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MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES APPROPRIATIONS FISCAL YEAR 2018

THURSDAY, MAY 11, 2017

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:30 a.m. in room SD–124, Dirksen Senate Office Building, Hon. Jerry Moran (chairman) presiding.

Present: Senators Moran, Hoeven, Collins, Boozman, Rubio, Schatz, Tester, Udall, Baldwin, and Murphy.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. DAVID J. SHULKIN, MD, SECRETARY

OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Welcome to our fifth subcommittee hearing of 2017. The subcommittee will come to order and thank you all for being here today as we discuss the future of community care within the Department of Veterans Affairs.

I am really glad to have this hearing today. I am glad to have our two witnesses with us. Choice is a topic of great interest to me and to many members of Congress and I regret that in my view because of antics of yesterday we were unable to have these two witnesses and other, including a number of veteran service organization representatives, testify before the authorizing committee. But we have a good opportunity to proceed with this topic which the Secretary has well prepared today.

We have had hearings before in this subcommittee. I mentioned this is our fifth. This one, of course, is on Choice, but we have had hearings regarding appropriations related to the programs at the VA in regard to suicide and telehealth, but Mr. Secretary, no VA program works without the trust of our veterans in the VA. And in my view, in fact, you have indicated that and I appreciate the statements that I have read that you have made.

Trust requires accountability. One of the surprising things to me in the past is that there were those at the Department of Veterans Affairs who testify that they had all the tools they needed in regard to accountability at the VA and I am pleased to see that you see that differently. You have expressed that desire, and I am grateful for that, and we want to know in a broader sense in this hearing or otherwise what tools and authorities you need.

Today legislation is being introduced. The chairman of the authorizing committee, Senator Isakson, and the Ranking Member, Senator Tester, I, and Senator Rubio, but also Senators Baldwin, McCain, Nelson, and Sheehan are introducing the Department of Veterans Affairs Accountability and Whistleblower Protection Act. And in my view, that is a significant development. We will work hard to see that it becomes law with your help, Mr. Secretary.

Choice has a long history. It goes back to 2014. And the challenges, difficulties, and perhaps crisis that was exhibited in a number of VA facilities across the country in regard to waiting lists and false waiting lists prompted, in my view, Congress to act to create a program with more opportunities for veterans to be cared for in the community and the effort was there to address the lack of personnel at the VA by providing more outside care and to reduce the waiting times for veterans across the country.

And while I think Choice was an important program, is an important program within the VA, in too many instances it did not work well. And we are here to find out how we can be helpful in making certain that whatever occurs in the future in regard to programs for veterans within the community are ones that work well and meet the needs of veterans across the country—rural, urban, and suburban.

There is a consensus that the VA should consolidate community care programs under one account not only to reduce the confusion for veterans and community providers, but to simplify the system for VA employees as well. Last year, this subcommittee created the Medicaid—excuse me—the Medical Community Care account as a way to identify how much the Department is spending in discretionary dollars on outside care, but having this separate account also defines how much is being spent in-house as well. The Veterans Choice Program is not currently included in this line.

Consolidating Choice and other authorities in the VA community care account will provide budget transparency and a more streamlined approach. So it is an area in which we as appropriators I think can help bring accountability to the Choice Program and give us a clearer picture of how taxpayer dollars are being spent and how veterans are being cared for.

We are here today at this point in time—your efforts to testify in front of the authorizing committee yesterday I think is an indication that you would recognize this newest secretary, but we are at a crossroads. You arrive at a time in which Choice Community Programs need significant and dramatic thorough attention and improvement. The Choice Program has been temporarily extended, presumably until about January based upon the funding levels that are available. And that gives Congress and the Department time to work together to determine the future of VA healthcare and what is in the best interest of our veterans—healthcare that is designed to serve veterans and not serve the VA.

So, Mr. Secretary, my questions in a broad sense are what are your plans and what resources are necessary for you to complete those plans? And what legislation is required to be able to implement those plans?

I and at least three other members of this subcommittee wear two hats. In this setting, we are appropriators charged with

prioritizing the funding for your Department, and in the other setting, as authorizers to provider the legislative authority that you need—that you believe you need and that Congress agrees to provide. I hope you will take the opportunity this morning to talk about those needs, the constraints you have financially, and I think in that regard you may tell us something that is very significant in regard to the dollars that you think will be required to meet your goals, as well as the constraints that you have statutorily.

Mr. Secretary, you were kind enough to meet with me yesterday. I want to compliment you and express my gratitude for that. In my time in the United States Senate, the hour that we spent together yesterday is the most useful conversation I have had with the leadership of the VA in the six and a half years that I have been in the Senate. And I am very grateful for that conversation and the beginning of a solid relationship with you and the Department. Your openness here today can be very helpful to all of us, and I welcome that as we try to figure out how to truly reform the VA to benefit those it is intended to serve.

[The information follows:]

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Senator MORAN. I would turn to the Ranking Member for his opening statement.

OPENING STATEMENT OF SENATOR BRIAN SCHATZ

Senator SCHATZ. Thank you, Mr. Chairman, and thank you to Secretary Shulkin and Dr. Yehia for appearing before this subcommittee to discuss the future of Choice and the future of VA's Community Care Program.

In the interest of time, I will submit my more extensive comments into the record, but I would like to make a couple of points. The first is on access.

The Choice Program has expanded care to many veterans who otherwise would not have had it, but I think we can all agree that the program has had its rough spots and that it has confused and frustrated veterans and providers alike.

Dr. Shulkin, I would like to hear from you not only about how VA will restructure and streamline Choice, but how it will integrate into a more modern VA. Community care is an important tool, but it will never replace VA's ability to meet the unique needs of our veterans through its network of medical facilities, clinics, and state of the art telehealth facilities.

The second point is about cost. Whatever program secedes Choice, it has to be developed in a fiscally responsible manner. Today, Choice is paid for through direct spending and all other community care is paid for with discretionary spending. This has

created execution problems for both programs and both of you. The obvious solution is to collapse all funding into a single source, but if that single source is discretionary funding, we have a very serious problem.

The VA spends in between $10 and $12 billion total on providing healthcare through Choice and care in the community, but about $3 billion of that is funded with direct spending. We do not budget for it on the discretionary side. Unfortunately, Congress continues to operate under strict budget caps that limit non-defense spending to an arbitrary level. Already annual increases in VA healthcare are squeezing other agencies, including other veteran's programs. Adding the Choice Program cost to the mix would bust the current caps.

We need to address this issue now, especially as Congress moves to develop a long-term Choice 2.0 bill that the Chairman mentioned. I hope my colleagues on this subcommittee will approach this with the urgency that it demands.

Again, thank you, Secretary Shulkin and Dr. Yehia, for coming here today. I look forward to the testimony.

Senator MORAN. I thank the Senator from Hawaii and I would like to introduce our panel. The Honorable David J. Shulkin, MD, is the Secretary of the Department of Veterans Affairs and he is accompanied by Dr. Yehia, MD—excuse me—Deputy Director. I got your name correctly and could not pronounce the word deputy—Deputy under Secretary for Health and Community Care at the Department of Veterans Affairs.

The subcommittee welcomes you both and we recognize the Secretary.

SUMMARY STATEMENT OF HON. DAVID J. SHULKIN

Dr. SHULKIN. Good morning, Mr. Chairman. Thank you for your comments. I too found our time together very useful and thank you for your membership. And Ranking Member Schatz, thanks for your comments. I agree with you about the fiscal responsibility issues that we have to address. Senator Murphy, Senator Baldwin, good morning.

I really appreciate the opportunity to spend some time with the committee talking about the Veterans Choice Program. I think it is very critical.

My overarching concern is that veterans have access to high quality care when they need it, regardless of whether that is in the VA facility or in the community. And our goal is to deliver a program that is easy to understand, simple to administer, and meets veteran's needs. We have made some recent progress, but in my view, we are not moving fast enough. Incremental change just is not going to work and now is the time to modernize the VA because it is the right thing to do for our veterans.

Mr. Chairman, let me first thank you for helping enact the Veterans Choice Improvement Act. Thanks to the bill's sponsors, and Senator Tester being one of them, but other committee cosponsors, and Senator McCain, we were able to get this bill through. The Choice Improvement Act removed the expiration date for Veterans Choice and it enabled us to be able to spend the full $10 billion that originally Congress had authorized for community care. It also

allowed VA to be the primary coordinator of benefits that enabled a better exchange of information between VA and community providers and took the veterans out of the middle of these payment issues.

These improvements will drive increases in veterans receiving community care and reduce the administrative burdens for veterans, community providers, and VA staff. We are already seeing increased demand as veterans opt for Choice more now than ever before. We have issued 35 percent more authorizations for Choice in the first quarter of fiscal year of 2017 as compared to the first quarter in 2016. Thus far in fiscal year 2017, we have approximately 18,000 more Choice authorized appointments per business day than in fiscal year 2016, but we have a lot more work to do and we need your help in modernizing and consolidating community care. Now is the time to get this right for our veterans.

A redesigned community care program will not only improve access and provide convenience for veterans, but it can transform how VA delivers care even within the VA. A new redesigned consolidated community care program must have several key components.

First, a new system must focus on clinical need and quality of care, not on wait times and geography. A new system should not rely on administrative roles and bureaucracy, but allow providers and veterans to make decisions. A new system not only allows veterans to seek care in the community when VA does not offer the service, but it also offers choice when quality of care is below community standards. A new system must also make it easier for veterans to access urgent care clinics to ensure that when they have urgent needs they can be addressed when and where it is convenient for them.

A new program must maintain a high performing integrated network that includes VA, Federal partners such as the Department of Defense, academic affiliates, and community providers. We need to ensure that VA is partnering with the best providers across the country in order to take the best care of our veterans. A new program must assist in care coordination for those veterans using multiple providers. We need to ensure that veterans do not experience gaps in care between VA and community providers. And finally, a new program must apply industry standards for quality, patient satisfaction, payment models, and healthcare outcomes. By doing so, veterans can make informed decisions about their care and VA will have the tools to compete within communities.

