

SHAPING THE FUTURE: CONSOLIDATING AND IMPROVING VA COMMUNITY CARE

HEARING

BEFORE THE

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

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

TUESDAY, MARCH 7, 2017

Serial No. 115-5

Printed for the use of the Committee on Veterans' Affairs



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

U.S. GOVERNMENT PUBLISHING OFFICE

29-371

WASHINGTON : 2018

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

COMMITTEE ON VETERANS' AFFAIRS

DAVID P. ROE, Tennessee, *Chairman*

GUS M. BILIRAKIS, Florida, <i>Vice-Chairman</i>	TIM WALZ, Minnesota, <i>Ranking Member</i>
MIKE COFFMAN, Colorado	MARK TAKANO, California
BRAD R. WENSTRUP, Ohio	JULIA BROWNLEY, California
AMATA COLEMAN RADEWAGEN, American Samoa	ANN M. KUSTER, New Hampshire
MIKE BOST, Illinois	BETO O'ROURKE, Texas
BRUCE POLIQUIN, Maine	KATHLEEN RICE, New York
NEAL DUNN, Florida	J. LUIS CORREA, California
JODEY ARRINGTON, Texas	KILILI SABLÁN, Northern Mariana Islands
JOHN RUTHERFORD, Florida	ELIZABETH ESTY, Connecticut
CLAY HIGGINS, Louisiana	SCOTT PETERS, California
JACK BERGMAN, Michigan	
JIM BANKS, Indiana	
JENNIFFER GONZALEZ-COLON, Puerto Rico	

JON TOWERS, *Staff Director*

RAY KELLEY, *Democratic Staff Director*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Tuesday, March 7, 2017

	Page
Shaping The Future: Consolidating And Improving VA Community Care	1
OPENING STATEMENTS	
Honorable David P. Roe, Chairman	1
Honorable Timothy J. WALZ, Ranking Member	3
WITNESSES	
Honorable John McCain, U.S. Senate, Arizona	5
Prepared Statement	47
Honorable David J. Shulkin M.D., Secretary, U.S. Department of Veterans Affairs	7
Prepared Statement	48
Accompanied by:	
Baligh Yehia M.D., Deputy Under Secretary for Health for Community Care, Veterans Health Administration, U.S. Department of Veterans Affairs	
Honorable Michael J. Missal, Inspector General, Office of the Inspector General, U.S. Department of Veterans Affairs	8
Prepared Statement	49
Randy Williamson, Director, Health Care, Government Accountability Office ..	10
Prepared Statement	56
STATEMENTS FOR THE RECORD	
Veterans of Foreign Wars	72
HVAC	75
Paralyzed Veterans of America (PVA)	76
The American Legion	79
Disabled American Veterans (DAV)	82
TriWest	87

SHAPING THE FUTURE: CONSOLIDATING AND IMPROVING VA COMMUNITY CARE

Tuesday, March 7, 2017

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

The Committee met, pursuant to notice, at 7:36 p.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Radewagen, Bost, Poliquin, Dunn, Arrington, Rutherford, Higgins, Bergman, Banks, WALZ, Takano, Brownley, Kuster, O'Rourke, Rice, Correa, Sablan, Esty, and Peters.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

Good evening and thank all of you all for being here and joining us tonight.

Though it is somewhat unusual for the Committee to meet in the evening hours, tonight's topic is one well worth staying up late for. I want to keep our work this evening laser focused on the future. On how we can all work together to create a better, brighter, healthier one, for our veterans, and for the health care system that was built to serve them, rather than on rehashing mistakes that we have made long ago. Yet as we begin to move forward this evening, we must not lose sight of where we started.

Three years ago, next month, in this very room, the Committee heard testimony from a veteran named Barry Coats, who spoke about waiting almost a year for care from the Department of Veterans Affairs medical facility in South Carolina. When Barry was finally seen, long after he should have been, he was diagnosed with stage IV colon cancer that had spread to his liver and to his lungs. He passed away in January last year.

It was Barry's story and accompanying allegations, that 40 veteran patients had died while waiting to receive care from the VA Medical Center in Phoenix Arizona, that kicked off a nationwide access and accountability scandal the likes of which the VA had never seen.

It also led directly to the creation of the Choice Program and to the allocation of billions of more taxpayer dollars to increase access to care for veteran patients. In the 3 years since then, more than 2 million authorizations for care have been approved and over 1 million veterans have been able to get care that otherwise might not have been readily available.

However, all of us around this dais continue to hear from veterans, day after day, experiencing lengthy and frustrating delays when attempting to schedule appointments through VA using Choice. In fact, just a couple of weeks ago, I was contacted by a veteran with a story much like Barry's. This veteran was diagnosed with cancer last fall and referred to Choice for treatment.

While I am relieved to say he is now receiving the care that he needs, from the provider of his choice, he suffered through weeks of doubt due to a series of mishaps and miscommunication between VA, the third-party administrative managing Choice, in this particular region, and the community provider who had agreed to treat him. It appears that 3 years after Barry's testimony, a lot has changed, but too much has stayed the same.

What is more, recent work performed by the VA inspector general, and the Government Accountability Office, illustrate very clearly that Choice is not set up to succeed at its primary mission: providing timely care to veterans who cannot access that care within the VA because it is either not offered, not available within a reasonable amount of time, or would entail a veteran traveling a great distance. For example, GAO is going to testify this evening that veterans could potentially wait up to 81 calendar days before receiving care due to the burdensome bureaucratic process the VA imposed on Choice. That is unacceptable to me and I am sure everyone in this room.

I ran a practice in east Tennessee for over 30 years, and I assure you it does not have to be this complicated and should most certainly not take this long.

Luckily, Choice is not the same program today as it was when it was reviewed by GAO and the IG last year, and it is certainly not the program that when it was first created. Through a series of four legislative changes and 70 contract modifications and counting, Choice has been continually improved upon and made stronger.

It remains far from perfect and in far too many cases it fails the very veterans it was created to serve. I am working diligently with the Ranking Member WALZ, with the Secretary and his senior leaders, and with our Senate colleagues, and with our veterans service organization partners to chart a path forward for Choice and for all VA care and the community programs in short order.

I hope to have draft language to share in the coming weeks and to have a VA health care reform bill on the President's desk this year. However, the first step to reforming Choice is making sure that there is a smooth transition to lead the way. This is why it is critical that this Committee act tomorrow to mark up H.R. 369, a bill I introduced earlier this year, to remove the current 3-year sunset date from the Choice Program.

Absent legislation, Choice will begin shutting down in just a matter of weeks and will end completely in 5 short months from today, cutting off a key access avenue at a time when veterans are seeking care in the community more than ever before and critically at a time when the VA's nonChoice community care account has been unable to absorb additional demand for care.

VA is already facing a \$3.4 billion deficit in the community care account next fiscal year that VA leaders have told the Committee,

staff will require additional appropriations to address. By removing the sunset date to the Choice Program, we are not endorsing the program in its current state, but we are ensuring that emergency funds that Congress made available for critical veterans care are used for that purpose until they are expended.

Community care appointments have increased by 61 percent overall since Choice was created, and last year, 30 percent of all VA appointments were held in the community rather than in VA medical facilities. The future of VA relies on not only a strong VA health care system, but on a VA health care system that is inextricably linked with community resources to fill the gaps and meet the need of our veterans when and where they are.

We must get this right and learn from the mistakes, miscommunication, and undue bureaucratic processes that have plagued Choice since its inception, not only for the veterans who depend on this system today, but also for generations of American heroes to come. That is what I am committing to once again this evening.

With that, I will now yield to Ranking Member WALZ for any opening statement that he may have.

**OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING
MEMBER**

Mr. WALZ. Well, thank you, Chairman Roe, for holding this important hearing. A special thank you to Senator McCain, always a champion for our veterans, and it is a pleasure to have you over here, Senator.

A special thank you to Secretary Shulkin. Again that sounds very good, and we appreciate you being here. We also have the inspector general and the GAO as well as the Committee Members who are here, the VSO's who sit behind you, and the American public, all who have the same issues and the same goal: the highest quality care in the most timely manner for our veterans. So I am grateful to each and every one of you.

Last Congress we heard from health care and veteran policy experts at VA, including Secretary Shulkin, our veterans service organizations, the independent assessments blue ribbon panel, and the commission on care about how we should shape the VA of the future. Now it is time to get to work, together, to make some decisions, pass some legislation to ensure our veterans receive the health care they deserve.

One of this Committee's highest priorities is to ensure that veterans receive the highest quality health care in a timeline manner in a safe environment, this includes care at the VA medical facilities and through community health care providers. I think we can all agree that care in the community must be utilized so that veterans do not have to wait too long or travel too far to receive care. However, from listening to our veterans and constituents who are still waiting too long to receive care, we need to make some changes to the Choice Program.

Our witnesses, the inspector general, and the GAO will testify to survey and audit data that back up what our constituents have been telling all of us: veterans are still waiting too long for community care and in many cases have been forced to manage care on

their own. As Dr. Roe said, it should never take 80 days to get an appointment in the community. Veterans in need of mental health care and our elderly veterans should not be struggling to make their own appointments and coordinate complex care.

Care decisions should be made between the doctor and the veteran, and the VA should be there to make sure the veteran gets a timely appointment, make sure a doctor has a health care record to treat the veteran, and make sure the veteran is not stuck with a huge medical bill after seeing that doctor.

As VA moves forward with its community care consolidation plan, I hope we can take some of the lessons we learned from Choice. We need strong leaders at the VA hospitals who are committed to putting the plan in place. Our VA facilities were responsible for filling in inadequate community care networks under Choice and providing the staff to support this new program. They should be involved in this new community care plan every step of the way.

We need technology to support our providers at the VA and our community providers treating veterans. This requires the VA to have a modern electronic health record and an IT system to reduce the time it takes for VA to coordinate care and process claims. VA's current IT system, or lack of IT systems, to support care coordination, are contributing to delays and increasing workload for staff, who are manually processing them.

To get this plan right, this will cost a significant amount of money. Our President has said he is committed to increasing funding for our veterans, but this does not mean the VA gets a blank check to continue programs that are not working, or that this money should all go to community care when veterans need the specialty care and coordination that only the VA can and should provide. This also means the VA must be able to better forecast the resources and staff it to provide veterans the care and the facilities and through its network of community providers.

Tomorrow we will be marking up legislation that will allow for the remaining Choice Program funds to be spent. Along with this, I think we have come to a bipartisan agreement that VA should be billed first before a veteran is billed for receiving community care and that community providers should be able to have access to veterans' medical records. This was a bipartisan agreement working with experts, and I applaud Dr. Roe and his folks for making this happen.

I hope that we can continue working together and make decisions that move forward to improve health care for our veterans and be good stewards of our taxpayer dollars.

Thank you, Chairman Roe. And I yield back.

The CHAIRMAN. Thank you very much. It is my pleasure to welcome a fellow veteran, American hero, and our colleague from across the Capitol, the Honorable John McCain, Senator from the great state of Arizona—

Senator MCCAIN. Well thank you Chairman Roe and—

The CHAIRMAN [continued].—We thank you for your service both in uniform and in the Senate on behalf of our servicemembers, veterans, and their families. I appreciate your willingness to be with

us this evening to talk about a topic that I know is a very personal and passionate one for you and for all of us.

You are now recognized for 5 minutes, Senator McCain.

STATEMENT OF JOHN MCCAIN

Senator MCCAIN. I thank you very much, Chairman Roe and Ranking Member WALZ. And thank you for your kind words.

Mr. Chairman, I am one of those whose number of landings does not match the number of take-offs. And I thank you for allowing me to be here. I would like to submit my full statement for the record, and I will try to be brief, since it is past my bedtime.

The CHAIRMAN. Without objection.

Senator MCCAIN. I would also like to comment on my strong support for Dr. Shulkin as the head of the VA, and I think all of us have great respect for his work.

Mr. Chairman, yesterday the front page of the Arizona Republic reported that there was a \$2.5 million settlement to an individual named Steve Cooper, an Army veteran of 18 years. Steve waited for almost 2 years before seeing a doctor at the Phoenix VA. By the time he received care, his routine urology appointment had turned into a diagnosis of terminal cancer. Everyone in this room has heard a similar story. It is not acceptable, it needs to be stopped, and I want to thank every Member of this Committee for their dedication to our veterans and to make sure that never again is there another Steve Cooper, who served his country with honor and then, because of a failure to get an appointment, is terminally ill.

He wasn't alone in his need for care. In 2014 our country was shocked to learn that Steve was one of 15,000 veterans standing in line for care in Phoenix, 3,300 of whom were urology patients. This disgrace served as a catalyst for the Veterans Access Choice Accountability Act. It created the Veterans Choice Program, which has enabled veterans to see providers in the community for their health care needs. More than 7 million appointments with community providers, for everything from diagnostic tests and urology screenings, to lifesaving heart and cancer treatment has been a result. There has been significant progress improving veterans health care. We have a long way to go to change the status quo plaguing the VA, and that is why I know none of us will abandon our effort to provide choice and flexibility in veterans' health care and why we must continue the hard work of refining and improving the Veterans Choice Program.

We need, as you mentioned Mr. Chairman, to reauthorize the Veterans Choice Program, which was set to expire in a few short months. If we let the program lapse, hundreds of thousands of veterans will lose their ability to visit a community provider, the VA system will once again become overwhelmed.

I come from a rural State. Members of the Committee come from large and small States. I don't want to have a veteran to drive for 50 miles or 40 miles in order to go to the VA, when he can go to a local area health care provider. It isn't any more complicated than that.

Could I say that the Choice authorization expiration is approaching, I understand the VA already has begun limiting care under the Veterans Choice Program for veterans whose treatments would

extend beyond August 7, 2017. I think that lends urgency to your action.

I am concerned that veterans nationwide may encounter significant lapses in care if we don't act quickly. The outcome is not only avoidable, but it is unacceptable, and we in Congress must act. Today I was pleased in the Senate side, we are the place where the snobs reside, we took a critical step forward by joining Senate Veterans Affairs Committee Chairman Johnny Isakson, Ranking Member John Tester, Senator Jerry Moran and others to introduce the Veterans Choice Program Improvement Act, companion to what you are doing, Mr. Chairman, you and the Members of the Committee.

Let me be clear. No one is advocating that we privatize the VA. Many veterans are satisfied with the VA, known for providing superior specialized treatment in the areas of mental health, post-traumatic stress disorder, and traumatic brain injury. At the same time, we can't afford to go back to the pre-scandal days when a VA bureaucrat had the final say on where and when a veteran received care. Such thinking was what resulted in nearly 15,000 veterans standing in line for care in Phoenix.

I know this Committee agrees, as does Secretary Shulkin, and I look forward to working with all of you and my colleagues in the Senate to extend the Veterans Choice Program and continue to keep faith with our Nation's veterans.

My dear friends, the world is in turmoil, and I believe that we will be sending our young men and women into harm's way in a lot of places in the world for years to come, and they will be veterans and they will come home someday. And I believe that the work that you are doing is the Lord's work, and because you are committed, as all Americans are, to giving the veterans the care that they need and deserve and they earn by defending this Nation.

I thank you for allowing me to appear before you. God bless.

[THE PREPARED STATEMENT OF SENATOR JOHN MCCAIN APPEARS IN THE APPENDIX]

The CHAIRMAN. I was going to thank Senator McCain, but he got out of here too quick. So, I didn't get a chance to do it.

I now invite our second panel to the witness table, where I am honored to welcome the newest Secretary of Veterans Affairs, who will be testifying for the first time in his new role, Dr. David Shulkin. And I certainly enjoyed, with the Ranking Member, being at the White House during your swearing in with your lovely family.

Secretary SHULKIN. Thank you.

The CHAIRMAN. Mr. Secretary, thank you for being here, and congratulations once again on your confirmation. One hundred to zip, I might add. I look very much forward to working with you, and beginning with tonight's hearing.

The Secretary is accompanied tonight by Dr. Baligh Yehia, the Deputy Under Secretary for Health and Community Care. Thank you for being here. Also, finally we are also joined by the Honorable Michael Missal, VA Inspector General, and Randy Williamson,

Health Care Director for the Government Accountability Office. Gentlemen, thank you for joining us tonight.

Secretary Shulkin, we begin with you. You are recognized for 5 minutes.

STATEMENT DAVID J. SHULKIN, M.D.

Secretary SHULKIN. Great. Good evening, Chairman Roe, Ranking Member WALZ. Members of the Committee. Thanks for being here so late. And thank you for this opportunity to discuss community care.

I also did want to thank Senator McCain, but he ran out so quick, for his leadership. I couldn't agree more with him that we have to act now to ensure that our veterans have timely access to the care that they need.

I also just wanted to offer my condolences tonight to the family of Dr. Thomas Starzel. He was a World War II Navy veteran and the father of modern transplantation, who worked in the VA and with veterans for over 50 years, and conducted the very first liver transplant at VA in 1963.

As you know, VA has provided community care to veterans for over 70 years. Since August 2014, we have also provided care through the Veterans Choice Program, and we appreciate your support in providing this legislation and funding to better serve our veterans. As directed in the law, VA implemented this program in 90 days nationwide. That is unprecedented for a program of this scope and complexity. And because of the design of the law and this quick implementation, we did run into challenges, many of which are going to be identified tonight in the evaluations by the GAO and the VA inspector general.

But since then, the Choice Program has evolved. We have worked with Members of Congress on four different amendments and with contractors on over 70 different contract modifications to improve access and efficiency, and as a result of these improvements, shortcomings identified in both the GAO and IG reports are now outdated. Choice is not the program it once was that these evaluations were released. I call it a living, growing program.

Since the start of the program, over 1.2 million veterans have received some community care. A million appointments in fiscal year 2015 now has increased to 5.5 million in fiscal year 2016. Even with these improvements and increases, we have much more work to do. We are not satisfied with it.

Our overarching concern is that veterans have access to high quality care when they need it regardless of whether it is in a VA facility or in their communities. Our goal for VA community care is to deliver a program that is easy to understand, simple to administer, and meets veteran needs. We know we are not there right now.

Both VA and community care are critical. Veterans rely heavily on both. Despite the large increases in the use of Choice, only about 5,000 veterans use the Choice Program as their sole health care provider. The overwhelming use both VA and Choice. And as, you know, many veterans prefer only to use the VA.

VA looks forward to continuing to partner with Congress to address the requested budget and legislative change, including pro-

vider agreements, making VA the primary coordinator of benefits and recording obligations to the time of payment. We have worked with veterans, community providers, VSOs and other stakeholders in the past, and we are going to continue to seek their input moving forward.

However we do need your help. The Veterans Choice Program is going to expire in less than 6 months, but our veterans' community care needs will not expire. This looming expiration is a cause for concern among veterans, providers, and VA staff, and we need help in eliminating the expiration date of the Choice Program on August 7, 2017, so that we can fully utilize the remaining Choice funds. Without congressional action, veterans will have to face longer wait times for care.

Second, 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 modernized and revised community care program must have seven key elements: first, maintain a high performing integrated network that includes VA, Federal partners, academic affiliate and community providers.

Second, increase choice for all veterans, starting with those with service-connected conditions.

Third, ensure that enrolled veterans get the care they need closer to their homes when appropriate.

Fourth, optimize coordination of VA health care benefits with the health insurance that an enrolled veteran already has.

Fifth, maintain the affordability of health care options to the lowest income of enrolled veterans.

Sixth, assist in coordination of care for veterans served by multiple providers.

And last, apply industry standards for performance quality patient satisfaction, payment models, and health care outcomes.

We look forward to working with Congress and other stakeholders to enact these changes for veterans. And within 6 months, we hope to present a plan, although we are still early in developing this. We actively are seeking input from VSOs and veteran advocates, and will continue to do so as we move forward.

We know our number one priority is to provide veterans access to the high quality care they have earned, in a VA facility, or as close to home as possible, in the communities where they and their families live.

Thank you for this opportunity to be before you today, and I look forward to any questions.

[THE PREPARED STATEMENT OF DAVID J. SHULKIN, M.D. APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Shulkin.

Mr. Missal, you are recognized for 5 minutes.

STATEMENT MICHAEL J. MISSAL

Mr. MISSAL. Mr. Chairman, Ranking Member WALZ. and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's work concerning VA's Choice Program and the future of VA's Community Care program. My written

statement includes details of our extensive work in this area, and I invite your attention to those matters.

For years, VA has relied on non-VA programs to help it carry out its mission of providing medical care. Today VA's purchase care programs include Veterans Choice Program, patient-centered community care, individual authorization, and other non-VA care programs. We have reported in our audits, reviews, and health care inspections, and discussed in hearings, the challenges VA faces administering these programs.

In October 2015, VA provided Congress with a plan to consolidate all VA's purchase care programs into VA's Community Care program. Under consolidation, VA continues to have problems determining eligibility for care, authorizing care, making accurate payments, providing timely payments to providers, and ensuring the necessary coordination of care provided to veterans outside the VA health care system. Without improvement in these areas, these issues will continue to be obstacles to ensuring veterans receive timely access to quality care.

To increase the program's overall effectiveness, VA and Congress must understand the historical barriers and control weaknesses that have plagued VA's purchase care programs and ensure they are adequately addressed in future purchase care programs.

With respect to the Veterans Choice Program, we have recently completed audits and reviews concerning the Choice Program, and our findings have substantiated problems with authorizing and scheduling appointments, consult management, network adequacy, and timeliness of payments to providers. Moreover, our hotline has received hundreds of contacts about the Veterans Choice Program. Most of these complaints were about appointments, scheduling, referrals, authorizations, and consults.

We also identified issues in the Patient-Centered Community Care program. The PC3 program is a VHA nationwide program that provides eligible veterans access through health care contracts to certain medical and mental health services. The PC3 program is used after the VA medical facility exhausts other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic and accessibility, or other factors.

We published a series of five reports on PC3 in fiscal years 2015 and 2016. We reported that the PC3 program, prior to including the Veterans Choice Program, did not achieve its estimated cost savings, provide timely access to care, or ensure that contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements.

In addition, we reported that PC3's inadequate provider network contributed significantly to VA medical facilities' limited use of PC3, and that PC3 contracts were not adequately developed and awarded.

A theme that was clear from our work was that VA clinical and support staffs were dissatisfied with PC3 in such areas as authorizing payer, scheduling appointments, and veterans waiting for care. These are some of the same issues we hear today about the Choice Program.

In summary, our audits, reviews, and inspections have highlighted that VA's has had a history of challenges in administering the purchase care programs. Veterans access to care, proper expenditures of funds, timely payment of providers, and necessary coordination of care are at risk to the extent that VA lacks adequate processes to manage funds and oversee program execution.

While purchasing health care services from community providers affords VA flexibility in providing expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. We will continue to provide significant oversight of VA's Community Care programs.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee may have.

[THE PREPARED STATEMENT OF MICHAEL J. MISSAL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

And Mr. Williamson, you are recognized for 5 minutes.

STATEMENT OF RANDY WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairman Roe, Ranking Member WALZ, and Members of the Committee.

In August 2014, Choice legislation was enacted for the express purpose of providing more timely health care access for eligible veterans. Currently, however, VHA has established a cumbersome bureaucratic Choice appointment scheduling process that sometimes does not provide timely health care access for veterans.

This process allows up to 81 days for the veteran to receive routine care from the time the VHA provider determines a veteran needs care, but in many cases, documented by GAO, the VA Office of Inspector General, and the press, wait times have been even longer for those veterans who have opted into the Choice Program.

For example, one of the VA Medical Centers we visited referred a veteran to the Choice Program for maternity care since VA Medical Centers do not offer this care. VA confirmed her pregnancy at 6 weeks, but waited almost a month and a half before sending an urgent referral to the VA's third-party contractor, who was responsible for making a prenatal appointment for her. It took another 2 weeks for the contractor to attempt to make an appointment for her. At this point, she was 15 weeks pregnant. Finally, when she was 18 weeks pregnant, almost halfway through her pregnancy and still without an appointment, she made her own appointment with the Choice provider. There was no way to know whether this case or cases like these are typical, because VA has no reliable data to measure how long the entire process takes.

As the current Choice Program is slated to sunset in August 2017, and the Congress is considering proposals to reauthorize what has been referred to as Choice 2.0 program, VHA faces daunting challenges that must be addressed.

One major challenge involves streamlining its current appointment scheduling process. Currently, both the VA Medical Center staff and third-party contractors are involved in this process, but

in the Choice 2.0 program, VA is now considering, VA Medical Center staff would perform all of the scheduling and contractors would bill provider networks and pay claims.

A key to achieving a streamlined appointment scheduling process is having an up-to-date and user friendly IT capability to help process the millions of Choice referrals linked with community providers to schedule appointments and connect with both the providers and the contractors to transfer medical records and process claims. VA is in a very early stages of procuring such an IT system. This will be a complex undertaking, one that will likely take years, not months, to become fully operational.

Another major challenge is establishing a robust network of community providers who can offer veterans the services they need. This has been somewhat problematic through much of the current program's almost 3-year implementation, especially in rural areas.

Finally, substantial resources will likely be needed to carry out Choice 2.0. Resources needed to fund IT upgrades and new applications for Choice are largely unknown but could be costly. Proposed changes in Choice eligibility requirements, such as eliminating 30-day, 40-mile requirement for eligibility, could potentially greatly increase the number of veterans seeking care through community providers and drive costs up considerably.

Also, if medical center staff begin scheduling all appointments under Choice 2.0, as VA currently envisions, hiring more VA staff will likely be costly and tediously slow. Already since Choice was established, VA Medical Center staff devoted to helping veterans access nonVA care have increased three-fold or more at many locations. VHA has not fully analyzed the cost or feasibility of increasing staffing at its medical centers to schedule Choice 2.0 appointments.

VHA is proceeding down the path toward its vision of 2.0, and as it does so, it needs to do so thoughtfully and carefully with goals that embody timely access for veterans to quality care and in the community at a reasonable cost.

Achieving these goals will require a clear approach derived from data-driven analyses of the benefits and costs of various proposals, a comprehensive action plan and roadmap for successfully implementing Choice 2.0, including specific timeframes and resources needed, and a robust system to measure performance, including wait times, that can be used to identify program improvements and hold VHA staff accountable for delivering timely services to veterans.

This concludes my statement.

[THE PREPARED STATEMENT OF RANDY WILLIAMSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Williamson.

I will now yield to vice-chair, Mr. Bilirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Thank you, Mr. Secretary. I appreciate the entire panel for testifying this evening. Thank you for your service to our true American heroes. I look forward, Mr. Secretary, to working with you on your role, and I am hopeful that together we can find the right balance, the entire

Committee, the VA in providing both VA and community care to our Nation's true American heroes.

We have spoken about credentialing private providers who desire to see VA patients as VA providers in the community. How do you think we can best equip these providers to understand the nature of the wounds, both visible and invisible, our warfighters incur during military service, and how do we direct private providers interested in providing service for veterans through Choice that are currently not qualified providers in the VA health network?

Secretary SHULKIN. Well, thank you, Congressman. This is a big challenge for us. Our studies have shown that the lack of military competency among community providers is quite significant. In the case of mental health providers, we have found that only 13 percent of community mental health providers have an adequate sense of military competency to be able to perform the right type of psychosocial counseling.

VA is very active in trying to work with its community providers, and that is why we are trying to develop a core network of providers so we can go out and provide education and do it through webinars, we do it through face-to-face academic encounters as well. We believe our Federal partners, Federal health care providers and our academic partners in particular are very eager to increase these relationships with us and have the military competency that we know we need.

Mr. BILIRAKIS. How do you speed up the process? I mean, we advertise the Choice Program when we talk to our constituents, you know, and in a lot of cases, it is not working. The wait times are too long and, you know, they kind of get disgusted. And they deserve the best health care, the best timely care.

So, I mean, what is going wrong? How can we fix it? I know we talked about the third-party administrators, what have you, but I hear this on a daily basis—

Secretary SHULKIN. Right.

Mr. BILIRAKIS [continued].—and it's unacceptable to me.

Secretary SHULKIN. Congressman, I hear it too. I travel around the country. I get letters from all of you and from veterans directly.

We are now embarking on listening sessions with our veterans groups to make sure that we have a good, comprehensive sense about what they believe the solutions are so we can design a system that works for them. And we are eager to continue our dialogue with all of you, to get your ideas, but here is what we do know. The system was designed, it was too complex and too difficult to maneuver.

Mr. BILIRAKIS. I will agree with that.

Secretary SHULKIN. And so we have proposed—that is why we have 70 contract modifications, we have issued 23 letters of correction to our TPAs, we have come back to you four times, you have helped us change the law, but we have more that we need to happen.

We have identified four specific changes to the program that we need now that we hope will be considered, including provider agreements, flexibility in funding, the ability for us to obligate our funds when we use them, and to be able to coordinate other health

insurance in a way that makes sense for veterans so they are not finding themselves getting billed inappropriately.

And so we want to work with you to get this right. And we believe right now we have to extend the Choice program, because veterans once again are getting caught in the middle, but we want to come back and we want to get this program so it works well.

Mr. BILIRAKIS. Very good. Thank you.

Mr. Williamson, GAO found that in some cases clinically indicated dates were changed by VA staff. As you all know, the falsification of wait time data is what led to the 2014 Access Accountability Act and the creation of the Choice Program in the first place.

Through your investigative work and interviews, why were the clinically indicated dates changed by the VA staff? What reason did they give? And what response did you receive from VA community leaders—care leaders when you brought this to their attention?

Mr. WILLIAMSON. That is an excellent point, and one that I find quite disturbing, because out of the 196 c, in 60 cases, those clinically indicated dates were changed. We tried to get to the bottom of finding out why, but we could not. You know, one could only surmise what happened.

As you know, VA policy only allows the provider, the clinician who first sets that date to change it, and it is not supposed to be changed because VA couldn't deliver the care in 30 days. So we don't know, but it is a doggone good question.

Mr. BILIRAKIS. Okay. I have got a couple more questions, but in the interests of time—

The CHAIRMAN. The time has expired.

Mr. BILIRAKIS. Yes.

The CHAIRMAN. The time has expired.

Mr. BILIRAKIS. Thank you. I yield back.

The CHAIRMAN. Mr. WALZ. you are recognized for 5 minutes.

Mr. WALZ. Thank you, Mr. Chairman. And again, thank you all for being here, again, that commitment that all of us have to make this work.

Secretary Shulkin, you talked about this, the complexity of this program and certainly the stepping it up, the provider networks and all that. In your assessment, was the complexity due to how Congress wrote it or the implementation between VA and the third-party providers?

Secretary SHULKIN. I think there is enough blame here to go around for all of us, so I would say—

Mr. WALZ. But certainly—

Secretary SHULKIN. Yes.

Mr. WALZ [continued].—no one's intent to was to that.

Secretary SHULKIN. Right.

