capacity to meet their mandate before HERO is terminated.

Madam Chairwoman, this concludes my statement. I will be happy to address any questions that you or the Committee may have.

[The prepared statement of Shane Barker appears on p.9.]

Ms. BUERKLE. Thank you to all three of you.

I will now yield myself 5 minutes for questions.

Mr. Barker, you talked about your concerns with regard to IT. Can you elaborate on that?

Mr. BARKER. Well, currently, there is no way for doctors to quickly or easily create a record of the service that was provided and get that over to VA. There is no—and VA has said they are working on a forms building IT solution that would allow doctors to quickly be able to choose a form that is appropriate for the care that was provided. We have also heard that they are working on the Cloud services piece of that to quickly transfer one piece to the other.

The fact that those are separate pieces to the IT solution means that this is a complicated matter, but without those things being available to doctors at the local level it just creates a lot more paperwork and takes a lot more time. The duplicative service piece comes into play there as well.

Ms. BUERKLE. Thank you.

Mr. Gadd, in your opening statement, you mentioned your concern that there was a lack of training for the non-VA personnel, and I wondered what specifically you were referring to.

Mr. GADD. Right. With the VA, they provide evidence-based treatments, for example, with PTSD or CPT, two of the evidence-based treatments for mental health and for PTSD. The VA rolled out that training to all of their providers for mental health, and it is just one example of all——

Veterans, as my colleague stated earlier, have unique injuries and illnesses from their service, environmental hazards, you know, different challenges than what we see in the private sector. But the VA has a robust training program, and we would like to see that shared with their clinicians that they contract with and to the community to make sure the treatments are the same.

Ms. BUERKLE. Thank you.

And, Mr. Gadd, can you elaborate on your comment that hiring of women veteran providers within the VA to provide gender-specific services should be carefully considered? As was mentioned by many of you, there is an increasing number of females in the VA system and I would like to hear your thoughts.

Mr. GADD. Of course. So we know that women are the fastest-growing population coming into the VA, but, unfortunately, we know that a lot of the gender-specific services are contracted out. So as VA develops its models for, you know, hiring and determining whether or not they should fee base or they should hire those providers in the hospitals, you know, that should be looked at so that they can provide that service and offer it, rather than having that contracted.

Ms. BUERKLE. Thank you.

Mr. Atizado, in your testimony you talk about VA reaching a confidence level that PCCC is an adequate replacement for Project HERO. What do you think would be an appropriate measure of that confidence? When do you think it would be safe to transition to PCCC from Project HERO?

Mr. ATIZADO. Well, I think the first thing that should be considered by VA before they terminate the Project HERO is to make sure that under PCCC veterans don't get less services, that they are not asked to drive further, that they are not asked to wait longer to receive care in the community, that the health information sharing does not exist or is not occurring.

Project HERO has a lot of things that DAV finds attractive, but I think how that contract affects VA and Delta Dental as well as Humana, they have their own issues with it. It is the first time VA has done this, so that is to be expected, but, really, we want to make sure it is a seamless transfer.

And that is really it, that veterans who experience care through Project HERO are very satisfied with it. They drive less, for the most part, less distance in Project HERO to VA. Their satisfaction is very high, if not comparable to VA's internal satisfaction survey. Their drive times, their access to follow up, if they don't make an appointment is there. So those patient-facing care coordination aspects of Project HERO would be one of the key elements that VA has to consider before they terminate Project HERO and solely rely on PCCC.

Ms. BUERKLE. Thank you very much.

My time has expired. I now yield to the Ranking Member, Mr. Michaud, for his questions.

Mr. MICHAUD. Thank you, Madam Chair.

Once again, I want to thank the panel for being here today. Also, I want to thank the American Legion for doing your report every year, A System Worth Saving. That is definitely a good report and good reading. So thank you for that as well.

I just want to follow up on that report. You heard my comment about Martha's Vineyard. Has the American Legion looked at—off the coast of Maine, we have a lot of islands. In your study of that, have you looked at fee for services for veterans that live on islands, particularly if they have a Federal qualified health care clinic that is located there on an island? Mr. Gadd?

Mr. GADD. Yes, sir. Our rural health report, we focus on four VISNs; and one of the VISNs was in New England. And so that was when we went up to Martha's Vineyard.

And we also received a lot of information regarding Project ARCH, Access Received Closer to Home. We understand that that program is working wonderful in northern Maine, that the vet-

erans that are being treated through that ARCH contract really have said a lot of great things about that.

As you know, that is another remote area up there where there are no services that are available. So I think we have looked at some of the rural through that report and how ARCH is a potential solution. If that continues to work, then that should be something that the VA considers as it moves forward with that contract.

Mr. MICHAUD. Thank you.

This question is for all the panelists. We will start with Mr. Barker first. It is a two-part question regarding the Patient-Centered Community Care.

The first question, has your organization—had any meaningful input into that process? And the second part of the question is, do you feel that the VA has the capability to effectively manage the community care program contracts?

Mr. BARKER. Thank you for that question.

I think the answer to the first part has to be no. We haven't—we have had regular briefings that are downloads, but there is not much upload. We can't really—I know that is in part because the RFP hasn't been released. It is not even a draft, and I understand that. But we have had some information download. But I wouldn't say it has been a great collaborative process, if that is fair. And whether VA can manage that or not I think it is really difficult to say without seeing the RFP.

I am not one to be overly negative. I don't think that it is impossible. But there is a sort of worrisome track record there, and we do want to make sure they get it right.

I would always say that more collaboration equals better results, which is why I hit on the importance of the collaboration between hospital staff and central office in my oral remarks as very important, and I would hope to see more of that from the VA.

Mr. GADD. Thank you for the question.

As Mr. Barker indicated, the VSOs have received briefings from the VA on the program. It is still new in conception; and, as it moves forward with RFP, we are going to be able to review whether all of our recommendations have been included.

They were many lessons learned from Project HERO. We know that Project HERO was extended until the spring. That being the case, they have a really short window to tighten their plan and make sure that when it comes out in the spring it has VSO input and we have an opportunity again to review it.

So thank you.

Mr. ATIZADO. Ranking Member Michaud, first, I want to say that I would like to say that the chief business office, particularly the individuals involved with overseeing the development for PCCC, has been very open with us at the DAV. We have had regular communication. Whenever we have had issues or questions, they have always been very open with us and tried to tell us as much information as possible without compromising the process.

However, as Mr. Barker said and my colleague, Mr. Gadd, until the draft RFP comes out, at which time we will be able to review and make comments and the final—the official RFP comes out and what that looks like, we really won't be able to answer that, your question to the extent you are looking for.

Mr. MICHAUD. Thank you. And if could you provide for the record, because my time has expired, the VA has not had a proficient record of paying claims efficiently, and I would like your organization to submit for the record your thoughts, the pros and cons of contracting that process out.

Thank you.

Mr. MICHAUD. Thank you, Madam Chair.

Ms. BUERKLE. The chair now recognizes Dr. Benishek, the gentleman from Michigan.

Mr. BENISHEK. Thank you, Madam Chairman.

I just want to touch on a couple of things specific to my district. I am a general surgeon. I worked at a VA hospital as a fee basis physician, and I have also seen patients in my office on a fee basis to help the VA out when they couldn't get the services at their facility.

My concern, number one, is this whole idea of not being able to manage the spending is a huge issue. I am just wondering, do you think in your mind an idea that the cost of the program is inhibiting the VA from sending people to a local facility for their care?

I mean, I have a case here that I am looking at—and I am sure my colleagues have many of these cases, too—where a guy had Agent Orange related cancer and he couldn't get his chemotherapy in his hometown because he was denied the fee basis care, and he was told, oh, you can drive 4 hours and 7 minutes to Detroit and get your chemotherapy in a facility in Michigan. So you are not geographically inaccessible to a VA facility. And yet it is 12 minutes to his local facility and 4 hours and 7 minutes to Detroit, plus 4 hours and 7 minutes back immediately after his chemotherapy treatment.

So is there some sort of a universal rule about who is eligible for—what distance qualifies you as eligible for fee-based care? Because my people don't seem to think there is, and it is basically up to the local VA facility to decide. And I am just wondering what the criterion are then for those people to just make that decision. Is it because the cost becomes a detriment because their budget is over?

Let me get your perspective in answering that thought that I am having here.

Mr. ATIZADO. Sure. Thank you for that question Mr. Benishek.

First of all, I think there is—I guess probably VA would be a better panel to answer.

Mr. BENISHEK. Well, I want to hear from—you must have heard these things before.

Mr. ATIZADO. Sure.

In order to get fee care, there has to be a clinical determination that the care is indeed needed and whether it can be provided through VA's hierarchy of care. There is a decision process on whether or not the care can be provided within VA, another VA facility that is close by, through DoD or academic affiliate sharing agreements. After that, it is contract care and then, after that, it is fee care. In addition to the clinical determination and availability of services, there is also an eligibility determination whether a veteran is eligible.

Mr. BENISHEK. What I am saying this guy apparently qualifies for all of that, except for the only difference is the distance.

Mr. ATIZADO. I understand that, sir. I cannot tell you what kind of justification was used. I don't know the details of the case. But this is just one example, as I am sure all the other members on the Subcommittee has, about the variation of how this delivery—model delivery is implemented in the field.

The NAPA study talks about that, about the wide variation on how the delivery of care—how care is delivered through fee care. That is a signature problem of fee care. What you get at one facility may not necessarily be the same at another facility.

To even take into account the geographical access—the geographical access in a rural area cannot be the same geographical access in an urban area or an area with a high amount of medical resources. So that all has to be fleshed out, which it really has not.

Mr. BENISHEK. Please.

Mr. GADD. That is a great question, and I think it is more VA system driven than patient driven. And I say that from what we have heard from veterans is, you know, where are they involved in the process with whether—if they do have to drive. So the first question we have is, how is the veteran part of the decision on whether they could be fee based?

VA is moving toward a patient-centered strategy. Those discussions should happen with the patient. What does the patient want? If they don't have—if they have to go for recurring appointments twice a week and they choose not to do that and they are elderly and they can't or they leave in geographically inaccessible places.

Then the second part is what recourse does the veteran have in the case that you had pointed out if they are not—or if they are denied.

Mr. BENISHEK. Well, they called me.

Mr. GADD. Right, right.

Mr. BENISHEK. I want to get this problem solved. Because I know that when I take care of patients they check me out. The VA checked me out to make sure I was board certified and made sure I had the experience to do what I am doing. I just don't understand why that doesn't happen in general. Why can't the local facility have been contracted or determined to be able to provide this service and just deal with it.

I think the VA needs to have a much more extensive outreach program to its local facilities to ensure people are qualified and there is somebody available to do it and have the fee all figured out in advance. I did stuff like that when I worked for the VA. Why doesn't it happen generally?

To me, the out-of-control cost business should not be. This should all be figured out in advance. It is very disheartening to me to worry that, because of the cost of it, this guy is having to stay, drive 4 hours because they are worried about cost.

So, anyway, I am out of time.

Mr. BARKER. If I may, I would also like to quickly respond to that.

I think that VA has said through NVCC one of the primary goals and first stages is to create a fee handbook, that everybody gets and receives all the same processes, that everything is standard-

ized. I think this is a great opportunity for you to effect change through good oversight of the creation of this handbook. Why have a handbook if it doesn't solve the problem that you are bringing out?

So I am just bringing that to your attention.

Ms. BUERKLE. Thank you.

The chair now recognizes the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. Thank you, Madam Chair.

Mr. Barker, you brought kind of up where I was going to go, standardization. When we throw variables in, it raises cost. Kind of touching on what you were talking about before—and all of you can comment on this because I think it is something—we deal with it in other areas of the VA, whether it is in the disability process. That form changes four times a year. Well, when you do that to a private individual and they are not aware of it, you are adding education costs, retraining of the people processing the claims, and all that processing goes back to maybe an IT component or some consistency in that manner which helped drive down the cost at the end of the day.

If could you comment on that, because I think that is a place to start. And, obviously, procedures and handbooks have a role in that kind of thing. But we have to stick to them, also. So we have to make sure it was done right the first time.

Mr. BARKER. You are absolutely right.

I think that one area that you could look to for ideas, honestly, is TRICARE. When TRICARE started, a lot of doctors were hesitant to enter into contracts with contract writers because of the fact that forms were not—they didn't make sense. They weren't like Medicare. They were a big administrative burden. And a lot of doctors said no, and TRICARE really worked to standardize and make that an easy process for doctors.

Now the administrative hassles of being a TRICARE provider isn't really the primary reason doctors don't enter into TRICARE. Now it is more about payments and that kind of thing. But there are ways to lower standardization, and I think the creation of simple forms that don't create a lot of administrative burden is one of the easy things, one of the low-hanging fruits that we can attack in this area.

Mr. RUNYAN. It is multifaceted. Also, to get the information back into the electronic medical claim, also, it has to be part of that process.

Mr. BARKER. Absolutely. I think it is VA's opinion—and you can ask them about this—but they want to have a system where they get as much data as possible and they get to decide what information goes out, and I think that that is great. I think it is good for veterans. But there is no reason why VA is not getting the information that they need.

Mr. RUNYAN. Thank you.

Madam chair, I yield back.

Ms. BUERKLE. Thank you.

I will ask the Ranking Member if he has any further questions?

With that, thank you very much for being here; and, most importantly, thank you for what you do for our veterans, for your advo-

cacy, and your leadership on veteran issues. So thank you very much.

I would now like to welcome our second panel to the witness table.

Thank you and good morning.

Joining us this morning are Mr. Brad Jones, the Chief Operating Officer for Humana Veterans Healthcare Services, Inc.; Ms. Kris Doody, RN, Chief Executive Officer for Cary Medical Center; and Dr. Gregg A. Pane, Chair of the VHA Fee Care Program Panel for the National Academy of Public Administration.

I am grateful for all of you for being here this morning; and, Mr. Jones, we will start with you.

STATEMENTS OF BRAD JONES, CHIEF OPERATING OFFICER, HUMANA VETERANS HEALTHCARE SERVICES, INC.; KRIS DOODY, RN, MSB, CHIEF EXECUTIVE OFFICER, CARY MEDICAL CENTER; AND GREGG A. PANE, MD, CHAIR, VHA FEE CARE PROGRAM PANEL, NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

STATEMENT OF BRAD JONES

Mr. JONES. Madam Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to discuss VA's fee process today.

Madam Chairman, I ask that my full written statement be included in the hearing record.

Humana Veterans is proud to be partnered with VA to provide health care services and care coordination to veterans designed to supplement the care received in the VA health care system. We currently have contracts with VA to provide quality health care through two congressionally mandated pilot programs, Project HERO and Project ARCH.

To date, we have served over 163,000 veterans, making over 300,000 patient visits, with an untapped capacity to serve even more veterans, including those who have mental health care needs and those who live in rural communities. Because of our extensive experience in providing timely, quality, and appropriate care in the community we have a unique perspective on the core program elements that are essential to ensure veterans receive these services through a veteran-centric care coordination program when VA refers veterans to care in the community.

This was the hypothesis of the congressionally mandated and VA designed HERO pilot. In a care coordinated program like HERO where community providers are an extension of VA's health care system, the veteran never leaves the VA system and just receives one or more episodes of care from a robust network of trained and credentialed community providers that the contractor maintains.

The community partner, in this case Humana Veterans, has the people, tools, and processes in place to help veterans navigate a complex health care system and help VA track and monitor veterans' care in the community.

In addition, Humana Veterans returns the clinical information to VA and manages all of the administrative components of the process, such as billing and appointing. By keeping these insurance-like

administrative tasks outside of VA, the Department can concentrate on what they do best and that is deliver world-class health care to our Nation's veterans.

Over the past 5 years, the HERO pilot program has proven that a national health care administrative services organization can collaborate effectively with VA to deliver results-focused, high-quality, and cost-efficient care. The success of HERO is substantiated by a strong set of performance metrics, and in 2010 VA reported savings of $16 million from Project HERO in the four pilot VISNs, despite the fact that only about 11 percent of the total non-VA outpatient visits were referred to HERO.

Based on VA's presentation to interested contractors, it appeared as though the planned follow-on program they are calling Patient-Centered Community Care, or PCCC, might only be a national contract for a network of providers to deliver medical and surgical service without the critical care coordination elements.

VA appears to be creating and building new inhouse capacity to handle the administrative functions associated with fee care through the Non-VA Care Coordination program, or NVCC. Instead of leveraging the capacity and expertise that already exists in the industry, NVCC will require significant resource investments both in staff and the necessary tools to properly handle the back office administration functions. If PCCC is supposed to be the nationwide follow on to HERO, the administrative functions of the program need to be conducted by the contractor. Failure to do so means that VA will not be able to fully replicate the success of HERO.

Rather than continue down the current path of these programs, now is the time for VA to incorporate the successful elements of HERO to create a veteran-centric collaborative health care program that will be a win-win for veterans and for VA. Veterans will benefit from a fully coordinated and integrated health care delivery system of both VA and community providers; and VA will be able to achieve cost savings by partnering with organizations that have existing systems, tools, and processes in place for efficiently managing fee-related administrative functions.

Both Congress by directing VA to establish the HERO pilot and the VSOs in the independent budget have supported the concept of a coordinated fee program that will both improve veterans' health care and lower costs. The inclusion of the elements of a veteran-centric collaborative health care program in PCCC will ensure that veterans realize all the benefits of care coordination between VA and community providers. This would create a truly integrated VA health care system that better leverages community health care assets, if and when VA decides to authorize such care.

If VA contracts for a provider network only, that will represent a retreat from the Secretary's commitment to implement a patient-centered VA health care delivery system that includes all VA health care for veterans both inside and outside the walls of VA.

Thank you for holding this hearing and tackling this vital issue. I appreciate the opportunity to share Humana Veterans experiences and views with the Subcommittee today, and I am happy to answer your questions.

[The statement of Brad Jones appears in the appendix.]

Ms. BUERKLE. Thank you, Mr. Jones.

Ms. Doody.

STATEMENT OF KRIS DOODY

Ms. DOODY. Good morning, committee Chairwoman Buerkle, Members of the Subcommittee, and our own revered congressman, Ranking Member Mike Michaud. I thank you for this opportunity to discuss the delivery of health care services to our brave men and women of the Armed Forces.

I am Kris Doody, the CEO for Cary Medical Center, a small rural hospital in northern Maine. We have had the privilege of providing services to veterans on our campus for more than 25 years.

Cary was the first community based outpatient clinic in a rural hospital in the Nation. The clinic opened May 14th, 1987. The clinic was to serve veterans who historically were forced to travel 300 miles to the only VA hospital in Maine at Togus. A small group of veterans representing multiple veterans' organizations worked passionately for some 8 years to secure the VA clinic. The clinic has become a model for the country, and today some 600 CBOCs are now providing care to veterans throughout the Nation.

The VA clinic was the first of what would become a growing center of veterans health care in Caribou, Maine. In 1990, the Maine veterans home opened 40 long-term care beds, with an additional 30-bed residential care facility for veterans with dementia in 2003 on our campus.

We continued to advocate for inpatient beds through the CARES Project, but that never materialized. That is why in 2011 we were so excited to be selected as one of only five locations in the country to launch Project ARCH. Since we already had the VA clinic and an excellent relationship with the Veterans Administration, we knew the implementation of the ARCH program would be a great success.

While the VA clinic provides all the primary care, our hospital provides a select list of specialty services, including general surgery, orthopedic surgery, and a variety of other services, including inpatient care. The model has benefited veterans in accessing care close to their homes, the VA in reducing costs for travel pay, and at the same time delivering high-quality, safe, and efficient care to veterans. And Cary Medical Center has been able to expand its market share such that we have been able to recruit additional specialists.

It is our understanding that at all five locations Cary Medical Center is the furthest distance from the nearest VA hospital, and in just this first year we have saved the VA a quarter of a million miles in travel pay. To date, some 1,000 veterans have taken advantage of Project ARCH. Recent patient satisfaction surveys indicate that veterans are extremely satisfied with the care they receive at Cary Medical Center and no longer have to travel hundreds of miles to receive specialty care.

One of the key reasons for our success is the relationship we have built with the Veterans Administration at the Togus VA hospital. We have worked with some outstanding center directors, including the current Director Ryan Lilly, and past directors Brian Stiller, Jack Simms, and Tom Holthaus, who provided the initial

administrative approval to launch the first VA clinic in a rural hospital.

We understand that the VA is considering other options for the delivery of care to rural veterans. We believe Project ARCH, in the unique model that has been developed in Caribou, Maine, has some tremendous advantages. First, with the VA presence on our campus, we are realizing a great coordination of care between the clinic and the hospital. Second, veterans feel a part of the VA system, even though they may be in a non-VA facility. Third, the establishment of integrated case management creates a virtual medical home for the veteran, making sure all of their care is delivered in an efficient and coordinated way.

While Project ARCH has been a marvelous success and benefit, some challenges do remain. One such challenge is the 14-day scheduling of VA patients. The VA wants to be seen within 14 days of authorization, and it has been a challenge for us to work these patients into the regular schedule of our specialists.

There are other administrative requirements that create a challenge, such as excessive monthly reports on every patient. In addition, now that veterans have experienced the level of care at our hospital for the select list specialty services, they would like more.

Another issue that we face in Caribou and that is unique to Maine has to do with Medicare reimbursement. Maine is amongst the poorest reimbursed States in the Nation by Medicare. Our Congressman, Mike Michaud, has been working tirelessly to change this reality, but it has been a difficult fight. We would like to see if this can be addressed moving forward in a more equitable way.

Finally, it has been a great privilege for Cary Medical Center to serve our Nation's veterans. It has been a source of pride for our hospital and for all of us who work there.

Our hospital, like many across the Nation, is a convener of sorts. We bring people together to best serve the needs of health care in our community. We have experience with virtually every health care service in our marketplace, including mental health, home care, and long-term care. We are a regional hospital that demonstrates the highest scores in patient safety, clinical quality, and patient satisfaction. We have built an excellent relationship with the regional VA health care center, and we have demonstrated that Project ARCH can work in even in the most rural frontier regions of America.

It is our hope that the VA will continue with Project ARCH and expand upon the number of health care services available to veterans living in the vast rural areas of this country.

I thank you so much for this opportunity, and I would ask that Congressman Michaud include my prepared and written remarks in the congressional record of this hearing.

I am also happy to answer any questions you may have.

[The prepared statement of Kris Doody appears on p.Q.]

Ms. BUERKLE. Thank you very much.

Dr. Pane.

STATEMENT OF GREGG A. PANE

Dr. PANE. Madam Chair, Members of the Committee, good morning to you all. I appreciate the opportunity to testify today on be-

half of a panel I chaired at NAPA in 2011. The Academy is an independent, nonprofit, nonpartisan organization dedicated to helping leaders meet today's challenges.

Over the past decade, the VHA Fee Care Program has grown from an infrequently used adjunct into a critical element of clinical care for veterans, in fact, approaching now one million veterans being served in a $5 billion program, 10 percent of VA's budget, with 2,400 FTEs.

After extensive research and analysis, the Fee Care Panel recommended that VA consolidate this program into three to five operating centers, while modifying its claim processing structure to become a more standardized system. Standardization of the IT infrastructure along with consolidation will allow fewer employees to work more efficiently and effectively, and a more structured rule-based environment should lead to fewer payment errors and greater program value.

The panel also emphasized the importance of contacting an independent analysis of contracting this function out, similar to the approach used by VA sister health care programs TRICARE, Medicare, and Medicaid.

Some quick background. In 2009 and 2010, the VA Inspector General reported significant problems in the Fee Care Program, including hundreds of millions of dollars in improper payments. Their recommendation that VA evaluate alternate organizational models led to the NAPA study.

The Academy convened a panel of fellows along with a professional study team, conducted interviews of VA staff, looked at all existing studies and audits, and spoke with Federal and commercial health care payor programs, as well as the OIG and others. Site visits were made to VISNs Denver and some of the other key areas as well as to Medicare and TRICARE.

Both Medicare and TRICARE contract out all of their claims work and spend a majority of their time overseeing the work of contractors. Several large commercial vendors specialize in providing large-volume processing of these health care claims.

TRICARE contractors report about 75 percent of their claims are automated and electronic, requiring no human intervention. The cost per claim is $2.25 to 2.50 for electronic claims.

For Medicare, 95 percent of claims are automated and electronic, with a cost of $0.40 to 1.60. This compares to $9.40 per claim for VISN 19, which is the highest-performing VISN, and 2.55 per claim for CHAMPVA.

A word about error rates. The chief business office, their own analysis of error rates in claims processing for recent activity is about 12 percent. If you extrapolate an error rate of 12 percent against total fee expenditures in 2011, erroneous payments would be $500 million.