Where VA excels, we want to make sure that we strengthen the services and programs further to allow VA to continue that excellence. Veterans need VA. For that reason, community care access must be guided by principles based on clinical need and quality. VA needs the support of Congress to level the playing field with industry by making it easier to modernize infrastructure, leverage IT technologies, hire the best talent, and operation more efficiently. We want to work with Congress to develop this needed legislation. We need to do it by the end of this fiscal year to ensure that we can implement regulatory and other changes necessary to implement the new vision.

With your help, we will chart a bold new direction for VA that increases access to community care and modernizes VA. We must also ensure we have a new system that is financially sustainable. It is simply unrealistic to expect our funding to continue growing at a rate it has over the past decade. I want to be clear. I am committed to strengthening the VA system and will not support efforts to privatize this much needed and essential system.

Veterans will be the ultimate judge of our success. With your help, we can continue to improve veterans care in both VA and in the community. This new system is being designed and developed for better results in veteran's experience. We anticipate working with you and our VSO partners to further define this approach.

Thank you and I look forward to any questions that you may have.

[The statement follows:]

PREPARED STATEMENT OF HON. DR. DAVID J. SHULKIN

Good morning, Chairman Moran, Ranking Member Schatz, and distinguished Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Community Care Program, including the Veterans Choice Program, which allows for Veterans to access the care they need and deserve. I am accompanied today by Dr. Baligh Yehia, Deputy Under Secretary for Health for Community Care in the Veterans Health Administration (VHA).

VETERANS CHOICE PROGRAM EXTENSION

We are extremely grateful for the recent efforts of Congress that resulted in the enactment of the "Veterans Choice Program Improvement Act," which removed the expiration date for the Veterans Choice Program and allows the Department to use the full $10 billion originally allocated to care for Veterans in the community. It also made VA the primary coordinator of benefits and allowed for better health information exchange between VA and community providers. These changes will lead to more Veterans getting community care and will reduce the administrative burdens of using the program for Veterans, community providers and Federal partners, and VA staff. While progress has been made, there is still more work to be done to serve our nation's Veterans.

FUTURE OF VA COMMUNITY CARE

VA needs a different approach to ensure we can fully care for Veterans. We need your help in modernizing and consolidating community care. Veterans deserve better, and now is the time to get this right. We believe that a redesigned community care program will not only improve access and provider greater convenience for Veterans, but will also transform how VA delivers care within our facilities.

This redesigned program must have several key elements. First, we need to move from a system where eligibility for community care is based on wait times and geography to one focused on clinical need and quality of care. This will give Veterans real choice in getting the care they need and ensure it is of the highest quality. At a minimum, where VA does not offer a service, Veterans will have the choice to receive care in their communities. Second, we need to make it easier for Veterans to access urgent care when they need it. This will ensure that Veterans will always have a choice and pathway to get their urgent needs addressed. Third, the new program must maintain a high performing integrated network that includes VA, Federal partners, academic affiliates, and community providers. We need to ensure that VA is partnering with the best providers across the country to take care of our nation's Veterans. Fourth, it must assist in coordination of care for Veterans served by multiple providers. Finally, we must apply industry standards for quality, patient satisfaction, payment models, healthcare outcomes, and exchange of health information. By doing so, Veterans can make informed decisions about their care and VA can have the tools to better compete within communities.

We believe redesigning community care will result in a strong VA that can meet the special needs of our Veteran population. Where VA excels, we want to make sure that the tools exist to continue performing well in those areas. Veterans need the VA and for that reason, community care access must be guided by principles based on clinical need and quality. VA needs the support of Congress to level the

playing field with industry by making it easier to modernize our infrastructure, leverage IT technologies, hire the best talent, and operate more like the private sector. A good example is management of our real property and infrastructure portfolio, where numerous barriers prevent VA from being agile in response to Veterans healthcare needs in different geographic areas. We want to work with Congress to discuss the best ways to bring common sense to this area.

VA also needs tools to improve our recruitment, hiring and retention of the best professionals to serve our Veterans. These tools could include improvements to hiring and pay authorities to better address vacancies in our medical center and VISN director positions, to help at least in part address disparities with the private sector. As a final example, there is Federal law that requires VA facilities to have a smoking area. We all know the impact on health from smoking, and smoking cessation is the most immediate and dramatic step a Veteran, or anyone, can take to improve their health. VA strongly supports H.R. 1662 which would repeal this requirement. Action in these areas will make VA more modern, and be an enabler for our dedicated workforce to be more effective in their service to Veterans.

In order to improve care for our Veterans, we want to work with Congress to develop needed legislation for the future of VA community care. This legislation would have to be enacted by the end of the fiscal year to ensure that VA has sufficient time to proceed with regulations and other changes needed to implement the new vision. If we can accomplish this together, we would set VA on a bold new direction to not only increase access to community care but also transform the VA itself. We are committed to moving care into the community where it makes sense for the Veteran. Finally, I want to make sure that everyone understands that making better use of community care must be done in a fiscally responsible way. We cannot continue to grow our funding in the same way we have done over this past decade. And, I want to be clear that I am committed to strengthening the VA system and will not support efforts to privatize this much needed and essential system. The ultimate judge of our success will be our Veterans. With your help, we can continue to improve Veteran's care, in both VA and the community.

Thank you and we look forward to your questions.

Senator MORAN. Mr. Secretary, thank you very much.

My understanding is that in your testimony and our conversation that the goal is to create a criteria about access to healthcare by veterans and that access also includes a quality component. Your goal, as you state, is how do we get veterans the best care possible I assume in the most timely fashion needed as a requirement of their medical care. And that makes sense to me, but I would like to hear a little bit more about how you would consider in your plan distance. And distance could be time limits as well.

It is 40 miles and 30 days has been the defining feature of Choice, but if the quality care is available in the VA but yet a veteran still lives miles or hours from that care, how do you account for the care for that veteran?

Dr. SHULKIN. Well, certainly distance has to be part of the equation, but under our current system of Choice, veterans that live within 40 miles of a primary care provider do not get the ability to access the Choice Program in the way that they should. And we want to essentially design a system that works for all veterans, no matter where they live. So if you are going to do that, you are going to prioritize clinical need and you are going to allow the doctor and the veteran to be more involved in making the decision.

If a veteran does not drive, they are going to need access to community care if they do not have any way of getting to a VA, even if they live ten miles away from a VA. So we actually want to design a system that works for the veterans and not based upon administrative or bureaucratic rules.

Senator MORAN. So who would make that decision within the VA? You talk about the physician and the provider and the veteran. So the veteran who lives 200 miles from the VA hospital, the

Dole Hospital in Wichita, the VA in Wichita provides the service and it is high quality and a veteran who lives close by would be admitted to that program and receive that care and treatment at the VA, but instead the veteran lives in my hometown of Hays and has more than two hours of a drive to get to Wichita. How does that veteran learn what his options—his or her options—are?

Dr. SHULKIN. We are looking to design a system that actually already works pretty well in the private sector. The way that these decisions are made all across America today are in the exam rooms between doctors and patients. And we do not want to put a third party in the middle of that. We believe that doctors and patients should be making these decisions. So let us go through a few examples.

If the service is not offered by the VA, then the veteran needs to get that care in the community. If the service is a simple service like getting a lab test or an x-ray or a flu shot, we do not believe that the veterans should have to travel a long distance to be able to get that. They could get that in the community. If the service is not performing at the standard in the community, at the quality level in the community, we believe the veterans should have the choice to get the care in the community.

But where the VA is providing a good quality service and the VA could meet the timeliness and the quality standards available, we do believe that is the purpose of the VA and that the veteran and the doctor would most likely come to the conclusion that the best place for the veteran is at the VA.

Senator MORAN. Dr. Yehia, you talk about a clinical needs decision tree in evaluating what care stays within the VA and what care goes outside the VA, so the question here is one of eligibility. Who is eligible to have what care delivered outside the VA? And if you would put some meat on those bones, that would be great.

Dr. YEHIA. Sure. Really, it goes back to the veteran and the provider relationship. Healthcare is local and healthcare is about relationship, so we want to empower the veteran and their provider to make the most informed decisions. We will be able to help them by being transparent about what we think those guiding principles are based on availability of service, access to quality of care, and also feasibility, which takes into account distance and geography and how simple the service is.

So I think by allowing them to know exactly what are the guiding principles or ideas to use, both to the patient and the doctor, they can come up to make the right decision that works best for that patient.

Senator MORAN. I appreciate both of your responses to my questions. I think this is one of the most difficult issues as we look at community care is eligibility and how we define that is a significant factor in whether or not community care is going to work and whether or not veterans are going to—we are going to achieve our goal of having veterans access the care that they need in a timely, quality fashion.

Senator from Hawaii.

Senator SCHATZ. Thank you, Mr. Chairman.

Following up on the quality measures, can you flesh out what those quality measures are going to be and after you are finished

explaining that, I have a concern that has to do with communicating to the individual veteran sort of what part of the labyrinth they are in because even if this makes perfect clinical sense and is a best practice that has been adopted across the private sector, it will be new. The distance requirement is now well established. People feel comfortable with it. And I get that it is somewhat arbitrary and there is a better way to do it, but you are going to have to explain this to the veteran's community in such a way that it does not feel like less and does not feel increasingly confusing. So if you could talk to the quality measures first and then how you are going to go about explaining this so that it does not cause additional confusion.

Dr. SHULKIN. Right. Well, these are excellent points and any successful program is going to have to take into account exactly what you have asked us about.

We have done a lot of listening to our veterans. Probably Dr. Yehia and I have traveled around the country in town halls and in other places to listen. And we know that even though we were clear about 40 miles and 30 days, we designed a system that was overly burdensome, complex, and that veterans did not like. So I hope you would agree staying with the status quo is not where we want to go. So together, we need to design a system that is easy to understand, easy to use, and meets their needs.

