

**CHOICE CONSOLIDATION: ASSESSING VA'S PLAN
TO IMPROVE CARE IN THE COMMUNITY**

HEARING

BEFORE THE

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

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CONTENTS

Wednesday, November 18, 2015

	Page
Choice Consolidation: Assessing VA's Plan To Improve Care In The Community	1
OPENING STATEMENTS	
Jeff Miller, Chairman	1
Prepared Statement	38
Mark Takano, Acting Ranking Member	2
WITNESS	
Honorable Sloan Gibson, Deputy Secretary, U.S. Department of Veterans Affairs	3
Prepared Statement	39
Accompanied by:	
Honorable David J. Shulkin M.D., Under Secretary For Health, U.S. Department of Veterans Affairs	
Baligh Yehia M.D., Assistant Deputy Under Secretary For Health For Community Care, Veterans Health Administration, U.S. Department of Veterans Affairs	
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CHOICE CONSOLIDATION: ASSESSING VA'S PLAN TO IMPROVE CARE IN THE COMMUNITY

Wednesday, November 18, 2015

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

The Committee met, pursuant to notice, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Costello, Bost, Brown, Takano, Brownley, Titus, Ruiz, Kuster, O'Rourke, Walz, and McNerney.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. The Committee will come to order. And I appreciate everybody joining us for today's oversight hearing entitled "Choice Consolidation: Assessing VA's Plan To Improve Care in the Community. In late July, we authorized the Department of Veterans Affairs to use a substantial portion of the Choice Program funds to cover a budget shortfall. And, in turn, VA was required to submit a plan to the Committee detailing how they were going to consolidate and improve the many fractured programs and authorities that the Department currently uses to refer veterans to non-VA providers.

So we are here this morning so that VA can present this plan to the Committee, and together, we can measure its merits and challenges. Non-VA care, or care in the community, as VA now calls it, is an increasingly vital component of the health care system of the Department of Veterans' Affairs. Each month, veterans, survivors, and certain dependents of veterans receive approximately 1 million appointments, more than 21 percent of all of the appointments that VA provides from doctors and nurses and other health care professionals in community hospitals and clinics outside of the walls of the Department of Veterans Affairs. Allowing veterans to see these providers is vital to ensuring timely and convenient access to care.

And I suspect that as the veteran population continues to grow in both age and in numbers, and as the health care landscape continues to shift, the need for non-VA providers to supplement—and note I said supplement, not supplant—the care that VA provides in-house will only continue to grow. I think the success of VA's Care in the Community Program is hampered by inconsistent and competing eligibility requirements, business processes, and reim-

bursement rates across the seven methods that they currently use to refer veterans to outside providers. And as a result, non-VA care, as we know it today, has become unmanageable and unsustainable.

The success of the VA health care system over the next several years will depend, in large part, on VA's ability to consolidate these seven desperate methods to a single coordinated program that is easy for veterans and community providers to understand and buy into and easy for employees to administer and to manage. And certainly, this is no easy task. It is going to require us to have some difficult conversations about the purpose of the VA health care system and what it should and feasibly can achieve. It is also going to require us to examine VA's massive physical footprint, and make decisions about the future of the facilities that once served great purposes, but may no longer be benefiting the veterans as they should be.

The plan that the Department submitted in late October to accomplish non-VA care consolidation and take the first steps towards building the VA health care system of tomorrow offers a promising, but really kind of a fuzzy definition or vision of the future. And so hopefully, we will be able to dialogue with the VA and bring things into a little more clearer perspective so that we can figure out where VA needs to go next.

I am hopeful that the testimony and the responses to our questions that we will hear this morning will shed some much-needed light on how VA intends to transform the collection of non-VA programs and authorities that we have today in the coordinated system of care that our veterans have earned. I am grateful to the Deputy Secretary, The Under Secretary for Health, and the two leaders of VA's consolidation efforts for being here this morning to present the Department's proposal. I now recognize the Acting Ranking Member this morning, Mr. Takano, for an opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF MARK TAKANO

Mr. TAKANO. Thank you, Mr. Chairman, for calling this hearing today. Access to safe, quality health care is a priority for this Committee, and one that veterans who have served expect. We owe them no less. Today, we are going to hear from the VA about their plan to improve access to care. Congress mandated this plan in Public Law 114-41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. About 2 weeks ago, along with the other three corners, the Ranking Member received a strategic-level briefing from VA on this plan. After listening to what VA had to say, she is generally in agreement with how VA is moving forward. During this briefing, VA told her that without Congressional support, they could not accomplish all of the tasks set forth in the plan.

Today, I am fully prepared to be in a listening mode. I do, however, have some concerns with the price tag that this plan comes

with, and the ability of the VA to implement this plan throughout the agency.

As we all know, VA does not have a great track record when it comes to implementation. The policies are in place, but VA has had difficulty in the past with compliance as many reports have revealed. VA has told us that the implementation of this plan will be a multi-year process, and will require an additional investment of money. I hope today, or in the very near future, we get to hear about the cost. Another concern is this plan seems to be relying, in part, on an IT structure that actually works. Congress has been very generous to the VA in the past, investing millions of dollars in IT solutions that don't seem to do what they are supposed to do. I do not want to see a repeat of these failures.

Mr. Chairman, while I recognize that VA cannot do it all by themselves, especially in rural communities, I want to reemphasize that privatizing the VA is not an option. I do believe that VA, with this plan, is headed in the right direction for providing more and better access to our veterans. I believe that we as a Committee need to listen today, and if what we hear makes sense, then hold them to this course that they have set out to follow to ensure that the veterans of today and of the future are assured quality, safe health care, wherever they choose to live. Thank you, Mr. Chairman, again, for holding these hearings. And I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Mr. Takano. Members, we are joined this morning by the Deputy Secretary, the Honorable Sloan Gibson. With him today is the Honorable Dr. David Shulkin, Under Secretary for Health; Dr. Baligh Yehia, who is the Assistant Deputy Under Secretary for Health and Community Care; and Mr. Joe Dalpiaz, VISN 17 network director. Thank you. It was great to visit with you guys the other morning when we had breakfast. Thank you very much for what you do. And Sloan, you are recognized for your opening statement.

STATEMENT OF SLOAN GIBSON

Mr. GIBSON. Thank you, Mr. Chairman. As you noted, David, I would further elaborate, has been with VA now for about 4 months. He comes to us from a career in the private sector, managing large health care organization. Baligh has been with us for about 18 months, extensive years of clinical experience, and continues to see patients in the VA system. And Joe has been with VA for over 30 years, much of it as a medical center director. And he has spent the last number of months as a co-lead working with Baligh on this report.

Mr. Chairman, at the Committee's May 13 Choice Program hearing, I discussed our need to consolidate our community care programs. I was gratified to hear you say, and I quote, "We must all prepare for the Choice Program of tomorrow, one that brings the universe of non-VA care together under one umbrella, so that the care of our veterans that they need to receive is more efficient and effective regardless of where it takes place," a statement that is echoed, again, in your opening remarks today.

We are determined to seize this opportunity and make the most of it. And we are grateful to the Committee for responding so posi-

tively to our indicated need for consolidation. VA is already in the midst of an enterprise-wide transformation called MyVA, which will modernize VA's culture, processes, and capabilities. Our proposal to consolidate community care is definitely a part of that effort. Care in the community has been and will always be a vital component of health care for veterans, when they live too far from a VA facility, when they need care that is only available in the community, and when increasing demand for VA care exceeds existing capacity as we have seen in recent years.

We are referring veterans to community care more than ever before. But as you noted in your opening statement, Mr. Chairman, we are saddled with a confusing array of programs, authorities, and mechanisms that greatly complicate the task of ensuring veterans getting the care that they need when and how they need it. Those include Project Arch, PC3, Choice, two different plans for emergency care, affiliates with other Federal agencies and academic partners, and then numerous individual authorities. Each of these has its own requirements, different eligibility rules, reimbursement rates, different methods of payment, and different funding routes.

It is all too complicated for veterans, for providers in the communities, and for VA staff. Consolidation will improve access and make the process easier for veterans to use. Veterans will have better access to the best care outside VA. Providers will be encouraged to participate and provide higher quality care. And VA employees will be able to serve both better, while also being good stewards of taxpayer resources. Our report is based on input from veterans, the independent assessment, veteran service organizations, VA employees, Federal stakeholders, and best practices in the private sector. We also appreciate the many discussions that we have had with the Committee staff. The report focuses on five functional areas: Veteran eligibility, a single set of eligibility criteria based on distance from a VA provider, wait time for VA care, and availability of services at VA with expanded access to emergency and urgent care.

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

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

Fourth, better coordination of care is a critical item, making health information easier to exchange and helping veterans make the best choices among community care providers. And, lastly, prompt provider payment. Improving billing claims and reimbursement processes to allow auto adjudication of most claims and faster, more accurate payments. These efforts won't just improve the way we do community care, they will make community care a part of the fabric of VA care, making VA a truly integrated health care system. Getting there will take time.

But even as we work towards the longer-term solution, we are working to improve the veteran's experience of care in the near term. We have already expanded the provider base by including providers participating in Medicaid. We have eliminated enroll-

ment date and the combat eligibility indicators as factors limiting choice eligibility. We have defined additional services as qualifying for exceptions to the 40-mile rule, and we have added urgent consult scheduling to get veterans seen in 2 business days when it is necessary.

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

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

I know that costs are an issue. But the critical cost right now, I believe, for our focus, is the \$421 million we expect to spend on systems redesign and business solutions in fiscal year 2016. Other costs will come later as we tackle other aspects of consolidation, such as expanding emergency and urgent care. But our initial investment and one-time improvement to systems and solutions will enable us to exercise more control over the veteran's community care experience.

We detailed our specific legislative proposals in the report. We have briefed their structure to your personal staffs. And we are happy to work with any Member on these issues. Thank you for the support that you have already shown. We look forward to working with you to fully integrate care in the community into the VA health care system.

[THE PREPARED STATEMENT OF SLOAN GIBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. You talked about needing legislation to be able to do some of the things you need to do. What things can you do without legislation? And talk to me about the things you have already done.

Mr. GIBSON. I would like to ask Dr. Yehia to respond.

Dr. YEHIA. Sure. Thank you very much. That is a great question. There are definitely some things that would require some legislative approval. But we are moving out today to do things that are within VA's control. And we call these quick hits. These are things that we hope to get accomplished in the next couple months. And these include things such as streamlining the referral and authorization process. Right now, it is very complicated to send someone out into care in the community. There is a number of steps that our employees have to go through and veterans have to go through. Those are some things that we can lean up and make it better.

We want to really build on our core network, which is described in the plan by standardizing sharing agreements with our DoD partners and our academic affiliates. Right now, every single individual VA medical center and their partner has a different agreement. We want to move towards a standard template that can actually start to tackle quality and specific issues. We want to leverage some of the MyVA work that is going on as it relates to customer service and start embedding that into community care. And as the Deputy alluded to, we want to carry out some critical make-buy decisions to determine if we need to purchase specific programs or solutions, or we need to outsource them to the private sector. And then during this time, also we want to create, really the implementation plan, where you create a timeline of the next steps and milestones that we would have to meet to accomplish the plan. So those are some of the things that we hope to do in the near term.

The CHAIRMAN. Sloan, can you talk about, under the new Veterans Choice Program, whether or not you will use a third-party administrator to manage the non-VA care networks? Or are you wanting to bring that in-house?