For a comparative benchmark, the national error rate for CHAMPVA is 1 percent and for TRICARE it is under .05 percent. That is a 25-fold error difference.

The panel findings, the Fee Care Program is currently operating at an inefficient level due to a number of payment errors and relatively low productivity; and the return on an investment analysis run by the panel indicates that a total consolidation of the Fee

Care Program would save the organization almost $4 billion over the next 10 years. These net savings were calculated by adding the savings by reducing the number of FTE through consolidation, integrating a more automated claims processing system, and reducing errors in payments.

Let me highlight the panel recommendations:

First, consolidate the Fee Care Program from the current 100 plus operating sites to perhaps three to five strategically located regional sites.

Second, leadership should set clear policy direction about performance, goals, and expectations for VA purchased care. This is a big blind spot for VA, and there is untold additional savings possibly available through better coordination of care and increased quality monitoring of veterans in this Fee Care Program.

Third, VA should build greater program management competence, including a program integrity component to look for fraud and abuse and a performance management system to look at performance outcomes.

Fourth, VA should procure an implemented enterprise-wide technology solution to facilitate virtual consolidation.

And, last, they should conduct an analysis of contracting out the functions similar to the sister programs.

By implementing these recommendations, the panel believes VA will be able to improve care and help ensure maximum participation in the program, resulting in better care for veterans.

Madam Chair, this conclude my prepared remarks; and I would be happy to answer any questions.

[The prepared statement of Gregg Pane appears on p.V.]

Ms. BUERKLE. Thank you very much, Dr. Pane; and thank you again to all of our panelists.

Mr. Jones, in your testimony you talk about Humana having an untapped capacity to serve more veterans, including those who have mental health needs and particularly those in rural communities. Can you comment on that?

Mr. JONES. I would be happy to, Madam Chairman.

Yes, we have—within the four HERO pilot VISNs we have a network of over 40,000 providers strong contracted. The volumes in HERO have been somewhat lower than they could have been. Given on the way you measure them, it is estimated that anywhere from 10 to 20 percent of the total fee basis referrals that went out went through Project HERO. So we believe we have more capacity—that we could have taken more.

Specifically in the area of mental health, that was part of the Project HERO contract, and a mental health network in the community has been established. But it especially has been lightly used. There have been very few referrals over the 5 years to that, and I think a lot more could be done in terms of serving mental health.

Ms. BUERKLE. Thank you.

Also, Mr. Jones, we are hearing rumors that, although the VA has announced the extension of Project HERO, some of the VISNs

are not going to continue on with the program. In your view, I would like to know what you anticipate or what you think about if there is a sudden cessation of Project HERO?

Mr. JONES. I am very troubled and concerned about that, Madam Chairman. Our volumes have declined significantly since early June when VA sent out a notice to the participating VA medical centers that HERO would be ending on September 30th and that they should revert to the regular fee program if the follow-on program were not in place at that time.

You are correct that they have now formally extended the contract, but I fear that medical centers are still in a state of not being sure what the status of program is.

There is one VISN that has formally taken the position they are not going to participate in the extension, and they have—in fact, we have been getting calls from our network providers that this VISN has been reaching out to them and contacting them, informing them that HERO has ended and that they would like to send care directly to them.

So I am very concerned about the veterans losing the care-coordinated benefits that they have had under Project HERO until the new program is in place. Unfortunately, I have already received one email from a provider stating that they have 33 veterans that need authorization for ongoing care and they have not been able to get that authorized through VA to date. So I would be concerned that veterans will get kind of caught in the middle of this transition if it is not done properly and suffer as a consequence.

Ms. BUERKLE. Thank you very much.

Ms. Doody, in your statement, you mention that Cary Medical has experienced over a thousand patient encounters since Project ARCH began. Is that what you were expecting during the first year and do you think that the program is being effectively administered by VA? And just comment on the program in general.

Ms. DOODY. Absolutely. Thank you, ma'am.

When we started the program we tried to anticipate the volume, and we knew that there was a backlog in certain specialties at VA Togus. So we anticipated that that would be the priority of getting patients into the ARCH program in Caribou, and that did materialize, because the majority of the patients are primarily in orthopedics. The backlog at Togus is out about 6 to 9 months to my understanding of patients trying to get in to be seen at the Togus hospital. So we have seen the majority of our numbers have been primarily in the orthopedic surgery evaluation.

Actually, at the end of the first year we did not anticipate a thousand. We are very pleased. We think it has been very successful. We are seeing a leveling on the number of authorizations each week. So we think we are getting now into a pattern that is probably not going to be at that level the coming year, because I think we took care of some backlog with Togus, but I think it will be fairly close even for this coming year.

Ms. BUERKLE. Thank you very much.

Dr. Pane, can you comment further on your statement that, despite a number of initiatives being undertaken to improve the current situation, the organization responsible for improving the system, the chief business office, has limited control and authority?

Dr. PANE. I think we pointed out the management challenges in our report. Of course, the current fee system is highly decentralized across VISNs, and VA medical centers and staff, of course, report locally, and the office has a big challenge trying to oversee.

There is wide variation on how things are done. You saw the wide difference in outcomes in terms of efficiency. And so the office has the leadership role, but there are a lot of challenges for them in terms of IT procurements and standardization across networks and reporting structures and so forth. So there is a lot of change that needs to occur, and then they have a big job on our hands.

Ms. BUERKLE. My time has expired. But if the chief business office doesn't have control or authority, who does?

Dr. PANE. Well, the Under Secretary—there is a large structure, so they certainly have the tools to get it done.

Anything this large across this big of a system, I think the way to look at it is, one, what are the immediate steps you can take based on some of the pilots and some immediate steps and then what is in parallel is the larger fix. And I think that is taking a look at what your fellow Federal programs do and looking at others who might be better at processing claims.

Ms. BUERKLE. Thank you very much.

I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

Before I begin my questions, I first off would like to thank Cary Medical Center for participating in this very important hearing. This year, Madam Chair, Cary Medical Center celebrates their 25th year of hosting the Nation's first community based outpatient clinic, and they continue to be a leader in providing high-quality care for our veterans.

And the reason why I know that, Madam Chair, is, first of all, Kris is committed to caring for our veterans, and it is reflected in the reports I get from veterans in the area, who praise not just Cary Medical Center for the high-quality care but also Kris and her willingness to really work with the veterans community in northern Maine.

So I want to thank you, Kris, and Cary Medical Center for all that you are doing to provide good-quality care for our veterans in a timely fashion.

Ms. DOODY. Thank you, Congressman.

Mr. MICHAUD. My question actually is for Mr. Jones and Ms. Doody. You talked about the ARCH program. My question would be, are there ways that we can improve upon the ARCH program that you would like to see? I know, Ms. Doody, you mentioned the 14 days. In talking with staff I believe the VA actually takes longer than 14 days, on average. So, Ms. Doody, I will start with you. What ways do you think that we can improve upon the ARCH program?

Ms. DOODY. Some of the metrics that we are looking at like the 14-day window I think we have to have some honest dialogue whether or not it is really reasonable. My understanding is the metric for being seen for the VA is 30 days, and it is hard for the VA to see the patients even within 30 days in their own VA hospitals.

Cary and the VA are both—we are very mature as it relates to IT. I think we could do a better job at integrating our information. The information we have to provide monthly, which is a lot of work, it is very cumbersome, I think we could streamline that by using information technology. Right now, it is all manual. In fact, we have had to add more resources because of the administrative burden about 2 months into the program because there was a lot of reports that had to be completed. I think the reports are important, because I think the quality metrics should be reported, but I think there are ways we can streamline it to make it a lot more efficient and not as manual and cumbersome.

The other issue I would like to talk about was adding additional services. I am hearing repeatedly from veterans additional services they would like to see, primarily ophthalmology, women's services, women's health services, and also podiatry. I am hearing repeatedly from our area veterans.

DCMN BURRELL

Mr. JONES. Congressman, first I would like to highlight before I talk about the improvements, there are some great successes out of ARCH, most notably what we are hearing from the veterans themselves in terms of gratitude of being able to get this access close to the home. So I think the program is hitting the bull's eye on that intended mark.

In terms of improvements that I think could make it go even farther, volumes are an important issue, my colleague referenced some of the administrative challenges and burdens that come with this program. And when you are dealing with community providers that are seeing very low volumes, combined with those administrative challenges, that creates an issue. So that would be an area we could look at, not necessarily in terms of sending more care outside of VA, but perhaps looking at the definition of the pilot sites. And as you know they were very narrowly defined.

In some cases we are seeing veterans having to travel a pretty good distance from outside of those pilot sites to come in and get the care they received. So I would say looking at that would be an option.

I also agree with my colleagues on some of the standards, including the 14-day metric is a challenge, but I would say probably the main issue would be looking at some of the other administrative burdens. There are some VA required training that has to take place that in many's view is not necessarily value added but it is an annual thing where the community providers have to go into the VA system and sign in and go through a fairly lengthy training module that again adds another administrative burden that they are not accustomed to and it creates a barrier to participation.

Thank you.

Mr. MICHAUD. Ms. Doody mentioned additional services, do you feel that would also be important?

Mr. JONES. Yes, I would agree and I want to commend my colleagues at VA and the Office of Rural Health that they have been treating this and managing this like a pilot, and they are looking at what is working and not working, and that is very important. And an example of that is we had in our case, cases where veterans

were getting discharged from surgeries, but because of those post surgery needs such as the rehabs and therapies weren't on contract, they may have gotten the surgery very close to home but then had to travel very far back to VA often on a recurring basis to get that follow-up care. So Office of Rural Health has put forward a modification of the contract that is currently being negotiated that would add those important services so the veteran could get the whole package of care there.

So, yes.

Ms. BUERKLE. The chair now yields to the gentleman from Michigan, Dr. Benishek.

Mr. BENISHEK. Thank you, Madam Chairwoman. I want to ask Dr. Pane a question sort of related to what we talked about in my previous opportunity. Is it your understanding, Dr. Pane, that the eligibility criterion for the fee basis care is different at each VA medical center and at the discretion of the director of that facility?

Dr. PANE. I cannot speak to specifics of how VA has operationalized this. I will say I think the panel did find wide variation in performance and management. And I am sure there is some variability in exactly how the program is done. In terms of specific criterion and outcomes, I couldn't comment. That would be better directed to VA.

Mr. BENISHEK. Right. Do you think national standards for this would be beneficial or do you think it is better to have local standards?

Dr. PANE. No, I think we certainly recommended that a greater degree of standardization is absolutely the way to go and a much greater automation. Most comparable large Federal programs like this and even in the commercial world they work with a claims processing entity, that is the guts and glue of your system. That is really what allows to you pay claims, to detect fraud, to monitor outcomes and to in a standardized audit trail way be able to document care. I think VA lacks this, and I think it is something they are trying to move towards, but it is a big challenge. But it is a big gap between what VA does and I think what comparable Federal programs, TRICARE, Medicare and Medicaid do today.

Mr. BENISHEK. Thanks for that answer. My experience with the VA has been good really. I thought that they investigated who I was and what I was doing and the quality of my care. And we had to submit a bill and we put our paperwork and we just sent it to them and they scanned it into the record. And I thought it was fairly efficient. But it is surprising to me that apparently this is not happening throughout the system. My local office I thought managed it fairly well, but not that it couldn't have used improvement. But I am looking forward to talking to the VA representative as well.

So thank you, Dr. Pane. I yield back the remainder of my time.

Ms. BUERKLE. Thank you again to all three of you for being here this morning. Ms. Doody, congratulations on 25 years, that is quite a successful milestone. Thank you all for what you do on behalf of our veterans.

I would now like to invite our third panel to the witness table. Representing the Department this morning is the Honorable Dr. Robert A. Petzel, M.D., VA's Under Secretary for Health. Dr. Petzel

is accompanied by Mr. Philip Matovsky, Assistant Deputy Under Secretary for Health, Administrative Operations; Ms. Cyndi Kindred, the Acting Deputy Chief Business Officer for Purchased Care; and Ms. Deborah James, the Non-VA Care Coordination Project Manager.

Thank you all very much for being here today, and Dr. Petzel, if you could please begin your testimony.

STATEMENT OF THE HON. DR. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PHILIP MATOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH, ADMINISTRATION OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; CYNDI KINDRED, ACTING DEPUTY CHIEF BUSINESS OFFICER FOR PURCHASED CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND DEBORAH JAMES, RN, NON–VA CARE COORDINATION PROJECT MANAGER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. PETZEL. Good morning, chairwoman, Ranking Member Michaud, and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs, VA's Purchased Care Program. I am accompanied today by Dr. Philip Matovsky, Assistant Deputy Under Secretary for Health for Administrative Operations; Ms. Cyndi Kindred, Acting Deputy Chief Business Office for Purchased Care; and Deborah James, Non-VA Care Coordination, NVCC Project Manager.

VA provides care to veterans directly in a VHA facility or indirectly through either individual authorizations or through contracts with local providers. This mix of in-house and external care provides veterans with the full continuum of health services covered under our medical benefits package. VA recognizes the improvements that are needed in a non-VA care program, including that part of this program previously known as fee basis. To address these concerns VAs have developed and managed multiple initiatives in the non-VA care program. These initiatives are designed to ensure that high quality care is consistently provided to veterans under these authorities.

My testimony today will discuss two initiatives, Patient Centered Community Care, or PCCC, and Non-VA Care Coordination, or NVCC. Both of these will help ensure that high quality care is consistently provided to veterans regardless if they receive their care in-house or from non-VA care providers.

I will provide you with an update on the Project HERO and update on Project ARCH and how our use of these non-VA care programs is increasing access to care for rural veterans.

We are aware of the numerous reviews performed regarding VA's non-VA care program and we concur with these findings. There is much that needs to be addressed. We are here today to provide a candid discussion of our efforts to diagnose and overhaul the way VA manages the care that we acquire from the private sector. We are transitioning our non-VA care program, we are taking a com-

prehensive look at this program and assembling what we believe is the right team to achieve lasting, meaningful results and reform. We are standardizing our approach to ensure non-VA care is cost effective, meets quality standards and is accessible within a reasonable distance.

Today I will outline two initiatives, as I mentioned earlier. VA developed and managed multiple initiatives to improve their oversight of the management and delivery of non-VA care. PCCC, or Patient Centered Community Care, will be a network of standardized health care contracts, including a range of services consisting of mental health, laboratory and skilled nursing home care. It is useful to think of PCCC as really a national extension of Project HERO, and we will discuss hopefully the details of that as we proceed.

Non Non-VA Care Coordination, or NVCC, is our internal program to improve our referral management practices. NVCC is a set of business processes that are going to be implemented through tools and templates to improve how we justify and authorize non-VA referrals. NVCC will standardize our practices and reduce or eliminate variation within the non-VA care program nationally. NVCC is explicitly addressing major concerns that were raised by the OIG and other reviews, as mentioned today.

Additionally, VA has worked to increase access to health care for rural veterans, as I mentioned before, through Project HERO and Project ARCH. The VA recognizes improvements are needed in our non-VA care program. We have reviewed our approach to management program, we have established a clear corrective action plan that will address our program shortcomings. We are also committed to a long-term strategy that will change the way we perform key business functions in the managed care program.

The corrective action plan will make measurable progress in reducing improper payments, creating a culture of accountability, enhancing internal control and data integrity, training and education, educating the field and establishing internal policies with heavy, heavy oversight.

Our long-term strategy consists of implementing health care claims processing software, consolidating claims processing functions, as mentioned by Dr. Pane, and continuing to strengthen the management and oversight of the program.

When necessary care is not readily available at one of our facilities, VA is authorized to provide that care to eligible veterans outside of VA's health care system. We expect that these non-VA care providers will deliver the same high quality care as our providers do. We believe that our current initiatives are major steps in the direction of providing the care that our veterans need and deserve.

And we appreciate the opportunity to appear before you to discuss VA's non-VA care program. My colleagues and I are prepared to answer your questions.

[The prepared statement of Dr. Petzel appears on p.a.]

Ms. BUERKLE. Thank you very much. I will now yield myself 5 minutes for questions. After listening to the last two panels I must say to you that I have grave concerns as to the previous folks who testified about what is going to happen with this fee basis service and how flawed the system is. As in all of these hearings and all

of these issues we talk about, time is of the essence because every day failure at the VA results in frustration, in this case physical or mental health issues, with our veterans. We don't have the luxury of time, which is what I am not sure VA understands. Time is of the essence, whether we are talking about prosthetics, today we are talking about fee basis care. We have to get this moving right away, because every time we fail our veterans are hurt. I cannot emphasize that enough that time is of the essence, that we do not have luxury of time.

This morning in a statement Mr. Barker from the VFW said that we have learned the contract care provider through PCCC will be prioritized over other avenues of non-VA care, which is a departure from Project HERO. Now in your testimony you just mentioned that really you could look at PCCC as an extension of Project HERO so if you could comment on that.

Dr. PETZEL. I am not aware, Madam Chairman, of what exactly he's referring to. But let me explain what PCCC is. It is, as I said, an extension of Project HERO. We want to create nationally three to five regional contracts that mimic all of what we see in Project HERO. The back office functions that Project HERO does would be done under the contract. All of the functions that we see in Project HERO would be a part of that contract. It would not just be a contract for a group of providers. I think there has been some misunderstanding on the part, particularly Humana VA, of exactly what that would be.

The priority always is going to be provide the care within the VA system if it is possible to do that, and perhaps that is what was meant by the comment. But in terms of it having less priority than other kinds of fee programs, et cetera, the problem here is meet the needs of the veteran, to provide accessible high quality care particularly in rural areas where we don't have as much of a presence as we would like to have, and that would be the same priority for the PCCC regional contracts.

Ms. BUERKLE. One of the issues we heard from previous members of the panels was about primary care being a part of fee basis service and I would like you to comment on that. What is the plan with regard to primary care and mental health care as well?

Dr. PETZEL. To take mental health care first and quickly dispense of that, mental health care will be a part of the contract. It is a part of contracts that we have now, and it will definitely be a major feature of the PCCC contracts.

Ms. BUERKLE. And if I could interrupt you because when Mr. Jones testified he talked about that they had a mental health network in place, but it isn't something that is being advanced by the VA, the numbers are very poor. Are we not letting our veterans know that this mental health service is available through Project HERO?

Dr. PETZEL. I can't answer the question about the use. We will go back and take a look at the data, Madam Chairman. I don't have that information in front of me. The way the contracts usually work is that the VA decides that something needs to be done for a patient. We don't have the service in a geographically accessible area or there is a long wait in the VA facility to do that. And then

we would turn to the contract provider and say we need to have this orthopedic consult. And then they would arrange to do that.

So it is not as much education of the patients as it is of our providers that those services are available.

I am going to have to go back, Madam Chairman, and look to see what the usage patterns are. I was not aware we were under utilizing when we need to use utilize the mental health features of our contracts.

Ms. BUERKLE. Comment on primary care in the short amount of time I have left.

Dr. PETZEL. Thank you. Primary care right now is not a part of Project HERO. It is being used in one of the five networks in Project ARCH, the network that is involved in Pratt, Kansas. VA views primary care as being its primary responsibility. We have primary clinics in our medical centers, we have primary clinics in our community based outpatient clinics, which are extensive. We have home based primary care where we reach into the home and provide medical care in rural areas, actually in the patient's home, and then we have telehome health where we are able to provide help in remote areas the connections to a primary care provider in a CBOC or a clinic.

We view this as our primary responsibility and do not think that this is an appropriate thing to be contracting for in the main. There are some instances in certain very remote areas where we may do this, but as a part of the contract, it is not featured as a part of either the HERO contract or the PCCC contracts.

Ms. BUERKLE. Thank you, Dr. Petzel. I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you, Madam Chair. And thank you very much, Dr. Petzel, for coming here today. I have a couple of questions. When you look at access to health care. And I know I sent you a letter as it relates to the Inspector General report for the Calais CBOC and one of the problems that came out of that report was the fact that the position wasn't filled for over a year. That caused some problems. I guess my question is particularly in rural areas, what are you doing to make sure that veterans can have that good quality access to health care in rural areas? And are you looking at contracting out with private providers, or what type of program are you looking at particularly in rural areas? I am sure it is not unique just to Calais in trying to find doctors to go to rural areas for the VA.

Dr. PETZEL. Thank you, Congressman Michaud. You are right it is not unique to Calais, Maine or to Maine in general. Our most difficult problem in terms of recruitment is finding primary care providers for remote areas. It is a very—we are not unique. This is a problem that many, many communities in the private sector around the country are having. We are trying to do several things. One in terms of making recruitment more desirable, we have the capacity to offer financial incentives, we have some flexibility in terms of salary, we have a debt forgiveness program where we can forgive a large portion of a person's medical school debt should they be coming out with that. We also are using other than physician providers. We have scattered now across the country a number of clinics that are being run under the supervision of physicians by

nurse practitioners and PAs, physicians' assistants. In Colorado and Utah a unique program where we are providing telemedicine primary care. There is a location in the community where we have telemedicine capability. There is an individual that operates, if you will, the tools, often a nurse. And they are then connected to either a community based outpatient clinic or either Denver or Salt Lake City. And we can actually do a primary care clinic and a primary care clinic visit follow-up, if you will, for medical problems in that kind of a setting. And then finally, as I mentioned earlier, Congressman, telehealth, telehome health and home based primary care are the things that we are trying to do.

I want to again emphasize the fact this is not a problem that is unique to us. We think we have a number of very good alternatives to address the problem, but it still I think quite honestly is going to remain a problem. The VA is in a unique position in terms of telehealth solutions here particularly. We have the largest telehealth network in the country. And I think we are the only or the first organization that has pioneered this telehealth primary care clinic. It may be a solution that we will be using around the country.

Mr. MICHAUD. Thank you. My next question actually, the previous panel talked about additional services, whether it is the ARCH program or HERO. What is the VA doing to expedite the needs out there, particularly the needs of programs for additional services? And I actually heard one of my colleagues earlier talking about veterans having to travel long distance and he is getting a lot of calls from the veterans that the VA is not providing those services. Likewise we keep track of the complaints we are getting from our veterans in Maine, and a lot of it has to actually deal with traveling a long distance. For instance, cancer treatment, that is a big issue, and if you look at veterans in different parts of the State, if they traveled to Massachusetts it could take 10, 11 hours and that is a huge concern. The bigger concern I have is that I think part of that is because of the VERA model and the VA and the different facilities being reimbursed because of the veterans they see. They are requiring veterans to go longer distances. It is only a thought on my part to go to Massachusetts, so they can get the numbers up. This is not veteran centric, it is VA centric.

Can you answer the question about additional services?

Dr. PETZEL. I will. I would like to give, Congressman, a little bit of background. First of all, the fee basis work does count in the way they get reimbursed. So it is not a disadvantage to the network necessarily that someone would be seen locally as opposed to going to the Boston VA medical center.

One of the things that has been commended on by others is the huge growth in the non-VA care program. 7 or 8 years ago it was a 1,700,000, now it is about 4.6 billion. This is because we have expanded dramatically our use of fee basis. As we do more of this, as we have more community based outpatient clinics, the need is noticed by both patients and providers that now these people that are being seen in the CBOC need to have specialty care. And my example in the network I ran was Williston, North Dakota, as far from the Fargo VA hospital as Atlanta, Georgia is from Washington, D.C. and to send somebody from Williston to Fargo for an

MRI or a CT scan is just not conscionable. So we now buy that service in Williston.

So the expansion that you see is the fact that we have expanded dramatically, Congressman, the services. There are many other things that we need to be looking at though. I am pleased to say that the Rural Health Office that runs Project ARCH is in the process of evaluating the other kinds of things, such as women's health services, et cetera, that we might be able to offer under Project ARCH.

I absolutely agree with the way I know you and Chairwoman Buerkle feel, and that is care closer to home is better delivered care.

Ms. BUERKLE. The chair recognizes the gentleman from Michigan, Dr. Benishek.

Mr. BENISHEK. Thank you, Madam Chairwoman. Dr. Petzel, I have finally gotten to you. The VA policy to provide eligible veteran care within the VA whenever feasible, could you please provide to the Committee the complete copy of the policy, as well as any additional guidance given to the field as to how this takes place?

Dr. PETZEL. Yes, sir, we will do that. Very quick answer to that if you don't mind.

Mr. BENISHEK. That is all I want from that question. How does the VA defined extraordinary distances from a veteran's home?

Dr. PETZEL. We have two definitions of—we have a definition for rural care, ruralness, and then people living in highly rural areas. It can be defined in two ways. It can be defined by distance, that is how far someone has to travel. Is it 60 miles or is it 200 miles. And it could be defined by time. And it matters that there are differences. In the Midwest where travel is on a freeway the distance may be long but the time could be relatively short.