The way that we are planning on doing that is by actually allowing patients and doctors to be much more involved in making these decisions and taking the roles and the third parties out of the way. So some of this we are not going to be as rigid. We are going to allow people to make decisions as human beings, make decisions based on particular circumstances.

As Dr. Yehia said, we are going to have some guiding principles. But we are going to essentially go back to what we know has always worked—doctors and patients having discussions about how they can best help each other.

Senator SCHATZ. But the challenge in any closed healthcare system, right?

Dr. SHULKIN. Yes.

Senator SCHATZ. Actually, in any healthcare system is the tension between the doctor-patient relation, the clinician-patient relationship, and what kind of care can be ordered at what cost, and then somebody trying to figure out how all of this adds up. So I guess my question is how does that change, which makes sense at the healthcare level, at the human level, impact our appropriations needs and our planning for the next several fiscal years?

Dr. SHULKIN. Well, I think that, first of all, we do already know that the best model out there is to get the administrators out of the way and let these be clinical decisions, so we are going to work towards that. We are also going to add some new patient protections in there so that we are going to allow veterans an opportunity where there are those tensions and it may not turn out that the right decision was made for the veteran, that they now have an ability to seek an appeal to that process. So we actually want to build in a safety net for our veterans to make sure that we are doing the right thing.

In terms of the resources necessary and what we need, I think your opening comments, Senator, were very appropriate. We understand that there are limits to the amount of resources that we can and should be asking for. And we do seek this redesigned system to meet veteran's needs better and to have an easier to use system by taking our resources, putting them more into clinical care and less into administrative care. And we will do this within the President's budget. We will not be seeking additional funding beyond what the President has proposed to be able to implement this program.

Senator SCHATZ. Is it fair to say though that the cost is—that you do have some sort of upside risk, right, in terms of the costs you incur? Because you are establishing a standard that is almost exclusively clinical in nature and so the bean counters cannot tell you what is and is not allowed and where care can be provided?

And I guess what I am saying, I am not trying to tell you not to do this.

Dr. SHULKIN. Yes.

Senator SCHATZ. I am just saying that I have this concern that you are going to come back and say that turns out to have costed more than——

Dr. SHULKIN. Right.

Senator SCHATZ [continuing]. Than we had anticipated. And I would rather fund it on the front end.

Dr. SHULKIN. Right.

Senator SCHATZ. So that we are not in this hand-to-mouth situation.

Dr. SHULKIN. I appreciate that. Part of the responsibility of running this system is to be fiscally responsible to taxpayers and we are trying to own that accountability. Our risk associated with costs and increased resource needs, and we have seen this historically in the VA, that VA has not as proactively asked for the need—the financial resources that it has needed.

Our risk is not associated, in our opinion, with the change in this model by giving veterans more choice. Our risk is associated with the growing complexity and age of our veteran population and the growing reliance that we are seeing, veterans choosing to come to VA more. And we are seeing that. So our models of projection into future years show the risk on the use of the VA system by veterans and the complexity of their care, not on these changes in the Choice model.

Senator SCHATZ. So it is mostly more veterans and more elderly veterans?

Dr. SHULKIN. Yes. That is right.

Senator SCHATZ. Thank you.

Senator MORAN. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, Ranking Member, and thank you guys for being here.

I do not really know where to start, so we will just start. Do you have an assessment on the productivity on the VA hospitals across the country, which ones are good, which ones are mediocre, which ones are bad?

Dr. SHULKIN. Productivity usually refers to the efficiency.

Senator TESTER. Yeah.

Dr. SHULKIN. But we have measures on efficiency——

Senator TESTER. Okay.

Dr. SHULKIN [continuing]. On service levels, and quality.

Senator TESTER. So you know which ones bear some watching right now today?

Dr. SHULKIN. Absolutely.

Senator TESTER. And what are you doing about that? Are you getting them staffed up? What are you doing?

Dr. SHULKIN. Well, first of all, we are requiring action plans from the ones that are performing at low levels.

Senator TESTER. Okay. Right. Okay.

Dr. SHULKIN. We are sending teams and special attention to those that we consider on the critical watch list.

Senator TESTER. Okay. To build those back up to get them to top performing?

Dr. SHULKIN. Yes.

Senator TESTER. So we talked on the phone the other day and I just kind of want to go over this because one of the things that I am very, very concerned about is that a lot of these places that do not perform quality care, at least from my perspective, are because of staffing shortages. That is my opinion. I could be wrong on that, but that is my opinion.

And I think that if we walk in and say to a veteran, "You are not getting quality care, so we are going to ship you to the private sector," without addressing those challenges that those healthcare facilities have, that would be a huge mistake long term and it will, in fact, privatize the VA over a number of years. Would you agree with that?

Dr. SHULKIN. I would agree with that.

Senator TESTER. Okay. So it is not your intention to just say, "Look, you are an underperforming facility, so we are going to pump you into the private sector," without dealing with those facilities in a very proactive manner, getting them up to snuff?

Dr. SHULKIN. My pure intent is to build the VA system to be providing the very best quality care. And that means staffing them at the appropriate level and modernizing the system. In the meantime, while we do that, I do not want veterans feeding stuff in a system that is not meeting their needs.

Senator TESTER. Got you. All right, I got you.

Dr. SHULKIN. Yeah.

Senator TESTER. And so the other question I have as one of my concerns is that, as I have told you before and I think you know, that folks get through the door like the VA healthcare, at least in Montana. I can say that. I can also tell you that if we do not deal with the staffing shortages in Montana in a very proactive way, they are not going to feel that way into the future. But I can also tell you that putting them in the private sector without a market assessment on what that private sector can do in that community is going to be a huge problem for the VA because you are taking responsibility for that civilian care now.

And so the question is do you guys have a market assessment? Do you plan on doing a market assessment? Where is it at in the process?

Dr. SHULKIN. Yeah. I am going to have Dr. Yehia talk about that, because we do, but I just want to reinforce why I think you are on target here.

Senator TESTER. Yes.

Dr. SHULKIN. We have seen with the Choice Program that simply sending veterans out into the community is not always the answer, that the wait times are often longer in the community, and sometimes the quality is not necessarily there. That is why part of our plan is to develop what we call a high-performance network of community providers that are meeting our stands. But why don't you talk about the market assessment?

Dr. YEHIA. Sure. Absolutely, we are engaging in market assessments now. We are at the stage of piloting it in three locations, but the idea is to do it across all the markets in the United States because we need to know over the coming years what is the demand for healthcare, what can we produce, and what does a community offer that we could potentially buy. And those market assessments will then feed a lot of important information. How do we design the right networks? How do we look at our infrastructure? How do we develop our staffing needs. So it is critical that they occur and that is what we are doing.

Senator TESTER. Okay. It looks to me like if you are—I mean, there is a lot of markets, man. I mean, it is—and when are we talking about putting this into play?

Dr. SHULKIN. So one of the issues is that probably about 15 years ago we created what you now know as VISN, the Veteran Integrated Network Services.

Senator TESTER. Yes. Right. No, I got you.

Dr. SHULKIN. And so part of the issue is the reason why they were created, healthcare has changed a lot in the last 15 years.

Senator TESTER. Yeah.

Dr. SHULKIN. The role of the VISN in the future needs to be that market assessment coordinator and they need to take on that role. The reason why we are starting with three pilots is to teach them how to do it.

Senator TESTER. I got you.

Dr. SHULKIN. We are using external resources to help us.

Senator TESTER. I have got you.

Dr. SHULKIN. Yeah.

Senator TESTER. But I think the market assessment is going to be critical as to what is going on. And the other thing I would just like to say, and you know I appreciate the work both of you do and I mean that, but unless you have a market assessment, what I just heard you say, Baligh, is that if they are offering a good care in the community you are just going to take them right out of the VA right away. Is that what you meant to say?

Dr. YEHIA. No. The market assessments will help us figure out what we are doing well and what is available in the community. At the end of the day, it is always up to the veteran.

Senator TESTER. Okay.

Dr. YEHIA. So they get to choose if they want to go in the community or not.

Senator TESTER. All right. So that brings me to another point. If the doctor and the patient disagree, what then? An appeal?

Dr. YEHIA. That is right. We want to ensure that there is patient protections. We probably think 98 percent of the time, 99 percent of the time, they are going to reach agreement. When I see patients and talking about them, they are looking for their doctor's opinion, but if there is a point of disagreement, it would be elevated to another clinical individual in the medical center.

Senator TESTER. And that does not complicate the situation?

Dr. YEHIA. I do not think so. I think the vast majority of the times there are going to be concurrence between the patient and the doctor.

Senator TESTER. Okay. Well, I just—and I want to thank the Chairman for having this meeting and I want to thank you guys for being here. It is too bad we did not have the hearing yesterday on the VA Committee, but we are going to try to make that happen hopefully next time. But the VA definitely has its issues, but I—and I know you are in a tough spot, Mr. Secretary, because the President has said we will just give everybody a card and let them go where they want.

First of all, the cost of that to the budget would be incredible, number one. Number two, as I said before, the veterans I have talked to like the VA. There are a few exceptions, but they like it. They like the people that are there. The guy who used to cut my hair, and unfortunately, he passed away, he used to tell me every time he cut my hair how the VA has saved his life, okay. So you have got some good people on the ground and you have got a good outfit. We need to build it and make sure because it is always going to be the backstop. And if we are starting to use community care, then you become responsible for that bad hospital in Havre, Montana. I do not want to point that out there—great hospital, okay. But the truth is every time there is a civilian facility and a veteran has a bad experience, it is your fault.

Dr. SHULKIN. Yeah. Right.

Senator TESTER. And I think you have less control over that. That is not to say that we do not need to use that community care facilities because I think they can be an incredible asset to the VA. So thank you.

Senator MORAN. I am glad you were able to find another barber.

Senator TESTER. I am not—well, no, she does a great job. I do not want to end up with a mohawk or wearing your style of hair.