Mr. WALZ. In other words, we wrote it, sent it out, to try to make it go there. Is there a way of think about this in 2.0? Do you feel comfortable we are all working together that we are very clear on our intent that we are very clear on how we want it to be delivered?

Secretary SHULKIN. We have learned a great deal. You know, I come from the private sector. I will tell you, we would not have designed the system quite as complex, but if you remember, the man-

aged care industry, which developed over the last two, three, decades, also at one point was extremely complex and not user friendly, with gatekeeping and pre-authorizations and all that, and that industry learned.

We had 90 days to do this. We know TRICARE did this over a period of years. We know the system is working much better today than it did when it started in 2015. So we have all of that knowledge together that we can go back and make this system work for veterans. I am absolutely confident we can do this.

Mr. WALZ. Are you concerned, and I share the GAO's concern on this, that I think the technology interface piece is going to be critical, and if it is not stood up when you try and stand up your community-based coordination, that seems to me that we are setting ourselves up for failure again.

Secretary SHULKIN. Yeah. I couldn't agree more. We are putting 35,000 schedulers in the VA system in a position where they have to be making judgments about how to record their appointments. That system doesn't work. We are going to have to do this through technology.

Our new scheduling system that is being rolled out actually records this in a technologically automated way, so it takes the scheduler out of having to make those decisions.

Mr. WALZ. What do you think the best thing to come out of Choice was?

Secretary SHULKIN. Well, I think we helped a lot of veterans. I think that is the—that was the intent. I applaud Congress for doing this. I think it was a national emergency, and I think it was the right thing to do, and I think we all tried to get it up as soon as we possibly can. And we have helped millions of veterans, 7 million appointments have been scheduled, and those are veterans who needed that care and shouldn't be waiting for care. So I think it was essential.

Mr. WALZ. We were discussing some of the positives on this. And one of the things we mentioned was do you think we got a more honest, transparent look at real wait times, that they were no longer hidden because of Choice?

Secretary SHULKIN. I think one of the things that surprised us all, even when we began to use Choice, the wait times grew longer. And what that was saying is there was a demand from our country's veterans for services that we weren't adequately addressing or meeting. And I think it exactly did that, which it showed us what the real demand is, and that gave us a look into this now.

Mr. WALZ. Because, I am curious about that. And for the IG, Mr. Missal, you concluded Choice did not reduce wait times for veterans in VISN 6. I do not know if that can be extrapolated to all. Usually that is the case. Do you concur with Dr. Shulkin that increased care and explosion that maybe came out of that could account for that in addition to Choice being complex?

Mr. MISSAL. Yes, I think it could. What we saw in VISN 6 obviously is limited to VISN 6, but it is not inconsistent with what we saw in wait times both with what the GAO found and some other work that we did.

Mr. WALZ. All right. And to the GAO, Mr. Williamson, what is it going to take to get them off the high risk list? What can they do right now to get off the high risk list?

Mr. WILLIAMSON. Well, I think one of the major things, of course, is to improve their oversight and accountability. You know, I think one of the early steps is to have also a detailed action plan that talks about timeframes, talks about resources needed, and so on.

It is just not a simple matter of addressing GAO recommendations. There are five different criteria for getting off the list, and certainly leadership commitment is among them. I think VA has, you know, offered leadership commitment on this matter.

Mr. WALZ. Over my time with this, that has been my experience, that the one constant amongst facilities that succeed or do not succeed is that leadership from the top, and that accountability, talk about personnel accountability, whether it be acquisition accountability, all of the things that go to that, but I would encourage, and Mr. Secretary, I know it is your desire too, whatever you need to help us do that, restoring that faith, expanding that care, we all have the same mission, and I think this community-based initiative is going to be critical for what the VA is going to look like in the future.

Secretary SHULKIN. Yeah. Congressman, I just want to add that last week I went over, I brought my team over to meet with Mr. Dodaro, who heads up the GAO. He and his team were very open. I told him it is my commitment to make significant progress to get us off that list, and that is my commitment.

Mr. WALZ. I appreciate that.

I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. I thank the gentleman. Mr. Coffman, you are recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

I guess for the GAO representative, on the—so in 2014, we had the appointment wait time scandal and we passed the Choice act.

Mr. WILLIAMSON. I am sorry, Mr. Coffman. What was that?

Mr. COFFMAN. I am sorry. In 2014 we had the appointment wait time scandal and passed the Choice act.

Mr. WILLIAMSON. Right.

Mr. COFFMAN. Because at that level of the VA in terms of those who did the appointments, were responsible for the appointments, essentially cooked the books to receive cash bonuses, and left veterans a number of veterans without treatment on the secret waiting list, starting with the Phoenix VA, but we found it in other parts of the VA system.

And so I understand the intention now is to get it—give the appointment—get the appointment process back to those same employees. How does that make sense?

Mr. WILLIAMSON. You know, I really—I really don't know on that one. It is a very difficult situation to deal with, I think.

Mr. COFFMAN. Mr. Shulkin, how does that make sense, Dr. Shulkin?

Secretary SHULKIN. Well, look, we have a choice and this is a choice that we are seeking feedback on. We know that when we gave it to a contractor, when we gave it outside VA, that we had a lot of problems with that. And so what we have done in 54 of

our medical centers is we have actually brought the TPA staff back in working with our medical centers.

So whether it is a combination of outside and inside people or whether it is VA staff that—under new leadership, new policies, no incentives to cook the books, as you said, and really strong oversight, which is what the GAO is recommending, we believe the most important thing is to meet the veterans' needs, and that is what we are committed to doing.

Mr. COFFMAN. I just have a question, because it would seem to me to be—so VA couldn't manage its own employees, it doesn't surprise me that it couldn't manage the contract with the appointment process, and so I am not sure that we are really making progress here.

Secretary SHULKIN. Well, Congressman, I—listen, the very, very best solution is to let veterans schedule it themselves with these self-scheduling applications, and we are working on that as well.

So my feeling is, and I share your concern, I do not want to go backwards on this, and so we are going to have to approach this in multiple avenues and ultimately make sure that we get the most direct way for a veteran to get an appointment.

Mr. COFFMAN. I was talking about this, talking to some of my health care providers back home, and the PC3, these PC3 agreements came up, where the VA has had—in fact, prior to the Choice Act had the ability to have direct negotiation with providers and arrive at an agreement to refer veterans directly to those facilities.

Every agreement is negotiated separately, and it takes a very long time to negotiate these agreements. So it doesn't seem like there is a boilerplate framework for that, yet we have the Medicare system with its well-established reimbursement rates. Why don't we simply use that in these provider agreements?

Secretary SHULKIN. Well, one of the areas we have had great success on is in getting providers into our network. Today it is over 480,000 providers. TriWest, who is here today, 180,000 providers in their network. And because of the Choice law, we use Medicare rates, with some exceptions of rural areas.

So I think we are trying to simplify this. We have been successful at building the network. We don't do a lot of rate negotiation, because of the way that the law was written.

Mr. COFFMAN. On the Choice act, but on the PC3, why don't we use Medicare rates on PC3?

Secretary SHULKIN. We probably should. We want to move towards one set of rules. Maintaining two different systems with two different rules, two different fee schedules adds to administrative complexity, confuses our providers. So I am all in favor of moving towards the simplified single system.

Mr. COFFMAN. Do you need legislation for that or can you—

Secretary SHULKIN. We do. We do. We have asked for, we call it funding flexibility. Now, maybe that is not a good term, but we are looking—

Mr. COFFMAN. That is different.

Secretary SHULKIN. Yeah.

Mr. COFFMAN. In terms of specific—

Secretary SHULKIN. Yes.

Mr. COFFMAN [continued].—that is the consolidation issue.

Secretary SHULKIN. Yes.

Mr. COFFMAN. You raised it, that is separately. What we are talking about here is do you have the authority to use—I would assume you do. If you have the ability to negotiate the rate structure and doing it separately with each particular entity on the PC3, I would assume that you do have the ability to say this is what we are going to do, we are going to do—we are going to do Medicaid reimbursement, period, on the rate—

Mr. COFFMAN. I don't know if that takes legislation.

Secretary SHULKIN. No. On the rate issue, I agree with you. On the rules that we have to do to manage these separate programs, we do need legislation, but there is some flexibility in there like you are saying, yes, sir.

Mr. COFFMAN. Mr. Chairman—

The CHAIRMAN. The gentlemen's time has expired. Mr. Takano, you are recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman. I have long said that the lack of continuity at the VA is a challenge to the organization, and I am glad we are joined by Secretary Shulkin tonight and many of the other familiar faces at the table. We need the institutional knowledge that Secretary Shulkin and his team provide to make the long-lasting improvements at the VA.

Now, as long as—now, as we have heard tonight, the Choice Program was a temporary fix to improve veterans' access to care. Unfortunately, as we have also heard tonight, that fix still resulted in long wait times, confusion about payments, and administrative headaches for veterans and staff at the VA.

It is our task now to come up with a long-term solution that gives veterans the care they deserve, and strikes a balance between care at the VA and care in the community, and keeps the VA's central role to improve care and coordination.

I would like to first turn my attention to staffing levels at the VA tonight, Mr. Secretary, and how that has impacted the program. Secretary Shulkin, the IG found that in VISN 6, the nonVA care coordination staff workload increased over 200 percent since the implementation of Choice and that VISN 6 did not provide sufficient staff to meet the growing work requirements, causing authorization delays and insufficient oversight of the contract with the third-party administrator.

Are these positions exempt from the Federal hiring freeze and has VISN 6 hired more staff?

Secretary SHULKIN. Yeah. Congressman, this was one of those unintended consequences that we learned. We thought if we outsourced all of our care to a third-party administrator, the workload would go down. In fact, as the IG found, our workload went up, because we had to be making more calls in chasing down veterans. So we have been in catchup mode and we have been adding to those staff.

The clinical staff are exempt from the hiring freeze. We have made that request, and that was granted. Business staff would not be at this point. So we sort of have to separate out those two functions. And we are developing staffing guidelines and staffing grids to be able to make sure that we are staffing up to meet the vet-

erans' needs, but you are absolutely right. This caught us by surprise.

Mr. TAKANO. But the hiring freeze and the fact that some of your VISN staff aren't exempt, that has complicated your ability to do your job. Am I not correct?

Secretary SHULKIN. Well, we have made the request of the White House of 37,000 clinical staff and support staff that we think are essential for patient safety. That has been granted for us. We are closely looking at the additional, approximately 8,000 staff, that we look at almost every week, to see whether they are impacting our ability to deliver care, and when we do find that they are impacting our ability to deliver care, then we are making those additional requests. We just made some additional requests.

Mr. TAKANO. But are the VISNs across the country hiring more staff to reduce authorization of processing times?

Secretary SHULKIN. I am going to—I am going to let you answer that, Dr. Yehia.

Dr. YEHIA. Yes. We are seeing an increase in staff across the country, but I don't want us to miss the key point. This process is too complicated. The GAO report and the IG report both showed that our traditional Community Care program works much better, and so it doesn't make sense to keep putting staff in a system that needs to be fixed.

So I hope that when we work on Choice 2.0, we make it simpler to administer than what it is today.

Mr. TAKANO. Well, I also believe the VA has a central role to play in regards to care coordination that improves patient outcomes. Under VA's plan to consolidate Community Care, how does VA plan to address potential fragmentation of care between VA and community providers?

Secretary SHULKIN. Why don't you take that.

Dr. YEHIA. Care coordination is critical. We are developing an integrated system, so the more integrated we become, the more we have to coordinate care.

We are testing today processes across the country that allow doctors to access our medical record completely for every lab, every radiology test. We want to make sure that they get the information they need to take care of veterans within the community. So we are front and center focused on this. We know we need to do more coordination when we do more community care.

Mr. TAKANO. Yeah. Well, one study cautioned that veterans being seen in two different health systems, the VA and the care in the community with different electronic records and different policies, procedures, face risks from a dual system health care that should not be ignored. What do you have to say about that?

Dr. YEHIA. Well, that is exactly why we want to get them read access only to our medical records so they don't repeat unnecessary tests, they don't order drugs that should not be ordered, so we are trying to prevent that by giving them full access to a record for those patients that they are seeing.

Mr. TAKANO. Mr. Chairman, my time has expired.

The CHAIRMAN. I thank the gentleman for yielding.

Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here. Mr. Secretary, congratulations.

Secretary SHULKIN. Thank you.

Mr. WENSTRUP. And welcome back, if you will.

You mentioned earlier about the military competency of the providers, and I think that is important, especially in certain areas, and you specifically mentioned mental health and as it relates to PTSD, I am sure, and I could think of other areas like if you are treating TBI, the effects of agent orange, those types of things. What other medical categories have you identified where you feel there is a strong need for that level of competency?

Secretary SHULKIN. Well, you know, I think that the primary areas that we are thinking about are in primary care and mental health, and the primary care provider has to understand the full comprehensive nature of what it takes to support well-being.

And, you know, the example that I use is that when a veteran who comes back from conflict comes in and talks to their primary care provider or their mental health provider about an IED, and the response is, "What is an IED?," you know, you sort of lose all that confidence and trust. So we think that is important.

Mr. WENSTRUP. And I agree. And also there are other areas in health, things that are endemic to the area they served, they should be pretty well versed on those types of things, or at least know where to turn to for that.

Would you be in favor of the system allowing the primary care doctor, when working with the patient, to have the authority to decide who they can see in Choice, or Choice or not Choice? In other words, you know, you may need to see an ophthalmologist, but you may need to see one that specializes in glaucoma. So just because the VA has an ophthalmologist doesn't mean that that is the best one for you to see.

So the question is, would you be in favor of the primary care doctor being able to say, yeah, there is one here within the walls that you can see next week, but I need you to see the glaucoma specialist, and that is the referral I want to make, without having to jump through a lot of hoops.

Secretary SHULKIN. Yeah. As long as I state my conflict of interest that I am a primary care provider, yes, I do support that. You know, second-guessing our physicians and our providers is never a good idea. I would support that.

Mr. WENSTRUP. Yeah, and I think that a deterrent to recruitment too—

Secretary SHULKIN. Yes.

Mr. WENSTRUP [continued].—if that is the kind of system you have to operate in.

So just one last question. Solution to the delay in payment to providers. You know, the system is too complicated and you really going through two systems, as I understand it. Is that correct? And so the money is not flowing the way it should. So what would your recommendations be to solve that problem?

Secretary SHULKIN. Well, we are doing a number of things. First of all, before coming to VA, I spent my life trying to get paid by insurance companies, so I am a firm believer if you deliver a serv-

ice, I know you did too, if you deliver a service, you deserve to be paid for it.

Today we are at 83 percent of payments within 30 days. That is a lot better than we were, but not good enough. We need to have greater electronic claims. Today VA is at 63 percent electronic claims. We should be at 99 percent. And we are 43 percent above where we were this time last year. So we are making progress, but we still have more to go.

We have to automate more. And we are also looking at other options, including if it can be done better outside VA, we are looking at those options in our new RFP process.

Mr. WENSTRUP. And I appreciate that. And that is all I have. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I also want to say congratulations. I am delighted that you are at the helm of the VA, where the buck stops with you, but I can't think of a better leader, so thank you very, very much.

I think—you know, I think the GAO report, I think, identified very well where the chokepoints are in this process. And we keep talking about, you know, the process is too complicated and where we need to improve upon in the processes, et cetera, lack of controls and all of that.

But I think the underlying issue in all of this, to me, is our IT systems. It still feels like we are driving a Model T down an L.A. freeway trying to keep up with the Teslas and the BMWs. And I—you know, when I see this report and just, you know, even one step saying, if we don't reach the veteran by telephone, then we will send them a letter.

And it just is mind-boggling that we are still, you know, in sort of this bureaucratic maze that is just prolonging, and this report says it can prolong it up to 10 days in the process. To me it seems that is a no-brainer. Why can't we fix that, like, now.

But the area for all of the hearings that we have had, the area that I have the least confidence in is all of the automation and all of the IT that has to take place. And so I guess my question is, how do you alleviate my fears that we will always be as slow as an un-automated process will be, and how are you going to allay my fears that we are on this and we are going to get it right?

Secretary SHULKIN. Well, I don't want you to stop worrying until we actually do something to give you confidence that we have this right. I think I too, and many of you have shared your concerns that you have heard us make promises before in this area and failed to deliver on it.

I have come to the conclusion that VA building its own software products and doing its own software development inside is not a good way to pursue this and we need to—

Ms. BROWNLEY. Hallelujah.

Secretary SHULKIN [continued].—we need to move towards commercially tested products. If somebody could explain to me why veterans benefit from VA being a good software developer, then maybe I would change my mind, but right now we should focus on the

things veterans need us to focus on and work with companies who know how to do this better than we do.

So you are going to see that change in direction, and—but I don't want you to stop worrying about it until we can actually show you we do it differently.

Ms. BROWNLEY. Well, I am delighted to hear that answer. I think we all are. So thank you very much for that.

Mr. Williamson, do you have a comment to make with regard to kind of the statement that I just made and where the chokepoints are and improvement, and do you think this consolidation program is going to help to improve that process?

Mr. WILLIAMSON. Yes, as I said in my opening comments, I think IT is really a critical component. And I think Secretary Shulkin's willingness to look at commercially available off-the-shelf systems is a really good move. And I think, even with that, however, VA still has to integrate any new system with legacy systems, like Vista, and and also integrate the new systems with provider systems and the TPA systems. So it is not a slam dunk, but I think IT is probably the number one issue, I would say.

Ms. BROWNLEY. Thank you for that.

Mr. Williamson, the other thing that popped out at me in your report too, a very troubling aspect, was when you identified 88 returned authorizations that were found, these were veterans sent to Choice for appointments but then returned to VA for various reasons. Not only does this greatly increase the length of time veterans have to wait for care, but GAO was also unable to determine if 20 of those veterans received any care at all. They sort of got lost, seems like, in the system.

Mr. WILLIAMSON. Right. And we have shared those 20 names with VA so they can make sure that those veterans did get care they need.

Ms. BROWNLEY. And, Mr. Shulkin, in terms of rectifying that, is it rectified now within the system?

Dr. YEHIA. Yeah, we have looked at every one of those different cases and made sure that veterans got the care they need.

Ms. BROWNLEY. Thank you very much.

I will yield back, Mr. Chairman. Thank you.

The CHAIRMAN. I thank you for yielding.

And, Mrs. Radewagen, you are recognized.

Mrs. RADEWAGEN. Thank you Chairman Roe and Ranking Member WALZ. Delighted also to add my congratulations, Mr. Secretary.

Before I ask my question, I would like to just briefly highlight some of the different challenges American Samoa and the U.S. territories face regarding community care for veterans. While living on a tropical island in the middle of the Pacific Ocean may be pleasant most of the time, it also means our territories' veterans live far away from any fully equipped VA health care facility well outside the Choice Act's 40-mile range or other distance qualifiers—3,000 miles away, in fact.

Compounding this issue, small island hospitals like the LBJ Tropical Medical Center in American Samoa may not be sufficiently equipped or staffed to provide veteran care. This means our veterans cannot take advantage of the Choice Act to reduce their travel and wait times even if they wanted to.

Having said this, would anyone on the panel please tell us what the VA is doing or planning to do to ensure that our veterans, who would otherwise qualify for the Choice Act but do not have access to adequate nearby facilities, are receiving the care they need in a timely manner? And are there any other insights you would like to share regarding access to care for veterans in remote, rural areas?

Secretary SHULKIN. Well, you know, we have talked about this several times, and I appreciate and really acknowledge your continued advocacy on behalf of the people you represent. We know America Samoans are some of the most patriotic Americans that there are and that they serve at very, very high levels and they do deserve the very best that we can give them.

The challenge that we have, whether you are on a Pacific Island 3,000 miles away from larger islands or in other parts of rural America, are actually similar. And while we need health care professionals in those areas, we are not always able to get people to go to those areas.

So we are looking primarily at technological solutions, and we are looking at the use of telehealth, which we are doing across VA on a scale that no other health system in America is even approaching: 2.1 million visits, over 700,000 veterans getting access through telehealth services. And so we are looking at this very seriously about dramatically expanding its use to be able to support where we don't have health professionals.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Ms. Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman.

And thank you, Secretary Shulkin, for being with us. We are delighted to have you confirmed and get to work. And this is very big news that you have just announced about looking into an off-the-shelf IT program, and we hope we can move forward with you on that.

I too want to speak about rural America. I just had a VA roundtable in the northern part of my district in New Hampshire, and I just want to quote real quickly. A nurse, Caroline Jordan of Berlin, New Hampshire, she was there with her husband, and she just cautioned about all this care outside the VA. "I don't want to see the VA medical centers closed. I don't know where this VA Choice card will take us. My concern is that the bonding of brother and sisterhood will be lost. They won't have the symbols, the flags, the stories, the jokes, crying together, laughing together. I am afraid that will be lost."

And she was very eloquent. And I said I wish she could have come here to testify. But how can you reassure veterans across the country, as we move into this patient-centered care and the programs such as the one that we are about to test out in northern New Hampshire, the coordinated care program, which I am excited about, but how can we reassure our veterans that we won't lose the camaraderie of the Veterans Administration care?

Secretary SHULKIN. Yeah. This is a significant issue for us. This is not just the camaraderie, which we think is important, but these are the real expertise that we have in our VA health care system.

Remember, we have four missions. The clinical care is what we always talk about, but we also have an education mission.

We train more American health care professionals than any other organization in the country. We have research that is dedicated solely to the improvement of the well-being of veterans, and we also serve a national emergency preparedness role. So all four of these missions are very important to us.

I would just say two things: One thing is, we know from the Choice Program that only 5,000 of the several of more now than 1 million veterans have used the program chose only to use the Choice Program. So they are saying exactly what your constituent told you, which is the VA is essential and important to them.

But we are not going to allow this—the VA programs to be diluted. And one of the reasons why that is so important is that we need to modernize the VA system. Our lack of capitalizing the VA system in terms of the buildings, the equipment, the IT systems, could make it a noncompetitive system. But we are going to make sure that the facilities that are open are the best for veterans, and veterans are going to want to continue to get their care there. The community care program is a way to make sure that we supplement the VA in an integrated fashion.

Ms. KUSTER. Well, I think you have our bipartisan support about providing the access, but it was just a reminder on making sure we keep that veteran-centered focus that we all have.

I just want to speak briefly, I am the founder and cochair of our Congressional Bipartisan Task Force to combat the heroin epidemic. And I am very concerned about opioid use and substance use disorder, particularly in the context of opioids from surgery or high rates of opioid medication being used for pain management.

Could you comment on what is being done in the VA? And I would like to work with you going forward, and your team, to work on pain management techniques that would reduce the use of opioid medication and treat addiction and substance use disorders for our veterans.

Secretary SHULKIN. Yeah. We recognize and understand that this is a public health crisis not only in the VA but across America. The VA recognized this as a crisis in 2010 before there was a lot of attention across the general media, and we started a campaign with a number of strategies to reduce opioid use.

I am pleased to say we have reduced opioid use by 22 percent. We have done it by involving our patients. They now—patients have to use informed consent to start these medications. We do academic detailing to our physicians. We do use information systems to be able to prescribe, to be able to help remind providers of other alternatives. We build up complementary care. We coordinate with the State prescription data monitoring programs.

So we are doing a number of things, and frankly, places around the country are coming to us to learn how we have done this. So we would be glad to work with you. We think that there is much more to do. And developing research in alternative pain management strategies is clearly one of our priorities right now.

Ms. KUSTER. Terrific. We look forward to working with you. Thank you.

I yield back.

The CHAIRMAN. Thank you.

Chairman Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman.

And congratulations, Mr. Secretary. I look forward to working with you.

I am going to go down on a little bit of a different road. I am a little concerned, and the Department itself has estimated that it can treat and cure most of the remaining 124,000 diagnosed cases of hepatitis C within the next 3 years. Is it the VA's commitment that that timeline will be held to and that these will be treated regardless of the level of their liver disease or where they might be at?

Secretary SHULKIN. Yes. Thanks to the support from Congress, we were provided the resources to meet that timeline. I actually think we are going to beat it, but with one caveat. What we have learned is that our initial outreach is we were getting thousands and thousands of veterans to come in and to get treatment. We have a treatment, of course, as you know, that now cures more than 95 percent of hepatitis C, so it is tremendous medical advance.

The doctor to my right is one of those doctors. He is an ID doctor who does this in his clinical work at the VA.

Mr. BOST. Thank you.

Secretary SHULKIN. What we are finding now is—and if Dr. Yehia wants to comment on this—we are finding that we are now seeing less and less veterans coming in to get cured. There is a substantial number of veterans for a number of reasons, either psychological reasons or social reasons, who are not taking advantage of this care. And so this is now becoming a research question for us. How do we have to begin to approach people that are saying, I have a disease that may end up killing me, but I am not interested in the treatment?

And so I think we are going to beat your 3-year timeline, but there is still going to be a subset of veterans that don't want to come in and get care. And so I don't know if—

Dr. YEHIA. Dr. Shulkin is exactly right. We call this linkage to care. So we have effective treatments when people actually get in, but actually getting them through the door is now our biggest challenge. It is not actually offering them therapy.

We had the same thing when the HIV epidemic first started. We had really effective therapies. We couldn't get people in the door. So now we are figuring out how we do outreach, working with our homeless coordinators and other things to get people into the VA to get their therapy.

Mr. BOST. Is it a lack of understanding that the cure is there or is it something other than that? That is very shocking to hear that, that is why—

Dr. YEHIA. A lot of it has to do with kind of the social behavioral aspects of not only health care but of people's situations. So I think a lot of folks understand that there is therapy there, but are they ready to take that next step.

Mr. BOST. Well, thank you for the answer on that.

And I have one more quick question, actually a couple questions in regards to what we are wanting to do tomorrow. Okay? You

know, the importance of the extension that we are going to be working on in our markup tomorrow, what would happen if we didn't make that extension go past the August 7, and what would be the final cutoff if we don't get it passed?

Secretary SHULKIN. Yeah. Well, first of all, if we don't do this extension, this is going to be a disaster for American veterans. We are going to see the same situation that we saw in April 2014 that Senator McCain started out tonight with that we saw in Phoenix.

And so here is the timeline: We do need to do this now, as I think Chairman Roe referred to. Already today, veterans are not able to use the Choice Program because the law states that we have to obligate the funds now for when the care is going to be delivered. So a pregnant veteran who comes to us and says, I want to get care using the Choice Program, they no longer can because 9 months from now is past August 7.

But this is now beginning to happen with care that is multiple months in length, like oncology care and chemotherapy and other types of therapies. We have a chart that shows that when you start getting towards the end of April to May, this is where you are going to start seeing a large number of veterans not being able to get access to care, because episodes of care that we are used to, like hip replacements and other things, are generally 3 to 4 months. So we think the time is now that we need to act.

Mr. BOST. Okay. So—but what we are doing is not any intention to privatize or anything like that. This is just making sure that those people who are on the Choice Program, that we are moving forward to make sure that those services are provided.

Secretary SHULKIN. Not only that, but this is not going to cost any additional money. We are just seeking the authority to spend the money that you have already given us past August 7 of this year.

Mr. BOST. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Secretary Shulkin, when you first started as under secretary for VHA, El Paso, the community I serve and represent, was ranked worst in the country in terms of mental health care access for veterans in our community. And we were able to work together on a pilot program that we are implementing now in El Paso that allows the VA to focus on PTSD, TBI, military sexual trauma, those conditions unique to service in combat. And the doctors and providers in our community have stepped up to fill in the gap and care for those veterans and those other conditions that are not unique to service in combat. We also had the partnership of Texas Tech Health Science Center, and it is really making a difference. Our access to mental health care has improved markedly, and we are focusing on hiring those mental health care professionals.

I think the most serious crisis facing veterans in this country today and for this Committee is veteran suicide, which you now estimate is 20 a day. That is the best estimate that the VA can come up with. I am convinced that it is connected to access to mental health care. Can you talk a little bit about what you are proposing

and how that will impact the ability to access mental health care and reduce the number of veteran suicides in this country?

Secretary SHULKIN. Well, thank you for your leadership on this issue. You are always pushing us, and frankly, it is welcomed.

There is no other clinical issue that I am as concerned about or that has my attention than veteran suicide, number one, for sure. What we are doing now—and we are doing a lot—isn't enough. And so we are not satisfied, and we are continuing to look for new approaches to be able to address this issue. We are reaching out to the very best and brightest from the academic world and the community world to come in and say, tell us what else we can do, because we need to do something else. So stay tuned for that.

But I will tell you something tonight that may make more news than the IT news, and that is that—and I do want to thank Representative Coffman for this, because it was a program that I went to that he was at that proposed his bill that actually changed my whole view on this, so this is really his leadership.

We are going to go and we are going to start providing mental health care for those that are other than honorably discharged for urgent mental health. And we want to work with Representative Coffman on his bill on this, and we want to do as much as we can. But I don't think it can wait, and so we are going to start doing that now. I believe that is in the Secretary's authority to be able to do that.

So many veterans that we see are just disconnected from our system. That is the frustration. Of the 20-a-day, as you know, 14 are not getting care in the VA, and yet we have this great comprehensive mental health system. So we are going to do whatever we can. We want to work with you. We want to work with Representative Coffman, all of you, to try to get this—because it is a—it is unacceptable. I don't think anybody thinks it is acceptable.

Mr. O'ROURKE. I want to thank you for the decision that you have made in not waiting for Congress to force the Administration to do it and showing the leadership in getting that done. And I also want to put a plug in for your vet centers.

Secretary SHULKIN. Yes.

Mr. O'ROURKE. I visited one in Laredo, met with 20 Vietnam veterans. We know that that is the single greatest cohort that is being affected by veteran suicide.

Secretary SHULKIN. Yes.

Mr. O'ROURKE. And they have access to your VA medical center, but they really prefer being at the vet center where they have, essentially, group therapy facilitated by one therapist, and all of them swore to it, to a person.

Secretary SHULKIN. Yes.

Mr. O'ROURKE. Quick question: Page 17 of the GAO report says, "VHA cannot calculate average number of days that the medical centers take to prepare Choice Program referrals." Are you able to calculate that today? Do we have that number? What is it?

Dr. YEHIA. Yes, we are working on getting those numbers.

Mr. O'ROURKE. How long before you have that number?

Dr. YEHIA. We do have those numbers. The problem is that we want to make it automated so that it is easier to pull.

Mr. O'ROURKE. Can you share that with us? What is the average time?

Dr. YEHIA. We are happy to share that, yeah.

Mr. O'ROURKE. Can you do it right now?

Dr. YEHIA. I don't have it off the top of my head, but we are happy to share it.

Mr. O'ROURKE. I think when we are talking about wait times and we were reminded about the wait time manipulation scandal, we need to know real wait times and we need to hold you accountable for that. And we are not doing our job in an oversight capacity if we don't know the real wait time across all care delivery within the four walls of the VA or through a Choice provider. So how soon can I get that from you?