Mr. GIBSON. As Baligh alluded to, there are a series of functions that have to be performed, creating the provider network, managing the claims process, including claims payment, some of the customer service dimensions like scheduling. So there are a whole series of functions. And what we are committed to do is in each one of those cases, to make a very deliberate make-versus-buy decision, the only two criteria being what is best for veterans and what allows us to be the best steward we can of taxpayer resources. And I would tell you, the one you have just noted is one of those where we will make that make-versus-buy decision and do what we believe is right for veterans and right for taxpayers.

The CHAIRMAN. Because the two people that are already working within the program have already set up networks. And I am just trying to figure out is it a duplication to go back and bring more folks in-house? I am glad to hear that you are going to look at that very closely.

Let me also ask you about the change to the 40-mile issue. In the request or the report, you talk about changing the 40-mile from a primary care provider. Why not allow veterans—I mean, because if somebody needs cardiac care or some other type of specialty care and there is not a provider within 40 miles, they are being hampered from getting care closer to home. And that is, I think, the focus that we are all trying to make, is to allow the veteran to get the care closer to where they live.

Dr. SHULKIN. Mr. Chairman, certainly we understand that point. And I do think that you are correct, that providing services closer to where veterans reside and making it more convenient is what we want to do. That really will end up being a choice that we are going to come back and need your help with, because that would require significant new resources to be able to fund that type of access delivery. So if that is something that we were provided the resources with, we would absolutely work to provide that type of service.

Mr. GIBSON. I would also add, if I may, that the authority you have recently given us to expand the aperture of undue burden

really gives us some flexibility today, the authority today to make some of those decisions at the margin where, for example, cardiac care, where a veteran ought not to be traveling 100 or 150 miles for care. We can get that care in the community under Choice now.

The CHAIRMAN. I think it is interesting that every time we talk about changing or improving our program, especially when you have two dual programs that are running side by side, the VA and the non-VA care, you are always adding additional money and not taking any savings over on the VA side. I know how CBO scores. But we need to be looking at savings. In the next round of questions, I do want to talk a little bit about that issue.

But the one last question I have for you, Sloan, is why is there such a discrepancy with the access-to-care numbers, the wait time that we currently see in the community when we talk with our veterans and those that VA is reporting out?

Mr. GIBSON. I think what you hear—I will tell you, I think VA is delivering great timely access to care hundreds of thousands of times every single day. Where we fall down is in that 5 or 10 percent at the margin that aren't receiving timely access to care. I have noted that over the last year and a half or so, the number of veterans waiting over 30 days has gone from about 300,000 now to about 550,000, because we have got more veterans coming to us for more care. And those are the veterans that are going to be the most vocal.

Having said all of that, we complete appointments, mental health in about 3 days, primary care in about 4 days, and specialty care in about 6 days. That is the average. So we are providing a lot of timely access to good care. It is just we are not able to do that consistently in every single instance.

The CHAIRMAN. So you are testifying to this Committee that if a veteran calls and needs primary care, that that veteran will get it within 4 days?

Mr. GIBSON. I am telling you what the data tells us is that completed appointments for primary care, on average, are about 4 days. I have no doubt, I know that there are instances out there where veterans have been waiting a month or 2 months or 3 months to get primary care. I know that. And that is the 5 or 10 percent that I am referring to that we have got to be able to address. But the challenge we run into is as we improve access to care, more veterans come to us for care.

We completed 7 million more appointments over that 1-year period of time after May or June last year, which should have been more than enough to absorb that 300,000 we couldn't see timely. What happened in the meantime is more veterans came to us.

The CHAIRMAN. Do you count emergency room visits as an appointment?

Mr. GIBSON. Emergency room visits are not counted in those totals. They are not.

The CHAIRMAN. That is not what our staff was briefed. Wait. Wait. We are going to have a—this is what our staff was briefed on, and if I am incorrect, let me know, that 20 percent of the appointments are emergency room visits.

Mr. GIBSON. No.

The CHAIRMAN. And we are being told, what staff was being told—

Mr. GIBSON. No. David?

Dr. SHULKIN. Twenty percent of our visits are same-day access, which means not the emergency room, but they walk in to primary care, into their physician appointments, or walk-in appointments. Urgent care can also be considered a same-day access issue.

The CHAIRMAN. Okay. That is emergency care.

Mr. GIBSON. Not emergency room.

The CHAIRMAN. I am sorry, Sloan, do what? Sloan is answering and I can't tell you what you just said.

Mr. GIBSON. Urgent care would count, but not emergency room care.

The CHAIRMAN. Not emergency room care.

Mr. GIBSON. Correct.

The CHAIRMAN. That is not, again, that is not what staff was briefed. We will go back and we will double-check.

Mr. GIBSON. Good. And we will do the same.

The CHAIRMAN. If you set a veteran's appointment at 21 days, and you hit that appointment at 21 days, does that appointment count as a wait of 21 days or zero?

Mr. GIBSON. It depends on when the clinically indicated date was or when the date the veteran wanted to be seen. If the veteran said I want to be seen in 21 days, then there is zero wait time. If the clinically indicated date, the doctor says I want to see you back in 3 weeks and we schedule it in 21 days, there is no wait time.

The CHAIRMAN. So you are saying that if a veteran calls and says I want to be seen today, and you say I can't see you today, but I can see you in 3 weeks—

Mr. GIBSON. Then that is 21 days wait time.

The CHAIRMAN [continued]. Okay. That is the way it is counted. Okay.

Mr. GIBSON. Yes. Absolutely.

The CHAIRMAN. Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman. One of my main concerns is how we streamline and improve the flow of information between the VA and community providers, whether that is sharing the medical records or improving the billing process. I see that in phase 2 of the plan, the VA expects to enable medical record sharing between VA and community providers. Can you go into more detail about what that will look like? Am I correct to assume that this will be electronic sharing and not just a sharing of paper records?

Dr. SHULKIN. Congressman, yes. That would be correct. Today, VA gets most of its record through paper. And what this plan is saying is that that no longer would be our intent in the future. We would develop a health information exchange. In almost all the communities that all of you represent, you have active health information exchanges. VA participates in many of those. But this plan would say we would develop a health information exchange specifically to have electronic information come back to the VA to be able to make this user-friendly and in a more timely fashion.

This is not complicated technology. It is commercially available. And we participate in many of these around the country. But this would be a specific HIE for this purpose.

Mr. TAKANO. How expensive will it be, do you think? I mean, we are talking about small providers and large community providers. I mean, I hear an earful about ACA and the meaningful use of electronic health records. And many of the small providers complain about the cost of this. So do we envision having to come up with more money to enable this to happen?

Dr. SHULKIN. Congressman, part of the \$421 million that the Deputy Secretary referenced in his opening statement would be for us to develop this type of portal, so that part of it would be so that we could get this health information exchange. So that is included in the figures that we would like to have available to us, the flexibility to use money from 802 funds to be able to help develop this.

Mr. TAKANO. Is this just the cost to the VA? Or are we also looking at the cost to the providers? Because to upgrade their ability, so I am envisioning these rural providers not necessarily having the capacity. Are we going to enable them through subsidies to acquire the technology?

Dr. SHULKIN. In my prior life before coming to VA, as a community provider, we participated in health information exchanges. This is so common right now that most providers are now participating in health information exchanges. And while there is some cost to it, most systems, most community providers have already developed these interfaces. So I do not believe we are looking at a lot of provider burden here. In fact, it should be easier for them than making photocopies and having to send the VA paper as they are currently doing right now. So I actually think this will be more efficient for the providers.

Mr. TAKANO. Okay. In the plan, VA indicates there will be a number of things VA can start doing to move towards implementation of the plan without additional authority. Can you tell the Committee what those are?

Dr. YEHIA. Sure, Congressman. I mentioned those a little bit earlier. But the point here is to really try to meaningfully improve the veteran experience and the experience of our community providers and employees in the short term. So we are moving out to accomplish a couple of things today. And those relate to such things such as streamlining the referral and authorization process that I mentioned, standardizing those sharing agreements with our DoD and academic affiliate partners, infusing customer service training into community care, and making some of these critical alternative analysis-or make-versus-buy decisions.

So those are some of the things that are within our control today, that we are already starting to act on them to meaningfully improve the experience of our stakeholders.

Mr. TAKANO. Well, the choice consolidation plan includes 13 legislative proposals that are integral to the success of the transformation. I know the provider agreement draft legislation that the Subcommittee on Health heard about yesterday is a top priority. Which other proposals are the most important immediately to setting the foundation for success?

Dr. SHULKIN. I would be glad to start, Congressman. The very top priority for us is to get provider agreements. Having the ability to be able to contract with the providers that we want, having the ability to work with our key partners, Department of Defense, our academic teaching affiliates, the Indian Health Service, other Federal entities, and other high-performing networks around the country, is going to be our critical feature here. So we absolutely would like to work with you and have your support in that.

Secondly, the flexibility of the community care funds that we have talked to you so much about and being able to have our funding make sense for what veterans are receiving in the community and not making it as difficult to access those funds is absolutely key for us to do. Having the flexibility to access the \$421 million from 802 funding, not new funding, but allowing us to access that funding so we can start developing these types of systems that we have talked about here in fiscal year 2016 is absolutely critical as well. And I would ask my colleagues if there are any other key features.

Dr. YEHA. Those are the critical pieces. And you will see in our legislative proposal section that we separated those out, because those are things that we need today to move out to deliver better care to veterans. There is a middle section of proposals that relate to how we consolidate all the different programs. And then the last piece relates to how we can improve some business and health information sharing processes. So those are kind of how our legislative proposals are divided. And we asked that we focus initially on these immediate legislative needs.

The CHAIRMAN. Mr. Lamborn, you are recognized.

Mr. LAMBORN. Thank you, Mr. Chairman. And thanks for having this hearing. Secretary Gibson, as I understand it from the briefings to staff, the VA previously wasn't tracking metrics for off-VA care. Can you explain why this was not being done, and perhaps what is being done now, if anything?

Dr. YEHA. I think what we were saying before is that because we have such a patchwork of different programs for delivering community care, the Choice Program, the PCP contractor, affiliations with DoD and academics, they all are in a silo. And VA doesn't have the visibility that it needs to really assess kind of supply and demand. Do we have the right population of doctors, the right specialties in the right areas? Can we actually assess and monitor quality at the regional and national level?

We don't have that level of visibility today. So in kind of the one-time cost system improvements that we articulate, those are the capabilities that we need. We need to have that visibility at the national level to be able to assess how to better match supply and demand, and how to monitor the quality of care for our veterans. So you are spot on, that is what we are asking for.

Mr. GIBSON. I think the other light to shed there, VHA has historically operated as a loose confederation of medical centers. And what we are talking about here is moving toward an integrated enterprise. And so, oftentimes, what I find is out at a medical center level, there actually is a pretty good finger on the pulse of the care that is being delivered by local providers, because doc providers inside VA know who they are referring patients to. They know about

that provider, and they are seeing their patients and assessing that provider experience. But that is not consistent all across the entire administration. We need to operate more like an integrated enterprise so that we have got that kind of consistency.