Senator MORAN. Oh, a path I should never go down.

We have a vote that is ongoing that has commenced. I am going to call on the Ranking Member who has other committee assignments this morning in banking and Senator Schatz will ask questions. Then we are going to recess momentarily while we go vote.

Dr. SHULKIN. Sure.

Senator MORAN. We will be back.

Senator SCHATZ. Thank you, Mr. Chairman. I will be as quick as possible.

Dr. Shulkin, Secretary Shulkin, can you talk about telehealth and how you see its future, both clinically and fiscally?

Dr. SHULKIN. Yes. Telehealth, as many people may not know, the VA is the largest user of telehealth. Over $1 billion a year goes into telehealth. It is absolutely a necessity for us to be able to fulfill our mission of providing care to veterans where we do not have facility

or they live distances that are just not practical for them to get to a facility. And so we are all in in telehealth and we are trying to expand the use of technology. I actually practice telehealth from Washington, D.C. to patients that I see in Grants Pass, Oregon where there are not many primary care doctors.

So what we are trying now to do is to actually use the technology so that we not only can do it from a VA facility to another VA facility, but that we can do it, use telehealth from a VA provider to a veteran in their home, on their mobile device, or wherever they are. For that, we have been working with the Department of Justice to try to clarify the roles that we can use our Federal licensing abilities to do that, but I believe that is essential for us to clarify that to be able to get more help to veterans.

Senator SCHATZ. And I assume you will let this committee and the Veteran's Committee know if there is anything you need in terms of statutory authorization or resources to continue your good progress.

Dr. SHULKIN. Well, there are some bills, my understanding are, before Congress. I think Senator Ernst and Senator Herona are sponsors of them. I believe that is important legislation to proceed with.

Senator SCHATZ. And then my final question in the interest of time, going into Fiscal 2017 the VA had $4.5 billion left for Choice and $7.5 billion for traditional care in the community. Your forecast for 2017 showed an uptick in veterans choosing Choice and a drop in veterans using care in the community, but community care is up—is almost, yeah, it is 15 percent over plan in the first quarter, so how are we going to do better on your projections?

Dr. SHULKIN. Well, it actually works out right. This is a nice balance. This has been a deliberate management strategy which is to utilize the resources that the American taxpayers have given us to help veterans get care in the community. So Choice is up about 20 percent and our community care is down around 7 percent. And when you balance the two together, we are right on plan.

The reason why we are seeking your help in future legislation to have the ability to have flexible use of the funds, because we do not like spending out of two different checkbooks. It is very, very hard when you are talking in the billions of dollars to balance your checkbooks exactly right. We are right on plan right now, but in the future, we would like one checking account.

Senator SCHATZ. Thank you.

Senator MORAN. Senator, thank you very much.

The Committee will stand in recess until the sound of the gavel.

[Whereupon, at 11:07 a.m., the hearing was in recess.]

[Whereupon, at 11:22 a.m., the hearing was resumed.]

Senator MORAN. To order.

When you had the conversation with my two colleagues earlier about community care, what providers will be eligible? What is the criteria before which a provider could provide care to veterans?

Dr. SHULKIN. Right now we have a pretty large network, almost 600,000 providers throughout the country that have been developed. And so they will be the initial network that is developed. But we are seeking to develop what is called a high performance net-

work, which is to develop standards for access, for satisfaction measures, and for performance and quality measures that would create essentially a preferred network to care for veterans.

Senator MORAN. Currently, the Choice Act requires the VA to pay Medicare rates.

Dr. SHULKIN. With a few exceptions in rural areas.

Senator MORAN. And that is something I would like to know. You told me something I did not know. What is the—what kind of exceptions?

Dr. SHULKIN. I think it is how many people need to live within a certain square mileage to be outside the Medicare rules?

Dr. YEHIA. Yeah. It is based on if they are an academic teaching hospital and if they live in a highly rural area. And then we have the special provisions for the State of Alaska and Maryland. We like those provisions, but we want to be able to move from the traditional Medicare fee for service to more contemporary payment models like value-based payments. And those are restricted under the Choice Act today that as we work together to development a new program allowing us to have all the tools that the private sector has to purchase value-based care.

Senator MORAN. Those rates in those certain rural areas like Alaska, are they higher than Medicare?

Dr. SHULKIN. Generally, yes.

Senator MORAN. Yeah. Okay. And so you would not expect this legislation to include—your preference would be this legislation not include the requirement that Medicare rates be paid.

Dr. SHULKIN. I think that we would like to see the ability to use these value-based principles. I think Medicare is a good starting place for many of the providers, but we want to be able to reward those providers that are performing better.

Senator MORAN. One of the problems with Choice today and that many veterans experience and many providers experience is, so the provider is approved. The veteran sees that physician, and then that physician needs—believes that the veteran, the patient, needs additional tests, x-ray, laboratory. And that has resulted in the veteran in most instances having to go back and get authorization for laboratory work or an x-ray recommended by the physician that the VA has referred the veteran to. One more step, more complication, and I assume there is a much better way of handling that circumstance than the way we do today.

Dr. SHULKIN. Yes. And one of the advantages of both Dr. Yehia and I still seeing patients is that we experience that and do not believe that is the right way that we should be handling it. So we have moved towards and already have taken steps towards this, to do what is called bundling of services.

So you know if you are going to do a hip replacement that you are going to need physical therapy and you are going to need x-rays and you are going to be able to need the equipment, you know, to help the patient at home so that you bundle those services together so authorizations are not required.

Senator MORAN. What is your ability to provide mental health services broadly across the country in rural and particularly urban core center of city areas?

Dr. SHULKIN. Well, there is no other health system anywhere in this country that approaches the comprehensive nature of behavioral health that the VA does. So we are doing more than anybody else. We are providing well over 50 percent of our veterans are receiving and have a diagnosis related to a behavioral health issue so that we have integrated it into the way that we deliver regular care.

In rural areas in the country where we have difficult time recruiting mental health professionals as does the private sector, we are using telemental health. And we are providing about 350,000 visits a year using telemental health, and that is growing. We have just established five national telehealth centers where we can recruit mental health professionals—they tend to be in more urban areas—to help support those rural parts of the country.

Senator MORAN. You indicated to Senator Schatz in response to one of his question or maybe he put these words and you agreed, which was that increasing cost associated with healthcare or related to demographics, number of veterans, aging veterans, and yet you indicated earlier that you expect to be able to—your request will be to fund this program within the fiscal year 2018 President's budget request. And incidentally, to my colleagues, we will have a June hearing, Mr. Secretary, in which we will ask you back to talk about the fiscal year 2018 budget and the appropriations process, in particular, but how do you do that?

Dr. SHULKIN. Well, first of all, as you know, we only have this skinny budget now, but the President did request a 6.6 percent increase in our budget. So we are very grateful that the President has recognized the resources that we need to be able to continue to improving care for veterans. But I do believe that we are now embarking upon addressing some of the inefficiencies in the system. And ask we aggressively move towards modernizing the system, we have got to streamline the amount that we put into administrative overhead and we have to fix some of the deficiencies because asking for and receiving a 6.6 percent increase year after year is just not sustainable and is not the right thing for the country.

So we are taking it upon ourselves to develop a system, and part of this is why we believe we need a high performance network, so that we can reward those that are doing care better and more efficiently is so that we are not coming back and asking for these types of increases.

Senator MORAN. Senator from Florida.

Senator RUBIO. Thank you, Mr. Chairman. Thank you both for being here.

Mr. Secretary, one of the hallmarks of the early days of your leadership have been the need for accountability. And as you are, I am sure aware, earlier, about an hour and a half ago or so, I along with Senator Tester, Senator Isakson, the Chairman, and others have filed a Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. And let me state at the outset that the purpose of this law is not simply to punish people. It is also in the best interests of the vast and overwhelming majority of the men and women of the Veteran's Administration who do an excellent job.

And one of the ways in which we recognize the great job they do is by ensuring that the people who either supervise them or work alongside them that are not performing and, or worse, involved in misconduct, do not remain in place and impede their ability to serve. The bottom line is we want to give you the tools to hire and reward good employees who are doing a good job, but also the tools to remove, demote, or suspend employees in an expedited manner who are not fulfilling their commitment to our nation.

One of the issues that has been debated in the last few days and I wanted to get your opinion on it is the burden of proof. As you know, under current law the evidentiary standard for someone for poor performance is substantial, basically substantial evidence, the degree of relevant evidence that a reasonable person considering the record as a whole might accept as adequate to support a conclusion, even though other reasonable persons might disagree. That is the substantial proof burden of proof that exists today for poor performance.

For misconduct, it is higher. For misconduct, the current law says that you need a preponderance of the evidence. And it is defined as the degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue. Some people have said that is a 50 percent standard; substantial is 30 percent. I do not know if those numbers are really there.

Our law, as you know, that we have filed, makes them both substantial. It keeps the current law and performance, but it lowers the substantial misconduct under the theory that misconduct is a lot easier to identify and a lot easier to meet quickly that standard, and not to mention some of the cases.

So I would ask two questions. Number one is in your view what is the appropriate approach? Is it to leave as is or to raise the standard on—lower the standard on misconduct, but raise it on performance; and second, if in fact your belief is that they should both be the substantial evidence model. If you have any example as to how the current standard, for example, on misconduct has been an impediment to accountability and being able to function in your new role.

Dr. SHULKIN. Great. Well, Senator Rubio, first of all, thank you for recognizing that the vast amount of our employees are doing terrific and heroic work and are serving this country's veterans and we should be proud of them and the work that they are doing.

We are talking here about a very, very small number of employees who have deviated and drifted away from the ethical and the responsibilities that they took on to serve our country's veterans and no longer should have the privilege of serving in our system.

In those cases, I wish it was not true. I wish today I could tell you I had the tools to do the right thing to be able to remove those employees. I do not. So, unfortunately, I need a new set of tools if I am going to be held accountable for turning this system around and doing what we all want to do to serve veterans. So I thank you for introducing this bill. I think it is necessary.

