

CHOICE CONSOLIDATION: LEVERAGING PROVIDER NETWORKS TO INCREASE VETERAN ACCESS

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BEFORE THE

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OF THE

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CHOICE CONSOLIDATION: LEVERAGING PROVIDER NETWORKS TO INCREASE VETERAN ACCESS

Tuesday, March 22, 2016

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Bilirakis, Roe, Huelskamp, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, Kuster, O'Rourke, and Brown.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. Good morning. The Subcommittee will come to order. Thank you all for joining us for today's Subcommittee hearing, Choice Consolidation: Leveraging Provider Networks to Increase Veteran Access. This is our third in a series of hearings on different key aspects of the Department of Veteran Affairs' plan to consolidate care in the community programs under a new and improved Choice Program.

In February, we discussed eligibility for care and billing and reimbursement under the consolidation plan. Today we will discuss provider networks. VA's consolidation plan proposes a tiered provider network composed of a core and external network of providers.

The so-called core network would be managed by VA and consist of federally funded health care entities from the Department of Defense, the Indian Health Service, tribal health programs, and federally qualified health centers, as well as academic affiliates.

The so-called external network would be managed by third-party contractors across four distinct regions and consist of commercial health care providers from the private sector who would be divided into a preferred network of providers who meet certain quality and performance metrics, and the standard network of providers who meet minimum standard criteria.

I understand the advantages of a tiered network. Namely, that it allows the VA to organize and differentiate between providers by type and quality. However, I am concerned that the tiered network the VA has proposed will hold government and academic affiliate providers to a different, perhaps a less stringent, standard than

private sector providers will be held to. That is fundamentally unfair; it is also unnecessary.

Government and academic affiliate partners have existing relationships with VA that are longstanding, unique, and important that already put them at a significant advantage when compared to private sector providers who, for far too long, have been held at arm's length by a department who did not want to treat them like peers and partners in providing high-quality care to veteran patients.

What's more, government and academic affiliate providers are fully capable of competing with private sector providers using the same quality and performance criteria that VA has proposed, and they should compete. Some government health care entities and some academic health care entities are world-class, best in show providers. But some are not. We need to know the difference between the two, and more importantly, our veterans deserve to know the difference between the two, and to be referred for care accordingly.

I also want to ensure that under the VA's tiered network proposal and individual veteran's choice in who to receive care from will still be preserved. Our veterans have earned their health care benefits in many cases through blood, sweat and tears. The least that they deserve in return is a choice.

Finally, I want to make sure that the significant infrastructure that has been built, largely with taxpayer dollars, since the current Choice program was created in 2014 is not lost as the VA transitions to a consolidated approach. Implementation of the current Choice program has not been a smooth or as easy as any of us would have hoped. Indeed, setting up a program of such magnitude under such time constraints never is.

I have heard complaints from providers in northern Michigan, for example, that report having to spend significant amount of staff time on the phone resolving authorization, scheduling, and payment issues. It is far from ideal. I would encourage the VA and both of the third-party administrators to continue to work to resolve issues as they arise and make Choice work better, faster, and easier for veterans and community providers.

However, a lot of gains have been made, a lot of lessons have been learned, and a lot of relationships have been built in the last year and a half around the current Choice program. As we move forward, we have to ensure that those gains are not needlessly sacrificed in pursuit of the new, which is sure to carry unforeseen problems all its own.

I look forward to hearing from all of our witnesses this morning, and thank you all for being here. And I will now yield to Ranking Member Brownley for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you for calling this hearing on VA's future plan to provide safe, quality health care to veterans by implementing a high-performing network in partnership with Federal partners, academic affiliates, and

the community. VA believes veterans will exercise their choice when it comes to where and when they receive health care.

This is the third in a series of hearings held by the Subcommittee to examine details of the care consolidation plan, which was submitted to Congress in October of last year. Last month we heard from stakeholders on eligibility criteria and VA's plan to improve community care billing and reimbursement. Today, we will receive testimony on the very important provider networks.

I understand the VA's plan is to build a high-performing network that will consist of three separate tiers, with tier 1 being with our Federal partners and academic affiliates. Tier 2 will consist of top-rated community providers. And tier 3 will be the community providers who meet standard criteria.

VA's objective is to ensure veterans will have the ability to choose which provider he or she would like to see for care. According to the VA, the tiered network structure will allow VA to provide the veteran with information to make an informed choice about the right provider to see. The goal is to reduce confusion for the veteran on where to seek high-quality health care by streamlining the transition from a VA facility to a community facility.

We are all aware that the devil is in the details. When the plan was first received, the implementation of a high-performing network was somewhat confusing and unclear. I hope the VA today will shed more light on their plan regarding how this network will be built and how veterans will, in fact, be able to choose their provider. Continuity of care and the quality of care provided through this network should be first and foremost the top priority of VA.

Additionally, we must ensure that lessons learned from the past programs such as PC3, ARCH, and the current Choice program will be considered as we move forward with a new veterans choice program. I appreciate the testimony we have received, and I look forward to hearing from all of our witnesses today. So thank you, Mr. Chairman, and I yield back.

Mr. BENISHEK. Thanks, Ms. Brownley. Joining us on our first and only panel this morning is Billy Maynard, the President of Health Net Federal Services; David McIntyre Junior, the President and CEO of TriWest Healthcare Alliance; Dr. Baligh Yehia, the VA Assistant Deputy Under Secretary for Health for Community Care, who is accompanied by Dr. Gene Migliaccio, the VA Deputy Chief Business Officer for Purchased Care. Thank you all for being here today, I am looking forward to this discussion.

Mr. Maynard, we will begin with you. Please proceed with your testimony, and you have five minutes.

STATEMENT OF BILLY MAYNARD

Mr. MAYNARD. Thank you, Chairman Benishek, Ranking Member Brownley, and distinguished Members of the Subcommittee, thank you for the opportunity to participate in this hearing.

Health Net Federal Services is proud of our work leveraging private sector best practices to supplement and complement Federal agency capabilities. To this hearing, we bring the perspectives and lessons learned from throughout our nearly three-decade history supporting government health care entities at the intersection of

their care capacity and their need to support their beneficiaries, in this particular case, eligible veterans with care in the community.

My commitment to VA health care is personal. I am a veteran myself. I served in the U.S. Army for ten years. I am the son of a Navy retiree, born at Portsmouth Naval Hospital, and I am the grandson of a World War II combat veteran who benefitted greatly from the services of the VA following his return from that conflict.

I take the mission of the Choice program to heart and in this vein, I offer comments informed as much by the spirit of service, the spirit that led me and many members of my family to service, as by our business experience.

I want to thank this Subcommittee, and the Committee as a whole, for your leadership on the issues at hand. This Committee acted decisively in response to the revelations of extensive wait lists at some VA facilities. In Choice, you have created the foundations of a program that can serve as a viable model for the integration of VA's direct care capacity and care in the community as we look forward.

I also want to express my thanks to senior members from the VA, who from Secretary McDonald on have worked tirelessly over the past year to make the current Choice program work. In particular, Dr. Baligh Yehia and Gene Migliaccio, both of whom are here, have led key efforts to evolve the initial program and proactively address issues that have hindered program effectiveness in its initial implementation.

Today, over 2400 Health Net Associates located throughout the regions we support, and the Nation as a whole, directly support the Choice program, and it is a great honor for us to do so. Working with their VA counterparts, our associates have accomplished much. We have fielded some 2.5 million phone calls from veterans and community care providers as well as veterans' affairs staff; appointed what is rapidly approaching half-a-million individual veterans to community providers who might otherwise have remained on a VA wait list, and we have built a registry of nearly 250,000 participating providers located throughout the VA regions we support.

While there is still much to do, real progress has been and is being made towards the kind of public-private partnership through contracts upon which the effective delivery of health care for our Nation's veterans now depends.

A few points specific to the topic of this hearing. First and foremost, we believe all health care provided in support of veterans is VA care, whether delivered directly by the VA, by its close affiliates, or by community providers. Seamless integration of that care, therefore, is key, particularly at the intersection of the VA's capacity and community care.

Based upon our years of experience, we believe the only way all care will be seen and received by veterans as VA care is through mutual accountability in the framework of a public-private partnership contract structure.

Second, it is now clear, based on eligible veteran demand, that significant and continuing access to community-based care will be absolutely necessary to support veterans' health care needs in the future. Standardization in consolidation and the development of

clear and comprehensive policies addressing the full range of community care eligibility and programs is, therefore, vital. This was a central point in the independent assessment, and it has been a lesson learned in the initial implementation of Choice.

Third, we believe the preferred, also often referred to as a tiered provider, network construct that is part of VA's plan for the future can effectively deliver the necessary access to care in the community going forward. While there are other approaches, given VA's significant direct care mission and capacity, a tiered approach will ultimately be the most effective way for VA to optimize and integrate care while extending VA's ability to better focus on its core competencies. Of course, throughout that development, veteran choice must be extended and preserved.

Whatever geographic or provider network development approach VA takes, we feel it is necessary that VA partner with single third-party entities within each geographic area to administer all community-based aspects of the program. TRICARE is a good example of the lessons learned from attempting to do otherwise, as learned in the early days of their journey to the integration of community and direct care.

The seamless integration of community care is vital for the provider and veteran experience, and without seamless integration, neither providers nor veterans will ultimately want to participate at the levels necessary to ensure all eligible veterans are cared for.

In closing, let me say that in a program like Choice, veteran and provider experience is paramount. The success of any future program will depend, in large measure, on three interrelated imperatives. First, strengthening VA's capacity planning and optimizing their capacity in the face of veteran demand through Choice so that community care can be tailored to ensure ready access in every location.

Second, making the provider experience as consistent with community standards as possible, while respecting and recognizing the VA's need for visibility and access to veteran health care information.

And, third, streamlining the veterans' and provider experience so they are better able to control the process and receive and deliver care when and as necessary.

Health Net is proud to stand as a partner with the VA and this Congress in helping deliver care to our Nation's veterans. Thank you, Mr. Chairman and Committee for this opportunity to present our views. I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF BILLY MAYNARD APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you. Mr. McIntyre, you are recognized.

STATEMENT OF DAVID J. MCINTYRE, JR.

Mr. MCINTYRE. Chairman Benishek, Ranking Member Brownley, and distinguished Members of this Subcommittee, it is a privilege to appear before you this morning on behalf of our company's non-profit Blue Cross/Blue Shield and University Hospital System owners, and our 3,600 employees, most of us who are veterans and vet-

eran family members, to discuss how the Choice program is evolving in our 28-state geographic area responsibility. I am going to focus on the current, and I am going to focus on the journey we have taken.

Mr. Chairman, Janet Van Hagen is an Army veteran who lives in rural America. Before you passed the Choice Act, she used to drive four hours each way for health care. Now, thanks to you, she receives her health care close to home. Janet's doctors, joined by more than 180,000 providers in our geographic area, that are leaning forward in at the side VA, to make sure that those who are in the 28 states, that we are responsible for supporting—receive the care that they need when VA is unable to deliver it directly.

Yesterday, as is the case every day, more than 5,000 veterans in our area received care from this consolidated network, accredited by your Act. That is up from 500 a day a year ago. Of course, you might ask if things are happening as result of Choice, why am I hearing complaints from my constituents? That is a fair question. I would like to be candid with you.

In spite of the early successes of standing up the program, there has, and remains work to be done. You have modified the law that was originally passed. We and VA together have been modifying the tools and the processes to make the program as you would have expected it. I would submit, however, that a 90-day implementation period is extremely short. And at the end of the day, those of us in the private sector had a little more than 30 days to do our part of that work.

If you look at the comparative of TRICARE, and I was there 20 years ago at the beginning, they had more than three years to design the program and implement it. And it did require adjustments as we went forward. I know it is probably not positive or popular in some quarters, but I believe that this was a good thing for you all to do. I think it was the right answer in response to the challenge that came out of Phoenix and the other areas, and Janet Van Hagen would agree with that.

I have been impressed with the courage and the uncommon intensity with which the VA has acted. Just like you, their focus remains sharp. And the sustained pace and intensity at which we all continue to operate is daunting. However, if you look at our geographic area of responsibility, I believe that we in VA are gaining on it.

This month, we will field more than one million phone calls, with an average speed of answer of less than 16 seconds, and an abandonment rate of less than 2 percent. More than 100,000 veterans in our part of the country will receive care closer to home; a long way from the 2,000 served in the first month of this program. And our claims processor will pay more than 97.5 percent of clean claims within 30 days. And we have now processed more than 1.8 million claims for providers.

Is our work finished? Not at all. We all have a lot of work to do. The topic of this hearing gets to the next generation, but we have work to do in our current generation. Our network is finished, it is tailored to the demands of the VA medical centers that we support. It includes the federally qualified health centers, and it includes most of the academic medical centers.

It is ready to be leveraged to have a tiered network in our area. And most of the network is at market rate, which means that we extend the buying power of the taxpayer in support of the VA with any discount accruing to the budget of the VA. And our turnover in network is less than 2 percent. It includes specialty, primary care and behavioral health. And less than 1 percent of the appointment requests that we have require us to go outside of our network looking for another provider.

Second, getting to scale is a challenge. We now have ten sites of operation, 3,600 employees. On Friday, I was privileged to be in El Paso to roll out the final operations center, which is now serving our area.

Chuck Byers is a Vietnam veteran. Chuck Byers asked me to convey to you his gratitude. Chuck Byers has cancer. Chuck Byers was in a line to get care. And he was in a line to get care not because people don't care, he was in a line to get care because the number of providers available to deliver care in the VA, in the market in which he resides, was not sufficient enough to meet his needs.

Chuck Byers saw a cancer specialist in our network. Chuck Byers is alive today. There are many Chuck Byers, and there are many Janes across our area. We are on a pathway to improvement, we are on a pathway to refinement, and we have work to do.

I believe that the leadership of the two gentlemen that are on this panel, the Secretary, the Deputy Secretary, the Under Secretary Shulkin, and this Committee, and Subcommittee, and those on the Senate side are going to allow us to achieve the success that we all desire. And that is that the Chuck Byers of this world, who served our country with distinction, have the opportunity when they have a need to have that need met, whether it is met in the VA directly, at an academic facility, a DoD facility, or in the community. Thank you for the privilege of being here today. Thanks for the privilege of supporting this population. And we, and our 3,600 employees, and 180,000 providers are privileged to lean forward at the side of those that served in the VA. Thank you very much.

[THE PREPARED STATEMENT OF DAVID J. MCINTYRE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you. Dr. Yehia, you are recognized.

STATEMENT OF BALIGH YEHIA, M.D.

Dr. YEHIA. Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you again for the opportunity to testify today regarding the Department's plan to consolidate community care, specifically to further discuss our community care network. I am accompanied today by Gene Migliaccio, who is a Deputy Chief Business Officer for Purchased Care.

Establishing a robust provider network is critical to increasing access to quality care for veterans. Our proposed network emphasizes veterans' choice, access to care, and quality by partnering with community providers. Let me be clear. Veterans will have a choice in our network.

First, they will choose whether they want to access community care at all. Second, for those who choose to access community care, they will be able to select a provider that best suits their needs and their preferences.

Over the last couple of weeks, I have had a number of meetings with folks on the congressional staff to discuss VA's proposed community care network. During those conversations, it became apparent to me that tiered networks has a different meaning for different people. Some think of having to pay a different cost share for providers in different tiers, others think of a narrow network that limits the numbers of providers or restricts choice. And when it comes to distinguishing between providers, some people describe tiered networks as emphasizing cost over quality. This is not how VA wants to set up our community care network.

First, there will not be any difference in VA copayments from provider to provider in the network. If a veteran does not pay a co-pay in the VA, they will not pay a co-pay in the community.

Second, we understand that some health plans distinguish providers as preferred based on their ability to control costs over quality. We want to flip that on its head by placing greater emphasis on performance metrics that are related to quality and satisfaction over cost. That is why we are working hand in hand with industry to determine which quality and satisfaction metrics are most appropriate and also commonly used in the community.

Last, some networks are often narrow, meaning there is a—they have a limited number of providers. That will not work for our veterans. We have veterans in every community across the United States and abroad. Therefore, we want to partner with as many providers as we can.

At the heart of it, a community care network is simply a way to organize our community partners and identify and reward high-performing providers. This structure will provide veterans with easier access to information so they can make informed decisions.

Veterans who are eligible for community care will have the ability to decide whether they prefer to receive care at a local VA or in their community. And if they choose to receive care in the community, they will have the ability to choose a provider. However, just giving them a list of providers is not enough. In my experience as a clinician, patients look towards us to help them navigate the health care system and their options. That is why it is critical for our network to identify quality providers which will ensure that veterans are able to make an informed choice.

We also want to be better partners for our community providers. Just this month, I sat down with a roomful of providers ranging from small practices to large health care systems in Florida. They were direct about what works and what doesn't work with Choice, and the changes they would like to see in the future.

Their comments mirror the more than 600 responses received from the private sector and 300 responses we received from our own employees on our draft community care network performance work statement. We are actively engaged, and this important feedback is being used to draft the next step of our contracting process, which is a draft request for proposals.

As we continue to move forward toward consolidating community care, it is important to maintain our relationships with Federal partners like DoD, and also our academic affiliates. For decades, they have served as a foundation of our community care network, and over time, these relationships have led to the delivery of high quality care and also robust care coordination.

Growing them will ensure that veterans continue to have access to not only quality care, but in many circumstances, state-of-the-art care while ensuring that we continue to train the next generation of clinicians that will serve veterans. Therefore, we want to make sure that these valued partnerships are supported by the consolidation of community care programs.