Mr. BENISHEK. Let me give you example of what I am talking about. This is a letter to me from the VA based on this case I mentioned before. Based on your inquiry, all available medical records and administrative information has been reviewed. Non-VA care is considered as an alternative to VA care when VA care is not available. The veteran's ability to travel is also a consideration. In this case VA care is available within the State of Michigan and the patient is considered capable of travel. So he is welcome to take advantage of the available health services in the State of Michigan.

So the place they wanted him to travel was 235 miles from Alpena to Detroit. So 4 hours and 7 minutes, according to the Google map, one way. So I mean to me this is what disingenuous, the VA care is available within the State of Michigan. I mean this distance is further than Detroit is from Fort Wayne, Indiana, it is further than Detroit is from Cleveland. It is a long way for something that is available in the local town 10 minutes from his home, besides the follow-up with the blood tests and stuff. So this concerns me. And I just want to get your explanation for this.

Dr. PETZEL. Well, I can't explain the case without taking a look at it. What I would like to do, Congressman Benishek, is to take the information about this patient and find out what is going on and get back to you immediately.

Mr. BENISHEK. Well, I understand. You yourself stated the fact that you have seen these patients between Atlanta and Wash-

ington. This is something like that. It concerns me that there doesn't seem to be any standards or criterion that I have been able to find out as to what makes this determination other than what you vaguely outlined.

The cost of all this of course is one of our main concerns. To me that should be something that is automatic and you guys have to do a lot better job in organizing that. But what really concerns me is the access to care. This fellow is 70 years old, he has chemotherapy for colon cancer and it is okay for him to travel 4 hours there and 4 hours back right after his chemotherapy. That doesn't seem in my view as a physician to be adequate access to care, frankly.

Dr. PETZEL. I would agree with you and we will take the information and find out what the problem is with that case. Thank you.

Mr. BENISHEK. Well, that is all I want to go into. Thanks.

Ms. BUERKLE. Thank you very much. We are going to have a second round of questions, Dr. Petzel, if that is okay with you. So I will yield myself 5 minutes for questions.

I guess my concern is we heard from previous testimony that Project HERO is expiring. There is some confusion among the VISNs and among the veterans as to—who is going to continue on with Project HERO, who is not. Now we are being told that PCCC will be on the heels of Project HERO to carry that forth. But what we are hearing from the veterans service organizations is that there is confusion and uncertainty and there is no formal plan in place. What is your vision for a timeframe for knowing what is going to happen for the veterans and for these critical services they get through this program?

Dr. PETZEL. Well, they should know now. And if there is that confusion and if there is a lot of knowledge of what is going on we will correct that immediately.

Let me go through the scenario as I see it occurring. We are about to send out the first RFI for the new set of contracts. And in the meantime the individuals that are enrolled in Project HERO have several alternatives. One is that they can continue using Project HERO and using that contract. And we will go back again and make absolutely certain that all of those VISNs that are involved with HERO understand that that is available.

But an alternative for that is to use regular fee basis. And if there is any fear that a veteran or anyone has because Project HERO is going to expire and maybe PCCC isn't spun up or whatever, we will use individual fee. I know of no instance right now where a veteran has been dropped from fee care, has lost their provider and we will not let that happen. We want these individuals to have continuity of care with the people that they are involved in now. And we have the ways to do that as we are bringing PCCC online.

Ms. BUERKLE. My concern is that VA and the health care that it renders to our veterans is very good care. In Syracuse we have a wonderful VA hospital. My concern is the business portion of this like the processing of claims and making sure that all of the providers get paid and paid appropriately and we are not wasting money, we are not under paying or over paying claims. I will just

say in my previous life I worked for a hospital who had fee basis. I worked for Upstate Medical Center but we accepted VA patients from the VA hospital locally. And when it came time to pay those claims they couldn't tell us what methodology was used to reach the fee. There was no standardization. Depending on the situation, the same procedure, be at a different payment rate. So I say to the VA, look, you really render health care fairly well and we want you to make sure our veterans have access to care in the community and to have rural health care. This business piece you don't do so well. Why do you want to hang on to that? Why don't we have VA focus instead on care and let the claims be processed by someone who does it and does it well and takes care of that piece?

Dr. PETZEL. Chairman Buerkle, I do share your concern about the business processes. Historically we have no argument with the findings from the National Academy of findings and from the IG findings. We have incorporated all of their recommendations into our plan for moving forward.

Now you need to think about fee care in several different categories. The contracts that we will have under PCCC which right now are 21 percent of our fee care and probably will increase somewhat with the contracts. All those back office functions will be done by the contractor as they are being done in Project HERO. That is good, that phenomena is going to continue. But there is a large segment of our fee that is not done by contract and quite a bit of it I think will remain at non-contract. We need to have in place the management processes to be able to do that management effectively.

There are six primary steps in fee management. The first two of those steps are being addressed right now. We have a champion facility in each one of our networks under NVCC that has addressed the two first issues that will be rolled out, the first two steps that will be rolled out across the country and in place and operating before the end of 2013. In addition that step two we have revised a handbook, it is going to be out by the 1st of January. We will have standard operating procedures, we will educate our people about how to manage this. And then finally when that is accomplished through 2013 we are going to consolidate our business practice, we are going to consolidate our payment into probably three to five regional payment centers to gain the efficiencies that we need, to gain the capacity to have good oversight over that payment.

This is our plan moving forward. We have incorporated industries and oversight recommendations in that plan. We have the right people in place now, and I don't think we did previously. We have a new chief in the business office. We have Ms. Kindred sitting next to me in the business office, and we have Mr. Matovsky overseeing all of those operations in his role with operations.

So I think we can do this. I don't think we can, I know we can do this in-house. And most importantly it is going to be less costly and less wasteful for to us do it in-house. Because we have the people, we don't need to hire anybody new. We have all the people there that we need to do it. We can do it.

Ms. BUERKLE. Thank you. Can you provide the plan to the Committee, please?

Dr. PETZEL. We will.

Ms. BUERKLE. Thank you. I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. They just called the vote, so I have a quick question. You mentioned you want to consolidate into five areas for this. I guess my only concern is consolidation probably is good, you probably could save more money. It depends on where you consolidate. I know when we went through the whole BRAC process, the Department of Defense did consolidate the DFAS facilities. But when they originally were going to do it before the Commission made a different decision, the consolidation efforts were actually consolidated in a less efficient facility, primarily because of a lot of issues when you look at employer of choice, and that is a big issue. If you have a huge turnover, particularly if you locate these facilities in large metropolitan areas where employees have an option of moving around anywhere they can, the turnover rate is huge and you might not get the best output and simply because you are consolidating it doesn't mean it is going to improve the system. So I would caution you on how you move forward in that particular consolidation process because it might not work out well. And so do you want to comment on that?

Dr. PETZEL. I would. But before I do, Congressman Michaud, I need to mention the fact that we have signed a contract with Martha's Vineyard hospital, care will begin being delivered there on October 1st.

Mr. MICHAUD. Okay, thank you.

Dr. PETZEL. So we have solved this problem. We need to go back and look at what happened with the lapse of that contract, et cetera. That is another issue.

I would use the example in terms of consolidation of the CPACS, this is the MCCF collection process. We consolidated that into seven areas and they happened to be pretty rural and remote, Leavenworth, Kansas and those sorts of places. And we have seen a substantial jump in the revenues that we are collecting, indicating to us we have a more efficient process, better control of our processes, et cetera. The consolidation in fee will be primarily the payment part of this. We have had issues, as you have pointed out, with payment in South Carolina, in Texas. Particularly there have been long delays and inefficient payment. We think we can add substantially to improving that by consolidation. We think that we can tremendously improve the improper payments, both overpayments and underpayments by consolidating. I do believe this will be an effective thing and we will be careful about where we do our consolidation.

Mr. MICHAUD. Thank you very much. Really appreciate your testimony today and look forward to working with you as we move forward in this area. Thank you.

Ms. BUERKLE. Thank you. In the plan that you are going to submit to us, Dr. Petzel, I would trust that there will be an IT plan included in that because one of the issues we heard this morning is lack of an IT plan, and that is such an integral part of success here.

If there are no further questions, I move that the members have 5 legislative days to revise and extend their remarks and to include extraneous material. Without objection, so ordered.

Before we end today I would just like to say that I think that given VA's continued struggles in managing the fee programs and the serious doubts that have been raised here today about VA's ability to properly construct staff and manage an in-house program that can provide a level of business related service, patient support and patient coordination and provider networks that is currently available under Project HERO, I would really respectfully request that rather than continue down this path that you would stop and you would think about what you have heard here today, and that you would come back to this committee with a plan that really incorporates the successful elements of Project HERO. We have heard good things about Project HERO. Why are we trying to reinvent the wheel? Let's take those good pieces and let's incorporate it going forward. And so I would respectfully request that you would be open to the testimony you heard here this morning and incorporate that into the plan that you are going to give to this committee.

Would you like to comment?

Dr. PETZEL. I would, Madam Chairwoman. We are incorporating all of those processes from Project HERO into the PCCC contract. That will be done almost exactly in terms of its processes as those other contracts have been done. We have done that, we absolutely have done that.

Ms. BUERKLE. I hope so. We will look forward to seeing the plan.

Dr. PETZEL. Okay.

Ms. BUERKLE. Once again I want to thank all of the panel members for being here today, the Subcommittee members, and of course my Ranking Member, Mr. Michaud. To the audience thank you for participating here today. We here in Washington and this government has no greater responsibility or moral duty than to make sure our veterans have the services and the care they have earned and they richly deserve. And as we end our hearing today always keep in our thoughts and prayers the men and women who serve our Nation and our veterans. We are a grateful Nation, and we thank you for your service.

This hearing is adjourned.

[Whereupon, at 11:25 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Chairwoman Buerkle

Good morning. This hearing will come to order.

Welcome and thank you all for being here for today's hearing, "VA Fee Basis Care: Examining Solutions to a Flawed System."

Recent years have seen tremendous growth in VA's Fee Care program, with independent assessments estimating growth of close to 300 percent from fiscal year 2005 to today.

Unfortunately, however, as the program has continued to grow, so have the management and oversight problems that have plagued the system through which the Department of Veterans Affairs (VA) provides care to veterans outside the walls of a VA facility.

It is seriously flawed, if not altogether broken.

In the last 3 years alone, the VA Inspector General has issued no less than seven separate reports detailing in-depth the serious deficiencies and challenges the Fee Care Program faces, including inadequate fiscal controls that have resulted in hundreds of millions of dollars in improper payments.

Further, last September, the National Academy of Public Administration (NAPA) issued a white paper on VA's Fee Care Program that drew alarming conclusions about VA's ability to effectively manage and oversee care and services under the program.

According to NAPA: VA's Chief Business Office has exercised limited and ineffective oversight of the Fee Care Program; the Program itself lacks operational objectives, performance goals, or, a clearly defined strategy for managing expenditures; and, VA doesn't understand what services are being procured through the Fee Program and at what cost.

There have been some bright spots. Congressionally-mandated pilot programs—Project HERO and Project ARCH—have shown promising results in achieving a more patient centered, coordinated, and cost-effective delivery model for fee care.

Small pockets of success—despite VA's reluctance to implement and utilize these programs to the fullest intent of Congress.

Recognizing the substantial deficiencies with the Fee Program, VA has begun implementing two new initiatives—the Patient-Centered Community Care (PCCC) Program and the Non-VA Care Coordination (NVCC) Program.

The Department is going to testify today that these two initiatives will address all of the challenges the Fee Program faces and, ". . . ensure veterans receive effective and efficient non-VA care seamlessly."

I wish that I could believe that was true. However, given the history of failure we've seen already, I have serious reservations that the actions VA is taking will address the core challenges VA faces and not simply lead to further fragmented care and an inability to deliver quality care in rural communities.

Most notably, VA lacks the information technology (IT) and administrative services solutions essential to establish in-house the clinical information sharing and electronic claims processing vital to a successful care-coordinated and veteran-centric program.

VA spent approximately $4.6 billion dollars to purchase care in the community for veteran patients last fiscal year. That is billion, with a "b."

We cannot afford to allow VA to continue to flail and struggle to test new programs in an inherently flawed system. We cannot rely on promises from VA that they can finally get it right.

Our veterans are everywhere; VA can't be.

And, at the end of the day, what fee care is about is the effective and efficient delivery of care to veterans where they need it, when they need it.

Getting it right is about honoring their preferences, choices, and daily lives as well as their service to our country.

Getting it right is about telling a Vietnam or Korean-era veteran that he doesn't have to travel 4 hours to the nearest VA medical center for his cancer treatments.

He can go to a hospital closer to his home and spend the time he would have spent on the road getting better.

Getting it right is about telling a Gulf War veteran that she doesn't have to take a day off of work to drive to the VA clinic two towns over for a physical.

She can go to the doctor down the street if she would prefer and get to work on time.

Getting it right is about telling a young veteran, recently home from Iraq or Afghanistan, that he doesn't have to wait all day in a VA waiting room to see his doctor.

He can choose another provider who can see him now and spend the afternoon with the people he missed while he was overseas.

That is what we are talking about today. And those stories—stories that my colleagues and I hear every day from veterans in our communities who are fed up—are what I want all of us to keep foremost in our minds this morning as we talk about how to make this program better and get it right.

I now yield to the Ranking Member, Mr. Michaud [ME–SHOW] for any opening statement he may have.

Prepared Statement of Adrian Atizado,

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important oversight hearing of the Subcommittee on Health. DAV is an organization of 1.2 million wounded and injured veterans, and is dedicated to empowering veterans to lead high-quality lives with respect and dignity; ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life.

We appreciate the Subcommittee's leadership in overseeing the Department of Veterans Affairs (VA) contract and purchased health care programs, including fee basis medical services, contract hospitalization, and scarce medical specialist services contracting, on which many service-connected disabled veterans must rely for their care. DAV recognizes these programs are essential in providing access to vital health care to veterans, but significant improvements are needed.

The delegates to DAV's most recent National Convention passed Resolution No. 212 regarding VA's purchased care program. Our resolution urges Congress and the Administration to conduct stronger oversight of the non-VA purchased care program to ensure service-connected disabled veterans are not encumbered in receiving non-VA care at the Department's expense.

This resolution also urges VA to integrate and promote care coordination with all non-VA purchased care programs and services. Such coordination should include provider credentialing, case management, ensuring quality of care and patient safety, timely processing of claims, reimbursing at adequate rates, integrating records of care with VA's electronic health record, and scheduling appointments through a centralized process. With the exception of the ongoing Project on Healthcare Effectiveness through Resource Optimization (Project HERO) pilot program,[1] today's VA contract and purchased care programs do not exhibit most of these attributes.

Under current law, VA practices three basic approaches in furnishing non-VA care: pre-authorized fee-for-service arrangements (called Non-VA Fee Care); contract care, including obtaining scarce medical specialists; and sharing agreements with the Department of Defense and VA's academic affiliates and their associated professional groups.

Non-VA Fee Care

The statutory authority for fee basis health care is title 38, United States Code, section 1703. This section authorizes VA to contract for inpatient care and limited outpatient care by contract or individual authorizations for certain categories of veterans, when VA facilities are unable to provide needed care, or when VA facilities are geographically inaccessible to those veterans. This contracting authority is not

[1] Project on Healthcare Effectiveness through Resource Optimization (See H. Rept. 109-305 for the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (P.L. 109-114). Project HERO's dental contract with Delta Dental of California will end September 30, 2012. Project HERO's medical and surgical contract with Humana Veterans Healthcare Services, Inc. is intended to be extended for six months to March 31, 2013.

limited to contracts that contain prices negotiated between VA and non-VA providers, but of individual authorizations that serve as price offers to non-VA providers chosen by eligible veterans. Contract hospitalization is generally reserved to emergency situations for which VA reimburses contract hospitals at Medicare rates.

Notably, the purpose of fee-basis health care is addressed in the regulatory authority which implements the statutory authority granted by section 1703. Specifically, title 38, Code of Federal Regulations, section 17.52, allows for individual authorizations when demand is only for "infrequent use." Over the past several fiscal years, however, expenditures for fee basis services have been rising dramatically. In fiscal year (FY) 2005, VHA spent approximately $1.6 billion serving approximately one-half million veterans. By FY 2011, that amount had increased by 185 percent to approximately $3 billion, serving nearly one million veterans. This expenditure now comprises an estimated 9 percent of VHA's total medical services appropriation.

In addition to our organization's concern regarding the lack of care coordination and rising costs in fee care, specific concerns have been raised by others. The program is highly decentralized to the facility level, and lacks a standardized business process across the VA health care system. These concerns and others were raised by the National Academy of Public Administration (NAPA) in its 2011 analysis of VA's organizational model supporting the fee-basis program, and by VA's Office of Inspector General (OIG) regarding the significant number of improper payments and the need for improvement in risk assessment in fee care.

Generally, fee basis and contract hospitalization are unmanaged, are not governed by a program office locally, are not standardized or consistent across the system, do not exhibit "patient-centered care" attributes that characterize VA's internal care programs, and their costs to VA have surged over the past decade without sufficient action being taken to ensure program integrity, efficiency, and integration in the Department's health care system.

In general, VA agreed with the observations and recommendations of OIG. DAV is aware of the Department's efforts to address these concerns. Among such efforts is the Non-VA Care Coordination (NVCC) project, which is a focus of today's hearing.

Non-VA Care Coordination

The Non-VA Care Coordination (NVCC) project is part of a major initiative VA calls Health Claims Efficiency (HCE). The purpose of HCE is to coordinate and accelerate the ongoing cost savings initiatives with new initiatives to allow VA to enhance services to veterans.[2] Specifically, this initiative includes reducing operational costs and streamline program deployment to enhance program efficiency, achieving cost savings through consolidated purchasing and reducing variability in non-VA care coordination clinical and business practice.

Currently VA lacks industry standard automated tool sets to identify and take action on improper payments, including fraud, waste and abuse. Further, while fee care's information technology systems and infrastructure have been improving, they have not been updated for cost effectiveness due to local variations in how they are established. DAV believes VA should continue to pursue private sector IT solutions to modernize the processing of non-VA health care claims.

With care coordination included in its name, a fully implemented NVCC as envisioned by the Chief Business Office will include improvements to patient-facing aspects of fee care. These include timely patient notification of Fee Care approval, appointment scheduling assistance, tracking appointments for completion, health care information sharing and timely notification of results to the patient as well as the VA provider responsible for the fee care referral.

DAV applauds VA for taking steps in the right direction to meet the goals of DAV Resolution No. 212 to provide proper care coordination in fee care and to make care coordination a standard business practice. To ensure these new processes are being achieved in each VA facility, we have requested from VA results for key metrics for this and other focus areas. Until DAV has had the opportunity to review these results, we are unable to provide further comment on NVCC and whether this initiative will address concerns outlined in this testimony.

The 2011 NAPA report observes that the organizational, administrative, and technological systems used to operate and manage fee care have not kept pace with the unprecedented growth of fee care. Unlike OIG reports, VA comments were not part of the report and DAV is unaware of any public response from the agency regarding the NAPA report.

Madam Chairwoman, it should be noted that VA is authorized to attempt to recover any improper payments. VA also has the authority to bill third-party health

[2] Department of Veterans Affairs Strategic Plan Refresh, FY 2011-2015.

insurers for non-VA care. DAV believes that internal controls should be improved to help prevent improper payments for non-VA fee care, and recovery auditing and third party billing should be included as a part of this Subcommittee's oversight and the Department's overall strategy to improve VA's purchased care programs.

Project HERO and Patient Centered Community Care

Under section 8153, the VA exercises discretionary authority to use contracts and sharing agreements with non-VA providers as a means to provide hospital care and medical services (defined in title 38, United States Code, section 1701) to all enrolled veterans. The stated purpose of VA's contracting authority under section 8153 is "[t]o strengthen the medical programs at Department facilities and improve the quality of health care provided veterans under this title by authorizing the Secretary to enter into agreements . . . while ensuring no diminution of services to veterans." Since the law does not address quality of care and care coordination, it only partially meets the goals of DAV Resolution No. 212.

VA has informed DAV of its plan to rely on the authority of section 8153 to create a new approach to centrally supported health care contracting, to be provided throughout the VA health care system. The program is to be entitled "Patient Centered Community Care" (PCCC). This effort is described by VA as a "soft approach" to contracting, but that it will apply lessons learned from Project HERO, now in its fifth and final year.

According to VA, the goal of PCCC is to create centrally supported health care contracts available throughout the VHA to provide veterans coordinated, timely access to high quality care from a comprehensive network of VA and non-VA providers. VA has completed a draft specification for PCCC, and we understand PCCC may include contracts covering five regional subdivisions with standards for access to care, quality of care, and medical documentation to facilitate the provision of care. Further, use of contract services under the PCCC umbrella will receive priority over other non-VA care options.

VA has repeatedly assured DAV that the care coordination that patients experienced under Project HERO will be made part of PCCC, but as of this date we are uncertain of these particulars. Information in more concrete terms will become available in VA's official Request for Proposals (RFP), which VA currently projects will be released in November 2012, with contract awards in March 2013. Given the national scope and complexity of this change by VA, the challenging history of contract care, and the current leadership vacuum in VA's Chief Business Office, we believe these plans may be overly optimistic. While building on the successes in Project HERO, this is an untested concept for the VA health care system, and one that is not intended for pilot-testing for effectiveness.

DAV considers Project HERO to have been a moderate success story. The Chief Business Office in VA Central Office and the contractors, Humana Veterans Healthcare Services, Inc., and Delta Dental, responded effectively to veterans service organizations' early expressions of concern about the potential for Project HERO to be corrosive or even destructive to Congress's intention that VA's contracting authorities be used to strengthen medical programs at VA facilities and improve the quality of health care while ensuring no diminution of services to veterans. While Project HERO is meeting those goals now, VA field facilities have been slow to utilize Project HERO principally because Project HERO lies low on a multi-tier algorithm used by VA fee-basis clerks, after their considering existing sharing agreements and availability of accessible services at other nearby VA facilities, but before authorizing unmanaged fee-basis services as described above. As a result, the volume of referrals to Project HERO has been low.

We believe the current approach in Project HERO is a good model for VA to pursue as it moves to the next phase in reforming non-VA purchased care. We have concerns nevertheless that VA will struggle to establish in-house the kinds of services, supports and provider networks that are available within the large managed care systems such as Humana and Delta Dental in fashioning the PCCC effort. In addition, we are concerned PCCC contractors will have too short an implementation period between the time contracts are awarded and when they become operational to establish robust networks of providers.

We applaud VA for announcing its intent to extend Project HERO for 6 months beyond the final option year that ends on September 30, 2012. Nevertheless, DAV urges VA to extend Project HERO for such additional time until VA has built its own capacity or determines to rely on a contract managed care firm (or firms if the program is regionally dispersed) to handle the workload of VA purchased care. Ending the Project HERO pilot program premature to VA's completing its new initiative would leave ill and disabled veterans, including many of our members, in jeopardy, and could lead to higher costs for non-VA care through the legacy fee-basis program.

When VA reaches a confidence level that PCCC is an adequate replacement for Project HERO or any other non-VA health care contract, then and only then should it be ended.

Need for Reorganization of All Fee and Contract Services

VA has a long and distinguished record of providing social support services (including health care services) to veterans, but VA continually struggles to provide adequate business-related services as a part of its responsibility. We see those problems reflected brightly here. We have witnessed this struggle year-in and year-out within the activities of the Chief Business Office, both in terms of its managing VA first- and third-party collections from veterans and health insurers, as well as its lack of management controls over these contract health care programs. With this backdrop we are doubtful that VA will be able to properly construct, staff, and manage a program overseeing VA contract health care that will perform as well as the Project HERO contractor is performing now. We urge the Subcommittee to closely examine VA's plans and make its own determination, but we hope the Subcommittee and VA will take our concerns into account. At minimum, we believe PCCC should be judiciously deployed and carefully expanded to ensure veterans are unencumbered when accessing contracted health care.

Madame Chairwoman, given the cost of this program and its importance to DAV and our service-disabled members, we believe bolder action is required than is currently envisioned by VA in NVCC and PCCC. In our view, the VA Chief Business Office is not the correct organization to build this new system. That office should concentrate on its original and basic mission to improve VA revenue performance for first- and third-party payments.[3] VA instead should establish in Central Office a new contract care services management office, charged with the responsibility to use managed care industry best practices in establishing new approaches to VA purchased health care for veterans, taking fully into its jurisdiction all non-VA purchased care under current law. All of these programs have been criticized at one time or another by external reviewers and this may be VA's best opportunity in years to respond effectively to improve them. We believe a new office of this type—if staffed by professionals experienced in private health insurance and the managed care enterprise—could concentrate these similar programs (in which VA pays a non-VA party for the care of a veteran, dependent or survivor) under one management structure, integrated with the VA health care system; clarify accountability for policy and practice effectiveness across the system; and set standards for compliance and reporting.