In response to your questions which are highly legal and technical—I only went to medical school, not to law school—I can tell you that I need substantial evidence in both of those cases in per-

formance and misconduct. That if we move towards a different standard than substantial, it will be harder for me to do the right thing and to serve the system the way that it needs to be led.

So substantial evidence, it is not my understanding it is mathematical. It is my understanding that it allows the Court to interpret the rulings in a way that is deferential to the Secretary, to the business. It takes the—we have to prove that it is in the agency's interest to be able to make a disciplinary action where if we went to a predominant standard that would be mathematical. You would have to show that 51 percent of the evidence is in favor of a disciplinary action and that would be a much longer process. It would delay our decisions from even where they are today. So I believe we need the substantial evidence.

Senator RUBIO. If I may, Mr. Chairman. I know I am out of time, but it would be very brief. In your time at the Veteran's Administration, have you ever seen or do you have any evidence of any instance in which supervisors or anyone in the agency has targeted individuals for dismissal because we just do not like them and we are going to make something up in order to get rid of them?

Dr. SHULKIN. Well, we have seen cases of documented whistleblower retaliation and we are not going to accept that among our supervisors. We will protect our whistleblowers and so I think that is an important part of also what you are introducing. But I want people to understand. I am not seeking this and I do not support your legislation so that we can willy nilly fire employees or allow supervisors to abuse employees. This allows due process. I believe it is very important that our employees have due process, the right to predecisional appeals, the right to be represented by the union or their attorneys. But in the cases that, frankly, we need to make the changes in management or other changes, today I just do not have that ability to do it.

Senator MORAN. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

Secretary Shulkin, I saw your profile piece in the New York Times this week and a story within it really caught my attention. When you asked for a summit on veteran suicide, you were told by staff that it would take at least 10 months to pull it together and you pushed back on your staff and said, "You need to do it in one month." The Times story notes, and I quote from it, "When his staff members pushed back, he pulled out a calendar and began quietly tapping, then showed them that during the delay nearly 6,000 veterans would kill themselves and they got it done in a month."

I think I speak for my fellow committee members when I saw that it is that sense of urgency that we admire and that sense of urgency that we expect and demand also from the VA in general. The same sense of urgency is one that I want to talk to you about with regard to the scheduling delays with the Choice Program and specifically with the third-party administrator, Health Net.

As you know, I recently wrote you about Health Net's constant delays, their mistakes, and their outright failures. I asked you to transfer the responsibility for scheduling appointments from Wisconsin veterans from Health Net to the local VA medical centers who have told me that they have the capacity to schedule these appointments, and you denied that request. But I wanted to today

give you some examples of why I asked for the removal of Health Net from the scheduling process.

Ten months. That is the amount of time it took a female veteran to get a mammogram scheduled through Health Net. From September 2015 to June 2016, a veteran waited for a mammogram. This includes an intervention from my office on her behalf to get this scheduled utilizing an escalation telephone number provided by Health Net. That escalation line has since been disconnected.

Just this week I heard from a veteran who is authorized to use the Choice Program to see an orthopedic surgeon in March. Health Net received the authorization from the VA, but never contacted the veteran. When the veteran contacted Health Net, they informed her that the authorization was expired, so the veteran was kicked back to the VA and she has still not seen an orthopedic surgeon.

Another veteran with a 100 percent service connected disability wrote to me and said, "I have been referred to the VA Choice Program four times. One time worked perfectly. That is good news. The other three were nightmares." Health Net told him that he would receive a call back in five days to schedule his appointment. They never called back, so he called them. Health Net told that veteran they would call back with his appointment. They never did. That happened four times. When Health Net did finally set up the appointment, it was with the wrong doctor three times.

These Health Net failures are harming our veterans. They are getting in the way of the care that our veterans have earned and they are giving the VA a bad name because very few people differentiate between Health Net and the VA.

I met with all three of Wisconsin's VA medical center directors to just a few weeks ago and each one of them told me that they have the capacity to schedule these appointments at their facilities directly. Given all of this, I would like to hear why you denied my request to remove Health Net from scheduling appointments in Wisconsin and I urge you to reconsider that decision.

Dr. SHULKIN. Okay. I have reconsidered. No. Thank you for your sense of urgency on this. You are absolutely right and those stories are horrific and I wish I could tell you that they were rare. So I think you are right on this.

We entered into a contract where essentially we outsourced this customer service and we have learned the hard way that good businesses do not do that. In our new system, we are going to release a new RFP for contractors that will be released in June. You will see that we are asking to bring that back to VA exactly like what you are talking about. So we are talking about managing a current contract during a remaining period of time until we issue our new RFP.

We will move forward. We have piloted exactly what you are saying with very, very good results in many locations around the country. And the reconsideration, we will move forward with the pilot in Madison. I wish we could do——

Senator BALDWIN. What about all of——

Dr. SHULKIN. What is that?

Senator BALDWIN [continuing]. All of Wisconsin.

Dr. SHULKIN. I wish that we could do all of them. We have contract issues with our contractor because we signed a contract with a process that outsourced this. They have been willing to work on pilots with us, so right now I can tell you we are working towards that in Madison. The new program will have it all back in.

And I think you are absolutely right. I do share your urgency on this. We are seeing improvements. We are seeing less of these stories than we did before, but any of these stories are unacceptable.

Senator BALDWIN. Okay. Mr. Chairman, I see my time has run out. I do have questions I will submit also for the record.

Senator MORAN. Thank you very much and thank you for expressing the concern on behalf of those experiencing Health Net problems. Our provider is TriWest and our circumstances are different, better. And I would encourage the Secretary and the Department to do everything they can to solve this problem as described by the senator from Wisconsin.

Senator from Arkansas.

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you for convening this very important hearing. We appreciate you guys. We appreciate all of your hard work. I know that you are working hard.

And I just recently came off kind of a tour through a lot of rural Arkansas, and was talking a lot about the Choice Program. And the good news is, for the most part people are starting to embrace that and really having a positive experience.

On the other hand and sadly, I wish we could talk more about those positive experiences because there are bunch of them out there, and again, the system is working that way. But there are problems that we are having. And one of the things that we had was that the 40 mile 30 day rule, it continues to cause a little bit of frustration and confusion and often time it penalizes the veteran. And certainly I know that that is not your intent.

In recent weeks, we have received several casework requests where the veterans who were previously in Choice eligible under the 40 mile rule, had used the service, have been notified and basically said, you are not in it because they were—I think one instance was 39.8 miles. And so, we have email correspondence between the VA and affected veterans brusquely telling the veterans that they should have never been eligible because they live 39.8 versus 40 miles from a VA facility, two-tenths of a mile. Worse yet, the VA did not have the courtesy to proactively notify the affected veterans that they no longer rated Choice eligibility. And so the frustration when they later sought treatment and provider coverage. So that really—things like that really are a problem.

I know that you have to have—well, you do not have to have, we have elected to have the 40 mile guidance, but I do think it is that we need to really provide some common sense. And hopefully we can work with—our VA employees who are working so hard and doing a great job of taking care of veterans. On the other hand, there is a little bit of a culture when we get into these kind of things, the regulatory atmosphere, where certainly they could do a better job and treat veterans in a little bit better manner.

Dr. SHULKIN. Right. I think you are making really good points, Senator. Remember, the law was implemented with a 40 mile re-

quirement, so it is a very rules based system. And I have been on record as saying that is not the type of system that I think meets veteran's needs. So we would like to work with you and come back with a new legislation that would replace the 40 mile rule and the 30 day wait time with a more clinically based system that would allow the flexibility that exactly you are talking about.

Senator BOOZMAN. And it would be interesting to look and exactly see the administrative cost——

Dr. SHULKIN. Yes.

Senator BOOZMAN [continuing]. That we are going through with some of these things that I doubt that there is a great cost savings.

In January, you were kind enough to brief me about your team's effort to transform the VA revenue collection to include third party insurance payments. You are about to begin a series of 120 day sprints or mini pilots. Can you provide us with an update as to how those efforts are going?

Dr. YEHIA. Absolutely. Our focus is to make sure we are most efficient and most people do not know this. We collect about $3.5 billion worth of revenue every year that goes right back to service veterans. I think we have opportunities there to increase that number. And so one of our pilots is in your state, Senator, Arkansas, working on three main areas of insurance capture, which we do not do a great job of, medical documentation, and then also coding. I would love to kind of have a follow up conversation with you and let you know about some of the work that has started in those medical centers and are already starting to produce some results.

Senator BOOZMAN. As we examine the future of community care for veterans, are there plans to integrate these efforts into a broader community care program? So, very definitely?

Dr. YEHIA. Absolutely.

Senator BOOZMAN. Good. That is great. Are there any down sides to doing that?

Dr. YEHIA. I do not think so. I think we need to become more efficient and function more like the private sector does. This is a little bit of the bread and butter of most clinics and hospitals of being able to collect and process insurance and collect from health plans. And we need to be able to develop those muscles and flex them and be able to get those revenues so we can better take care of veterans.

Senator BOOZMAN. Yeah. No. No. I agree. It seems like, that we are leaving millions of dollars on the table that you could redirect and deal with some of the urgent problems that you have.

Thank you, Mr. Chairman.

Senator MORAN. Thank you, Senator.

Senator from North Dakota.

Senator HOEVEN. Thank you, Mr. Chairman, and thanks for holding this important hearing. And to all three of you, thanks for the work you do.

Secretary Shulkin, I think the fact that you are a medical doctor is a real strength that you bring to this job and——

Dr. SHULKIN. They did not agree, I guess.

Senator HOEVEN. I am not sure what that is all about. But not only, you know, your experience administratively, but—yeah. I will try a different one.

Senator MORAN. You are just high maintenance.

Senator HOEVEN. I guess so. We will try it again.

Dr. SHULKIN. Thank you.