In summary, we want to empower veterans to make informed choices and improve their health outcomes. We also want to ensure that we set up a program that aligns with the private sector and encourages collaboration between VA and community providers.

Mr. Chairman, I appreciate the opportunity to appear before you today, and we are prepared to answer any questions you or other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF DR. YEHIA APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. Yehia. I will now yield myself five minutes for questions. And there are so many things I want to talk about because I don't really understand the different tiers, to tell you the truth, and how it all works. But I guess the key question that comes to my mind is, is a veteran going to be able to call and get an appointment for themselves?

I mean, it seems to me that a huge part of the problem in getting an appointment is somebody is making the appointment for the veteran. Are you going to change this? When I, as a physician, I refer the patient to somebody, I tell the patient who I am planning to refer them to, and then they make their own appointment. So is that going to happen now in this new community care program? Dr. Yehia, can you answer that?

Dr. YEHIA. I can. So let me—I think that is an excellent question, and we want to move more and more towards—in that direction.

Mr. BENISHEK. I think that maybe they can't hear you.

Dr. YEHIA. Okay.

Mr. BENISHEK. Okay.

Dr. YEHIA. Is that better?

Mr. BENISHEK. Yes.

Dr. YEHIA. Currently what we do is, we do outbound calls. So once a veteran is eligible, we send the phone number—their information to our contracting partners and they reach out to the veteran. But just as you describe, some patients want to coordinate their own care.

Mr. BENISHEK. Like most patients, I would say.

Dr. YEHIA. A lot of patients, yes. In our future state, where we are hoping to move towards, is VA would be more in the center of customer service and care coordination. I think for veterans that want to make their own appointments, we want to be able to provide that option. However, we want to make sure that we can connect the dots. And so we don't want to just say, here, go see your—

make your own appointments, we want to figure out a way to get that information back, so when they do come back to the VA if they have to see another doctor, we have the clinical information from that community provider.

And, as you know, some veterans have a lot of comorbid conditions or complicated social circumstances, and they want the VA to help them with—

Mr. BENISHEK. Yeah, I know, but that is sort of a internalistic viewpoint, in my opinion.

Dr. YEHIA. I think what I was getting at is that we want to give them choices. Some folks want to say I want to make my own appointment. And with that, we say great, we want to make sure that we have the right process to get the information back.

Mr. BENISHEK. Well, can't the appointment be made right at the time that the patient is referred, right there so the patient can participate? The problem is that the appointment is made without the patient's awareness, so then they find out he is not available when the appointment was made.

Dr. YEHIA. Yeah. We definitely don't want to do anything that you are describing, which is more blind scheduling. So the way that we work now, it is more of we get the veteran's preference, and then we contact the community provider, and we link the two up. But in some circumstances like you are describing, a lot of patients say, hey, I will just make my own appointment. And I think that is great, we just want to make sure that we are able to track that, yes, they were able to get in to see a doctor, and that we were able to get the health information back from that visit.

Mr. BENISHEK. So the other question is, I guess I don't understand the difference between why are there separate tiers? I mean, why is there a core provider and then there is a preferred provider? And what is that all about? I don't understand that. Why isn't there one set of providers?

Dr. YEHIA. Yeah. So over the last couple of months I have been talking more and more about this. And the way that we present it in the plan is just a way to organize providers. So from the veterans' perspective they will not see tiers, they will see a directory of providers. And those providers, as best as possible, will have information about where they are, what specialty they are, their affiliations, their quality, satisfaction.

So it will be—this is kind of behind the scenes stuff. It is, now we organize ourselves so that we can make sure that we know that like providers are grouped together. For example, we talk about DoD and Indian Health Service. We work with them in a completely different way than the private sector. We don't use Medicare rates. We pay Indian Health per person. So the way that we actually interact with them is different. That is why they are grouped together. And then we want to be able to distinguish and reward those top quality providers, and they are another group. So to the veteran, they won't see tiers. They will see information about different providers. But for the VA and for the provider community, we will be able to organize ourselves so we can—we know the different types of providers in a network.

Chairman BENISHEK. So the top tier providers are incentivized some way than some other providers?

Dr. YEHIA. No. The way that the incentives will work, the incentives of giving no value-based payments is independent of the structure of the network. So we want to group like providers together. So if you are delivering excellent quality, other veterans are recommending you, they are giving you high satisfaction scores, somehow, we want to say that we are measuring those, and we are providing the information for the veteran to make a choice.

Based on those metrics, you will be able to get, as we move more and more towards value-based payments, you will be able to get rewarded for delivering excellent quality care.

Chairman BENISHEK. I am out of time. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you. Well, just to follow up on that line of questioning, so I understand in terms of the tiered process, the veteran will not know the different tiers, in essence. It is for internal use.

But it seems to me, I still, you know, in terms of the second and third tier, you know, a preferred, well-qualified doctor compared to a adequate doctor. And it seems as though, quite frankly, we would want, you know, the best qualified doctors for our veterans. And to make a distinction between two qualifications seems odd to me.

Dr. YEHIA. We, because we serve veterans in every corner of the United States, we need as many as providers to partner with us as possible. And so I think, at minimum, we want to set the standards. You have to have a license. You have to be able to practice in that state. So we will set a bar so that we make sure that the veterans, when they see community providers, they are credentialed, and they are able to serve them.

But just by setting one bar and not being able to reward those providers that perform really well, I don't think that goes far enough. And so the idea is, we would love to have every single one of our providers preferred. It is not like we are going to set, like, a percentage of all the providers will be preferred. If you meet the quality and the satisfaction metrics of the VA, anyone can become a preferred provider.

So it is not like we are limiting who can enter that group. It is just based on your performance.

Ms. BROWNLEY. Okay.

Dr. YEHIA. We want to make sure that those performance metrics align with industry. A lot of folks are already reporting on those today. So we are not going to create some new measures that don't exist. We want to use existing data sets.

Ms. BROWNLEY. So to Mr. McIntyre and Mr. Maynard both, I think the VA just testified that they had had interviews in Florida in terms of their network providers, to ask what works and what doesn't work. I wasn't there for that process, so I would ask you the same question in terms of your experience so far. What do you think is working, what is not working, where improvements should come from?

Mr. MCINTYRE. We have done interviews with providers in our network for the last nine months to determine what changes needed to be made in our processes. And we have implemented those changes. We put the provider first from that standpoint, because if the provider engagement doesn't work, nothing else works at the

end of the day. And we are in the process of finalizing what we call Provider 2.0.

I will tell you as part of that, and a follow-up to the question on tiering of networks, we set up our systems at the beginning of 2014 with the adoption of PC3 to actually give our appointing staff the ability to tier the networks. And so among the best providers in our communities, they are the first that we go to for appointing.

So if we know, for example, there is a neurology appointment need in a particular community, or there is a urology need that is very specific, we will seek the top urologists out of our network, and they will end up in our systems in the front of the appointing staff first. That is not an uncommon strategy, and we have been using that from the start.

Ms. BROWNLEY. So in terms of providers and—I understand that you are interviewing. You are hearing from them. You are making improvements, you know, daily as you have moved forward to kind of perfect the system—

Mr. MCINTYRE. Yes, ma'am, it is—

Ms. BROWNLEY [continued]. —and within the network, and are there any outstanding issues that you have limitations, where you are hearing from the provider, but because of VA and regulations that are limitations to you to improve it, do you have full authority to make all of those improvements?

Mr. MCINTYRE. Yeah, great question. The first set of things we brought back to Congress. Because there were limitations in the original law that was passed, and you all have acted on those now, and the VA has acted on them policy-wise and pushed them over to us operationally.

The set that we are working now, and we are down to the lower part of that list, we in the VA, particularly these two individuals that are leading the effort internally to VA, are working those last remaining mile issues to make sure that we have worked through what needs to be done to make the provider engagement better in our geographic space.

Ms. BROWNLEY. Thank you. And Mr. Maynard, do you have anything to add?

Mr. MAYNARD. Yes, if I could just add one thing specific to the questions both you and the Chairman have asked on this issue. If there is a remaining challenge as we look forward, I think it centers on the concept of eligibility and the parameters of authorizations under which eligible veterans are seen.

And this begins even at very routine levels. I know there are many doctors here on this distinguished panel. But even at the primary care level you have providers that are looking at a presenting patient who presents with a variety of conditions that may, in fact, go beyond the boundary of the eligibility. Many of the challenges in delivering care begin right then and there around the boundaries of the authorization or the eligibility and what presents itself as medically necessary.

So we continue to work with the VA around the definitions of those eligibility parameters, particularly at levels like primary care, where patients present and may actually need to be expedited directly from there to a specialist or to some further care beyond the boundary of the original eligibility.

I think the more that we can do to expedite that and ensure that providers are not prohibited from addressing what is medically necessary while they are there as the veteran presents, and that from there, the path to whatever follow on care is itself expedited, the more we are focused on those issues, the more the program will improve in support of veterans.

Ms. BROWNLEY. My time is up. I yield back. Thank you.

Chairman BENISHEK. Dr. Roe, you are recognized.

Mr. ROE. Thank you, Mr. Chairman, and thank you and the Ranking Member and the staff for putting this together. And I certainly appreciate the fact that this is not easy. To put a network together across the country is a big bite of the apple.

And I think consolidating all of these, certainly into tiers, I don't have any particular problem with that. The real question that I have are more about function. I have a health care card here. I know exactly where I can use it, what it is good for. Does a veteran actually have that?

And the example I am using here is, like with Dr. Benishek was trying to get to it a minute ago, if I go in and I don't think I am getting the care that I need—and Mr. McIntyre presented a very compelling case of a veteran who did get the care they need, I can tell you one who didn't, who last April went to a VA, got a FIT test for colon cancer screening, because they don't do routine colon cancer screening.

He had some bowel changes. Came back in August of this past year. Had a positive FIT test. His colonoscopy was scheduled for April 5th of this year, 2016. Went to the Choice—finally got to the Choice program after having X-rays done. That was in November. He finally got his colonoscopy in January, and he has Stage IV colon cancer.

So those stories can be told over and over. That was a failure. The question is, does the veteran actually have a choice when, what Dr. Benishek was saying, when I go in there, if I don't like the care I am getting, can I go take my card and make an appointment and see a doctor that I want to see? Because I think that is how the VA gets better and, certainly, we can credential easily.

I mean, I look at our local system—at our hospital system—if you are credentialed to do surgery at the hospital, your license is good in the state, that can be done fairly expeditiously, because the patients go back and forth between those hospitals anyway.

So that is not a hard thing to do. Maybe in rural areas it is a little harder, but in most areas of the country now, we have primary care people and specialists. Can the veteran actually take this card and go see a doctor that they choose? That is a question I am asking.

Dr. YEHIA. In part. I mean, that—what you are asking—what you are describing is the way that typical health insurance plans work, which is, you have a health insurance—you go—you look at the network, go to whoever you want. But VA's community care network is not a health insurance plan. It is an integrated system with the direct care and the community.

So who can do—there are some folks that could do that, so our 40-milers today. If you live more than 40 miles' driving distance from a facility, you can take that card, and you can go to someone

in the network and receive care. But the other criteria of how you access community care is from being—not offering the services of the VA or a wait time. So it is harder for someone to just walk—without knowing if you are actually waiting on a list to know if you can actually access community care.

Mr. ROE. See, I think that is a mistake. I think what we need to do is, the veteran needs to be in charge of their health care, and we as providers, both the VA and the community, need to provide that care for them.

Many veterans will very much like the care they get at the VA at home.

Dr. YEHIA. Yeah.

Mr. ROE. They love it. I mean, I have to say that they have very high marks. I meet very few people who don't. There are some, but for the most part, I think if you surveyed the folks in our area, they would say the VA does a great job, and there would be no problem. In other places that is not true.

And so I think the veteran should be able to have a choice, a real choice, and not get hung up like this particular—and hundreds or thousands of other veterans—are tied up in the system.

And as Dr. Benishek was also saying, that the absolute simplest thing I ever did in my practice—I have said this until I am blue in the face—is to make an appointment. And if I saw someone, I would walk them out or send them out to the front desk, make an appointment with Dr. Jones. My staff would pick the phone up and call and get an appointment with Dr. Jones. If it had to be urgent, I might even get on the phone with Dr. Jones. That is how it works. And it works really well.

Dr. YEHIA. Yeah.

Mr. ROE. And what we have done with the VA has complicated this with so many layers of bureaucracy. We have made something that is complicated, that is not. So I think the choice needs to be the veterans'. And they should be able to have that appointment when they leave the VA. If they see a VA provider that day and that VA provider says, "Well, you need to see so-and-so, and he is not available here at our VA,"—maybe it is a back issue, hip, whatever—before they leave that VA that day, that appointment should be made.

And what I was told when I went home and talked to the providers that a primary care provider has a registered nurse, an LPN, and an assistant. I never had anywhere near that kind of sophistication. If four people like that could not make an appointment that day, you need to re-evaluate your processes, I think.

Dr. YEHIA. Yeah.

Mr. ROE. You agree with that?

Dr. YEHIA. No, I agree. I think that, you know, I was just in clinic last Friday, and I did the same thing. I had a patient that needed to be seen by a specialist, and I picked up the phone, and I called them and got them in for next week. So I think that is how a lot of people—

Mr. ROE. That works.

Dr. YEHIA [continued]. —practice. I think that is the intent why we are here today, is to consolidate and improve care. There is a part of the plan that we talk about, this referral and authorization

process, that is so clunky right now. And there is the eligibility criteria that we have been talking about. There is so many variations on it.

If we get to very crystal clear, if you are eligible or you are not eligible for community care, then I think we can move up when you can—an appointment to the time when you are leaving the clinic. We have to get there first, because right now we have to double check and triple check—

Mr. ROE. Yeah.

Dr. YEHIA. —if they meet this, if they meet that. And that requires people. And the scheduling clerk sometimes can't do all that, which is different than what it is in the private sector.

Mr. ROE. Sorry, my time has expired. But just, your motivation when you saw that patient last week was to get their care given.

Dr. YEHIA. That is right.

Mr. ROE. And all that other stuff in between, you weren't interested in. And all the patient was motivated was to get the care.

Dr. YEHIA. Yeah.

Mr. ROE. That is what we need to simplify. Yield back.

Dr. YEHIA. I agree with that.

Chairman BENISHEK. I now recognize Ms. Brown, the Ranking Member of the full Committee.

Ms. BROWN. First of all, I want to thank both of you all for letting me sit in on this meeting, and I am going to be really quick. But I have two people there from my area, Dr. Yehia, and I want to follow up. And also, I have a statement from Action News Jacksonville Investigation, and I want both of you, one from Jacksonville and one from Gainesville University of Florida, we are very happy.

But following up with Dr. Roe's question, because I understand the card, but the main thing is that patient has to have prior approval in order to get paid. And Dr. Roe would be very upset—and I have heard lots of discussion in this Committee about people not getting paid and why they are not getting paid, and so their practice is closing or something. So you have to address that.

And then the person, Madeline (?), who attended school in Jacksonville, the same school my daughter attended, Sandalwood, I need you to talk about this Action News investigation of the VA in my area, because I am the Ranking Member, and there is a serious wait time, or not happy with Choice. So those are my two questions. I met with all of you all before, had hearings in my area. So can you please address it?

Dr. YEHIA. Sure, why don't I start?

Ms. BROWN. Yes, sir.

Dr. YEHIA. Thank you so much for that question and for representing your area so well. We have to be good partners to community providers. It is how you build a network, and one of—the most critical thing, probably, is making sure that we pay timely and accurately, 100 percent.

And I think right now there is three areas that we have to improve on. Number one is the eligibility criteria that we just talked about with Dr. Roe, is some veterans will take their Choice card, and they will just walk right up to a community provider and they will deliver care. However, that is not how the law was written.

There is certain criteria that you have to meet in order to receive that health care.

So when we get a bill, we can't pay that bill. Even though we would like to pay it, we can't pay it, because that veteran did not meet criteria that were established. So getting to a simple set of criteria that makes sense to the veteran and that we clearly communicate to everyone so they know who is eligible and who is not, will be very important.

Number two—and this is something that we fixed about a month ago—is that we were requiring medical records before we actually paid the bills. And as a clinician, I want the medical records back. It is very important. And we still want them back. But we don't have to tie it to payment, and remove that, and the payments have become better and better and better on both sides of the United States for Health Met and TriWest.

Ms. BROWN. Is that retroactive so those physicians will get their pay.

Dr. YEHIA. I—is that retroactive, do you know? I would have to check.

Mr. MAYNARD. Yes. Coupling with the medical bills.

Dr. YEHIA. Yes, it is. Thank you for that.

Ms. BROWN. Okay.

Dr. YEHIA. And then lastly is, we want to provide more transparency for the doctor. So the doctor right now sends a bill, and they don't know where it is at. And I think on both our partners, Health Met and TriWest, are taking action so that we can improve the visibility into the system, because many times, you just want to know did I get—did they receive the bill? Do we have to send them another one? When am I going to get my check? And that ambiguity, or lack of information, creates anxiety. And so we want to be able to improve that. And that is some of the things that we are doing over the last couple weeks.

Ms. BROWN. Thank you.

Mr. MAYNARD. Yes, ma'am? Good to see you again and good to meet with you earlier this morning on some of these issues.

First of all, I would just like to state that any shortcoming or inability to facilitate health care in support of eligible veterans is, obviously distressing and requires attention, every single individual one, even in the face of the increasing demands and the volumes that are there.

I think it was particularly unfortunate—you know, we have been reaching out in Jacksonville to the press outlet, in particular, about the specific issue, and I think it is quite unfortunate that both the personnel from the provider offices where veterans were involved chose to remain anonymous, which makes it very difficult to find exactly the specific instance that they are addressing there. Nevertheless, it is something that we take quite seriously.