Dr. YEHIA. Tomorrow.

Mr. O'ROURKE. Okay.

Dr. YEHIA. Yeah.

Mr. O'ROURKE. And we will share that with the Committee. Thank you.

I yield back.

The CHAIRMAN. Thank you, Mr. O'Rourke.

Mr. Poliquin, you are recognized.

Mr. POLIQUIN. Thank you very much, Mr. Chairman, appreciate it.

Mr. Shulkin, congratulations. It is good to see you again, sir. And I just want to, from the bottom of my heart, thank you very much for all the great work you did coming up to northern Maine. And we really, really appreciate you reauthorizing that program such that our veterans in the most rural part of our State, one of the most rural parts of the country, can get their health care close to home instead of driving 5 hours with the snow blowing sideways in Aroostook County. So thank you very much.

And, Mr. Chairman, I didn't tell you this, but we recommended that Mr. Shulkin fly into Portland, Maine, and drive to Aroostook County, so by the time he got there, he was exhausted and he knew how rural our district was, but it paid off. And thank you very much, and congratulations, Mr. Secretary.

Mr. Secretary, I am very concerned about the claims processing part of your organization. I know you have a very big job. I understand that, sir. My understanding is that when claims are processed at Medicare, about 90 percent of the claims to pay our providers never touch a human hand. And then over at—for the TRICARE program rather, about 75 percent.

But here is what I am concerned about, sir, is that this is the accounts receivable over at Eastern Maine Medical Center in Bangor, and they are one of the largest health care providers in our State. They have, you know, Inland Hospital in Waterville and the Aroostook Medical Center up in Presque Isle, what have you. And I am looking at this, sir, and they are owed \$13 million by you folks, and about 60 percent of the claims have been outstanding for over a year. That is a real concern.

Now, this is another graph of the claims—excuse me, Mr. Chairman—of the claims backlog over the last year. You can see it is flat lined. And this is for Maine Medical Center, which has another network of hospitals throughout our district throughout the State.

So you can see it is not getting any better. They are owed about \$9 million and Eastern Maine Medical Center is owed about \$13 million.

Now, my understanding, and help me out with this please, Mr. Secretary, is that there are about 95 claims processing centers around the country that do this work. And unlike for TRICARE and unlike for Medicare, they are processed manually. So my question to you is the following: My first question is what does that mean? What does a manual claims process look like? That is the first question.

Secretary SHULKIN. Right. So let me try to do this, and I will invite my colleague who probably knows five times as much as me on this topic. You are exactly right, Congressman. The VA is not using as much automation as you would find in the industry. We are moving towards that, and we are seeing our percent go up significantly.

But one of the reasons is the complexity of our program. We have to determine on each claim whether it was service-connected or not service-connected. Medicare or TRICARE does not have to do that. We have to adjudicate our claims in a more thorough way than you see in the private sector as well. So our process, again, of the complexity goes back to why this is taking us so long.

In terms of Maine Medical Center and Eastern Maine Medical Center, you know, this is the business I was in. I will tell you that they think that we owe them more money than we think we owe them, and this is not uncommon, because claims get rejected—

Mr. POLIQUIN. Well, I know you will err on the side of Maine.

Secretary SHULKIN. Right, of course. Of course.

Mr. POLIQUIN. Thank you very, very much.

Secretary SHULKIN. So we have been in touch with Eastern Maine Medical Center, and we will send a team or have a team go over those claims, and we do want to settle those as quickly as possible.

Mr. POLIQUIN. Yeah. If I may interrupt you too, Doctor, before you speak.

Secretary SHULKIN. Yes.

Mr. POLIQUIN. Again, sir, you know, this is \$13 million—

Secretary SHULKIN. Yes.

Mr. POLIQUIN [continued].—and we are a small State. Could you give us an idea, or Eastern Maine an idea. Because it is not just Eastern. I mean, it is all the health care providers throughout their system—when do you think they will get their \$13 million?

Dr. YEHIA. So we actually had a conversation with them today. We have a meeting later this week. We have been working with them. I think the—I don't want to miss this point that Dr. Shulkin made is, we want it to work like Medicare.

Mr. POLIQUIN. I know you do.

Dr. YEHIA. Help us do that. The Choice law has eight different eligibility criteria. We have to determine if they are service-connected or not, we have to determine if they have another health insurance or not, we have to look at if it is ER care or not, so we want to be able to get to the point where it is actually simpler.

Mr. POLIQUIN. I only have 30 seconds left. We promise we will work with you on that. But, Doctor, could you tell me again, please,

so everybody can hear, when Eastern Maine will get their \$13 million and when Maine Medical will get their \$9 million, roughly? Today is Tuesday.

Dr. YEHIA. I don't think it is actually \$13 million, but we are meeting with them this week.

Secretary SHULKIN. So just to be clear, they think it is 13 million; we don't. Whatever number we agree with, we will cut them a check.

Dr. YEHIA. Exactly.

Mr. POLIQUIN. Soon.

Secretary SHULKIN. And make his day. Is it going to be within 3 weeks?

Dr. YEHIA. We can do it in 3 weeks.

Mr. POLIQUIN. You know, the weather is clearing up. We don't have any more snowstorms coming. It is a good time to go to Maine.

Thank you very much, Mr. Secretary. Appreciate it.

Thank you, Mr. Chair.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Correa, you are recognized for 5 minutes.

Mr. CORREA. Thank you, Mr. Chair, and thank you Ranking Member WALZ and the Committee for organizing this Committee hearing. And Secretary Shulkin, again, congratulations.

I live in a community, southern California, very multi-ethnic, a lot of new Americans who English is their second language. First question to you: As you know, the number of Latino veterans is rapidly rising in this country. Over the next decade, they will probably make up 15 percent of all the veterans. So with that in mind, maybe language challenges. How are Latino veterans finding and fairing under the Veterans Choice Program?

Secretary SHULKIN. You know, I have not seen a specific study on that issue. It is probably a good thing for our office of minority and diversity to take a look at to make sure that they are not fairing any worse.

Our workforce tends to reflect the makeup of our veterans since more than 40 percent of our workforce are veterans, so we do have a large contingent of Latino workforce as well. And I hope that we are certainly meeting the needs of all of our veterans, but that is something that I think we would like to work with you on.

Mr. CORREA. Mr. Chair, I would like to see, you know, some goals or maybe some data on that area.

Secretary SHULKIN. Yes.

Mr. CORREA. A lot of them, again, their families are Spanish speaking, possibly English is their second language as well. I just want to make sure that language is not a barrier to them receiving the proper benefits, veteran services that they are, you know, entitled to.

Second question is an important one. Under existing immigration laws, if a legal permanent resident veteran is convicted of a crime, even nonviolent offense or minor infraction, some of them face deportation. These men and women have defended our country with honor, yet their lives continue to be disproportionately affected. So are we doing anything to ensure that these veterans, resident vet-

erans who fall into these categories, have the access to health care without fearing deportation?

Secretary SHULKIN. That is something that I think that we are going to have to work with our general counsel on. I understand the concern. I am not aware of any particular circumstances right now, but we certainly—we have a veterans court program. We have a veterans justice outreach program. We work very closely with veterans who do get into trouble with the law, and we work with judges in particular on those issues. So I would hope that we could work in a way that would help our veterans.

Mr. CORREA. And I would love to work with you on this issue in Orange County. Our district was probably the first in California to have a veterans court. This is a unique issue, a unique wrinkle in the sense that legal permanent residents who violate the law are convicted are—lose their residency and are being deported. So it is a little bit of a different wrinkle.

And I know a lot of them are now concerned about where do they go, where do they access, and do they face deportation. There is a growing group of these veterans right south of the border who are now living there because, of course, they have lost their legal permanent residency. I would like to maybe explore this issue with you a little bit further.

Secretary SHULKIN. Absolutely. Thank you.

Mr. CORREA. Thank you, sir.

The CHAIRMAN. I thank the gentleman for yielding.

Dr. Dunn, you are recognized for 5 minutes.

Mr. DUNN. Thank you, Mr. Chairman.

And thank you also, Secretary Shulkin, and all of you gentlemen for spending your evening with us. I am sure that it is exciting for you to be here.

I also want to thank Secretary Shulkin for mentioning Dr. Tom Starzl, who passed away this last weekend. He was a champion for veterans, a champion and a pioneer in the transplant surgery realm, and I was fortunate to study under him many years ago.

Mr. Secretary, just yesterday, a veteran I represent provided to my office an account of his experience receiving specialty care through the Choice Program, and it underscored a number of the challenges we have discussed here today. In particular, the veteran encountered poor communication between the VA and the third-party administrator and also between the VA and his Choice provider, and it severely delayed his access to care.

And although he ultimately did get an appointment with a podiatrist through the Choice Program, the nearest provider was hours and hours away from his home. And he had some difficulty getting his prescribed custom prosthesis and orthotics. And ultimately, he did the math on the round trip, multiple, multiple round trips to these, and the prosthesis was cheaper and the medical care was cheaper out of his pocket, and that is what he did.

And this letter is actually, it is an amazingly lucid and articulate and polite letter. And I will make that available to the Committee because it reads like a Marx Brothers skit. It is—I won't bother you with it now, though.

My question to you, Mr. Secretary, is what should this Committee keep in mind in regard to the particular needs of the spe-

cialty care of patients like this? And how does that differ from the primary care referrals that this is sort of a special situation?

Secretary SHULKIN. Yeah. Well, what we are doing to make sure that we get this right is we are doing community-by-community assessments, because there is, you know—just like real estate, all health care is local. And so there is some areas that have over supply of specialists and some under supply, and it sounds like your constituent lives in an area where there might be a shortage of specialists in some of those areas.

Mr. DUNN. Yeah, on your panel clearly, and I know there are specialists near him, but for whatever reason they are not on the panel.

Secretary SHULKIN. Yeah. Yeah. We are continuing to grow our network, so if there are available specialists in the area and we have a shortage of them, we are continuing to grow that area. We actually have a slide of this where you can see the progress that we are making in provider growth right now. It might not pop up. Oh, there it is, 133 percent growth. But we need to continue to build out the network. And stories like that are impactful, so I am glad you are going to make it part of the record and we can look at that.

Mr. DUNN. In my practice, we were on your Choice network, and I will say that a lot of times the problem was not that the—I mean, the veterans are there in town, we are there in town, we have slots for them, we can see them, but the problem was authorizations. I mean, the system in a number of ways is dysfunctional.

Mr. Poliquin mentioned the payment system is just also pretty dysfunctional, but more basically, it is important to get them in and get them taken care of. And they had to go back for authorizations again and again and again just to see the same doctor about the same problem. You know, what are we going to do to make that system work a little better?

Secretary SHULKIN. When we started, our authorizations were only good for 60 days. We did a contract modification. We made it for a year. And so as we learned the problems in the program, much like the way that you are describing, we are doing these modifications, and have had 70 of them since the contract started. So—

Mr. DUNN. So they would come to see me and they wouldn't be able to get x-rays. I mean, I could see them, I could prescribe them medicine, which they would have to go get at the VA, but they couldn't get the x-rays and I couldn't see the x-rays. The delays were just atrocious.

Dr. YEHIA. Yeah. In addition to lengthening the breadth (ph) of care, what we are doing now is bundles. So, you know, if you are getting your hip replaced, the PT comes with it, the x-ray comes with it, the MRI comes with it. So we are trying to tackle that problem as an episode together so we don't split up and we maintain continuity of care.

Mr. DUNN. Thank you. We look forward to working with you. We are all excited about the possibility.

Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Dunn.

Mr. Sablan, you are recognized.

Mr. SABLON. Well, thank you very much. And good morning, everyone, because where I am from, it's 11 o'clock in the morning. I know I have been nodding off a bit, but when it takes you 25 hours to get here, you get tired.

And because it is so far away—Mr. Secretary, congratulations also on your appointment, on your confirmation. I truly wish you all the success in your term in office. You were successful in your previous job running a huge hospital.

But the veterans in my district believe that our country has forgotten them. When I first got in, in 2009, I don't stop over anywhere in the country going home or coming back, but I stopped over in Hawaii. I met Dr. Hastings. I urged him to complete the contract that he was negotiating with one doctor who actually now provides service to a certain number of veterans, the only doctor on the island providing service to veterans. And then we now have one VHA employee. But the Department—the country—the veterans feel that the department that is tasked with administering veteran benefits and services have done little to change their feelings about they are being forgotten.

Over the years, we have had VA cases, but in the last 9 months, my office has seen a significant increase in complaints about VA service from veterans, their family members, advocates, and service providers, that I have taken it upon myself—I have no use of VA resources—have brought in people who helped with teaching breathing methods for people with PTSD.

I brought in this documentary and Tom Voss who walked the country to handle—learn how to handle his demons. We just had a resource fair 2 weeks ago, sir, and I have never had a more successful fair. For veterans, we put together all potential resource providers and brought our veterans in and—in all three islands and were very successful.

And then all of a sudden comes in your administrator from Hawaii and his deputy or her deputy. And they couldn't make it to the fair, but now they are having a 1-1/2 hour townhall, after stopping in Guam for the night. So my question is, will you pledge to work with me please to improve the quality of and access to veteran VA services for our veterans? I am from the Northern Mariana Islands. Somehow we truly need your service, sir.

Secretary SHULKIN. Yeah. I would like to come and see you, and let's try to figure this out together.

Mr. SABLON. Thank you very much. Thank you, Mr. Secretary. That commitment is important.

Mr. MISSAL, that is you, sir. Right?

Mr. MISSAL. Yes, it is.

Mr. SABLON. You are inspector general?

Mr. MISSAL. Yes.

Mr. SABLON. Yes, sir. In your evaluation of the Choice Program implementation, what have you found to be the experience of veteran patients in the outlying areas or insular areas or territories, some people say the colonies, such as the Northern Marianas, in accessing health care in a timely manner under the Choice Program?

Mr. MISSAL. Well, sir, we have looked at it in a number of different ways. We haven't just isolated it in those particular areas

you mentioned. But the same issues we found, whether it is with VISN 6, whether when we looked at it more nationally, are going to be the same issues that impact people in those more rural areas, which are the complexity of the programs make it very difficult to administer, which increases the time involved.

And then one of the other issues that I know we have talked about already is care coordination, to make sure that when a veteran leaves the VA system—and one of the strengths of the VA system, it is an integrated system where they can watch very closely the care for the patient. When they leave that system, you have to make sure the records go out with the patient and you have to make sure they come back in. And we have seen challenges to both of those situations where they are not going out as quickly and coming back as quickly as they should.

Mr. SABLAN. Well, my question was, so that is the experience you have found in veterans accessing health care in a timely manner, or is that an answer that says really that you don't know what you are talking about?

The CHAIRMAN. I would hold that answer, and we will come back.

Mr. Rutherford, you are recognized for 5 minutes.

Mr. SABLAN. My time is up.

Mr. RUTHERFORD. Well, thank you, Mr. Chairman.

Mr. Secretary, thank you for your long testimony here tonight. You have probably heard the old saying, you know, that vision without action is just daydreaming, and action without vision is chaos. And sometimes I hear from veterans in my district—I am from Florida 4, which is the northeast corner of Florida, and we have a very large veteran population.

Secretary SHULKIN. Sure.

Mr. RUTHERFORD. Sometimes they talk about the chaos of the system. But I have heard a couple things here tonight that really struck me. One was that your number one concern is—and it happens to be mine as well—is veteran suicide.

Secretary SHULKIN. Yes, sir.

Mr. RUTHERFORD. I am very pleased to hear that.

In addition to that, I heard that another vision that you have is that the VA is going to get out of developing IT software and those kind of things and look for those off-the-shelf type packages. Those are significant cultural shifts, I think, within the VA.

Secretary SHULKIN. Yes.

Mr. RUTHERFORD. Could you just give me one or two more that you had—you know, visions that you have about the VA and how to—what will change the culture?

Secretary SHULKIN. Yeah. The three biggest areas that I am focused on are, number one, giving veterans additional choice. And, you know, I think that I have already explained tonight, this means keeping the VA system strong. I happen to believe the way you keep the VA system strong is by allowing veterans to decide where they want to get care and giving them more choice, and I believe that is going to make us a stronger system.

I think it goes along with, secondly, what Dr. Roe has introduced, which is accountability. For me, accountability—and we have had this discussion with the Chairman and the Ranking Member as well, that accountability is not only making sure that if you lose

your way and you lose your values, you shouldn't be working in the VA, but also that the Secretary has the tools to recruit and retain the very best in health care. And I do believe we have among the very best health care professionals in the country working at the VA today. I want to keep them there.

And third is I want the system to be modernized. I believe veterans deserve the very best that this country can offer, that means modern IT systems, modern facilities, modern types of programs and professionals and technology. So I think those three areas are really what is driving the transformation of the VA.

Mr. RUTHERFORD. Thank you, Mr. Secretary. And I can tell you, I believe the entire Committee looks forward to working with you and making that happen.

And in light of the hour, Mr. Chairman, I will yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Esty is recognized.

Ms. ESTY. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, and all those who are staying in the late hours with us here tonight.

I think we are all extremely heartened to hear the word about IT. I certainly heard a lot about that over the last few days in meetings with veterans across my district, and it is urgently needed.

This issue about coordinated care, I had—one of my roundtables yesterday, someone came forward and said a friend of theirs had just gotten a \$36,000 hospital bill that went straight to the veteran despite Medicare, Medicare Extension, Aetna, or Blue Cross Blue Shield, and VA. And the hospital sent him a \$36,000 bill.

Now, this is someone who is recovering from surgery, is already qualified, served this country, and is over 65. And that is just shameful and wrong. And we absolutely need to have a system where that can't happen. They cannot, a first recourse when you go outside the system, send that bill.

I heard the same issue with ER care. Again, veterans getting those ER bills, they don't know what to do. They are told they have a bill to pay, they panic, and they don't pay other bills, and they pay the ER bill. That is wrong. And we need to have clarification about what these rules are. It should not take a 150-page manual I spent the last 2 days fully with veterans, and it just should not be that hard.

Ms. ESTY. On military suicide, I think we are all very heartened to hear your commitment around that. I find for a lot it is people who have not come into new system at all. So you may have the best care available, but if nobody is coming into the system, you don't—like my friend, Beto, I know our veteran centers are providing that care for many of our Vietnam veterans now.

We need to figure out how to reach out over the last 20 years for them at least, for veterans, because they are not in the system whatsoever. And we are getting those calls in our office. And we have had to have—we have had suicide calls come into the office and had to patch people through and track down their provider. You shouldn't be having to call your Member of Congress to get help.

So we need to work together and figure out how to actually bring people in so that we are not saying, hey, we have got great care, but you are never going to see it.

One of the issues you did not flag, which I would like you to, is on women veterans. That needs to be a priority. We are integrating our forces. There have been some unwelcome news out of the Marines in the last couple of days, which if you want to talk about the damage that does to our system and our ability to attract and retain the best and the brightest, that does real damage.

And that underscores the need to have that kind of care. It is a little specialized. And as we look at care outside of the system, those distances become an issue. Mine is one of those districts. I am in Connecticut, but it is rural. The northwest corner of my State looks a lot like Vermont or Maine, and so to actually get to a VA facility might be 60 miles or 70 miles.

But there is a CBA (ph) that is 20 miles away. We need to deal with that issue about where you may have outpatient that is really close, but actually what you need is going to be further.

So I would like your feedback on whether we can have Choice recognize the difference between a facility that is within the 40 miles and actually what you need. And it may not even be that specialized, but if you are talking women veterans, it may be more specialized.

Secretary SHULKIN. Yeah. Well, Congresswoman, you have identified so many important issues, I don't even know how to begin to address them all, but let me just try to make one point about each one.

On the putting the veteran in the middle with these bills, absolutely horrible. I am going to tell you what to do: Call 1 (877) 881-7618. That is a special hotline for veterans who are in the situation where they are being billed inappropriately, and we are going to get them out of that credit situation.

On the issue of veteran suicide, thank you for your recognition on that. We know VA can't do this alone. It has to work with community providers, and we are strongly looking for community groups and other partnerships who are willing to go into the community and reach people that you are talking about.

On the issue of women veterans, absolutely. It is an oversight not to mention it as one of our key areas, fastest growing group of veterans. We have done a lot, but we need to do a lot more, and it is not uniform across all of our facilities, our specialized women's care, but we are getting there.

On the Choice Program, as I have said, if I were designing a program, I would not have picked mileage and wait times as my criteria, you know. I tend to think more clinically about how you meet health care needs of veterans and patients. So that is what we look forward to working with you.

If I didn't mention it, we are very supportive of an extension program now for Choice, but we want to come back and we want to work with you on a redesigned Choice 2.0. We are going to have a better name for that too. And we really want to get that done with you by September. That would be our goal to get that done and to get a system that makes sense.

Ms. ESTY. Thank you. And I see my time has expired. Thank you very much.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Higgins, you are recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Secretary Shulkin, I very much support H.R. 369, the extension of Veterans Choice Program. The remaining \$1 billion of American treasure certainly needs to be dedicated to American veterans.

In your testimony, you noted that Congress should pass legislation to clarify criteria for veterans to receive care closer to home, to facilitate the development of a network of community care providers, and to better coordinate veterans benefits.

I would like to bring our conversation completely closer to home, all the way to the home. As you know, many of our most severely wounded veterans prefer to receive their care from their family at home, so I am referring to family caregivers. And specifically, as we move forward with what you referred to as Choice 2.0, with an eye towards making a real difference in the lives of American veterans that are seeking health care and need it, do you believe it is in the best interest of American veterans to expand the program of comprehensive assistance of family caregivers to include pre-9/11 vets whereby they can receive their care from those that know them the best, their loved ones? Would you please give us your feedback on that?

Secretary SHULKIN. Yeah. One of the parts of VA that I am most proud of is our support for caregivers. I think we have demonstrated, when we send somebody off for war, we are not just sending them off, we are sending their entire family. And the family needs to be part of the solution when they come back home, and our support for caregivers is something vital.

Now, as you mentioned, it was only authorized for veterans post-9/11. I do believe it needs to be for all veterans, particularly our older veterans who want to stay at home, and then maybe they wouldn't have to leave their home into an institution.

The cost for that program right now, it would be scored in the—about \$4 billion. I believe that is not an accurate reflection on the true cost because I believe we are going to save money—

Mr. HIGGINS. Save money.

Secretary SHULKIN [continued].—by not institutionalizing people. So we are now beginning to come back with a true reflection of the cost, but I am supportive of that.

Mr. HIGGINS. I thank you for that answer. It is very encouraging. God bless you for that, sir.

I yield my time back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

And, Mr. Banks, you are recognized for 5 minutes.

Mr. BANKS. Thank you, Mr. Chairman.

Secretary, it is an honor to have you here today. You have answered so many questions and addressed so many issues.

As a recently deployed veteran, post-9/11 veteran, I am especially interested in transition assistance programs. To get to the heart of the veteran suicide rates among post-9/11 veterans, what can we do at the outset, the beginning of the process?

My personal experience was in Sembach, Germany, in the Navy's Warrior Transition Program, which was a terrific program that, in hindsight, benefited me greatly on my return home trip from Afghanistan. I wonder, what lessons have you learned about other TAPS programs in the other branches?

As I understand, the Navy has a model program in Sembach. Can we protect it? Can we model it, any other branches? What can this Committee do to support you with TAP programs as well?

Secretary SHULKIN. Well, first of all, thank you for your service. And I would like to work with you because it sounds like you have some experience that maybe we could benefit from.

I do believe this transition period and the TAPS program is an area that is ripe for even doing better in. And we hear too many stories where people just didn't think about the transition in the way that we would like them to and then find themselves without knowing how to seek help.

I was speaking to the President about this last night. And one of the things that we are going to be doing is Secretary Mattis and I are going to be getting together to talk about how we can get organizations to focus on this in a different way and work together in a closer way. So with your input, I think we would be better prepared for that conversation.

Mr. BANKS. I look forward to working with you on that.

On another note, we have a number of veterans in Indiana, where I live, who are interested in alternative treatments like hyperbaric oxygen chambers or other alternative treatments to the traditional treatments to PTSD and TBI. What, under your leadership, can we look forward to in opening up new avenues for treatment for our post-9/11 veterans especially?

Secretary SHULKIN. Well, first of all, I was just in Indiana last week visiting the VAs there and toured the VA with the governor, Governor Holcomb. The areas that I am most concerned about are areas that veterans have a high predilection of, like PTSD, traumatic brain injury, other conditions, that today we do not have great state-of-the-art treatments in. So I am not as worried about treating pneumococcal pneumonia, because we have penicillin, but in these areas, I think we have to be looking for new solutions and treatments.

We have established a new office called the Office of Compassion and Innovation, where ideas such as hyperbaric, where the VA had traditionally been very close to, have an opening to come in, and we will work with them to explore new ideas.

It so happened the very first one of these that we looked at and that we have granted access to is the use of service dogs for veterans who have PTSD or other emotional disorders. And while there isn't, believe it or not, great science behind the fact that service dogs help, I think it is commonsense that service dogs help. And so we hear it every day from veterans. So now we have started to make them available.

And so ideas such as what you are talking about, hyperbaric is a very interesting story because DoD and VA have studied it three times and found the negative association, but yet we are finding veterans who say they have been helped by it. So we want to continue to look at issues like that.

Mr. BANKS. Well, thank you. I am excited about your leadership. I look forward to working with you.

And, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Banks. And actually, two Sheltie dogs and a bluegrass guitar keep me sane, so I believe in it.

We are going to have a roundtable later in the year. I had several meetings over the recess and just yesterday on trying to bring a lot of the people out in the community who are working with veterans, try to bring together and coordinate some of these efforts.

So many people—I have met with now three people in the last 4 days who are doing something here, somebody over here. But let's get everybody, not with the cameras on but just around the table, and find out how we can better coordinate this with the VA.

Gentleman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. And I am last, right?

Thank you, all of you, for being here tonight. Just before coming in, I had a tele-townhall, 2,000 people or so dialed in. About 50 percent of the questions that came were related to veterans.

Michigan, as a State, has a higher than average percentage of veterans. The first district of Michigan has double the percentage of veterans of the other districts. So we have got a lot of folks in our district that—let's put it this way: They laid it all on the line for the country; now we need to lay it all on the line for them.

By the way, Mr. Missal, did I get it right? Is that how you pronounce it?

Mr. MISSAL. That is how you pronounce it.

Mr. BERGMAN. Okay. Just want to make sure because, you know, pronunciation counts.

You know, in your written testimony, you discuss how the VA accounts for community care expenses. The topic is extremely complex. Let me try to state it in laymen's terms, as I understand it.

I am a Marine, so this will be simple here. Currently, the VA estimates how much each individual episode of care is going to cost and sets aside funds for that care. That doesn't happen quickly or accurately. When the estimate is too high, the excess funds remain set aside and the VA has to do an adjustment to put them back in the pot.

Mr. MISSAL. Correct.

Mr. BERGMAN. Those adjustments don't happen very quickly either. The Department wants to change this to stop estimating each episode of care and instead do one big estimate at the beginning of the year.

My question for you is, if we allow VA to make this procedural change, but they don't get more accurate in their estimates, what are the potential downside consequences that could result?

Mr. MISSAL. Well, they are a pretty significant downside. Accounting for dollars in the community was seen as a material deficiency in the audit that we conducted of the financial statement. So obviously, as you are getting into estimating, it is very tricky. By doing it at the beginning of the year where you are doing it as more broadly, you are going to have some of the same issues that you are going to have when you are doing it on a case-by-case basis.

Mr. BERGMAN. Okay. And also, Mr. Missal, you mentioned in your testimony the VISN 6 report released publicly last week that included shortcomings within Choice, particularly that most veterans reviewed were waiting in average of 84 days to receive care.

Mr. MISSAL. Correct.

Mr. BERGMAN. Your staff informed the Committee that it provided the VA its findings around August of 2016 for agency review. In the 7 months from when they were provided to VA until the report was released publicly, did the OIG make any substantive changes to the findings, and if so, what types of information was changed?

Mr. MISSAL. We did make some changes. Our process is when we finish a report, we do share it, the draft, with VA. It is our report. We are going to stand by our finding. But the important thing is we want to make sure we get it right. So we did meet with senior leadership at VA to talk about it. We wanted to clarify some things. So I would put it more in terms of we didn't change our findings, we just clarified things to make it absolutely clear exactly what we had looked at, what the methodology we used, and any comments from VA.

So Dr. Shulkin, who is an under secretary, responded with some comments that are included in our report.

Mr. BERGMAN. Okay. Thank you.

And in the interest of the lateness of the hour, I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

And Mr. Missal and Mr. Williamson, you are finding out the same as I do; it is always good to do a townhall with a Senator because they never have to answer any questions, just like the Secretary tonight when you two are here, he answers most of the questions.

I will use my 5 minutes very quickly and just state some things that we have heard tonight.

I think, number one, we all agree that we need Choice extension sooner rather than later; number two, I think we need the Choice consolidation, and what I am hearing is a reform of the Choice Program, and I am going to ask a specific question; number three, it was a breath of fresh air to hear that, I think, the VA is going to quit developing IT and try to be Microsoft or Apple and go ahead and let somebody do that and we will absolutely work together with you.

I think if we can accomplish getting the IT started and those other two things this year, it would have been one of the most successful years in VA history. I believe that. And I think we can do that. I truly do.

The CHAIRMAN. I have laid that out, and that is—we know where we have been with the VA, we know where we are now. And I think I would like to hear, Dr. Shulkin, you go ahead and tell us your personal vision for transforming the VA and how this Committee can be of help to you in doing that.

Secretary SHULKIN. Well, first of all, thank you. And having sessions like this where we really do get a chance to share opinions, I think, is a really important start, because any solution is going to have to be all of us wanting to get this done together.

I think the vision for the VA is to transform this organization to be a veteran-centric organization. In order to do that, it is not rocket science. You have to have the right people caring for veterans. And I think we are very fortunate that we have such a great workforce, but we have all seen examples where there are people that shouldn't be working in the VA that it has been too hard to get them to leave, and I think your accountability bill is an important step forward in that.

I also need the tools, as we have talked about, and I appreciate your willingness to consider both the carrots and the sticks, because that is the dual part of accountability, getting the right people in the door and getting the great people to stay in the organization.

I think we need to transform the culture in many ways that we learned our lessons in 2014 by having the wrong incentive systems in place, by not having management understand their jobs, and by not being transparent enough. So I think we need to change our culture that way.

I think we do need to put the control of health care back into the hands of veterans so it is their choice on where they get health care. They are the ones who make their appointments, they are the ones that essentially say whether we are doing a good job or not, and we have to—we have to do that.

And, finally, the last piece, as we have talked about several times tonight, is modernizing the VA system. And by the way, there is probably not enough money to completely modernize the system, so we are going to have to be creative in our solutions. We are going to have to leverage existing technology that is out there in the market. We are going to have to partner with our community partners to provide the right types of facilities. So it may mean that VA is not going to be building as many brand-new hospitals, but working with community hospitals to share resources with the Department of Defense and other Federal facilities.