This new office should coordinate with the TRICARE Management Agency (TMA) in the Department of Defense in developing its plans and policies, and as well with the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services. The TMA office has more than two decades of experience in dealing with managed contract care policy and practice for a very large constituency of military servicemembers, their families and the military retired community. The CMS is the Federal Government's expert on both health care and pricing policies.

The end goal of this new office would be to allow veterans and other eligible family members to live a higher quality of life with respect and dignity, through receipt of better services, including care coordination, continuity and quality of care, at a defensible and lower cost to VA and taxpayers. Absent this kind of bold action and change, DAV fears that VA's poor record in the management of contract and purchased care will not be corrected or improved.

Madame Chairwoman, thank you for this opportunity for DAV to testify on an important topic to our members. I would be pleased to address your questions, or those of other Members of the Subcommittee.

Prepared Statement of Shane Barker

Madam Chairwoman, Ranking Member Michaud and Members of this committee, on behalf of the more than 2 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to present our views on the Fee Care Program.

[3] In May 2002, VA established the Chief Business Office in its Veterans Health Administration (VHA) to underscore the importance of revenue, patient eligibility, and enrollment functions; and to give strategic focus to improving these functions by directing VHA's Revenue Office and to develop a new approach for VA's first- and third-party collections activity.

The VFW is very appreciative of the efforts made by this Subcommittee to better understand and address a persistent, growing challenge for VA. Your interest in this issue is critical to affecting positive change as we enter into a pivotal time in the life of the Fee Basis Program. Our veterans are from all walks of life and live in urban and rural areas. Some live in what we describe as highly rural areas, and their access to care is limited as a result. VA has for decades operated the Fee Basis Program to meet their needs by allowing them to utilize civilian doctors as part of the care VA provides. I would like to take this opportunity to identify some shortcomings of that program, and how we can address them to both save money and enhance the quality of care we provide.

We have no shortage of evidence to convince us that change is necessary. Between Fiscal Year (FY) 2005 and FY 2011, overall costs for the Fee program increased nearly 200 percent, from $1.6 billion to nearly $3.9 billion per year. During this same period the population size rose 95 percent, adding nearly 400,000 patients to the program and bringing the total to 893,421 unique veterans. However, VA constrained overall cost per unique veteran to 33 percent. During that time, it rose from $3,246 to $4,331 per year. For all the cost increases and more veterans utilizing the program, care is not coordinated between the private sector and VA in the traditional Fee program. Because of inadequate technology and an aversion to change that persisted within VA for years, VA did not consider this a priority. We hope that sentiment is changing, and are hopeful about the direction in which VA seems to be heading.

As we face the reality of fiscal restraint, cost increases of this magnitude rightfully cause us to pay attention and work to enhance the performance of this program. The VFW is convinced that it can be done, and we want to be a part of the solution. This committee obviously understands the need to restrain unnecessary growth in the Fee program to ensure the program survives over the long-term, and we appreciate your efforts to put it on a more solid footing.

Fee Basis Care was created to ensure that a civilian doctor is meeting the needs of veterans when VA is unable to meet the demand. It has been in place to meet the needs of eligible veterans for decades, ensuring that those who live great distances away from a VA medical facility or require non-VA provided specialty care are granted care through a civilian doctor closer to home. VA is mandated to consider allowing a veteran to use the Fee program based on distance from VA facilities, their portfolio of services, wait-times, and the availability of the specific doctors and treatments a veteran requires. Obviously, this function is a necessary and inextricable part of VA's mission. VA's ability to decide when a veteran should be able to utilize the Fee program is an inherent strength of the program, and the VFW strongly believes that VA must retain absolute responsibility for their patients when they receive care in the private sector. There are many implications that emanate from this conviction that VA retain ultimate control for every veteran they send into the private sector, and VA bears the burden of responsibility for their well-being regardless of where they seek treatment.

The shortcomings of the Fee Basis program were painstakingly detailed in a September 2011 report of the National Academy of Public Administration (NAPA). The report paints a stark picture of the current state of the program, and validates many of our long-standing concerns with the lack of care coordination and spending controls. Of their many specific and disconcerting findings, the totality of the situation led NAPA to find that VA is utterly lacking in the ability to discern the return on investment for the program. There is not one single factor that would lead NAPA to make such a serious claim; rather, the numerous inefficiencies taken as a whole are the culprit.

Administration from VA Central Office

The Fee program is orchestrated from the Chief Business Office (CBO) in VA Central Office (VACO). However, their influence over how the program is operated at lower levels in the system is limited. CBO enjoys limited cooperation with the field. CBO gathers no standard performance metrics, has no mechanism to receive documentation from providers, and does not validate credentialing of private physicians. CBO has no way to verify that billed services have been rendered, and far too often pays rates that are far too high for billed services. VACO also does not audit how Fee Basis dollars are spent at the local level. To our knowledge, they do not conduct the oversight needed to analyze when the Fee program operates within budget, and when available funds are exhausted earlier than expected.

NAPA recommended consolidating the authorization and claims processing function of the 100 plus Fee Basis program offices nationwide, eliminating the vast majority and creating a regional system of three to five sites. They make clear in their

report that this change would not centralize clinical decisions or leave them to the bureaucracy. Clinical decisions would still be made by medical staff. The VFW believes this recommendation makes sense. However, in considering such change, the VFW hopes the Committee will be mindful that the lack of a comprehensive IT solution may complicate a regional approach to administering the Fee program.

Technological Limitations

For years VA has relied upon antiquated technologies that are simply out of step with the private sector and among other Federal agencies such as the Center for Medicare and Medicaid Services (CMS). Policymakers in the Chief Business Office have very limited access to clinical data from veterans episodes of care in the civilian sector. This is an enormous disadvantage that directly impacts the quality of care for veterans. It slows down civilian and VA doctors by eating away at their time and making decisions more complicated. It also hinders VA's ability to detect and prevent improper payments, creating an environment that is susceptible to waste, fraud and abuse.

The Fee program does not have the ability to broadly automate incoming or outgoing bills or payments. By way of comparison, the Department of Defense (DoD) aggressively pursues automation wherever possible. They are currently contracting with Wisconsin Physician Services (WPS) through the TRICARE Management Activity (TMA) to process the vast majority of their claims. In doing so, TMA saves both time and money for DoD, allowing that department to focus on core competencies. We believe it is time for VA to consider what they can do to bring their operations in line with industry standards and generate dollars through such efficiencies.

To their credit, VA is working to resolve many of these issues. VA has openly acknowledged the shortcomings and failures in their IT infrastructure, and it is our understanding that VA has been working to affect change at many levels—including within the acquisition process. VA's Office of Information & Technology (OI&T) seems to be adopting a more modern and lean process to build the IT systems needed to coordinate and provide care in today's complex health care infrastructure. Changes like the implementation of agile systems development hold the promise of faster, cheaper, more usable software solutions. Though we have seen some evidence of success at VA, it is just a start. VA is working on a common platform to provide civilian doctors with an easy way to provide CBO with searchable clinical data from visits resulting from using the Fee program. Though we do not know the development and implementation timeline, the possibility of providing doctors with an IT solution that gives VA the information they need—and is quick and easy enough for doctors to use without unnecessary burden—holds great promise. The VFW will continue to closely monitor the development of IT projects underway.

The Question of Contracted Care

Over the years, VFW has heard many stories of veterans who enter into the Fee program, only to be confused and disappointed by the experience. What should be an easy and convenient alternative to direct care for veterans often leaves them feeling detached from VA. The reasons are clear: VA does not reach back to the veteran to gauge their satisfaction with episodes of care in the civilian sector; veterans are left to make their own appointments, completely independent of any VA facilitation; and they are sometimes responsible for getting patient records to VA from their civilian providers when possible. Once they enter the Fee program, they have little contact with VA, and are given no direction from them.

Congress attempted to address this issue in 2005 with the ongoing Project on Healthcare Effectiveness through Resource Optimization (Project HERO) pilot program. To date, it is VA's single foray into the business of contracting for the provision of private care to veterans, and it has achieved generally positive results. We all know that the 5-year pilot program had a rough start. However, VA responded to the concerns of the Veteran Service Organization (VSO) community and the program is drawing to a close with a successful record. It regularly met quality measures outlined by VA, while also saving money. For this and other reasons, the VFW is concerned it may be ending too soon.

Project HERO is still meeting VA requirements for customer satisfaction and distance metrics. The data shows they have greatly reduced missed appointments through regular communication with patients, providing them with timely reminders. Because VA gets clinical notes from providers Humana has contracted with for Project HERO, care is being coordinated properly. VA can be certain of this because they regularly receive all the metrics they have asked for from their remaining con-

tracted partner, Humana Veterans Healthcare Services, Inc. Unfortunately, the traditional Fee Basis program provides no such metrics.

One benefit of coordinated care has been the elimination of many duplicative services. As a result, VA has saved money even though referrals into the program were low throughout the life of the program. In addition, VA doctors have the requisite information to bring veterans back to VA when it was in the best interest of the veteran. Humana's contract was extended beyond the planned termination date until March 31, 2013 to allow for more time to transition out of Project HERO and to prevent veterans using current Project HERO providers from any interruption of service. It should be noted that VA still plans to end the contract with Delta Dental, their other partner in Project HERO, on the original contract termination date of September 30, 2012.

Meanwhile, VA has been working on their plan to replace Project HERO with a permanent program, known as Patient-Centered Community Care (PCCC) for some time. This program was designed to incorporate the lessons learned over the past 5 years working on Project HERO alongside Humana and Delta Dental. To the best of our knowledge, this program is being crafted to allow VA Central Office to establish numerous contracts for coordinating timely and high-quality care that could comprise both VA and non-VA providers at the discretion of VA clinicians. Veterans would have to be referred into PCCC by a VA physician, thereby ensuring the decision to send a veteran into these contracted networks would be maintained in-house. VA doctors would also have the benefit of detailed clinical notes from each patient visit in the network, and thus would be far better equipped to make a decision to transfer to a different provider or bring a veteran back into VA care based on clinical data. VA would coordinate the care for these veterans through the Patient-Aligned Care Teams, in cooperation with a care coordinator working for the PCCC contracted network provider. Doctors would potentially have the latitude to treat one condition in a VA setting, while allowing the veteran to remain in PCCC for other conditions. For example, a female veteran with PTSD could be sent into the network for maternity care, while continuing to visit the VA clinicians she has already bonded with at her VA facility.

According to VA, initial market research began in November 2010. In June 2011, PCCC became an official program through an Executive Decision Memorandum of the National Leadership Council. In the closing months of 2011, VA released a Request for Information (ROI) and held three "industry days" to allow companies to dialogue with VA on a one-on-one basis.

Since then, VA has worked to prepare the Request for Proposals (RFP) and had intended to release it last month. Because of various delays, we now expect the RFP to be released in November 2012. The VFW looks forward to the release, as it should answer many remaining questions about PCCC. So far, we have learned that PCCC is projected to include five regions, which we assume will be managed by different contractors. We have learned that contract care provided through PCCC will be prioritized over other avenues of non-VA care; a departure from Project HERO, as it was given a low priority when being considered for Fee Basis services. Unfortunately, the issue of mental health services being included in PCCC is still an open question. The November 2, 2011 RFI regarding PCCC explicitly stated that mental health would not be included. However, this committee and VA are now assuring us that mental health will be a part of PCCC. We hope that the RFP will make VA's intentions clear.

The contract award for PCCC is scheduled for March 2013, barely 6 months from now. Project HERO—a relatively small pilot program that got off to a slow start—is scheduled to end the same month. The VFW is concerned about a possible service gap between the end of Project HERO and the indeterminable point in the future when PCCC can serve veterans at full capacity. The VFW believes extending Project HERO for 6 months was the right thing to do. We also believe that they should extend Project HERO until contracts under PCCC are mature enough to handle the full caseload for every veteran in the program with a fully capable nationwide network of all contracted services. It is unfair to our veterans to give them a cold handoff from Project HERO to PCCC. Though we are confident VA would do all they can to ensure a smooth transition, they deserve someone on the civilian side of the equation as well.

VA's Plan To Improve Internal Shortcomings in the Fee Basis Program

The VFW believes VA is finally taking the shortcomings in the traditional Fee Basis Program seriously. Since the release of the 2011 NAPA report, VA has initiated an ambitious plan to meet many of the NAPA recommendations by significantly overhauling referral management processes. The initiative, known as Non-VA

Care Coordination (NVCC), seeks to establish end-to-end documentation for patients admitted to civilian facilities. If properly implemented, NVCC will also standardize all business rules to document the reasons for using the Fee program, thereby facilitating administrative and clinical reviews of such decisions. It is designed to establish a system-wide practice that will avail veterans to all internal services, such as sharing agreements with DoD and university affiliates before being referred into the Fee program. NVCC is intended to decrease missed appointments by engaging veterans in the appointment management process, and will also move VA to a system of form templates to smooth out the paperwork and create a database that is searchable. A fully implemented NVCC program would also notify patients when Fee Basis—or non-VA, as it is now referred to—care is available to them. Through bulk purchasing of care, NVCC will hopefully save money and standardize the care provided across the country, leading to better outcomes for veterans and metrics for VA to use for continuous improvement of the program.

The VFW will be watching how NVCC is implemented, both at Central Office and across the country. We believe it is vitally important that such an ambitious program not reside solely within VA Central Office. It must be implemented at the local level, even if the up-front costs are high. We must not allow more failings at VA because of low morale or a culture of indifference. The changes envisioned must take effect. Today, NVCC stands as the best vehicle for these changes to take place, and we fully support the stated goals of the program.

VA has a tall order ahead. PCCC must retain the successes of Project HERO, and NVCC must fix the internal shortcomings of the traditional Fee program. None of these changes will succeed without leadership. In the end, it always comes back to leadership. Leaders at the highest levels of VA must commit themselves to a coherent and sensible approach that meets each of these objectives. Policies that are made must be clear, comprehensive and must be enforced at all levels within VA. Solutions must leverage the best practices in program management, design and information technology. Any long-term success must also include cultivating relationships with a number of entities in the private sector that believe VA is a capable and responsible partner.

The VFW believes these shortcomings represent a clear-cut opportunity to fix a badly broken system, and we are confident that veterans can receive better quality of care with greater coordination at a lower cost. With that in mind, the VFW hopes this committee will take a holistic approach to fixing the Fee program. Each circumstance that we resolve creates opportunity, and a systematic fix has the potential to both save a considerable amount of money and improve the quality of care for veterans using the program.

Madam Chairwoman, this concludes my statement. I am pleased to address any questions you or other Members of the Committee may have.

Prepared Statement of Jacob B. Gadd

Chairwoman Buerkle and distinguished Members of the Subcommittee on Health:

Thank you for this opportunity to submit The American Legion's views on the Department of Veterans Affairs (VA) Fee-Basis Program.

Title 38, United States Code (U.S.C.) Section 1703a states when VA 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, the Secretary may contract with non-Department facilities in order to furnish medical care (1)."

According to the Veterans Health Administration (VHA), if a medical service or procedure cannot be provided in a timely manner by VHA due to capability, capacity or accessibility, the service may, with approval, be fee-based or contracted outside of the VA. Typically, VA will utilize fee-basis as a last resort and prefers to treat the veteran within their closest hospital, another hospital within Veteran Integrated Service Network (VISN), through a sharing arrangement with a Department of Defense (DoD) Military Treatment Facility before purchasing care in the community. However, VA utilizes fee-basis programs as a first resort when the VA Medical Center is short on staffing and needs to meet a performance measure for timeliness of appointments or care within the established wait time guidelines.

In a Senate Field Hearing on "Improving Access to Quality Healthcare for Rural Veterans" our American Legion Past National Vice Commander Merv Gunderson said, "The American Legion urges VA to reconsider its national non-VA purchased care policies to allow VA Medical Center Chiefs of Staff to use their best judgment

and discretion to prevent veterans from being forced to drive hours to a facility for several routine and reoccurring appointments" (2).

There is a need for VA to develop and raise fee-basis care program policies and procedures with a patient-centered care strategy that takes veterans' interest and distance into account. The directive could clarify the roles and responsibilities of the Chief Business Office's Purchased Care Office, VISN, VA Medical Center, Business Office and clinical staff's policies and procedures for fee basis directives and policies to reduce variance and improve coordination between National, VISN and VA Medical Centers. The new policy should be well-defined, explained to veteran patients and be consistent policy within all VA Medical Centers.

In the last 4 years, non-VA purchased care has doubled from $2.2 billion in FY 2007 to $4.5 billion in FY 2011 along with a corresponding increase of 615,768 veterans served in FY 2007 to 970,727 veterans served in FY 2011 (2). VA program leadership has stated the reasons for growth of non-VA usage are: the increase of unique veterans seeking VHA care; economic conditions; waiting times because of more veterans enrolling in the system; and growth of number of CBOCs and emergency medical needs in rural areas (2). During our System Worth Saving site visits, Directors and VA hospital finance staff have told us the fee-care is between 15–25 percent of their medical center budgets and continues to grow. The facilities struggle with what services they can provide in-house and whether they should hire a full-time specialist to balance the number of veterans requesting the specialty services or contract out this care.

Nowhere is this challenge more evident than with women veterans' gender specific specialty services. The majority of women veterans' gender-specific care and services are contracted out as VA does not currently have the numbers of women veteran staff and demand for services. Yet, as women veterans are the fastest growing demographic of veterans enrolling in VA, the hiring of women veteran providers within the VA to provide gender-specific services should be carefully considered.

In an effort to reduce the continued rise in fee-basis costs as well as to improve coordination of care between VA and non-VA purchased care, VA is developing a Patient Centered Community Care (PCCC) program. The PCCC program is defined as an "effort to create centrally supported health care contracts available throughout the VA. Additionally, "the goal is to provide veterans coordinated, timely access to high quality care from a comprehensive network of VA and non-VA providers." The PCCC is taking many of the lessons learned from Project Access Received Closer to Home (ARCH), a 5 year pilot that recently was completed.

In a Chief Business Briefing in May 2012, VA stated that current individual fee program care concerns include: "veterans obtains an authorization, veterans chooses provider, services are provided (accreditation/credentialing status is unknown), no shows are not tracked/reported, VA Medical Centers pay the local fee schedule rate, provision of medical documentation is not always consistent or timely and access, timeliness, safety and complaints are not always a part of traditional fee requirements" (3).

VA's future plan through PCCC is to refer veterans to network provider, require accreditation and credentialing and VA Medical Center pays the national negotiated rate rather than the local fee schedule rate. By establishing national contracts for non-VA purchased care, VA can reduce these program costs by improving economies of scale and lowering of fee prices as well as ensuring VA's standards for timeliness and quality is tied to these contracts.

However, VA must be cognizant that not all fee-basis coordination can be managed nationally. Many rural areas do not have specialty or even primary care providers so some collaboration and coordination between the facility and local community providers should be leveraged and encouraged to ensure small private practice providers, which may be the only option in a community, and especially rural areas, continue to be permitted to submit contracts.

Quality of Care Findings with Fee-Basis Programs

Along with the cost reduction and efficiencies the PCCC program is proposing, it is equally important that quality standards for contracting care must be the same or better than the care the veteran would otherwise have if they were treated in VA.

Since 2003, the System Worth Saving Task Force has conducted site visits to VA Medical Centers to assess the timeliness and quality of veterans health care programs and to provide feedback from veterans on their level of care. Across the country, we have heard from veterans that in many cases, the quality of care they have received from non-VA providers has been great and they were treated close to their home.

However, a few concerns were identified during our System Worth Saving site visit interviews with VA Medical Center leadership, staff and by local veterans. These concerns include: lack of training and education program for non-VA providers; making sure veterans receive list of comprehensive network of VA and non-VA providers;lack of integration of VA's Computer Patient Record System (CPRS) with non-VA providers' computer systems/delay in contractors submitting appointment documentation; and the lapsing of Martha's Vineyard Fee Basis/Contract.

Lack of Training and Education Program for Non-VA Providers

In the System Worth Saving Report on Rural Health it stated, "In a recent article published in the Journal of American Medical Association in February 2012, Dr. Kenneth Kizer, former Under Secretary for Health for VA said, "Physicians in private practice may not be prepared to treat conditions prevalent among veterans—for example, the Reaching Rural Veterans Initiative in Pennsylvania found that primary care clinicians lacked knowledge of PTSD, and other mental health disorders prevalent among veterans, and were unfamiliar with VA treatment resources for such conditions." (5)

There is a need for development of military culture and awareness training for non-VA providers to educate and certify them on specific veterans' injuries/illnesses such as blast induced TBI, PTSD, and suicide prevention prior to contracting any veterans to them for care. The VA is a leader in mental health treatment and development of evidence-based therapies for PTSD. In addition, the majority of women veterans' gender specific care in VA is contracted out to the community. Non-VA clinicians need women veterans' specific training on the unique challenges women veterans face through injuries/illnesses they incurred during their military service.

If non-VA providers had a formal training and education program for military injuries/illnesses, it would ensure they are held to the same quality of care standards and treatments as VA providers.

Make sure veterans receive list of comprehensive network of VA and non-VA providers.

VA is developing a national database of local community providers that they have fee-based/purchased care from in the community. If this effort is expanded, veterans ultimately would receive a list of community providers for fee-basis or contracted care so they can determine the best provider for them.

Lack of Integration of VA's Computer Patient Record System with Non-VA Providers Computer Systems/Delay in contractors submitting appointment documentation

Non-VA providers do not have full access to VA's Computer Patient Record System (CPRS) to ensure the veteran receives the same or higher quality of care. First, access to the veterans' medical record will allow the contracted community provider to review the patient's full record and history in order to make a proper diagnosis and treatment plan. Currently, VA makes copies of the veteran's record for any relative injuries/illnesses relating to the appointment but the provider does not have the full record in order to understand the patient's medical record and any co-occurring medical conditions. Second, sharing of the medical record will help the community provider to meet all of the quality of care measures tracked in CPRS as well as promote screening for TBI, PTSD, depression, substance use and suicide or other quality of care measures tracked in CPRS. Thirdly, allowing the non-VA provider access to the medical record will speed up receipt and documentation from the encounter instead of VA having to wait weeks or months to receive documentation back from a non-VA provider.

With emergence and development of the Lifetime Virtual Electronic Record (LVER) and Nationwide Health Information Exchanges across the United States, Federal agencies will be integrated with private hospitals and companies to improve the interoperability of medical records if a veteran is contracted into the community for care.

Martha's Vineyard Fee-Basis/Contract

The American Legion conducted a site visit to Martha's Vineyard last year for our report on Rural Health Care. In 2000, a contract was signed between the Providence VA Medical Center and Martha's Vineyard Hospital. Through the contract, veterans living on Martha's Vineyard were able to receive care at Martha's Vineyard Hospital through fee basis instead of having to travel off of the island. The contract lapsed around 2004 which the VA did not realize until 2008 when the hospital acquired

new management. Veterans who were being treated under the original contract found out the contract lapsed when Martha's Vineyard Hospital sent collection bill notices to those veterans for medical expenses previously covered under the contract.

Since 2008, VA has been negotiating a new contract between Providence VA and veterans are forced to take a ferry from Martha's Vineyard and drive 2 hours for care at the Providence VA Medical Center. Veterans on the island continue to be promised that VA is working on the contract but coordination and the processing of the contract between VA Central Office, VA's Purchasing Care Office, VISN and the Providence VA Medical Center has continued to be delayed.

While there are only a few veterans that live on the island, this delay illustrates the frustrations that veterans living in rural and isolated locations or other areas across the country experience in waiting for contracts and receiving assurances from VA that the contract will be resolved. VA should develop and implement a process to ensure all VA and non-VA purchased care contracts are inputted into a tracking system to ensure they remain current and do not lapse. If there are instances with a contract lapsing, such as in Martha's Vineyard, VA should make every effort to hold stakeholder meetings with veterans from those communities to solicit input and keep veterans enrolled in these contracts/services informed.

In order to improve situations like Martha's Vineyard, VA must strive to create a tracking database of all non-VA purchased care contracts to ensure contracts do not lapse and veterans are involved as stakeholders and VA regularly communicate with veterans on the status of contracts.

Madame Chairwoman, thank you for allowing The American Legion to testify today. I look forward to answering any questions you may have.

References:

(1) Title 38, United States Code (U.S.C.) Section 1703a

(2) Chief Business Office Purchased Care VSO Briefing to Veteran Service Organizations. May 2, 2012. PowerPoint Presentation.