I think as Dr. Yehia addressed in a previous response just a few minutes ago, real progress has been made, but there have been challenges around some of the—and I think he used the word "clunky"—procedures of referrals and particularly incidents that began where a veteran was seen and required further care, does activate a loop going back through from that provider or veteran back

into the VA and back out through our processes to authorize that care and actually get it appointed again.

I think as this Committee has been rightfully focused on, that is not directly in accordance with all the commercial best practices that could be applied, and I do believe that not only the improvements that we have seen, as you and I discussed, we are appointing some 800 to 1,000 veterans just within the Jacksonville domain itself, not counting all the way down to Gainesville, more than 90 percent of those are being appointed well within the five-day standard. There is plenty of access within the network.

Nevertheless, as veterans need to be seen, secondarily or subsequently, there is much that we can continue to do, and will continue to partner on with the VA to expedite that care as it presents itself to providers and as it develops.

And just on the provider payment issue, quickly to follow up to Dr. Yehia, I want to, again thank the Department's very close collaborative work with both Dave McIntyre and my company over the past three to four months to evolve and modify the contract. I think we are all very convinced and already have evidence that those providers that were challenged by the more complex payment methodologies are already seeing a very significant relief in the first three weeks after that modification. I think we expect all providers to be current very expeditiously as we move into the spring.

Ms. BROWN. Well, thank you all for your service, and thank you all for letting me sit in.

Chairman BENISHEK. Dr. Abraham, you are recognized.

Mr. ABRAHAM. Thank you, Mr. Chairman. I want to kind of reflect on what Dr. Benishek and Dr. Roe started the discussion on. I am just a country doctor here, private care. I have practiced for many, many years. And, yeah, it is a big bite of the apple to institute this. But I don't think it is that big of a bite. I mean, this is what you two guys do for a living. I mean, you enroll people, and this is you all's forte. You all are experts in your field.

And like Dr. Roe said—again, maybe I am making it over simplistic—but have the card, get the providers accredited. And, again, we keep having the same discussion over and over about accreditation. Well, if they come from an accredited medical school, if they are licensed, and they don't have any criminal investigations, well, why not put them in the network and see how they do?

And I know you need your records back. Well, let them have access to the EHRs or put the onus on the private physicians to either fax or email you a copy of that office visit. Again, I am the private practice guy, and I am the primary care guy here.

I guess my question to you Dr. Yehia first, what is a veteran going to see? You say these objective datas, these quality measurements, are internal. What is that veteran going to see that will steer him or her to a tier 2 or tier 1 provider as opposed to a tier 3 provider?

Dr. YEHIA. So what we want to do is provide them with information. So they won't even see a tier 1 or tier 2. That won't be a term that—

Mr. ABRAHAM. No, I understand, but—

Dr. YEHIA [continued]. Yeah. The way that—

Mr. ABRAHAM [continued]. —how are they going to know—

Dr. YEHIA [continued]. Exactly.

Mr. ABRAHAM [continued]. —whether it is a tier 2 or tier 3 based on just, you know, pixie dust, basically, if you are going to say, well, it is tier 2 or tier 3. But what is a veteran going to see, he or herself—

Dr. YEHIA. Yes.

Mr. ABRAHAM [continued]. —that will actually—this is why this is a tier 2 or a tier 3, or a tier 1 provider?

Dr. YEHIA. So they will be able to choose whoever they want. What we are going to be able to do is give them information to choose what they want. So first there will be basic information about the provider, where they are located, their specialty, what they do. That is, kind of, that is set. And then using, kind of, private sector metrics, so things that are already agreed upon that CMS uses—

Mr. ABRAHAM. Do—

Dr. YEHIA [continued]. —such as—I was going to—

Mr. ABRAHAM. And let me interrupt you.

Dr. YEHIA. Yeah.

Mr. ABRAHAM. Do you already have that objective check box formulated for the VA as for those metric measurements that will distinguish between a tier 2 and a tier 3 provider?

Dr. YEHIA. We have—we don't have that today in our community care program, but in the draft request for proposals that we are developing, we are putting a list of different quality metrics that we want to measure. And so those get to—like do you have—is your hemoglobin A1C in control?

Mr. ABRAHAM. Right.

Dr. YEHIA. Are you asthmatic and do you actually have an inhaler? So they are not—we are not talking about things that are so off the wall. These are basic things that a lot of your providers—

Mr. ABRAHAM. And I guess that is my point. These metrics—

Dr. YEHIA. Yeah.

Mr. ABRAHAM [continued]. —are already in any electronic health record—

Dr. YEHIA. Yes.

Mr. ABRAHAM [continued]. —I have ever accessed.

Dr. YEHIA. Yes.

Mr. ABRAHAM. And I have seen my share of them, I am sure. And, again, you check the box. It is a matter of hitting the key—

Dr. YEHIA. Yeah.

Mr. ABRAHAM [continued]. —and the computer picks it up. And then it is part of the record. I guess my other concern is, as a family doc—like, Dr. Roe was saying, like you were saying—when you had your patient the other day and you immediately went and made a referral, if I need—if I have got a patient with hematuria, blood in the urine—

Dr. YEHIA. Sure.

Mr. ABRAHAM [continued]. —and going back to your urologist example, and I need a urology appointment, am I going to have to go back to the VA to get that specialist, or can I walk out to my receptionist and say, “Go to Dr. Smith right down the street, the urologist?” Again, if I have to go back to the VA for that specialty

care, then I worry what—all of a sudden the cycle starts again, and it may be 30, 60, 90 days before he or she can be seen.

Dr. YEHIA. No, I think you have a great point. So if you are being seen in the community for urology and let's say you discover that someone has diabetes and you can't just directly refer them to the endocrinologist because we didn't authorize that care. However, the way that they would do is, they would call the VA and they say, "Hey, this person who I figured out has diabetes, is there a diabetic specialist that could be seeing him timely?" If not, then we will—then they can access the network for that.

Mr. ABRAHAM. And I guess that is my rub, is that call that I have to make that interrupts my patient care, because then I lose that patient back to the VA and may or may not get those records back, if I don't have that access to the electronic health record. So it is just that continuity of care that I worry about.

Dr. YEHIA. I am agreeing with you in that spirit is that we have to find better ways to share information. You made my point for me, which is a lot of those things are in the EHR. The only thing that we want is to be able to get that information and present it to the veteran.

And so it is not asking for the community provider to take something more onerous than what they normally do. And to be able to report this information will be voluntary. It won't be a requirement for them to share that with us. So for those that have—that feel inclined, will be able to take that information and share it with—for the veteran, so they can make decisions.

What we are working on doing is, how do we get to a place where they don't even have to fax us anything?

Mr. ABRAHAM. Exactly.

Dr. YEHIA. Like, we can actually start sharing information.

Mr. ABRAHAM. Right.

Dr. YEHIA. This is something that I think all of health care is struggling with now. So it is not just the VA, because I don't think anyone has, you know, figured it out completely. When you are in an internal health care system, it is easy to share records. But when you start going from one health care system to the other, it becomes harder.

So I think we are going to continue to evolve as health care evolves there.

Mr. ABRAHAM. Okay, thank you.

Dr. YEHIA. Thank you.

Mr. ABRAHAM. Thank you, Mr. Chairman.

Chairman BENISHEK. Mr. Takano, you are recognized.

Mr. TAKANO. To follow up on these concerns, I would just take my own—the kind of questions that Dr. Abraham was asking and Dr.—

VOICE. Roe.

Mr. TAKANO [continued]. —Dr. Roe—excuse me I was blanking on his name—Dr. Roe is asking about patient choice, I think we face in the private sector health care the same anxieties. But the stakes can even be even higher, right?

If I go out of network, I can pay 50 percent more for going out of network. And it is on me to find that out. And I don't know that

dealing with my private sector health care folks are any easier getting through on that customer service line.

So I don't know that, you know, putting these expectations on the VA, which is not an insurance plan, right? Well, you were not set up as an insurer. You are having to do a whole new thing in terms of creating payment plans.

I mean, the concerns of my colleague from Florida, our Ranking Member, about making sure providers get paid, you are trying to simplify and consolidate all the different care in the community. In other words, care in community means—care in community means are non-VA private sector providers out there who are under all these different plans, right?

So my question is for Mr. Maynard and Mr. McIntyre. Do you—are you optimistic that this consolidation plan under the VA is going to make it far more easier for you to recruit people into your networks if providers can be assured that they are going to be paid timely and there is a simplified process, do you think that is going to really enable you to provide robust networks?

Mr. MCINTYRE. I think that the consolidation makes a lot of sense. It is confusing to everybody that is involved in this process when you have got multiple plans that pay at different levels, that have different requirements, and require different types of management. And the VA is to be commended for taking a look at how do they bring those pieces together?

As it relates to recruiting itself on the provider side in the area that we are responsible for, we have been able to successfully reach out and bring providers into the network in the areas where we in the VA believe that they are necessary. The one thing that I would say is that, you know, these things take a while to refine.

And back to the issue of tiered networks, the Defense Department has a term called “right of first refusal.” And the objective there is to make sure that the Federal footprint that has been paid for by the taxpayers is maximally leveraged. And what we did in TRICARE during the term that we were involved in that, was to actually profile each facility and determine what kinds of services were available and in what supply. And those were the only ones that we went back and determined whether there actually was the ability to push that specialized patient back in.

So I think this—I think you are on the right path. The VA's on the right path in terms of trying to move these pieces.

Mr. TAKANO. Well, let me ask this. So Dr. Yehia, from the point of view of the veteran, they are just going to see whether the doctor is in network or out of network, right? They just—it is—they will see if the VA provider they want to go to is eligible and that is, kind of, a point one, but not every veteran will be eligible to see certain practitioners; is that right?

Dr. YEHIA. They will not see in and out of network. They will just see one network, and that network will have all the VA facilities and the community providers. So there is not an out-of-network benefit.

Mr. TAKANO. So it is much, so from a standpoint of veterans, much simpler than the task I have, right?

Dr. YEHIA. Yes.

Mr. TAKANO. Because I have to figure out who is in network, who is out of network—

Dr. YEHIA. Exactly.

Mr. TAKANO [continued]. —where I can—and who is going to be paid, which facility, which emergency room will take me. So for the veteran, it is potentially a lot simpler.

Dr. YEHIA. That is right. And I think you made an important point, which is, I think some folks think of the community care network, or the community care program, as an insurance plan. It is not. It cannot stand alone. If there was no direct VA care, that program cannot stand alone to provide all the health care needs of veterans. We have to think of it as an integrated system where together internal VA care, community care, now that actually forms the health plan, that actually forms what is called, you know, minimal essential—

Mr. TAKANO. So if you are a provider, if you get everything in order, all your ducks in order, the payments, and you attract a lot more physicians, a lot more partners, the veteran could probably have a lot more choice than someone like me potentially.

Dr. YEHIA. They probably will. Yeah, I mean we have a—not only that, because of some of our specific relationships, they all have access to some services that people in the private sector don't have that don't have access to. Let me give you a quick example. In my practice, in Philadelphia, we were doing—across the street at the university we had clinical trials that no one else had access to except for our veterans. And so our veterans were getting access to some of the new hepatitis C medicines before they came on the market. And so I think our network and what is part of our network, not only delivers good quality care, but access to some state of the art care that other folks don't have access to.

Mr. TAKANO. Well, I don't have time to get into the cost, but potentially, even the cost at below what some of—and in the private sector as well, because you negotiate the drugs and all that sort of stuff. So access to the latest drugs at better costs, so potentially the choices are even better for the veteran under the track you are going.

Well, thank you. I yield back.

Mr. BENISHEK. Dr. Wenstrup?

Mr. WENSTRUP. Thank you, Mr. Chairman. So my thought is that I would like to see the primary care doctors be the gatekeeper for the referrals. That is the doctor you have a relationship with, that is what you just did in the example you gave. And I would even like to see it, whether there is an option, you know, of the 30 days or 40 miles. This is whether—even if someone is available within the walls of the VA, but you know that the doctor down the street is probably the better one for this patient for whatever reason, shouldn't the primary care doctor have that authority? Do we need to grant that authority on this level? How can we help here?

Dr. YEHIA. So actually in our plan, because I believe the heart of care coordination is the veteran-primary care doctor relationship.

Mr. WENSTRUP. Agreed.

Dr. YEHIA. And we talk all about that here. And I also agree that they are the heart of the referrals. And for—if you have a primary

care doctor within the VA, they will be the ones that coordinate referrals. Some referrals will go inside, some referrals will go outside.

Mr. WENSTRUP. Uh-huh.

Dr. YEHIA. That is true. I think it becomes a little bit harder when you have a primary care doctor outside.

Mr. WENSTRUP. Uh-huh.

Dr. YEHIA. The only thing that, but I think we can improve on that. The only thing that we want to do is provide more visibility to the community primary care doctor about what services are offered at the VA—

Mr. WENSTRUP. Uh-huh.

Dr. YEHIA [continued]. —because traditionally, most of the veteran—the patient they see they would send to their friend down the street, or someone—

Mr. WENSTRUP. Right.

Dr. YEHIA [continued]. —else in the community, partly because they don't know what is offered. And I think if we can give more visibility on, oh, actually we have really good, you know, diabetes doctors here, and really good, you know, cardiologists at the VA, they can start referring things back in an appropriate fashion. So I agree with you, the center relationship is that veteran with the primary care doctor.

Mr. WENSTRUP. Yeah, and you are right, I mean it just becomes an awareness of who is at the VA and who is available, because they are not the person you have traditionally referred to.

Dr. YEHIA. Yeah.

Mr. MCINTYRE. That is exactly what we did in TRICARE with that concept I was talking about in terms of right of first refusal. And then you want to map out what is available facility by facility so that you are not posing a challenge to someone when they are trying to find care that needs to be delivered. In our network, there are 50,000 primary care providers stretched across every zip code in the 28 states. And so if you are outside of 40 miles, you have the ability to go and see a primary care provider if we are able to put that in place.

Mr. MAYNARD. If I could just add one point to that. I think that is why it is very critical that if we are going to actually have veterans' choice, veterans' choice really needs to begin with the choice as to where to be linked from a primary care perspective, to be linked within the VA directly, or to choose to be linked for primary care purposes in the community so that then the processes can proceed from there, and that gateway that you spoke to will actually be established.

Mr. WENSTRUP. Is there anything we need to change from the legislative end to make that more workable?

Dr. YEHIA. I think there is—I think to be able to highlight that relationship would be important, and we can chat more offline about some options.

Mr. WENSTRUP. Okay.

Dr. YEHIA. Thank you.

Mr. WENSTRUP. Thank you. I yield back.

Mr. BENISHEK. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you, Mr. Chair, and thank you to the panel for being with us.

I have a question on the academic medical centers. And in New Hampshire, where I am from, we have a top-rate academic medical center, Dartmouth Medical School, and a close relationship with the VA. Dartmouth is also affiliated with a very, very, large medical center, one of the rare rural tertiary hospitals in Lebanon, New Hampshire. And also a series of clinics around the state, including my district. And my question is, when you talk about including academic medical centers, are you also including their network of care in a situation like this where they run clinics all around the state?

Dr. YEHIA. Yes, we want to sign up as many providers as possible. When we talk about the specific partnerships with academics, we focus on those teaching relationships where we actually have residents and fellows that go back and forth. And so I think that there was a point that the Chairman made about making sure that they have the same standards as everyone else. And we want that to be the case. So we are not going to like *carte blanche*, just because you are an academic, we send you all our business. There are specific relationships where we send trainees back and forth, and there is a volume need. So they need to have a certain case mix, you know, in surgery, to be able to actually have an accredited residency and to be able to support trainees. So it is only in those circumstances that they are considered core providers. If we don't have a relationship, let's say we don't have any residency in dermatology, they would compete and be on par with everyone else in our commercial sector tier.

Ms. KUSTER. Okay. I understand that from your perspective; I want to understand it from the veteran's perspective. Is your answer meant to lead to the veteran being able to access the care in their community through these clinics?

Dr. YEHIA. Yes, I think from the veteran's perspective and the community provider's perspective, we are interested, and I am sure Dartmouth is an excellent institution, we would love to sign up every single one of the providers. And so from the community provider perspective, we want them all to join the network. That means more choice for the veteran.

Ms. KUSTER. And along the lines of the indicators of quality, I just want to make a point, Representative Kaufman came to New Hampshire for a regional field hearing on our heroin epidemic, which we now know that four out of five heroin users started on prescription medication. And we have now uncovered that part of the problem is an inadvertent use of quality indicators in Medicare that is leading to reimbursement decisions being made on the basis of pain surveys, which is leading to the unintended consequence of over-prescribing of opiates. And we have a bill, Representative Mooney, our colleague from West Virginia, and myself, have a bill to change that. But I am concerned, and I want to put this on the record right up front, that that not be used as a quality indicator in anything that you may be doing, because veterans have had a very challenging experience with this.

Dr. YEHIA. Yeah, and I would agree with that. I think there is some, this is one of the things that we distinguish ourselves from the private sector. I think they probably had a well-intentioned reason to do those satisfaction surveys, but I have seen many of my

colleagues that are excellent clinicians and they are doing the right things, and that may mean not prescribing an opioid, but maybe physical therapy or acupuncture. And because the patient didn't walk out with a prescription, they give them a bad score, but they are actually excellent doctors. So we have to be very clear about the metrics that we use. I definitely would agree with that.

Ms. KUSTER. Yeah, and if we could just say that right up front, that any type of—you have to think through what might happen in using these different metrics.