So it is doing business differently, it is being willing to take some risks that maybe we haven't, and that is where I think us doing it together is really going to be the right formula for success for veterans in this country.

The CHAIRMAN. You are seeing that consolidation on the private side too—

Secretary SHULKIN. Yes.

The CHAIRMAN [continued].—that is going on in this country right now. So it is not just the VA system.

Just a couple of quick questions. Do you believe, I don't think there are, but do you believe the provider networks now are robust enough to provide care for veterans in a timely fashion?

Secretary SHULKIN. You mean—

The CHAIRMAN. The Choice Program.

Secretary SHULKIN [continued]. Well, I think we have come a long way, but I think that we have much more to do. Our vision is a network of providers that have made commitments on both the service and the clinical side to caring for America's veterans, and that is what we want to work towards developing.

The CHAIRMAN. I would suggest, Dr. Shulkin, that you and I take the suits off one day and probably go in a VA, put our stethoscopes

back on, and go in an examining room and find out the frustrations. And I would say if you were back in the examining room and you had a patient you felt that needed to see a cardiologist, a rheumatologist, and how hard we have just described tonight that is—

Secretary SHULKIN. Yeah.

The CHAIRMAN [continued].—and the lengths of time people go, months, to get an appointment, it would—the rest of the hair, the few that are still on my head, would fall out.

Secretary SHULKIN. Yeah.

The CHAIRMAN. And I want you to tell me how you—if you were making that appointment, what would you expect to happen?

Secretary SHULKIN. Well, first off—

The CHAIRMAN [continued]. You just said—

Secretary SHULKIN [continued]. First off, you just gave me a softball. I am inviting you to join me the next time I go and put on my stethoscope, because I see patients in Manhattan and in Oregon. So you can decide where you want to go with me. And Dr. Yehia sees patients as well.

Look, we have focused in the VA on making sure that urgent care is delivered at the right time. That is why we have same day access now in every one of our medical centers for mental health and primary care. We are focused on getting stat consults down. Right now, there is less than 100 across the VA that are stat consults more than 30 days, so it is a functional zero. And we are working to make all of our specialty care more accessible, but of course, we do need to use community care to do that.

The CHAIRMAN. I thank you. My time has expired.

I am going to open it up for a second round for 1 minute, and the Chairman will be very—very, very careful about the 1 minute.

Mr. WALZ.

Mr. WALZ. Yeah. Thank you, Mr. Secretary. Your vision is where we are all at. I appreciate it, and know that we are there to try and give you the tools. We will have our discussions in here, we will have family discussions, we will deliver you something, Veterans First Act that we had. We want to give you accountability, because I am glad you mentioned—what I can tell you is we can say we are going to remove people fast, but without leadership, without hiring, without due process, those are going to be things that aren't going to give you the tools, so we are going to work on giving you that. Your vision is solid.

We have been followed tonight online by a lot of folks who are watching. They care deeply about this. I can tell you overwhelmingly the veteran suicide issue resonated. There was a military spouse, Alesandra, said, I am a mother, my father—my son's father served 25 years. My son will not serve because of his suicide.

We understand that this is a faith issue. I just appreciate your vision, I appreciate the leadership, I appreciate the Chairman being there. And the folks sitting behind you, they have got your back, they have been out there, and there is a lot of those groups. So let us get this done together.

Secretary SHULKIN. Thank you.

Mr. WALZ. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you, Mr. WALZ.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman.

For Mr. Missal, there have been many instances and issues that have related to veterans care which the VA has attributed those failures to poor training. In instances when a VA employee engaged in suspected criminal activity such as fraud, falsification of patients' records, or failures that have led to patient harm, is the VA OIG authorized to investigate?

Mr. MISSAL. Yes, we are. Under the Inspector General Act of 1978, we do have the authority to work with the Department of Justice and other law enforcement to bring criminal charges, and we have done that on a number of occasions over the years.

Mr. BILIRAKIS. Okay. Very good. That is what I wanted to know, and I appreciate it.

How do you prioritize these particular cases that are brought to your attention?

Mr. MISSAL. We look at it in a number of different ways. We look at the extent of the harm, the number of veterans impacted, the amount of dollars impacted, how long the conduct has been going on. So we look at a variety of different factors and try to prioritize the one that are the most serious in nature.

Mr. BILIRAKIS. Very good. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Secretary Shulkin, we are hearing from veterans online who want to ask you questions. Many of the questions are about improving mental health care. What more can we do to ensure timely access to mental health care and how can we better recruit and retain mental health care providers?

Secretary SHULKIN. Well, I think we are working on two things right now. One is we need to hire more mental health professionals. So if people are following us online and they are interested in coming to work for the VA, we are interested in talking to them. So we need about 1,000 more mental health providers.

The second thing we are doing, we are leveraging our areas of the country where we do have a good supply of mental health providers, which are what we call our hubs, for telemental health. And so we are providing those professionals to the more rural areas of the country where we don't have the providers. So we are trying to leverage it that way. And we are working with our community providers, like Beto O'Rourke mentioned in El Paso, where there are great centers like Texas Tech that we can work with.

Mr. TAKANO. Mr. Chairman, at some future time, I would like to ask more about graduate medical school, GMEs, and how we are using those, but my time is up.

The CHAIRMAN. Okay. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Dr. Shulkin, thank you again for your service to this country. The one question I have is that doesn't the VA—I have read that the VA has a certification system for mental health professionals within the community outside the VA where they can be certified to deliver care to our veterans. And I think you mentioned your

concern that the average provider outside the VA may not understand the culture of the military—

Secretary SHULKIN. Yes.

Mr. COFFMAN [continued].—and that is a real concern. I wonder if you can explain how this program, this certification program works, and is it being utilized today to sign up more providers outside the VA?

Secretary SHULKIN. Yeah. We are doing outreach to our community providers that we are working with to make sure that they do have the education and the materials to be able to see veterans. This is part of our concept of our high performance network to get providers in there who want to and are committed to seeing veterans to provide the type of quality care we believe they deserve.

Mr. COFFMAN. But it is a formal certification process, is it not?

Secretary SHULKIN. Yes.

Mr. COFFMAN. Okay. And so tell me, can you give some, you know, metrics in terms of how that program is going right now?

Secretary SHULKIN. We measure the number of providers that take advantage of our educational programs in that and that we have outreach too. So we can get you more information on the number of providers. We feel we need to do more of it.

Mr. COFFMAN. Because I would just think that that is—there is a multiplier capability—

Secretary SHULKIN. Yeah.

Mr. COFFMAN.—in terms of having resources by virtue of leveraging what is in the community but certifying them or making them go through a training process where we know that they meet the requirements—

Secretary SHULKIN. Yeah.

Mr. COFFMAN [continued].—for the VA.

Secretary SHULKIN. I think we have more work to do on formalizing that program. I think that is the direction that we are headed in, though.

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

The CHAIRMAN. The gentleman's time has expired.

Mr. CORREA, you are recognized for 1 minute.

Mr. CORREA. I will pass.

The CHAIRMAN. Okay. The gentleman yields.

Mr. Rutherford, you are recognized.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

Mr. Secretary, I just want to say, you must be a real man of action, because that mental health—service dogs for the mentally ill, our members who are veterans who are suffering from PTSD and TBI were told 3 years ago that there was going to be a study to, you know, determine the efficacy of it, and then at the end of that 3 years they were told, well, it is going to be another 3 years before that report will be finalized. You have done it like in 30 days.

Secretary SHULKIN. What—

Mr. RUTHERFORD. Thank you.

Secretary SHULKIN [continued]. Let me tell you about that study. First of all, it will be another 3 years before we get the study results, and I am not willing to wait—

Mr. RUTHERFORD. Thank you.

Secretary SHULKIN [continued].—because there are people out there today suffering. But when they did the study, this is what I learned. They did—like any good study, there are two arms, right, one that should be with dogs and one without dogs so they can learn.

Mr. RUTHERFORD. Right.

Secretary SHULKIN. They couldn't find a single veteran who was willing not to take a dog. I mean, I think that tells you something right there. So I said, give them all dogs.

Mr. RUTHERFORD. Well, thank you very much, because I can tell you that is going to be a resounding success back in my hometown. God bless you.

Secretary SHULKIN. Thank you.

The CHAIRMAN. Mr. Sablan, you are recognized.

Mr. SABLAN. Yeah. Thank you very much, Mr. Chairman.

Mr. MISSAL, let me go back again. I don't mean to be disrespectful in any way, and I know that you have said that you have looked at veterans in other rural areas. I am talking about my area, my district, the Northern Mariana Islands, sir. The experience there and experience in rural areas are not the same, so I am asking you to consider looking at the veteran experience in the outlying areas, like my district.

You do know where the Northern Mariana Islands are?

Mr. MISSAL. Yes, I do.

Mr. SABLAN. Yes, sir, because you guys come through Guam all the time, but don't—again, Mr. Secretary, your director out of Hawaii and her assistant are on site for an hour and a half today. I mean, it has been a while since anyone has been there, but they took an hour and a half today. Thank you very much. But I would like to work with you again some more. Thank you.

The CHAIRMAN. I thank the gentleman for yielding.

I am now going to yield my time to Dr. Wenstrup, who I rudely ignored a minute ago.

Mr. WENSTRUP. Just call me Skip, Mr. Chairman.

I want to go to something that Mr. Takano was bringing up, and that is the GME and residency programs. And as you know, most doctors in America spend some time in a VA as part of their training. So what are you looking at with that where we can be of help as far as what specialties we may want to engage with further, such as in mental health, but also association with academic institutions in making those more robust programs?

Secretary SHULKIN. Right. Well, we are doubling down on our relationships with our academic centers. We think it is one of the best and strongest features of the VA, and it benefits not only veterans, but all Americans in the way that we train our health care professionals.

The Choice Program, as you know, gave us the additional GME spots. We have taken advantage of those. Almost all have gone to mental health or primary care. We believe that we could still do more. I would like to look at some ways of getting them into some of our rural parts of the country that don't have teaching programs. That would be a big, I believe, addition to helping us in increasing the quality of the environments that our veterans get care in. So we would like to work with you for ways to expand it.

As you know, the country needs more graduate medical education spots. They have been expanding the undergraduate medical education spots but not the GME spots, and somehow that formula is not going to work out if we don't expand the GME spots.

Mr. WENSTRUP. Thank you.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Higgins, you are recognized.

Mr. HIGGINS. Secretary Shulkin, I am a veteran. I represent the portion of my State, my district has the highest density of veterans in the State, and only about 20 percent of my fellow veterans regularly access the health care system.

We have seen improvements in the Choice Program, and I have confidence that it is going to allow greater access to health care for all veterans to penetrate that number and help more veterans access the health care that they have earned and deserve. I have a high degree of confidence that tomorrow this sunset window will go away and a billion dollars will be invested, as it should, in the lives of our veterans that have earned it.

Will you work with this Committee and this body to help us develop a furtherance of the Choice Program and continued improvement of it? Please share with us in the remaining 3 seconds a resounding yes.

Secretary SHULKIN. Yes.

Mr. HIGGINS. Thank you, sir. I yield back.

The CHAIRMAN. I thank the gentleman.

General Bergman, you are recognized.

Mr. BERGMAN. Secretary Shulkin, by the way, congratulations, you are now the dog that is caught in the tire.

Secretary SHULKIN. Yeah.

Mr. BERGMAN. But some of the rest of us are in the same boat. So the point is that vehicle has multiple tires, and there are a lot of us with our teeth into it right now.

There is, and I believe it has some visibility within the Veterans Administration already, of a proposed beta project, Cherry Tree, out of Traverse City, Michigan, that involves not only health care for veterans, but education, jobs, housing. And I am looking forward to working with the Veterans Administration to bring Project Cherry Tree to a level where it gets a good look to see what is in the art of the possible, because we are all in this together, and the results that we are going to achieve will only be limited by our desire to achieve them. So thank you very much.

And I yield back.

Secretary SHULKIN. Thank you.

The CHAIRMAN. I thank you all. And the questions now have ceased.

I want to thank the panel. You all have been very, very generous with your time tonight. And I think you can see the interest from the number of members that have stayed around this long and the folks in the audience too that have stayed here. It is truly one of the most important things we will have tasked to us as Congressmen and women, is to help make the VA. We have learned what the problems were in the last 114th, and pointed those out clearly and we have had help with the GAO and the IG in clarifying that, but I think now it is to solve the problems, and I look forward to

doing that with you all. I think this entire panel does. They are huge and not easy, I certainly understand that, and we have mentioned and brought up a lot more tonight. But I am optimistic, and I am certainly more optimistic after tonight's hearing. I think we have all got the oars in the right and we are all pulling in the same direction, and I think that is going to get some results.

Mr. WALZ. you have a—

Mr. WALZ. Mr. Chairman, I ask unanimous consent to submit into the record a statement on some case study work on Choice from Mr. Nolan, our colleague.

The CHAIRMAN. Without objection, so ordered.

The CHAIRMAN. Do you have any closing comments?

Mr. WALZ. I do not. I would just like to echo the Chairman's comments. We are in this together. We are grateful. The right people are on the bus and on the right seats, and so we are here to do what we can do. So thank you. And thank you, Mr. Chairman, for all your work.

The CHAIRMAN. Thank you.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 9:57 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable John McCain

Thank you Chairman Roe and Ranking Member WALZ for the opportunity to appear before this committee to discuss the Veterans Choice Program.

I want to talk to you about veterans' access to care and how we got here, starting with the Steve Cooper, an Army veteran who served his country for 18 years. In return for his service, Steve waited for almost two years before seeing a doctor at the Phoenix VA. By the time he received care, his routine urology appointment turned into a diagnosis of terminal cancer.

Steve wasn't alone in his need for care. In 2014, our country was shocked to learn that Steve was one of 15,000 veterans standing in line for care in Phoenix - 3,300 of whom were urology patients. This national disgrace served as the catalyst for the Veterans Access, Choice and Accountability Act that created the Veterans Choice Program, which has enabled veterans to see providers in the community for their health care needs.

The Choice Act required the VA to implement the Veterans Choice Program in under 90 days - an ambitious undertaking that experienced some growing pains. Despite a few road-bumps, the Veterans Choice Program to-date has accomplished its intended goal of increasing access to care for our Nation's veterans. In fact, since its inception, veterans have made more than seven million appointments with community providers for everything from diagnostic tests and urology screenings, to life saving heart and cancer treatment.

While there has been significant progress in improving veterans' health care, we have a long way to go to change the status quo plaguing the VA. That is why we must not abandon our effort to provide choice and flexibility in veterans' health care, and why we must continue the hard work of refining and improving the Veterans Choice Program.

In order to achieve this, Congress must first act quickly to reauthorize the Veterans Choice Program, which is set to expire in a few short months. Have no doubt: if we let this program lapse, hundreds of thousands of veterans will lose their ability to visit a community provider, the VA system will once again become overwhelmed, and veterans will go back to the pre-scandal days of unending wait-times for much-needed care. Continuing the Veterans Choice Program is the only way we can fully eliminate the wait-time problem at the VA and ensure veterans have access to timely and quality care.

With the expiration of Choice authorization rapidly approaching, I understand the VA already has begun limiting care under the Veterans Choice Program for veterans whose treatments would extend beyond August 7, 2017. I also understand that the VA's new plan for community care will not be fully operational until at least 2019. Given this reality, I am concerned that veterans nationwide may encounter significant lapses in care if we do not act quickly. This outcome is not only avoidable, but it is unacceptable and we in Congress must act.

I am pleased to have introduced the Veterans Choice Continuation Act, with the Senate Veterans Committee Chairman, Senator Johnny Isakson, the Committee's Ranking member, Senator Jon Tester, as well as Senator Jerry Moran. This bipartisan legislation would remove the current sunset date for the Veterans Choice Act. I applaud you and your committee for taking up companion legislation that would do the same.

Reauthorizing the Veterans Choice program would not only benefit veterans, but it would also provide Congress with the time we need to work with Secretary Shulkin to refine the next generation of Choice - a consolidated and even more standardized network of community care. The VA has provided Congress with its proposal for the future of community care, and we deserve time to study that proposal to ensure it strikes the right balance.

In closing, let me be clear - no one is advocating that we privatize the VA. Many veterans are satisfied with the VA, which often provides superior specialized treat-

ment in the areas of mental health, post-traumatic stress disorder and traumatic brain injury. At the same time, we simply cannot afford to go back to the pre-scandal days when a VA bureaucrat had the final say on where and when a veteran received care. Such thinking was what resulted in nearly 15,000 veterans standing in line for care in Phoenix. I know you agree, as does Secretary Shulkin, and I look forward to working with all of you and my colleagues in the Senate to extend the Veteran Choice Program and continue to keep faith with our nation's veterans.

Thank you for the invitation to join you this evening and for your leadership on this critical matter. I'm confident that by working together, we can preserve access to health care for those who have borne the price of battle.

Prepared Statement of Honorable David J. Shulkin, M.D.

Good evening, Chairman Roe, Ranking Member WALZ, and Members of the Committee. Thank you for the opportunity to discuss VA Community Care, including the Veterans Choice Program, which makes it easier for Veterans to access the care they need and deserve. I am accompanied today by Dr. Baligh Yehia, Deputy Under Secretary for Community Care at the Veterans Health Administration.

History of Choice

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA), which established the Veterans Choice Program, was enacted in August 2014 to help Veterans access timely care both within the Department of Veterans Affairs (VA) and in the community. VA appreciates Congress' support in providing this legislation that enhanced authorities and provided funding to better serve Veterans.

VACAA gave VA only 90 days to fully implement a nationwide program. This was unprecedented and created many growing pains. To put things in perspective, the TRICARE program took approximately three years to fully implement. The law also directed VA to change the way it operated both internally and with community partners, creating additional steps to purchase care.

In order to implement the Choice Program on this aggressive timeline, VA held an industry day seeking partners in the private sector to operate the program. Unfortunately, given the short implementation timeline, there was limited interest from industry. VA's only option was to modify previously existing national contracts for community care, which were never intended to handle the scale, scope, and complexity of the Choice Program. Despite these challenges, VA met the congressionally mandated deadline and launched the Choice Program on November 5, 2014.

Veterans Choice Program Improvements

The new requirements set forth in VACAA and the aggressive timeline for implementation presented challenges for the VA. VA is aware of these issues and has been working continually with all our stakeholders to make immediate and long-term improvements.

VA appreciates the evaluations that the Government Accountability Office and VA Office of Inspector General (OIG) conducted regarding implementation of the Choice Program. The OIG report reviewed the first 11 months of the Choice Program, a period that started more than two years ago. Specifically, the report highlighted three issues: (1) cumbersome Veterans Choice Program processes requiring Veterans to schedule their own appointments using third party contractors; (2) an inadequate network of community providers; and (3) reluctance by Veterans to use the Choice Program because of potential financial liability for treatment by community providers. VA has made significant improvements to address these and other issues. As a result, the Choice Program is no longer the program it was when it rolled out.

VA and Congress worked together on four amendments to VACAA since 2014 that improved the Veteran experience with the Choice Program including by increasing the number of Veterans eligible and expanding the number of community providers who can treat Veterans under the Program. Working with our contractors, VA issued over 70 contract modifications to improve access, efficiency, and address many of the issues raised by our oversight organizations. For example, in November 2015, VA implemented a modification requiring the contractors to initiate calls to Veterans, simplifying the cumbersome scheduling process described in the VA OIG report.

Prior to this modification, Veterans had to call the contractor, an unnecessary step. In late February 2016, VA completed a modification that decoupled the receipt of medical records from payment to the contractors. This helped improve the timeliness of payments to providers, addressed issues in the VA OIG report, and resulted

in more providers joining the Choice network. In Spring 2016, VA clarified timeframes for the contractors to schedule and complete appointments, shortening the time it takes to receive community care. VA learned from TRICARE that embedding contractor and VA staff together is an effective model to improve operations and assist Veterans. In late 2015, VA implemented this model at the first location. Since that time, we have embedded contractor staff at over 50 VA medical centers across the country.

As a result of these changes and many others, more Veterans are utilizing the Choice Program than ever before. Since the start of the Choice Program, over one million Veterans have received some Choice care. In Fiscal Year (FY) 2015, Veterans received 380,000 authorizations for Choice care. In FY 2016, Veterans received over 2,000,000 authorizations for Choice care. VA has quadrupled the number of authorizations from FY 2015 to FY 2016.

Looking at early data for FY 2017, we are on a trajectory to increase use of the Choice Program even more than last year. In the first quarter of FY 2017, the number of Choice authorizations, approximately 750,000, is over 35 percent more than the same period in FY 2016. In addition to increasing the number of Veterans accessing the Choice Program, VA is working to increase the number of community providers available in the program. In April 2015, the Choice Program network had approximately 200,000 providers and facilities contracted. As of February 2017, the Choice Program network had over 400,000 providers and facilities contracted a growth of more than 125% during this time period.

Future State of VA Community Care

While progress has been made, and we are moving in the right direction, we recognize there is still work that needs to be done - and there is no time to waste. The Choice Program is set to expire in less than six months. We need Congressional action to extend the program beyond August 7, 2017 and improve the program to positively impact the Veterans' and community providers' experience. Many Veterans are using the Choice Program today, and it is important to continue to care for and support those Veterans.

These improvements are just the beginning for community care. We think Veterans deserve better, and now is the time to get this right for the future. We need a bold transformation, which will require legislation. This legislation must do three things: (1) provide standardized, clear eligibility criteria for Veterans to get care closer to home; (2) facilitate building a high-performing network of community care providers, which has our Department of Defense, other Federal, and academic affiliate partners as the foundation, and reimburses for care using contemporary payment models; and (3) better coordination of benefits for Veterans, allowing VA to work directly with third-party insurers. We look to Congress and our stakeholders to help enact these changes for Veterans within six months. This way, once all the Choice funds are depleted, there will be a plan in place and Veterans will continue to receive uninterrupted community care.

We are committed to moving care into the community where it makes sense for the Veteran. The ultimate judge of our success will be our Veterans. So, our only measure of success will be our Veterans' satisfaction. With your help, we can continue to improve Veteran's community care.

Thank you and we look forward to your questions.

Prepared Statement of Honorable Michael J. Missal

(7 footnotes inbedded from pdf)

Mr. Chairman, RankingWALZ. and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work concerning VA's Choice Program and the future of VA's Community Care Program. Our statement covers our work related to issues discussed in VA's Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (Consolidation Plan), submitted to Congress as required by Public Law 114-41, Surface Transportation and Veteran Health Care Choice Improvement Act.

BACKGROUND

For years, VA has relied on Non-VA programs to help it carry out its mission of providing medical care, including delivering outpatient services, inpatient care, mental health services, dental services, and nursing home care to veterans via purchased care. Today, VA's purchased care programs include Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA

care programs. We have reported in our audits, reviews, and healthcare inspections and discussed in hearings the challenges VA faces administering these programs.

In October 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs into VA's Community Care Program. Under consolidation, VA continues to have problems determining eligibility for care, authorizing care, making accurate payments, providing timely payments to providers, and ensuring the continuity of care provided to veterans outside the VA healthcare system. Without improvement in these areas, these issues will continue to be obstacles to ensuring veterans receive timely access to quality care. To increase the program's overall effectiveness, VA and Congress must understand the historical barriers and control weaknesses that have plagued VA's purchase Care programs and ensure they are adequately addressed in future purchased care programs. I would like to highlight our work in:

- Veterans Choice Program
- Financial Accounting of Community Care Funds
- Patient Centered Community Care (PC3) Program
- Non-VA Fee Program

VETERANS CHOICE PROGRAM

We have recently completed audits and reviews concerning the Veterans Choice Program and our findings have substantiated problems with authorizing and scheduling appointments, consult management, network adequacy, and timeliness of payments to providers.¹

VA initiated the Veterans Choice Program in response to the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) (P.L. 113-146). Following enactment of VACAA, VA contracted with Health Net Federal Services, Limited Liability Corporation (Health Net) and TriWest Healthcare Alliance Corporation (TriWest), the administrators of the Patient-Centered Community Care (PC3) program, to administer the program including establishing provider networks nation-wide. The Veterans Choice Program allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates or veterans who live more than 40 miles from a VA facility. From November 5, 2014 to December 31, 2016, about 2.1 million appointments were provided to veterans under the Veterans Choice Program. Total program expenditures during that period were over \$2.2 billion, of which \$2.0 billion (89 percent) was spent for medical care and the remaining \$235 million (11 percent) was paid to Health Net and TriWest for program start up and administration costs. An additional \$1.7 billion of Choice funding, which was reallocated through the Veteran Health Care Choice Improvement Act of 2015 (Public Law 114-4), was spent on Hepatitis C and Emergency Care in the Community during the same time period.

Our OIG Hotline has received over 700 contacts about the Veterans Choice Program from October 1, 2015 through January 31, 2017. These complaints fall into the following general categories:

- 48% had concerns about appointments and scheduling
- 35% had concerns about referrals, authorizations, or consults
- 12% had concerns about veteran and provider payments
- 5% had concerns about program eligibility or program enrollment.

In February 2017, we published Audit of Veteran Wait Time Data, Choice Access, and Consult Management in Veterans Integrated Service Network 6 (VISN 6). We assessed the reliability of wait time data and timely access within a VISN. We selected VISN 6 for this audit to determine whether they provided new patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. We reported that veterans who were authorized Choice care in VISN 6 did not consistently receive the authorized health care within 30 days as required by Health Net's contract with VA.

We reviewed a statistical sample of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of fiscal year (FY) 2016. Based on our sample results, we estimated that for the approximately 34,200 vet-

¹ Audit of Veteran Wait Time Data, Choice Access, and Consult Management in Veterans Integrated Service Network 6, March 2, 2017; Review of the Implementation of the Veterans Choice Program, January 30, 2017; Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System, October 4, 2016; Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, FL, February 5, 2016; Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, CO, February 4, 2016

erans who were authorized Choice care in VISN 6, approximately 22,500 veterans who received Choice care waited an average of 84 days to get their care through Health Net. We estimated it took VA medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and 42 days for Health Net to provide the service. We identified delays related to authorizations for primary care, mental health care, and specialty care. VHA's Chief Business Officer addressed a potential cause for delay in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment, rather than require the veteran to contact Health Net as was required prior to the change. Our analysis showed that, while still untimely, this change lowered the percentage of veterans who waited more than 5 days for Health Net to create an appointment from 86 percent to 69 percent.

The Under Secretary for Health concurred with our 10 recommendations and provided a responsive action plan and milestones to address the recommendations regarding monitoring controls over scheduling requirements, wait time data, and access to health care and consult management. There were also recommendations to ensure staff used clinically indicated and preferred appointment dates consistently, medical facilities conduct required scheduler audits, and staffing resources are adequate to ensure timely access to health care. The report's recommendations remain open.

We also published in January 2017, Review of the Implementation of the Veterans Choice Program. Our objective was to determine whether veterans were experiencing barriers accessing Choice during its first eleven months of implementation ending September 30, 2015. We reviewed monthly reports to identify average wait times for multiple stages of the Choice process, including the authorization of care, scheduling, and the delivery of health care to veterans. We determined several barriers existed in accessing care through Choice, to include cumbersome authorization and scheduling procedures, inadequate provider networks, and potential veteran liability for treatment costs. VHA identified approximately 1.2 million appointments to the Veterans Choice List (VCL) from November 1, 2014, through September 30, 2015, for veterans waiting over 30 days for care at VHA medical facilities. During the same period, about 283,500 Choice authorizations were created for veterans who opted into the program because VHA medical facilities could not provide treatment within 30 days. In total, veterans waited approximately 45 days on average from the time they opted into the program to pursue medical treatment to the time they received care through Choice. We calculated a 13 percent rate of Choice utilization based on the number of Choice appointments that were provided (149,000) compared to the number of veteran appointments that were eligible to receive care (1.2 million) through Choice (as shown on the VCL).

We recommended the Under Secretary for Health streamline procedures for accessing care, develop accurate forecasts of demand for care in the community, reduce providers' administrative burdens, ensure veterans are not liable for authorized care, and ensure provider payments are made in a timely manner. The Under Secretary for Health concurred and provided a responsive action plan and milestones to address our six recommendations. The report's recommendations remain open.

In October 2016, we published Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System (PVAHCS). We analyzed all open consults at PVAHCS through August 12, 2015, and determined that more than 22,000 individual patients had 34,769 open consults at PVAHCS. This included all categories, statuses, and ages of consults. Of the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. These included consults in a status of pending, active, scheduled, and partial results. In addition, more than 10,000 patients had nearly 12,000 community care consults that exceeded 30 days. Consults for care in the community included traditional non-VA care and Choice.

The Under Secretary for Health and the VISN 22 Director concurred with our 14 recommendations and provided a responsive action plan and milestones to address them. The Under Secretary for Health agreed to update VHA's consult policy. The remaining 13 recommendations were issued to the VISN 22 Director to improve consult management, to follow up with patients who may not have received the requested care and to close consults in accordance with national and local policy. The report's 14 recommendations remain open.

In another report issued in February 2016, Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, CO, we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental

Health, Neurology, Optometry, Orthopedic, and Primary Care Services. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days. For 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. As a result, VA staff did not fully use Veterans Choice Program funds to afford Colorado Springs Community Based Outpatient Clinic veterans the opportunity to receive timely care.

The Acting Director of Eastern Colorado Health Care System concurred and provided a responsive action plan and milestones to address our four recommendations. We recommended that scheduling staff use the correct clinically indicated date or preferred appointment date when scheduling primary care patient appointments, new patients are scheduled timely appointments, eligible veterans are added to the Veterans Choice List, and there are sufficient staff to act on consults. The report's recommendations were closed in September 2016.

We are continuing to provide ongoing oversight of the Choice Program. For example, we will submit as required by VACAA a report after 75 percent of the almost \$10 billion dollars appropriated to the Veterans Choice Program is spent or when the program ends in August 2017, whichever occurs first. That project is ongoing. We also plan access to care reviews at other VISNs over time.

FINANCIAL ACCOUNTING FOR COMMUNITY CARE FUNDS

Careful management of funds for purchased care is also important to ensure their availability to pay providers. Our contractor for the audit of VA's consolidated financial statements, CliftonLarsonAllen LLP (CLA), an independent public accounting firm has reported VA purchased care under the Community Care Program as material weaknesses in VA's FYs 2016 and 2015 Financial Statements.