Mr. LAMBORN. Okay. Thank you for that answer. And I am going to shift gears and ask about IT. We had a hearing recently, a combined hearing with another OTR committee, about how the VA and DoD is not able to share medical records. But some of what the plan is you are talking about for the future is hinged on a cloud IT system for better sharing between the VA and community providers. So if the DoD and VA haven't been able to really integrate after 17 years, why do you feel it is going to work to do something differently with the community providers and the VA?

Mr. GIBSON. First of all, as it relates to interoperability with DoD, this came up at our breakfast the other day. And I would plead with any Member of this Committee, give us an opportunity to come over and demonstrate for you today what is happening, the information exchange that is happening between VA and DoD. We routinely offer those briefings. We get staff coming, but we never can seem to get a Member to come.

So please, we would love to have you come. I will come too. And we will put on that demonstration so that you can see we are exchanging electronically vast amounts of information with DoD every single day. We would love to share that with you.

The CHAIRMAN. If the gentleman will yield. Members, we will take the VA up on that. It may be an early morning breakfast event. I will bring the chicken biscuits. And we would love to see it.

Mr. GIBSON. Wonderful.

Mr. LAMBORN. Mr. Chairman, thanks for your initiative on that.

Mr. GIBSON. But the other part of the issue has to do with the health information exchange, the portal that Dr. Shulkin was talking about earlier. Other comments to add there?

Mr. LAMBORN. Dr. Shulkin, can you add anything to that, the cloud IT system, that community provider sector?

Dr. SHULKIN. When you come to this, to this demonstration, because I had a chance to see this in North Chicago, one of our integrated facilities with the Navy, as our doctors were going back and forth between DoD and VA systems. So this joint viewer does allow that. A health information exchange exactly provides that opportunity with community providers. So you do use the cloud. And you are able to go back and forth. It is not one integrated medical record. I mean, we would all love to see that, but the commercial companies are guarding their software protection to do that. So what you have is the ability to see information, clinical information. I think that is what you get with the health information exchange as well.

Mr. LAMBORN. Okay. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. My question has to do with implementation. Let's just say, hypothetically, today was the day that we approved all the legislation that you needed to move forward with the program. Can you talk a little bit about the implementation and the timeframes associated with that?

I know, I mean, I looked at the plan and saw the three phases. And I think by the third phase, it is 4 or 5 years out is my understanding. But there is also a lot of what you classify as make-buy decisions that have to be made that are going to be, I think, really important to that timeline. And certainly thinking about the role of third-party administrators, I think is, at least one that I think is a pretty big deal, a pretty big decision on all of this. So if you could just talk a little bit about the challenges, but what your timeline is.

Dr. SHULKIN. Yes. Congresswoman, great question. First thing which I want to make sure that you understand is that we are out there every day, traveling all the time. And we are hearing from veterans that the current system isn't working well enough for them. And they are pretty clear about this. I know you are hearing the same thing too. So we are not taking a wait-until-we-improve-the-system approach. We are, right now, understanding things aren't working, and we are making these types of incremental approaches as fast as we possibly can. We are doing it in partnership with our TPAs and our provider partners, Department of Defense, academic centers. So we are starting right now, and have been, actually, to make this better. We want to get there as quickly as we can. So the timeline you are talking about, I am going to actually have Dr. Yehia go through.

Dr. YEHIA. Yeah, I think that is such a critical point. Because the way that we set up the implementation plan or the transition plan is not to have some grand reveal in a number of years. We really want to make incremental improvements. So that is why we came up with these different phases. The first phase is really to develop the implementation plan, those details that you need and we need of milestones and how we are going to get there, those critical make-buy decisions, and then deliver on the—what we call minimally viable solutions, incremental improvements.

The next phase, which is another year, is to start connecting different systems, getting these capabilities up. And the third phase is rolling out some of these larger ones and starting to maintain them. I think one thing to remember about implementation, I know IT has been mentioned a lot, is that from day one, when we started this plan, we were joined at the hip with our IT colleagues. So our assistant secretary for IT, LaVerne Council and her team, were partners with us. They helped us develop a lot of these recommendations. They helped us come up with the cost estimates. And now they are standing up a project management team just for community care.

So I couldn't agree more that we need to do this as an enterprise. It's not going to be run out of VHA. It is not run out of IT. It is run at the Department level. I think the other really important point about implementation and why it is different than before is this collaboration that we have created between field leadership, program office leadership, and also external consultants that have expertise in things such as health plans and value-based care, that VA doesn't have all those specific competencies today.

So we are assembling these, what we are calling tiger teams, dedicated staff, multidisciplinary, to start rolling out some of the

different aspects of implementation which, in my mind, makes it unique.

Ms. BROWNLEY. In terms of the make-buy decisions, and, again, going back to third-party administrators, so, again, that seems like a pretty big decision. And I know that we have—it has been slow in terms of the Choice Program and so forth. But it is my understanding, I can't speak for Health Net, but with TRICARE, I know they have invested quite a bit over the last, you know, 6 months, anyway. It appears they are improving. But, again, it is going to be customer satisfaction that tells the true story. But give me some idea of your thinking, some of the pros and cons of using our existing third-party administrators, or taking all of those services within the VA. And you have 20 seconds.

Dr. YEHIA. I can't stress enough that they are our partners. So we are working with them day in and day out. They are embedded in some of our medical centers. So they are our partners in making the Choice Act work. I think we have engaged some external consultants to help us determine what we are calling an announceable alternative to determine what is best for taxpayers and best for veterans. We are not taking this decision lightly. It is not just an—we are using all the resources we have to help us make the best informed decision.

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

The Chairman. Thank you very much. Dr. Roe, you are recognized

Mr. ROE. Thank you, Mr. Chairman. And, Dr. Yehia, you will get all the tough questions being a University of Florida grad, okay, from me. First of all, health care is changing in America as we all know. And we are looking now, instead of just procedural things, outcomes-based medicine. I know we have a VISN director here who has been a hospital director also. And if you look at the local hospital system, they will know pretty much in that area where they are, who the providers are they can use.

I will give you an example. At home, we have, and I will do a little shout-out to my own practice, but we have a group of about 500 primary care providers. We formed a Medicare ACO. It is the best performing ACO in America with 25,000 or less people in it. So the VA could easily integrate and get results back from that. Mayo, Scott and White, I mean, on and on, Marshfield, we all know those systems that can provide a lot of care.

And I absolutely do believe you are on the right path. I want to support what you are doing 100 percent, because I think this blended system is the one that is ultimately going to provide the care to veterans. I really believe that. And simplifying the system has to be done. And it has to be for your sanity and the veteran's sanity both.

So I want to give you a shout-out for that. To Mr. Lamborn's comments about the IT system, I have had the fortune, or misfortune, to be in North Chicago twice in the winter. It wasn't as seamless as I would like to have seen it as a provider. As a provider, seamless, if you are the boots on the ground doctor, something that takes you 2 or 3 or 4 minutes to get information from, you are hopelessly behind at the end of the day. You have heard me say this over and over again, having used an EMR system.

So we have to have a system that works for the provider because, otherwise, it doesn't work for the patient. Those things, what I would like to know is what percent of the veteran population do you think will actually utilize this system? Because you have got a little bit of an onslaught. I think some of that was a woodwork in process, people heard about it and hey, maybe I can go get that care. So how many do you think will actually be in non-VA care and VA care?

Dr. YEHIA. I think that is a great question. As a provider in the system, you know, we are trying to design a system that works great for veterans, our providers, and employees, and community providers as well. When I see patients, I want—3 minutes is too long. So I can't agree more. And so I think it is important that whatever we end up designing in partnership with Congress works for us. Because I am going to be living it day to day as well as I see patients.

With that in mind, your question about how many people are accessing community care, about a million and a half veterans have received some sort of community care. That doesn't mean all of their care is in the community. They might have gone out for a particular procedure or an episode of care. But there are a good chunk of veterans that get their care in the community.

Recently with the expanded Choice legislation and removing the eligibility date and the 40-miles-from-primary-care physician, that makes about 900,000 veterans are now eligible under the 40-mile geographic criteria. So there is a big population of our veterans that are now eligible to access community care.

Dr. SHULKIN. Dr. Roe, let me just say, I think what you just talked about, your statement, is a precise articulation of what this plan is about. So I thank you for that. Health care in America is changing, and changing rapidly. And this is actually a plan that recognizes that and says VA has to not only keep up with it, but take advantage of everything that is happening good in American medicine. So I used to run our accountable care organizations. It is exactly those networks we want to tap into to get the best care for our veterans.

Mr. ROE. And it is easily reproducible. I mean, you can get that data quickly back. The electronic health record is a challenge, because in ours, where we brought in other doctor groups, 40 different electronic health systems. And that is a huge challenge across the country trying to figure out how to make these things integrate. And that will be ongoing. I think the other thing I want to do, as Ms. Brownley asked, what is the timeframe? If this goes exactly like we think, which it won't, how do you think the timeframe will be? Couple of years?

Dr. YEHIA. Yeah, I think it is such a critical question. We are really doing this in an iterative way. It is kind of like agile design. As I mentioned before, we are not looking for a grand reveal after a number of years. So we are hoping that even starting today, we are starting to deliver incremental improvements to veterans, employees, and our community providers. After some of these make-buy decisions, and the portal is an example, those take a little bit of time to actually get into place. But that doesn't mean we are not

going out today and starting to make the system better. That is our intention.

Mr. ROE. My time has expired. But I thank you for what you are trying to do. And also, if you could just do one thing is make sure—and Medicare does a pretty good job of this—are timely payments to providers. If they are sitting there for months and months and months, they are not going to participate. I yield back.

The CHAIRMAN. Ms. Kuster.

Ms. KUSTER. Thank you very much. And thanks so much for being with us. I think this is a really important conversation to have, because the conversations I have been having with my VA for several months now, actually over the last couple of years, is that there is just such a patchwork of programs. And they prefer the programs where they can stay in touch with the providers in the community.

We have also had some challenges with our third-party contractor on implementing the Choice Program in New Hampshire. I have to ask one very parochial quick question. We are one of only two States in the country without a full-service VA hospital. And we had a special amendment under the Choice Card to reduce to 20 miles. Can I reassure my folks in New Hampshire that this 40 mile is not going to cause them to be driving over the mountains in the snow again to get to the VA Hospital? I told you it was parochial.

Mr. GIBSON. Well, no, we expected the question, quite frankly.

Ms. KUSTER. Thank you. We are dogged in our determination to care of our veterans.

Mr. GIBSON. We deliberately, in the plan, did not address the special circumstances in Alaska, Hawaii, and New Hampshire. And so part of the process here as we work through this is to, very deliberately, with all the stakeholders, look at each one of those instances and figure out exactly the right thing for veterans and for taxpayers. And we commit to you that we will do that.

Ms. KUSTER. Thanks. We will be on it. And just having said that, and whether you say 20 miles or 40 miles, this picks up on a previous question, part of the confusion is that to use this distance when it is not relevant to the care that is being provided, I think is really a dilemma. To say I am 20 miles or 40 miles from a facility, if it doesn't—you know, look, I need heart surgery, I don't need to go to a primary care physician. So are we going to resolve that particular aspect of this as well?

Dr. YEHA. Yeah, so I think that is a great question. Because we heard that from our veterans and our community providers. The way we articulate in the plan is not to a facility, but to the relationship. And so we say that it is 40 miles from a primary care provider. Because in health care, that relationship between the patient and the primary care provider is probably the most critical relationship there is. They are the care coordinators. They provide access to specialty care. And so the way that the eligibility criteria of the plan is designed is, if you live far away from that critical relationship, all the veterans health benefits package is available to you in the community. So it is more relationship-based and less facility-based.