And then the last question has to do with one that frequently comes up when we are talking with the Secretary and the VA, and that is the issue of co-pays, out-of-pocket expense to the veteran. I know that we want to keep that as low as possible, but I am concerned, just given that the taxpayers are at the other end of this equation, that we are not sort of incenting people to use the VA when they have perfectly good health insurance from another source that might be more appropriate. And for this I am talking about not the veteran experience related, and I think I may be going over my time, but if we could submit that for the record.

Thank you very much.

Mr. BENISHEK. Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. Thanks to the panel as well.

With regard to the costs, I have a question. Of course quality of care, veterans deserve the best. No question, that is imperative. But do you have any metrics as to—are you tracking what the costs would be within the VA and also outside the VA under the Choice program?

Dr. YEHIA. Yeah, we are monitoring the spend on the Choice program very closely. We have a set limit that was provided by Congress, and so we monitor that very closely. So we do have that.

Mr. BILIRAKIS. Can you give me some answers?

Dr. YEHIA. Sure. So we spent last fiscal year, we had about \$3.5 billion that we used out of Choice funds to deliver care to veterans. This year we are anticipating kind of something similar, about \$3 billion to \$3.5 billion. So that gives you a little bit of a sense of—at least just from Choice, that is only Choice care that we spend financially.

I think to your point though, I think what you are getting at is, as we continue to make the program better, more and more people are using the program. And that is something that we have to be very cognizant about, because as we make a product that people want to use, there comes—there is a cost that is associated with that. And as we start considering developing new legislation that will consolidate community care and create a new program, how do we make sure that we have the right resources to actually deliver that benefit? We are seeing more and more people using the program than ever before.

Mr. BILIRAKIS. How are you getting the word out? I know we are doing our job here to get the word out, with regard to the program, the eligibility requirements, what have you. Tell me that, and also, how are we getting the word out to the providers or potential providers that want to participate in the program?

Dr. YEHIA. So we have done a number of outreach for both veterans and community providers, you know, including, we have a website, that website specifically has an area just for providers, an area just for veterans. We have issued letters to all of our community providers that we were working with before Choice, encouraging them to join Choice, similarly to veterans, mailers, so we kind of, are trying to use different avenues to reach more people. I will say probably the biggest thing that we do is really word of mouth, which is the local medical center talking to their veterans in town halls and their local providers, ask them to sign up. And as Dave and Billy can attest to, we have seen a big increase in the number of providers that have joined both of the networks.

Mr. MCINTYRE. And on our end, we had the Blue Cross/Blue Shield plans and universities that own our company that are indigenous to the 28 states reach out to their networks across their states to be able to give them the sense that this was there, and how they would sign up. And we are signing 300 to 500 doctors up a day.

Mr. MAYNARD. And it is the same with us and both Dave's organization and mine also had deep foundations in the TRICARE program, and were able to approach all of the participating providers there who also were reimbursed under Medicare and have been very receptive to expanding access and support of veterans as well under this new program.

Mr. BILIRAKIS. With regard to dental care, those who are eligible under the VA, are they also eligible under the Choice program?

Dr. YEHIA. Yeah, yes, sir. So if you meet the eligibility criteria for dental, which are pretty high—

Mr. BILIRAKIS. I know that.

Dr. YEHIA [continued]. —there is a number. And we can't—either we don't provide dental care at the VA, or there is a wait issue, they can get that care in the community. Also, we know that a lot of the dental care is already delivered in the community today. We don't have dental practices at most VAs, so most of that benefit is delivered in the community already.

Mr. BILIRAKIS. Very good.

Dr. YEHIA. Thank you.

Mr. BILIRAKIS. Okay. Anyone else want to comment on that?

All right. Thank you very much. I yield back, Mr. Chairman.

Mr. BENISHEK. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman, and I would like to thank everyone who has testified today, and thank you also for your answers to our questions.

Mr. McIntyre, you mentioned being in El Paso on Friday. Thank you for being there, for making the commitment to our community, and we really appreciate TriWest having an operation center that is hiring veterans in El Paso. And Dr. Yehia, through you, I want to thank Mr. Joe Dalpiaz, VISN Director for Texas, who was also there, for his commitment to the community, and for everything that you all are doing.

I have two questions, I think, on this subject. We were told by Dr. Clancy last week, that while we thought we had 41,500 authorized funded but unfilled positions at VHA, the number is now 43,000. Given this consolidation, this admission that the VA will

not be able to provide all things for all veterans within the walls of the VA medical facilities, this excellent article by the Under Secretary Shulkin in the New England Journal of Medicine last week, to that same end, a couple things. One, can we dispense with the fiction that we will ever hire, or maybe even need to hire, those 43,000?

Related to that, number two, Dr. Shulkin mentions in the article the need for the VA to focus on those conditions and disabilities and illnesses that are connected to military service and to combat. And I think of post-traumatic stress disorder, traumatic brain injury, military sexual trauma, traumatic amputation, those things that you generally are not going to see in the civilian population. And should there not be sooner, I hope, rather than later, some kind of behavioral health dividend related to those conditions, where if we are not focused on hiring all 43,000, we are going to really focus on those specialties like mental health that we really need that will prevent veteran suicide and do a better job for all of our veterans?

And then the second question, if you can get this in, in the time remaining, I held a veteran town hall on Saturday, 28 veterans approached the microphone to share their experiences at the VA. Thirteen of those 28 mentioned that their primary care physician left the VA in El Paso, they were never notified. They only found out when they went to refill a prescription and couldn't, or were waiting for a referral that never came through. High level person at the El Paso VA medical center said there is actually a problem right now where we cannot refer somebody to community care. We first have to have 30 days to demonstrate that we couldn't get it done in here. We need the flexibility to recommend right away. I know this has come up in other questions. Could you just address that specific to those dropped veterans who have lost their primary care physician and don't know what to do, and wait months to get an answer?

Dr. YEHIA. Yeah, and thank you so much, Congressman. This gets back a little bit to the eligibility criteria. And the way that I describe those eligibility criteria is three areas: wait time, geography, and availability of service. And so I think at El Paso there is a number of things that are not available there. So by definition, we automatically partner with the community to deliver that. Geography, if they live more than 40 miles away. And then wait time, the 30 day criteria.

That is only—the way that I think of it, that is only the floor. So that is a minimal set of eligibility criteria. We need to make sure, and this is something that I think Congress can help us with, is make sure that there is adequate flexibility so that if there is a special circumstance, if I am seeing someone in my clinic that I think has to go out of the community, even though we don't have a wait in that area, we have some of that flexibility to do that. And some of that was afforded to us when the most recent iteration of the Choice law was passed over the summer. So I think keeping that front and center is important so that it is not so rigid to just those three areas, but there is some flexibility so that the local VA can work with their veterans if someone needs to go in the community.

I don't know specifically about the issue in El Paso and the primary care providers; however, if there is a wait for primary care, they automatically are eligible for Choice, and so that is something that we can make sure that they are aware of that option, and they can offer that up to their providers—or to their veterans.

Mr. O'ROURKE. And then the other question is, you know, I would like to get into the specifics of that offline, but the other question is, can we now tighten our focus on hiring mental health providers, and if that means increasing what we pay for them, just having the attention to that, prioritizing that over other conditions that might be more better served by a network that they can refer out to, what are you seeing towards that? I am out of time, so I may need to get your answer for the record, but we are acutely interested in that right now.

Thank you.

Mr. BENISHEK. Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. First of all, if I understand this right, Dr. Yehia, under your—this VA's proposal, it is the VA that will do the scheduling for the third-party providers or administrators?

Dr. YEHIA. Yeah, in our proposed plan, we want to be more of the face of customer service and scheduling. That could mean, as we talked about before, just saying to the veteran, "you are eligible for community care, here is your options, do you want to schedule your own appointment?" But we would be more the ones that would be having that conversation, rather than the contractors.

Mr. COFFMAN. Yeah, I am very concerned with VA doing the scheduling, and let me tell you why. The whole reason for the Choice program was that there was a scandal in the VA on scheduling, that the level of corruption, systemic corruption across the VA in scheduling, driven by cash bonuses in order to bring down the wait times, and they created these secret lists. And now what you want to do, and what the VA wants to do, is let's give it back to those same people.

Dr. YEHIA. So first of all, the reason why we want to do this is because we have heard from veterans and community providers.

Mr. COFFMAN. Yeah.

Dr. YEHIA. So when I—and in all the town halls that I have, and that I sit down and talk to folks, they say, "why is there a middleman—

Mr. COFFMAN. Yeah.

Dr. YEHIA [continued]. —in the scheduling?" And the folks that actually do the scheduling for community care are different than those that do the in-house.

Mr. COFFMAN. We need to get the system to work. But we need to get it to work without getting VA back into the system that got us to where we are today. I mean, unbelievably incredible, that—and I got to tell you, those who have been responsible have not been held accountable. We don't even have a mechanism, and the Secretary doesn't support one, to claw back bonuses for people that fraudulently got them on this scheduling scandal. And yet we want to move it back? I mean, I just think that that is absolutely incredulous. And that is truly an exercise in poor judgment. And let me tell you, this Member of Congress will be in a blocking position, if

you are familiar with that term. I don't know if you served in the military.

Dr. YEHIA. I didn't, sir.

Mr. COFFMAN. The blocking position, well, take it from a Marine Corps officer, infantry officer, that is to stop you from doing that, because I think that that is an incredible exercise, again, in poor judgment. You know, and I think you are reluctant to let go, I think the VA is reluctant to let go of this and so creating an excuse rather than fixing the system, let's give it back to the VA. And, again, I think that that is an incredible mistake.

Mr. Maynard and Mr. McIntyre, both Health Net and TriWest have experienced managing care networks with TRICARE. Based on your experiences with both DoD and VA, where can VA learn from the methods and practices employed by DoD with TRICARE?

Mr. MAYNARD. I think there are a couple of key points that would really facilitate, that even though the benefit or eligibility structure is different, are still there as critical lessons learned. I think one of them is really clear: eligibility criteria, linked with standardized reimbursement. The more we standardize reimbursement around Medicare, there is sufficient provider support in the community to largely accept Medicare reimbursement in support of eligible veterans. That represents a savings itself from commercial rates, but it standardizes and simplifies and streamlines a good bit of the provider relationship.

The other, I think, is continuing to remove the very points that you have been emphasizing, that impede ready access. I think—I myself believe that scheduling going forward, while it started as a critical and well-intentioned component of the initial Choice program, really did have an unintended consequence of obstructing a bit the ready flow in terms of the way the facilitation of health care works. I think as we look forward, that scheduling service should be a secondary or tertiary availability to veterans who individually need help. But to the point that you raised, there are very sophisticated and increasingly capable commercial sector capabilities, including, for example, our own relationship with 1-800-DOCTORS that has auto-adjudication and auto capabilities to link into community care hospital and provider systems to automatically schedule necessary appointments. So I think keeping an eye on the evolution of the way that customer services are delivered, ensuring that industry is not impeded from bringing best practices to the support of veterans are critical concerns as we look forward to serving veterans into the future.

Mr. MCINTYRE. I would agree with Billy. I would add, though, that I think there is the opportunity to take advantage of the first right of refusal process so that when we have got veterans that are far out, making them aware of what is actually accessible in the VA would be a good idea, but not force them to go there.

Secondly though, as it relates to rate structures, two-thirds of our network is actually built at market rate. And it is a full pass-through to the VA budget. And what that means is we have doctors and hospitals all over our 28 states that said, "You know what, we will give you up to Medicare, not Medicare." And you don't want to lose that, because it is built into the base of the budget.

Mr. COFFMAN. I just want to, again, just—oh, I am over my time. Mr. Chairman, I will yield back.

Mr. BENISHEK. Mr. Huelskamp, you are recognized.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I apologize for being late. I had another Subcommittee hearing, Small Business Committee, also talking about health care. But I appreciate the questions of Mr. Coffman. I do have my assistant here, my youngest son, Alexander, on spring break. This is exactly what every nine-year-old likes to do on spring break, I must admit, so. But thanks for—Alex for joining me.

I would like to follow up with the questions from my colleague to the west about scheduling and he already stole my question about how can we learn from TRICARE experience as well. But under TRICARE, does the DoD schedule the appointments?

Mr. MAYNARD. No. There are no scheduling services. Originally, there were various services. There are a few military treatment facilities, or MTFs, that maintain some appointing support for their own appointing, but not outside the walls, and neither has it really proven a critical issue at all in terms of the facilitation of care on behalf of TRICARE beneficiaries.

Mr. MCINTYRE. You would have to go back a decade to find that. And it took a bit of refinement, just like this is doing, to get it right. And you know, part of the challenge, I think, in the scheduling space was, we stood this program up in a little over 30 days, because you were responding to a crisis, and appropriately so with the right kind of intensity. And how we are doing scheduling now, in our area, is vastly improved over the first couple of months of what we were doing it. And part of that is, we took the geography and broke it down into segments. So now we are not serving people out of one or two geographic areas; we have ten operations centers. We stood them up since the summer. Went from 400 staff to 3,600 as of last Friday. And so we built a hub and spoke environment. That is what you have to have. You have got to have a relationship with the providers in the community. And it takes a little while to get that refined. At the end of the day, I do believe there are areas where it makes a lot of sense for the VA to be absolutely at the nuclear center of scheduling. And Alaska is one of those examples. Far too complicated for everybody than to be having a third party involved in that process. But in many parts of our environment, that is not the case anymore. And we are not getting the negative feedback from the providers that we were getting even six months ago.

Mr. HUELSKAMP. I would agree, and prompt payment helps lessen feedback, and I appreciate the VA announcing some of the reductions in paperwork that is making that happen, still have some pushback, but the idea we would go back. I had a local VA clinic, or maybe, I guess, maybe this wasn't local, it certainly wasn't local VA clinic, but they wanted to do some scheduling for a veteran, and I think they scheduled, said, "well, the nearest provider is five states away." They misunderstood, they were looking at the city, and didn't recognize they were states away. I mean, I think that was online with the VA. You hear that again, but it might be different, Doctor, maybe in an urban area, but in my district, they know the hospital. You know, and don't forget, these veterans, this

is not their first rodeo to go to the local hospital. Most of them are already going to the local hospital. And that was the fear that somehow they would overwhelm the VA system as they rushed in. All we are saying is let them keep going where there are going, in many cases, and they don't need the VA calling the local doctor they saw at church on Sunday.

And again, it might be different in an urban area where you have got the VA hospital a couple miles away and you have been waiting your 30 days. But for our rural areas, if we went back and centered scheduling, we would have even more problems than before. We would have even more complaints. The robustness of this network is developing, and I think is continuing to improve, and the providers I talk to, they are signing up just to make sure that they get paid on time. But, again, let's not envision this as a veteran that is getting 100 percent of their health care. It is the case sometimes they are starting to drop in, and then say "Hey, can we get this taken care of," if this is going to work. So we will hopefully see this continue to develop and work with the folks that have experience in other networks.

And again, don't forget that you have a veteran that may be a senior officer, he has served alongside as TRICARE for life, he served four years, "Why can't I go to my local hospital," but the guy that has long-term benefits the rest of his life, you know, he gets to go to the local hospital, but I got to drive 200 miles. Obviously, we want to avoid that. So let's continue to work and develop that network. I know in western Kansas, central Kansas, they are ready and waiting, they are slowly adding providers, actually quickly, and I have got 70 community hospitals, you know, unlike some of the other areas, they are begging for patients, you know, and they are hopefully getting the veteran once. They might even get his wife and get his kids as well and it is these kind of things that develop.

My concern as well is that the temporary nature of the language, and I know the Secretary has promised that he wants to make this permanent, but the sooner we can make this permanent, the sooner we can make these relationships more long term, and for the veterans as well as for the providers, Mr. Chairman. So I appreciate the timeliness of this topic. I yield back.

Mr. BENISHEK. Thank you, Mr. Huelskamp.

Does anyone have any further questions? I know there is lots of—

Ms. BROWNLEY. Just quickly?

Mr. BENISHEK. Yeah, sure.

Ms. BROWNLEY. If you don't mind. Thank you, just quickly. I have just a couple of quick questions, and hopefully they are just all yes answers. But so in my district we are still having issues with regards to inappropriate billing, when a patient, a veteran, is seeing a community doctor. And we have a particular issue, case-work that we have not been able to resolve for one of our veterans that saw an orthopedist, was very satisfied with his care there. He stepped on a landmine in Vietnam, ended up getting two splints that he needed, but he is being billed \$500 for those splints. And we have worked really hard in our district office to resolve this

problem. If you could help us resolve it, I would appreciate it very, very much.

Dr. YEHIA. If you give us their name, we would be happy to work it out.

Ms. BROWNLEY. Terrific.

And in terms of just following up on Mr. O'Rourke's question about staffing. If you are going to send him information, I would be interested, you know, in the same information as well.

And the last question I had is, if you have wait time data for veterans who are using the Choice program, and if you have any analysis of comparing that nationally, in terms of wait times, compared to what the VA is providing with regards to wait times.

Thank you. Thank you for your indulgence, Mr. Chair.

Mr. BENISHEK. Oh, no problem.

I am sure there may be other questions that we come up with as you are developing this program, and I look forward to that dialogue. But other Members may want to submit some questions for the record even yet. So thank you all for being here today. It has been an education, and I am sure it will be as we go forward.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material. And without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 11:35 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Mr. Billy Maynard

BIOGRAPHY OF BILLY MAYNARD

Mr. Billy Maynard has been the President of Health Net Federal Services, LLC since May 1, 2015. Previously, in addition to holding a variety of defense sector positions, he was a partner at the management consulting firm InfiniTek for 12 years. At InfiniTek, he specialized in federal health care strategy and provided strategic business planning and organization development support to Health Net and other leading government sector health care service delivery and technology companies.