Senator HOEVEN. The experience you bring as a physician is important as well as the experience you have at VA administratively. Just two areas that I want to touch on. One, Senator Boozman was talking about, and that is in rural areas the 30 day 40 mile rule creates problems and gets some nonsensical outcomes based on where you have facilities, both your healthcare facilities and your CBOCs.

You are aware of this. We have talked about it, but your discretion and your empowerment of your staff to make good decisions rather than technical decisions.

Dr. SHULKIN. Right.

Senator HOEVEN. And it follows in the footsteps of the non-VA care model.

Dr. SHULKIN. Yes.

Senator HOEVEN. You are doing that in North Dakota. You have been tremendously helpful. It has made a big difference not only in terms of getting appointments and getting our vets in to get their healthcare, but also in making sure that community providers get paid timely. And so I want to again thank you for the pilot program we have in North Dakota, the Veteran's Care Coordination Initiative. It is working very well and it is a testament to you are willing to engage and empower your people.

Along that line, we need to do more for long-term care of veterans, both institutional long-term care, our nursing home care, and home-based care. Now this is incredibly important. I know you know we have been working on it, but we need your help. And in a nutshell, of course, if somebody goes into a nursing home, sometimes they take Medicaid reimbursement, that nursing home. Sometimes it takes Medicare reimbursement. But if they take VA reimbursement, they have a different and additional set of standards.

This needs to change. This needs to be fixed. And we need your help to do it. Now, if we cannot do it administratively, then the bipartisan bill that I have with Senator Manchin, we did pass through the VA Committee last session of Congress, but we are back—because we did not get it passed across the Floor and across the House, we are back doing it again. And so I am asking for your advice, your thoughts, and your help in moving that bill because when a veteran goes into a—you know, something like 10 to 15 percent of our nursing homes across the country will take VA reimbursement.

Now they all take Medicare. They all take Medicaid. But if they want to take VA, they have got to go through a whole different set of standards. Now, that is not fair to our veterans and we need to do something about it. How do we get this done?

Dr. SHULKIN. Well, first of all, I would like to work with you on this. I think you are right. We just announced two weeks ago something very, very similar. Our building standards for VA where we would give grants to states were so over the top and created an additional 30 percent cost factor on the states and building their facilities. And they actually cut down on the number of veterans that

we could serve because of these increased costs. So I suspended all of the Federal requirements and now we are going to use the state requirements across the country in a very, very similar way. So I would like to work with you on this piece and see if we can get to a result that makes sense.

Senator HOEVEN. Well, and so I need a point person from you or somebody. We have got long-term care on board.

Dr. SHULKIN. Yeah.

Senator HOEVEN. You know, this is all about making sure that veterans—it is really the mirror of what we are doing on the healthcare side. We are doing the same thing on the long-term care side. Making sure that our veterans can, you know, get care and long-term care in the community, either a nursing home or homebased care. And so I need a point person. I need something from you to help to work with my crew to drive this to completion.

Dr. SHULKIN. Well, let's not only do that, but let's set a time limit. When do you want to do this by, Senator?

Senator HOEVEN. Well, I would like to get it passed through this session of the Congress.

Dr. SHULKIN. Okay. Me too.

Senator HOEVEN. I mean, ideally this year.

Dr. SHULKIN. All right. Okay. Yes, absolutely, absolutely. So we will reach out to you and get a direct point contact and this will be something that we will work with you on because I think it is the right thing to do.

Senator HOEVEN. Well, thank you, Secretary, and I agree. I think it goes to what you are—I believe you are doing, and that is getting things done. We have got a lot to do, a lot more to do. We recognize that.

Dr. SHULKIN. Right.

Senator HOEVEN. But you are working to get things done and I really appreciate it.

Dr. SHULKIN. Absolutely. Thank you.

Senator HOEVEN. Thank you.

Senator MORAN. Senator, thank you very much.

We are going to bring this hearing to a conclusion. Before I do that, let me ask you, Secretary Shulkin, last week you testified in front of our counterparts, House Mil Con VA Subcommittee regarding mandatory funding. And your testimony indicated that you were supporting mandatory funding. Mandatory funding is certainly included in the Choice Act, but that was considered an emergency. And I just want to know if you misspoke or there was intention that you believe that the new program will be mandatory funding versus discretionary funding.

Dr. SHULKIN. Well, I think it is going to be a combination of both. I think we are going to need to have some funding on the mandatory side which essentially allows us to continue what we have known as the Choice funding, as well as using the discretionary funds for community care. What we are going to be seeking and working with you with is to ask whether we can have flexibility between those two funds to allow us not to be operating out of two different sets of rules. We want all of this money combined to be able to help veterans get care in the community.

Senator MORAN. I should not have asked that question because it gave time for the senator from New Mexico to arrive.

Senator UDALL. You always love it, Mr. Chairman, when I arrive. I know because we——

Senator MORAN. We are glad you are here.

Senator UDALL [continuing]. Work on so many things together, so thank you. And I apologize for keeping you, Mr. Secretary.

Dr. SHULKIN. No problem.

Senator UDALL. But I had some things I wanted to cover here. Just I will try to be brief.

It is really good to see you again and congratulations on your confirmation earlier this year. I believe you are the only Cabinet member to be confirmed unanimously and that is a significant accomplishment in our current political environment, wouldn't you say, Mr. Chairman?

Senator MORAN. Absolutely.

Senator UDALL. But it is not surprising since you led the Veteran's Health Administration under President Obama. You have continued to demonstrate your commitment to veterans and to ensuring they receive quality healthcare and I really, really thank you for that service.

My first question relates to your testimony to our sister subcommittee on the House side last week on the realignment of VA facilities. I voted to authorize the Choice Program and I have worked with my colleagues on the subcommittee to make many essential improvements, but I absolutely did not vote to privatize the VA and I do not think many other senators did either. But, frankly, it is troubling to me and to many veterans in New Mexico who heard talk of realignment and closing VA facilities in a conversation about veterans seeking care in the private sector.

The Veterans Choice Program is one thing, but we do not want to force veterans into the private sector where in many cases private health providers do not have the experience treating veteran's specialized cases like chemical exposure, traumatic brain injury, and PTSD. This concern is not just speculation. In fact, a GAL report published just last week found that the VA does not adequately work with local veteran communities when they shut down a facility or relocate services. Specifically, GAL found that and I quote here, "The VA has not consistently followed best practices for effectively engaging stakeholders in facility consolidation efforts," and "The VA's efforts to align facilities with veteran's needs were challenged."

So, Secretary Shulkin, would you please clarify what you meant by realignment and how you plan to improve the VA's community engagement and specifically related to the 431 vacant buildings and 735 underutilized buildings you cited last week?

Dr. SHULKIN. Yeah. Thank you for asking that question. And I think that you have stated it well, what a reasonable position here is.

If you take a look at my testimony that I gave last week, the testimony, I believe, is accurate. The way it was reported, unfortunately, was not exactly accurate. This is—the intent here is to dispose of resources or buildings that are not helping veterans today,

that are sitting vacant or unutilized, not to eliminate or close facilities that are taking care of veterans.

So let me just share with you. We have 449 buildings today from the Revolutionary War and the Civil War. We have 591 buildings today from World War I. Of the ones in the Revolutionary and Civil War, I do not know which is worse, that we have 449 buildings or that 96 of them are vacant. I was talking about the 96 that are vacant. Of the World War I buildings, we have 141 that are vacant.

I do not want to continue to spend taxpayer money, which is $25 million a year, maintaining buildings that are vacant or underutilized, particularly ones of that age, when I could be using that money to support the capital needs of buildings and facilities that are helping veterans. I have no interest in privatizing the VA. I am interested in using our resources to help veterans.

Senator UDALL. Secretary Shulkin, is there a public list of these facilities so that communities and their elected representatives can understand what may or may not be closed as part of this realignment?

Dr. SHULKIN. Yes, there is.

Senator UDALL. And you have made that available to us?

Dr. SHULKIN. I would be glad to make that available to you.

Senator UDALL. Okay. And you would make it available to the committee.

Dr. SHULKIN. Yes.

Senator UDALL. It will be available for members to see.

Dr. SHULKIN. Absolutely.

Senator UDALL. Let me see here if there is a—I think I am going to submit these for the record.

Dr. SHULKIN. Thank you.

Senator UDALL. The Chairman has been very generous here to allow me to go near the end here and really appreciate it, Mr. Chairman, and thank you very much again for your service.

Dr. SHULKIN. Thank you. Thank you, sir.

Senator MORAN. We are glad to have you and appreciate your questions.

I am ready to conclude this hearing. Mr. Secretary, I do want to bring to your attention a letter that the four here in the House and Senate received from the Inspector General yesterday. It was a letter to Dr. Ali on conditions at the District of Columbia VA Medical Center. OIG issued a report on April 12th. They are now reminding us again yesterday of serious conditions, according to the IG report, at that hospital. And I want to make certain that you and the VA are taking the steps necessary to correct those problems. And what I hope you would assure me is those steps have already been taken.

Dr. SHULKIN. Yes, Mr. Chairman, and I appreciate the change to comment on this.

We do appreciate the IG's work and their continued vigilance to make sure that our facilities are up to the standards and providing the best quality care. And so we work closely when the IG issues these reports to us. We had people on site there yesterday from the Central Office.

I would say two things. First of all, what they observed yesterday was actually a process that works. When we identified that there

was any safety concerns to a patient, we simply stopped the procedure and corrected the situation so that there has not been in any of these Inspector General concerns any evidence of harm ever to a veteran.

Secondly, the letter that was issued to you did not have fully accurate information. We have written back to the IG to share our perspective so that what we are trying to do is to do exactly what you are saying, which is to make sure that we are on top of these issues, monitoring it. We have no safety concerns today about patients being cared for there. We do believe that it is a high quality environment, but we will be vigilant and we will work with the IG to make sure that we are addressing the needs as appropriate.

Senator MORAN. Senator Collins, because I asked one more question, I recognize you.