Ms. KUSTER. Okay. Thank you. I appreciate that. And part of what I wanted to get at, and I think this is a goal, is just the confusion of the bureaucracy. And you all inherited this as well. It is complicated which veterans are eligible for which services, what kind of health care we are offering. And I think there is sort of a built-in conundrum for us on the Committee and in the veteran community between focusing on those types of injuries and ailments that come from their service, versus those types of injuries and ailments that have to do with aging and other disease processes that are built in to the DNA before they even head overseas.

In our case, we have 65,000 Vietnam veterans in New Hampshire aging. But I want to keep the promise to them, because many of their concerns, health care concerns, mental health care concerns are related to their service. We didn't know it at the time. It took us a while to sort it out. But it is very clear to me now as I meet with these folks, and I will add in the folks coming back from—we have a high percentage coming back from Iraq and Afghanistan, the TBIs, the MST, the PTSD. Can you just comment on serving the whole veteran, if you will.

Dr. SHULKIN. Yes. I think you have said this very well, that the current experience today is confusing and overly complex. I would note that this is not purely a VA issue. This is the managed care industry in general, right? Nobody really understands their managed care benefits and the complexity of what is happening in American health care.

Ms. KUSTER. I absolutely agree.

Dr. SHULKIN. But we recognize what you are saying. The point of what we are trying to do, this type of incremental change, is to simplify this. If you work with us to allow us to get the flexibility of care in the funding, care in the community, care-funding together, we think that will go a long way towards allowing us to simplify the eligibility requirements, the understanding of what veterans can and cannot get from the VA. And we are committed to doing that early on in this timeframe. And we are using veterans focus groups. And we are out there in the MyVA efforts to try to make this more veteran-centric.

Ms. KUSTER. Well, I look forward to working with you. And thank you very much for your presentation.

The CHAIRMAN. Dr. Benishek, you are recognized.

Mr. BENISHEK. Thank you, Mr. Chairman. Welcome. I just want to reiterate what Dr. Roe said, that, frankly, I think this is great that we have one way of VA veterans getting access to community care rather than the hodgepodge of efforts. My concern, of course, is the implementation and making it work. I will give you an example here. I got many complaints from providers in my district about the Choice Program due to the inability of the Health Net to communicate with the VA and with the private providers. I had a provider that told me they had to wait weeks to hear back from Health Net. They want to update authorization for care. And when they do hear back, they have to spend 40 to 75 minutes on the phone to check on each and every authorization. This is like, just this week.

So, I mean, I know that this Choice thing came in quickly. And you tried to get it. But the implementation of this is what scares

me about it. Do you know what I mean? Are you aware of this problem with these third-party providers? Who is dealing with that?

Dr. SHULKIN. We are not only aware of it, we are painfully aware of it. We are hearing this every day, many, many times a day. And so the Choice Program, which was brought up with the best of intentions, has experienced considerable problems, putting the veteran in the middle, quite frankly, but also the providers. We are working with both TPAs. And the CEO of TriWest is here in this room with us today. We are working with both TPAs.

We have gone through multiple, multiple contract modifications to make this work better. And we are using pilots in several locations throughout the country. We are actually co-locating the staff from the TPA with the VA staff. One of the things that we learned in looking back on this, it was the VA staff who had the relationships with the providers in the community, and the relationships with the veterans. And when we removed them from the process, problems began. So we are working now with the TPAs to—

Mr. BENISHEK. I tend to agree with your assessment. As you know, I worked at the VA. And I know the guys at the VA. I knew their local providers. And that system actually seemed to work okay in my community. And then having somebody they have no idea who they are contracting with you, you know, taking a percent of the money doesn't make much sense to me, to tell you the truth. I am not sure that we were all that happy with the plan to do that.

Dr. SHULKIN. Right.

Mr. BENISHEK. Let me just talk to you a little bit more about another issue and that is, the core competencies in the VA. The plan calls for the VA to access non-VA care for veterans outside of certain core competencies that the VA should handle. What are those core competencies?

Dr. YEHIA. I think that is a great question. When we started this process to consolidate care in the community, Joe and I really had to step back, because we couldn't look at it just in a silo of how do you make this part of the system work better without figuring out how it interacts with the rest of the system, which is why, in the preamble of the report, we talk about the future of VA health care. And I think the principle there is that we cannot provide every single service in every single location to every single veteran. And that is the concept there. I think if we want to move towards that integrated health care system, really creating a complementary provider network to internal VA care.

This doesn't mean we are outsourcing VA or dismantling the VA. What we want to do is have a more complementary integrated system, so that if we are providing mental health care and primary care in that area, we probably don't need a lot of mental health care and primary care docs in the network. We need other things that aren't provided at the VA. So we are calling these kind of foundational services that VA would provide. A lot of that is going to be locally determined. As you know, health care is local. What is available in one market may not be available in another. So that is where that spirit comes from, is how to get to that integrated health care system and creating a complementary network.

Mr. BENISHEK. Well, to tell you the truth, I really appreciate your enthusiasm and your response. That may be due to your relatively short tenure at the VA. I am hoping that that will continue. And I know that, you know, that two physicians up there are relatively new. And I actually really welcome their input and leadership. And I am happy to work with you to make this plan happen. I just have my concerns about the pace. Thank you.

The CHAIRMAN. I think part of it is because the Gators are 9 and 1 right now. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman. I just want to begin by telling you each how encouraged I am by this report that you produced and your testimony today and your answers to our questions, and how grateful I am on behalf of the veterans that I represent for this initiative. And, Dr. Shulkin, you talk about changes in American medicine that you are anticipating and incorporating in the proposal that you have put forward. And it is restoring the VA to its rightful place as a leader in American health care who can set the standard and become known for excellence and figuring out problems that are fundamental to how we provide health care in this country.

So this, for me, in the—you know, as another short-timer who hasn't been here yet 3 years, is certainly the high watermark in terms of our work with and collaboration with the VA. And I share, you have heard it from many of my colleagues so far when they are asking you how long will this take. And, Dr. Yehia, you have done a great job of avoiding the question and saying we have got an iterative process and we are doing this, that, and the other. I don't want to speak for anyone else.

What I am concerned about is you have just a little over a year left in this administration. And this is a very exciting, necessary, essential proposal to reform VA care. And I want to make sure that you can do and we can help you do everything necessary to make it happen. So you don't have to answer that question. But just know that is the interest. And I, for one, want to help legislatively in any capacity I can to make sure that we get this done.

I want to point out a couple of things that I think are really encouraging. The focus on care coordination, which you have talked about, and making it a fundamental principle of excellence for the VA is just so important if we are going to get this done. You mention in your report that you are seeing rising demand for outpatient visits and decreasing demand for inpatient hospital beds. And that seems to answer this frustration we have with the \$1.1 billion overage in Aurora, and hundreds of millions of dollars over in Orlando and Las Vegas and New Orleans.

We shouldn't be building stand-alone VA hospitals to only take care of veterans. On top of that, 41,000 funded, authorized positions unfilled. We have to prioritize where we are going to focus in the VA. And so core competencies, as Dr. Benishek raised, I think it is really important that that is a fundamental aspect of this plan. And I like the way it is articulated on page 18 of the proposal.

One question related to this, Secretary Gibson, you have said in a previous hearing that for every 1 percent increase in VA patient demand on the system, you incur an additional \$1.4 billion in cost.

Does this plan, through care coordination, investment in IT systems, et cetera, create some of the necessary efficiencies for us to be able to afford greater veteran participation going forward?

Mr. GIBSON. I will start and then you guys can finish. It was actually Bob that used the 1 percent and \$1.4 billion. But I will own it. There are certainly efficiencies built in here. As I alluded to in the opening statement, the fact remains that as we improve access to care, and as we improve the veteran's care experiences, we are going to find more veterans coming to us for care, especially when it is financially advantageous to the veteran, when their out-of-pocket costs are going to be lower to come to VA. So we are going to continue to see that. But there are some savings that are built in to this overall cost picture. And I will ask Baligh to touch on those.

Dr. YEHA. So I think what you see here is that we are moving towards best practices that are in industry. So we talk about, by streamlining a lot of these processes, it is more automated, less manual. Our employees can spend more time with veterans. And so there is efficiencies gained there. By working with high-performing providers in the community, providers that understand the principles of high-quality care and utilization management, there is efficiency there because they are not going to be ordering that extra CAT scan that may be unnecessary. Or they may be preventing an admission for a diabetic that may require an inpatient stay for someone else.

So I think it starts with making the system a little bit better, getting the right providers in the network. And then probably the last component is how we start leveraging lessons learned from CMS. CMS is doing a lot of great work in value-based payments. So we are not reimbursing just for episodes of care but for more outcomes-driven care. So we articulate some of those there. That is the direction we want to move to. We want to skate kind of where the puck is going and not necessarily be tied to the systems today.

Mr. O'ROURKE. Thank you. And, again, thank you for your work. And I look forward to working with you on this. I yield back.

The CHAIRMAN. Thank you very much. Mr. Huelskamp? Mrs. Walorski?

Mrs. WALORSKI. Thank you, Mr. Chairman. And I also want to add to the panel how grateful I am that you are here as well, and that we sound like we are on the same page, at least in the concept of moving forward in trying to be able to rebuild that trust with veterans and the VA.

The one question I have is all the way back to when the Chairman started on this whole issue of Choice. And let me start by saying, you know, I want the VA to be healthy. I want the VA to work for my constituents in northern Indiana. Unfortunately—so when I sit in these hearings and I listen to every single question my colleagues are asking, I still think in the back of my mind, we are not as functional in the State of Indiana as some of our neighboring colleagues here.

And that is my desire. That is the desire of our veterans. They want everything to work for them because we promised them that when they went to fight. And so, that is my goal is to continue—to work as closely as we can to get the VA healthy. And so I so

much appreciate the report that you have and the plans and that kind of a thing.

But I am still caught in the question that Representative O'Rourke didn't want an answer, but it will help me to have an answer on when can we see some of this happening. Because I was on the conference committee back in October when we did the reform, reset type thing. We still don't really have a Choice Program in my district, in northern Indiana. And so I just—it is interesting, I just had a phone call with my district staff that works on all of our VA case work in the district and they were just telling me that just recently, we got a call from an actual VA hospital in the State of Indiana telling the veteran to call my office because the VA hospital can't get appointments and can't get anything through for this veteran.

I am thinking to myself something is wrong. There is some kind of a clog in the line. And I would ask you guys, and even Mr. Gibson, if you would—I am more than willing to come to that computer IT show-me-the-world type thing. I am more than willing to be there. I will be there. But I am, again, asking if you or the Secretary could seriously come into my district, and if we could have conversations about how we make this work better, because I think that would be one of the quickest ways, and much more efficient ways to actually see that it just isn't happening like you are describing it around some of these other areas around the country, that would be my first question.

Mr. GIBSON. We will do it. Bob or I will come, we will bring some of our medical center leadership from Indiana, and we will also bring senior representation from the TPA, from the country.

Mrs. WALORSKI. I really appreciate it, I really do.

And then my second comment is back to this Choice Program. I remember being on the conference committee when we talked about that 40-mile radius. I am and still very, very concerned. When you are looking at areas that have rural places which are the hardest sometimes to get care to, that is why this evolved in the first place. So it is like let's get care to them from a community-based hospital, somebody near them.