(3) Chief Business Office Purchased Care VSO Briefing to Veteran Service Organizations. May 2, 2012. PowerPoint Presentation.

(4) Senate Field Hearing on "Improving Access to Quality Healthcare for Rural Veterans."

(5) Wong, Fang. National Commander of The American Legion. 2012 System Worth Saving Report on Rural Healthcare. May 2012.

Prepared Statement of Brad Jones

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee:

Introduction

Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) Fee care process, which allows eligible Veterans to receive medical care in the community when VA determines that care is not available at VA facilities. Humana Veterans is proud to be partnered with VA to provide health care services and care coordination to Veterans authorized to access care in their community designed to supplement the care received in the VA health care system.

Humana Veterans Healthcare Services, Inc. (Humana Veterans), a Humana Government Business subsidiary, has contracts with VA to provide quality health care through two congressionally-mandated pilot programs—Project HERO (Healthcare Effectiveness through Resource Optimization) in VISNs 8, 16, 20, and 23 and Project ARCH (Access Received Closer to Home) in Farmville, VA, Pratt, KS, Flagstaff, AZ, and Billings, MT. In both of these pilot programs, Humana Veterans provides access to a competitively priced network of physicians, institutions and ancillary providers who adhere to high quality and access to care standards. To date, we have served 163,951 Veterans making 300,930 patient visits through HERO and ARCH, with an untapped capacity to serve more Veterans including those who have mental health care needs and who live in rural communities. In addition, through our subsidiary company Valor Healthcare, we operate 21 Joint Commission certified VA Community Based Outpatient Clinics (CBOCs) across the country that serve more than 58,000 Veterans, accommodating over 100,000 patient visits on an annual basis with services ranging widely from primary care to counseling and group therapy.

With our extensive experience in helping Veterans receive timely, quality, and appropriate care in the community, we have a unique perspective on the core program elements that are essential to ensuring that Veterans receive these services through a Veteran-centric care coordination program. This is the essence of the congressionally mandated and VA-designed HERO pilot. In a care coordinated program like HERO where community providers are an extension of VA's health care system, the Veteran never leaves the VA system and just receives one or more episodes of care from community providers. The community partner, in this case Humana Veterans, returns the clinical information to VA and manages all the administrative components of the process, such as billing and appointment-making. By keeping these insurance-like, administrative tasks outside of VA, the Department can concentrate on what they do best—deliver world class health care to our Nation's Veterans. Through our work in HERO, we have proven the hypothesis that a national health care administrative services provider can deliver timely and quality specialty care with significant cost savings. VA's annual report on Project HERO for FY 2010 stated that VA saved $16 million in the four piloted VISNs. That savings figure becomes even more impressive considering the fact that only 11 percent of the total non-VA outpatient visits in the pilot VISNs went to Project HERO during that time period. Extrapolating the savings across total number of non-VA outpatient visits suggests that VA could have saved $142 million that year in those four VISNs if HERO were fully implemented. The estimated 950,000 Veterans who were authorized for and received care in the legacy Fee process last year would have been better served under a contract care program with a strong care coordination element, such as the tried and tested HERO pilot program that can be implemented nation-wide. The additional bonus would be that these Veterans would remain connected to VA because in HERO, the Veteran's care is coordinated and the clinical information from the Fee treatment is returned to VA.

VA's Fee Process Challenges

The current Fee process is not integrated with VA's health care delivery system and there is no coordination or care management of Veterans with Fee care authorizations. This is a fundamental flaw of the Fee process; moreover, the importance of care coordination in health care has been widely documented and has a broad base of support. For example, the National Quality Forum (NQF), a non-profit organization dedicated to improving health care quality, has stated the following:

> *"Care coordination is a vital aspect of health and health care services. When care is poorly coordinated- with inaccurate transmission of information, inadequate communication, and inappropriate follow-up care- patients who see multiple physicians and care providers face medication errors, hospital readmissions, and avoidable emergency department visits. Health care is not currently delivered uniformly in a well-coordinated and efficient manner."*

NQF has also provided a framework for defining care coordination by identifying key domains, which include a health care home, proactive plan of care and follow-up, communication, information system and data exchange, and transition of care.[1]

Using this framework, the current Fee process fails Veterans in each of the above domains. With the exception of Veterans participating in Project HERO and Project ARCH, Veterans are left to navigate a confusing health care system on their own and become lost to VA. VA has no mechanism to track and monitor the care that Veterans receive in the community and there is no guarantee that these Veterans do not lose the quality, safety and other protections that HERO and ARCH provide. For example, these Veterans may not be seen by credentialed and qualified community providers, clinical information often does not return to the VA in a timely manner, and there is no single point of contact who integrates the care that Veterans receive within and outside of the VA health care system. Without this care coordinator, it is not possible to provide Veterans with the benefits of a proactive plan of care and seamless transition of care between VA and community providers. In addition, the lack of care coordination hinders VA's ability to optimize its resources because there can be duplicative and conflicting treatment regimen. This not only results in wasted resources, but also can cause adverse medical outcomes. Without the care coordination element, VA is foregoing significant potential savings and cost avoidance from reducing duplicative and conflicting care.

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[1] National Quality Forum, *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination.* October 2010. Web. 5 Sept. 2012, *<http://www.qualityforum.org/Publications/2010/10/Preferred__Practices__and__Performance__Measures__for__Measuring__and__Reporting__Care__Coordination.aspx>.*

Another missed opportunity is in the area of claims payment. At a recent House floor debate in May on H.R. 5854, Military Construction and Veterans Affairs and Related Agencies Appropriations Act of 2013, various members raised serious concerns about past due claims payments from VA and the economic realities that will force community providers to stop serving Veterans without timely payments. The Fee process not only has issues with delayed payments, but also has major challenges in erroneous payments. Despite VA's best efforts to automate the Fee claims process through various pilot programs over the past 10 years, claims are still not automated today and the current manual claims process places VA at high risk for improper payments. For example, a March 2012 report by the VA Office of Inspector General identified the Fee program's improper payment rate at 12.4 percent,[2] and the Government Accountability Office's February 2012 report placed the Fee program among the top 10 Federal programs with the highest reported improper payment rates.[3] These findings are consistent in the September 2011 report by the National Academy of Public Administration (NAPA). The NAPA study also discusses the Fee program's use of "antiquated systems and technology" and points to private sector payors who provide "much more efficient and accurate claims processing".[4] Case in point, when VA transferred this function to Humana Veterans for Project HERO, we demonstrated our ability to make timely and accurate payments to our network of providers, which is further explained later in this testimony.

National Contract for Medical and Surgical Services

Over the past 5 years, the HERO pilot program has proven the hypothesis that a national health care administrative services provider can collaborate effectively with VA to deliver results-focused, high quality, and cost-efficient care. The success of HERO is substantiated by a strong set of performance metrics, which include access to care, quality standards, safety requirements, return of clinical information, and Veteran satisfaction. News of this success has begun to spread with the demand for the HERO program growing amongst the local VA Medical Centers that fall outside of the pilot locations. Project HERO has presented this contracted care as an alternative preferred option to the uncoordinated Fee process. However, based on VA's presentation to interested contractors, VA is not leveraging the lessons learned from HERO in the planned follow-on HERO program that they are calling Patient Centered Community Care (PCCC). PCCC, as presented to interested companies by VA, would only create a national contract for a network of providers to deliver medical and surgical services without the critical care coordination elements. This means that PCCC would be nothing more than a discounted Fee network, with no added benefits for Veterans.

PCCC, while well-intentioned, would significantly limit the contractor's role to one of establishing and managing a provider network. Under PCCC, the contractor would not be able to provide the administrative services that exist in the HERO pilot and which were instrumental to the contractor's care coordination role. The positive outcomes achieved under the HERO pilot would be eliminated once the contractor no longer has the ability to enforce the VA requirements and quality standards within the community provider network. Another unintended consequence of removing contractor-provided administrative services is the threat to the contractor's ability to maintain a provider network that is responsive to VA's changing needs. Specifically, the contractor's ability to guarantee a low no-show rate and make timely, predictable reimbursements were effective incentives. In exchange for these benefits, the network community providers returned clinical documents on a timely basis and adhered to an extensive list of VA specific requirements that do not exist in the providers' other patient populations. Given the on-going challenges VA faces with claims payments and inability to match the low no-show rates that Humana Veterans achieved, network providers will experience an increasing number of missed appointments and delayed and erroneous payments. In effect, the Department will lose these once valuable incentives that are so critical in driving good behavior and will ultimately result in community providers leaving the network. There is also the issue of a predictable minimum workload. VA can analyze data

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[2] VA Office of Inspector General. *Department of Veterans Affairs: Review of VA's Compliance with the Improper Payments Elimination and Recovery Act.* Mar. 14, 2012. Web. 5 Sept. 2012, <*http://www.va.gov/oig/pubs/VAOIG–12–00849–120.pdf*>.

[3] U.S. Government Accountability Office. *Improper Payments: Moving Forward with Government-Wide Reduction Strategies.* Feb. 7, 2012. Web. 5 Sept. 2012 <*http://www.gao.gov/products/GAO–12–405T*>.

[4] National Academy of Public Administration. *Veterans Health Administration Fee Care Program.* Sept. 2011. Web. 5 Sept. 2012 *http://www.napawash.org/wp-content/uploads/2011/11/White__Paper11012011webposting.pdf.*

on past authorizations for purchased care to develop a floor for a minimum number of referrals. This will ensure that VA receives the most advantageous pricing while also having a positive impact on the recruitment and retention of community providers to create a robust network that supplements the VA health care system.

Based on VA-provided information, Humana Veterans believes VA is misinterpreting the lessons learned from HERO to create and build new in-house capacity to handle administrative functions associated with the Fee care authorizations, visits and treatment through the Non-VA Care Coordination (NVCC) program. Instead of leveraging the capacity and expertise that already exists in industry, NVCC will require significant resource investments both in staff and the necessary tools to properly handle the "back-office" administrative functions. VA's implementation of NVCC in the 100+ Fee program offices in the field also runs counter to the NAPA recommendation. Rather than consolidate to no more than 3 to 5 strategically located regional sites, VA is continuing to invest resources to growing the 100+ Fee program offices and is reinforcing NAPA's message that the "Fee program has grown haphazardly". If PCCC is supposed to be the nationwide follow on to HERO, the administrative functions of the program need to be conducted by the contractor.

Veteran Centric Collaborative Health Care Program

Rather than continue down the current path for PCCC and NVCC, there is still time for VA to incorporate the successful elements of HERO to create a Veteran centric collaborative health care program. This program should be centered on care coordination and enhanced partnerships with national health care administrative services providers that will be fully integrated in the continuum of the VA health care system as the Department's network of community care providers. Such a program will be a win-win for Veterans and VA. Veterans will benefit from a fully coordinated and integrated VA health care delivery system of VA and community providers, whereas VA will be able to achieve cost-savings by partnering with national health care administrative services organizations that have existing systems, tools, and processes in place for efficiently managing Fee related administrative functions.

There are numerous advantages of a Veteran centric collaborative health care program for Veterans, as explained below. Mainly, Veterans for whom VA has authorized community care are guaranteed to receive care from a network of community providers who are fully credentialed and certified so that geographic distance is no longer a barrier to access to care. For example, through the HERO pilot program, Humana Veterans provides a robust network of about 42,000 providers in the four pilot VISNs with the ability to expand pending increased referrals. This has made it possible for Veterans to travel a median distance of only 13 miles even though 45 percent of the HERO appointments were in rural or highly rural areas. Beyond the HERO program requirements, VA could charge the contractor with the responsibility for training the network of community providers on military and Veteran culture where VA provides the training materials and contractors are reimbursed for the training.

Another key advantage to Veterans is the clinical information exchange, which ensures timely return of clinical decision-making while also minimizing duplicate care and services. This was demonstrated in the HERO pilot program where Humana Veterans returns 94 percent of clinical information to the VA within 30 days with a median return of 9 days. In addition, Humana Veterans' care coordinators help each Veteran in Project HERO navigate the care that they receive in the community. For example, Humana Veterans assists Veterans in identifying network community providers, scheduling the appointment, and following up to ensure that the Veteran made the doctor's visit. As a result, Humana Veterans achieved a no-show rate of 5 percent, which is significantly below the industry average that ranges between 14 percent and 24 percent. Humana Veterans also provides VA direct access to the Authorization and Consult Tracking (ACT) system, which is our proprietary IT tool for care coordination that allowed VA to track and monitor Veterans with Fee authorizations for the very first time.

Among the other HERO lessons that should be included in a new Veteran centric collaborative health care program is a strong clinical quality management program to respond to patient safety events. Under Project HERO, Humana Veterans operates a clinical quality management program, which provides a structured way of identifying and addressing possible patient safety events. Through the clinical quality management program, Humana Veterans reviews all identified potential quality indicators and investigates 100 percent of confirmed quality issues, as well as engages VA in a discussion of outcomes through the jointly operated Patient Safety Peer Review Committee. Project HERO has also demonstrated the ability to ensure accurate and timely claims payment. Using our automated claims process and con-

tracted rates that minimize the risk for improper payments, Humana Veterans makes 99 percent of claim payments to our providers within 30 days and maintained an extremely low payment error rate in FY 2011.

The Veteran centric collaborative health care program could also go beyond the lessons learned in HERO by requiring a VA-provided and a contractor-provided care coordinator to work together in managing the care that Veterans receive. Additional program enhancements should focus on eliminating variations, with VA making more consistent determination of non-VA care authorizations for Veterans. VA should also retain the flexibility to define the standards for referrals and authorizations, as well as retain its "gate-keeper" role. This means that VA retains the decision-making control of, if and when they use the community provider network as a tool to supplement the care that Veterans receive in VA facilities.

When VA determines that it is appropriate to send a Veteran to a community provider, there must be accountability established to ensure that the care is arranged through the Veteran centric collaborative health care program. Use of the Project HERO contract was made optional for the participating VA Fee offices, and less than 20 percent of the total Fee care services in the pilot VISNs went to Project HERO. Not only was this often confusing for Veterans and community providers, but it resulted in VA not realizing all of the benefits and cost savings that could have been achieved through full implementation of the HERO pilot. The Veteran centric collaborative health care program must be structured to ensure maximum utilization with very limited exceptions by all VA Medical Centers.

Conclusion

PCCC presents an excellent opportunity to effect positive change in Veterans' health care experience and outcomes. The inclusion of the above elements of a Veteran centric collaborative health care program in PCCC will ensure that Veterans realize all the benefits of care coordination between VA and community providers. VA has a unique opportunity to expand the HERO program now available to Veterans in only four VISNS to all VISNs. This would create a truly integrated VA health care system that better leverages community health care assets if and when VA decides to authorize such care. If PCCC ends up being a rent-a-network contract or something short of a full care coordination model, it will represent a retreat from the Secretary's commitment to implement a patient-centered VA health care delivery system that includes all VA health care for Veterans—both within and outside the walls of the VA.

Thank you for holding this hearing and tackling this vital issue. I appreciate the opportunity to share Humana Veterans' experiences and views with the Subcommittee today, and am happy to answer your questions.

Brad Jones

Mr. Brad Jones serves as Chief Operating Officer (COO) of Humana Veterans Healthcare Services (Humana Veterans). As a senior leader at Humana Veterans, he is responsible for the day-to-day operations and the successful execution of all Department of Veterans Affairs contracts including Project HERO, Project ARCH, and over 20 VA Community Based Outpatient Clinics across the country.

After obtaining a Bachelor of Science degree in Computer Science from the University of Kentucky, Brad began a career in the life and health insurance industries that has spanned over 25 years. From 1986 to 1996, he served as a management information systems professional with both Kentucky Central Life Insurance Co. and Jefferson Pilot Life Insurance Co. In 1996, Brad was selected to join Humana Military Healthcare Services (Humana Military) where he worked on TRICARE contracts with the Department of Defense. He was responsible for all electronic health care claims initiatives, implementation of Health Insurance Portability and Accountability Act (HIPAA) regulations, as well as direct oversight of provider data management systems. In October 2007, he was promoted to his current position of COO with Humana Veterans.

Humana Veterans Healthcare Services, Inc., a subsidiary of Humana Government Business, Inc., is currently providing administrative services to the Department of Veterans Affairs under the following contracts:

Project HERO (Healthcare Effectiveness through Resource Optimization), originally awarded in 2007 and currently in the fourth and final option year. Humana Veterans provides administrative health care services to Veterans referred outside of the VA health care system for specialty care.

Project ARCH (Access Received Closer to Home), was awarded in 2011. Services under the contract began on August 29, 2011, and include administrative health

care services to Veterans who meet certain eligibility criteria and agree to participate in the program.

Valor Healthcare, Inc., a subsidiary of Humana Government Business, Inc., currently operates 21 VA Community Based Outpatient Clinics across the country that provide services ranging widely from primary care to counseling and group therapy.

Prepared Statement of Kris Doody

Veterans Health Care Closer to Home

My brief oral presentation at the Veterans Affairs Sub-Committee on Health did not provide an opportunity to relate in some detail the unique model that has developed at Cary Medical Center in Caribou, Maine for the delivery of VA health care services to eligible, rural Veterans. In my extended remarks that follow I will review the advantages of our current model as well as some of the challenges we face in providing VA care at a non-VA facility.

It might be wise to consider the current demographics of Veterans living in the United States. In 2010 there were 21.8 million Veterans living in America. Nine million of the Veterans are over age 65. The number of WWII Veterans in 2011 are estimated to be nearly 2.1 million but this number is expected to be cut in half by 2015 and in 15 years will be down to 50,000. The average age of the WWII Veteran is 86. Surviving Korean War Veterans are estimated to be between 3 and 5 million with some 3.2 million between 65 and 74 and another 363,000 over age 75. Surviving Vietnam Veterans number some 7.6 million with an average age of 60–65. Nearly 3.5 million U.S. Veterans have service connected disabilities with some 698,000 at 70 percent or higher.

Pertinent to this discussion is that some 3.4 million Veterans or about 41 percent of the total enrolled in the VA Health Care System live in rural or highly rural areas of the country. In recent years the Veterans Administration has been working to improve access to care for rural Veterans and Cary Medical Center has had the privilege to be part of that process. Cary Medical Center is unique in that the hospital is located in highly rural Northern Maine. Historically Veterans would have to travel some 500–600 miles round trip to access care at Maine's only VA hospital at Togus, Maine. Togus is the oldest VA hospital in the United States.

As early as May of 1946 the Department of Maine American Legion was advocating for a Veterans Administration Hospital in Aroostook County sighting the disadvantage suffered by Veterans living in this vast and remote area. In 1979 the Aroostook County Veterans Medical Facility Research and Development, Inc. (ACVMFRD) was formally incorporated with a single purpose of establishing local health care for Veterans living in the County. Providing access to health care for Veterans living in rural areas was not a strong suit for the VA. During their original efforts to create VA health services the local Veterans group learned that in order to establish a formal Veterans Administration Outpatient Clinic the VA required that some 180,000 Veterans exist within a 60 mile radius. With less than 100,000 in total population it was clear that Aroostook County would not go the existing route to secure access. From 1979 to 1987 this small group of Veterans worked with the state's congressional delegation, the VA, the local hospital, Cary Medical Center and multiple Veterans Service Organizations.

While Senator George Mitchell initiated the first attempt to create an outpatient VA Clinic in Caribou, Maine based on a new priority of improving VA services to rural Veterans, it would not be until the Director of the VA Hospital at Togus, through his own authority, cleared the way, administratively for a small 'follow up' clinic to be opened at Cary Medical Center, a public acute care hospital. It would become the first such clinic of its kind in the United States. Senator George Mitchell, Senator Bill Cohen and then Congresswoman Olympia Snowe joined in a united effort to address the issue of rural health care for Veterans and helped pass legislation which established a study committee to assess the state of care for rural Veterans and to make recommendations. The timing was great and as the issue of rural health care became more of a priority for the VA, the health care services in the new fledgling VA Clinic in Caribou, Maine began to grow.

Over the last 25 years the clinic has seen numerous expansions and now encompasses some 5,000 square feet and serves some 120 veterans per day including more than 5,000 clinical visits annually. The clinic now has a staff of 21 and provides outreach to satellites in northern and southern parts of Aroostook County. Primary Care, Mental Health Services, Home Based Care, Tele-Health Services, Health Promotion and Education, and Smoking Cessation are among the offerings at the cen-

ter. A number of other CBOCs have now been opened around the State of Maine based on the Caribou model and some 600 clinics are available nationwide.

Collaboration Key to Success

It would be easy to just assume that providing convenient access to health care for Veterans living in rural and highly rural areas of the Nation would be a 'no-brainer'. Veterans who live in rural communities demonstrated the same level of valor and courage as those living in metropolitan and large urban areas of the country. However, there were many challenges and these challenges remain. The VA Clinic in Caribou, Maine is a great laboratory for the ongoing development of rural VA health care. The clinic came about because of a grassroot effort by local Veterans and the relationship that was created between the Veterans groups, a local hospital, and the Veterans Administration. The development of the VA clinic was a gradual process. The clinic started as a follow up clinic for specific patients that had been treated at the VA hospital in Togus. The VA than established a contract with a local physician and expanded care. Finally came the establishment of the first VA Community Based Outpatient Clinic staffed by a VA physician and staff. All along the way there was a communication process that started to open the window for expanded services without creating an adversarial or combative environment between the constituencies. The VA and its leadership began to hold 'Town Hall Meetings' at Cary Medical Center in Caribou. They listened to the concerns of Veterans and their families. The VA hospital director would bring key staff specializing in eligibility, benefits, claims processing, women's health and others to hold one on one sessions for Veterans with specific issues to resolve. A bond was built that allowed for collaboration to grow.

This dialogue between Veterans, the VA, and the local health care providers is absolutely critical to the growth of rural health care for Veterans. There must be an understanding that the kinds and numbers of clinical services available to Veterans in these rural parts of the country depend greatly on the scope of services available in the local health care system. Throughout our experience with Veterans they were keen on preserving the VA health care system and wanted to stay connected with it but they also wanted to be able to access more routine care locally. The credibility of the VA health care system and the quality of the system has come a great distance in the past 25 years. Veterans generally have confidence in VA health care and that has been demonstrated by the growing numbers accessing VA care. Recent surveys point out that when asked if they could choose a health care provider more Veterans are indicating that they would choose VA care. In fact based on a CBO Paper, published December, 2007—The Health System for Veterans—An Interim Report; the VA Health Care System scores significantly higher than the private sector on multiple measures including Clinical Practice Guidelines and Patient Satisfaction. The growth of patients seeking care within the VA System has also grown dramatically from 3.6 million to more than 5 million. The VA system in 2011 treated some 6.1 million Veterans and saw some 80 million outpatient visits.

The entire world changed for Veterans Health care when the Veterans Health Care Eligibility Reform Act was passed in 1996 greatly increasing the numbers of Veterans eligible for VA care. In the past decade the health care budget in the VA has increased from $17 billion to $36 billion The VA has established a priority system with levels 1–8 with level 1 serving those with service connected disabilities and level 8, for which enrollment has been frozen since 2003, for any honorably discharged veteran.

The challenges faced by the growing VA health care system are not unlike the traditional American health care system. Many Veterans like many Americans are aging. The availability of convenient, local access to health care services for this aging population is paramount in providing high quality management of chronic illness which impacts many of the elderly. Helping individuals to remain in their homes, reducing hospital admissions, preventing pre-mature institutionalization and supporting patients so that they may enjoy a high quality of life during the aging process is also a key goal of both the VA and the private health care sector. The VA has proven itself, in recent years, to be very adept at managing some of the most difficult chronic conditions. Recent studies point out that patients with the VA Health Care System receive significantly better care for depression, diabetes, hyperlipidemia, and hypertension. This has come about primarily because of the expansion of services including more than 882 ambulatory care and community-based outpatient clinics. Still the problems facing Veterans in rural America remain a major challenge. How can we use the knowledge and experience gained over the past 25 years to solve these challenges?

The Cary Medical Center Model

We have already discussed the history of the VA clinic at Cary Medical Center in Caribou, Maine. While there are many aspects of this development that involved pure advocacy of local, dedicated Veterans for their fellow comrades, the integration of the VA clinic in Caribou within the traditional or private health care system offers a unique and intriguing perspective as to future approaches to expanding VA Healthcare in rural communities.