A veteran of the U.S. Army, Mr. Maynard was Executive Assistant to NATO's Supreme Allied Commander, Europe, from 1983 to 1990. During this period, he was twice decorated with the Defense Meritorious Service Medal for contributions in support of the NATO Alliance. Mr. Maynard is a graduate of the U.S. Army Institute of Personnel and Resource Management (Adjutant General Corps); studied business administration at the University of Maryland University College Europe; and holds a postgraduate certification in organization development (strategic planning and change leadership) from DePaul University.

A HISTORY OF PARTNERSHIP

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to participate in this hearing on provider networks under the Department of Veterans Affairs (VA) plan to consolidate Community Care programs. Health Net Federal Services (Health Net) is proud to be one of the nation's largest and longest serving health care administrators of publicly-financed government and military health care programs. To this hearing, we bring the perspectives and lessons learned throughout our nearly three decade history supporting government health care entities at the intersection of their care capacity and their need to support their beneficiaries with care in the community. Today, Health Net and its affiliates, through health plans and government contracts, provide health benefits and related beneficiary services to more than five million eligible individuals across the country through VA, TRICARE, Medicare, Medicaid, group, and individual programs.

For more than 25 years now, we have served as a partner to the Military Health System (MHS) as a Managed Care Support Contractor (MCSC) in the TRICARE Program. Health Net was the original CHAMPUS Reform Initiative (CRI) contractor, the predecessor contract to TRICARE. Currently, as the TRICARE North Region contractor, we facilitate the community-based delivery of nearly \$3 billion in spending to support the health care needs of nearly 3 million active-duty service members, military retirees, guardsmen and reservists, and their dependents in 22 states and the District of Columbia.

We also deliver a broad range of customized behavioral health and wellness services to military service members and their families, including those in the National Guard and reserves. These services include the Military and Family Life Counseling (MFLC) program, which provides non-medical, short-term, problem solving counseling; rapid-response counseling to military units; and reintegration counseling. In support of MFLC, we have more than 700 professionals deployed with the military worldwide, including professionals embedded in support of special operations forces in various theatres.

As an established partner of VA, Health Net has collaborated in supporting veterans' physical and behavioral health care needs through Community Based Outpatient Clinics (CBOCs) and the pilot Rural Mental Health Program. We also have supported VA by applying sound business practices to achieve greater efficiency in claims auditing and recovery and, previously, through claims repricing, both of which resulted in increased funds available for health care services delivered by VA.

Our singular mission in all these endeavors is to enable government agencies, such as VA, to leverage private sector best practices in order to supplement and complement their in-house capabilities through an effective public/private partnership. Our focus on supplementing and complementing is important because our work as a private sector company focused on organizing and facilitating community-based capabilities and services begins where the direct care capacities of the agencies we support ends. The shared goal from that point is not only to ensure ready access to care but also to enable our government agency partners to continue to provide the high-quality and often highly-specialized services that constitute their core mission.

Our commitment is not just professional; it is personal as well. I am a veteran; I served 10 years in the U.S. Army, including as the Executive Assistant to NATO's Supreme Allied Commander, Europe. I am also the son of a Navy retiree and grandson of a WWII combat veteran who was one of a family of brothers who all saw combat and were supported by VA upon their return home. The mission of health care integration in support of our nation's eligible veterans is one I take to heart personally. That is true of our other associates, as well. Many of the top leaders in Health Net are veterans, military retirees, or military spouses. Several of our younger leaders are still serving as reservists. We take pride in our commitment to our comrades in arms and our fellow veterans. We take our work personally because we have friends who use the services we provide. My remarks are informed as much by the spirit that led me and so many of my colleagues to service as by my business experience.

It is from this long-standing commitment to supporting the military and veteran communities that we offer the following perspectives on provider networks under VA's plan to consolidate Community Care programs.

COMMENTS ON BUILDING A HIGH-PERFORMING NETWORK

First and foremost, we believe that all health care provided in support of eligible veterans is VA care, whether delivered directly by VA or its affiliates or community providers. Therefore, care must be designed and delivered in ways that care in the community is understood and considered as VA care by all involved, most especially eligible veterans and health care providers. For this to be achieved, the approach to delivering care must be as seamless and integrated as possible - especially at the point of intersection between VA's capacity and care delivered in the community. Based on our years of experience, we believe the only way all care can truly be seen as VA care is through the establishment of mutual accountability within the framework of a public/private partnership.

Second, we strongly agree with the Independent Assessment of the Veterans Health Administration (VHA) released on September 18, 2015. Specifically, that report highlighted the challenges of VA's current approach to purchased care through the seven programs already in place or in development. This report concluded that the programs' "sheer multiplicity suggests the drawbacks of a piecemeal approach, absent a guiding orientation and strategy for VHA's purchased care enterprise as a whole." We strongly support standardization and consolidation across the full range of Community Care programs.

Turning attention to VA's plan to build a high-performing network composed of a Core Network of federal partners and academic affiliates and an External Network of community providers: in principle, we support the concept that a preferred provider network construct could deliver the significant community-based access to care that will be necessary to support eligible veterans and to enable VA to fulfill its mission in the future. While there are other approaches, given VA's significant direct-care mission and capacity, a preferred provider approach - sometimes referred to as a tiered network approach - will be the most effective way for VA to optimize and integrate care delivery.

We believe that whatever geographic or provider network development approach VA takes, whether that be tiering or some other preferred provider design, it is absolutely essential that VA partner with a single, third-party entity within each geographic area to establish and administer all community-based aspects of the program.

Like VA care, the TRICARE program also depends on the effective integration of health care at the intersection of a large direct care system and supplemental community-based capabilities. After 28 years of experience, there is perhaps no more important lesson learned than that the only way to ensure consistency and clear lines of authority and responsibility across the program is through the responsibility of a single contractor, on a geographic basis. This approach is the most effective solution for veterans, providers, and VA. It is also the only proven way to actually succeed in standardizing a national-level initiative such as the "new VCP" and mak-

ing it operational in all locations. A single, third-party entity by geographic region will also be the most fiscally responsible method.

The effective implementation of any future version of the Veterans Choice Program is contingent upon optimizing the capacity of VA (including VA Medical Centers and local community-based outpatient clinics); making the provider experience as consistent with community standards as possible; and streamlining veterans' experiences to enable better control of their health care experience. All this can be done while maintaining care in the community as a complementary capability within the broader context of VA health care. We believe this can be done in ways that will preserve and extend the very important relationships VA maintains with DoD and its academic affiliates.

DISCUSSION OF THE DRAFT PERFORMANCE WORK STATEMENT

Turning attention to VA's Draft Performance Work Statement (PWS) for Community Care Networks, we support the comprehensive nature of the requirements outlined and believe it to be a good start toward future procurements that the managed care industry can effectively support.

The Draft PWS requires contractors, within newly defined health care regions, to develop the community-based elements of a High-Performing Network that would provide a full complement of services in support of the consolidated new Veterans Choice Program ("new VCP"), including: network management, credentialing, medical management, call centers, and claims processing.

In the process, VA has defined a draft baseline that is much more TRICARE-like and incorporates a substantial number of industry recommendations made during the market research phase of the acquisition development process. That said, it is important to note the Draft PWS suggests that VA will retain initial appointing and appointment scheduling responsibilities, which is a significant change from the current Choice Program.

The future success of any program, even one based upon an existing program, is laying the appropriate foundation. The transition period for the "new VCP" should have a baseline transition period of at least 12 months from contract award to the start of health care delivery. This will allow the program to "go live" with fully developed and tested networks and operating processes based on lessons learned.

Among the lessons learned in Choice, and similar to those learned in the early TRICARE experience, is that a vital element to the smooth operation of any health care delivery program is a set of standardized written policies and procedures. These policies must answer the "who, what, when, and why" of delivering care. We commend VA for starting this process by releasing the beginnings of an operations manual with the Draft PWS. Much of the friction in the current Choice Program has come as VA tried to implement the intent of Congress and this friction translated to the veteran and provider experience. Having a clear set of guidelines before a complicated question arises, such as how to compute eligibility or what defines an episode of care, is vital to the veteran and provider experience. A thorough transition period will allow for the development of consistent, standardized written policies and procedures. Clear guidelines will also speed any adjudication processes and result in a better experience for veterans and providers through faster responses.

Even with a clear operations manual, however, the veteran experience will be compromised if the intersection of public policy and supplemental community-based capabilities is not executed in a context in which providers are prepared to operate. Therefore, the operations manual and associated processes must align with industry standards. The more unique the requirements to participate in and execute the "new VCP" the more friction will result at the provider level, and the more difficult the experience will be for veterans. Medicare is the common standard upon which all other government programs are based and providers across the country are familiar with Medicare requirements. In addition, VA has stated a goal of moving toward the value-based reimbursement methodologies that Medicare is driving.

THE WAY FORWARD

In closing, let me say that in a program like Choice, veteran and provider experience and satisfaction is everything. The success of any future version of the Veterans Choice Program will depend upon optimizing the capacity of VA (including the VAMC and local community-based outpatient clinics); making the provider experience as consistent with community standards as possible; and streamlining veterans' experiences so that they are able to control the process and receive care when necessary.

All this can be done while maintaining care in the community as a complementary capability within the broader context of VA health care. Health Net has effectively built an excellent customer and provider experience in other government

agency programs such as TRICARE, which was tied at number one with Kaiser Permanente for customer satisfaction, according to a national survey on health plans, the 2015 Tempkin Experience Ratings, conducted by the Temkin Group. We see no reason that VA and industry partnerships should not result in eligible veterans being just as highly satisfied.

Health Net is proud to stand as a partner with VA and Congress in helping to deliver care to our nation's veterans. Thank you for the opportunity to present our views and I look forward to answering any questions you may have.

Prepared Statement of Mr. David J. McIntyre, Jr.

Introduction

Good morning, Mr. Chairman and Members of the Veterans Affairs Subcommittee on Health. I am pleased to appear before you this morning to discuss the status of the development of the community care network in our geographic area of responsibility, which includes 28 states and three U.S. territories. The last time I appeared before you on this particular topic was last Summer, and a lot has occurred since then that has positively impacted access to care for the Veterans who call our area of responsibility home.

Before I get started with my remarks, Mr. Chairman, I would like to thank the Chairman of the full Committee for his leadership and focus on ensuring that our nation's Veterans have access to the health care they earned with their service. It has been and remains a privilege to be of service to his constituents. I know that they are going to miss him when he retires at the end of this Session; however, know that we will continue to stay focused at the side of the Department of Veterans Affairs (VA) in meeting the needs of those he has represented so capably. And, I am confident that his legacy will long endure, as VA continues to re-set for this generation's warriors and the next.

It is a privilege to appear alongside Dr. Baligh Yehia, from the Department of Veterans Affairs. From personal experience, I would like to observe that his hands-on and focused leadership, and that of a very capable team within VA, is enabling us all to move the needle and start to achieve success in the re-setting of VA's leveraging of care in the community to augment that which is available directly within its direct delivery system.

TriWest and VA continue to work in close partnership to improve access to care for Veterans across our service area. While we are beginning to see the fruit of our labors, I would be the first to admit that more remains to be done to fully fulfill the promise of the nation to those who have worn the uniform and sacrificed in service to this great nation.

A Historical Perspective

During TriWest's 20 year history, the company I was fortunate to help form with a group of non-profit health plans and university hospital systems - and have been privileged to lead since then as President and CEO - has focused exclusively on leveraging the core competencies of our owner organizations and their strong market presence to ensure access to needed care when the federal systems on which those in uniform rely are unable to meet the needs directly. And, we and our more than 3,500 employees, most of whom are Veterans or family members of Veterans, count it an honor to be part of the team stretching ourselves in service to our nation's heroes!

Our first 18 years were spent supporting the Department of Defense (DoD) in standing up and operating the TRICARE program in a 21-state area. I'm proud of the work that we did to assist DoD in making TRICARE the most popular health plan in the country and meet the needs of millions across the TRICARE West Region who relied on us for that support. And, as those of us who were around in the early days of TRICARE can attest, we know it was neither an easy nor painless road. Now, working at the side of VA, while the challenges of implementing a new program have been similar to the early TRICARE days, due to the added layer of complication that led the Choice Program to be brought forth so quickly, I believe we can achieve the same results for Veterans who look to VA for their health care needs.

In our experience under the TRICARE program, we had 15 months to prepare for the start-up of TRICARE and then nine months to stand up the program before the demand for services arrived. With the Veterans Choice Program, this 24-month period was shrunk to a little more than 30 days. Since then, you, VA and we, have been focused on making the changes necessary to achieve the success we all desired

with a program that demanded the aggressive design and implementation schedule given the crisis out of which it was born.

While not yet where we all want to be in the re-setting of VA and the programs that exist to support it in the delivery of needed care and services for our nation's Veterans, I would submit that a lot of progress has been made and I am proud of the fact that 100,000 Veterans are now being served each month in our geographic area of responsibility through the Choice Program.

First, most of the policies that needed to be re-set have been acted on and are operational, to the benefit of Veterans and the providers that serve them.

Second, the remaining operations gaps that exist are identified and the needed adjustments are being made. This is largely a result of the work that Dr. Yehia has done in bringing all of us together to form a common focus around five core initiatives: Simplify the Referral and Authorization Process; Decrease Returned Authorizations; Improve Customer Service; Get the Right Provider Every Time; and, Better Visibility into the Networks.

Third, the networks in our vast area of operations, have now been fully tailored and are being leveraged to begin to deliver on the demand profile that exists.

And, fourth, just last Friday, we finished the six month roll-out of an infrastructure and scale that is now beginning to deliver on the demand that exists. This took us from two sites of operations to 10 sites, with Friday's opening in El Paso.

I know that the road has not been painless or easy on anyone involved, especially for the Veterans we all seek to serve; however, there has been tremendous progress in our area, we are maturing the program and WILL achieve the expectations that you and your fellow members of Congress had when you mandated the creation of the Choice Program to more optimally meet the health care needs of our nation's Veterans. As one who was there at the start of TRICARE, and through all of the painful periods and the refinements necessary to smooth out the operation... making it a model program for our nation's defenders and their families, I would say that we are well on our way. And, enabling VA to consolidate all of the community care programs should be the last mile of modification needed to put us on a path to achieving the excellence we all expect of ourselves and wish for those we are privileged to serve.

We all know the pathway we have been on, but I think it deserves repeating.

Where We Started: PC3

In September 2013, VA awarded the brand new Patient-Centered Community Care (PC3) contracts, and we were selected to serve 28 states and the Pacific. And, we were given 90 days to begin operations.

TriWest rose to the occasion by leveraging the existing networks and strong relationships already in place due to our prior work under the TRICARE contract. Initial access to specialty care from our existing network providers began in January 2014 with the ongoing expansion and addition of primary care providers coming on-line over the months that followed. That network building continues to this day as VA and we learn more about where demand exists that was otherwise not being met before this program began.

PC3 was intended to be a nationwide program giving VA Medical Centers (VAMC) an efficient and consistent way to provide access to care for Veterans from a network of credentialed specialty care providers in the community when VA was unable to deliver the care directly. This would provide a consolidated network in each area, rather than continuing the inconsistent and expensive ad hoc approach of trying to contract by site for an array of providers. This was one of TriWest's primary missions as a TRICARE contractor. So, we quickly embarked on the path of putting this together, only to learn that the VA sites really did not have a good handle on their demand profile, a challenge that would become even more extreme with the adoption of Choice. And, when you do not know the size and shape of your demand it makes it nearly impossible to effectively tailor networks, as we discovered painfully in the early days of PC3 and Choice. The goal, though, of having a tailored network of community providers to allow for the optimization of VA's direct delivery system and meeting the specific needs of the Veteran population across each state unable to be met directly by VA remains very doable, as we are now proving in our area of operation.

I will say that the concept proved its worth early in the State of Arizona, where an extensive network was available in Maricopa County starting in January 2014. In fact, it was that network of nearly 7,000 community providers that would prove to be an invaluable tool in the Spring of that year.

A Historical Perspective of Choice Program

In April 2014, the “furnace lit off” in Phoenix, and the country was shocked to learn of the shortcomings in the system. This served as the catalyst for fueling a focus on VA reform throughout the nation and the conversation about what a VA re-set should look like. At that time, nearly 15,000 Veterans were discovered to be on waiting lists for care in Phoenix alone. It is but one example of the re-setting that was needed and has since begun under the leadership of Secretary Bob McDonald, Deputy Secretary Sloan Gibson, and Under Secretary for Health Dr. David Shulkin. Since then there have been a number of Office of Inspector General reports published outlining similar findings, all pointing to the reality that Veterans were not getting the care they needed and deserved in a timely manner.

The recognition that further reform was needed to meet Veteran health care needs led, as you know, to the Veterans Access, Choice and Accountability Act (VACAA) and ultimately, to the Veterans Choice Program. In August 2014, Congress appropriately passed VACAA, and required that this program be stood up quickly in the marketplace. VA faced with these new revelations and the urgent Congressional mandate asked its two PC3 contractors, TriWest and Health Net, to help implement the new Choice Card Act. In fact, we had just over 30 days to go from the policy specs being received from Congress and interpreted by VA to having a program designed and stood up by November 5, 2014 - just 16 months ago.