One of the things that I find in my district, which I find so frustrating to say, if we are going to look at broadening that radius, it is going to cost a whole lot of money. And I know when you are talking about you need our help, that means money. But it is so problematic in places in these rural areas. And to Representative Kuster's point, when you are dealing with winter weather. Winter weather in my State closes States. We have state of emergencies, and we can't travel, you know. I am finding myself getting involved. The veterans are calling my office, and then having me make phone calls to try to get Choice implemented. It literally is not rolling out in our district. So can you just comment on that? I mean, when can we see that actually happening?

Dr. SHULKIN. One of the points that Secretary McDonald constantly makes is the VA is the canary in the coal mine for American medicine. So the problems that you are describing about rural health care are problems in every aspect of health care.

Mrs. WALORSKI. True.

Dr. SHULKIN. Getting providers there, getting the right specialties there.

VA is looking at this issue. We are desperately trying to hire psychiatrists in El Paso and specialists in Indiana. But one of the ways that we are beginning to do this is to really use telehealth. In a way for rural—

Mrs. WALORSKI. Telehealth is working in my district, I will tell you that. But for specialized care, and for things like cancer and those kinds of—it is so hard.

Dr. SHULKIN [continued]. We are moving rapidly toward specialty telehealth. In fact, people don't realize, nobody is doing more telehealth in the country than VA. We are driving this faster than anybody. And that can't be the total answer, but we have to look towards new technology.

Mrs. WALORSKI. Right.

Dr. SHULKIN. And we have to get more—

Mrs. WALORSKI. I do agree. Yeah, I will give you that, it does definitely work in our State. But I appreciate your willingness to come and help us troubleshoot. I yield back.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman. I, too, would like to, first of all, applaud the Committee for showing that we can simultaneously do our duty of oversight on accountability, and start to provide vision for the future, because I think what we are talking about in hearing people, this is our opportunity to shape VA 2050, if you will.

Amongst the crisis situation that arose from Phoenix and others, I think this is the silver lining that we are starting to move towards that blended system you hear about.

And Deputy Secretary Gibson, I do have to say, at the time when the VA so needed it, you instill confidence, your candor and steady leadership is appreciated. And I think that needs to be said publicly, because we are moving towards solutions, so thank you.

My team and myself, and I know many have done this, have gone on deep dive on this. It gave us that opportunity, working with everyone from Health Net and TriWest who you said are here today—not only are they here today, they were at roundtables in Brainerd, Minnesota, with veterans. And at a time when people could have ducked and covered, they didn't. They stood up in the face of this and were very candid. I appreciate that.

Private providers, county veteran service officers, the Minneapolis VA, VISN 23, American Hospital Association and central office are digging into this. People want to fix this, they want to get there. And you have heard it today, it is working. I think the point that was brought up by my colleague from Indiana just brought up, separating VA health care from health care in general is—you cannot do it, the lack of rural providers in the private sector is every bit of a problem as it is for veterans.

My question to you and I want to be specific on this, and you have answered it some degree, but out of all of those meetings and other things that came, one of the things I am hearing from the providers, from the private providers, is the standards in the program are not industry standards, resulting in some of them opting out. I want to understand why you think, in your opinion, why are

some providers opting out of this? Because I know they want to help care for veterans, but we shouldn't make it at a loss to them. If you could take that one, I know you have answered it to a little degree, but this was asked of my people out there of why this is happening.

Mr. DALPIAZ. If we look at rural areas in particular, two big reasons: One is, and we have this in the plan, we need to continue with or enhance special dispensation for rural providers. The other finding, and it should have been very obvious to all of us is when we wrote the initial requirements, we wrote in very burdensome requirements for providers, and we know in rural areas, there is a lot of small operations. And what we hear from rural providers is, this is so burdensome for me to participate, I have to hire additional staff, and I can't do that.

So when we look at future requirements for a network, we built in flexibility for special dispensation for different parts of the country, rural areas being one. And we have to take a very critical clinical look at the things that we are requiring them to send back to us. They seem to be the two things that are most troublesome and push people away from our system. And we have learned those lessons.

Mr. WALZ. So when we go forward, will that be a contract thing that you have the capacity to do, or does this need legislative improvements?

Dr. YEHIA. So I think it is a combination of both. There are some requirements that we have today that are not industry standard, and the principles laid in here is to move us more towards that. What are the leading practices? One of them is tying the medical record to claims. That doesn't exist typically in the private sector. Not saying that we don't want records back, but there are other ways that we can incentivize our community providers to get us health information back without saying we are not going to pay you.

The critical thing that we would need is provider agreements, and this is a simplified way that we can partner with providers of the community. And those are exactly the providers you are talking about; typically, the local, mom-and-pop, small practices. These aren't the large conglomerations that could enter in complicated, far-based contracts with us. Those we can work through very complicated contracts with. But the smaller providers won't work with us if we have them jump through a number of hoops that Medicare doesn't require, or partnerships with other health plans don't require.

So that, I think, is critical for us. If we can get provider agreements passed, it is going to allow us to partner with community providers, and then increase access to those providers for our veterans.

Mr. WALZ. That is exactly what they are saying. How quickly can we do this?

Dr. YEHIA. We have I think at the last Subcommittee hearing, VA presented their proposal, and I think the Committee is considering it. I know there is a counterpart bill in the Senate that has been introduced. We would love for you to move as quickly as possible in that.

Mr. WALZ. Because I don't want to put these people in the position either. It is pretty wrenching for them that they want to do this, and they don't want to be seen as not providing for veterans. So I think that is a positive step forward.

Again, I thank you for your work, and I have to say this is—there are some positive developments, and we need to focus on where there is crisis, we need to continue to have accountability, but I think it is important for us to show that there is lot of good happening too, so thank you for that.

The CHAIRMAN. Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman. It is a very encouraging meeting today. And I want to thank you for listening, because that is what we are seeing taking place here, you know. In the last couple years, we have had these types of discussions about where, I think, we should be headed, and we are seeing it happen. And I appreciate that very much.

I do agree with the Chairman when he mentioned that when we are outsourcing, it doesn't necessarily cost us more if we are lowering on the other side. We may find ourselves, and probably will, in a situation some day, where we say we don't need all these physical plants in the VA, and we can reduce our footprint. And so we can save in a lot of ways and continue to work on increasing productivity.

I especially like what you were just talking about, provider agreements. If there is something in the way coming from here that is making that more difficult, then we need to change that. And you are right, especially in rural areas, letting that lone practitioner out there be able to be a VA provider. Which brings me to another point that, I don't really think we need to say that this is non-VA care, you know. Our practice, I guarantee you, 20-some orthopaedic surgeons, we would have been glad to have a sign out in front of our building saying "VA provider" and put the VA logo up there. So I think we should shift away from calling it non-VA care, but extending VA care, and I think that would be helpful.

Mr. GIBSON. That has been my campaign for the last 6 months, to eradicate non-VA care from our vernacular, and instead, refer to it as VA community care.

Mr. WENSTRUP. Well, I appreciate that. Great minds must think alike. I don't know. But I also appreciate what you were talking about with the information sharing, because in our practice, you know, we could go to—a patient comes to our practice, we could get their information from any hospital in the region without having to jump through a lot of hoops, and it makes a big difference. So I applaud you for being in the right direction, and I yield back. Thank you.

The CHAIRMAN. Thank you very much. Dr. Ruiz.

Mr. RUIZ. Thank you, Mr. Chairman. Secretary Gibson, simplifying and improving the process for veteran seeking community care remains at the top of my priority list, and the veterans living in my district. We—as soon as the Choice Act was passed, we held some workshops in my district with physicians, TriWest and the VA, and we heard a lot of the different obstacles that were involved, including the enormous amount of bureaucracy and the lack of information that our providers had in order to enroll.

The two VA community clinics located in my district are Palm Desert and Blythe, they are the point of care for VA-based care in my district. I am eager to make those facilities more veteran-centric. And I believe your proposal, while not perfect, is a step in the right direction.

I, too, am a little concerned about the implementation plan, and the deadlines, and the inherent evaluation, and oversight that you have within the plan in order for us to meet the goals that you set forward in the time that you want to set them, and not have another over-budgeted plan, or I should say, under-budgeted plan, where we get a surprise bill for billions of dollars in the near future.

My questions rely on the fact that we are going to start relying on community physicians to provide care in areas that have low access to veterans facilities. Yet those are, oftentimes, the rural underserved area. And in my district, we have one doctor per 9,000 residents. So how are you going to account for the physician shortage in the community for the general population, and rely on them for the physician care for veterans?

Dr. SHULKIN. If you have the answer to that, that would be great, because—yeah. This is a significant problem for America. VA, I think, can bring to this several things: One is, thanks to your additional authorities in the Choice Act, you allowed us additional graduate medical education funding. And so, for us to create partnerships with medical schools, and to create new GME spots that focus on the shortage areas and focus in the rural areas is absolutely top among—

Mr. RUIZ. Well, we should talk. I was senior associate dean of a new medical school that had that exact plan that took my students in under grad in college from underserved communities into the under grad, into those medical schools in developing residency programs in those underserved areas. One of the key places that you can start having your residents go to, and that are involved that are eventually going to work at the VA, is FQHC.

So let me ask you another important question, because I am limited with time. I have a veteran in my district who is not the only veteran that has told me this story, who had bad, I guess, consequences from the third party not paying their bills on time, and therefore, the provider then would bill the veteran. And the veteran didn't have the resources to pay that. And also, the veteran was under the impression that the third party was going to pay those bills.

My veteran now has poor credit scores because it went to collections, and it went through all these other things. What are we going to do to protect the veterans in case there are glitches like that so they don't have the financial harm?

Dr. SHULKIN. We spend a lot of time right now, our central business office spends a lot of time helping veterans work through these situations. Again, the VA is not dissimilar to what is happening in the private sector. Patients don't understand their bills and third-party payers are sometimes inappropriately billing. So in those situations, we are there to support the veteran. Sometimes the veteran does have an obligation, because it wasn't a covered

service, but many times, we step in the middle to support the veteran. We do not want to see what is happening—

Mr. RUIZ. How do you support the veterans, do you take on the cost?

Dr. YEHIA. If I may, I think the perfect example of this is ER care. And right now, because of the different rules and requirements that we have, a lot of veterans think they are eligible for that benefit, but get denied the care. And that is part of the reason why we wanted to tackle that—

Mr. RUIZ. One last comment, because I have about 25 seconds. You talk about the relationship that is important in terms of primary care physicians, and you are absolutely right, but our veterans need pain management, that primary physicians are not trained, they are not pain specialists. They also need psychiatric care.

So I believe that that relationship, that the access or the criterion in which you allow a veteran to see a provider outside of the VA, or in the community, should not just be the relationship with a primary care physician, but it should be service-based. So if they don't have a pain specialist at that VA location, then they are allowed to see a pain specialist within the community?

Dr. SHULKIN. Yep.

Mr. RUIZ. When is that going to happen? Does it require a bill, or can you guys make it happen?

Dr. YEHIA. Yeah, I think that does, I mean, the concept of going from the service would expand the aperture greatly for all those, because we don't have pain providers everywhere. So we can—I think we are open to having those discussions, but those come with significant resources.