First, and perhaps most important, the successful implementation of the rural VA outpatient clinic must have near universal support from local Veterans Organizations. When the small group of Veterans began their advocacy work in the late 1970's, a visionary Chief Executive Officer at Cary Medical Center, a small centrally located acute care hospital in Aroostook County, Maine offered to help. The hospital and the Veterans group created a bond of mutual support and respect that still strongly exists today. Once the Veterans were satisfied that the hospital had the commitment and resources to take on the challenge of an integrated program with the Veterans Administration Medical Regional Office Center at Togus, Maine, they utilized the expertise of the hospital in advancing the medical, political, and public support that would be required.

The hospital began by approaching the VA about utilizing space to establish a physical presence on the hospital campus. While initially contracting a member of its own medical staff to the VA for the purpose of seeing a limited number of patients for follow-up after surgical procedures at the VA Hospital, the demand for additional services began to grow. The VA then moved to recruit a physician from the region to staff the clinic as a Veterans Administration Employee. Gradually the VA began to expand staff based on volume and the continuing requests of the Veterans advocacy group.

The expansion of the VA clinic came with it a growing relationship between the hospital and the VA. This included the hospital's understanding of the VA Fee Schedule. Initially only a limited number of services were available to Veterans outside the VA clinic. However with the passage of the Veterans Health Care Eligibility Reform Act of 1996, access to more outpatient services was expanded. There continued to be some hesitancy of the VA to 'let go' of traditional care involving Veterans traveling hundreds of miles to the VA hospital for minor outpatient procedures but over time services available locally began to grow.

The growing integration between the hospital and the VA was a tremendous benefit to area Veterans. The success of the VA clinic inspired the Veterans advocacy group to explore other important health care needs of Veterans living in Aroostook County. The State of Maine had established the 'Maine Veterans Home' program in the 1980's. The first home was in Augusta, Maine some 300 miles from Caribou. Veterans in Aroostook County organized an effort to build a long term care facility. Working with the State legislature, and the VA, a new home was opened, only the second of its kind in 1990. There are now five such long term care facilities in Maine as part of the Maine Veterans Homes system. Then in 2003, a new 30-bed Maine Veterans Home Residential Care facility was opened on the campus of Cary Medical Center.

While the long term care facilities and the VA outpatient clinic are clearly separate, one is directly tied to the VA and the other is a purely State run organization, there are common threads which involve eligibility requirements, reimbursement issues and a connection to the greater Veterans community in Aroostook County.

While the growth of VA health care in Aroostook County presents a very dramatic and unique scenario, the effort to monitor, study, explore and expand services continues to be a top priority for both Veterans and the hospital. For more than 25 years the hospital has maintained a liaison relationship within the Veterans community. A member of the hospital's administrative staff is charged with monitoring the VA health service at the hospital and to assist with any potential issues, and the hospital's CEO conducts quarterly meetings with key Veterans leadership. These meetings are designed to address a variety of issues including recent national developments in VA health care and the needs of the local VA clinic. These meetings are pivotal to the continued success of the VA clinic and have led to the ongoing expansion of services.

Over the years the clinic has expanded multiple times and current plans are for another expansion. The key to this growth, again, has been the dialogue, collaboration and partnership among the major players; Veterans groups, the Veterans Administration, and the hospital. Each expansion has been based on priority need, a well-developed strategy, cost benefit analysis, and the answer to a key question, how the expansion will impact rural Veterans living in Aroostook County. Over the years the level of mutual trust and respect that has been established have become a way

of life here and the rancor and turmoil that characterized so much of the relationship between the VA and the Veterans community of the 1970's and 80's has all but disappeared.

Project ARCH—The Next Step

Throughout the years of working with the VA Outpatient Clinic and the development of long term care for Veterans through the Maine Veterans Homes one key priority eluded the Veterans community in Aroostook County, Inpatient and Specialty Care. While Veterans continued to advocate for these services the VA stood firm in protecting the current system of patients being transferred to the VA hospital for any surgical or medical services requiring hospitalization. The impact of such a reality for Aroostook County Veterans and others living in highly rural areas of the Nation should be obvious.

Patients who require hospitalization are often the most medically burdened elderly and may find it difficult to travel the hundreds of miles required to receive the services. In rural Northern Maine we have no Interstate system and our roads our icy and snow covered for many months every year. Many of the Veterans in need of this care are low income and while the VA does reimburse travel for the Veteran, family members and others who may be key support to the Veteran are often unable to make the long trip to the only VA hospital in Maine. The support of family and friends has been demonstrated to be a key element in the ultimate and early recovery of patients.

Over the years the issue of inpatient hospital care has been discussed and in fact, the CARES project revealed a serious need to address hospitalizations for Veterans in rural communities. The project actually designated specific areas, including Northern Maine, as a priority location for inpatient beds. Funding to execute the findings never materialized. The establishment of Project ARCH, Access Received Closer to Home, has finally made this piece of the care continuum available to Veterans living in five areas of the Nation as a pilot or demonstration project. Fortunately Aroostook County was one of these selected areas and Cary Medical Center was the hospital selected to contract with the Veterans Administration to provide a select number of specialty services including hospital care for eligible Veterans.

Once again this project benefits greatly from the long history that Cary Medical Center has with the Veterans Administration and the Veterans community. The VA already has primary care and other related services on the hospital campus. The level of satisfaction with hospital care experienced by Veterans and the hospital's ongoing support and advocacy for Veterans health care also played a key role in attracting Veterans to Project ARCH project. The compassion and quality of care provided by the VA outpatient clinic itself was another key driver for the initial and remarkable success of the project.

A key question with Project ARCH was whether or not the community hospital could meet the stringent demands for quality and customer satisfaction required by the VA. In the CBO Interim Report—The Health Care System for Veterans sighted earlier addressed the improving quality of care in the VA system. The VA has adopted the Institute of Medicine (IOM) definition of quality: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The IOM also noted that health care should be Safe, Effective, Patient-Centered, Timely, Efficient and Equitable. The VA tracks many aspects of its health care along the dimensions highlighted by the IOM. Based on established Clinical Care Guidelines and other measures the quality of care in the VA has significantly improved since the organization experienced reengineering from 1994–2000.

Early indicators are that Cary Medical Center is not only capable of meeting these quality expectations but has exceeded them both in specific measures of clinical quality and patient satisfaction. The hospital has worked closely with its VA contracting office and has established a team of key stakeholders in the care delivery process including clinical personnel, case management staff, administration, finance and other aspects of the project. While the project is just now completing its first year of operations nearly 1,000 clinical encounters including a number of surgical procedures and hospital stays have been completed. We are now in the process of assessing the outcomes and opportunities for improvement. The vigilance of the VA in monitoring quality and patient satisfaction for Veterans eligible for health care close to home is admirable.

While we wait for the specific and detailed data on the first year experience with Project ARCH it is appropriate to pause and consider where we have come. From our earlier discussions on the long history of the development of the first VA Community Based Outpatient Clinic (CBOC) in a rural hospital in the United States to

the reality of providing overnight hospitalization and specialty services to eligible Veterans closer to their homes much has been accomplished. The Veterans Health Care Eligibility Reform Act of 1996 made it clear that our Nation wanted to do more for those men and women who gave so much in service to our country. We have also discussed the aging of our Veterans population and the declining WW II survivors. Our Korea and Vietnam Veterans are also aging and the implications for their medical needs and those that will come after from experience in Iraq and Afghanistan are daunting. Visionary ideas like Project ARCH will go a great distance in advancing access to care for rural Veterans.

While we applaud the VA for its consideration of our Nation's Veterans and the advancement of both access and quality of care, there are some issues that we face here in Maine that are of particular concern. The VA has a reimbursement program based on the Medicare Fee Schedule. Unfortunately the State of Maine is among the lowest, in the Nation, in the level of Medicare reimbursement. While the complicated implications of this payment system are much too voluminous for discussion here such reimbursement unfairly impacts Cary Medical Center as we provide care to Veterans through the VA system. Payment for the same service here at Cary Medical Center such as a total joint replacement is far lower than the same procedure performed in other states. We continue to work with our congressional delegation, including Congressman Mike Michaud to gain a more equitable Medicare reimbursement rate which would, in turn, support improved reimbursement for health care services we provide to Veterans.

At the same time and perhaps counter intuitive in light of the current reimbursement structure, Veterans who have experienced care at the local level from Cary Medical Center are clamoring for more access. The ability to still feel connected to the VA through accessing primary care at the VA Community Based Outpatient Clinic and at the same time obtain specialty care, and, if needed hospital care close to their homes has been a very positive experience for Veterans. It is our hope that the Veterans Administration will, over time, consider adding more specialty care options for eligible Veterans in Project ARCH such as Ophthalmology. The idea of expanding specialty care in rural communities to meet an expanding market share of eligible VA patients has a number of positive implications for not only the Veterans who will be served but for the entire local community.

Often times specialty services are not available in a rural community due to the number of patients needed to support such services. While access to primary care has dramatically improved in Caribou, Maine thanks to the expansion of our Federally Qualified Health Center, Pines Health Services, additional medical specialists are needed. Thanks to the growth in volume presented by Project ARCH we have already been able to expand services in Cardiology, Pulmonology, Neurology, General Surgery and Orthopedic Surgery. Such development speaks well for the future of the hospital and the quality and availability of specialty care for the communities we serve including a growing number of Veterans.

Another challenging issue for providing VA health care in non-VA facilities has to do with measures of access. Within the current ARCH contract the VA has included strict access guidelines. The contract calls for Veterans to be scheduled with a specialty medical provider within 14 days of authorization. This has been a difficult task for our local hospital as we try and build the Veterans patients into the routine schedule of very limited specialists, often a single specialist deep. Recent figures sighted by the VA IG suggested many VA patients were not receiving appointments within 30-days within the VA health care system itself. Still, creative solutions are being developed to cope with this issue including additional recruitment of specialists, 'set-aside' days where the specialists schedule only VA patients or 'catch-up' days that may be held on a Saturday or other non-traditional access times.

The beauty to the seamless integration of the private sector health care system at the local community hospital level and the VA primary care clinic is that as these issues surface and mutual team, committed to improving the delivery of care to the Veteran, comes together and creative solutions are identified, tested, modified and implemented on an ongoing basis. This process has helped to create what we believe is a potential national model for community based Veterans health care.

A Focus on Prevention and Patient Education

We have established the many benefits of bringing health care closer to home for patients within the Veterans Administration Health Care System. We have also demonstrated that through closer partnership and with mutual trust and respect a strong collaborative approach can be developed assuring the provision of quality care and high customer satisfaction. But one key advantage that we believe can

have significant implications in the future is the growth of patient education and prevention. This is one area that has only begun to evolve. The partnership that exists between the community hospital and the VA outpatient clinic holds great promise in the collaborative approach to educating patients about chronic disease, preventing Type 2 diabetes, reducing the risk for heart disease and stroke and many other preventable health conditions. The resources of the local VA clinic may be limited for such general community work but partnering with the hospital and its strong outreach programs could lead to a healthier more personally accountable general population as well as a healthier Veterans Community.

Conclusion

It is our hope that we have been able to present a strong case in support of Project ARCH and the continuing willingness of the VA to work with rural communities in establishing more locally available health care for our nations deserving Veterans. Once again we applaud the VA for its continuing advancements in technology, patient safety and overall quality of care. It is our belief that the continuing dialogue between the VA and the private health care sector in rural areas of the country will lead to an ever increasing partnership and improving health status for the communities in rural America.

Cary Medical Center particularly salutes the Veterans Administration Regional Medical Office Center at Togus, Maine for their visionary and remarkable outreach in advancing the care of Veterans in rural Maine. We stand ready to offer any assistance we can in advancing such efforts and we pay tribute to the Veterans, many of whom have now passed, for their tireless efforts on behalf of their Veteran brothers and sisters to establish Veterans health care close to home. While all of us can hope for an end for the wasteful violence and tragedy of War we recognize the many perilous and dark forces that challenge freedom on nearly a daily basis. Those men and women who put themselves in harm's way offering the greatest sacrifice deserve our best efforts in guaranteeing that they will be well cared for when they return home to a grateful nation.

Thank you.

Prepared Statement of Dr. Gregg A. Pane

Madam Chairwoman and Members of the Committee, I appreciate the opportunity to testify today, on behalf of a Panel I chaired at the National Academy of Public Administration (the Academy) in 2011. Established in 1967 and chartered by Congress, the Academy is an independent, non-profit, and non-partisan organization dedicated to helping leaders meet today's most critical and complex challenges. The Academy has a strong organizational assessment capacity; a thorough grasp of cutting-edge needs and solutions across the Federal Government; and unmatched independence, credibility, and expertise. Our organization consists of over 700 Fellows—including former cabinet officers, Members of Congress, governors, mayors, and state legislators, as well as distinguished scholars, business executives, and public administrators. The Academy has a proven record of improving the performance and enhancing the accountability of government at all levels.

Over the past decade, the VHA Fee Care Program has grown from an infrequently used adjunct to traditional VA health care services into a critical element of clinical care for veterans. After extensive research and analysis, the Academy's Fee Care Panel recommended that VHA consolidate this program into three to five operating centers while modifying its claim processing structure to become a more standardized system. Standardization of the IT infrastructure along with consolidation will allow fewer employees to work more efficiently and effectively, and a more structured rule-based environment should lead to fewer payment errors and greater program value. The Panel also emphasized the importance of conducting an independent analysis of the costs and benefits for contracting out this function—similar to the approach used by TRICARE and Medicare—to provide important information for Congress and VA.

BACKGROUND

The Veterans Health Administration (VHA) provides the majority of medical care services to eligible veterans with Department of Veterans Affairs (VA) assets. In some instances, however, VHA procures the services of health care providers outside of the VA health care system. These services are referred to as "Fee Basis Care" or "Fee Care."

Fee Care is typically utilized when a clinical service cannot be provided by a VA Medical Center (VAMC), when a veteran is unable to access VA health care facilities

due to geographic inaccessibility, or in emergencies when delays could lead to life-threatening situations. In recent years, Fee Care has been increasingly used to meet patient wait-time standards.

VA's Fee Care Program expenditures have grown 275 percent since Fiscal Year (FY) 2005. At the time the study was conducted there were approximately 2400 Full Time Employees (FTEs) working in the program. Paid claims rose from $3 billion in FY 2008 to $4.4 billion in FY 2010 (46 percent increase), while the number of unique patients served increased from 820,000 to 952,000 (16 percent) in the same period.

In 2009 and 2010, the VA Office of Inspector General (OIG) reported on significant problems with the accuracy and efficiency of claims paid in the Fee Care Program. The VA OIG reported that VAMCs made hundreds of millions of dollars in improper payments—including duplicate payments and incorrect amounts, both under- and over-payments—because VHA had not established adequate organizational management structures and processes. The OIG audit report also included a recommendation that VHA evaluate alternative organizational models and payment processing options to identify mechanisms to improve payment processing costs and timeliness. This recommendation provided a primary impetus for this study.

As part of its strategy to improve payments in this Non-VA Care (Fee) Program, VA contracted with the National Academy of Public Administration to conduct an independent assessment of the program, with the intent of providing VHA with options on the most efficient model(s) for its future state.

THE ACADEMY STUDY

The Academy formed an independent Panel of Fellows to conduct this review with support from a professional study team. The Panel's assessment focused on promoting active participation and direct engagement by all parties involved. The primary methods for collecting information as well as verifying our understanding of VA's internal and external dynamics approach were to:

- Conduct targeted interviews with VA staff and stakeholders.
- Review all existing reports, studies, and audits of the current program.
- Collect and analyze data and metrics regarding the current performance of the existing program from all available sources.
- Interview staff and research the performance of other Federal and commercial health care payer programs.
- Prepare an analysis of findings based on the above collection methods for review by the Academy's expert Panel. Draft proposals were sent to VA for consideration and comment prior to finalization.

The study team also met with some of the OIG authors to gain additional insights into the studies. Another recent, highly relevant study was the Indiana University/Purdue University Fee Service Evaluation Project, which examined best practices within 13 VHA claims processing sites and evaluated overall efficiency, operations management, and cost metrics. The Academy study team also interviewed the Indiana University/Purdue University researchers.

In addition to existing reports and studies, another important source of information was site visits. The Academy study team visited the VHA Chief Business Office Field Office and the National Fee Care Program Office in Denver, Colorado, Veterans Integrated Service Networks (VISNs) with consolidated centers, and VISNs that still process claims in individual VAMCs.

The study team also visited Medicare and TRICARE program officials in Falls Church, VA and Denver, CO. Interviews were conducted with officials from some of the major contractors used by Medicare, Medicaid, and TRICARE to process claims, including TriWest, Health Net, Affiliated Computer Services (ACS), and Humana.

TRICARE AND MEDICARE MODELS

Both Medicare and TRICARE contract out all of their claims work and spend a majority of their staff time on overseeing the contractors and contracts. Several large commercial vendors specialize in providing large volume processing of these health services claims.

Medicare provides approximately $400 billion in health insurance coverage to people who are aged 65 and over, those who are under 65 with certain disabilities, and people of all ages with end-stage renal disease. The Medicare Program offers an alternative to current VHA organizational structures because all administrative (back-

office) functions have been contracted out. Each of five Medicare Regional Offices oversees various activities of the Medicare Administrative Contractors (MAC), which in turn are responsible for providing services to Medicare's enrolled population.

TRICARE's $40 billion a year program has outsourced its administrative office functions, dividing the United States into three regions, each awarded to a separate contractor. Contractors are responsible for ensuring that TRICARE's enrolled population receives care, developing and maintaining a network of providers, and maintaining an information system based on guidance established by TRICARE. Taken a step further than Medicare, TRICARE has tried to create contracts that push some "program risks" to the contractors and has created a robust Program Integrity Office with clearly-defined criteria and staff consisting of lawyers, statisticians, physicians and nurses (RNs). This office directs contractors in identifying and limiting fraud and abuse throughout the program.

TRICARE contractors report that about 75 percent of the claims processing is fully automated, that is, not requiring human intervention. The contractors also reported to the study team a cost per claim of $2.25 to $2.50 for electronic claims and $3.50 for paper-based claims. This serves as another basic benchmark to gauge the potential for productivity improvement in the Fee program.

Medicare contractors report that about 95 percent of the claims processing ranges from about $0.40 to $1.60 per claim depending on whether the claim is electronic or paper-based, type of claims, and other factors (compared to $9.40 per claim for VISN 19 and $2.55 for CHAMPVA). Processing of commercial claims cost about the same, ranging from $0.85 per claim for electronic claims to $1.60 for paper-based claims.

CHAMPVA

VA currently runs a centralized claims processing business line for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) in Denver, Colorado. CHAMPVA provides coverage for non-VA purchased care provided to the spouse or widow(er) and to the children of a veteran who is rated permanently and totally disabled due to a service-connected disability or who died of a service-connected disability. In FY 2009 nearly 300 claims processing staff in Denver processed over 6 million CHAMPVA claims annually. The average number of claims processed per staff member is over 20,000. This level of productivity far exceeds the productivity of the most efficient sites for the Fee program, and can be viewed as a target for the Fee program to achieve.

There are certain significant differences between the two programs that add unique challenges to each program. Authorization at the local VA hospital is a significant step in the Fee program that does not occur in CHAMPVA. Likewise, CHAMPVA has some requirements that do not exist in the Fee program. For example, CHAMPVA handles payment or reimbursement of service in foreign countries.

THE FEE CARE PROGRAM'S CHALLENGES

Several studies and numerous study team interviews point to the following significant challenges and areas for improvement in the Fee Care Program:

- Decentralized mode of operation across VA hospitals resulting in inefficient operations
- High error rates
- Fee Care Program organizational alignment, staffing, grade profiles, education, training, training certification, performance standards and performance expectations vary significantly across VISNs and operating sites
- Interpretation and application of rules vary across Fee operating sites.

The study team's research found:

Limited VISN-wide executive oversight of purchased care programs

No clearly defined operational objectives or goals

No defined strategy for optimally managing program expenditures

Minimal understanding of the services being procured and prices paid for those services

No pronounced effort to effectively capitalize on the expertise, resources and economies of scale of the VISN.

Error Rate Analysis

Three VA OIG audits issued over the last 3 years report hundreds of millions of dollars in erroneous payments or missed revenue collection opportunities. The Audit of Non-VA Inpatient Fee Care Program report (August 18, 2010), for example, concluded in its report highlights:

"VA Medical Centers (VAMCs) improperly paid 28 percent of inpatient Fee claims during the 6-month period of January 1, 2009 through June 30, 2009. The improper payments occurred because VHA's policies for determining eligibility for inpatient Fee care did not provide adequate guidance on how to determine eligibility for inpatient Fee care or were not understood by Fee staff. Other payment errors occurred because Fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors. We estimate that VHA made net overpayments of $120 million on inpatient care for veterans in FY 2009 or $600 million in improper payments over the next 5 years."

The VHA's Chief Business Office (CBO)'s own analysis of error rates in claims processing for recent activity is about 12 percent. This measure of error rate is net of under and over charges on the billing. It does not include procedural errors or errors that do not result in inaccurate billing. An error rate of 12 percent applied against total Fee expenditures in FY 2011 indicates erroneous payments of $500,000,000. The FY 2011 error rate of 12 percent is an improvement over the rate reported the previous year (13.8 percent).

For a comparative benchmark, CBO reported to the study team that the national error rate for CHAMPVA for this year is 1.03 percent. This is based on using the same measurement processes (payment error compared to total payments) that was used to calculate the Fee Basis payment error rate of 12 percent.

The TRICARE program may serve as an example of high performance with respect to management of improper payments as well. In interviews TRICARE program integrity officials reported error rates that are under .05 percent.

TRICARE's Program Integrity office executes policies and procedures regarding prevention, detection, investigation and control of fraud, waste and program abuse. It provides oversight of contractor program integrity activities. It liaises with Department of Justice, law enforcement agencies, state and Federal agencies, and private plans. TRICARE program integrity tools include: mandated use of fraud detection software; automated computer edit software program; post-pay duplicate software; quarterly and annual audits; prepayment review; beneficiary/provider education; and anti-fraud data mining (e.g., spike detection, outliers). TRICARE maintains and tracks electronic records of all adjudicated purchased care claims in its TRICARE Encounter Data (TED).

PANEL FINDINGS

The Fee Care Program is currently operating at an inefficient level due to the number of claim payment errors and the relatively low productivity of its staff compared to other similar programs. In fact, the return on investment (ROI) analysis run by the Panel indicates that a total consolidation of the Fee Care Program (which is a combination of virtual and VISN consolidation) would save the organization almost $4 billion in the next 10 years, net of the investment costs. The net total savings was calculated by adding the amount of net savings affected by reducing the number of FTEs through consolidation, integrating a more automated claims processing system, and reducing the errors in payments.

A consolidation effort would maximize efficiency and reduce staffing levels. After reviewing the costs and running a ROI analysis, the Panel has concluded that total consolidation shows more efficiency, lower error rates, lower resource needs, and over all higher return on investment. The standardization of the IT infrastructure along with physical consolidation will allow a smaller number of employees to work more efficiently and with a more structured rule-based environment resulting in a decrease in errors made while processing claims.

The Department of Veterans Affairs' Fee Care Program needs to change. Historically, this program constituted a small fraction of health care resources. The Panel estimated that it would constitute approximately 10 percent of the VA's total health care budget in FY 2012. During this period of unprecedented growth, the organizational, administrative, and technological systems used to operate and manage the

program simply have not kept pace. VA is different from most Federal health care systems in that it is both a provider of health care and a payer of health care claims.

The Panel reached the following conclusions:

1. Given the significant organizational and productivity challenges within the Fee Care Program, VHA has limited understanding of the services it is procuring through this program or their costs.
2. The Fee Care Program is significantly more inefficient and has higher error rates than benchmarked organizations. Productivity across operating sites varies considerably. CBO estimates the error rates (that is, erroneous payments) at 12 percent per year, or approximately $500 million in FY 2011. By contrast, TRICARE has a reported error rate of 0.42 percent. Productivity varies so greatly across operating sites that the productivity of the most efficient processing site is nearly 10 times greater than the most inefficient site.
3. The Fee Care Program has grown haphazardly over the years and the technology and administration of Fee care claims have been neglected. As VA's Fee Care Program has grown, the Department has been playing catch-up in its attempts to modernize and improve its decentralized and inefficient claims processing system. Despite a number of initiatives being undertaken to improve the current situation, the organization responsible for improving the system, CBO, has limited control and authority.
4. VA has an opportunity to create a markedly improved Fee claims system but faces major challenges. In addition to the significant changes recommended for VHA field operations outlined below and the needed technology enhancements, the Panel also believes that CBO needs to change the organizational alignment within the Fee office to achieve more focus, effective leadership, and improved lines of authority to bring about the necessary changes.
5. CBO has struggled to meet its mandate to provide a single accountable authority to develop administrative processes, policy, regulations, and directives regarding the delivery of VA health benefit program.
6. The support environment within VA and VHA—particularly IT, H.R. and Contracting—plays key roles in improving the functioning of the Fee Care Program. The Panel believes that strong leadership support from senior VA and VHA officials will be required to provide the Fee Care Program with the institutional support required to bring about the recommended changes.
7. Although the Fee Care Program can significantly improve just by changing its organizational and administrative processes, the most significant performance breakthroughs can take place only through technology. Two excellent examples of how technology can do this are the Medicare and TRICARE programs, which respectively handle 90 percent plus and 75 percent of their claims without human intervention. VA in contrast, cannot process any claims without human intervention.
8. CBO also needs to develop stronger program management capabilities. Although CBO does not exercise direct line authority over field Fee operations, they still can develop mechanisms that can help to drive desired outcomes by using the traditional tools available to program managers:

Metrics—CBO needs a balanced set of metrics to oversee Fee operations in the field. This would include measures of speed, accuracy, costs and customer satisfaction.