Within record time, we created the infrastructure, hired and trained hundreds of staff, and got Choice Cards into the hands of four million Veterans in our area of responsibility. TriWest stood up a state-of-the-art contact center making sure that callers to the toll-free line were greeted by the voice of Secretary McDonald, thus underscoring the importance of this new initiative. All of this was accomplished within 30 days which you mandated in law.

I recall vividly sitting in a meeting that VA held with industry in mid-September 2014, as they were seeking to determine how to implement this necessary new program, and hearing many say that a program of this magnitude would take a minimum of 12-18 months to stand up and that DoD had been given about 36 months to design and then stand up a similar program with TRICARE.

However, that was just not good enough in the face of the revelations of the delays that had come to light. Those who served our country without hesitation are not afforded such luxuries of time when our nation sends them across the globe in defense of our country. So, we swallowed hard and agreed to lean all the way forward to stand up the program knowing that it would be imperfect, just as TRICARE was in the early days, but that getting it in place and refining as we went forward would be critical to helping our fellow citizens who were standing in line because they were in need of care that was not available directly within VA.

So, we stepped into the fire at the side of VA and did what others said could not be done and jointly stretched ourselves to stand up this critical new program in weeks (not months or years). Our contact centers went into operation, the Choice Cards went out, and care started to be rendered in the community when it could not be directly provided by VA.

The partnership between VA and TriWest has progressed and matured substantially over the past year. This is a dynamic relationship in which we continue to refine and strengthen operational processes and communication, both on our end and VA's end. Do we still have work to do? You bet we do! But, I am very proud of what we have all accomplished in such a short timeframe. And, I am confident that the trajectory on which we are all on to improve this much needed program will produce the same results as experienced with the refinements that came quickly within the TRICARE program.

One of the core challenges when the PC3 program was first implemented was that we didn't have a clear view of the demand for care. Thus, it made it difficult to ensure a precise supply of network and the subsequent infrastructure of systems and people needed to support that demand as a company. Additionally, we faced programmatic and statutory challenges with the Choice Program when it was first launched (which is discussed in detail later). But, we had to start moving and then refine later - which is exactly what we have done and continue to do with intensity, and will continue to lean forward to ensure that Veterans receive the care they have earned, and that Congress envisioned with the enactment of Choice!

Volumes were low in the beginning as Veterans were just learning of the new access they were gaining through this program. Care requests were about 2,000 for that first month of 2014. While volume increased each month, care requests under PC3 only reached their peak at about 20,000 per month by the end of that year when the Choice Program came into the picture.

The second iteration of the program, beginning in January 2015, focused on implementing Choice and finding solutions to some of those challenges - both internally at TriWest, as well as within VA itself. We saw steady increases in care requests

month by month. TriWest is now scheduling over 100,000 Choice appointments per month in 28 states, up from 2,000 per month in January 2015, a dramatic 50-fold increase.

Network Growth

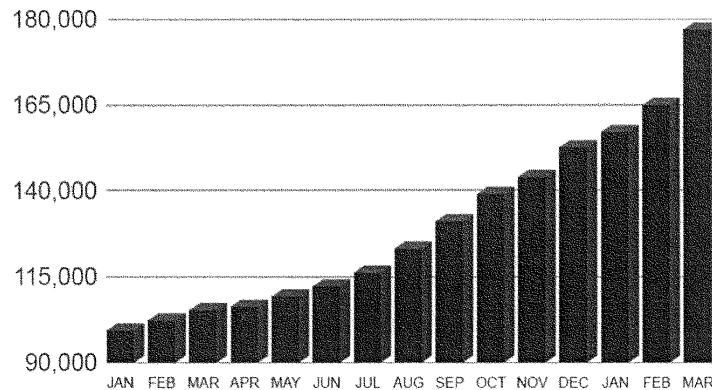
Foreseeing the likely increase in utilization, we initiated a process with the team from VA to assess demand and determine the distribution and supply of network that would be needed in the community to support that demand. We call it the “Demand Capacity Assessment Process”, which last Summer was conducted with nearly every VAMC within our service area. We met one on one with each medical center to assess how many providers of each specialty would be needed in addition to the supply of providers working at the VAMC to meet the needs of Veterans in each geographic area. This included not only a projection of the demand that was already known to exist but that which seemed ready to materialize with the added policy decisions regarding Choice coming out of Congress. We then took the output of this data-driven process and turned to our owner/network subcontractors and started to grow the network on a tailored basis to match the demand.

We implemented the tools for this process Memorial Day weekend of 2014 for the work that we were tasked with to assist the Phoenix VA in working off the backlog of nearly 15,000 Veterans waiting in line for care. Those tools allowed us to assess the demand and the needed provider and staff supply to assist the Phoenix VA in successfully eliminating the initial backlog by the end of August 2014.

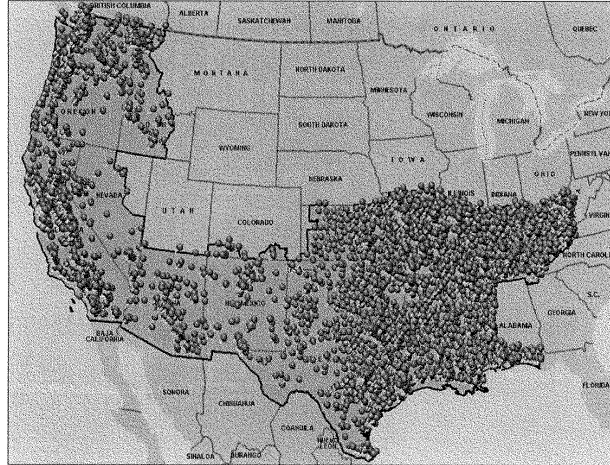
Armed with the Demand Capacity Assessment Tools, we and the VAMCs in our geographic area of responsibility worked to assess demand and then we went about mapping the supply of providers that would be needed in each community to provide that which VA was unable to deliver directly. This targeted approach has resulted in the tailored construction of a network that now totals nearly 180,000 providers across our service area.



PROVIDER NETWORK GROWTH
(Jan 2015 - Mar 2016)



The following is a map which plots the density and distribution of provider network:



While expanding the provider network was of primary focus, we also recognized that assuring the quality of our provider network also deserved special focus. To that end, in August 2015, TriWest was awarded full health care network accreditation pursuant to the Health Network, Version 7.1 from URAC, a Washington, D.C.-based health care accrediting organization that establishes quality standards for the health care industry. TriWest demonstrated that we meet key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement, and consumer protection. This accreditation is valid for three years, and demonstrates that those Veterans we are privileged to serve in support of VA have access to quality care.

And, as we continued to focus on the expansion of our network, this past Summer 2015, Congress refined the design of the Choice Program by enacting changes to help expand eligibility, thus providing greater access to care for Veterans. As a result, the number of care requests we received for private care has continued to grow dramatically.

The Veteran Experience

As part of our commitment to achieving the same performance outcome as we produced in TRICARE, we turned to a 20-year partner of ours to repeat an effort we undertook in that work. Once we had a few months of experience under our belt at the side of VA, we started a very focused and intentional effort to assess and understand current experience, identifying gaps and opportunities for improvement by conducting in person, “blueprinting” sessions alongside the industry leading Arizona State University’s world-renowned Center for Services Leadership (ASU CSL). In fact, it is they who train such industry leaders as Proctor and Gamble, Starbucks, Disney, and the like in the techniques of customer service mapping and process improvement.

One of the initial blueprinting sessions held last Summer included Veteran representatives, Phoenix VAMC leaders, Veterans Service Organization leaders and TriWest stakeholders. As a result of the blueprinting effort, TriWest and VA made changes to processes, program materials, and training to improve the experience for Veterans. The very early indications are that this time-tested approach, mirroring that of the most highly regarded customer service brands in America, is beginning to yield results that matter. TriWest has also introduced the ASU CSL process known as “service recovery” to address customer service breakdowns identified in our complaints and grievance process for inquiries received from Veterans, providers, Congressional offices and VSOs. This process ensures that root causes are analyzed by the leadership so that process improvements to customer service can be made.

The Provider Experience

Similarly, the provider experience is critical to both TriWest’s and our network subcontractors’ ability to build and maintain networks to serve Veterans. The Choice Program only works if it has strong participation from local providers who are reimbursed by the government in a timely manner for the service they provide

to Veterans. We recognize that many of the requirements placed on providers to participate in the PC3 and Choice programs create a significant administrative burden and often go beyond what is typically required of providers to treat patients. It is for this reason that we are making efforts to reduce this burden, where it can be controlled by TriWest, by streamlining our processes. As a result of the provider blueprinting effort, TriWest is now revising our provider letters and redesigning our Provider Portal (similar to what we did this past year with the VA portal) to improve the overall provider experience. We call this upgraded experience, "Provider 2.0" - that will make it easier for providers to join the network and receive timely payments for the services they render under the Choice Program. We are taking the provider experience to another level for the almost 180,000 providers in our network who serve the health care needs of our nation's Veterans.

In an effort to lean forward further in the critical space of behavioral health, we have worked closely with the Phoenix VA, and initiated a pilot project to care for Veterans in urgent need of behavioral health services, who present themselves to the VA emergency department. TriWest has committed to helping place such individuals into the private sector for their emergency behavioral health needs in a timely manner, and to date has ensured that more than 200 Veterans have received the urgent behavioral health care they needed. That number represents saved lives. The behavioral health network is being utilized by some of the VAMCs in our 28-state region; in January 2016, 1,639 Veterans were served in the behavioral health community taking three days on average to get appointments scheduled, and 90% of them saw a provider in less than 30 days. We want to thank the team at VA for having the confidence to turn to us as a teammate, so that together we might address a challenge they were facing.

Another example which illustrates the great partnership we have developed with VA - a partnership aimed at taking care of the Veterans that we are so privileged to serve - occurred in Phoenix (as well as nine other locations in the regions where we operate).

In November 2015, TriWest energetically joined with VA on a special initiative - "Stand Down Day" to advance efforts to reduce the number of Veterans with high-priority or urgent care problems waiting longer than 30 days and to learn together what should constitute our focus in the months to come as we seek to further refine the operation of Choice.

In a collaborative effort with VA, TriWest assembled a team to provide real-time, onsite support for the Stand Down efforts within 10 pre-determined VAMCs. Through this collaborative effort, TriWest worked 6,500 Choice Veterans and the associated referrals. On Saturday, November 14, 2015 TriWest supported the Stand Down with 868 employees working across all hub locations. TriWest staff responded to inbound phone calls from Veterans and VAMC representatives, responded in real-time to VA comments posted through the shared web portal, data entered all new referral requests received on the 14th, and placed outbound phone calls to Veterans to initiate the appointment process. In addition, TriWest staff (including myself and other senior leadership) joined the VA staff in 10 specific VAMCs to provide real-time, onsite support.

As a result of VA initiating the Stand Down project, VA and TriWest were able to close the gap on outstanding health care service requests at VA and place a significant number of Veterans in the care of a community provider. The results for clinically urgent care were particularly strong as the large majority of care requests were appointed within five business days.

For example, in Phoenix, the Phoenix VA submitted a file to TriWest containing Choice referrals for approximately 298 Veterans. TriWest identified 502 referrals for this population. Beginning on November 14, 2015 (and continued through December 11, 2015) TriWest staff researched all unresolved referral requests and initiated contact with Veterans, providers, and VA staff. Overall, TriWest has been successful in reducing the number of those pending referrals to less than 30. The results for Phoenix demonstrate the growth of the network of community physicians as well as the tremendous collaboration between TriWest and VA to drive favorable outcomes in a timely manner.

In the area of educating Veterans, providers and others about this program and its operation, TriWest has shown its presence at a number of local town hall and community meetings, as well as attendance and support at a number of Congressional Veteran Resource Clinics. We have briefed government, non-profit and civic leaders on the program and efforts to improve the processes. We are also very active with our support of the Veterans Economic Community Initiatives (VECI) program that was launched by Secretary McDonald in June 2015. This program is committed to providing employment opportunities for Veterans and their families through a network of support at the community level. In fact, many of our operations centers

we have opened throughout the country are located in VECI communities, and we opened our last Operations Center in El Paso, TX on March 18, 2016.

Operational Growth, Innovations and Program Improvements

Beginning in May 2015, TriWest responded to the growth in care requests by ramping up our workforce, expanding our footprint and our network, and working on operational efficiencies. To meet the increase in demand of care requests that is on pace to hit over 110,000 authorization requests by the end of this month, we have added eight new operations centers across our geographic areas of responsibility and implemented a VISN-centric strategy with each of our locations, to better serve those geographic areas “on the ground”. Over the past few months, TriWest has opened operations centers in: San Diego (270 employees), Kansas City (over 500 employees); Tempe, AZ (400 employees); Nashville (250 employees); Honolulu (60 employees); Sacramento (270 employees); New Orleans (300 employees) and just a few days ago opened a final location in El Paso (235 employees) with the full collaboration of Congressman O’Rourke and his dedicated staff. My expectation is that once we are fully staffed at each of these sites (based upon the eligibility criteria that exists today), with all new staff online, that we will be able to fully handle the increasing demand coming through this program, which frankly has continued to be a bit of a struggle, as demand has continued to exceed all of our projections.

At the same time, TriWest spent 2015 focused on innovations to help improve program operations across the enterprise. In addition to opening operations centers, hiring thousands of new employees and building networks, a large focus has been on upgrading systems. We stood alongside our partners at the Phoenix VA almost one year ago today to obtain their requirements for a new portal - a region-wide system that enables VA staff to seamlessly order and track health care services between themselves and TriWest. We had a team of people working in shifts, around the clock for three months, to develop the upgraded portal, which was implemented in several phases beginning in May 2015. The new portal was available to every VAMC within our region by July 2015. Today, VA has over 2,500 trained users on the system, and they rely on this system to manage most aspects of community health care delivered through the Choice Program.

Another major initiative TriWest implemented to help manage the surge in program volume and growth in usage among Veterans, and aimed at customer service, was a new Customer Relationship Management System. This new tool will ultimately assist our staff in delivering effective and efficient customer service encounters, just as we did in TRICARE for those who have served. The system also brings improvements to the user interface and the ability to document outbound and inbound calls with Veterans - all aimed at improving customer service.

And within our operations centers, we recently have also implemented a Behavioral Analytics Call Monitoring System which helps improve staff interactions with customers, VA staff, providers and Veterans alike. TriWest operations centers are now fielding nearly 300,000 incoming calls for care per month. Our operations centers are being built just as they were under our TRICARE contract - which was recognized for call center operation customer satisfaction excellence for five consecutive years under the J.D. Power and Associates Call Center Certification Program. That distinction acknowledges a strong commitment by TriWest operations centers to provide “An Outstanding Customer Service Experience.” It is how we have always operated, and we are committed to that high level of customer service operations again under this program.

On the provider side, we have worked to streamline the claims payment process whereby providers submit their claims electronically which helps improve provider satisfaction with claims processing. Today, TriWest pays clean claims at a rate of 97% in less than 30 days.

With all of these initiatives, tools and expansions in mind, I would be remiss if I did not mention that all these needed upgrades that have been implemented over the past 12 months or so, do not come without cost. Our company’s sole line of business is to care for Veterans - it’s who we are; it’s what we do. And from all we have done in dedicating ourselves to this mission, we have put the priority on getting this right for our nation’s Veterans because we and our non-profit owners believe that is the right thing to do.

Investing around \$70 million of our owner money thus far to further our and VA’s joint objectives to develop more optimal tools, tailor networks, and scale and re-footprint the company to more optimally deliver customer service at the side of VA, we are pleased with the refinement that is starting to materialize. The fact is that we continue to work hard alongside VA to do whatever it takes to make this program meet the vision from which it was created.

Still Hard At Work to Tackle Challenges

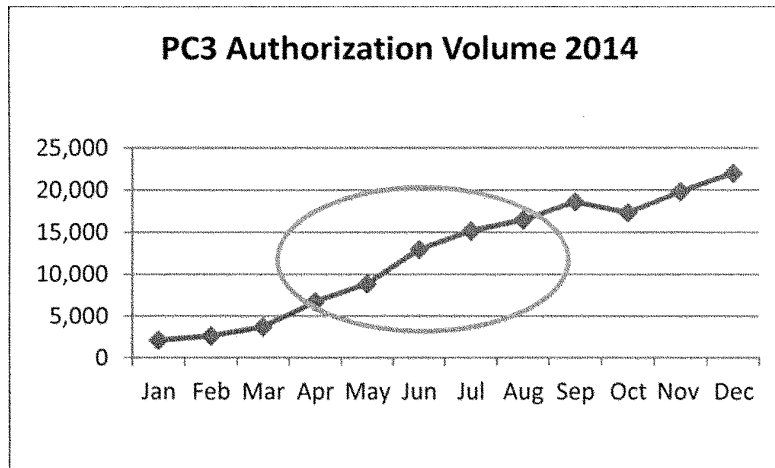
Choice is working. We all know that challenges remain as the program continues to progress and mature, but the customer experience under the Choice Program is getting better with each passing day. Information provided by TriWest staff is more consistent and more accurate; providers are more familiar with the program; and we have implemented an initiative that allows any provider in our region to register online with us to be a Choice provider. Knowing who is willing to treat a Veteran under the Choice Program, even if they are not already a TriWest network provider, goes a long way towards speeding up the appointing process.

Every day we focus on improving the program. I say this because each challenge presents an opportunity to make the system better and prove to Veterans that good can come from their utilization of this system which you created to facilitate the benefits they have earned. Whether it's the 95-year old Veteran in northwestern Arizona who used to drive three hours to Phoenix for care (and now gets his physical therapy 10 minutes from home) or the Veteran who spoke with one of our staff after his knee replacement, noting he's had 20 surgeries in his life and the process through Choice was "the easiest of them all" and "perfect", we know that Veterans are beginning to recognize the benefit of this program as utilization increases.