CLA's audit of VA's FY 2016 Financial Statements identified Community Care obligations, reconciliations, and accrued expenses as a material weakness.² This audit is an annual requirement of the Chief Financial Officers Act (CFO) of 1990. Key control deficiencies were as follows:

- The manual process for estimating costs of care caused a wide variation in amounts estimated. CLA noted numerous examples of obligations being overstated compared to the actual payments made during testing. VA management performed its own analysis and recorded journal entries in the approximate amount of \$1.9 billion to liquidate the overstated Choice obligations and \$2.6 billion to liquidate the overstated Fee Basis obligations in VA's general ledger at September 30, 2016.
- VA did not have a centralized and consolidated process to validate or monitor the obligation amounts recorded for Choice or Fee Basis programs. As a result, funds were being held as obligated when they should have been closed out. Furthermore, untimely liquidation of obligations due to patients having other health insurance also contributed to obligations being overstated for the Choice program during FY 2016.

VA's Financial Management System (FMS) accrued the entire outstanding balance of an obligation when the end date for the contractual performance period had passed, regardless of whether goods or services were provided at period end. As a result, the overestimation of medical care obligations resulted in an overstatement of accrued expenses at period end. Management performed its own review and recorded journal entries in the amount of \$1.1 billion to reverse the Choice accrued expenses in excess of actual needs and \$1.9 billion to reverse the Fee Basis over accrued expenses at September 30, 2016.

- A nationwide consolidated reconciliation for community care authorizations recorded in the Fee-Basis Claim System-exceeding \$4.9 billion as of September 30, 2016-was not performed with the amounts recorded in FMS for obligations and disbursements throughout most of the year.

CLA also reported processing and reconciliation issues related to purchased care as a material weakness during its audit of VA's FY 2015 financial statements.³ CLA

² Audit of VA's Financial Statements for Fiscal Years 2016 and 2015, November 15, 2016

³ Audit of VA's Financial Statements for Fiscal Years 2015 and 2014, November 16, 2015

increased its focus on purchased care given increased funding and implementation of the Choice Act. CLA reported problems with the cost estimation process and additionally noted the lack of reconciliation between the Fee Basis Claims System used to authorize, process, and pay for non-VA Care and VA's Financial Management System where obligations are recorded.

All of these issues-lack of tools to estimate VA purchased care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling purchased care authorizations to obligations in FMS-makes the accurate and timely management of purchased care funds challenging. In addition, the Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities also were not integrated with VA and VHA CFO responsibilities under the CFO Act of 1990 to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating costs, VA has requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone-i.e., obligating funds at the time of payment-would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls and sufficient staff trained to monitor accounting, reconciliation, and management information processes to ensure they effectively manage funds appropriated by Congress.

PATIENT-CENTERED COMMUNITY CARE

The PC3 program is a VHA nationwide program that provides eligible veterans access through health care contracts to certain medical and mental health services. The PC3 program is used after the VA medical facility exhausts other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. In September 2013, VA awarded Health Net and TriWest PC3 contracts totaling approximately \$5 billion and \$4.4 billion, respectively. As noted above, on October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the Veterans Choice Program.

We published a series of five reports on PC3 in FYs 2015 and 2016.⁴ We reported that the PC3 program prior to including the Veterans Choice Program did not achieve its estimated cost savings, provide timely access to care, and did not ensure contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements. In addition, we reported that PC3's inadequate provider network contributed significantly to VA medical facilities' limited use of PC3, and that PC3 contracts were not adequately developed and awarded. A theme that was clear from our work was that VA clinical and support staff were dissatisfied with PC3 in such areas as authorizing care, scheduling appointments, and veterans waiting for care. These are some of the same issues we hear today about the Choice Program.

In September 2016, we published Review of VA's Award of the PC3 Contracts, where we determined whether VA's PC3 contracts were adequately developed and awarded. VA awarded the PC3 contracts to provide veterans with a comprehensive, nationwide network of high quality, specialty health care services. The contracts were awarded for an estimated \$9.4 billion, with a potential cost to VA of \$27 billion. OIG found significant weaknesses in the planning, evaluation, and award of the PC3 contracts. The PC3 contracts were not developed or awarded in accordance with acquisition regulations and VA policy intended to ensure services acquired are based on need and at fair and reasonable prices. The contracting officials solicited proposals from vendors without clearly articulating VA's requirements. Thus, the vendors bidding on the solicitation did not have sufficient information on the type of specialty health care services they would need to provide, where to provide them, and the frequency. Although the contracting officer had the authority to execute these contracts, accountability for ensuring the effective award of these contracts was not vested with a senior executive at VA for the level of oversight for this de-

⁴ Review of VA's Award of the PC3 Contracts, September 22, 2016; Review of Patient-Centered Community Care Health Record Coordination, September 30, 2015; Review of Patient-Centered Community Care Provider Network Adequacy, September 29, 2015; Review of Alleged Delays in Care Caused by Patient-Centered Community Care Issues, July 1, 2015; Review of VA's Patient-Centered Community Care Contracts' Estimated Costs Savings, April, 28, 2015

gree of contract risk. We recommended the Interim Under Secretary for Health revise VA's PC3 cost analyses. Additionally, we recommended the Executive Director, Office of Acquisition, Logistics, and Construction, require contract documents be maintained in the PC3 contract files. The Interim Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction concurred and provided a responsive action plan and milestones to address our report recommendations. The report's four recommendations are still open.

In another OIG report from September 2015, *Review of Patient-Centered Community Care (PC3) Health Record Coordination*, we reported that VHA lacked an effective program for monitoring the performance of their two contractors, Health Net and TriWest. We estimated that only about 32 percent of the PC3 episodes of care had complete clinical documentation provided within the time frame required under the PC3 contracts. This was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation. As a result, we found that VA lacked adequate visibility and assurance that veterans were provided adequate continuity of care, and VA was at risk of improperly awarding incentive fees or not applying penalty fees. We estimated 20 percent of the documentation was incomplete, and an additional 48 percent was not provided to VA within the time-frame required by the contracts. This delayed the processing of payments and we estimated that from January 1 through September 30, 2014, VA made about \$870,000 of improper payments. Additionally, we reviewed 433 episodes of care and identified 3 critical findings related to the providers' discovery of malignant colon tissue affecting patients in TriWest's network. We examined each critical finding and did not find contract-required elements annotated in the clinical documentation returned by TriWest's providers, such as the name of the VA medical facility staff member contacted and date and time notified. Without this information and the timely receipt of critical findings, VHA lacked assurance that critical findings were being reported in accordance with the contract's performance standards. The Under Secretary for Health concurred and provided a responsive action plan to address the seven recommendations in our report. We recommended VHA implement a mechanism to verify PC3 contractors' performance, ensure PC3 contractors properly annotate and report critical findings in a timely manner, and impose financial or other remedies when contractors fail to meet requirements. All of the report's recommendations were closed in December 2016.

In our September 2015 *Review of VHA's PC3 Provider Network Adequacy*, we reported that inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA only spent \$3.8 million of its \$2.8 billion FY 2014 non-VA care budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its non-VA care expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3; the CBO lacked an effective implementation strategy for the roll-out of PC3; and neither VHA nor Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health concurred and provided a responsive action plan and milestones to address the recommendations in our report to strengthen controls over the monitoring of PC3 network adequacy and planning for future complex healthcare initiatives. The report's five recommendations were closed in November 2016.

In our July 2015, *Review of Allegations of Delays in Care Caused by Patient-Centered Community Care (PC3) Issues*, we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts had caused the nine VA medical facilities with both PC3 contracts had caused the nine VA medical facilities with both PC3 contracts had caused the nine VA medical facilities with both PC3 contracts had caused the nine VA medical facilities with both PC3 contracts had caused the nine VA medical facilities⁵ we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind

⁵ Four facilities were serviced by Health Net and located in Denver, CO; Fayetteville, NC; Minneapolis, MN; and Richmond, VA. The remaining five were serviced by TriWest and located in Phoenix, AZ; Portland, OR; Prescott, AZ; Seattle, WA; and Tucson, AZ.

scheduling.⁶ Health Net and TriWest scheduled appointments without discussing the tentative appointment with the veteran, which VHA refers to as blind scheduling. We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submitted timely authorizations, and Health Net and TriWest scheduled appointments and returned authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. We recommended the then Interim Under Secretary for Health ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements. The Interim Under Secretary for Health concurred and provided a responsive action plan and milestones to address our report recommendations. The report's 10 recommendations were closed in June 2016.

At the request of the U.S. House of Representatives Committee on Appropriations, we reviewed VA's budget submission that stated PC3 contracts would save VA \$13 million, respectively, in FYs 2014 and 2015. In April 2015, we published, *Review of PC3 Contracts' Estimated Cost Savings*, which we analyzed disbursed FY 2014 PC3 payments. We reported that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates of contract services by veterans impeded VA from achieving its \$13 million PC3 cost saving estimate in FY 2014. Further, VA lacked sufficient price analysis to support its \$13 million cost savings estimate. VA also lacked an implementation plan to ensure adequate utilization of PC3. VA had established contractual arrangements that the PC3 contractors would develop adequate provider networks, medical facilities would achieve the desired utilization rates, and the accrued PC3 cost savings for health care services would more than offset the contractors' fees. Flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent utilization rate in FY 2014. Because of the under-utilization of veterans using PC3, we estimated that VA would need a utilization rate between 25 and 50 percent to achieve their \$13 million cost saving estimate. The Under Secretary for Health and the Executive Director, Office of Acquisition, Logistics, and Construction, concurred and provided a responsive action plan and milestones to address our report recommendations to revise VA's PC3 cost analyses, address VA's low PC3 utilization rates, and maintain required contract documents in PC3 contract files. The report's three recommendations were closed in March 2016.

Non-VA Fee Program

VA can purchase health care service on a fee-for-service or contract bases under Title 38 of the United States Code, Sections 1703, 1725, and 1728, when VA medical facilities cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. We have conducted numerous audits, reviews, and inspections on VA's non-VA Fee program.⁷ In October 2016, we published *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, which reported consult management issues at the Phoenix VA Health Care System (PVAHCS). We determined that, as of August 2015, more than 22,000 individual patients had 34,769 open consults at PVAHCS. The total open consults included all categories, statuses, and ages of consults. Open consults included traditional clinical consults within the facility, community care consults, such as non-VA care and Choice, prosthetics consults, and administrative consults. Of all the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. In addition, more than 10,000 patients had nearly 12,000 community care consults exceeding 30 days. We made 14 rec-

⁶VA prohibits VA medical facilities from scheduling appointments without the discussing details with the veteran. VA commonly refers to this scheduling practice as "blind scheduling".

⁷Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, SC, December 20, 2016; Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System, October 4, 2016; Review of VHA's Alleged Mismanagement of Ophthalmology Consults at the Oklahoma City VAMC, August 31, 2015; Audit of Non-VA Medical Care Claims for Emergency Transportation, March 2, 2015; Audit of Selected VHA Non-Institutional Purchased Home Care Services, September, 30, 2013; Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds, January 10, 2013; Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System, November 8, 2011; Audit of Non-VA Inpatient Fee Care Program, August 18, 2010; Review of Outpatient Fee Payments at the VA Pacific Islands Health Care, March 17, 2010; Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, August 3, 2009

ommendations, including that the Under Secretary for Health update VHA's consult policy. The remaining 13 recommendations were issued to the VISN 22 Director to improve consult management and to follow up with patients who may not have received the requested care. This included recommendations to develop a routine review of closed consults and documenting consults in accordance with national and local policy. Ten of the 14 recommendations remain open.

CONCLUSION

Our audits, reviews, and inspections have highlighted that VA has had a history of challenges in administering its purchased care programs. Veteran's access to care, proper expenditure of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lacked adequate processes to manage funds and oversee program execution. While purchasing health care services from community providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. We plan to provide significant oversight of VA's Community Care programs over the next 3 years.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee may have.

Prepared Statement of Randy Williamson

VETERANS' HEALTH CARE

PRELIMINARY OBSERVATIONS ON VETERANS' ACCESS TO CHOICE PROGRAM CARE

Chairman Roe, Ranking Member Walz, and Members of the Committee:

I am pleased to be here today to discuss our ongoing work related to veterans' access to health care services through the Veterans Choice Program (Choice Program). The majority of veterans utilizing health care services delivered by the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) receive care in VHA-operated medical facilities, including 168 VA medical centers (VAMC) and more than 1,000 outpatient facilities. However, some VHA medical facilities have long wait times for veterans to obtain appointments or do not offer certain specialty care services on site. In recent years, we and others have expressed concerns about VHA's ability to provide health care services within its own facilities in a timely manner.¹ In some cases, the delays in care or VHA's failure to provide care reportedly have resulted in harm to veterans. Due to these and other concerns, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.²

These serious and longstanding problems with veterans' access to care were highlighted in a series of congressional hearings in the spring and summer of 2014, when a well-publicized series of events raised additional concerns about VHA's ability to deliver health care services in a timely manner. In response to these concerns, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) was enacted on August 7, 2014. This law provided temporary authority and \$10 billion in funding through August 7, 2017 (or sooner, if those funds are exhausted) for veterans to obtain health care services from non-VA community providers to address long wait times, lengthy travel distances, or other challenges accessing care at VA

¹ See, for example, VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, GAO 13 130 (Washington, D.C.: Dec. 21, 2012); GAO, VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care, GAO 14 808 (Washington, D.C.: Sept. 30, 2014); GAO, Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care, GAO 16 83 (Washington, D.C.: Oct. 8, 2015); and GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, D.C.: Oct. 28, 2015). See also: Department of Veterans Affairs, Office of Inspector General, Healthcare Inspection: Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina, Report No. 12-04631-313 (Washington, D.C.: Sept. 6, 2013) and Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Report No. 14-02603-267 (Washington, D.C.: Aug. 26, 2014).

² GAO, High-Risk Series: An Update, GAO 15 290 (Washington, D.C.: Feb. 11, 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

medical facilities.³ Under this authority, VA introduced the Choice Program in November 2014, and as of October 1, 2016, about \$4.5 billion of the \$10 billion originally appropriated remained available for the program.

In accordance with the law, VHA had up to 90 days to prepare for Choice Program implementation from the time the Choice Act was enacted. To cope with the compressed implementation timeframe, VA modified contracts it had previously established with Health Net Federal Services (Health Net) and TriWest Healthcare Alliance (TriWest) for the administration of a different VA community care program to give them responsibility for Choice Program administration. Each contractor-or third party administrator (TPA)-is responsible for delivering Choice Program care in a specific multi-state region, where they establish networks of community providers, schedule appointments for eligible veterans, and pay community providers for their services. Recent media reports and congressional hearings have highlighted weaknesses affecting the Choice Program, such as insufficient provider networks, significant delays in scheduling appointments, and a lack of timely payments to network providers.⁴

My statement today will draw from our ongoing work examining the timeliness of veterans' access to care through the Choice Program. We plan to issue a final report on our review in spring 2017. In particular, this statement reflects our preliminary observations examining:

- 1.the process VA has established for scheduling Choice Program appointments for routine care;
- 2.what is known about the timeliness of veterans' Choice Program appointments for routine care and urgent care; and
- 3.VHA's recent actions and plans to improve the timeliness with which veterans receive health care services through the Choice Program.

As part of our ongoing work, we reviewed applicable laws and regulations; VA's contracts with the TPAs; relevant VA and VHA policy directives, guidance, and training materials for VAMCs; and relevant VHA documentation about Choice Program improvement projects, such as summaries and fact sheets. We also interviewed a VA contracting official and officials from VHA's Office of Community Care (the office responsible for implementing and overseeing the Choice Program), as well as officials from the two Choice Program TPAs, Health Net and TriWest.

In addition, we examined non-generalizable samples of six VAMCs and 196 authorizations for veterans who were referred to the Choice Program by those six VAMCs between January 2016 and April 2016.⁵ We selected our sample of VAMCs to include variation in geographic location, three VAMCs that serve rural veteran populations, three VAMCs that serve urban veteran populations, three VAMCs that were served by Health Net, and three that were served by TriWest. (See table 1.)

Table 1: Non-Generalizable Sample of Veterans Affairs Medical Centers (VAMC) GAO Visited for Review of the Veterans Choice Program (Choice Program)

VAMC (location)	Rural or urban ^a	Choice Program third party administrator that serves the VAMC	
		Health Net Federal Services	TriWest Healthcare Alliance
Togus VAMC (Augusta, ME)	rural	✓	
Muskogee VAMC (Muskogee, OK)	rural		✓
Alaska VA Health Care System (Anchorage, AK)	urban – location rural I – population served		✓
VA Eastern Colorado Health Care System (Denver, CO)	urban	✓	
VA Northern California Health Care System (Mather, CA)	urban		✓
Durham VAMC (Durham, NC)	urban	✓	

Source: GAO | GAO-17-397T

³Pub. L. No. 113–146, 128 Stat. 1754 (2014).

⁴See, for example, Lawrence Quil, Eric Whitney, and Michael Tomsic, “Despite \$10B ‘Fix,’ Veterans Are Waiting Even Longer To See Doctors.” Morning Edition (radio program), May 16, 2016. Accessed January 27, 2017. <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>. Also see Lee Romney, “Veterans Choice is flawed, but Congress is stymied on a solution,” The Center for Investigative Reporting, September 28, 2016. Accessed January 27, 2017. <https://www.revealnews.org/article/veterans-choice-is-flawed-but-congress-is-stymied-on-a-solution>.

⁵These were the most recent Choice Program authorization data that were available when we began our ongoing review.

To select our random, non-generalizable sample of 196 Choice Program authorizations, we obtained VA data on all authorizations created by the TPAs between January and April 2016 for veterans who were referred to the program by the six VAMCs we visited. The 196 authorizations included 55 randomly selected authorizations for routine care and 53 randomly selected urgent care authorizations for which the TPAs succeeded in scheduling appointments for veterans.⁶ We selected our sample of routine and urgent authorizations to include only authorizations for which the TPAs did not meet VA's appointment scheduling goals at one phase of the appointment scheduling process: when the TPAs attempt to schedule appointments after the veterans have opted in to the program.⁷ This was to ensure that our sample included only authorizations for which scheduling was delayed, so that we could examine the potential causes of appointment scheduling delays, whether delays also occurred at other phases of the process (such as when VAMCs were preparing the veterans' referrals or when the TPAs were attempting to reach the veterans to opt them into the program), and the veterans' overall wait times for Choice Program care.⁸ The 196 authorizations also included 88 randomly selected authorizations that the TPAs returned to VA without scheduling appointments for any one of the following three reasons: (1) VA requested the authorization be returned, (2) VA data was missing from the referral, and (3) the veteran declined or did not want Choice Program care.⁹ For all 196 Choice Program authorizations in our sample, we reviewed VHA documentation (specifically, the veterans' VA electronic health records) and TPA documentation to track the number of calendar days that elapsed at each step of the Choice Program appointment scheduling process.¹⁰ For the authorizations that the TPAs returned to the VAMCs without making appointments, we examined VHA and TPA documentation to determine whether the veterans eventually obtained care through other means—such as through another VA community care program, a different Choice Program referral, or at a VA medical facility—and how long it took to receive that care. To assess the reliability of the authorization data we used, we interviewed knowledgeable agency officials, manually reviewed the content of the data, and electronically tested it for missing values. We concluded that these data were sufficiently reliable for the purposes of our reporting objectives. The findings from our review of Choice Program authorizations cannot be generalized beyond the VAMCs and the veterans' Choice Program authorizations we reviewed.

We are conducting the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our preliminary findings and conclusions based on our audit objectives.

We shared the information in this statement with VA to obtain its views. Officials provided us with technical comments, which we have incorporated as appropriate. When we complete our ongoing work, we will also make recommendations related to improving the timeliness of veterans' Choice Program care as appropriate.

Background

Choice Program Eligibility and Required Referral Hierarchy

⁶Under VA's contracts with the TPAs, Choice Program referrals and authorizations are to be marked as "urgent" when a VA clinician has determined that the veteran needs care that (1) is considered essential to evaluate and stabilize conditions and (2) if not provided would likely result in unacceptable morbidity or pain when there is a significant delay in evaluation or treatment. Under VA's Choice Program contracts, urgent care is not the same as care provided for a medical emergency, which is covered through different VA community care programs. Urgent care (rather than emergent care) delivered through the Choice Program is care that is delivered when there is no threat to the veteran's life, limb, or vision but the veteran's condition needs attention to prevent it from becoming a serious risk to the veteran's health.

⁷Under VA's contracts with the TPAs, VA requires that the TPAs schedule routine Choice Program appointments within 5 business days after veterans opt into the Choice Program. VA also requires that the TPAs schedule veterans' urgent Choice Program appointments and ensure that veterans attend them within 2 business days after veterans opt in to the Choice Program.

⁸As we discuss later in this statement, VHA could not provide complete, reliable data that would have allowed us to include authorizations in our sample that were delayed at other points of the Choice Program appointment scheduling process, such as the period when VAMCs prepare referrals for the TPAs or the period between the TPAs' receipt of referrals and initiation of appointment scheduling.

⁹We limited our sample of returned authorizations to these three return reasons because we wanted to determine if the return reasons entered by the TPAs could be substantiated by evidence from the veterans' VA electronic health records.

¹⁰In this statement, "days" refers to calendar days, unless otherwise indicated.

As stated in VA's December 2015 guidance, the Choice Program allows eligible veterans to obtain health care services from the TPAs' network providers rather than from VHA providers when the veterans meet any of the following criteria:

- the next available medical appointment with a VHA provider is more than 30 days from the veteran's preferred date or the date the veteran's physician determines he or she should be seen;
- the veteran lives more than 40 miles driving distance from the nearest VHA facility with a full-time primary care physician;
- the veteran needs to travel by air, boat, or ferry to the VHA facility that is closest to his or her home;
- the veteran faces an unusual or excessive burden in traveling to a VHA facility based on geographic challenges, environmental factors, or a medical condition;¹¹
- the veteran's specific health care needs, including the nature and frequency of care needed, warrants participation in the program;¹² or
- the veteran lives in a state or territory without a full-service VHA medical facility.¹³

In addition, in May and October of 2015, VHA issued policy memoranda to its VAMCs requiring them to offer eligible veterans referrals to the Choice Program before they authorize care through other VA community care programs.¹⁴

Choice Program Utilization from Fiscal Year 2015 through Fiscal Year 2016

From fiscal year 2015 through fiscal year 2016 (the first two years of the Choice Program's implementation), data we obtained from the TPAs indicate that more than half of the veterans who were referred to the Choice Program and for whom the TPAs scheduled appointments were referred because the services they needed were not available at a VA medical facility.¹⁵ The second-most-common reason for referral was that the wait time for an appointment at a VA medical facility exceeded 30 days. (See figure 1.)

¹¹A determination about whether the veteran meets this criterion will be made in conjunction with staff at the veteran's local VHA medical facility.

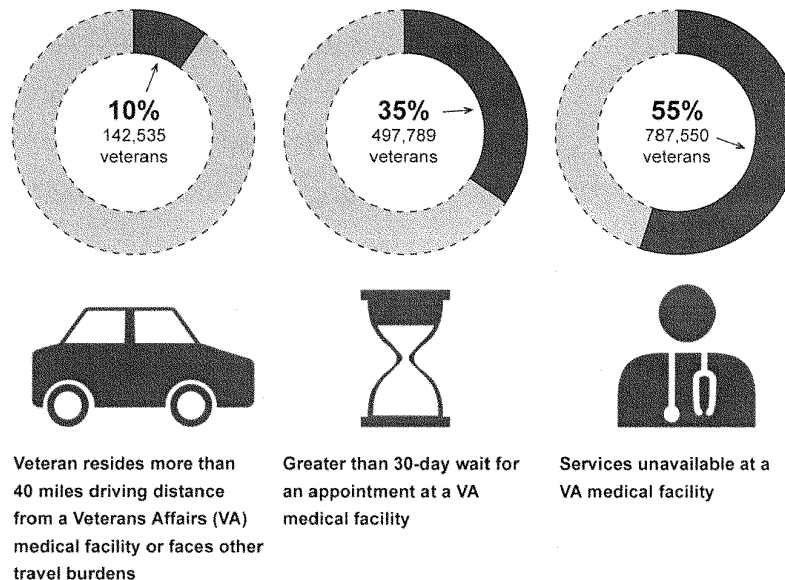
¹²A determination about whether the veteran meets this criterion will be made in conjunction with staff at the veteran's local VHA medical facility.

¹³Specifically, veterans who reside in Alaska, Hawaii, New Hampshire, or a U.S. territory would be eligible for the program under this criterion. Veterans residing in New Hampshire are only eligible if they reside more than 20 miles away from the White River Junction VAMC, which is located in Vermont.

¹⁴Specifically, when services are unavailable or the veteran cannot receive an appointment within 30 days; these memoranda require VAMCs to determine whether needed services are available in a timely manner from another VA medical facility or from a facility with which the VAMC has a sharing agreement, such as a Department of Defense, Indian Health Service, or Tribal Health facility. If care cannot be arranged in this manner, VAMCs must offer eligible veterans the opportunity to receive care through the Choice Program before attempting to arrange care through any other VA community care program.

¹⁵Prior to obtaining these data from the TPAs, we requested data from VHA on the number of veterans who were referred to the Choice Program because (1) services were unavailable, (2) there was a greater than 30-day wait, or (3) the veteran resided more than 40 miles from a VA facility or faced other travel burdens. However, VHA officials stated that VHA's data grouped veterans who were referred to the Choice Program because services were unavailable together with the veterans who were referred because of 30-day wait times. Only the TPAs could break these groups of veterans out separately, so we are instead reporting the TPAs' data here.

Figure 1: Most Common Reasons Veterans with Scheduled Choice Program Appointments Were Referred to the Program, Fiscal Years 2015 through 2016



Source: GAO analysis of data from Health Net Federal Services and TriWest Healthcare Alliance. | GAO-17-397T

Note: This excludes 7,198 veterans with scheduled appointments who were referred to the Choice Program in fiscal year 2015 and fiscal year 2016 because they faced an unusual or excessive travel burden to access care at a VA medical facility. Only one of the two third party administrators (TPA) could separately report veterans who were referred under this Choice Program eligibility criterion. The other TPA does not distinguish veterans who were referred for unusual or excessive travel burden from the other three Choice Program referral reasons listed here.

Process for Choice Program Appointment Scheduling

Through its policies and standard operating procedures for VAMCs and its contracts with the TPAs, VA has established a process for Choice Program appointment scheduling.¹⁶ The process differs depending on the criterion under which a veteran is utilizing the Choice Program. Table 2 below provides an overview of the appointment scheduling process that applies when a veteran is referred to the program because the veteran cannot obtain an appointment within 30 days. VA's contracts require that routine care appointments for these time-eligible veterans shall take place within 30 days of the clinically indicated date on the VAMC's referral to the TPA, which is consistent with VA's wait-time goal for care at a VA medical facility.¹⁷

¹⁶Officials from VA's Denver Acquisition and Logistics Center are responsible for developing and managing Choice Program contracts with the TPAs. Contracting officer's representatives in VHA's Office of Community Care are responsible for monitoring the TPAs' performance. VHA's Office of Community Care is also responsible for developing policies and standard operating procedures, communicating contract modifications and other programmatic changes to VAMCs, and providing training for VAMC managers and staff on their roles in coordinating veterans' Choice Program care.

¹⁷The clinically indicated date on the VAMC's referral is the date that it would be clinically appropriate for the appointment to occur, as determined by the sending VA provider. The clinically indicated date determination is based upon the needs of the patient and should be the soonest date that it would be clinically appropriate for the veteran to receive care. While appointments for routine care for time-eligible veterans must occur within 30 days of the clinically indicated date on the VAMC's referral, VA's contracts require that these veterans' appointments for urgent care shall take place within 2 business days of the TPA accepting the VAMC's referral.

Table 2: Process for Veterans to Obtain Choice Program Care if They Are Time-eligible^a

Steps of the Choice Program scheduling process	Steps completed by staff at VA medical center (VAMC)	Steps completed by staff at Choice Program third party administrator (TPA)	Steps completed by the veteran
1. A Veterans Affairs (VA) clinician determines the veteran needs care.	✓		
2. VAMC staff confirm the veteran's eligibility for Choice Program care and begin contacting the veteran to offer a referral to the Choice Program.	✓		
3. The veteran agrees to be referred to the Choice Program.			✓
4. VAMC staff compile relevant clinical information (including a description of the specific services and type of medical specialist the veteran needs) and submit the veteran's referral to the TPA.	✓		
5. TPA staff review the veteran's Choice Program referral to ensure it contains information needed to proceed with appointment scheduling and accept the referral if the information is sufficient.		✓	
6. TPA staff contact the veteran by telephone to confirm that they want to opt in to the Choice Program. If the veteran is not reached by telephone, the TPA sends a letter requesting that the veteran contact the TPA to opt in to the program.		✓	
7. If the veteran opts into the Choice Program, TPA staff create an authorization and begin efforts to schedule an appointment with a community provider.		✓	
8. TPA staff schedule an appointment with a community provider. The authorization (which contains relevant clinical information, a description of authorized services, and a period of validity) is sent to the community provider. The veteran is informed of the date and time of the appointment.		✓	
9. The veteran attends the initial appointment with the Choice Program community provider.			✓

Source: GAO analysis of VA and VHA documents. | GAO-17-397T

Note: VA's contracts require that Choice Program appointments for routine care for time-eligible veterans shall take place within 30 days of the clinically indicated date on the VAMC's referral to the TPA. The clinically indicated date on the VAMC's referral is the date that it would be clinically appropriate for the appointment to occur, as determined by the sending VA provider. The clinically indicated date determination is based upon the needs of the patient and should be the soonest date that it would be clinically appropriate for the veteran to receive care. While appointments for routine care for time-eligible veterans must occur within 30 days of the clinically-indicated date on the VAMC's referral, VA's contracts require that Choice Program appointments for urgent care take place within 2 business days of the TPA accepting the VAMC's referral. Veterans are time-eligible for the Choice Program when no VA appointments are available within 30 days.

When veterans are eligible for the Choice Program because they reside more than 40 miles from a VA medical facility, VA's contract requires the TPA to schedule an appointment within 30 days of the veteran's preferred appointment date. For these veterans, VAMCs do not prepare a referral and send it to the TPA. Instead, these veterans can contact the TPA directly to request Choice Program care. See table 3 for an overview of the Choice Program appointment scheduling process that applies for distance-eligible veterans.