Data—reliable performance data is essential for Fee Care Program oversight. This study found numerous examples of questionable and clearly erroneous data used in Fee Care Program reports. It was also clear that this information was not being adequately reviewed by Program officials.

Program integrity—CBO should create and manage a program integrity component in each of the consolidated operating centers as well as at its headquarters for determining whether work is being done in the prescribed manner.

Use existing authority—both CBO and all VISN directors report to the Deputy Under Secretary for Health/Operations and Management. In matters of insuring field business office structural and business process consistency, this office should exercise more direct control.

Over the past decade, the Fee Care Program has grown from a small, relatively infrequently used adjunct to traditional VA health care services, into a critical element of clinical care for veterans. While the Fee Care Program has grown exponentially in terms of volume and budget outlays, there has been insufficient strategic oversight of the program and its administrative and support systems have languished.

PANEL RECOMMENDATIONS

After analyzing the costs and ROI, the Panel concluded that consolidating the Fee Care Program into three to five operating centers while modifying its claim processing structure to become a more standardized system is the appropriate course of action in order to increase effectiveness and efficiency. Standardization of the IT infrastructure along with consolidation will allow fewer employees to work more efficiently and effectively. A more structured rule-based environment would lead to fewer payment errors and greater program value.

More specifically, the Panel recommended that VHA take the following steps to strengthen the Fee Care Program:

Organizational Consolidation and Management Changes

1. Consolidate its Fee Care Program from the current 100+ operating sites to the smallest number possible that will provide necessary redundancy and surge capabilities. This should result in no more than three to five strategically located regional sites.
2. High level VA management should provide clear policy direction about performance goals and expectations for VA purchased care, including the allocation of resources between VA-provided and purchased care to best meet strategic goals.
3. VHA should build greater program management competence and capacity for overseeing the Fee Care Program and supporting the consolidated claims processing sites. VHA should look both within and external to VA for expertise in this effort.

Create and manage a program integrity component in each of the claims processing sites, in addition to the planned headquarters component.

Establish a performance management system having performance metrics for productivity, accuracy, timeliness and customer satisfaction, among other things.

VHA should establish short and long-term performance goals.

Build greater program management competence for overseeing the Fee program.

Technology and Virtual Consolidation

4. VHA should procure and implement an enterprise-wide technology solution to facilitate virtual consolidation.

Other Considerations

5. Conduct a cost-benefit analysis of contracting out the processing of claims as with other payer models (such as TRICARE, Medicare, Medicaid, and Blue Cross Blue Shield) and their applicability for VA. This was outside the scope of the Academy Panel's mandate in this study.

By implementing these recommendations, the Panel believes that VA will improve service to Fee Care providers, which will help ensure maximal participation in the Fee Care Program and, consequently, more available health care options for veterans. The savings gained from more efficient administration and more accurate payments can be redirected back into improving other health care services for veterans.

Madam Chairwoman, that concludes my prepared statement, and I would be pleased to answer any questions you or the Committee members may have.

Prepared Statement of The Honorable Dr. Robert A. Petzel, M.D.

Good morning, Madam Chairwoman, Mr. Ranking Member, and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) purchased care programs. I am accompanied today by Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations; Cyndi Kindred, Acting Deputy Chief Business Officer for Purchased Care; and Deborah James, Non-VA Care Coordination (NVCC) Project Manager.

VA provides care to Veterans directly in a VHA facility or indirectly through either individual authorizations or through contracts with local providers. This mix of in-house and external care provides Veterans the full continuum of health care services covered under our medical benefits package. VHA recognizes that improvements are needed in the Non-VA Care Program, including that part of this program previously known as Fee Basis. To address these concerns, VA has developed and

managed multiple initiatives in the Non-VA Care Program. These initiatives are designed to ensure that high-quality care is consistently provided to Veterans under the non-VA care authorities. They are also designed to ensure Veterans receive effective and efficient non-VA care seamlessly.

My testimony today will discuss two initiatives, Patient-Centered Community Care (PCCC) and Non-VA Care Coordination (NVCC), both of which will help ensure that high-quality care is consistently provided to Veterans regardless if they receive their care in-house or from a non-VA care provider. I will also provide you with an update on the Project HERO (Healthcare Effectiveness through Resource Optimization) Program, Project ARCH (Access Received Closer to Home) and how our use of non-VA care is increasing access to care for rural Veterans. My testimony will discuss the clinical metrics and standards we have instituted to ensure Veterans receive the same quality care from non-VA providers participating in the Non-VA Providers Program as Veterans receive in-house.

Non-VA Care Generally

It is VHA policy to provide eligible Veterans care within the VA system whenever feasible and to the extent authorized by law. When VA cannot provide all of the necessary medical care and services at a VA medical facility, VA is, generally speaking, authorized to provide the needed care through non-VA providers in a manner consistent with the requirements and parameters of the non-VA care program and its underlying legal authorities.

VA uses criteria to determine whether non-VA care may be used. VA may consider non-VA care due to a lack of an available specialist, long wait times, or extraordinary distances from the Veteran's home. Purchasing the services will only be considered if other options within VHA are not appropriate or viable. If purchasing services is required, two principal avenues exist for contracting health care services: conventional commercial providers and academic affiliates.

VHA's academic affiliates (schools of medicine, academic medical centers and their associated clinical practices) provide a large proportion of contracted clinical care both within and outside of VHA. All non-competitive VHA health care resource contracts valued at $500,000 or more and competitive contracts over $1.5 million are reviewed through a thorough process that includes the Office of General Counsel (for legal sufficiency), VHA's Office of Patient Care Services (for quality and safety), VHA's Office of Academic Affiliations (for affiliate relations assessment), and VHA's Procurement and Logistics Office (for acquisition technical review for policy compliance). In addition, the Office of Inspector General performs a pre-award audit of all non-competitive contracts valued over $500,000.

VA is focusing on two initiatives to improve the oversight, management, and delivery of non-VA care: Patient-Centered Community Care (PCCC), which is still in development, and the Non-VA Care Coordination (NVCC) program. In earlier discussions with stakeholders, including this Subcommittee, VA has heard concerns regarding the implementation of PCCC and NVCC. I assure you, we are taking the necessary precautions to see that these initiatives provide timely, high quality medical care.

Patient-Centered Community Care (PCCC)

PCCC will consist of a network of centrally supported standardized health care contracts, available throughout VHA's Veterans Integrated Service Networks (VISN). This initiative will focus on ensuring proper coordination between VA and non-VA providers. PCCC is not intended to increase the purchasing of non-VA care, but rather to improve management and oversight of the care that is currently purchased. This includes improvements in numerous areas such as consistent clinical quality standards across all contracts, standardized referral processes, and timeliness of receipt of clinical information from non-VA providers. The goal of this program is to ensure Veterans receive care from community providers that is timely, accessible, and courteous, that honors Veterans' preferences, enhances medical documentation sharing, and that is coordinated with VA providers when VA services are not available.

While VA intends to administer these contracts directly, it has not yet determined how they will be managed. Additionally, VA is currently researching the appropriateness of incentives tied to performance standards to help ensure the selected contractors provide excellent customer service and timely care. VA conducted a business case analysis which compared the cost of purchasing care through individual authorizations and through regional contracts. The analysis showed that regional contracts are more cost-effective, with the cost/benefit ratio improving as participa-

tion increases. The PCCC contracts will cover inpatient and outpatient specialty care and mental health care. Primary care is not included in the solicitation because it is an essential function of VA and is the key to coordinating Veteran health care. Chronic dialysis is also excluded from the solicitation; currently 7 contracts and 19 Basic Ordering Agreements are in place nationally to purchase dialysis services, and these contracts are proving to be very successful in ensuring quality and accessible services are available for our Veterans close to where they live.

The original schedule for release of the Request for Proposal (RFP) and subsequent evaluation of proposals and award was first quarter fiscal year (FY) 2013. However, in an effort to strengthen the requirements, incorporate a broader range of ideas from key stakeholders such as our Veterans Service Organizations and the private sector, VA will release a draft RFP for comment before the release of the final RFP in the interest of making this effort a more effective solution. VA now plans to award the new contracts in late second quarter of FY 2013.

Non-VA Care Coordination (NVCC)

NVCC is VA's internal program to improve and standardize our processes for referrals to non-VA care. The NVCC model centers on effective referral management and consistency in documenting, tracking, managing receipt of supporting clinical documentation and coordinating patients in community health facilities. Through NVCC, non-VA care staff use standardized processes and templates for the administrative functions associated with non-VA care. VA successfully conducted initial pilot programs in VISNs 11 and 18 in FY 2011. VHA incorporated best practices from the pilot sites and created the structure that is currently being deployed to one champion site per VISN. All champion sites will be completed in late fall 2012. Full national deployment will be complete by the end of FY 2013.

Quality Standards

VHA exercises its responsibility to provide quality contracted care to Veterans through several clinical and business mechanisms. These include credentialing and privileging, quality and patient safety monitoring, medical documentation sharing requirements, financial and compliance reviews, and specific quality of care provisions included in the contract itself. Facility directors are responsible for ensuring that these oversight mechanisms are consistently and effectively applied to all medical services provided under contract in a VHA facility. Ensuring quality standards for VHA contracted care outside of a facility is more difficult, but VHA includes language in such contracts that requires industry standard accreditation or certification requirements are being met, clinical reporting occurs, and oversight mechanisms are in place to ensure that this care meets VA standards.

Rural Care

Project HERO (Healthcare Effectiveness through Resource Optimization) is a pilot program in VISNs 8, 16, 20, and 23 that helps eligible Veterans receive the care they need when it is not available at a VA facility. The objectives of Project HERO are to provide as much care as possible within VHA, efficiently refer Veterans to high quality community-based care, foster high quality care and patient safety, improve the exchange of information, and increase Veterans overall satisfaction of care. The Project is currently in its fifth year. Medical care is offered through contracts with Humana Veterans Healthcare Systems (HVHS) and Delta Dental Federal Government Programs (Delta Dental). Project HERO provides Veterans with access to a pre-screened network of medical and dental providers who meet VA standards for quality care. These providers must meet VA defined standards for credentialing, accreditation, and quality. Specifically, these contracts require that HVHS and Delta Dental have quality management programs that comply with VA, Joint Commission, Federal, and state requirements.

Once VA determines that contract care is appropriate, HVHS and Delta Dental communicate directly with Veterans to schedule appointments, and Veterans see HVHS or Delta Dental doctors or dentists. Requests for additional services must be referred back to VA, which allows the Department to coordinate each patient's care and maintain oversight of each patient's care needs. Following each appointment, HVHS and Delta Dental providers send patient records and invoices to HVHS and Delta Dental, which in turn submit medical records and claims to VA.

VA learned many lessons from Project HERO and is using this information to develop the PCCC contracts. We also realized success in several key measures, such as scheduling and completing appointments within 30 days and receiving updated clinical information within 30 days. We confirmed that we can ensure availability

of credentialed and accredited providers that meet our standards for care. Additionally, when compared to traditional fee basis care, Project HERO has yielded a significant cost savings, amounting to more than $27 million through July 2012.

The lessons learned over the course of Project HERO will be incorporated into PCCC as it is fully implemented. To ensure a smooth transition from Project HERO to PCCC, VA has notified HVHS of its intent to extend the current medical/surgical services contract until March 2013. This extension will help ensure Veterans currently seeing a Project HERO provider have no disruption of service while the PCCC contracts are being awarded. The extension will also allow VA medical centers in those four VISNs to continue taking advantage of the quality, access, and medical documentation sharing requirements in the Project HERO contract. If the PCCC contracts are not in place by the expiration of this extension, VA will ensure Veterans will still receive timely and quality non-VA care through the use of individual authorizations.

Additionally, VA's Office of Rural Health has implemented a 3-year pilot program to provide health care services through contractual arrangements with non-VA care providers—Project ARCH (Access Received Closer to Home). This pilot intends to improve access for eligible Veterans by connecting them to health care services closer to home. Five pilot sites have been established across the country: Caribou, ME; Farmville, VA; Pratt, KS; Flagstaff, AZ; and Billings, MT. On July 29, 2011, health care delivery contracts were awarded to: Humana Veterans in VISNs 6, 15, 18, and 19, and Cary Medical Center in VISN 1. This program became operational on August 29, 2011.

Conclusion

As the Nation's only health care system designed specifically to treat Veterans, VA offers services and benefits unavailable elsewhere. This system has been designed and continuously updated to respond to the unique needs of Veterans in an environment that understands and honors their military service. For these reasons, VA's first preference is to provide care to Veterans within its system, but we recognize that we cannot provide the necessary care to every Veteran in our facilities, which is why we utilize non-VA services where appropriate. Veterans receiving care from non-VA sources should rightfully expect the same quality care from these providers as they would receive from ours. Consequently, VA has developed a strategy to improve its purchased care programs to achieve quality improvements and cost savings. This strategy entails greater use of standardized contracts through PCCC and better referral management through NVCC. We are currently in a moment of transition for VA's purchased care program, and we appreciate the advice and counsel of our stakeholders—the Veterans we serve, the Service Organizations that represent them, and Congress—as we proceed.

Madam Chairwoman and Mr. Ranking Member, VA has utilized its authorities to provide eligible Veterans quality care in non-VA settings. We have also instituted new models and controls to ensure Federal resources are used appropriately. We appreciate the opportunity to appear before you today. My colleagues and I are now prepared to answer your questions.

Prepared Statement of the Office of the Inspector General, U.S. Department of Veterans Affairs

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to provide testimony concerning the Office of Inspector General's (OIG) work related to VA's purchase of health care services for veterans from non-VA providers. As health care costs continue to increase, ensuring that VA has strong controls over purchased care activities is a critical aspect of providing the health care veterans need.

Over the past 3 years, the OIG has issued seven reports [1] on VA's fee care program. Our audits and reviews of fee care have identified significant weaknesses and

[1] Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (August 3, 2009); Audit of Non-VA Inpatient Fee Care Program (August 18, 2010); Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program (June 8, 2010); Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (November 8, 2011); Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado (April 12, 2012); and Review of Enterprise Technology Solutions, LLC, Compliance with

inefficiencies. Specifically, we found that VA had not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly contracted and billed.

BACKGROUND

Title 38 of the United States Code permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA facilities, when VA medical centers (VAMCs) cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. At the time of our initial work in fiscal year (FY) 2008, the Veterans Health Administration's (VHA) medical care budget totaled approximately $39 billion. In FY 2011, the medical care budget increased to about $48 billion. We estimate that of this amount, VHA spent about $4.6 billion to purchase health care services from non-VA entities such as other government agencies, affiliated universities, community hospitals, nursing homes, and individual providers. VHA uses various mechanisms to purchase health care services, including sharing agreements with affiliated universities and the Department of Defense, Federal Supply Schedule (FSS) contracts, the Non-VA Fee Care Program, Project HERO, and the Foreign Medical Program. According to VHA managers, the authority to purchase services from non-VA sources helps to improve veterans' access to needed health care services, in particular specialty care that may not be available at VAMCs.

OIG REPORTS *Audit of Non-VA Outpatient Fee Care Program*

At the time of our audit in FY 2008, 137 VAMCs processed an estimated 3.2 million outpatient fee claims at a cost of about $1.6 billion. These claims were for a wide range of diagnostic and therapeutic services including visits to primary care physicians, x-rays and diagnostic imaging procedures, chemotherapy and radiation therapy, dialysis, physical therapy, and outpatient surgical procedures. Based on our review of a statistical sample of 800 claims, we concluded that VHA had not established adequate management controls and oversight procedures to ensure that claims for outpatient fee services were accurately paid, justifications for services were adequately documented, and services were properly pre-authorized. We concluded that the improper payments, justifications, and authorizations occurred because VHA had not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. For example:

VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimated that in FY 2008, VAMCs overpaid $225 million and underpaid $52 million to fee providers, or about $1.13 billion in overpayments and $260 million in underpayments over 5 years.

For 80 percent of outpatient fee claims we reviewed VAMCs did not adequately document justifications for use of outpatient fee care or properly pre-authorize services as required by VHA policy, thereby increasing the risk of additional improper payments.

We identified three specific areas that required strengthening:

Comprehensive Fee Policies and Procedures—VHA did not have a centralized source of comprehensive, clearly written policies and procedures for the Fee Program. Instead, fee supervisors and staff had to rely on an assortment of resources including the Code of Federal Regulations, outdated VA policy manuals, and other procedural guides, training materials, or informal guidance.

Identification of Core Competencies and Required Training for Fee Staff—Because the Fee Program is very complex and requires significant judgment by fee staff to ensure correct payments, processing fee claims requires specialized knowledge and skills, such as understanding medical records, insurance billing concepts, and medical procedure coding. However, VHA did not require fee staff or their supervisors to attend initial or refresher training.

Clear Oversight Responsibilities and Procedures—Strong oversight of the Fee Care Program should include procedures and performance metrics for assessing compliance with program requirements, conducting risk assessments, assessing program controls, and monitoring accuracy and quality of claims processing. However, no one from VHA's Chief Business Office, National Fee Program Office, Veterans Inte-

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Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations (August 20, 2012).

grated Service Networks, or Compliance and Business Integrity Office was routinely performing oversight activities of the Fee Program.

We made eight recommendations to strengthen controls over the Outpatient Fee Care Program. The Under Secretary for Health agreed with the findings and recommendations and has since implemented all the recommendations.

Audit of Non-VA Inpatient Fee Care Program

In our report, *Audit of Non-VA Inpatient Fee Care Program*, we estimated that VAMCs had a combined authorization error and improper payment rate of 30 percent during the 6-month period of January 1, 2009–June 30, 2009.[2] VAMC staff made authorization errors because VHA's policies did not provide adequate guidance on how to determine eligibility for inpatient fee care or were not understood by fee staff. Payment errors occurred because fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors. We estimated that VHA made net overpayments of $120 million on inpatient care for veterans in FY 2009 or $600 million in improper payments over 5 years. For example:

VAMCs improperly paid 9 percent of all inpatient fee claims by authorizing non-emergency inpatient fee care for veterans who were not eligible for this care. These errors occurred because VHA's policy did not adequately address how to determine eligibility for non-emergency inpatient fee care.

VAMCs improperly paid 4 percent of all inpatient fee claims by authorizing emergency care for veterans who were ineligible for this care. These errors occurred because fee staff did not understand the individual eligibility criteria for emergency inpatient fee care, such as the authorized treatment must be related to a service-connected disability.

VAMCs paid improper amounts for 17 percent of pre-authorized inpatient fee claims. VAMCs made three types of payment errors; they did not:

- Know where to find inpatient transfer information needed to determine when to apply per diem payment methodology.
- Utilize Preferred Pricing Program rates because the Program process was not timely.
- Pay other proper rates because fee staff were provided with inaccurate rate information or made clerical errors.

We made recommendations to establish guidance on how to determine eligibility, to develop and implement mandatory training on eligibility criteria for inpatient fee care, to establish guidance on where to find inpatient transfer information needed to determine when to apply the per diem payment methodology, and to implement a quality control mechanism to address the types of payment errors identified by this audit. The Under Secretary for Health agreed with the findings and recommendations and has since implemented the recommendations.

Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program

As a result of the identification of the lack of outpatient and inpatient fee care program controls and the problems reported in other Federal medical programs, we also reviewed the fee care's fraud program and controls. In June 2010, we completed a review that determined VHA had not established controls designed to prevent and detect fraud primarily. This occurred because it had not identified fraud as a significant risk to the Fee Care Program, even though VHA's Fee Care Program is not significantly different from other health care programs that have identified numerous cases of fraud. We estimated that the program could be paying between $114 million and $380 million annually for fraudulent claims. We recommended that the Under Secretary for Health establish a fraud management program that includes such fraud controls as data analysis and high-risk payment reviews, system software edits, employee fraud training, and fraud awareness and reporting. The Under Secretary for Health agreed with our finding and recommendation and completed all corrective actions.

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[2] The population of claims consisted of 32,380 non-VA inpatient claims valued at approximately $386.2 million for the 6-month period. Our review was of 791 inpatient fee claims valued at $10.6 million which identified 235 payments errors valued at $1.6 million. We found 181 overpayments valued at $1.7 million and 54 underpayments valued at about $25,000.

Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System

In November 2011, we issued *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* approximately 2½ years since we issued our first report on the Fee Care Program. However, we found that this medical facility mismanaged fee care funds and experienced a budget shortfall of $11.4 million or 20 percent of their FY 2010 fee care program funds. We concluded that the authorization procedures were so weak that the Phoenix Health Care System (HCS) processed about $56 million of fee care claims without adequate review.

The reason for the shortfall was the lack of effective pre-authorization procedures, a problem we reported in August 2009. The Phoenix HCS did not have effective pre-authorization procedures for fee care because the physician who was responsible for reviewing and pre-authorizing virtually all of the of fee care claims routinely approved requests for fee care with no substantive questions or requests for additional information. Further, the medical facility did not have adequate procedures to obligate sufficient funds to ensure it could pay its commitments for these services.

The mismanagement of fee authorization procedures at the Phoenix HCS highlights the risks to the Non-VA Fee Care Program, such as authorizing:

Diagnostic tests or procedures that are not medically necessary.

Services that are available at a VA medical facility.

Unnecessary and often excessive numbers of medical treatments.

Our recommendations included the establishment of monitoring procedures to ensure that the official designated to pre-authorize fee care thoroughly review fee care requests and that fee staff obligate sufficient funds for approved fee care. The Interim Director of the Phoenix HCS agreed with our findings and recommendations and is working to implement our recommendations.

Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado

The OIG Administrative Investigations Division recently completed an administrative investigation regarding the Deputy Chief Business Officer for Purchased Care. We substantiated that the Deputy Chief Business Officer for Purchased Care engaged in improper contracting activities by instructing subordinates to issue sole-source task orders to one specific contractor and engaged in a conflict of interest when failing to maintain an arm's-length relationship with two VA contractors.

This is significant because VHA's Patient-Centered Community Care (PCCC) initiative proposes to purchase non-VA care by contracting with various provider networks. The engagement of improper contracting practices at the senior executive level and previous OIG findings on ineffective and improper contracting in the Department, only highlights our concerns that VA must ensure proper controls are implemented and monitored before, during, and after contracts are awarded. In addition, responsible contract officers and contracting officers' technical representatives (COTRs) must be properly trained and supervised to effectively oversee PCCC vendors.

Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations

The OIG Office of Contract Review initiated and conducted a compliance review of subcontracting limitations contained in five contracts with Enterprise Technology Solutions, LLC (ETS) for re-pricing fee claims. The review was initiated after VHA requested an audit of a claim submitted by ETS regarding an unauthorized commitment that VHA procurement officials appropriately refused to ratify. ETS is a service-disabled veteran-owned small business (SDVOSB) concern and all five contracts for re-pricing fee claims were awarded as SDVOSB set-asides.

We determined that ETS subcontracted all of the re-pricing tasks to its subcontractor Health Net Federal Services (Health Net), a large business. We concluded that ETS did not process any of the claims nor did they have the expertise or capability of re-pricing claims and never intended to perform the work. Health Administration Center contracting personnel were fully aware that ETS was subcontracting all of the work to Health Net in violation of the provision in the contract limiting

subcontracting because ETS had VA forward all claims directly to Health Net for processing.

Based on work conducted by the Office of Contract Review and by the Office of Healthcare Inspections, we also determined that the revised regulations implemented in February 2011 allow for VA to use the amount submitted by a re-pricer if the amount is lower than the Medicare rate established by the Centers for Medicare and Medicaid Services. We found that the amounts submitted by the re-pricer were not lower than the established Medicare rates; therefore, we questioned whether VA was overpaying for the services given the hierarchy for payment established in the regulations. We also questioned whether it was fiscally sound to pay for both a Medicare pricer and a re-pricer to review each claim for VA to determine which is lower. This is especially true given the significant fees paid to the re-pricer regardless of whether there was a cost savings.