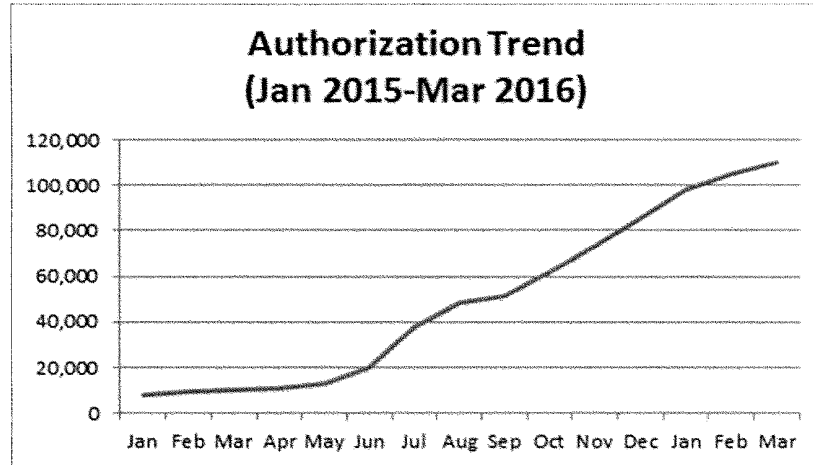
TriWest Performance - Becoming "the Answer" for VA

General George Patton said "a good plan violently executed now is better than a perfect plan executed next week". I think we now know personally the definition of "violently executed", as that has been required of us. We adopted this mindset to begin working off the significant care backlogs in place when we were called upon to implement Choice in addition to our initial contract. And while more time to implement the program would've been ideal, not one of us involved in this wanted Veterans to wait a moment longer than absolutely necessary. It was critical to begin coordinating Veteran's health care immediately.

Beginning in 2014 when PC3 was implemented, the program started out slowly with a couple thousand care requests per month. Networks were being developed, and we phased our implementation by region beginning in January 2014. Then, in April 2014, the furnace lit off in Phoenix, which ignited a rapid increase in program utilization nationwide. Over time, program adoption grew, and by the end of 2014, TriWest received almost 22,000 care requests from VAMCs throughout our regions, as displayed below:



At the tail end of 2014, and moving into 2015, the Choice program was birthed. At the start of the Choice program, we received requests for only 2,000 appointments for the entire month. This number has skyrocketed and expected to surpass 110,000 this month - just one year into the program. For those of us who are math minded, that's over a 4,900% increase in volume. The chart below shows the upward trajectory for the number of authorizations received per day in 2015, and the first two months of 2016:

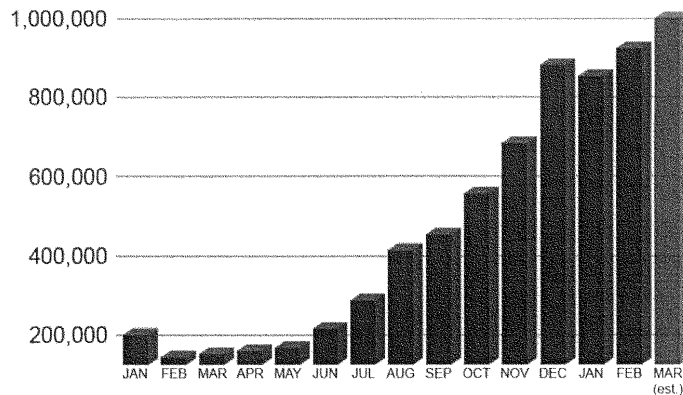


Although this massive growth is a positive indication that more and more Veterans are receiving the care they deserve, it does call upon us to push the envelope in meeting the challenges. Despite having added numerous operations centers since last Summer, increasing staffing by thousands, adding several innovations to systems and process, we are still not finished with our task of catching up fully with the continually increasing demand.

What is particularly staggering is the growth in the number of phone calls received. Just this last month, total calls were nearly 1 million. The growth in calls has been a bit like chasing a Tsunami, as the chart below illustrates.



TOTAL CALL VOLUME
(Jan 2015 - Mar 2016)



And, while we are still refining our operations in this area of staggering growth, I believe that the statistics are something about which we can be justifiably proud and demonstrate that we are gaining on it. They are as follows: less than 16 seconds average speed to answer, and an abandonment rate of 2%.

In the midst of this surge in demand, a number of policy and operational improvements have been made. For example, most recently VA implemented a change order to our contract in early October 2015, which aimed at lessening the wait lists and speeding the Veteran's access to care. That change involves using a more proactive approach to making health care appointments for Veterans, through the use of out-bound calling. That is, through a streamlined process with VA, we now reach out to call the Veteran directly versus waiting for the Veteran to call us. The new out-reach processes we have developed jointly with VA keeps the care requests moving rapidly through the system, so the Veteran receives care more expeditiously.

Finally, processes improvements continue to be worked as we fully implement additional operations centers, rounding out our presence in each of the VISNs within our regions. As any of us do in a new implementation or new job, we are striving to embrace a steep learning curve. Our employees will continue to become more efficient in their work, systems will continue to be tailored, and processes refined, ultimately resulting in the kind of favorable outcome that all Veterans deserve - thus fulfilling the overall goal of this program.

Refinements in Policy

At the outset of this crisis, Congress acted quickly to implement a program which provided enhanced access to Veterans health care. Since then, many legislative changes have occurred to address some nuances of this program that were unforeseen in the beginning.

The first of such changes began in January 2015, under the Omnibus Appropriations Act, when Congress addressed the rate issues and this change helped align rates in the area with the marketplace - a key component to provider satisfaction and contracting in that state.

Several months later, in July 2015, to further improve the program from a policy perspective, the "Surface Transportation and Veterans Health Care Improvement Act of 2015" modified several requirements of the Veterans Choice Act of 2014.

First, the Act repealed the 60-day limit on follow up care. Instead, the authorization extends for the entire episode of care. In January 2016, we received the formal modification to implement this change, which has opened the doors for many Veterans who need urgent services lasting beyond 60 days, and helps with certain provider groups who desire to provide care to Veterans, but had been stifled by the 60 day authorization rule. Now, Veterans who face serious conditions (such as the case studies I shared with you earlier) are able to receive the entire episode of care (chemotherapy treatment, maternity care, etc.) that is required to complete their treatment.

Second, the Act repealed the August 1, 2012 enrollment limitation on eligibility of Veterans in the patient enrollment system. This critical change removed the requirement that you have to be enrolled in VA prior to August 2, 2014, to be eligible for Choice Program. The impact was great to Veterans, allowing near instantaneous determination of eligibility by the VAMC.

Third, the Act extended provider eligibility to any health care provider meeting VA criteria - this change helped open the pool of providers who could provide health care to this deserving population.

Finally, the Act based the 40-mile distance requirement as the distance traveled from a VA medical facility instead of 'as the crow flies', including one offering primary care for a Veteran seeking primary care. This gave more Veterans access to the program, especially in complicating geographic areas.

Another program change last Summer that was directed at improving access was VA's implementation of the Choice First program - which immediately expanded eligibility and opened the flood gates to care by giving a Veteran the ability to obtain services in the network when such specialty was not available at all within their local VA medical facility.

Congress continued assessing necessary program modifications later into 2015. In September 2015, TriWest received a contract modification regarding outbound calls, and elimination of blind appointing, and we were authorized to begin working these changes on October 1. This more proactive approach to making health care appointments for Veterans prevents an authorization from sitting and aging, awaiting a phone call from the Veteran. As a result, more Veterans receive health care, and they receive it more timely.

In late 2015, Congress expanded access to private doctors where its Community Based Outpatient Clinics lacked sufficient provider access, expanding the number of patients who are eligible to seek care in the community under the Choice Program. As a result, if VA has no primary care doctor on staff, a referral for private care is not required. This change alone estimated opening up the program to about 160,000 more Veterans.

Finally, in November 2015, we received federal approval within our contract to allow TriWest to staff employees at VAMCs with the execution of an appropriate Memorandum of Understanding. As a result, TriWest has several cells of "embedded staff" within a multitude of medical centers, including New Orleans, Dallas, Harlingen, Anchorage and Phoenix, to more optimally coordinate work at the local level. Oftentimes, Veterans are able to walk right down the hall after a medical appointment that identified need for care in the community. In that office, they can get educated about the program, we learn of their preferences, and we start the process of securing them an appointment in the community. We know from our work during

the TRICARE program that having staff embedded in a medical facility can go a long way toward making the use of the program a more seamless experience. Those TriWest staff got to know the government staff, the beneficiaries, and also the providers in the community. All of that helped speed the process of getting care provided in a timely manner in the community.

Overall, I commend Congress for all the steps it has taken this past year which have driven great program improvements. In addition to the changes that have already been modified into our contract, we also anticipate a change in Medicare payment, whereby providers no longer have to be Medicare participating in order to see one of our nation's Veterans. This change has recently occurred with behavioral health providers, whereby behavioral health care can now be provided by master's level counselors; therefore, master's level counselors will now be able to participate in PC3 or Choice and will be eligible to receive authorizations to provide behavioral health care to Veterans. This change will help enhance Veterans' access to such services, and will be another piece to the puzzle of opening up more access to care for those providers who wish to provide care for Veterans nationwide.

The pace is swift and, as you can see, changes are plentiful, but we are implementing quickly, changing programs and refining processes along the way, and MUCH has been done to set the groundwork to improve the overall program and enhance access to care for our nation's Veterans.

Looking Forward - Pushing the Art of the Possible

Now that we have had a glimpse into the past, let me take you to a very important part - the future and the 'next generation' of the program, so that Veterans get the best care they need and deserve. Here's what I see over the next six months that is part of the formula for success moving forward.

At this point, I can confidently say that the Choice Program is working—more Veterans are receiving the care they have earned and deserve. It must work even better and faster to meet Veterans' needs, and TriWest is committed to the continued partnership with VA to continue to close the gaps.

One thing we know for certain is that through all of this, the Choice Program brought significant availability to health care for Veterans by making many community providers available to enhance access when access to care in VA is not sufficient to meet the need. Deputy Secretary, Sloan Gibson, stated during the House VA Committee hearing on November 18, 2015 that there have been seven million more appointments scheduled this year compared to last year. While not all of this has flowed through Choice, the volume is continuing to increase as we refine our capability and enhance our supply of network and staff to match demand. Despite all the maturation that still needs to occur to perfect the program, this is great progress, because millions more Veterans are receiving health care under this program than last year. Now, Veterans are demonstrating that they are gaining trust in the program and TriWest, and they are seeking the care they need. Veterans are voting with their feet—despite the start-up challenges, in the TriWest area of responsibility, last month over 100,000 Veterans chose to use Congress' VA Choice Act, including the 95 year old Veteran in Phoenix who no longer has to drive three hours for his physical therapy.

Demand for health care will grow as Veterans who may have become discouraged and given up seeking care will return as the backlogs are reducing across the system and as we continue to work together to effectively address access issues. We expect that as Veterans continue to gain trust in the Choice Program, they will continue to seek out this care when VA is unable to meet the need directly. It is for this reason that we will continue to expand our operations over the next six to nine months and beyond to ensure we do our part to see that Veterans get the care they have earned.

The network will continue to expand and be high performing, so that the Veterans we serve - and the VAMCs we serve alongside - will continue to have the ability to access needed care in a timely fashion.

Legislative advances to help move this program forward will have taken a strong foothold. And, we and VA just executed a change in the contract that allows us to decouple the receipt of medical documentation from payment for a provider. While we will still pursue the needed medical documentation from the provider, so that it can get to the VA doctor quarterbacking the care for the Veteran and end up in the Veteran's consolidated medical record in VA, this will speed up our ability to pay the provider so that nearly all payments will match our performance on clean claims of more than 97% being paid within 30 days.

We are in the midst of a major VA health care reform, and we have the opportunity to make the health care delivery model the most efficient it can be. In my opinion, the best system for Veterans is a VA public-private partnership that builds

on what VA does best, while leveraging private sector provider networks and best business practices created by TriWest. This partnership provides accountability and transparency while also fostering innovation. But, VA must ultimately be the backbone, focusing on their core mission of taking care of its soldiers inside the four walls of VA. And, VA must allow their private sector partner, TriWest, to do what we do best which is to build and enhance networks, process claims, schedule appointments, and help coordinate care for the best outcomes for the Veteran, with flexibility, effectiveness and efficiency. We must continue to work together for the betterment of VA health care, alongside VA and Congress, and we all must continue to build upon the core that we have already developed.

Conclusion

Mr. Chairman, I hope my testimony has provided some useful information as to how TriWest became a part of this effort, where we are today, and where we are headed in the future. I also hope it has convinced you that the company I am proud to lead considers it an honor and privilege to work every day to provide access to care for those who have served this nation in uniform. We have always stood ready to implement VA health care needs within record speed and record time, and will continue to dedicate ourselves to this critical task, all in support of our nation's Veterans. It is an awesome responsibility and our non-profit owners look forward to continuing to be a large part of the formula for future success in assisting VA in delivering on its responsibilities to our heroes on behalf of a grateful nation!

Thank you again Mr. Chairman for this opportunity to appear before you and your colleagues this morning. I look forward to answering any questions you might have.

Prepared Statement of Dr. Baligh Yehia

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to further discuss the plan to provide Veterans access to a community care network as described in the Department of Veterans Affairs (VA) October 30, 2015, report on the consolidation of community care programs. The community care network will provide Veterans with access to high-quality providers and the ability to make an informed choice regarding their health care. I am accompanied today by Dr. Gene Migliaccio, Deputy Chief Business Officer for Purchased Care.

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 the 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, community providers, and 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, 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 (Choice Act).

On October 30, 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs. The plan included some aspects of the current Veterans Choice Program established by Section 101 of the Choice Act and incorporated additional elements designed to improve the delivery of community care.

VA currently has a variety of agreements with providers in the community, but limited national visibility into supply and demand needs. There are no standardized approaches for provider credentialing, quality monitoring, or identification of

best-in-class providers. High-performing networks in health care apply standardized credentialing and quality criteria. They can identify and recruit high-quality providers for the network. As described in the plan, the VA Core Network includes

high-quality health care assets in the Department of Defense (DoD), Indian Health Service (IHS), Tribal Health Programs (THP), Federally Qualified Health Centers (FQHC), and academic teaching affiliates. The community care network includes commercial providers in Preferred and Standard tiers based on quality and value performance. Standardized credentialing will decrease administrative barriers for providers, while more rigorous and consistent quality monitoring will promote high-quality care for Veterans.

BACKGROUND

To identify provider eligibility requirements and design a high-performing network for VA, we have examined best practices for provider networks, credentialing, and quality standards. Provider network design and implementation are constantly shifting to accommodate changes to the U.S. health care landscape, including coverage requirements and provider incentive models. A provider network consists of licensed health care professionals (e.g., doctors, nurse practitioners, physician assistants, and nurses) and medical facilities (e.g., hospitals, outpatient surgery centers, and diagnostic imaging centers) that agree to provide services at pre-negotiated rates. A robust provider network has an adequate number of health care professionals in terms of quality, mix/type of specialty, and geographic distribution, as well as facilities, to meet demand needs.

High-performing tiered networks promote high-quality care, improve health outcomes, and reduce system costs. They include providers who meet the minimum standards and preferred providers who meet additional quality and value standards. These networks help patients identify providers who can deliver culturally competent care and publish provider information for patients (e.g., quality designations and patient feedback).

To effectively develop and maintain high-performing tiered networks, industry-leading organizations use network development, contracting and reimbursement, provider relations, credentialing, and clinical quality monitoring functions. The network development function implements provider payment strategies and determines the optimal size, composition, and geographic distribution of the network. Contracting and reimbursement capabilities include negotiating provider agreements, obtaining exception approvals to standard provisions as needed, and maintaining reimbursement data. The provider relations function manages ongoing communication and education initiatives with the provider community, while also addressing inquiries and grievances. To improve the stakeholder experience and simplify processes, leading organizations invest in customer service personnel and web-based tools for patients and providers (e.g., navigation tools to help patients become familiar with care processes).

Credentialing is the process of reviewing the general qualifications and practice history of providers using guidance from organizations such as the National Committee for Quality Assurance (NCQA) or The Joint Commission. Commercial provider networks review education, training, employment, and disciplinary history. Leading organizations use credentialing systems that automate tasks and incorporate analytics-driven decision-making. The processing time for credentialing a new provider in a commercial network is typically 30 business days. Commercial networks re-credential providers to monitor ongoing adherence to standards based on regular intervals (usually 24 - 36 months). Providers that do not meet specific standards (e.g., because of recurring malpractice claims or sanctions against a professional license) can be removed from the network.

In the U.S., health care is not delivered consistently. There are notable differences in health care spending, resource utilization, and quality of care depending on factors such as the licensed health care professional, medical facility, geographic region, and patient population. Increased utilization and spending do not always lead to better outcomes. To promote consistent high-quality care that is safe, timely, effective, efficient, and patient centered, industry-leading organizations are working to measure provider performance and recognize high performers. Metrics employ evidence-based performance criteria based on rigorous and transparent methodologies. Sources for quality measures can include NCQA, the National Quality Forum, Agency for Healthcare Research and Quality, and The Joint Commission. Effective coordination of care and health information management also directly affects quality of care.