Table 3: Process for Veterans to Obtain Choice Program Care if They Are Distance-eligible

Steps of the Choice Program scheduling process	Steps completed by staff at VA medical center (VAMC)	Steps completed by staff at Choice Program third party administrator (TPA)	Steps completed by the veteran
1. The veteran contacts the TPA to request Choice Program care.			✓
2. TPA staff verify that the veteran is eligible for the Choice Program care and that the requested care is medically appropriate.		✓	
3. TPA staff create an authorization and begin efforts to schedule an appointment with a community provider.		✓	
4. TPA staff schedule an appointment with a community provider. The authorization (which contains relevant clinical information, a description of authorized services, and a period of validity) is sent to the community provider. The veteran is informed of the date and time of the appointment.		✓	
5. The veteran attends the initial appointment with the Choice Program community provider.			✓

Source: GAO analysis of VA and VHA documents. | GAO-17-397T

Future Consolidation of VA Community Care Programs

The VA Budget and Choice Improvement Act, which was enacted on July 31, 2015, required VA to develop a plan for consolidating all non-Department provider programs (currently about 10) into a new, single program to be known as the “Veterans Choice Program.”¹⁸ VHA submitted this plan to Congress on October 30, 2015, and according to this plan, the agency expects to implement a consolidated community care program in fiscal year 2018. While the existing Choice Program will expire on or before August 7, 2017, the consolidated community care program VHA described in its October 2015 plan and in the December 2016 request for proposals (RFP) issued by VA’s Denver Acquisition and Logistics Center is similar to the current Choice Program in certain respects. For example, VHA’s consolidated community care program would be partly administered by TPAs, which would establish regional “high-performing networks” of community providers and process payments to those providers. However, the RFP states that staff at VAMCs will have responsibility for appointment scheduling. The RFP also indicates that the department is planning to award contracts before the end of fiscal year 2017. To support VHA’s planned consolidation of its community care programs, VA has requested that Congress enact legislation to streamline and simplify veterans’ community care eligibility requirements.

VA Has Established a Choice Program Appointment Scheduling Process Under Which Veterans’ Wait Times for Routine Care Could Exceed VA’s 30-Day Goal

Our preliminary analysis of VA’s process indicates that veterans who are referred to the Choice Program for routine care because services are not available in a timely manner at VA could potentially wait up to 81 calendar days to obtain care. This is in contrast to VA’s wait time goal for the Choice Program, which is that time-eligible veterans receive routine care no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider (referred to as the clinically indicated date), or if no such determination has been made, 30 calendar days from the date the veteran prefers to receive care. In practice, the maximum potential wait time of about 81 calendar days encompasses 21 or more calendar days for VAMCs to prepare veterans’ Choice Program referrals, 30 calendar days for TPAs to schedule appointments, and another 30 calendar days for appointments to occur, as follows:

- **VAMCs’ process and timeframes for preparing routine Choice Program referrals.** According to VHA policies and guidance, VAMC staff have at least 21 calendar days to confirm that veterans want to be referred to the Choice Program and to send veterans’ referrals to the TPAs:¹⁹
 - They have up to 7 calendar days after a VA clinician has determined the veteran needs care to begin contacting an eligible veteran by telephone to offer them a referral to the Choice Program.
 - They have up to 14 calendar days after initiating contact to reach the veteran by telephone or letter and confirm that they want to be referred to the Choice Program.
 - After confirming that a veteran wants to be referred to the Choice Program, however, VA has not set a limit on the number of days VAMCs should take to compile relevant clinical information and send referrals to the TPAs.

¹⁸ Pub. L. No. 114–41, § 4002, 129 Stat. 443, 461 (2015). In addition to the Choice Program, VHA has purchased health care services from community providers through other programs since as early as 1945. The primary means by which VHA has traditionally purchased care is through individual authorizations. In addition, VHA purchases community care (for example) through two different emergency care programs and through the Patient-Centered Community Care Program, which is also administered by Health Net and TriWest. For more information about VA’s other community care programs, see GAO, Veterans’ Health Care: Proper Plan Needed to Modernize System for Paying Community Providers, GAO 16-353 (Washington, D.C.: May 11, 2016).

¹⁹ According to officials from VHA’s Office of Community Care, VAMC staff are to follow VHA’s policy directive for consult management when they are preparing veterans’ Choice Program referrals. See VHA Directive 1232(1), Consult Processes and Procedures (Aug. 24, 2016, as amended on Sept. 23, 2016). VHA’s Office of Community Care has provided further guidance related to the responsibilities of VAMC staff in preparing Choice Program referrals through standard operating procedures and training materials. The 21-calendar-day time period begins with the date the veteran’s VA clinician signaled the veteran’s need for care by entering a consult into the veteran’s VA electronic health record. A consult is a request entered by a VA clinician on behalf of a patient seeking an opinion, advice, or expertise regarding evaluation or management of a specific problem.

- **TPAs' Choice Program appointment scheduling process.** Through its contracts with the TPAs, VA has established a process that allows the TPAs about 21 business days (or approximately 30 calendar days) after receiving VAMCs' Choice Program referrals to schedule veterans' routine care appointments:²⁰
 - 2 business days to review the VAMC's referral and accept it if it contains sufficient information to proceed with appointment scheduling,
 - 4 business days to contact the veteran by telephone and confirm they want to opt in to the Choice Program (which means that the veteran wants to receive care through the Choice Program and have the TPA proceed with appointment scheduling),
 - if the veteran is not reached by telephone, 10 business days for the veteran to respond to a letter confirming that they want to opt in, and
 - 5 business days to contact providers and successfully schedule the veteran's Choice Program appointment.²¹
- **VA's method for monitoring the timeliness of appointment completion.** When VHA monitors the timeliness with which Choice Program appointments for routine care occur, the date it uses as a starting point varies. Although VA's contracts require routine care appointments for time-eligible veterans to take place within 30 days of the clinically indicated date in the veteran's referral, VA does not always use the clinically indicated date to monitor the TPAs' timeliness of appointment completion. If the clinically indicated date on VA's referral occurred before the date the TPA received the referral—as was the case for about 76 percent of the Choice Program authorizations in the sample we reviewed—VA uses the date on which the TPA succeeded in scheduling the veteran's initial appointment as the starting point for determining whether veterans' Choice Program appointments for routine care occur in a timely manner.²² In these cases, VA considers an appointment to be timely if it occurred within 30 days of the date the TPA scheduled it.²³

See figure 2, below, for an illustration of the 81-day potential wait time for veterans to receive routine care through the Choice Program.

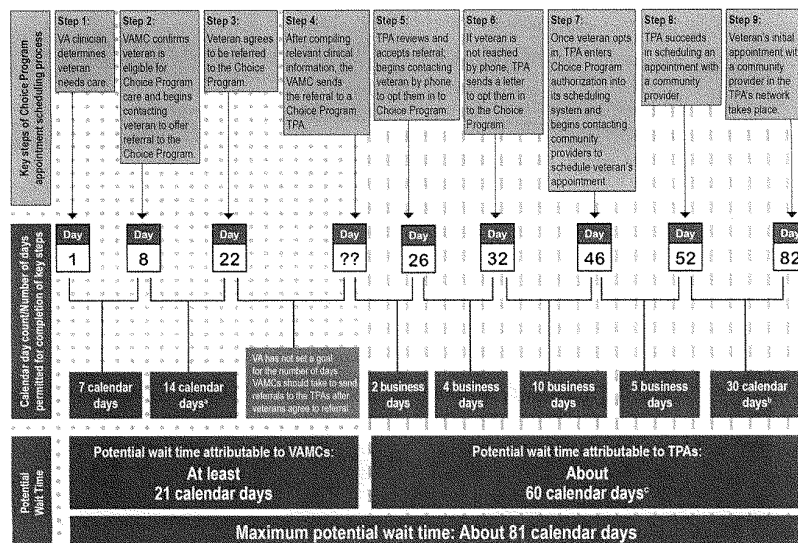
²⁰The contractual requirement that Choice Program appointments for routine care shall take place within 30 calendar days of the clinically indicated date does not account for the potential 21 days that may have already elapsed during VAMCs' process for preparing Choice Program referrals.

²¹The TPAs would have 29 calendar days to complete the appointment scheduling process if the VAMC sent the referral on a Monday, Tuesday, Wednesday, or Thursday and 31 calendar days if the VAMC sent the referral on a Friday. If there are holidays, the total number of calendar days permitted to elapse may be greater than 29 or 31 calendar days.

²²Our 76 percent calculation is based on 134 of the 196 Choice Program authorizations in our sample. We could not identify either VA's clinically indicated date or the date the TPA received the referral for a total of 62 of the authorizations in our sample because (for example) the authorizations were for distance-eligible veterans who self-referred to the Choice Program or they were related to requests for additional services after veterans had already initiated an episode of Choice Program care.

²³According to VA's contracts with the TPAs, performance metrics for timeliness start with a valid authorization for services and specifically state that the contractor will not be penalized in its metrics for delays caused by VA.

Figure 2: Potential Wait Time for Veterans to Obtain Routine Care through the Choice Program Process



2 9 Veterans Affairs Medical Center (VAMC) process

2 3 3 Third party administrator (TPA) process

Source: GAO illustration based on analysis of VHA and TPA documents. | GAO-17-397T

Note: This figure illustrates potential wait times for veterans who are referred to the Choice Program because services are not available in a timely manner at a Department of Veterans Affairs (VA) medical facility. Veterans who are using the Choice Program because they reside more than 40 miles from a VA medical facility would begin the appointment scheduling process by contacting the third party administrator (TPA) directly to request an appointment. For these veterans, the appointment scheduling process would begin at step 7 in the figure above. Because these veterans do not have referrals from VA medical centers (VAMC), VA measures the timeliness of routine appointment scheduling and completion for these veterans on the basis of whether the initial Choice Program appointment occurred within 30 days of the date the veteran preferred to receive care.

*a*VAMCs must attempt to contact veterans at least once by phone, and if the veterans are not reached, VAMCs must then send letters to the veterans and wait up to 14 calendar days for the veterans to respond that they want to be referred to the Choice Program.

*b*The 30-calendar-day appointment completion timeframe begins with the date the TPA scheduled the appointment only if the TPA receives the VAMC's referral for routine care after the clinically indicated date for a time-eligible veteran has already passed. If the TPA receives a referral before the clinically indicated date has passed, VHA measures timeliness of Choice Program appointment completion on the basis of whether the veteran's appointment occurred within 30 days of the clinically indicated date.

*c*The potential wait time attributable to TPAs would be 59 calendar days if the VAMC sent the referral on a Monday, Tuesday, or Wednesday and 61 calendar days if the VAMC sent the referral on a Thursday or Friday. If there are holidays, the total number of calendar days permitted to elapse may be greater than 59 or 61 calendar days.

VHA's Monitoring of the Overall Timeliness of Choice Program Care is Limited, and Selected Veterans Have Experienced Lengthy Waits for Routine and Urgent Care

Data Limitations Hamper VHA's Monitoring of Veterans' Overall Wait Times for Choice Program Care

Our preliminary analysis indicates that VHA lacks complete, reliable data to monitor the overall timeliness with which veterans have received routine and urgent care through the Choice Program. Our analysis of a random, non-generalizable sample of 196 Choice Program authorizations indicates that the data VHA uses to monitor appointment wait times in the Choice Program have several key limitations, which include (1) an inability to monitor VAMCs' timeliness in preparing Choice Program referrals, (2) a lack of data on the TPAs' timeliness in accepting referrals and opting veterans in to the Choice Program, (3) issues with the reliability of clinically indicated dates on VAMCs' Choice Program referrals, and (4) VAMCs' and TPAs' miscategorization of routine Choice Program referrals as urgent care referrals.

VHA Cannot Calculate the Average Number of Days VAMCs Take to Prepare Choice Program Referrals

Our preliminary analysis indicates that the data VHA currently uses to monitor the timeliness of Choice Program appointment scheduling and completion do not capture the days it takes for VAMCs to prepare veterans' referrals and send them to the TPAs. This is because VHA has not standardized the manner in which VA clinicians and VAMC staff categorize consults that lead to Choice Program referrals.²⁴ We observed inconsistency in the titles of consults that were associated with the non-generalizable sample of Choice Program authorizations we reviewed. For example,

- consult titles sometimes included the word "Choice," but in other cases they included the words "non-VA care."
- Some of the consult titles indicated the criterion under which the veteran was eligible for the Choice Program and the type of care the veteran needed (for example, "Choice-First Physical Therapy"), while other consult titles only indicated the type of care the veteran needed (for example, "pain management").²⁵

We observed this variability among consult titles both within single VAMCs and across all six of the VAMCs we visited.

In the absence of standardized consult titles, VHA has no automated way to electronically extract data from VA's electronic health record and calculate the average number of days it takes for VAMC staff to prepare veterans' Choice Program referrals after veterans have agreed to be referred to the program. Further, without standardized consult titles, VHA cannot monitor veterans' overall wait times—from the time VA clinicians determine veterans need care until the veterans attend their first appointments with Choice Program providers.

The lack of standardized consult titles also prevents VHA from tracking average overall wait times and monitoring the timeliness of care for veterans whose Choice Program authorizations are returned by the TPAs without scheduled appointments. When authorizations are returned, VAMC staff must attempt to arrange care either at a VA medical facility, through the Choice Program by initiating a new Choice Program referral, or through another VA community care program.

Available VHA Data Do Not Capture the Time Spent By TPAs in Accepting VAMCs' Referrals and Opting Veterans into the Choice Program

Our preliminary analysis indicates that the data VHA currently uses to monitor the timeliness of Choice Program appointments for routine and urgent care capture only a portion of the process that the TPAs carry out to schedule veterans' appointments after they receive referrals from VAMCs. Specifically, VHA's data reflect the timeliness of appointment scheduling and completion after the TPAs create authorizations in their appointment scheduling systems, which (according to VA's contracts) the TPAs must do only after they have received all necessary information from VA and the veteran has opted in to the Choice Program. Therefore, VHA's

²⁴A consult is an electronic request entered in VA's electronic health record by a VA clinician who is seeking an opinion, advice, or expertise regarding evaluation or management of a veteran's condition. For the purposes of the Choice Program, the consult entry date is the date a veteran's need for care was originally identified. When there is a wait for a VA appointment or services are unavailable at VA, staff at the VAMC use information from the consult—such as the clinically indicated date determined by the VA clinician and a description of needed services—to prepare veterans' Choice Program referrals.

²⁵The term "Choice-First" pertains to veterans who are referred to the Choice Program because services are unavailable at a VA medical facility or the veteran cannot receive an appointment at a VA medical facility or another federal medical facility within VHA's timeliness standards. It comes from VHA's May and October 2015 policy memoranda, which required VAMCs to offer eligible veterans the opportunity to receive care through the Choice Program before attempting to arrange care through any other VA community care program.

timeliness data do not capture the time TPAs spend (1) reviewing and accepting VAMCs' referrals, and (2) contacting veterans to confirm that they want to opt into the Choice Program.

During our ongoing work, when we asked how they are monitoring the timeliness of Choice Program appointments, VHA officials provided us the following types of data on the TPAs' appointment scheduling timeliness, all of which reflect the time that elapses only after veterans have opted into the Choice Program and the TPAs have created authorizations:

- the average number of business days the TPAs take after creating authorizations to schedule appointments for routine and urgent care,
- the percentage of appointments for routine care that the TPAs schedule within 5 business days after they create authorizations, and
- the percentage of appointments for urgent care that the TPAs schedule within 2 business days after they create authorizations.

In addition, VHA officials have provided us data on the timeliness with which Choice Program appointments have occurred. Specifically, VHA has provided the following types of data, almost all of which reflect the timeliness with which appointments occur only after veterans have opted into the Choice Program and the TPAs have either created authorizations or successfully scheduled veterans' appointments:

- the average number of business days after the TPAs create authorizations in which appointments for routine and urgent care occur,
- the percentage of appointments for routine care that are completed within 30, 60, 90, and 120 business days or more after the TPAs create an authorization,
- the percentage of appointments for routine care that are completed within 30 calendar days of either (1) the TPAs scheduling appointments, (2) the clinically indicated date on the VAMC's referral, or (3) the veteran's preferred date, and²⁶
- the percentage of appointments for urgent care that are completed within 2 calendar days of the TPAs creating the authorizations.

Because, as previously explained, VHA lacks data on the average timeliness with which VAMCs prepare Choice Program referrals, and VHA also lacks data on the average amount of time that elapses between when the TPAs receive VAMCs' referrals and when veterans opt in with the TPAs, our preliminary analysis indicates that VHA cannot track veterans' overall wait times for Choice Program care from the time VA clinicians determine that veterans need care until the veterans attend their first appointments with Choice Program providers. In addition, the lack of data on the timeliness with which the TPAs have (1) accepted VAMCs' referrals and (2) opted veterans in to the program also prevents VHA from assessing whether the TPAs' average timeliness in completing these actions has improved over time.

Clinically Indicated Dates Are Sometimes Changed by VAMC Staff

Our preliminary analysis of a sample of 196 Choice Program authorizations shows that another limitation of available VHA data is that the clinically indicated dates included on referrals that VAMCs send to the TPAs may not be identical to the clinically indicated dates that were originally entered by the VA clinicians who treated the veterans. The clinically indicated date is the earliest date an appointment is deemed clinically appropriate by a VA clinician. It could be the same as the date the VA clinician determined the veteran needed care, if there is no clinical reason that the veteran should delay care. If VAMCs' Choice Program referrals have clinically indicated dates that are different from than the ones VA clinicians originally entered, there is risk that VHA's data will not accurately reflect veterans' actual wait times.

²⁶ If a veteran is using the Choice Program because services at VA are unavailable or cannot be accessed in a timely manner, VHA's method for determining whether appointments for routine care occur in a timely manner is dependent upon whether the clinically indicated date on the VAMC's referral occurs before or after the date the TPA received the referral. If the clinically indicated date on the VAMC's referral occurred before the date the TPA received the referral—as was the case for about 76 percent of the 134 Choice Program authorizations in our sample for which we could identify clinically indicated dates—VHA uses the date the TPA succeeded in scheduling the appointment as the starting point for monitoring the timeliness of appointment completion. If the clinically indicated date on the VAMC's referral occurs after the date the TPA received the referral, VA considers an appointment for routine care as having occurred in a timely manner if it occurs within 30 days of the clinically indicated date on the VAMC's referral. If veterans are using the Choice Program because they reside more than 40 miles from a VA medical facility, VHA measures the timeliness with which appointments for routine care are completed on the basis of whether the initial Choice Program appointments occurred within 30 days of the date the veterans preferred to receive care.

VHA's policy directive on consult management and its Choice Program standard operating procedure for VAMCs state that the clinically indicated date is to be determined by the VA clinician who is treating the veteran. However, in reviewing VA's electronic health records for our sample of Choice Program authorizations, we identified 60 cases where the clinically indicated dates VAMC staff entered on Choice Program referrals they sent to the TPAs differed from the clinically indicated dates that were originally entered by VA clinicians.²⁷ We could not conclusively determine the reason the dates differed. It is possible that VAMC staff mistakenly entered incorrect dates when they manually entered clinically indicated dates on the veterans' Choice Program referrals. It is also possible that VAMC staff inappropriately entered later clinically indicated dates when they sent the referrals to the TPAs because the VAMC staff were delayed in completing the necessary steps of contacting the veteran, compiling relevant clinical information, and sending the referral to the TPA.

VAMCs and TPAs Frequently Miscategorize Routine Choice Program Referrals as Urgent Referrals

Our preliminary results indicate that another limitation of VHA's available data on the timeliness of Choice Program care is that VAMCs and TPAs do not always adhere to the Choice Program's contractual definition for urgent care when they are processing referrals and scheduling appointments. If Choice Program referrals for routine care are inappropriately categorized as urgent care referrals, VHA's data on the timeliness of urgent appointment scheduling and completion will not accurately reflect the TPAs' performance.

Among the sample of 53 Choice Program authorizations for urgent care we reviewed, VHA and TPA documentation showed that 39 authorizations (about 74 percent) did not consistently apply VA's contractual definition for urgent care authorizations. According to VA's contracts with the TPAs, Choice Program referrals are to be marked as "urgent" when a VA clinician has determined that the veteran needs care that (1) is considered essential to evaluate and stabilize conditions and (2) if not provided would likely result in unacceptable morbidity or pain when there is a significant delay in evaluation or treatment.²⁸ It is VA's goal that the TPAs schedule appointments for urgent care and ensure that they take place within 2 business days after veterans opt in to the Choice Program. In some cases, VA clinicians marked consults as routine but VAMC staff changed the status to urgent when they sent the referrals to the TPAs. In other cases, TPA staff changed the referrals from routine to urgent after receiving them from the VAMCs. Based on our preliminary analysis of the authorizations, it appeared in some cases that these changes were made in an effort to administratively expedite appointment scheduling when the VAMCs or TPAs were delayed in sending referrals and scheduling veterans' Choice Program appointments.

Selected Veterans Experienced Lengthy Overall Wait Times for Choice Program Care in 2016

The sample of 196 Choice Program authorizations we reviewed included only authorizations for which there were delays when the TPAs attempted to schedule appointments after the veterans had opted into the program; however, our preliminary analysis of these authorizations indicates that delays occurred at other phases of the referral and appointment scheduling process as well. Many veterans in our sample experienced lengthy overall wait times for Choice Program care—as measured from the time their need for care was identified until they attended their initial appointments—and only a portion of the overall wait time could be explained by the TPA's delay in scheduling an appointment after the veteran opted into the Choice Program. Our analysis of veterans' VA electronic health records and the TPAs' records for a sample of 55 routine care authorizations and 53 urgent care authorizations for which the TPAs succeeded in scheduling appointments identified the following average review times:

²⁷ We were able to identify clinically indicated dates for 134 of the 196 Choice Program authorizations in our sample. We could not identify VA's clinically indicated dates for a total of 62 of the authorizations in our sample. Clinically indicated dates were missing for these 62 authorizations because (for example) they were for distance-eligible veterans who self-referred to the Choice Program or the authorizations were related to requests for additional services after veterans had already initiated an episode of Choice Program care.

²⁸ Under VA's Choice Program contracts, urgent care is not the same as care provided for a medical emergency, which is covered through different VA community care programs. Urgent care (rather than emergent care) delivered through the Choice Program is care that is delivered when there is no threat to the veteran's life, limb, or vision but the veteran's condition needs attention to prevent it from becoming a serious risk to the veteran's health.

- It took VAMC staff an average of 24 calendar days after the veterans' need for routine care was identified to contact the veterans and confirm that they wanted to be referred to the Choice Program, compile relevant clinical information, and send veterans' referrals to the TPAs. It took an average of 27 calendar days for the VAMCs to complete these actions for the urgent care authorizations in our sample.²⁹
- For the routine care authorizations in our sample, it took the TPAs an average of 14 calendar days to accept referrals and reach veterans by telephone or letter to opt them in to the Choice Program. It took the TPAs an average of 18 calendar days to complete these actions for the urgent care authorizations in our sample.
- After the TPAs succeeded in scheduling veterans' appointments for routine care, an average of 26 calendar days elapsed before veterans in our sample completed their initial appointments with Choice Program providers. For urgent care authorizations in our sample, it took an average of 18 days for the veterans to complete their initial appointments after the TPAs scheduled them.

See the following text box for specific examples of the overall wait times experienced by some veterans in the samples of routine and urgent Choice Program authorizations we reviewed.

Examples of Delays Experienced by Veterans for whom the Choice Program Third Party Administrators (TPA) Scheduled Appointments

- One veteran was referred to the Choice Program for magnetic resonance imaging (MRI) of the neck and lower back because these services were unavailable at a Veterans Affairs (VA) medical facility. It took almost 3 weeks for VA medical center (VAMC) staff to prepare his Choice Program referral for routine care and send it to the TPA, and then it took an additional 2 months after the VAMC sent the referral for the veteran to receive care. Notes in the veteran's VA electronic health record indicated that his follow-up appointment with a VA neurosurgeon was at risk of being rescheduled because VA had not received the results of the MRI after the appointment with the Choice Program provider occurred. Ultimately, the veteran's appointment with the VA neurosurgeon where the imaging results and treatment options were discussed did not occur until almost 6 months after the VA clinician originally identified the need for the MRI.
- One veteran was a diabetic who was referred to the Choice Program for his annual retinal exam because there was a wait for services at a VA medical facility. However, it was not until 30 days after the VA clinician determined the veteran needed this care that VAMC staff sent the Choice Program referral to the TPA. It then took the TPA 36 additional days to reach the veteran and confirm he wanted to opt in to the Choice Program. In all, the veteran waited almost 5 months after his VA clinician determined he needed this routine care until his appointment with a Choice Program provider occurred.
- Three veterans were referred to the Choice Program because they needed maternity care, which is generally not available at VA medical facilities. For one of these veterans, almost a month and a half elapsed from the time VA confirmed her pregnancy (when she was 6 weeks pregnant) to when the VAMC sent the Choice Program referral for urgent care to the TPA. It then took 2 additional weeks for the TPA to attempt to schedule a prenatal appointment; by that point, she was almost 15 weeks pregnant. At 18 weeks pregnant, the veteran finally scheduled her initial prenatal appointment herself, almost 3 months after her pregnancy was confirmed at a VA medical facility.
- One veteran was referred to the Choice Program for thoracic surgery to address a growth on his lung because there was a wait for VA care. TPA documentation we reviewed indicated that VAMC staff contacted the TPA four times to inquire about the status of the veteran's appointment, and the TPA contacted five Choice Program providers in its unsuccessful attempts to schedule the urgent

²⁹ Our calculation for the average number of days it took VAMCs to send Choice Program authorizations for routine care to the TPAs is based on 41 of the 55 routine authorizations in our sample, and our calculation for authorizations for urgent care is based on 36 of the 53 authorizations in our sample. We could not include in our calculations all the authorizations in our sample because either the date the veteran's need for care was identified or the date the VAMC sent the referral to the TPA was missing. We also could not determine what portion of the total time it took VAMCs to prepare veterans' Choice Program referrals was accounted for by the interim steps of contacting the veteran or compiling relevant clinical documentation because we could not find in VA's electronic health record sufficient evidence of the dates these actions were completed for all of the authorizations in our sample.

appointment for the veteran. Ultimately, the veteran scheduled his own initial appointment with a thoracic surgeon in the community and informed the TPA that he had done so. The veteran's initial appointment occurred 3 weeks after the VAMC sent his referral to the TPA. -

Source: GAO analysis of VHA and TPA documentation. / GAO 17 397T

Note: The above examples come from GAO's random, non-generalizable sample of 55 authorizations for routine care and 53 authorizations for urgent care for which the Choice Program TPAs scheduled appointments between January 2016 and April 2016.

Our preliminary results also show that veterans in our sample experienced lengthy overall wait times to receive care when the TPAs returned their authorizations without scheduling appointments. When veterans' Choice Program authorizations are returned, VAMCs must attempt to arrange care through other means—such as through another VA community care program, a new Choice Program referral, or at a VA medical facility. Among the 88 returned authorizations in our sample, we determined that 53 veterans eventually received care through other means after their authorizations were returned.³⁰ These 53 veterans ended up waiting an average of 111 days after the VA clinician originally determined they needed care until their first appointment with a VA clinician or with a community provider occurred. See the text box below for some examples of delays experienced by veterans in the sample of 88 returned Choice Program authorizations we reviewed.

Examples of Delays Experienced by Veterans Whose Authorizations were Returned to Veterans Affairs Medical Centers (VAMC) by the Choice Program Third Party Administrators (TPA)

- The VAMC took almost 3-and-a-half months to refer one veteran to a physical therapist to address her pelvic floor prolapse. When the preferred provider listed in the VAMC's referral was outside the TPA's network, the TPA sent a message to the VAMC via its Web-based portal to ask if they should try scheduling the appointment with a different provider. By the time VAMC staff responded to the message in the TPA's portal, the TPA had already returned the authorization—almost 2 weeks after accepting it. Two months later, the VAMC realized that the veteran still needed this care and sent a new Choice Program referral to the TPA. It then took the veteran another 2-and-a-half months to attend her first appointment. Overall, this veteran waited more than 8 months to receive physical therapy.
- It took about 2-and-a-half weeks for the VAMC to send one veteran's referral for pain management to the TPA after a VA clinician originally determined he needed these services. However, information the TPA needed for scheduling the Choice Program appointment was missing from the VAMC's referral. The TPA requested the information from the VAMC twice using its Web-based portal, but VAMC staff did not reply, and the TPA returned the authorization 2 weeks after receiving it. It then took another month before the veteran ended up receiving pain management services at a VAMC. Overall, this veteran waited almost 2-and-a-half months for pain management services.

Source: GAO analysis of VHA and TPA documentation. / GAO 17 397T

Note: The above examples come from GAO's random, non-generalizable sample of 88 Choice Program authorizations that the TPAs returned to six VAMCs between January 2016 and April 2016.

VHA Is Taking Steps to Improve the Timeliness of Veterans' Choice Program Care, Although Nationwide Implementation of these Actions Has Been Limited

³⁰ These 53 veterans received care either at a VA medical facility, through another VA community care program, or through a new Choice Program authorization. We could not conclusively determine whether 20 of the 88 veterans in our sample received the care they needed after the TPAs returned their Choice Program authorizations. We provided these veterans' names to VHA officials in December 2016, and the officials said they would follow up on these cases. In addition, 14 of the 88 veterans in our sample either declined care or no longer needed the care that was authorized. Three of those 14 veterans no longer needed care because they died before the TPAs or VAMCs could schedule appointments. Two veterans had been diagnosed with cancer, had emergency inpatient admissions after they were referred to the Choice Program, and died before the TPAs could schedule appointments. The third veteran had been referred to the Choice Program for in-home physical therapy but also had a series of inpatient admissions that made it difficult for the TPA to arrange his care. The one remaining veteran in our sample was no longer eligible for services, which is why the TPA returned her authorization to VA.