Dr. SHULKIN. I would just add that the pain management is a different issue than the behavioral health. We integrate—when Dr. Yehia talks about primary care, we are actually talking about a team called our pack teams, with behavioral health integrated into the primary care services. Nobody does this on the scope that VA is doing this now. So I think that one's different than the pain management.

Mr. RUIZ. Okay.

The CHAIRMAN. Dr. Abraham.

Mr. ABRAHAM. Thank you, Mr. Chairman. We were fortunate last week to be able to be back in our districts among our veterans. And certainly, my study, or my county was unofficial and small, but I did poll my veterans, about 56 or 60. And what I found is what we alluded to the Chairman's statement earlier in this hearing, that up to 62, 63 percent of my veterans are still having significant wait times. And again, an unofficial, small study. I understand that.

So, I guess my question, Secretary Gibson, to you, is under VISN 16 when Secretary McDonald was here before, we had some issues, that you guys said it is greatly improved, and I will take your word for that to a point, you know that. But are we—and again, it may just be my lack of knowledge—are we able to access the VA's data as to how you figured wait times, the actual tactics and logistics of how you got to those numbers?

Mr. GIBSON. We would be glad to come walk through exactly that.

Mr. ABRAHAM. I would appreciate that.

Mr. GIBSON. We would be delighted to do that.

Mr. ABRAHAM. I would just like to understand how your figures, how you get the numbers you get to?

Mr. GIBSON. We would be delighted to do that. And that includes figuring out whether or not emergency department visits are included in the average wait times. Because people keep handing me notes that say they are included, and I have been told repeatedly they are not. So we are going to figure that one out definitively.

Mr. ABRAHAM. Thank you. And Dr. Shulkin, I will ask you this: Will the veterans be able to choose a community care provider of their own, or will it be from an approved VA list?

Dr. SHULKIN. The concept here is to have strict criteria that are based on performance, clinical outcome measures and service measures.

Mr. ABRAHAM. So you will judge that community provider based on the criteria?

Dr. SHULKIN. We are going to create network.

Mr. ABRAHAM. Can I get a copy of those criteria?

Dr. SHULKIN. Yes, yes. This would be still in development, but we have developed two types of principles. One is what develops, what we are calling this core service, or foundational service, about what VA really needs to be expert in and what can be done in a community. And secondly, the specific criteria for criteria on quality and service measures.

Mr. ABRAHAM. And again, what I am, I guess, more interested in certainly from my aspect, is just the criteria part of the primary care, because I think this is where we started and we talked about specialists earlier, and you said you would need more approps to go that direction.

Dr. SHULKIN. Yes, sir.

Mr. ABRAHAM. And the other question I have is how much cost savings would result from setting all non-VA care reimbursement at the Medicare liable rate?

Dr. SHULKIN. There are some savings. I think that they are built into the plan. Do you recall the number?

Dr. YEHA. So we—I don't have the number off the top of my head, but what we hope to do is move more towards regional Medicare rates, and those rates include calculations for graduate medical education, as you know, in geographic rural areas. That is our intention is to move more towards Medicare rates. We know we can't get there 100 percent in every locale, because there is going to be certain geographic location and certain specialties, that in order for them to partner with us, where the community rate is higher than Medicare. So our goal is to move towards—closer and closer to a standard Medicare rate that is regional across the country, and allow exceptions as necessary for local communities.

Mr. ABRAHAM. Thank you, Doc. My last question, should the emergent and urgent care expansion that the plan introduces be implemented? Will coverage of emergency care be available to veterans who are enrolled in the VA health care system, but are inactive, which VA currently defines as a patient who has not accessed VA care in 2 years. Dr. Shulkin, you are nodding your head.

Dr. SHULKIN. The plan that we have proposed for you says that a veteran would need to have active contact with the VA system in the past 2 years to be eligible.

Mr. ABRAHAM. To be eligible for the emergent and—

Dr. SHULKIN. That is correct.

Mr. ABRAHAM. Okay, thanks. That is all the questions I have, Mr. Chairman. Thank you so much.

The CHAIRMAN. Thank you. Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman. I would like to give a first shout-out to Ghost and the Marine Riders at the Leatherneck Club in Las Vegas. I rode on the back of one of their motorcycles in the Veterans Day Parade. This was a great honor for me, but also, I am no dummy, because in a parade, somebody's going to boo you. But when you are on the back of a Marine motorcycle, you are just getting a lot of this and a lot of this and a lot of cheers.

Mr. GIBSON. We want to see pictures. We hope they are on your Web site.

Ms. TITUS. That made me feel really good.

Second, I want to thank you, Mr. Gibson, and the Secretary for helping us to get a director for the new hospital. That was very important, you did that. I am looking forward to meeting Ms. Kearns when she gets there on the ground and working with her. So thank you very much for that.

We have heard around the room a lot of people talking about the confusion over the Choice Act and the community care programs; there are different ones, different benefits. And it is not just the veterans that are confused, but also the staff is confused. Now just about the time they get the hang of that, we are going to change it all over the next 5 years and have another new program. I want to be sure that you are building into your plans ways to train people and to educate the public so we don't have to go through this every time.

Dr. YEHA. I will take that, that is such a great question. And in the actual system redesign and solutions, that first bucket of costs, are a lot of resources dedicated to training and communications. When we were developing the plan, as I mentioned before, we looked towards industry, but also to our partners at DoD and TRICARE. That was one of the big lessons that we learned when we sat around the table with our TRICARE colleagues, is over their decades experience of delivering such a system, the importance of educating the staff, the community providers and their beneficiaries on that. So some of those costs for training are baked in. And in that \$421 million that we are requesting, that includes some of those exact things so that people—to eliminate that confusion.

Ms. TITUS. I think that would be very helpful so that people will know where to go, what they are getting, one program, and understand it. And that will be a big hurdle that will be overcome.

Another thing, since this is a 5-year program, I think we are seeing move very rapidly, medical marijuana, in the States, half the States already have it. It is recommended, it is legal. Doctors in communities do this, issue cards. We see it in the MILCON bill on the Senate side, saying the VA can do it for maybe this year. Are

you considering this, let's not get behind the ball again on an issue, let's get ahead of it.

Dr. SHULKIN. We would need legislative support to be able to consider that. Right now as you know, we are not able to offer that. I think that the science on this and the experience in the community that is happening across the country suggests that this is something that we should be looking at more carefully, and we welcome working with you on that.

Ms. TITUS. I just think it is going to be a community health issue. And if we are moving to more of that kind of service, we need to be aware of it, not put our heads in the sand on this issue.

Ms. BROWN. Would the gentlewoman yield for a question?

Ms. TITUS. I will yield.

Ms. BROWN. My understanding is that we in Congress passed a law saying that the VA doctors, even in the States that it is legal, they cannot administer marijuana.

Ms. TITUS. I appreciate that, and I will take my time back. I understand that is the case, but I also understand that it has been put into the MILCON bill on the Senate side for 1 year that in States where it is legal, the VA can't refuse to do it. So I don't know if that is going to be part of the compromise or not, but I hope it is. I am supportive of that. But either way, it is an issue that is moving very rapidly, and we need to be on top of it. I yield back.

The CHAIRMAN. Mr. Coffman, coming from a State where marijuana is legal.

Mr. COFFMAN. Thank you, Mr. Chairman. I think you are going to bring those chicken biscuits and we are going to have some brownies from the State of Colorado.

Mr. Gibson, you touched on—first of all, I think this is moving in the right direction, but you did touch on some issues involving TPAs, the third party administrators. And I think being at a decision point whether or not you want to move that in-house and what the problems are. Could you, just briefly, touch on some of the issues, again, that you see with TPAs?

Mr. GIBSON. First of all, and we do this every single day. I think the guys get tired of hearing me do this. I say, guys, we are just going to do the right thing for veterans, and allows us to be the best steward of taxpayer resources. So as you look at all the different functions, scheduling would be a function, processing claims would be a function, building and maintaining the provider network. I am sure I am leaving some out.

So you have got all these different functions, in every case, we have to make a deliberate decision, do we do this ourselves or do we outsource it? And the criteria are just that simple. What is right for veterans, what allows us to deliver the best service to veterans, and allows us to be good stewards of taxpayer resources.

So where it makes sense for us to outsource, believe me, we are going to head off in that direction.

Mr. COFFMAN. I would encourage you not to bring the third party administrator functioning in, simply because I think you have been objective with this Committee on problems with third party administrators. I think we have had a problem, quite frankly, when issues are done internally. Sometimes we just don't get those re-

ports that are accurate. My situation with the hospital in Aurora, Colorado, where we have been told, even despite the fact in 2013 there was a GAO report that said this hospital, and three other hospitals that were currently under construction, were each, hundreds of millions of dollars over budget, years behind schedule, that we would be told by Mr. Hagstrom before this Committee that everything was fine, and it could be built for \$604 million.

He testified in Colorado. Last year at a formal field hearing that it could be built for \$604 million. Then all of a sudden, the VA loses litigation in December of last year. The general contractor walks off the job and says, we are not going to come on the job unless the VA is off the job. The Army Corps of Engineers steps in, does an assessment and comes up with a number of \$1.73 billion.

So I just think that I like the idea that there is this tension between yourselves and a private entity, and that you're objective with us in terms of the problems. Because what we tend to do is find out problems from whistleblowers or litigation in the case of the Aurora Hospital. And so, I just want to encourage you that whatever issues you have, make it work with them because I think that the problems would be much greater in-house, and we, quite frankly, would not be made aware of those problems on a timely basis.

Dr. SHULKIN. Congressman, I would just say as the Secretary says, as the Deputy Secretary says, and as I say, this is not business as usual. We have learned painfully from those lessons, and we are looking at every issue as they make—

Mr. COFFMAN. I am sorry. God bless you for trying, but we get that every time, every year. Every year, there are VA leaders that step before us to say, it is going to be different now, we are going to change now, the culture is going to change. We got—it is newer, bigger, better, and then the following year, we find out it is not, newer, bigger and better. And the same problems exist, if not deeper. So it is what it is, and I think you mitigate that by using things like a third party payer, you know. I think that arm's length distance between them is positive. And I think make it work, because I certainly will not support expanding the VA bureaucratic footprint after the experiences we—I have observed being a Member of this Committee. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much. Mr. McNerney.

Mr. MCNERNEY. I thank the Chairman, I thank the panel for having a welcome positive hearing today. The thing that I am concerned about is we have a plan to consolidate the purchase care programs. And maybe I missed your testimony earlier on that, but what sort of—what is the basis for believing that this is going to be a better provider than what we already have or what has already been tried in the past? Is there a statistical basis? Is there a model that you have seen that has made this transition? What makes you think that this is going to be a better program?

Dr. YEHIA. So thank you. I think that is a great question. I think the goal here was that we have a number of these different programs, this patchwork of different community care programs. We want to move more towards a standard, what we are calling a high performing network. And so, we think this is good because this is where health care industries are moving. We have learned lessons

from our Federal partners, such as DoD and TRICARE. And at the end of the day, we want to create that seamless connection to a complementary network in the community that veterans can access. And we are basing that on things that have been demonstrated well in the community, in the private sector.

Mr. MCNERNEY. Has there been any coordination with the DoD in terms of transferring data or care information so that veterans that are recently out don't have to go through the huge rigmaroles?