Senator COLLINS. Thank you, Mr. Chairman. I am so grateful that you did. I had three hearings this morning and I know how frustrating it is when a member comes in just as you are about to adjourn, but this is so important that I did want to get here.

Both of our witnesses, it is great to see you again. And each of them accompanied me last year to my hometown of Caribou, Maine, to observe the ARCH Program firsthand. And I want to first express my appreciation once again. We have talked about it since then, but the appreciation of the veterans and the healthcare providers who really were so grateful that you drove the 250 miles from the Togus Medical Center, the VA Hospital in Augusta, to Caribou so that you would have a sense of the driving difficulties often faced by veterans in northern Maine.

You also kept your word in ensuring that veterans who participated in the ARCH Program maintained the same seamless community care even after that particular program expired, and I am grateful for that.

As Congress and your Department work to reform and consolidate VA's community care authorities, will you pledge to continue to ensure that veterans in northern Maine experience another seamless transition and continue to enjoy the convenient and efficient and cost effective community care that they are receiving now, Dr. Shulkin.

Dr. SHULKIN. I am going to let Dr. Yehia answer.

Senator COLLINS. Dr. Yehia.

Dr. YEHIA. Yeah, absolutely. ARCH has really been a learning lesson for us. And our pilots that we have today in the Choice Program in North Dakota and Alaska are modeled after ARCH. What ARCH got right and we want to make sure is right in the new program is the importance of relationships. Veterans have a consistent point of contact. They know where and when to go. And the VA is involved with their community provider to make sure that it is a seamless connection. And so we actually look to take that model in Maine and in other parts of the country and use it as the standard bearer for the new program of how we coordinate care.

Senator COLLINS. That is exactly what I had hoped you would do once you saw how effective it was and I know the Chairman is a big supporter of this program as well. And it really—that is the goal we should all have and I appreciate the fact that you are repli-

cating it because we felt here is a model that is working. Let's bring it to other remote or rural areas.

I want to bring up another issue that has been a problem in Maine, and that is the prompt payment of VA claims. And it continues to be a problem not only in my state, but in others as well. For smaller rural providers, it really can mean the difference between whether they are going to be able to keep practicing or not, but it is not just our smaller providers that have experienced a problem.

And the Eastern Maine Medical Center, as you know, has been working, and Doctor, you have worked very closely with us on this. It has been working with our office and with yours to try to resolve a huge backlog of some 2,000 claims. And I know that there are different views on why the backlog is so big, but nevertheless, there is a backlog. I think all of us could agree with that. And my worry is that we really need prompt payment in order for the Choice Program to work well.

So what can be done to speed along the process of resolving disputed claims and to pay those that are not disputed more rapidly so that providers are not stuck?

Dr. YEHIA. Yeah. Making sure that we are good partners for our community providers is critical because we will never be able to build the high performing network that we want if we are not good business partners for our community providers.

I have had the chance to have personal phone calls with the CEO of Maine and other facilities and it has been great to work with them. And we have made a lot of progress. We have actually paid them more just this time this year than the entire last fiscal year. We still have a little of a ways to go, but I feel like we are making good progress there.

We could use your help, Senator. Part of the challenge is that we have multiple programs, each with different rules and authorities. And I think as we work towards a new modernized community care program, having a criteria that is easy to understand, not only for the veteran, but for the administrators and the community providers, will go a long way. Most of the claims that we end up denying are because of care that was not approved or did not follow the rules of some program. It should be easier than that and so we want to work with you to streamline those efforts.

Senator COLLINS. I am certainly happy to work with you and I appreciate the efforts you are making. I hope they will continue. I also think you need to look at your IT systems and that there is still an awful lot of paper claims that are filed and that is not the case in Medicare, for example. And I think that slows the process. I know that requires money, and but I think the onerous paper system is part of the problem as well.

And I can see I am getting the hook understandably from the Chairman who has been extraordinarily patient. I truly thank you, Mr. Chairman, because I have had a Help Committee markup, the Intelligence Committee has been meeting, and yet this is so important that I really wanted to get here. So thank you for asking that final question.

Senator MORAN. Senator Collins, thank you very much for joining us. I should not give you many compliments because someone

else might arrive in the time that I am complimentary of you, but I very much appreciate your interest in these issues, and particularly the ones you raised in your questions. I am the author of the legislation that created ARCH back in my House days and we are glad to hear Dr. Yehia say that it has made a difference in providing a role model.

And payment claims, the payments of claims, is so critical in those small towns who are—those hospitals are hanging on by a thread and cash flow is an issue for them every month. So I appreciate what you had to say and I appreciate your continued diligence on behalf of the veterans of Maine, not New Hampshire.

And I would also indicate that I would expect a couple of things. I would expect that once we get through the budgetary process, this subcommittee probably will look at IT issues and the Secretary is pursuing a decision in that regard. So maybe we can get some of the questions that you have in regard to improving our IT. Also, the passage of the Vet Improvement Act that extended the Choice Program removes the third party provider from the payment process. And again, our hope is that that has a significant consequence.

Dr. SHULKIN. Yes.

Senator MORAN. In the timeliness of those providers being paid. And I do not know the timeframe in which that will take effect. I assume that it is not implemented yet or is there——

Dr. SHULKIN. Yeah. Now.

Senator MORAN [continuing]. Now?

Dr. SHULKIN. Yeah.

Senator MORAN. So the third party provider is not involved in the——

Dr. SHULKIN. Well, the VA will be the initial provider of the payment, so it takes the veteran out of the middle.

Senator MORAN [continuing]. Great. It would be interesting to confirm that that is a time saving change. And I assume we will have evidence of that in part from the hospital and providers that call me.

Dr. YEHIA. Yeah. We know it is saving time. Yeah. The community providers before had to bill the other health insurance, then bill us, so there was a two-step process. Now they only have to do one step. They bill the Veterans Choice Program.

Senator MORAN. And that is in effect today?

Dr. YEHIA. Yes, sir.

Dr. SHULKIN. Yeah.

Senator MORAN. Great. Now, I thank our witnesses for being here today. We will continue to work along the lines that we discussed today. We have a great opportunity, I think, to make a significant difference. And again, I appreciate the conversations that I had with you yesterday. I appreciate your time today. This subcommittee looks forward to working closely to find the right solutions.

ADDITIONAL COMMITTEE QUESTIONS

For members of the subcommittee, any questions you have for the record should be turned into the subcommittee staff no later than Thursday, May 18th.

QUESTIONS SUBMITTED TO HON. DAVID J. SHULKIN

QUESTION SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. As you look at modernization, what are the scope of services that you feel should always remain available within the VA system?

Answer. VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will focus on its foundational services—those areas in which it can excel—and build community partnerships for complementary services.

VA Delivered Foundational Health Services are: (1) those services that provide management of military-related conditions/disorders AND there is limited expertise and/or access to that care in the national market; OR, (2) those services that manage and coordinate the overall health of Veterans across their lifespan.

For example, service-related conditions like traumatic brain injuries (TBI), polytrauma care, posttraumatic stress disorders, blind rehabilitation, and prosthetics are areas where VA care is critical. Decisions on foundational services will vary from market to market based on Veteran needs and what is available in the community, but integrated primary care and mental health is another area where VA often provides services that are best in class. Providing these foundational and critically needed services for Veterans distinguishes VA from the private sector and is one of the many reasons for investing in VA direct healthcare.

VA will continue to assure that the full array of statutory VA healthcare services are made available to all enrolled Veterans. No aspect of the definition of implementation of "VA Foundational Services" will reduce the scope of services made available through a high performing integrated network.

QUESTION SUBMITTED BY SENATOR THAD COCHRAN

Question. While the VA has had great success deploying telehealth in some areas, challenges remain. In many states, academic medical centers have stood up outstanding telehealth programs. The University of Mississippi Medical Center in Jackson is a leading example. These academic medical centers serve as partners with the VA in many ways, often even being co-located with VA medical centers. How can Choice and other purchased care programs take advantage of these existing telehealth programs based at academic medical centers to reach more veterans, especially in rural areas?

Answer. VA is a leader in the area of telehealth. On August 3, 2017, VA announced it is initiating a national rollout of VA Video Connect, a software application that will enable VA providers to use video telehealth from anywhere to anywhere.

The VA Office of Community Care (OCC) has used telemental health services in some locations, and we continue to explore opportunities to utilize telehealth through our agreements with academic medical centers and through our contractors, TriWest and Health Net. There are challenges in providing access to the technology required to enable telehealth services, and we continue to look for new ways to provide these services through local academic medical centers.

The Office of Telehealth Services provided data on the number of Veterans served through telehealth encounters at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi, from October 2016 thru mid-August 2017. During that period, over 4,000 Veterans accessed VA care through more than 7,600 telehealth encounters. All of these telehealth services were provided by VA staff. Currently, there are no telehealth collaborations with the University of Mississippi Medical Center at Jackson.

QUESTIONS SUBMITTED BY SENATOR TOM UDALL

Question. My office has worked with veterans and families that have experienced significant gaps in access to essential care for substance abuse issues. Access to mental health services at the Raymond G. Murphy Veterans Affairs Medical Center in Albuquerque is increasingly difficult for many New Mexico veterans.

According to your letter to me dated April 25, 2017, out of the 80 beds in the Albuquerque VA Hospital allocated for in-patient treatment for mental health and substance abuse, one quarter of the beds are vacant due to staffing shortages. And despite approximately twenty open beds, veterans have to wait on average 56 days for Substance Abuse, Trauma, and Rehabilitation Residence.

Time is critical when connecting veterans to mental health treatment options, for treatment of substance use issues, homelessness, or suicidal thoughts. But, many veterans prefer to wait to receive care in the VA rather than use community services. There is often a stigma going to a substance abuse treatment program, and there are concerns that outside providers won't understand the issues that are specific to veterans. Furthermore, the GAO reports—in some cases—veterans have to wait up to 81 days before receiving treatment through the Choice Program.