During the course of our ongoing work, VHA officials told us about several recent actions they have taken or that they plan to take that are intended to improve the timeliness of veterans' Choice Program care. Below is a chronological summary of several such actions, along with VHA's progress in implementing them.³¹ Many of VHA's changes have been implemented within the last calendar year, and so far, implementation of these actions has often been limited to a few VAMCs or to the VAMCs that are located in a few Veterans Integrated Service Networks (VISN).³²

- **Co-Locating TPA staff at selected VAMCs. In November 2015**, VA modified the Choice Program contracts to allow for TPA staff to be co-located at selected VAMCs—an action that VHA officials said could help improve communication between VAMC and TPA staff as they work to schedule veterans' Choice Program appointments. For example, VHA officials expect that one potential benefit of co-locating TPA staff will be that fewer veterans' Choice Program referrals will be returned to VAMCs due to missing clinical information because TPA staff can help resolve such issues locally before the TPA returns referrals. As of December 2016, TPA staff were working at 54 of VHA's 168 VAMCs—or about one third of all VAMCs. However, according to VHA documentation, only 13 of those 54 VAMCs had co-located TPA staff prior to October 1, 2016, which means that the majority of the 54 VAMCs with co-located TPA staff have only recently received such support.
- **Automating VAMCs' preparation of Choice Program referrals.** VHA is in the process of establishing a Web-based tool that it says would automate the process by which VAMC staff compile clinical information for veterans' Choice Program referrals. Currently, VAMC staff must manually retrieve and collate key clinical and contact information from veterans' VA electronic health records. If there are mistakes or missing information, the TPAs may either contact the VAMC to correct or obtain the missing information or return the referral to VA without attempting to schedule an appointment, and this could delay veterans' access to Choice Program care. In early 2016, to decrease the rate of returned authorizations and speed up the process for VAMCs to prepare veterans' Choice Program referrals, staff from two VAMCs developed a Web-based tool-called the “referral documentation” (REFDOC) tool—which, according to VHA documentation, automates the process of gathering necessary information and assembling it in a standardized format. VHA's initial analyses of the REFDOC tool's effectiveness found that it sped up the process of preparing Choice Program referrals by about 20 minutes per referral. VHA officials we interviewed said they intend to roll out the REFDOC tool across all VAMCs, but nationwide implementation has been slowed by limitations of VA's information technology systems. As of November 2016, according to documentation provided by VHA, the REFDOC tool had been implemented at only 18 of VHA's 168 VAMCs. Officials have stated that they expect to implement the REFDOC tool at all VAMCs in March 2017.
- **Requiring TPAs to return referrals if appointments are not scheduled within required timeframes.** A June 2016 VA contract modification requires the TPAs to return Choice Program authorizations to VAMCs when the TPAs do not meet standards set forth in the contract related to the timeliness with which they review and accept referrals and schedule appointments after veterans have opted into the program. Previously, the TPAs had to return referrals if veterans had not opted in 10 days after the TPA sent a letter, but there was no requirement for the TPAs to accept referrals within a certain timeframe or to return authorizations if the TPAs had not scheduled appointments within required timeframes after veterans opted in. This contract modification has the potential to limit appointment scheduling delays that would be attributable to the TPAs, but it does not affect the timeframes by which VAMCs are required to prepare veterans' Choice Program referrals and send them to the TPAs.
- **VAMC scheduling pilots.** In July 2016 and October 2016, VHA began implementing pilot projects at two VAMCs, whereby staff at the VAMCs have taken

³¹VHA has taken actions to address various other Choice Program weaknesses. In this statement, we are highlighting our preliminary observations on those actions which relate most directly to improving the timeliness of veterans' access to care.

³²VHA's health care system is divided into areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA medical facilities that are within their boundaries. Each VA medical facility is assigned to a single VISN. At the start of fiscal year 2016, there were 21 VISNs, but VA is in the process of consolidating some networks so that by the end of fiscal year 2018, there will be 18 networks.

over the responsibility of scheduling veterans' Choice Program appointments from the TPAs, according to VHA officials. Specifically, VA modified its contracts with TriWest and Health Net to implement the two VAMC scheduling pilots at the Alaska VA Health Care System and the Fargo VA Health Care System, respectively. In these two locations, VAMC staff schedule veterans' appointments and send relevant clinical documentation to the Choice Program providers, and the TPAs send authorizations to the Choice Program providers before veterans attend their appointments. VHA officials told us that they plan to make similar contract modifications to implement pilots at four other VAMCs prior to the Choice Program's expiration. They also plan to evaluate the implementation of the appointment scheduling pilots and use the findings of those evaluations to help inform the design of the VAMC appointment scheduling process they plan to include in the consolidated VA community care program they intend to implement after the Choice Program expires.

- **Real-time, Web-based communication tool for VAMCs and TPAs.** Between August and October of 2016, VA implemented a real-time communication tool (specifically, a Web-based chat program) at VAMCs in five VISNs. VHA officials and VAMC staff can use the tool to communicate with TPA officials about problems that have arisen with specific Choice Program referrals (such as missing clinical information), or patterns of problems that have emerged with Choice Program referrals. VHA officials told us that they planned to implement the chat room at all VAMCs nationwide by the end of January 2017.
- **Planned standardization of consult titles for Choice Program referrals.** According to documentation VHA officials provided to us in December 2016, they plan to implement a process for standardizing the consult titles associated with Choice Program referrals over the course of calendar year 2017. They planned to pilot the process at four VAMCs beginning in February 2017 and expected to gradually roll out the standardized consult titles across all other VAMCs over the remainder of calendar year 2017. As previously discussed, having standardized consult titles associated with Choice Program referrals will allow VHA to monitor (1) the timeliness with which its VAMCs prepare veterans' Choice Program referrals and send them to the TPAs, and (2) veterans' overall wait times for Choice Program appointments.

Chairman Roe, Ranking Member WALZ, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann (Assistant Director), Alexis C. MacDonald (Analyst-in-Charge), Daniel Powers, and Michael Zose. Also contributing were Christine Davis, Krister Friday, Jacquelyn Hamilton, and Vikki Porter.

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO

e mail you a list of newly posted products, go to <http://www.gao.gov> and select “E-mail Updates.”

Order by Phone

The price of each GAO publication reflects GAO’s actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO’s website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512–6000, toll free (866) 801–7077, or TDD (202) 512–2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, LinkedIn, Twitter, and YouTube. Subscribe to our RSS Feeds or E mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov and read The Watchblog.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424–5454 or (202) 512–7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512–4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512–4800

U.S. Government Accountability Office, 441 G Street NW, Room 7149, Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512–4707

U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548

Statements For The Record

VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)

STATEMENT OF CARLOS FUENTES, DIRECTOR

NATIONAL LEGISLATIVE SERVICE

Chairman Roe, Ranking Member WALZ, and members of the House Committee on Veterans’ Affairs, on behalf of the nearly 1.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, I thank you for the opportunity to submit a statement for the record regarding the Choice Program and how to consolidate and improve VA community care.

The VA health care system delivers high quality care and has consistently outperformed private sector health care systems in independent assessments. The VFW’s numerous health care surveys have also validated that veterans who use VA health care are satisfied with the care they receive. In fact, our latest survey found that 77 percent of veterans report being at least somewhat satisfied with their VA health care experience. When asked why they turn to VA for their health care needs, veterans report that VA delivers high quality care which is tailored to their unique needs and because VA health care is an earned benefit.

VA has made significant strides since the access crisis erupted in 2014 when whistleblowers across the country exposed how long veterans were waiting for the care they have earned and deserve. However, VA still has a lot of work to do to ensure all veterans have timely access to high quality and veteran centric care. But

VA cannot be everything for everyone. It must leverage private sector providers and other public health care systems to meet its obligation to the veterans it was created to serve, but community care is only part of the solution.

Veterans deserve reduced wait times and shorter commutes to their medical appointments. This means turning to community care when needed, but also means improving VA's ability to provide direct care. The VFW thanks Congress for its commitment to improving VA's community care authorities and programs. VA also needs the resources and authorities to quickly recruit and properly compensate a high performing health care workforce, properly train its employees, hold wrongdoers accountable, and update its aging capital infrastructure.

In the past three years, the VFW has assisted hundreds of veterans who have faced delays receiving care through the Choice Program, and has surveyed more than 8,000 veterans specifically on their experiences using VA community care and the Choice Program. Through this work, the VFW has identified a number of issues with the program which must be addressed. For example, veterans continue to receive bills from private sector doctors who were unable to receive payment from VA because of complicated rules determining when VA is able to pay and when it serves as a secondary payer. Veterans should never be billed for care that VA is responsible for paying. To address this issue, the VFW urges Congress to remove the secondary payer requirement under the Choice Program.

Choice Program doctors also tell us it takes too long for them to receive the medical documentation from VA that they need in order to treat veterans. One doctor said "it's easier to get gold out of Fort Knox, than it is to get medical records from VA." VA is taking steps to improve this process and will implement a new program soon to ensure Choice providers can view a veteran's medical record. However, an outdated law which requires VA to withhold the medical information of veterans who have been diagnosed with substance use disorder, human immunodeficiency virus, and sickle cell anemia hinders VA's ability to transfer medical records with its community care partners. Congress must remove this statutory limitation to ensure veterans who use the Choice Program do not encounter scheduling delays.

As the VFW has highlighted in our two Choice Program reports, which can be found on our website, www.vfw.org/vawatch, the eligibility criteria for the Choice Program must also be reformed. The VFW thanks this Committee and VA for making several VFW recommended improvements to the Choice Program, such as measuring mileage by driving distance instead of "how the crow flies" and making the clinically indicated date the date on which veterans become eligible for community care. However, several recommendations remain.

First, the VFW firmly believes that VA must reevaluate how it measures wait times. In the VFW's most recent VA health care report, only 67 percent of veterans indicated they had obtained a VA appointment within 30 days, which is significantly less than the 93 percent VA reported in its most recent access report. This is because the way VA measures wait times is not aligned with the realities of scheduling a health care appointment.

VA uses a metric called the preferred date to measure the difference between when a veteran would like to be seen and when they are given an appointment. However, this completely ignores and fails to account for the full length of time a veteran waits for care. For example, when veterans call to schedule an appointment they are asked when they prefer to be seen. The first question they logically ask is, "When is the next available appointment?" If VA's scheduling system does not preclude them from doing so, schedulers have the ability to input the medical facility's next available appointment as the veteran's preferred date—essentially zeroing out the wait time. VA must correct its wait time metric to more accurately reflect how long veterans wait for their care.

However, VA's wait time measurement must not be used as an eligibility criterion for the Choice Program. While the VFW agrees that using a clinically indicated date to determine eligibility is the right approach, we do not believe Congress or VA should dictate how long veterans must wait before receiving care from community care providers. Arbitrary thresholds such as 30-days or 40-miles do not reflect the health care landscape of our country. Veterans may not need to be seen within 30 days for appointments such as routine checkups. Likewise, such arbitrary thresholds do not account for veterans with urgent medical needs for which they need to be seen before 30 days, or veterans who suffer from disabilities which prevent them from traveling 40 miles.

A recent independent assessment on VA access standards by the Institute of Medicine (IOM) was unable to find a national standard for access similar to the Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. That is why Congress should not dictate eligi-

bility for community care with arbitrary or federally regulated access standards, such as 30-days or 40-miles. When and where a veteran needs to be seen is a clinical decision made between a veteran and his or her doctor.

Overall, Congress and VA must take the lessons learned from the Choice Program and other community care programs such as Project ARCH, Project HERO, and PC3, and create a single, sustainable community care program that integrates the private sector into the VA health care system. VA has outlined its vision for consolidating its community care programs in a report it was required to send Congress under Public Law (PL) 114-41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. It is time for Congress to act on VA's proposal to ensure VA is able to transform the way it provides community care.

Congress' self-imposed budget rules have stopped several bills that would have enabled VA to begin implementing its consolidation plan. As the Choice Program gets closer to expiring, Congress continues to debate on the way forward. Instead of waiting until the 11th hour to act on a consolidation bill, which would limit VA's ability to continue to serve veterans, Congress must allow VA to continue the Choice Program under its existing community care authorities.

To be clear, VA has the authority to carry out the Choice Program past its expiration and is willing to do so, but lacks the community care appropriations. While it would be best for Congress to pass a consolidation bill that would improve the Choice Program and consolidate VA's numerous community care authorities, the VFW does not believe Congress can do so without slowing or degrading VA's ability to carry out the existing program. That is why the VFW believes it is best for Congress to simply provide VA the resources it needs to carry out the program under its existing authorities, rather than move forward with a comprehensive community care consolidation bill which is unlikely to become law.

Veterans have used approximately \$3 billion in care through the Choice Program per year and that demand for care will only continue to increase as more veterans turn to VA for their health care needs. VA currently sends nearly 200,000 authorizations for care a month through the Choice Program and will be required to immediately cease the program—requiring it to start from scratch and losing the trust and confidence it has worked so hard to restore—if it does not receive the funding needed to continue the program before it expires.

VA estimated that its authority to use the \$10 billion emergency mandatory appropriations account Congress created to fund the Choice Program will expire before funds are fully exhausted. To ensure these funds are used for their intended purpose, the VFW supports eliminating the expiration of this account. But to be perfectly clear, the VFW would oppose any future efforts to refill this account. Appropriations for VA community care must be included in VA's annual budget. Furthermore, VA must have that ability between its community care and medical services accounts to ensure care is delivered where veterans demand it, not where Congress dictates.

VA has also requested authority to develop a nationwide system of urgent care at existing VA medical facilities, and to reimburse veterans for urgent care they receive from smaller urgent care clinics around the country to fill the gap between emergency care and traditional appointment-based outpatient care. Doing so would ensure veterans with acute medical conditions that require urgent attention, such as the flu, infections, or non-life threatening injuries, do not wait days or weeks for a primary care appointment. Establishing urgent care would also curb the reliance on emergency rooms for non-emergent care, which is more expensive for veterans and VA. The VFW urges Congress to consider and swiftly pass legislation authorizing VA to reimburse veterans for using community urgent care clinics.

The VFW also urges Congress to swiftly pass provider agreement legislation. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not viable options.

Provider agreements are particularly important for VA's ability to provide long-term care through community nursing homes. The majority of the homes who partner with VA do not have the staff, resources or expertise to navigate and comply with FAR requirements and have indicated they would end their partnerships with VA if required to bid for FAR contracts. In fact, VA's community nursing home program has lost 400 homes in the past two years and will continue to lose 200 homes per year without provider agreement authority. This means thousands of veterans are forced to leave the place they have called home for years simply because VA is not able to renew agreements with community nursing homes. Congress must end this injustice by quickly passing provider agreement legislation.

HVAC

Dear Chairman Roe and Ranking Member WALZ.

Thank you for holding tonight's hearing on "Shaping The Future: Consolidating And Improving VA Community Care" to examine the Department of Veterans Affairs' Choice Program and the future of VA community care programs, authorities and budget impact. While the Veterans Choice Program was stood up in a time of need and with the best of intentions, I believe modest improvements could be made that would address many of the program's issues and frustrations, many of which are exemplified in the following examples my staff and I have personally resolved since the program came online.

Casework Example #1) "Tom" was automatically eligible to use his Choice card and a local provider because of the distance he lived from the nearest VA healthcare facility, but was having trouble scheduling an appointment for an MRI. Our office contacted our HealthNet Liaison requesting that his request be reviewed and approved as soon as possible. They responded and the appointment was conducted. The result of the MRI called for immediate orthoscopic knee surgery. The provider contacted HealthNet requesting approval for the knee surgery, which HealthNet granted along with additional service visits. The hospital submitted the bill for the approved procedures and was denied payment from HealthNet, who claimed the appointments weren't approved so they would not reimburse for any of the procedures including the MRI, knee surgery, follow up appointment, and knee injection. Our office had to go back to the beginning with HealthNet and use the authorization they sent to pressure them to pay the provider. It was ultimately paid for, but not without their unnecessary error delaying payment and contradicting their own authorization that had been sent to the patient, provider, and our office.

Casework Example #2) "Russ" was waiting over a year for a neck epidural, so our office became involved and we were able to schedule a Veterans Choice appointment within a week of contact, but only to find out that HealthNet scheduled the appointment with an unauthorized provider. The veteran was thus turned away the day of his appointment. We then called to reschedule and fix this error. He was rescheduled with a provider after a prolonged back-and-forth about which doctor to use. We then found out that this appointment was for testing and examination, and he would have to wait again for the neck epidural. HealthNet repeatedly had errors in which provider to use. At this point, I had to personally intervene and call HealthNet. Ultimately, Russ was able to see Doctor who had access to all of his testing and examinations from previous visits, and HealthNet covered the cost, well over a year from the initial contact.

Casework Example #3) "Darin" came to our office because he was having problems getting a past Choice appointment for a cancer check-up paid for and because he was having a hard time getting another Choice appointment set for an Orthopedic assessment. This veteran is located over 300 miles from the Minneapolis VA Hospital, so he strongly desired to utilize more local treatment whenever possible. Our office started reaching out to HealthNet in March 2016. It took multiple emails over a period of two months to HealthNet to finally get a response. It then took another set of inquiries back and forth to get a response on his request for a new appointment to see an Orthopedic specialist in the Twin Cities. We eventually got his original appointment set and the past bill paid for after a period of five months, which included at least 10 inquiries out to HealthNet and the VA, many phone calls, and a lot of confusion all around.

As these examples illustrate, the Choice program would be much better served by ensuring greater accuracy (of at least 95%) of provider payments and timely reimbursements (within 30 days), and better education - especially on the provider side - regarding the billing and authorization process. I would also urge the Committee to examine moving the program more towards a "case-management" model so that Veterans do not have to repeat their particular situation each time they speak with a different TriWest/HealthNet representative, particularly when there is a problem.

Finally, in the transition between the VA's administrative efforts and the enactment of legislative solutions to improve the delivery of community care, I do want to voice my support for allowing Veterans who have faced extraordinary difficulty with Choice utilize the Traditional VA Care in the Community/Non-VA Medical Care Program (previously known as "fee basis care"). However, a wholesale transfer of Veterans in Choice to Non-VA Medical Care could create serious unforeseen con-

sequences and additional backlog problems, so I would urge the Committee and VA to proceed with deliberation if such a policy is to be considered.

Thank you for your review and consideration of these recommendations and examples from my rural Congressional District in Minnesota. Please do not hesitate to contact me if I may be of further assistance.

Sincerely,

Richard M. Nolan
Member of Congress

PARALYZED VETERANS OF AMERICA (PVA)

Chairman Roe, Ranking Member WALZ, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to offer our views on consolidating and improving the Department of Veterans Affairs' (VA) delivery of community care. The magnitude of the impact that veterans health care will have on present and future generations of veterans cannot be overstated, and we are proud to be part of this important discussion.

PVA's historical experience and extensive interaction with veterans around the country leads us to confidently conclude that veterans prefer to receive their care from VA. We recognize, however, that while for most enrolled veterans VA remains the best and preferred option, VA cannot provide all services in all locations at all times. Care in the community must remain a viable option. As VA seeks to take the next major step in improving access to quality care for veterans, we appreciate the Committee's significant efforts in this matter.

As an initial matter, PVA supports the Chairman's bill, H.R. 369, which would eliminate the August 7, 2017 sunset date for the current Choice program and allow VA to continue to provide care with the remaining funding. VA currently estimates that remaining funds can carry the program an additional three months. This would provide both more time to formulate a plan for the next phase of community care and a mechanism to bridge the gap during the transition. Trying to pin down exactly when funds will run out, however, is like shooting at a fast-moving target. It is imperative that Congress not lose its sense of urgency as we push toward consolidation and reform. Failing to protect against overly-optimistic funding projections could lead to a painful transition if the Choice program came to an abrupt halt prior to the next iteration being implemented.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of VA. As the Department continues the trend toward greater utilization of community care, Congress and the Administration must be cognizant of the impact those decisions will have on veterans who need VA the most.

Any legislation designed to reform VA health care must incorporate or match the attributes that make VA's specialized services strong. For example, VA utilizes outcome-based standards of care across the spinal cord injury or disease (SCI/D) system, which, in turn, allows us to measure and scrutinize the quality of care provided. When individual facilities are lagging behind, the evidence is not just anecdotal. When the entire system is questioned, Congress can commission an independent assessment, similar to the one carried out as part of the original Choice legislation. What are the equivalents in the private sector? Congress should examine more closely how VA will monitor the quality of care veterans are receiving in the community. This question goes beyond a plan for care coordination. If VA is unprepared to retain ownership of responsibility for care delivered in the private sector, Congress will be helpless in conducting adequate oversight.

Many advocates for greater access to care in the community also minimize, or ignore altogether, the devastating impact that pushing more veterans into the community would have on the larger VA health care system, and by extension the specialized health services that rely upon the larger system. Broad expansion of community care could lead to a significant decline in the critical mass of patients needed to keep all services viable. We cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. If these services decline, then specialized care is also diminished. The bottom line is that the SCI system of care, and the other specialized services in VA, do not operate in a vacuum. Veterans with catastrophic disabilities rely almost exclusively upon VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers.

PVA, along with our Independent Budget (IB) partners, Disabled American Veterans (DAV) and Veterans of Foreign Wars (VFW), developed and previously pre-

sented to this Committee a framework for VA health care reform. It includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high-quality, veteran-centered health care system. Our framework stands on four pillars: 1) restructuring the veterans health care system; 2) redesigning the systems and procedures that facilitate access to health care; 3) realigning the provision and allocation of VA's resources to reflect the mission; and 4) reforming VA's culture with workforce innovations and real accountability. With this perspective, we offer our views on consolidating and strengthening the delivery of care in the community.

I. Restructuring the system in a way that establishes integrated health care networks designed to leverage the capabilities and strengths of existing local resources in order to provide more efficient, higher quality and better coordinated care.

PVA strongly supports the concept of developing high-performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. This approach is gaining consensus among stakeholders, including the most recent and current VA Secretaries, the IB, most major Veteran Service Organizations (VSO), the Commission on Care, and congressional leadership. As stakeholders coalesce around this concept, though, divisions are still apparent as to the dynamics that govern the boundaries of this network.

PVA believes, like many stakeholders and members of Congress have stated, that the definition of an integrated VA network is one that utilizes private providers to supplement, not supplant, the VA health care system. Unfettered choice of provider granted to all veterans is not an acceptable outcome for a healthy VA health care system capable of sustaining critical, veteran-centric, specialized services. It is flat-out cost-prohibitive and, in many cases, leads to fractured care as veterans attempt to navigate the private health care system without assistance in care coordination. We believe that the design and development of VA's network must be locally driven with national guidance and reflect the demographics and availability of resources within that area. While faith in VA to develop dynamic provider networks on its own may be weak, the proactive efforts of Third Party Administrators (TPAs) to work with VA and evaluate gaps in service have proven to be a valuable asset thus far in filling gaps.

VA would be able to make greater strides in this area if given the ability to bring more community providers into the fold with flexible provider agreements. The current requirement that providers enter into agreements with VA governed by the federal acquisition regulation (FAR) system has suffocated VA's attempts to expand access to care in a timely manner. Smaller health care provider organizations otherwise disposed to serve the veteran population are especially resistant to engaging in the laborious FAR process. And yet they remain a vital piece to filling the gaps in health care services in certain areas, especially rural areas.

Care coordination is an essential part of delivering quality health care. VA must continue to own the responsibility for care coordination for veterans. VA's proposal for care coordination in its Plan to Consolidate Community Care Programs revolved the patient's circumstances, specifically the intensity of coordination needed and whether or not the non-VA care was being provided based on a wait time or geographical distance.¹ In light of the Secretary's recent comments indicating a desire to remove the 30-day/40-mile standards for determining eligibility for community care, this aspect may soon need to be revisited.

There is also another serious concern that has been overlooked in the expansion of community care access. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability is incurred or health care problem arises. Under 38 U.S.C. Section 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility or as a result of care provided by a VA provider. Responding to PVA's inquiries, VA confirmed that this protection does not follow the veteran receiving care in the community. If medical malpractice occurs during outsourced care, the veteran must pursue standard legal remedies unlike similarly situated veterans who are privy to VA's non-adversarial process. Adding insult to literal injury, these veterans, if they prevail on a claim, are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again.

¹Department of Veterans Affairs, Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care, October 30, 2015, pp. 21–24, <http://www.va.gov/opa/publications/va—community—care—report—11—03—2015.pdf>.

This is simply unacceptable. Congress must ensure that these protections follow the veteran into the community. Congress must ensure veterans who receive care in the community retain current protections unique to VA health care under Title 38, particularly including medical malpractice remedies governed by 38 U.S.C. Section 1151, clinical appeal rights, no-cost accredited representation, and Congressional oversight and public accountability.

II. Redesigning the systems and procedures that facilitate access to care in a way that provides informed and meaningful choices.

PVA firmly believes that eligibility and access to care should be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans should be able to choose among the options developed within the high-performing network and schedule appointments that are most convenient for them. Access decisions dictated by arbitrary wait times and geographic distances have no comparable industry practices in the private sector. We are encouraged by the Secretary's recent comments indicating a desire to move away from the current 30-day/40-mile standard in favor of a clinical determination. VA should be able to ensure that when and where the veteran receives care is based on clinical need and availability of services. It shifts the organizational mindset and focus of VA to clinical outcomes instead of catering to arbitrary metrics governing access to care in the community.

PVA and our fellow IBVSOs continue to advocate for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care. This is consistent with current health care trends. VA previously proposed in its Plan to Consolidate Community Care Programs a more common sense determination of what constitutes reimbursable emergency and urgent care, thereby expanding access, but it came with the imposition of cost-sharing for otherwise exempt veterans. We strongly oppose co-payments for veterans who are otherwise exempt. Using co-payments as a means to discourage inappropriate use of emergency care by service-connected veterans is not an acceptable method of incentivizing behavior. VA should instead incentivize use of primary care providers by increasing the ease with which veterans access care in its integrated network.

III. Realigning the provision and allocation of VA's resources to reflect the mission.

While much of the focus is keyed to addressing smooth integration of community care, we reiterate that the access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system. PVA is proud to have been an integral part of the efforts that led to reinstating the capacity reporting requirement last Congress. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of veterans health care demand and utilization measured against VA's staffing, funding, and infrastructure. However, VA's capacity metrics have been based on deflated utilization numbers that fail to properly account for the true demand on its system.

The nurse shortage within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and forced SCI/D centers to reduce the amount of veterans they admit. A decrease in the daily average census at some SCI/D centers naturally followed, suggesting that there is a lack of demand in the system. In reality, veterans who want to access SCI/D care are turned away because those centers lack the staff to man available beds.

A reduction in capacity to provide services is the immediate effect of staffing shortages. But second and third order effects follow and create a negative feedback loop that is detrimental to the entire SCI/D system of care. As staffing thins and those remaining behind attempt to cover more responsibility, individual patients receive less attention and staff burn out. It impacts morale and eventually erodes the overall quality of care. As this cycle takes hold, demand for care in these facilities shrinks. When VA calculates demand under these conditions, the new demand metrics have been artificially depressed and tend to justify reduced staff, further perpetuating the downward spiral.

With the capacity reporting requirement reinstated, Congress now has the means to conduct effective oversight and ensure VA stays ahead of the curve in determining where shortages exist and what gaps need filled. Congress should start immediately by determining how VA plans to abide by the newly reinstated reporting requirement. A Government Accountability Office (GAO) report in October 2014 revealed that VA utterly failed to address staffing shortages after years of trying to implement a nationally standardized methodology for determining an adequate and

qualified nurse workforce.² Specifically the report found a lack of oversight and a failure to ensure preparedness for implementing the staffing methodology, including the necessary technical support and resources. Without strong Congressional oversight and the provision of adequate resources, history will repeat itself.

These types of issues are not new, and the Independent Assessment's report in September 2015 repeated findings similar to those in a report from a bipartisan presidential task force back in 2003: there is a disconnect in alignment of demand, resources and authorities. Beyond simply providing more and more funds, though, PVA supports certain changes being requested by VA that would impact how those funds are spent.

One change would increase efficiency and accuracy in funding by allowing VA to record non-VA care obligations at the time of payment instead of when the care is authorized. The current practice requiring VA to project obligations at the time of authorization incentivizes over-obligation to avoid violating the Anti-Deficiency Act and ultimately results in forgoing funds previously provided by Congress—money which could otherwise be spent on medical care.

The second change we support is giving VA the flexibility to allocate funds in a way that accommodates shifts in demand for health care services. While consolidation of community care programs might obviate the need to lift restrictions on using Choice Program funds to reimburse community providers operating under Patient-Centered Community Care (PC3), any consolidation effort should permit VA to develop internal capacity if utilization patterns demonstrate increasing demand for care in VA facilities.

IV. Reforming VA's Culture with Transparency and Accountability

It is no secret that VA's administrative bureaucracy has ballooned in recent years. Arguably, resources devoted to expanding administrative staff have significantly jeopardized the clinical operations of VA. We believe serious consideration needs to be given to rightsizing the administrative functions of VA to free critical resources and dedicate them to building clinical capacity.

Additionally, VA has struggled with the notion of accountability. Too often, VA staff who should be terminated are "removed," but not in the way the ordinary citizen in the workforce would envision that action. VA has allowed too many VA employees who have compromised the public's trust to collect a full paycheck while under reassignment in one of those positions that are neatly tucked away from public view, or to simply retire with full benefits. The public has grown tired of this happening. So have America's veterans. We implore Congress to provide the new VA secretary whatever authority he needs to prevent this from continuing.

PVA believes that substantial reform in health care can be achieved, and the time is ripe to accomplish this task. Our organization represents clients with some of the most complex issues, and we cannot stress enough that moving forward should not be done at the expense of the most vulnerable veterans. We must remain vigilant and appreciate the benefits of bringing together the variety of stakeholders who are participating and bringing different perspectives and viewpoints—it is a healthy development process that ensures veterans remain the focus. Thank you for the opportunity to present our views on these issues.

THE AMERICAN LEGION

"DEPARTMENT OF VETERAN'S AFFAIRS (VA'S) CHOICE PROGRAM AND THE FUTURE OF VA COMMUNITY CARE PROGRAMS, AUTHORITIES, AND BUDGET. "

Mr. Chairman, Ranking Member WALZ, and distinguished members of this critical, veteran-serving committee, The American Legion believes in a strong, robust veterans' healthcare system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances there are situations where the system cannot keep up with the health care needs of the growing veteran population requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion has called for the VA to "develop a well-defined and consistent non-VA care coordination program, pol-

²U.S. Government Accountability Office. (October 2014). VA Health Care - Actions Needed to Ensure Adequate and Qualified Nurse Staffing. (Publication No. GAO-15-61). Retrieved from www.gao.gov/assets/670/666538.pdf on March 2, 2017.

ity and procedure that includes a patient centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account."¹

As congress is now discovering and as The American Legion predicted, costs are skyrocketing beyond all budget predictions because congress failed to implement established cost control measures that had been used by VA for years, and instead opted to open access using the Choice act which encouraged virtual uncontrolled spending. By committing \$10 billion to this new procurement vehicle congress removed all established contracting control measures used in VA's other community care programs; instituted third party administrators, additional eligibility criteria, higher and inconsistent reimbursement rates, and a disconnected billing authority; in addition, the Choice act required VA to issue physical Choice cards to every enrolled veteran that were essentially worthless, wasting millions and millions of dollars on designing and procuring millions of these cards in 90 days or less.

The one thing the Choice act did do effectively was expose VA's practice of managing to budget as opposed to managing to need. While the Choice act set a restrictive access boundary of 30 days of wait time, and 40 driving distance miles by presenting it as increasing access, the truth is, VA already had the authority to contract those patients out they just rarely used the authority because their budget could serve twice as many veterans if redirected toward campus or established community care contracts.

Every year VA would send their budget request to the Office of Management and Budget (OMB) as calculated by the number of veterans they projected would require medical care from VA in the upcoming fiscal year, and every year OMB would recommend less money than VA had requested for the president's annual budget request. To congress' credit, each year congress would fund VA at an amount greater than what the president would request, but still lower than what VA had predicted their needs would be. This budgetary tug-o-war continued for years while returning injured veterans became new patients of VA, aging Vietnam and Korean War veterans consumed more medical services, congress opened free access to all returning combat vets regardless of whether or not they had a service connected disability, and The Affordable Healthcare Act pushed veterans into VA who were eligible for VA care but never used VA because they had access to private care, but who's private care didn't qualify for Obamacare. It was this combination of events in tandem with the national shortage of primary care doctors that contributed to the backlog of patients that erupted in 2014.