Dr. YEHIA. Yeah, when we first started this effort, we worked very closely with our DoD partners. Again, recognizing them as having many similarities to VA, they operate TRICARE. And so, we sat down with them on multiple occasions to learn about lessons learned, best practices and we continued to work with them. The concept of them vetting some of our TPAs in our medical centers, that was something that TRICARE did. And so we are using a lot of those lessons learned from them.

Mr. MCNERNEY. I mean, one of the biggest concerns we have is the transition between the DoD and the VA. I have often thought that we just need to have a czar that can tell people what to do instead of having bickering back and forth, but—so you are saying, hey, this is actually happening, we don't need to have a big gun that is going to make this happen. Is that right?

Dr. SHULKIN. Yes, that is correct. We are—DoD has been very integral in support of our move towards this type of new plan. And we have several oversight Committees that we jointly chair between DoD and VA, where this is a standing agenda item, we are working in between meetings, but also have oversight over this. And actually, I think, from my perspective, this is going in a very positive direction.

Mr. GIBSON. I will tell you, we all spend a lot of time out in the field. There are countless examples of close collaborative work locally between VA facilities and DoD medical treatment facilities, where they are just doing amazing. I was in Charleston, South Carolina, Baligh and I both were down there last week. I went out to Goose Creek where we jointly operate a clinic with the Navy. And one of the things we were able to do is jointly fund the purchase of an MRI. What you find is you have got a DoD doctor, you have got VA med techs that are running the facility day in and day out. And on 2 days of the week, you will find DoD patients coming in; on 2 days of the week you will find VA patients coming in.

It is that kind of close and collaborative relationship, and it is happening all over the country. The one other issue that gets at this VA-DoD collaboration that I sort of sense you are alluding to, has to do with the exchange of health information. And before you arrived, the Chairman has agreed to buy the chicken and biscuits for us and come over and do a demo for the Members of exactly how we are exchanging information today, day in and day out.

Mr. MCNERNEY. That was going to be my next comment is how useful would it be for the Members of the Committee to actually see that. So Chairman, you are ahead of me. I congratulate late you. I yield back.

The CHAIRMAN. Thank you. Mr. Huelskamp, you are recognized.

MR. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the gentleman for joining us here today some very exciting questions and comments. I have some follow-up I would like to ask.

First, I did have a town hall in Colby, Kansas, which is way up in northwest Kansas. And a veteran was actually leaving that town hall, was going to drive to Aurora, Colorado, to pick up a hearing aid. That is 227 miles, one-way drive. Gentleman, there is a provider in Colby, Kansas, that you won't approve. I mean, Choice is supposed to fix that. Telling him to drive that far for something he should drive two or three blocks is unacceptable.

Mr. GIBSON. We agree completely. It shouldn't happen.

Mr. HUELSKAMP. It shouldn't happen. And that is what we were hoping to fix. Couple of questions on that. But first, on the aspirational document, it certainly is aspirational, especially if you look at the cost. What is the 3-year cost, your estimate to implement this plan?

Mr. GIBSON. As I pointed out in my opening statement, the essential costs that we are focused on right now is actually the cost of the consolidation itself. The much larger numbers have to do with anticipated, increased reliance. And the other module, if you will, which has to do with opening the aperture on access to emergency care and urgent care, which we believe is really—we are not serving veterans well today with the current statutory approach that we have to those aspects of care.

Mr. HUELSKAMP. And I agree. By the way, you did pay that veteran to drive the 454 miles, that is just a minor savings, but he also did that same drive just to get the appointment.

Mr. GIBSON. Let me make just one really quick comment, because we started working this over a year ago where we weren't able to use audiologists in the communities because they weren't able to access our advantageous contract for hearing aids. And what we have done is we have changed that. We fixed it so that now an audiologist in the community can actually access our advantageous contracts for purchase of hearing aids. This, what you are describing should—absolutely should not be happening.

Mr. HUELSKAMP. Yeah, I agree. But on the budget, if I did the figures correctly in pulling the Choice out of that, which is another question, if I read correctly, it is about a \$10 billion, 3-year cost for implementation moving forward on this plan, is that rough and ready figures?

Mr. GIBSON. Again, what you are referring to are the costs associated with increased reliance, as well as the cost associated with opening the aperture.

Mr. HUELSKAMP. Well, I just wanted to make sure, because—

Mr. GIBSON. The critical issue, at this point, has to do with consolidating these seven or eight different programs into a single channel for community care that veterans and providers—

Mr. HUELSKAMP. Oh, I understand the approach here, and I have some follow-up questions on that. But not even including the extension of Choice, I think I see the figures is 10 billion in 3 years, so if I am wrong on that, please confirm that. So it is certainly an aspirational document. There is not going to be \$10 billion we are throwing out there for this.

But one thing I want to ask strictly for the authors of the report, I mean, you only had 2 months to put this together. Can you lay this over top of the 4,000-page independent assessment that said we have a leadership crisis here? How are you going to fix—I think you have to fix the leadership crisis before you even talk about implementing this massive change. It is very big. So gentlemen, if you can provide some insight.

Mr. DALPIAZ. Well, I think I will leave the leadership question to the Deputy. What we did with the independent assessment is we pulled out each one of the items that related to community care. So anything that looked like it would line up, with our proposal, we literally took word for word from a document, incorporated it and assured that we are covering it, and that it was sensitive to the independent assessments. The leadership part I will leave to others.

Dr. SHULKIN. Yeah. Just very briefly, two quick things. The amount of money that we need to get this going to consolidate care in the community is \$421 million. The other parts of it are things that—

Mr. HUELSKAMP. That is not what is in the numbers. The incremental cost of implementing its consolidation plan, just one portion is \$400 million to \$800 million annually. That over 3 years is about \$2 billion just for the incremental cost of implementation. So if you could clarify that for the Committee, I mean, these are your numbers.

Dr. SHULKIN. Right, right. In fiscal year 2016, it will be \$421 million incrementally. And those systems then would essentially carry into the future years. You are right.

The emergency care that the Deputy referred to is, has a separate price tag that is decided upon. That could be decided not to proceed with, or that could be decided to proceed with, and the increased reliance has a separate price tag. That means when you make the system more useable, we think more veterans will come into the system.

In terms of the leadership issue, you are absolutely correct, Congressman; this is our critical factor. We do not have a hope of implementing this plan without the correct leadership, and we are focused on getting leaders in to fill our medical center positions, our regional positions and our central positions, including finding a Deputy Under Secretary that will oversee plan who has the experience in managed care and population health to make this successful.

Mr. HUELSKAMP. Is this the new Under Secretary position that you proposed to create?

Dr. SHULKIN. We have submitted an organizational chart to you that this is a new position, because VA currently does not have this level of competency in a senior executive position who knows how to implement this plan.

Mr. HUELSKAMP. Hopefully, we might have a second round, Mr. Chairman. I apologize.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. First of all, let me just say that as far as the leadership team in front of me, I am im-

pressed. In particular, with the medical leadership with the graduate from the University of Florida.

Now on for my questions. I understand that TRICARE had 2-1/2 years for preparation before it rolled out its program. We had less than what, 2 months? If you had more time, I mean, we insisted that you roll it out in this time period, we put in some new rules and regulations, particular as pay to the providers. Can you give me some feedback on that?

Mr. DALPIAZ. Having the opportunity now to look back on those 60 days that someone had to write requirements, we learned a lot of lessons. One of which is, in the future, we probably wouldn't contract out the customer service portion of what we do. We did that. And when we talk about the requirements for what a future network might look like, that really is coming from not only the lessons we learned in the last year, and last year and a half. It is really TRICARE lessons as well as you point out.

So one of the requirements that you see are things that we envision in the future network based on our experience and things that we would have done much differently if we had more than 60 days to stand this up.

Ms. BROWN. In the draft agreement legislation you submitted to the Subcommittee on Health, you discussed requiring providers to submit medical records to the VA. Will payments to the provider and return of records be linked? There has been a source of controversy for current providers under the Choice Program, and, of course, it is about timely payment.

Dr. SHULKIN. Congresswoman, we recognize that the timely payment issue to our providers is a critical issue, because it could threaten access to veterans. And coming from the provider side, I am very sensitive to providing a service and not getting paid. So we are going to be encouraging two things of our providers. The reason why we don't perform as well as we should on timely payments is because only 40 percent of our payments are received electronically, and the industry standard is above 95 percent.

Secondly, we are adjudicating 100 percent of our claims when the industry standard is more like 5 percent. So we want to fix both of those and we are going to be reaching out to the providers. We saw the article recently about the Florida providers and the amount that is owed to them. We are going to be reaching out to them to ask them to send us their information electronically, and delink some of the requirements for medical record documentation. We do need to get the documentation back to provide good continuity of care, but we want to be providing prompt payment to our providers.

Ms. BROWN. When we collapse the various programs and, you know, it has been a lot of discussion about the Choice Program and the program that we had in the community for years, but I think it is a difference in the payment, one program over another; what will this plan be for the future?

Dr. YEHA. So, that is exactly right. When we looked at all the different programs, they all had different eligibility criteria, different payment rates for providers, different rules that they have to sign up to work with us. So we are trying to move more towards a uniform standard approach.

I think as it relates to payment, we want to move towards industry standards, which, in many areas, is Medicare, and so those are the regional local Medicare rates. They take into account if you are living in a very rural area, or have a training program. And so this is our intention, is to move towards that standard payment, with the caveat being that in some locales, like Alaska or highly, highly rural areas, or certain specialties, we might have to go higher than the Medicare rate. But the standard we want to move to is towards Medicare.

Ms. BROWN. Mr. Chairman, I yield back. Are we going to have a second round?

The CHAIRMAN. Thank you very much. We are going to do a second round of questions, if I can. I may deviate just a little bit from the purpose of the hearing.

But, Mr. Secretary, how much money remains in the Choice fund, and what is the current estimated time of depletion of the current funds?

Mr. GIBSON. There is currently, in the 802 section of funds, about \$6 billion roughly. And a rate at which we extinguish that will be very much a function of care in the community utilization during fiscal year 2016.

The CHAIRMAN. Do you expect that it will be depleted by the end of fiscal year 2016?

Mr. GIBSON. I think that there is a chance it could be. We have got about \$9 billion in care in the community budget in our core budget for care in the community for 2016. And so, as you look at current run rates, we actually spent over 10 in 2015, but there was an awful lot of ramp-up that happened over the course of the year. So we could potentially find ourselves exhausting the remaining \$6 billion. But based on the numbers I see right now, I think it is less likely that we would.

The CHAIRMAN. Okay. I asked the question because on a—in a hearing on the 25th of June, you stated, and I quote, “Referring to hepatitis C anti- and viral-infected veterans to the Choice Program is not the best model to provide care for taxpayers or veterans,” end quote. And we infused a large amount of money to help you with your capacity. You said you had the capacity internally to handle that. But I have been told now that VA has reduced new treatment starts to about 300 per week, and it is treating only those patients with advanced liver disease. So all the veterans that are seeking the hep C treatment are being pushed outside to Choice. And I want to know if that is a true statement. And if so, why has the guidance and the model from care from HCV changed from September?

Mr. GIBSON. Yeah, first of all, we appreciate allocating the \$500 million that you did to allow us to pay for the pharmaceuticals. We did dramatically accelerate starts during that period of time and we are able to get—I am not going to remember the number off the top of my head—a very large number of veterans started before the end of year, expending somewhere over \$400 million worth of the \$500 million that was allocated.