CURRENT STATE

Current VA community provider relationships are formed through multiple overlapping programs with federally funded health care entities and commercial providers. VA contracts or has agreements with approximately 40 DoD facilities (with access to TRICARE Managed Care Contractors on a case-by-case basis), 100 IHS fa-

cilities, 80 THPs, 700 academic teaching affiliates, 700 FQHCs, 76,000 locally contracted providers, and 200,000 additional providers through current national contracts, such as PC3 and Choice. Despite the large numbers of providers, VA does not have ongoing visibility into many provider locations, nor an understanding of supply and demand imbalances. Therefore, VA does not have coverage in certain areas to provide accessible care to Veterans, nor a single mechanism to actively manage provider relationships.

VA has multiple processes for credentialing community providers and different credentialing criteria, depending on the authority that is the basis for furnishing community care. VA does not have a standardized approach to measure delivery of quality care furnished through contracts and agreements with community providers. Some sharing agreements are administered locally, and quality reporting requirements vary depending on the agreement. As a result, VA currently has limited visibility into best-in-class providers. Once providers have agreed to provide care to Veterans, VA does not have a national mechanism to track quality of care issues. With variable quality monitoring processes, providers are held to different standards and VA faces a larger burden in monitoring quality compliance.

FUTURE STATE

To align with VA's mission to better serve Veterans, VA plans to provide access to a high-performing network drawing from best practices across industry and federally funded organizations. Key elements of the high-performing network include:

- Applying industry-leading health plan practices for tiered network design;
- Enhancing unique relationships with federally funded and academic teaching affiliates;
- Promoting Veteran choice, access to care, and high-quality care delivery;
- Using streamlined and consistent credentialing and quality monitoring processes;
- Incorporating network management functions, including network development, contracting and reimbursement, credentialing, clinical quality monitoring, and provider relations;
- Consistently monitoring supply and demand changes to make appropriate network adjustments, achieving access standards, and coverage for primary and specialty care;
- Effectively coordinating care in a Veteran-centered way; and
- Using clinical and administrative metrics to continually measure and improve performance.

As proposed in the October 30, 2015, report on the consolidation of community care programs, the VA Core Network will include providers in the DoD, IHS, THPs, FQHCs, and academic teaching affiliates. VA's relationships with these providers are unique and have evolved over time. Sustaining and expanding Core Network relationships aligns with VA's mission, vision, and strategies. VA will work to develop simple and consistent agreements with Core providers that are principle-based and focus quality and outcomes.

External providers - those outside the Core Network - can belong to Standard or Preferred tiers, which will expand over time. VA plans to make the process for joining the external network simple. Providers in the Preferred and Standard tiers must meet uniform credentialing requirements to participate in the high-performing network. Based on industry feedback received from the Department's February 9, 2016 "VA Community Care Network" draft performance work statement, VA is working to develop requirements that match industry standard. Providers in the preferred tier must meet minimum credentialing requirements while also demonstrating high-value care.

The high-performing network will require network development, contracting and reimbursement, credentialing, clinical quality monitoring, and provider relations functions. VA will employ an audit function to oversee credentialing and adherence to quality standards. Veterans will have the ability to choose community providers and make informed decisions based on publicly available information. Veterans currently accessing community care can remain with their community providers, if the provider meets minimum requirements, or choose other providers in the network. Veterans also can recommend their providers for inclusion in the network. VA will consider publishing provider designations, credentials, and Veteran feedback. To promote awareness about military culture and unique issues Veterans face, VA will encourage providers to complete relevant trainings and make available educational resources.

VA faces significant access challenges in delivering care to Veterans due to geographic limitations and the unique needs of the Veteran population. VA plans to in-

clude the highest quality providers, but also recognizes the need to establish a broad and flexible network providing convenient care near to where Veterans live. In the high-performing network, credentialing processes will be simple, consistent, and in alignment with best practices. The re-credentialing process will evaluate ongoing provider qualifications to confirm health outcomes and adherence to standards. These can include value, complaint history, Veteran experience, and a baseline assessment of care appropriateness every 24 - 36 months. VA will audit and enforce credentialing practices in the high-performing network. High-level provider credentialing standards include:

- Educational credentials, certifications, licensure, training, and experience;
- Employment and pre-employment history;
- Supplemental attestation questions, disciplinary screening, and sanctions; and
- Agreements with providers to meet access and quality of care standards.

VA will work directly with providers currently caring for Veterans to include them in the network for continuity of care. Providers who meet credentialing criteria will complete a simple enrollment process and can join the VA network. Over time, poor performing providers will be removed from the network.

In the VA Core Network, VA will delegate credentialing or perform credentialing functions when applicable. Federally funded credentialing institutions include DoD, IHS, FQHCs, and THPs. In the external network, either VA or a “network manager” will assume ownership of credentialing and will apply industry-leading practices. VA will work toward establishing simple, consistent, and high-quality agreements with Core and external providers in the high-performing network. In order to promote quality of care, VA will monitor and enforce rigorous quality reporting and performance standards in line with industry, conduct data analytics on disease management, and share VA critical pathway information. VA plans to shift toward adopting value-based care models in the high-performing network.

Creating a community care network will maximize the use of high-quality federally funded health care assets, while sustaining unique and important VA relationships. In addition, VA promotes high-quality care by creating preferred and standard tiers. For the preferred designation, providers must meet quality and value metrics that are based on evidence-based care guidelines. VA plans to uniformly apply best practices to determine criteria for both tiers. VA will work to determine specific metric reporting and performance benchmarks using recognized institutions.

CONCLUSION

VA appreciates the opportunity to discuss the community care network element of our plan. The Network system described in our plan would empower Veterans to make informed decisions about which providers they want to use, by highlighting providers with higher quality, care coordination, and satisfaction scores. Additionally, it will help reduce confusion for Veterans as they interact with and transition between VA facilities and community facilities. This provision also supports our efforts to make our system more in line with industry standards, as tiered networks are common in the delivery of value-based care, as seen with TRICARE and many private sector health plans.

As we have described at other hearings, VA will implement improvements to the delivery of community care through an incremental approach as outlined in the plan. VA looks forward to continued discussions on how to refine the approach described in our 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. These improvements, like many of the enhancements VA has already made, are only possible with Congressional support, including legislation and necessary funding.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other Members of the Committee may have.

Statements For The Record

THE AMERICAN LEGION

The American Legion believes in a strong, robust veterans’ healthcare system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances there are situations where the system cannot keep up with the health care needs of the growing veteran popu-

lation requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion has called for the Department of Veterans Affairs (VA) to “develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient centered care strategy which takes veterans’ unique medical injuries and illnesses as well as their travel and distance into account.”

Chairmen Benishek, Ranking Members Brownley and distinguished members of the Subcommittees on Health on behalf of National Commander Dale Barnett and The American Legion; the country’s largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we welcome this opportunity to comment on “Choice Consolidation: Leveraging Provider Networks to Increase Veteran Access.”

BACKGROUND

Historically, one of the main missions of VA is to be a provider of direct healthcare to veterans through the Veterans Health Administration (VHA). However, for many decades the VA has also acted as a payer by relying on non-VA care providers, i.e., care in the community, when it has not been able to provide that care in a timely or cost effective manner.

The 2014 veterans’ access to care crisis revealed, though, that VA was not appropriately utilizing these provider/payer programs to meet the needs of the growing veteran population requiring VA services.

As a result, Congress created the Veteran Choice Program (VCP) after learning that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

Therefore, Congress passed the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015 after VA sought the opportunity to consolidate its multiple care in the community authorities and programs. This legislation required VA to develop a plan to consolidate existing community care programs.

On October 30, 2015, VA delivered to Congress the department’s Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan seeks to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other federal health care providers, academic affiliates and community providers. It promises to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care.

Generally, The American Legion supports the plan to consolidate VA’s multiple and disparate purchased care programs into one New Veterans Choice Program (New VCP). We believe it has the potential to improve and expand veterans’ access to health care and address many of the existing problems currently experienced by veterans who elect to receive some of their care in the community when they can’t do so within the VHA.

LEVERAGING PROVIDER NETWORKS TO INCREASE VETERAN ACCESS

Under the New VCP program, VA would establish a single set of eligibility criteria for private care; expand access to emergency treatment and urgent care; simplify the referral and authorization system; and improve the claims, billing and reimbursement processes.

The health care network under New VCP would be larger as well. VA Undersecretary Shulkin aptly describes it in a recent New England Journal of Medicine article.

The network would consist of three groupings of providers. The core network would include all VA-run hospitals, clinics, and centers, as well as appropriate facilities run by other federal agencies, tribal health partners, and academic teaching institutions that have already established relationships with the VA. Many of these facilities have expertise in military service-related conditions, and all have the core competencies required for providing comprehensive, coordinated care. These facilities would increase access to highly specialized care and address the needs of some veterans living in remote areas.

The second network would include organized private-sector delivery systems that meet performance criteria for clinical outcomes, appropriateness criteria, access

standards, and service levels. The process for acceptance into this second network would be highly competitive and based on documented results. Integrated systems of care would be ideally suited for inclusion, since their providers have been investing in coordinated care for some time.

A third network would allow veterans to obtain care from additional participating private-sector providers, ensuring access for veterans who don't live within a reasonable distance of providers in the other networks. Providers in this network would need to agree to submit clinical data and documentation to VA health information exchanges.

At a March 15, 2016, Senate Veterans Affairs Committee hearing, The American Legion commented on VA's concept of a Tiered High Performance Network indicating that we support Senator Tester's language in S. 2633: Improving Veterans Access to Care in the Community Act which allows VA to set up tiered networks.

As we understand it, this structure is meant to empower veterans to make informed choices, provide access to the highest possible quality care by identifying the best performing providers in the community, and enabling better coordination of care for better outcomes. However, it does not dictate how veterans will use the network.

The American Legion wants to make clear, though, that we do not support a wholesale option to circumvent the VA infrastructure or healthcare system entirely. Veterans can and should receive their care within the VHA system, as the benefits available to them within this system are myriad. Not only do veterans vastly prefer to receive care within VA and comment highly favorably on the care they get when they have timely access, the VHA system is specifically designed with the needs of the veterans in mind. No other healthcare system or network provides the kind of comprehensive care that considers the factors of the circumstances of a veteran's military service. No other system is primed to ensure that veterans who have served in areas with known associations to toxic exposures such as Vietnam or the Persian Gulf region are screened for conditions known to be associated with those exposures. No other system is as proactive in screening for and providing treatment for posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) the "signature wounds" of the Global War on Terror.

In addition, for over half a century, the VHA has had a long-standing and outstanding relationship with their medical school affiliates. VHA uses medical school affiliations to recruit, and retain high quality medical professionals to provide veterans with access to cutting edge technologies that may have not be offered in the private sector. VHA has the largest coordinated education and training program for health care professionals in the country and medical school affiliations allows their new medical professionals to be trained in the VA healthcare system. Clearly leveraging public-private relationships, particularly with educational institutions, will be a key component in building successful networks of providers to handle the overflow from VA in community care.

A secondary advantage of the partnerships with medical schools is it opens a clear and natural avenue for research partnerships. Often overlooked while solely focusing on the provision of care aspect of VA's mission is the research component of VA's core mission. VA can and should return to its top position as a cutting edge innovator in America medicine and affiliations with medical schools and research are a critical component of that ascendancy. The American Legion is strongly committed to support for mutually beneficial affiliations between VHA and medical schools.

The root of the problem comes down to the question of whether or not VA is capable of building the required networks of care, or whether this task should be outsourced to third party agencies (TPAs) as was done for the Choice program. While VA has struggled in the past with large scale project organization, such as with the four recent hospital development plans in Florida, Nevada, Colorado and Louisiana, the decision to use TPAs may not be much better. The two TPAs chosen for the Choice program, TriWest and HealthNet, were chosen during the very short 90 day period VA had to begin implementing the program. There were certainly problems working with those providers getting Choice up and running including infrastructure problems as well as billing. When the options for building the network of providers are VA doing it themselves and using TPAs, both sides perhaps raise more questions than they answer.

This is a complicated problem and The American Legion can't attest to VA's capabilities one way or the other that would support or deny success, but we can say that if VA is capable of building such a network as they propose, that it will be more cost effective and support VA's mission to be in a better position to provide better and a more seamless healthcare experience for veterans. Based on our experience

with Access Reach Closer to Home (ARCH), Patient Centered Community Care (PC3), and Community contracted care, in many ways, VA is already doing it.

A plan for a New Veterans Choice Program needs approval from Congress. VA needs to overhaul its outside care reimbursement programs, consolidating them into a more efficient bureaucracy able to dynamically interact with the network of federal, public, and private providers that are to supplement VA direct provided care. The American Legion believes that VA's plan is a reasonable one given the desired results.

As you know, Senators Tester and Burr in conjunction with the Senate Veterans Affairs Committee are crafting legislation to fix the Choice program and codify the New VCP. The American Legion encourages this committee to work closely with your senate colleagues on a final compromise bill which incorporates the best of the proposals that are being considered.

In conclusion, The American Legion believes that together we can accomplish legislative changes to streamline Care in the Community programs before the end of this session of Congress. We can't let another year slip away. Our veterans deserve the same sense of urgency now that Congress has shown numerous times since the VA scandal first erupted in 2014.

As always, The American Legion thanks the Subcommittees on Health for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org

VETERANS CHOICE IN HEALTH CARE FACTSHEET

- The structure of the network facilitates provider participation; it does not dictate how Veterans will use the network.
- A Veteran seeking community care will have the ability to choose his or her providers.
- Tiered Networks empower Veterans to make informed decisions about which providers they want to use, by highlighting providers with higher quality, care coordination, and satisfaction scores.
- Use of tiered networks is common in industry and government (e.g., Medicare TRICARE Prime), and is useful in delivering value-based care.

VETERANS WILL HAVE CHOICE IN PROVIDERS:

- A Veteran will have the ability to choose which provider he or she would like to see for care. The tiered network structure will allow VA to provide the Veteran with information to make an informed choice about the right provider to see.
- The tiered network will improve the way Veterans interact with community care by reducing confusion in where to seek care, providing the highest-quality care available, and streamlining the transition from a VA facility to a community facility.
- A Veteran seeking community care will be asked which provider he or she would like to see and will primarily fall into one of the following scenarios:
 - Veteran with specific provider request: The Veteran has requested a specific provider (e.g., cardiologist) in mind. If the provider is in the network, the Veteran will be able to schedule an appointment with that provider. If the provider is not in the network, they will be asked to join the network. Once the provider is in the network, the Veteran will be able to schedule an appointment with that provider.
 - Veteran without specific provider request: The Veteran does not have a specific provider (e.g., cardiologist) in mind. VA will provide a recommendation of providers in their geographic area for Veterans to choose from. Providers will be organized based on quality and alignment with academic affiliates and Federal partners.
- Bottom line is that a tiered network structure creates value for Veterans by providing informed choice on which provider to see for care.

TIERED NETWORKS ARE USEFUL TO ORGANIZE PROVIDERS:

- VA is proposing 3 tiers:
 - Tier 1: DoD, Indian Health Service, Tribal Health Programs, Federally Qualified Health Centers, and academic affiliates providers
 - Tier 2: Top rated community providers (e.g., quality)

- Tier 3: Community providers who meet standard criteria (e.g., Medicare-eligible and have an active health care licensure)
- The tiered network will be a back-end structure used by VA to
 - Monitor quality of care Veterans receive
 - Improve the Veterans experience with care
 - Provide oversight

ADVANTAGES OF USING A TIERED NETWORK STRUCTURE

- A tiered network structure will enhance Veterans choice. It will:
 - Empower eligible Veterans to make an informed decision on which community provider he or she wishes to see.
 - Provide Veterans access to the highest quality care by identifying the best performing providers in the community.
 - Incentivizes providers to continuously evaluate and improve their performance.
 - Provides comprehensive care coordination between VA and community providers.

TIERED NETWORK STRUCTURE IS CRITICAL FOR ACADEMIC AFFILIATE PARTNERSHIPS

- VA accomplishes critical education and training efforts through coordinated programs and activities in partnership with affiliated U.S. academic institutions. VA is affiliated with more than 1,800 educational institutions (95% of allopathic medical schools and over 87% of osteopathic medical schools).
- A tiered network structure maintains VA's commitment to teaching and training health care professionals through the inclusion of Academic Affiliates in Tier 1.
- Some Academic Affiliates did not choose to participate in the Choice Program and therefore were no longer able to receive Veteran patients since VA was using Choice as the first option in buying care. This dramatically impacted the teaching programs of some Academic Affiliates. Inclusion of Academic Affiliates in the Tiered Network will enable VA to sustain and strengthen relationships with affiliated and allow Veterans access to the high quality, timely care they deliver.
- VA's ability to provide clinical care depends on our relationships with Academic Affiliates as many internal VA providers are Affiliated with Academic Institutions. As a result, deterioration in these relationships could result in less providers available to care for Veterans.

TIERED NETWORK STRUCTURE IS CRITICAL FOR DEPARTMENT OF DEFENSE (DoD)

- A tiered network structure maintains VA's commitment to teaching and training health care professionals through the inclusion of Department of Defense facilities in Tier 1.
- Partnership with VA enables DoD appropriate personnel readiness as:
 - Treating Veteran patients allows DoD health care professionals to see the additional volume of patients with the diversity of needs necessary for maintenance of certain licenses.
 - VA provides resident training programs for Military health care providers
 - DoD providers gain additional hands-on health care experience, contributing to the improvement of overall quality of care.
- Partnership Highlight: VA and DoD recognize the importance of providing coordinated and comprehensive rehabilitation services to support recovery from polytrauma. Both agencies have a long history in partnership in providing polytrauma care that is a patient-centered, interdisciplinary approach that works with the injured individual and his or her family to address all aspects of the injury as it impacts the person's life.