In your opinion, are veterans better served by increasing the capacity and the number of providers inside the VA—rather than sending them outside where care might be further delayed or the services might be inadequate to meet the veteran's needs?

Answer. VA's goal is to provide timely, high-quality access to care for Veterans when and where they need it. VA needs a different approach to ensure we can fully care for Veterans. We need your help in modernizing and consolidating community care. We believe that a redesigned community care program will not only improve access and provider greater convenience for Veterans, but it will also transform how VA delivers care within our facilities.

With regard to "concerns that outside providers won't understand the issues that are specific to veterans," VA understands this potential obstacle and has ensured that free training is available to community providers. Free training and continuing education are available to community providers via the national program, "Training Finder Real-time Affiliate Integrated Network" (TRAIN). The Military Culture portion of the training focuses on Core Competencies for Healthcare Professionals and includes four modules: Self-Assessment/Intro to Military Ethos; Military Organization and Roles; Stressors and Resources; and Treatment, Resources, and Tools.

Question. Over the past two weeks, we have heard from the VA about your priorities for telehealth and telemedicine for fiscal year 2018—including the ability to assist treating mental health issues. One thing came up in testimony last week in relation to broadband. The Federal Universal Service Fund has not made broadband universally available.

Many veterans living in rural areas do not have access to broadband to be able to utilize the VA's newest efforts for Home Telehealth. And I know there's a reluctance in terms of stepping outside your agency. But if we had a national effort to put that broadband into all these rural areas, it would really make a difference in terms of the VA's vision.

I'd urge you—as Cabinet Secretary—to be at the table when the president puts together his infrastructure package. Can you commit to advocating that it's absolutely essential to fill these holes so that we can get telehealth out into the rural areas of America?

Answer. The telehealth is mission-critical to the future of VA healthcare. VA looks forward to advancing telehealth capabilities to enhance its capacity to provide clinical services by hiring more providers in major metropolitan areas to serve Veterans in rural and underserved areas; to increase Veterans' access to care from home or a VA community clinic; and to increase the quality of VA care by leveraging VA's national roster of experts in rare or complex conditions.

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Question. Secretary Shulkin—you previously indicated in a House MilConVA hearing that the VA selected a commercial vendor for the Medical Appointment Scheduling System or MASS and a pilot location was proceeding. Are you aware the task order to begin the pilot project was never ordered? If so, when will that task order to begin the project will be ordered and when will the commercial solution roll out system-wide?

Answer. The Medical Appointment Scheduling System (MASS) task order, which implements the MASS pilot in Columbus, Ohio was awarded on June 15, 2017. It is planned to take about 1 year to implement the software and an additional 3 months to evaluate the results before making a national deployment decision. That national deployment decision will necessarily be made with consideration of the just announced negotiation with Cerner. In the interim, VA is deploying VistA Scheduling Enhancement (VSE), a software scheduling solution that improves the current system, between June and October 2017.

Question. Secretary Shulkin—I recently heard from a veteran who was referred to the Choice Program for a colonoscopy. It took 3 months for his colonoscopy to be scheduled. Veterans should not be waiting 3 months for colon cancer screenings when an in home test is readily available.

In 2016, the United States Preventive Services Task Force (USPSTF) identified several seven strategies to increase colorectal cancer screening, designating them as A-rated. An A-rating signifies with high certainty that the net benefit of these screening strategies is substantial when compared to potential drawbacks.

New strategies have subsequently been adopted by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS), measures used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. For example, Tricare provides coverage for each one of the major strategies included in the USPSTF and HEDIS. The enrollees of the VA deserve, at a minimum, the same treatment that all military personnel eligible for Tricare enjoy.

In home tests like Cologuard are approved by FDA, Medicare, Medicare Advantage, Medicare Advantage Star Ratings and Tricare. However, VA declined to offer Cologuard to veterans because their delivery methodology involves sending the test directly to the veteran. I have an extremely hard time accepting this reasoning when the VA is unable to get a veteran a colonoscopy screening appointment in 3 months and then denies a simple solution that can be sent directly to a veteran. This saves a veteran a trip to a healthcare facility, yields better outcomes and reduces costs to the system.

If this test is good enough for our active military, why not our veterans? If you are not aware of this, can I get your commitment to re-evaluate this decision?

Answer. The United States Preventive Services Task Force (USPSTF) recommendations were very carefully reviewed by the Veterans Health Administration subject matter expert panel that made recommendations for colorectal cancer screening. In their 2016 JAMA publication, the USPSTF gave colorectal cancer screening for 50–75 year old individuals a grade A recommendation, though they did not give any specific tests a graded recommendation. Per this publication, "the USPSTF found no head-to-head studies demonstrating that any of the screening strategies it considered are more effective than others, although the tests have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations." The USPSTF stated that "Multitargeted stool DNA testing (FIT–DNA) is an emerging screening strategy that combines a [fecal immunochemical test] FIT with testing for altered DNA biomarkers in cells shed into the stool. Multitargeted stool DNA testing has increased single-test sensitivity for detecting colorectal cancer compared with FIT alone. The harms of stool-based testing primarily result from adverse events associated with follow-up colonoscopy of positive findings. The specificity of FIT–DNA is lower than that of FIT alone, which means it has a higher number of false-positive results and higher likelihood of follow-up colonoscopy and the risk of experiencing an associated adverse event per screening test. There are no empirical data on the appropriate longitudinal follow-up for an abnormal FIT–DNA test result followed by a negative colonoscopy; there is potential for overly-intensive surveillance due to clinician and patient concerns about the implications of the genetic component of the test." Results from the associated decision-model estimates of the benefits, harms, and burden of various colorectal cancer screening strategies screened show that FIT–DNA every 3 years results in fewer life-years gained compared to annual FIT or colonoscopy (226 life-years gained per 1,000 screened with FIT–DNA vs. 244 and 270 with FIT and colonoscopy, respectively). The USPSTF further stated that the lack of empirical evidence on appropriate follow-up of abnormal results "[makes] it difficult to accurately understand the overall balance of benefits and harms of this screening test."

VA currently offers the option of home screening tests for colorectal cancer screening and has for many years. These home screening tests are available without delay to Veterans who choose this option based on a shared, decisionmaking conversation with their healthcare team. VA is very proud of the high rate of colorectal cancer screening in our population with these various screening options. A recent publication found that 82.3 percent of Veterans insured through the VA, TRICARE or other military insurance iwere up-to-date with colorectal cancer screening, compared to 80.2 percent of those with Medicare coverage, 74.5 percent among those with private coverage, and 60.1 percent of those with Medicaid coverage (May et al. Dig Dis Sci 2017;62:1923–1932).

After considering the available evidence and the above-mentioned USPSTF document, the VA expert panel did not recommend Cologuard because they felt that the scientific information supporting its use is not as mature as that which is available for other colorectal cancer screening modalities, including colonoscopy, flexible sigmoidoscopy and fecal occult blood testing. The VA colorectal cancer screening recommendations are periodically reassessed and are updated, as needed. Despite the lack of a formal recommendation from VA, individual VA healthcare providers may

request tests that they deem are medically indicated for individual Veterans. These requests are reviewed locally.

Question. Secretary Shulkin—during our conversation at the hearing on Thursday, May 11, you noted that you while you could not grant my full request to remove Health Net from scheduling appointments in Wisconsin, you would move forward with a scheduling pilot at the Madison VAMC. As of Monday, May 15, Health Net informed me that they had received no such request for a contract modification for a Madison VAMC scheduling pilot that you mentioned. Can you please provide details about this expansion of a scheduling pilot program at the Madison VAMC—when will it begin and how will this process change from what veterans currently experience in the scheduling process. In addition, if you are able to make this contract modification with Madison VAMC, why not also include the Tomah VAMC and the Milwaukee VAMC?

Answer. VA is actively engaged in the development of a contract modification for the care coordination (scheduling) model with HealthNet. As that work continues, we are working closely with Madison and Iron Mountain to prepare for implementation of the process changes.

Site	Site Assessment	Clinical Assessment	Training	Go Live
Madison Wisconsin	Conducted virtually by VA Office of Community Care Staff	Week of June 26, 2017	Week of July 24, 2017	Mid-August
Iron Mountain, Michigan	Conducted virtually by VA Office of Community Care Staff	End of August.	September, 2017.	September, 2017.

The care coordination model enables VA staff to work directly with the Veteran to schedule an appointment within the VA or with a network provider in the community. The VA staff are familiar with the providers and Veterans in their area. They are aware of the type of specialty care available within the community and can schedule care much more efficiently than the contractor. Once the appointment is scheduled, VA staff upload the referral information to the contractor portal, and the contractor in turn provides the referral information to the community provider. When the appointment has been completed, the medical documentation is submitted to the VA medical center from the community provider for access by the VA referring provider.

Community care staff at the VA have scheduled appointments for Veterans under our traditional community care program for several years. These interactions enabled them to build strong working relationships with the providers in their community and with their Veterans. In the care coordination model, VA staff leverage these relationships to schedule Veteran appointments more quickly and efficiently. As this model is deployed at each site, the VA Office of Community Care implementation team identifies lessons learned and incorporates strong practices from these sites into the model, and this knowledge is applied at the next location.

The VA Office of Community Care has made implementation at the Madison, Wisconsin VA Medical Center (VAMC) a priority. As a tertiary care facility, the Madison VAMC serves as a catchment for the Tomah and Milwaukee VAMCs. Implementation of the model in Madison will provide them with processing efficiencies and opportunity to renew and strengthen relationships with their community providers. This will positively affect appointing capability for Veterans who travel to Madison from other locations within the Veterans Integrated Service Network. The VA Office of Community Care will continue to move forward with the roll out of the care coordination model at additional locations in the new fiscal year.

SUBCOMMITTEE RECESS

Senator MORAN. The hearing is adjourned.

[Whereupon, at 12:11 p.m., Thursday, May 11, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]