We made seven recommendations to the Under Secretary for Health: terminate the five ETS contracts for claims re-pricing; determine if there is a need for any contract(s) to re-price non-VA care fee claims; ensure that the requirements for future contracts do not preclude competition; establish procedures to ensure that all non-VA fee claims are submitted to VA's Medicare pricer; determine whether claims re-pricing for non-VA care have resulted in rates that are lower than Medicare rates; implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition; and ensure justifications for sole-source awards receive appropriate approvals. The Under Secretary for Health concurred with our findings and recommendations. The contracts with ETS were terminated for cause in August. We will follow up on the remaining planned actions until implemented.

CONCLUSION

While purchasing health care services from non-VA providers may afford VHA flexibility in terms of expanded access to care and services that are not readily available at VAMCs, it also poses a significant risk to VA when adequate controls are not in place. Although the Under Secretary for Health agreed to our recommendations and provided implementation plans to correct identified issues, VHA still faces major challenges managing the fee care program. Improper contracting practices as reported in other OIG reports only highlight our concerns that VA must ensure proper controls are implemented and monitored before, during, and after contracts are awarded, and responsible contract officers and COTRs must be properly trained and supervised to effectively oversee future PCCC vendors.

Prepared Statement of Paralyzed Veterans of America

Chairwowan Buerkle, Ranking Member Michaud, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for allowing us to submit a statement for the record on the issue of health care purchased by the Department of Veterans Affairs (VA) and delivered outside of the health care system—commonly referred to as fee-basis care. There is no doubt that fee-basis care provides an important tool to the VA in order to provide quality, timely health care services when those services are not readily available in the system or when that care is geographically inaccessible to a veteran.

As we have stated many times in the past, it is the position of PVA that the VA is the best health care provider for veterans. The VA's unique "veteran specific" expertise is unrivaled. However, the VA serves a large veteran population with a myriad of complex medical needs, and when the VA is not able to provide that care it must partner with community providers through its Non-VA Care program.

The Non-VA care program provides contracted care services that are authorized at the discretion of VA leadership. The contracted services are reserved for veterans who have sustained a service-connected disability, or a disability for which a veteran was discharged or released from active duty, and provided when the VA is not capable of delivering the needed care, or such services are geographically inaccessible.

Over the years, PVA has remained concerned about the non-VA health care services provided to veterans as it relates to the VA's ability to monitor the quality of care delivered, as well as the lack of a system to facilitate care coordination with non-VA providers so that veterans have a seamless exchange between the two systems. One mechanism used by the VA that began to address these concerns was the implementation of pilot project Healthcare Effectiveness through Resource Optimi-

zation (Project HERO). The VA implemented Project HERO as a pilot in selected Veterans Integrated Service Networks (VISNs) to identify how a system could manage care that is provided through contracts with non-VA providers when the VA is not able to provide health care services to veterans. The pilot focused on objectives such as health care access, patient safety, and care coordination.

As the pilot is in its fifth and final year, the VA has identified the Patient Centered Community Care (PCCC) initiative and the Non-VA Care Coordination (NVCC) program to improve its Non-VA Care program. While the Project HERO pilot resulted in some positive outcomes and lessons upon which the VA can build an improved Non-VA Care program, PVA still has concerns regarding the implementation and management of the PCCC and NVCC programs. Most importantly, we remain concerned about the VA's ability to monitor the quality of non-VA health care services, and coordinate care with outside providers.

Patient Centered Community Care (PCCC) and Non-VA Care Coordination (NVCC)

The VA describes the PCCC program as a centralized system to manage non-VA provider contracts. Specifically, through PCCC the VA intends to create a standardized contract referral process that will allow veterans to receive care outside of the VA, when necessary and authorized, in a timely and coordinated manner. In conjunction with PCCC, the NVCC program will focus on referrals for non-VA health care services. NVCC will also require that non-VA providers utilize required VA procedures and processes to allow for an exchange of information between providers and facilitate care coordination.

PVA appreciates that these two programs combined, in theory, address our concerns regarding the quality of non-VA purchased care and the VA's ability to coordinate such care, and creates a permanent system to better manage non-VA contracted care. However, we believe that the success of PCCC and NVCC depends on the VA establishing systems that allow for a seamless exchange of information between non-VA providers and the VA, and the VA's ability to collect data to measure the quality of non-VA care.

While the VA is in the implementation phase of re-creating its fee-basis care program and has not yet commenced PCCC and NVCC in all VISNs, it also has not provided details on the systems that will need to be in place to guarantee care coordination. Of particular concern to PVA is the transition phase when Project HERO has ended and PCCC and NVCC are expected to begin. If these two programs are not fully implemented when Project HERO ends, what happens to those veterans already receiving care coordinated through Project HERO? Coordination of veterans' care cannot be compromised during this transition.

One of the major components of PCCC and NVCC is having a system that allows for care-coordination. Care-coordination requires systems that exchange information that is timely and reliable. As the Project HERO pilot is ending, it is essential that VA ensure that the technological capabilities and the systems that are capable of sharing data, standardized templates, and programs with private providers are in place when PCCC and NVCC are implemented to coordinate care with community providers.

In order to support a system of care coordination between VA and community providers, a system for electronic information exchange must be a strong foundation. A primary goal for both the PCCC and NVCC programs should be to enable VA and non-VA providers to exchange information in a timely manner. Such information includes medical records, medical documentation, and payment information. If such a system for exchange of information is not available when the Project HERO pilot ends and these programs begin, then we believe the VA will be moving in the wrong direction.

It is also important to note that care coordination not only involves the VA and community providers, but must also include veterans. Veterans must have access to support services through the VA as they seek non-VA purchased care and referrals. As previously stated, PVA strongly believes that the VA is the best health care provider for veterans and as such we recommend that the NVCC program work closely with veterans' Patient Aligned Care Teams to coordinate with community providers and ensure that veterans continue to receive their care through the VA health care system while receiving authorized treatments from outside (contract) providers. Another serious concern for PVA is quality management. How will the VA manage the quality of care provided to veterans by non-VA providers? PVA believes that PCCC and NVCC programs must collect data on quality metrics such as patient satisfaction, safety and timeliness to adequately measure the quality of care provided by non-VA facilities. Such information not only serves as important

metrics to identify areas for improvement, but also allows VA to hold private providers accountable for providing care that meets VA's standards for quality. The VA must make certain that non-VA providers consistently provide veterans with timely, quality care that is patient-centric.

PVA understands that as the health care demands of veterans continue to evolve, and enrollment in VA's health care system increases, so too does the need to partner with community providers. This partnership must be well managed, veteran-centric, and serve as a supplement to the quality of VA health services. PVA believes that the VA is moving in the direction of improving its non-VA purchased care program; however, many pertinent details are not in place. As the VA determines how to best implement PCCC, PVA believes that the VA must exercise its power to give final authorization to the providers with which it is entering contracts. Additionally, VA must determine the selection criteria to ensure that its quality standards for health care delivery are not compromised, and that the care provided meets VA's other standards for safety and patient satisfaction.

Until PCCC and NVCC can be implemented with the systems that will allow electronic exchange of patient information and the collection of quality metrics, PVA recommends VA extend the Project HERO pilot program, and extend its existing fee-basis program as part of a continuing safety net for veterans. We also strongly encourage continued oversight from this Subcommittee to monitor the progress of the VA implementing these systems. Meanwhile, we must reemphasize that as the VA works to improve its purchased care and care coordination programs, foremost remains the fact that none of these initiatives should be designed to replace the high quality of care provided by the VA health care system. These programs should only serve to provide access to care where it is not readily available within the VA system.

Chairwoman Buerkle, and Members of the Subcommittee, once again PVA thanks you for holding this hearing on such an important issue for the many sick and disabled veterans who are unable to directly access VA facilities for their care. We also thank VA leadership for keeping veteran service organizations informed and involved during this process. We look forward to working with both the Subcommittee and VA leadership to improve the delivery of veterans' health care services, whether those services are provided directly from VA, or through effective contract arrangements.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

Fiscal Year 2012

No Federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$262,787.

Fiscal Year 2010

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$287,992.

Prepared Statement of National Coalition for Homeless Veterans

Chairwoman Ann Marie Buerkle, Ranking Member Michael Michaud, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health.

The National Coalition for Homeless Veterans (NCHV) is honored to present this Statement for the Record for the hearing, "VA Fee Basis Care: Flawed Policies Not a Fix for a Flawed System," on Sept. 14, 2012. On behalf of the 2,100 community- and faith-based organizations that NCHV represents, we thank you for your commitment to serving our Nation's most vulnerable heroes.

VA's "no wrong door" approach

The Department of Veterans Affairs (VA) strives to make world-class health services available to veterans in communities nationwide. Yet to directly provide equitable care in every locality would stretch VA resources thin beyond recognition. A robust contract-care program, therefore, is needed to supplement VA care, harnessing existing service delivery systems in areas where veterans do not have reasonable access to the department's health facilities.

NCHV recognizes the potential of the VA fee basis care program to fill this role. In fact, the program could be well-situated to help fulfill VA's self-described "no wrong door" approach to ending veteran homelessness, in which veterans who seek assistance can receive it from VA programs, from community partners or through contract services.[1]

Unfortunately, this philosophy is at odds with reality. The fee basis program requires that veterans obtain preauthorization for non-VA care at a VA medical facility. In some cases, this means that a veteran must travel hundreds of miles—passing several qualified community providers along the way—in order to apply for fee basis care with no guarantee they will succeed.

For veterans with mental illness, chronic substance abuse and other disabilities, this practice is exclusive rather than inclusive. A daytrip to a distant VA medical facility may be unrealistic even for relatively healthy veterans, especially if they are among the 1.4 million with extreme low incomes.

Financial stewardship issues

Homeless veteran service providers know better than most the impact that limited VA dollars can have on entire communities. In light of the fee basis program's record of financial stewardship, we join those who call for its immediate reform.[2]

In FY 2011, the fee basis program accounted for an estimated $500 million in erroneous payments, according to the Veterans Health Administration Chief Business Office. By any measure, this is a tremendous loss of taxpayer dollars. By our measure, this amounts to more than VA's expenditures in FY 2013 on *both* the HUD–VA Supportive Housing (HUD–VASH) Program—directly responsible for reduction in chronic veteran homelessness—and the Homeless Providers Grant and Per Diem (GPD) Program, which has been the cornerstone of community-based homeless veteran assistance for more than two decades.

An effective reform of the fee basis program should represent a significant departure from existing policies, and must shift the burden of responsibility for authorized care from the veteran to the VA health care system.

Legislative proposals and departmental initiatives

NCHV submitted written testimony to this Subcommittee in April 2012 regarding H.R. 3723, Rep. Bobby Schilling's "Enhanced Veteran Healthcare Experience Act of 2011." As originally written, this bill would replace the current fee basis system with a contract-based "veterans enhanced care program." While we recognize that this legislation may not be a cure-all for the fee basis program's deficiencies, we are supportive of an approach to make much-needed health services accessible to veterans who live in areas without a VA presence.

VA does not support H.R. 3723, but it is undertaking new initiatives that seek to expand and improve its contract-based care, among them the Patient-Centered Community Care (PCCC) program. The PCCC program will foster contractual agreements with non-VA providers when VA facilities are not able to provide needed specialty care for veterans.[3] It is fair to say that this program has not been given an opportunity to succeed, as it is in the early stages of implementation.

It is our understanding, however, that the program will not cover mental health services, primary care and dialysis.[4] This may be precisely the support that some

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[1] "VA Secretary Announces $41.9 Million to Help Homeless," *U.S. Air Force* (Oct. 5, 2010). Accessed Sept. 10, 2012. <*http://www.af.mil/news/story.asp?id=123225103*>.

[2] *Veterans Health Administration Fee Care Program: White Paper*. National Academy of Public Administration (September 2011). Accessed Sept. 7, 2012. <*http://www.napawash.org/wp-content/uploads/2011/11/White_Paper11012011webposting.pdf*>.

[3] "Patient Centered Community Care (PCCC) Notice" (Nov. 3, 2011). Accessed Sept. 11, 2012. <*https://www.fbo.gov/*>.

[4] "Witness Testimony of Shane Barker, Senior Legislative Associate, Veterans of Foreign Wars," *U.S. House Committee on Veterans' Affairs* (April 16, 2012). Accessed Sept. 8, 2012. <*http://veterans.house.gov/witness-testimony/shane-barker-2*>.

veterans need to avoid entering what VA Secretary Eric Shinseki has characterized as "that downward spiral towards joblessness, depression and substance abuse that often leads to homelessness and, sometimes, to suicide."[5] If we are going to strive for a "no wrong door" approach to ending veteran homelessness, it must apply to health services through the PCCC program as well.

In Summation

Thank you for the opportunity to submit this Statement for the Record for today's hearing. It is a privilege to work with the House Committee on Veterans' Affairs, Subcommittee on Health, to ensure that every veteran in crisis has reasonable access to the health care they earned.

John Driscoll
President and CEO
National Coalition for Homeless Veterans

NCHV Staff Biography
John Driscoll, President and CEO

John Driscoll joined the staff of NCHV in January 2002. He served in the U.S. Army from 1970–1980, including a tour as an air-evac medic and platoon sergeant with the 575th Medical Detachment during the Vietnam War. After returning from Vietnam, he served as the senior clinical specialist on the Surgical Intensive Care Unit of the Walter Reed Army Medical Center in Washington, D.C., from 1973–1980, and remained a certified medevac specialist for both fixed-wing and helicopter aircraft until his discharge from the service.

Driscoll graduated from the University of Maryland with a Bachelor of Arts degree in journalism in 1988, and spent 13 years as a group newspaper editor for the Chesapeake Publishing Corporation. As a journalism student intern in 1987, he wrote a series on homeless veterans living on the streets of the Nation's capital which was submitted for Pulitzer Prize consideration in two categories by Chesapeake Publishing.

Significant publishing credits while working with NCHV, in partnership with the Department of Labor-Veterans Employment and Training Service (DOL–VETS), include "Planning for Your Release, A Guide for Incarcerated Veterans," distributed to more than 20,000 employment specialists, transition assistance counselors and incarcerated veterans—this guide was adapted by the Department of Veterans Affairs for its state-specific transition resource guides; "Assistance Guide for Employment Specialists Helping Homeless Veterans," used by DOL–VETS as a training resource for homeless assistance providers; and the "HVRP Best Practices Project," a study of 36 community-based programs cited for exemplary performance in helping formerly homeless veterans prepare for and obtain steady, gainful employment.

Driscoll is responsible for the development of the NCHV Web site (*www.nchv.org*) into the most comprehensive homeless veteran assistance on-line resource in the Nation, providing information and service referrals to more than 85,000 visitors each month. His work with veteran assistance programs nationwide gave rise to the Nation's first Veteran Homelessness Prevention Platform in 2006, a document that has helped steer development of initiatives to reduce the risk of homelessness for veterans of the wars in Afghanistan and Iraq, and their families. Eleven of the 18 recommendations in that document have been signed into law or are in various stages of development.

Driscoll has prepared testimony and has testified before both the U.S. House of Representatives and U.S. Senate on a number of landmark homeless veteran assistance initiatives since 2005. He meets regularly with the leadership of Federal agencies invested in homeless veteran services, and is frequently invited to speak as a subject matter expert on homeless veterans issues and assistance programs at conferences and symposia nationwide.

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[5] "Remarks by Secretary Eric K. Shinseki: 2012 National Coalition for Homeless Veterans (NCHV) Annual Conference," *Department of Veterans Affairs* (May 30, 2012). Accessed Sept. 10, 2012. <*http://www.va.gov/opa/speeches/2012/05_30_2012.asp*>.

NCHV Disclosure of Federal Grants

Grantor:	U.S. Department of Labor
Subagency:	Veterans' Employment and Training Service
Grant/contract amount:	$350,000
Performance period:	8/13/2010–8/12/2011
Indirect costs limitations or CAP limitations:	20 percent total award
Grant/contract award notice provided as part of proposal:	Yes
Grantor:	U.S. Department of Labor
Subagency:	Veterans' Employment and Training Service
Grant/contract amount:	$350,000
Performance period:	8/13/2011–8/12/2012
Indirect costs limitations or CAP limitations:	20 percent total award
Grant/contract award notice provided as part of proposal:	Yes

MATERIAL SUBMITTED FOR THE RECORD

Questions from Honorable Michael H. Michaud and responses from Honorable Dr. Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

September 14, 2012
Hearing on
VA Fee Basis Care: Examining Solutions to a Flawed System

Questions for the Honorable Dr. Robert A. Petzel, M.D.,
Under Secretary for Health,
Veterans Health Administration,
U.S. Department of Veterans Affairs

Question 1: Painful and disabling joint and back disorders continue to be reported as the top health problems of veterans returning from overseas. According to a report in the *Journal of General Internal Medicine,* diseases of the musculoskeletal and connective system, the precise maladies doctors of chiropractic (DC) treat, is the *primary health issue diagnosed* among veterans returning from combat theatres of operation with over 56 percent of veterans reporting this ailment. Further, the report recommends that veterans suffering from musculoskeletal injury with chronic pain be transitioned off opiates to alternative analgesics, including referral to a Doctor of Chiropractic, which is consistent with the widely recognized belief that chiropractic is one of the safest drug-free, non-invasive therapies available for the treatment of chronic musculoskeletal pain. **Given the magnitude of this problem and serious complications and costs associated with the extended use of opiates, do you think the DVA should develop a program involving both on-site and off-site DCs to help provide an avenue of treatment that would provide an alternative to the use of these drugs? If this has not been considered wouldn't it be a good idea for the DVA to explore doing so?**

Response: Department of Veterans Affairs (VA) currently provides chiropractic services both on-site at VA facilities, and off-site using community Chiropractors as needed. At the end of fiscal year (FY) 2012, 38 VA facilities offered chiropractic care totaling more than 98,000 patient visits, while VA also provided similar services on a fee basis means at over 4,000 non-VA facilities to more than 9,000 Veterans in FY 2012. Chiropractic services have been embraced by VA providers and Veterans as an appropriate option in pain management treatment. Between FY 2008 and FY 2011, the number of Veterans receiving chiropractic care increased by 67 percent for on-station and by 82 percent for fee basis. In March 2012, the Under Secretary for Health (USH) directed VA's Office of Rehabilitation Services to review the current utilization of chiropractic services and strategies that support continued awareness and access to utilization. Utilization of chiropractic services within VA will continue to be monitored and reported regularly to the USH to ensure that availability, access, and utilization of services within VA continues to meet Veterans' needs.

Chiropractic care is provided in the context of a comprehensive National Pain Management Strategy that promotes multidisciplinary and integrated care. Although opioid therapy is one important pain management strategy, VA/DoD Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain emphasize strategies for promoting the safe and effective use of opioid therapy in the context of a comprehensive, integrated Veteran-centered treatment plan. To support this approach, VA is working diligently to build its capacity to manage most common pain conditions in the primary care setting while providing routine and timely Veteran access to specialty pain medicine, rehabilitation, behavioral health, complementary and alternative medicine, and other specialty pain management services, when indicated. VA is also committed to developing Commission on Accreditation of Rehabilitation Facilities (CARF) accredited tertiary, interdisciplinary pain rehabilitation programs in each Veterans Integrated Service Network (VISN). Through this effort, chiropractic services are represented in the planning and dissemination of guidance on pain management options within these programs.

Question 2: Where there are Doctors of Chiropractic on staff at DVA treatment facilities, I understand the arrangement is working very well. Referrals are taking place—and this obviously wouldn't be taking place if the PCM's did not think it was appropriate to do so. What about locations without a DC on staff. **Does the DVA have a plan to place DCs at all major DVA treatment facilities? If not, why not? If yes, how long before this plan will be fully implemented? In locales without DCs on staff has the DVA engaged in a formal education campaign to inform beneficiaries of their ability to obtain a referral to a DC? If not,**

why not? Obviously, if a patient does not know he or she has access to chiropractic care as an alternative they probably aren't going to ask for it.

Response: VA policy is that each Veterans Integrated Service Network must have an on-station chiropractic clinic located at a minimum of one facility, while other facilities can provide the service either on-station or by non-VA care per Veterans Health Administration (VHA) Directive 2004–35. Chiropractic care is part of the standard benefits package and is included in the list of available services made known to all Veterans. While VA does not currently have a plan to place Chiropractors at all major treatment facilities, decisions on use of chiropractic services for musculoskeletal conditions are made by the individual VA facilities. VA facilities make staffing determinations by assessing their local needs and resources, including the need for chiropractic services and available options. A fact sheet listing current VA on-station chiropractic clinics, as well as a table reflecting patients seen by chiropractic by facility over for FY 2008–FY 2011 is attached (attachment 1 and 2).

A VHA multidisciplinary group recently completed a utilization review of chiropractic services in VA, and implemented a plan to increase awareness, access, and utilization of chiropractic services across VA. Utilization of chiropractic services will continue to be monitored and reported regularly to the Under Secretary for Health through fiscal year FY 2013 to ensure that availability, access, and utilization of services in VA continues to increase.

VA Chiropractic Services

Since late 2004, chiropractic services have been included as part of the Medical Benefits Package (Standard Benefits) available to all enrolled Veterans. As with all specialty services, a chiropractic consultation request must be initiated by any VA provider who is caring for the Veteran.

VA provides these services on-site at one or more VA facilities in each VISN. If a VA facility does not have an on-site chiropractic clinic it will provide chiropractic services via the fee-basis mechanism. The decision to use on-station vs. fee-basis chiropractic services is made at the facility level.

As of September 2011 the following VA facilities have established on-site chiropractic clinics:

VISN	Location
1	Togus, ME
	West Haven, CT
	Newington, CT
2	Buffalo, NY
	Batavia, NY
	Canandaigua, NY
	Rochester, NY CBOC
	Bath, NY
	Syracuse, NY
3	Bronx, NY
4	Butler, PA
5	Martinsburg, WV
6	Salisbury, NC
7	Augusta, GA
8	Tampa, FL
	Miami, FL
	Oakland Park, FL
9	Mountain Home, TN
10	Columbus, OH
	Dayton, OH
	Chillicothe, OH
11	Danville, IL
12	Iron Mountain, MI
	Tomah, WI
15	Kansas City, MO
	St. Louis, MO
	Poplar Bluff, MO
16	Jackson, MS
17	Dallas, TX

VISN	Location
	Temple, TX
	Austin, TX
	San Antonio, TX
18	Phoenix, AZ
	Albuquerque, NM
19	Ft. Harrison, MT
20	American Lake, WA
21	Sacramento, CA
	Redding, CA
	Martinez, CA
22	West Los Angeles, CA
	Sepulveda, CA
	Loma Linda, CA
	Las Vegas, NV
23	Sioux Falls, SD

References

General VA Medical Benefits

http://www.va.gov/healtheligibility/coveredservices/StandardBenefits.asp

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Questions from the Honorable Michael H. Michaud and responses from Jacob B. Gadd, Deputy Director for Healthcare, The American Legion

October 22, 2012

Honorable Michael H. Michaud
Ranking Democratic Member
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Ranking Member Michaud:

Thank you for allowing The American Legion to participate in the Subcommittee on Health hearing entitled "VA Fee Basis Care: Examining Solutions to a Flawed System" on September 14, 2012. I respectfully submit the following in response to your question:

1. **"Many studies have shown us that the VA is not the proficient in paying claims. In fact, their track record for over paying and underpaying providers is not very good. Some of that is due to ineffective training of those who process the claims. What are your organization's thoughts on the pros and cons of contracting out this process?**

The American Legion currently adopted Resolution no. 46, Department of Veterans Affairs (VA) Non-VA Care Coordination Programs at the fall 2012 National Executive Conference meetings in Indianapolis. In the resolution, The American Legion recommends VA 1) develop a non-VA care coordination that is patient-centered and takes their travel and distance into account; 2) implement a military culture and evidence-based treatment training program for non-VA providers to ensure veterans receive the same or better quality of care and 3) provide non-VA providers with full access to VA's Computer Record System (CPRS) to ensure the contracted community provider can review the patient's full medical history which allows the community provider to meet all of the quality of care screening and measures tracked in CPRS. A copy of this resolution is attached in this letter for your review and reference.

In regards to your specific question as to whether VA should outsource its non-VA provider payment system, The American Legion presently does not have an official position.

The American Legion appreciates the opportunity to provide written comments to your question and looks forward to working with you on behalf of our Nation's veterans.

Sincerely,

Jacob B. Gadd
Deputy Director for Healthcare
The American Legion

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