I suspect that part of what has happened there is that we cleaned out some of the pipeline. We basically had veterans that

were in the queue to receive that care and that were eligible for the care, and that basically, we started getting them that care.

I also know that the funds, budgeted funds for hep C in 2016 are substantially, very substantially less than what we had allocated and spent during 2015. And that does create a situation where we have got to ensure that we don't get ahead of ourselves in terms of spending those funds.

The CHAIRMAN. And if I might, Ms. Titus talked about a parochial issue, or Ms. Kuster, I think it was, a minute ago. I have one too, but I have a sneaking suspicion it is not just to the first Congressional district. I had a veteran come up to me at a ceremony on Saturday that said that he had been scheduled for a surgery at a VA facility, and he was called on the Tuesday of that week, and was told that VA didn't have any money in order to perform that surgery, and that he would have to be put in the Choice Program which would delay his surgery.

So my question, I guess, is twofold. Number one, why in the world would anything like this ever occur? And number two, it appears to me that there may be facilities that are protecting their internal funds by pushing folks out into Choice so that they will have those dollars to utilize them. This was an elderly veteran. We have since talked to him and gotten the laydown as to actually what was said. But can you explain why anybody would say VA had no money?

Mr. GIBSON. Sure. Well, no, I can't explain that. Please ask John to let me know—give me some particulars—I was looking for him, but I don't see him—oh, there you are, had your head down—to give me some information on the particular veteran so that we can follow-up specifically and make sure that that veteran gets the care they need.

Secondly, I cannot conceive of why we would say that we don't have any money to perform that surgery inside VA. So that makes absolutely no sense to me.

Third, I would tell you, as we look at October obligations, total obligations in October for care in the community exceeded \$1 billion. Only \$140 million of those were for Choice. I can't imagine why we would be telling a veteran, you know, you have got to go outside for Choice instead of us providing that care inside, or either with another community provider. It makes no sense.

The CHAIRMAN. Thank you. Ms. Brownley.

Ms. BROWNLEY. I don't have any further questions, but I just wanted to make a quick apology, because I made the common mistake in my earlier comments of calling TriWest, TRICARE. So I wanted to apologize to TriWest. I presume everybody understood what I was saying because nobody corrected me until my staff, after I finished, said I kept saying TRICARE instead of TriWest so I wanted to apologize. Thank you, Mr. Chairman.

Mr. GIBSON. Thank you. I know Dave appreciates that.

The CHAIRMAN. Mr. Huelskamp.

Mr. HUELSKAMP. Hopefully they will be short here. If I might make a request following up on the gentleman that wrote the report. Would you go back and read the independent assessment and provide some direction compared to how you can implement the Under Secretary as well. Something in writing so I can wrap my

arms around this. And appreciate the Chairman's questions about the funds left in Choice. I wouldn't want to run—run out of money with that at a very critical time. 2016 becomes—every 4 years, becomes kind of a silly season around here, and so I appreciate the reference to that.

But to follow-up with the gentleman that talks about moving to the Medicare reimbursement rates, which is perfect. That is all my hospitals, and we have 70 of them are looking for, and the independent providers. Medicare audiology obviously doesn't work well, different rate structure. But what bothers me is requiring these providers and dozens of hospitals to go through a different certification system.

Why is the Medicare certification system, which has been around for decades and has its problems, but it is there, they are qualified for Medicare. And by the way, these hospitals serve more veterans than you all do, those that are outside the system. So explain why we just can't use all the Medicare certification system, and save all the problems and move on?

Dr. YEHA. Well, I agree with you. I think what we want to do is move more towards that industry standard. I think two points there: One in terms of rates; and two, how we partner with providers. So the concept of provider agreements, again, going back to that. We have—a lot of that is based, and the word "provider" is based on Medicare. And so it is how we can simply partner with our community providers to be able to deliver care to veterans without going through a complicated contracting process. That is exactly what we are looking to do.

And when we think of credentialing, the plan talks about moving to standardized credentialing that everybody else does. So we don't want to require anything—we don't want it to be burdensome for these critical community providers that we need to partner with to deliver care to veterans.

Mr. HUELSKAMP. Currently, there is a separate credentialing process or just VA compared to Medicare?

Dr. YEHA. Currently, there is different credentialing rules for the different programs. So when the Choice Act was written into law, there was actually various credentials that we have to have in order to work with those providers. The Committee was able to expand some of those eligibilities to include, like, Medicare payments and—or Medicare providers and others. So some of those were Medicaid providers and others. So some of those have been, are in statute or regulation. So if we are looking toward moving towards that standard, we might need your help to change some of these laws so that they are consistent with those standards.

Mr. HUELSKAMP. I don't remember those restrictions being in there. That was my outcome. That would save us all some time, trouble, and money, and folks driving 227 or 400 miles. That is what we are aiming at, so I appreciate your recognition of that. So I have—again, 70 community hospitals could tell you, we have already credentialed and the payment agreement is—understood. I mean, if you can tie into the Medicare rates, I think you solved about 50 percent of the problems for these providers and for their veterans. So I appreciate that, and appreciate the response. And if

you put this in writing as well, so I can understand that, Mr. Chairman. So thank you for the time.

The CHAIRMAN. Ms. Brown, do you have any further questions?

Ms. BROWN. Just a comment. With the change of the presidential administration in 18 months, and the turnover of higher level employees in the VA, are you concerned about starting the consolidation program, and then having it stall? And just, I have been listening to some of the candidates speak and they clearly don't have any understanding about VA's operation, and, I mean, comments candidates make, someone has been in an emergency room waiting to be seen for 8 hours. Bull. So can you respond to that?

Mr. GIBSON. I certainly—I would love to. And I would tell you two different thoughts here: Number 1, what we are trying to do is to lay out a path that has been developed collaboratively with Congress, with VSOs, with the provider community, so that this winds up being something of an inexorable direction that we want to head for care in the community.

The second thing that it would offer up, I think one of the vital roles that this Committee can play is helping to ensure some continuity of effort across the administrations. So as we work together on developing some of these solutions, having this Committee, and all of Congress frankly, Senate Subcommittees, as a collaborative partner in this process, it gives you an investment in the direction that we are taking so that there is some expectation that that continues in the future administration.

Ms. BROWN. I agree 100 percent. This Committee that I've been on for 23 years, has always been very bipartisan. I mean, when veterans go to fight, no one asks them what party, you know, Democrat, Republican, or Independent. And, of course, I think that Congress, you know, for many years, we did not adequately fund the VA. And I am glad that we are now soldiering up. I like that word. I learned it last week, and I am using it. And we need to do our part. So any final comments?

Mr. GIBSON. We are trying to do our best to soldier up too. Okay?

Ms. BROWN. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Ms. Brown, very much. Thank you to the witnesses for being here today. We appreciate the effort that you are putting into this consolidation program. We know it is moving in the right direction. There are many, many moving parts. We will have more questions, I am sure, as the process continues on. But I would ask unanimous consent that all Members would have 5 legislative days with which to revise and extend their remarks, and add any extraneous material. Without objection, so ordered. With that, this hearing is adjourned.

[Whereupon, at 12:31 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Chairman Miller

Thank you all for joining us for today's oversight hearing entitled, "Choice Consolidation: Assessing VA's Plan to Improve Care in the Community."

In late July, Congress authorized the Department of Veterans Affairs (VA) to use a substantial portion of the Choice program funds to cover the Veterans Health Administration's multi-billion dollar budget shortfall.

In turn, VA was required to submit a plan to the Committee detailing how VA would consolidate and improve the many fractured programs and authorities that the Department currently uses to refer veterans to non-VA providers.

We are here today so that VA can present this plan to the Committee and, together, we can measure its merits and challenges.

Non-VA care - or, Care in the Community, as VA now calls it - is an increasingly vital component of the VA health care system.

Each month, veterans, survivors, and certain dependents of veterans receive approximately one million appointments - more than twenty percent of all the appointments VA provides - from doctors and nurses and other health care professionals in community hospitals and clinics outside of the Department's walls.

Allowing veterans to see these providers is vital to ensuring timely and convenient access to care.

And, I suspect that, as the veteran population continues to grow in both age and number and as the health care landscape continues to shift, the need for non-VA providers to supplement - and please note that I said supplement, not supplant - the care that VA provides in-house will only continue to grow.

But, the success of VA's Care in the Community program is hampered by inconsistent and competing eligibility requirements, business processes, and reimbursement rates across the seven methods that VA currently uses to refer veterans to outside providers.

As a result, non-VA care as we know it today has become unmanageable and unsustainable.

The success of the VA health care system over the next several years will depend in large part on VA's ability to consolidate these seven disparate methods into a single, coordinated program that is easy for veterans and community providers to understand and buy into and easy for VA employees to administer and manage.

This is no easy task.

It will require us to have some difficult conversations about the purpose of the VA health care system and what it should and feasibly can achieve.

It will also require us to examine VA's massive physical footprint and make decisions about the future of facilities that once served a great purpose but may no longer be benefiting our veterans as they should.

The plan that the Department submitted in late October to accomplish non-VA care consolidation and take the first steps toward building the VA healthcare system of tomorrow offers a promising but still poorly defined vision of a future ideal state of VA care that offers little in the way of concrete details, timelines, or goalposts - leaving us blind as to how VA intends to get from where we are now to where we all know VA needs go next.

I am hopeful that the testimony and responses that we will hear this morning will shed some much-needed light on how VA intends to transform the fractured collection of non-VA programs and authorities that we have today into the coordinated system of care that our veterans truly deserve.

I am grateful to the Deputy Secretary, the Under Secretary for Health, and the two leaders of VA's consolidation effort for being here this morning to present the Department's proposal and I now recognize Ranking Member Brown for any opening statement she might have.

Prepared Statement of Honorable Sloan Gibson

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

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in demand for care, it is essential for VA to partner with providers in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans and community providers, as well as VA employees.

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

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

VA Budget and Choice Improvement Act Legislative Elements

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

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

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

VA anticipates improving the delivery of community care through incremental improvements as outlined in this plan, building on certain provisions of the Veterans Choice Program. The implementation of these improvements requires balancing care

provided at VA facilities and in the community, and addressing increasing health care costs. VA will work with Congress and the Administration to refine the approach described in this plan, with the goal of improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs.

The Path Forward

The design of the New VCP (Legislative Element 1) is based on feedback from Veterans, Veteran Service Organizations (VSOs), VA employees, Federal stakeholders, and best practices. VA's plan centers on five functional areas. Within each functional area are key points to enable Veterans to receive timely and high-quality health care.

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

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

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

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

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

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

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

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

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

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

The New VCP will use a system of systems approach to enhance these five functional areas as part of the larger VA health care transformation. This approach stresses the interactive, interdependent, and interoperable nature of external and internal components within VA's health care delivery system. The New VCP includes enhancements to the following systems, which will have a positive impact on VA and the greater Veterans' health ecosystem:

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

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

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

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

requirements (Section 5) and legislative proposal recommendations (Section 6) for additional information.

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

VA cannot reach the future state alone. Ongoing partnership with Congress will be critical to addressing the budgetary and legislative requirements needed for this important transformation, including outstanding decisions on aspects related to sustainability and cost-sharing. The support and active participation of Congress, Federal partners, VA employees, VSOs, and other stakeholders are necessary to achieve more efficient, effective, and Veteran-centric health care delivery.

Conclusion

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

Thank you. We look forward to your questions.