Over the years, VA has implemented a number of non-VA care programs to manage veterans' health care when such care is not available at a VA facility, could not be provided in a timely manner, or is more cost effective through contracting vehicles. Programs such as Fee-Basis, Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program (VCP) were enacted by Congress to ensure eligible veterans could be referred outside the VA for needed, and timely, health care services.

Congress created the VCP after learning in 2014 that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

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

On October 30, 2015, VA delivered to Congress the department's Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan sought to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other federal health care providers, academic affiliates and community providers. It promised to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care. That legislation was never enacted.

The American Legion commends this committee for recognizing the need to fix the Choice program. The American Legion supported passage of the Veterans Access, Choice and Accountability Act of 2014 as a temporary fix to help veterans get the

¹ Resolution No. 46 (2012): Department of Veterans Affairs (VA) Non-VA Care Programs

health care they need, regardless of distance from VA facilities or appointment scheduling pressure. As congress now recognizes long-term solution requires consolidating all of VA's authorities for outside care, including Choice, PC3, Project ARCH and others, under one authority to help veterans only when and where VA cannot meet demand. The American Legion supports a strong VA that ultimately relies less and less on outside care, rather than move toward vouchers and privatization. An initial hope for the emergency Choice program was that whatever worked from that program, or previous programs such as ARCH and PC3 could be incorporated into a single program that learned best practices and lessons from the predecessors.

While many veterans initially clamored for "more Choice" as a solution to scheduling problems within the VA healthcare system, once this program was implemented, most have not found it to be a solution, indeed, they have found it to create as many problems as it solves. The American Legion operates the System Worth Saving Task Force, which has annually traveled the country examining up close the delivery of healthcare to veterans for over a decade. What we have found, directly interacting with veterans, is that many of the problems veterans encountered with scheduling appointments in VA are mirrored in the civilian community outside VA. The solutions in many areas may not be out in the private sector, and opening unfettered access to that civilian healthcare system may create more problems than it solves. National Public Radio recently noted that "thousands of veterans referred to the Choice program are returning to VA for care - sometimes because the program couldn't find a doctor for them" or "because the private doctor they were told to see was too far away."²

Additionally, we note that the \$10 billion originally appropriated for the Choice Program which was expected to be depleted by May 2017 still has funding available, and The American Legion wants to make sure that VA retains access to those funds until fully depleted.

The American Legion has serious concerns about future years funding shortfalls for the VA. We urge this committee and Congress to take additional steps now to ensure VA has the tools and resources it needs to address the needs of America's veterans next year and for years to come. The American Legion expects a fully funded VA from Congress. Since the access to care crisis, it was apparent that VA needed to expand its ability to provide care through its own facilities and by providing access for eligible veterans to private-sector health care. In short, VA needs enhanced capacity and that takes funding.

As predicted by The American Legion, sending patients off VA campuses to community providers absent well-crafted contracts such as those used for Project ARCH and PC3 has led to inadequate compliance by local physicians to return treatment records to VA following care provided by Choice. When the Choice legislation was being developed, The American Legion insisted that any doctor treating a referred veteran have access to the veteran's medical records so that doctors would have a complete history of the veteran's medical history and be able to provide a diagnosis based on a holistic understanding of the patients medical profile. This is important for a litany of reasons, not the least of which includes the risk of harmful drug interaction, possible overmedication, and a better understanding of the patients previous military history - all important factors in wellness.

Also, The American Legion was adamant that any treating physician contracted through Choice had a responsibility to return treatment records to be included in the patients VA medical file so that VA could maintain a complete and up-to-date medical record on their patients. We believed that safeguarding of the veterans medical records was so important, that we helped craft a provision that was included in the language that prevented VA from paying physicians until they turned over the treatment records to VA. Sadly The American Legion was forced to acquiesce our position in favor of paying doctors whether they turned over the medical records or not, because doctors weren't sending the records - it just wasn't that important to them, and when VA refused to pay, they blamed VA for not paying them, ultimately billing the veterans and refusing to see any more VA-referred patients until they got paid. Since it was more important that veterans had access to sufficient medical care and not have their credit damaged, The American Legion supported repealing the current provision.

Chairman Roe, this, among other reasons including unsustainable cost, is why Choice is not the answer. The equation is simple; a dramatic increase in cost is guaranteed to result in an increased financial burden to veterans using VA care which will include higher co-pays, premiums, deductions, and other out-of-pocket expenses currently suffered by non-VA healthcare programs.

²NPR - May 17, 2016

Mr. Chairman, Ranking Member WALZ, and other committee members, The American Legion thanks you for your time, and urges you to take serious action to make access to quality care across this nation a priority of the 115th Congress.

Disabled American Veterans (DAV)

STATEMENT OF JOY J. ILEM

DAV NATIONAL LEGISLATIVE DIRECTOR

Chairman Roe, Ranking Member WALZ, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this hearing to examine the Department of Veterans Affairs (VA) Choice program, as well as plans to consolidate community care programs and reform the VA health care system. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Today's hearing is critically important to DAV because most of our members choose and rely heavily or entirely on VA health care.

Mr. Chairman, in exactly five months the authorization to provide community care through the Choice program - established by the Veterans Access, Choice and Accountability Act (VACAA) (Public Law 113-146) - is set to expire, even though there is projected to be approximately \$1 billion remaining in Choice account at that time. Born out of the waiting list scandals and access crisis in that culminated in the spring of 2014, the Choice program has never met Congress' or veterans' expectations. Despite the difficult rollout of the program, VA saw both increased access to care in the community and increased demand for care in VA. If the Choice program and its resources were to suddenly disappear in August without an effective and functioning replacement, there would be tremendous dislocation and hardship for hundreds of thousands of veterans who would find themselves unable to access timely care in an already overburdened VA health care system.

For these reasons, Congress and the new Administration must take action soon to ensure that veterans who currently receive care through the Choice program continue to have access to needed medical services. We urge Congress to pass a temporary extension of Choice while also moving forward with the next evolution of the VA health care system in order to provide all enrolled veterans with timely access to comprehensive, high-quality and veteran-focused care.

Over the past year, DAV, along with our partners in The Independent Budget (IB) (Paralyzed Veterans of America and Veterans of Foreign Wars), other major veterans service organizations (VSOs), VA Secretary Shulkin, the Commission on Care and many Members of the House and Senate, have discussed, debated and ultimately coalesced around a common long-term vision for reforming the veterans health care system. All support the concept of developing an integrated network that combines the strength of the VA health care system with the best of community care to offer seamless access for enrolled veterans. VA should remain the coordinator and primary provider of care with community partners, including the Department of Defense and Indian Health Service systems, providing additional expertise and access whenever and wherever necessary. That is a system that puts veterans first and gives them real choice. However, the continuing push by some for unfettered and unlimited "choice" is unrealistic and has the potential to delay and distort plans to move forward with implementing the shared vision of the veterans community and active users of the VA health care system. In order to better understand where VA needs to go in the future, it is important to first understand the lessons and problems of the past.

BACKGROUND

Since the catalyst that began this debate was lack of access, it is important to understand the true underlying causes of the access problems facing veterans.

For more than a decade, DAV and our IB partners have testified to Congress about the challenges in accurately measuring and consistently providing veterans with timely access to VA health care; and these testimonies have been validated by outside audits. For example, in December 2012, GAO investigated reports of long wait times for outpatient medical appointments and found that the metrics provided by VHA were "unreliable." Furthermore, GAO found that VHA's scheduling policy and training documents were "unclear" and led to inconsistent reporting of wait times. We have also consistently testified about the inadequate scheduling, financial

and IT systems, as well as aging infrastructure that all hindered VA's ability to meet veterans health care needs on a timely basis. Furthermore, the limited funds provided to local facilities too often forced them to choose between meeting internal clinical needs or expanding purchased community care.

The ability of VA to provide veterans timely access to medical care is primarily driven by four factors: how many medical personnel are available to provide medical care (resources), how much usable space is available to treat veterans (infrastructure), how well VA leverages health care capacity in the community (purchased care), and can VA produce accurate and valid data to properly manage access issues (metrics). Each of these interrelated issues challenged VA for years and the inability to fully address them eventually led to the most recent access crisis and subsequently, enactment of the VACAA in 2014.

When Congress created the Choice program, they also authorized an "independent assessment" of VA health care to study the causes of and offer solutions for the access problems, resulting in a report by the MITRE Corporation, the Rand Corporation, and others in September 2015. The independent assessment's first finding was that there was a "disconnect in the alignment of demand, resources and authorities" for VA health care. Its first recommendation was that VA must "address the misalignment of demand with available resources both overall and locally." In terms of access to care, it found that "increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years," with a core recommendation of "increasing physician hiring." The report also identified key barriers that limited provider productivity, including "a shortage of examination rooms and poor configuration of space," and "insufficient clinical and administrative support staff," all of which would require additional funding for the VA health care system.

Furthermore, the assessment found that the "capital requirement for the Veterans Health Administration (VHA) to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen." It estimated this gap at between \$26 and \$36 billion over the next decade, although management strategies could potentially lower the projected gap down to between \$7 billion and \$22 billion.

The findings of this assessment confirmed what The Independent Budget veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet the mission of care for veterans. While there are many factors that contributed to the access crisis, when there are not enough doctors, nurses, and other clinical professionals or enough usable treatment space to meet the rising demand for care by enrolled veterans, the result will be rationing of care, waiting lists and access problems.

To be clear, DAV and our IB partners have not suggested that simply increasing funding by itself-without making significant reforms in VA-will lead to better health outcomes for veterans over the next 20 years. However, history shows that no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true demand for services. With more and more veterans seeking out VA as it improves access, Congress will have to continue investing resources to allow VA to keep up with rising demand, or make difficult decisions to restrict enrollment or propose increased fees or copayments for veterans' care.

CHALLENGES IMPLEMENTING AND OPERATING THE CHOICE PROGRAM

As approved by Congress on August 7, 2014, the Choice Program allows certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for required care or to travel more than 40 miles to a VA facility to receive such care. However, despite the scope and scale of the law, VA was required to stand up this nationwide program for potentially all 9 million enrolled veterans in just 90 days.

Since its inception just over 2 years ago, the Choice program has been beset with problems, some resulting from the flawed design of the law and others due to the unrealistic implementation schedule mandated by Congress. Within weeks of the Choice program's commencement, both veterans and VA health care personnel reported confusion about how, when, and for what types of care the program was to be utilized. Problems with scheduling, health record transfers, care coordination, doctor payments, and veterans' copayments all hindered usage of the Choice program during its first several months. To address these and other technical and implementation challenges, Congress passed, and the President signed, two subsequent pieces of legislation (Public Law 113-175 and Public Law 114-41) which, among other changes, redefined how to calculate the 40-mile distance criteria for

Choice eligibility and removed a requirement that medical records be returned to VA before provider payments were made.

These adjustments, as well as additional training of VA personnel, slowly increased utilization of the program. Today, about 31 percent of all care paid for by VA is delivered through Choice and other community care programs, up from about 22 percent just a couple of years ago. At the same time, the VA is also delivering more care inside its own facilities and wait times are dropping, according to VA, as new access programs, such as same day care, are instituted. The challenge is how to move forward with a long-term solution that continues to close access gaps, while maintaining a robust VA health care system that millions of disabled veterans choose and rely on.

DEVELOPING PLANS FOR REFORMING VA HEALTH CARE

As mandated by Public Law 114–41, VA developed and submitted a plan to Congress in September 2015 to consolidate non-VA community care programs, including the Choice Program. VA’s plan called for creating a “high-performing network” comprising both VA and community providers to create seamless health care access for enrolled veterans. In building its network, VA proposed first relying on the most cost-effective, compatible, and highest quality community partners (particularly the Department of Defense [DOD], the Indian Health Service [IHS], and other federal health systems), then university hospitals that have existing academic affiliations with VA, followed by the best of private providers. Under its plan, VA would serve as the coordinator and guarantor of care for veterans to ensure that all veterans have a seamless experience when accessing VA and non-VA care in the community. Most enrolled veterans would continue to get most of their care directly from VA, with network partners filling in access gaps whenever and wherever they occur.

In 2015, DAV and our IB partners developed our proposed Framework for Veterans Health Care Reform based around four main pillars. First, we proposed restructuring the veterans health care delivery system by creating local integrated veteran-centric networks to ensure that all enrollees have timely access to high quality medical care. VA would remain the coordinator and primary provider for most veterans. We also called for establishing a veterans-managed community care program to ensure that veterans living in rural and remote areas have a realistic option to receive veteran-centric, coordinated care wherever they may live. This would require local communities to work with VA’s Office of Rural Care to develop relationships with local providers, as well as increased flexibility in reimbursement rates to attract and retain community partners.

Our second pillar for reform called for redesigning the systems and procedures that facilitate access to health care by creating a new urgent care benefit and taking other actions to expand access to care, such as extended hours in evenings and on weekends, as well increased use of telehealth. We recommended that as the new integrated networks are fully phased in, decisions about providing veterans access to community network providers should be based on clinical determinations and veteran preferences, rather than arbitrary time or distance standards that exist in the current Choice program.

Third, we proposed realigning the provision and allocation of VA’s resources to better reflect its mission by making structural changes to the way federal funds are appropriated, distributed and audited. Our plan calls for strengthening VA’s budget and strategic planning process by establishing a Quadrennial Veterans Review, similar to the Quadrennial Defense Review currently used by the Department of Defense.

The fourth and final pillar of our framework called for reforming VA’s culture with transparency and accountability. In this regard, we strongly support the MyVA initiative, which has already resulted in good progress in making system-wide changes putting veterans in the center of VA’s planning and operations, so that their needs and preferences are paramount.

COMMISSION ON CARE

VACAA also required Congress to create an independent Commission on Care to study and report recommendations to VA and Congress about how to strengthen the VA health care system over the next 20 years. The Commission examined a wide range of ideas and options, including the IB’s proposed Framework and VA’s Community Care Consolidation Plan. It also considered proposals to privatize or dismantle the VA health care system, but ultimately the Commission rejected such radical ideas, instead reaching an overwhelming consensus on a series of recommendations to strengthen and reform the VA health care system.

The Commission’s principal recommendation called for establishment of “high-performing, integrated community-based health care networks.” Similar to the VA and

IB plans, the Commission recommendation would maintain VA as the coordinator and primary provider of care and use community providers to expand access in circumstances in which VA is unable to meet local demand for care. Unlike the IB framework or VA plan, the Commission proposed allowing veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care in a timely fashion. The Commission itself recognized that this would likely result in higher costs for networks under its recommended “choice” option, cautioning that VA “must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans’ choice, yet would also consume far more financial resources.” In fact, the Commission’s economists estimated that the recommended “choice” option could increase VA spending by at least \$5 billion in the first full year and that it could be as high as \$35 billion per year without strong management control of the network. The Commission also considered a more expanded “choice” option to allow veterans the ability to choose any VA or non-VA provider without requiring it to be part of a VA network. The economists estimated such a plan could cost up to \$2 trillion more than baseline projections over just the first 10 years.

The Commission acknowledged that, “veterans who receive health care exclusively through VHA generally receive well-coordinated care . . . [whereas] . . . fragmentation [of medical care] often results in lower quality, threatens patient safety, and shifts cost among payers.” While veterans’ individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high-quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the commission’s report states, “well-managed, narrow networks can maximize clinical quality,” while “achieving high quality and cost effectiveness may constrain consumer choice.”

With such broad consensus among veteran experts and stakeholders, the question that this Committee and this Congress face is whether to continue debating prohibitively expensive, clinically unsound and politically unrealistic proposals to offer every veteran unfettered “choice,” or whether to move forward and build integrated networks capable of ensuring that all veterans have a real choice for quality care.

EXTENSION OF TEMPORARY CHOICE PROGRAM

Mr. Chairman, with just five months until the current authorization ends, it is critical that Congress work with VA to extend the Choice program to allow VA to utilize all of the remaining funds in the Choice account and to ensure continuity for veterans who access care through this program. H.R. 369, legislation you introduced earlier this year, would accomplish that by removing the sunset date and allowing the program to continue until the funds provided for this program are exhausted. DAV supports this legislation as a short-term and temporary measure to ensure that veterans using Choice do not fall through the cracks while waiting for further reforms, as discussed above, to be enacted and implemented.

However, Choice should be extended on a short-term basis and only for as long as necessary to enact and implement a long-term solution based on the integrated network model. Choice should not be expanded to open up the program to new categories of veterans for both clinical and fiscal reasons. Absent a well-managed, high-performing network, putting more veterans into the Choice program would result in less coordination of care, increased fragmentation of services, lower quality and ultimately worse health outcomes for more veterans. In addition, even a limited expansion of the current eligibility for the Choice program would add significant fiscal costs at a time when demand for VA health care is already rising faster than resources provided by Congress.

In order to ensure continuity, Congress will need to act quickly, however there are additional changes that have been proposed to address related issues with Choice and community care programs, including making VA the first payer, changing when obligations are recorded, and authorizing new provider agreement authority. These changes would strengthen not just Choice, but all community care programs, and are essential to support the creation of an integrated network proposed by DAV, VA, the Commission and others. Whether some or all of these and other improvements to integrated community VA care are included in the legislation to extend the Choice program’s authorization, these changes should be fully debated, carefully drafted and subsequently enacted in order support development of integrated networks necessary to provide veterans with real choices for quality care.

In addition to providing a short-term bridge, VA needs to move forward with its Request for Proposal (RFP) that was drafted and issued late last year. The RFP developed by VA in consultation and collaboration with a number of stakeholders, in-

cluding DAV and other VSOs, would lead to a contracting process with national health care providers capable of serving as VA's community partners in an integrated network. Given the history of problems standing up the Choice program, it is essential that VA and its new partners have sufficient time to carefully develop and implement the new integrated network model of care. There are, however, a number of critical issues that still need to be fully resolved before such implementation; including new scheduling and claims payment systems, as well as the ability for sharing health records, providing care management and defining patient eligibility. While continuing to appropriately fulfill its oversight responsibilities, we urge Congress to support VA's efforts to move the RFP process forward so that VA can enter into contracts with appropriate national providers before the end of this year.

Furthermore, Congress must work with VA to set realistic expectations for the implementation of these much needed long-term reforms. Many of the supporting systems and technologies necessary to support a truly seamless integrated network capable of delivering consistently high-quality and timely care will need to be developed, optimized and customized for VA before full implementation of the new system. Also, the goal of eliminating all access limitations on community care, including the current 40-mile and 30-day Choice standards, can only be phased out as the integrated network becomes fully operational to avoid unintended negative fiscal and clinical outcomes. Further, the challenge of providing seamless, timely access to veterans living in rural and remote communities will require special attention, creative approaches and sufficient time and resources to be accomplished. The Commission's charge was to develop plans to strengthen the VA health care system over the next 20 years. In its report, the Commission makes clear that this is a significant undertaking that will likely take a decade or more to accomplish. The report states: "The fruits of the transformation, will not be realized over the course of a single Congress or a single 4-year administration." Considering the magnitude and importance of this transformation, it is imperative that Congress and VA begin moving forward, now.

SETTING THE RECORD STRAIGHT

Unfortunately, despite the broad agreement among stakeholders and policymakers, there are still some individuals and organizations promoting an unrealistic vision of "choice" without providing any clear definition or specifics, adding confusion and delay. That's why DAV is continuing its "Setting the Record Straight" campaign: to ensure that the cost and consequences of "choice" are understood in any plan that Congress considers. Last month we released a short video entitled "Putting Choice in Context" that explores the real costs and consequences of unrealistic "choice" options, and debunks a number of misconceptions about "choice" and VA health care. For example, the idea that veterans would be able to choose any doctor in their community is simply not true. Some doctors don't accept "choice" payment rates and in many communities, particularly rural America, there are not enough or even sometimes any physicians to choose from. For too many veterans, simply having a "choice" card could leave them without any options to find a qualified physician.

Another false premise is that allowing all veterans to go to private providers would lead to better quality health care and outcomes. The reality is that numerous independent studies by Rand Corp. and others have consistently shown that VA today provides equal or better care than the private sector. Furthermore, if expanding "choice" forces more veterans to receive part of their care in the community - without first establishing a managed and coordinated network, the result will be more care that is fragmented, which can actually lower quality and lead to worse health outcomes for many veterans. Even the idea that "choice" will increase access for veterans is a much more complicated issue. If "choice" were significantly expanded, moving more veterans to the private sector, VA would almost certainly be forced to significantly downsize or close some hospitals and clinics, and curtail medical services in others due to lesser demand. However, veterans who continue to choose VA for their care would find fewer services being offered, or they would have to travel further or wait longer to receive care. The result for many veterans, particularly disabled veterans who disproportionately rely on VA, could be less access and no "choice" to use VA.

The idea that "choice" is a "magic bullet" capable of solving all of VA's health care challenges is simply not supported by objective facts, was not the conclusion of the Independent Assessment or Commission on Care and does not have significant support within VA or the veterans community. The use of community care, or "choice," should certainly be a part of the long-term solution, but only if it fits into the big picture of strengthening and reforming the VA health care system as outlined above.

Mr. Chairman, after more than two years of spirited and passionate debate in the 114th Congress over the future of veterans health care, there is now a growing consensus on how best to strengthen, reform and sustain the VA health care system. Veterans and their representative organizations, independent experts, VA leaders and many members of Congress agree that the best veterans health care system would consist of integrated networks that combine the strength of VA with the best of community care to offer veterans real choices for quality and timely care. We look forward to working with you to help fill in the details of such a plan for the next evolution of VA health care and we urge you and your colleagues in the 115th Congress to start implementing this shared vision so that ill and injured veterans can get the care they have earned and deserve, whenever and wherever they need it.

TRIWEST HEALTHCARE

WRITTEN TESTIMONY MR. DAVID J. MCINTYRE, JR.

PRESIDENT AND CEO

Introduction

Good evening, Mr. Chairman and Members of the House Committee on Veterans Affairs. Thank you for the opportunity to submit this statement regarding the status of the Choice Program in our geographic area of responsibility, which includes 28 states and three U.S. territories. It is a privilege to be of service to the Veteran constituents of so many on this distinguished committee in support of VA's critical mission to care for those who have borne the cost of the battle.

We count it a privilege to have been working in close partnership with VA since the start of the Choice Program to improve access to care for Veterans across our service area. And, we look forward to doing our part to support Secretary Shulkin and his team in the successful execution of the elements of his 10 Point Plan that are relevant to our work.

As I am sure we would all agree, there is still work to be done to mature the program so that it fully fulfills what was envisioned by Congress when it was necessarily enacted quickly in response to the access crisis. I am pleased to report, however, that our provider network has now delivered more than 4.2 million appointments for Veterans in support of VA's critical mission to care for those who have borne the cost of the battle.

A Historical Perspective

TriWest was formed 21 years ago by a group of non-profit Blue Cross Blue Shield plans and university hospital systems for the sole purpose of bringing their core competencies and unrivaled market presence to the side of government as it sought to fulfill the nation's commitment to those who answer the nation's call and their loved ones by turning to community providers to provide the needed elasticity to fully meet demand. For the leadership team of TriWest and our more than 3,000 employees, most of whom are Veterans or family members of Veterans, what we do is more than a job; it is an honor to which we are steadfastly and passionately committed!

Our first 18 years were spent supporting the Department of Defense (DoD) in standing up and operating the TRICARE program in what would ultimately be a 21-state service area. I'm proud of the work we did to assist DoD in making TRICARE a great success. While the early days of TRICARE were also challenging, we soon made it through them and that platform fulfilled its potential, especially at the height of the War on Terror, as it gave the DoD the ability to deploy a substantial portion of its medical assets to support the war fighter while we and our provider network handled a substantial portion of the need domestically.

Getting to success in TRICARE, just has been the case with each new large health program, starting with the implementation of Medicare and Medicaid in the 1960's, took several years. And, with TRICARE, DoD and the contractors had 15 months to prepare for the start-up of TRICARE and 9 months to implement it. With the Veterans Choice Program, however, this 24-month period was necessarily shrunk to a little more than 30 days. And, like after the start-up of TRICARE, we are very focused on the needed refinements so that the program matures to what was envisioned with its passage. To this end, Mr. Chairman, we look forward to responding to whatever refinements that your Committee and the Administration believe will be needed to get the program to its next iteration.

Progress Made in Refining Choice and Enhancing Access

In April 2014, the country was shocked to learn of the access crisis at the Phoenix VA Medical Center and the 14,700 Veterans standing in line waiting for care (including some 3,300 urology patients). Of course, as we now know, Veterans in many other communities were also suffering from a lack of access to needed care. Thus, it is little surprise Mr. Chairman that you and your colleagues in Congress would respond to the crisis with the sense of urgency that you did.

Shortly after the August 2014 enactment of the law creating the Choice Program, VA conducted an industry meeting to seek input on implementing the Choice Program and were told by most in industry that they simply could not respond in the timeframe required. Not believing it was appropriate to leave our fellow citizens who had borne the cost of war in a line waiting for needed care, we took a deep breath, rolled up our sleeves and stepped forward to answer the call. At that point, we and VA had a little more than 30 days to design and stand up the Choice Program; however, it was an opportunity to step up and answer the call in support of those who did whatever it took to respond in the nation's hour of need!

While I understand that it is hard for most to see past the very early challenges we experienced and those that still remain, I will tell you that I have never been more impressed in my two decades of being engaged in this work than with the uncommon focus and tireless efforts of the team at VA who rose to the occasion and collaborated fully and vulnerably to ensure that we were operational on Day One. Within record time, we created the infrastructure, hired and trained hundreds of staff, and got Choice cards into the hands of 4 million Veterans in our area of responsibility. We even stood up a state-of-the-art contact center architecture even making sure that callers to the toll-free line would end up with the right contractor and were greeted by the voice of the Secretary, thus underscoring the importance of this new initiative.

That spirit of full collaboration between VA and TriWest has progressed and matured significantly over the past two years, completely earning our respect in this very complicated and challenging journey on which we necessarily find ourselves. This is a dynamic relationship in which we all continue to refine and strengthen operational processes and communication. Although there is still work to do, I am very proud of what we have collectively accomplished and I am confident that the trajectory on which we are on will lead to continued refinement to make it even better than the solid TRICARE program is today.

One of the core challenges when we started our work with VA was that they did not have a clear view of the demand for care, which is likely part of how we all ended up here in the first place. Thus, it made it difficult to ensure a properly tailored network of providers and the subsequent needed infrastructure of systems and people to support the real demand as a company. But, after a lot of effort and expense that reality is now well behind us in our area of responsibility.

And, then when we turned everything on we found the initial volumes to be very low and take a time to build as Veterans were just learning of the new option for access they had as a result of this program. In fact, in the first month, January 2015, we responded to and facilitated a mere 2,000 appointment requests across our entire 28 state service area. Today, we are scheduling over 100,000 Veterans a month for care in the community, a dramatic 50-fold increase in just over two years. In total, the 180,000 providers in our network have served the health care needs of more than 800,000 Veterans to the tune of over 4.2 million appointments. The average number of days to make an appointment with a community care provider is now 3 days, with less than 2% of the care requests being returned due to lack of a network provider of the specialty type needed. Further, we are now processing and paying about 97% of clean provider claims within 30 days.

Not only is the network tight and mapped to the demand profile of each market to optimally support VA in the markets in which we are privileged to serve in support of VA, to optimize customer service delivery we rolled out an infrastructure model that provides localized service in now 10 operational sites, with at least one per VISN. And, our performance is reasonably tight, with an average speed of answer below 30 seconds and servicing more than 800,000 calls per month.

Not yet finished, we and VA are in the process of building new enhancements and piloting ways to make the program even more Veteran centric and to improve the experience for community providers, just as was done in the early years of TRICARE.

I know that the road has not been painless or easy for anyone involved, especially for the Veterans we are here to serve and the providers we have asked to join us in taking care of their needs. However, tremendous progress has been made in refin-

ing the Choice Program in our area of responsibility and a lot of access is being provided.

But the mission is not yet complete, and we know that is part of the reason for today's hearing.

Mr. Chairman, like you, your colleagues on this Committee and in the rest of Congress, and the team at VA, we believe that understanding the challenges and gaps that still exist is critical to ensuring that we are focused on the right things in fulfilling the promise you all had in mind with the creation of the Veterans Choice Program.

To that end, the work of the VA OIG and GAO, and your own Committee, is critical to understanding where we sit and the road still to be travelled.

As you know, the IG recently released a report regarding their assessment of the early days of the Choice program. And we know that the GAO has been looking at the same. The work of both entities is imperative to understanding where we were in the early days of this understandably challenging journey. So, too, is knowing where we stand today, so that any action might be informed by today's reality rather than yesterday's challenges. To that end, you will find an attachment to this testimony that takes the OIG Report findings for our area of responsibility and brings the data and program performance information to the present period. We hope this will be a helpful lens to you and your colleagues on the Committee as you contemplate where we really stand with regard to this program in at least one half of the country and what makes sense for the way ahead as you and VA seek to continue to refine this invaluable tool to enhance access to care for our nation's most treasured asset, its Veterans.

Appointments/Program Demand

As I stated previously, the network of 180,000 providers built by TriWest Healthcare Alliance's non-profit Blue Cross Blue Shield and University Hospital system owners has now facilitated 4.2 million appointments for Veterans in our area of responsibility. Without the Choice Act, those appointment requests would have increased appointment wait times at VA hospitals and clinics for all Veterans in need of care. Moreover, 95% of all appointments are being scheduled within 5 business days of authorization.

As a result of now streamlined processes, in the first 6 weeks of 2017, TriWest's staff had scheduled Veterans from the creation of their authorization within an average of 2 business days (a decrease of 60% from the 2015 average of 5 business days). And rather than the required 30 days in which the appointment must be completed, TriWest's network is seeing Veterans on average in 15 days, a decrease of 33% from our average wait time in 2016 of 20 days.

Since the beginning of the year, we have already appointed over 87,600 Veterans to care in the community.

We have also been very focused on trying to increase the accuracy of appointing. And, while we are not yet finished with the initiative, we are pleased to report that TriWest is now scheduling 98% of Veterans with the correct provider the first time.

Also important, as highlighted in one of the recent reviews, is the need to shrink the amount of time that it takes for an appointment to be scheduled with the community provider from the time that VA identified the need. While VA has been focused with its parts of the process in order to speed up the time it takes to get a Veteran to us for appointing once the need is identified, we have been focused on our part of the process that pertains to when we receive the appointment request to the date on which the Veteran is seen. We are pleased with the progress that we have made in reducing the cycle times for the various steps in our part of the process of getting the Veteran placed with the needed provider. The chart below highlights the progress we have made in this area of significant focus from the period of January-April 2016 to December of 2106:

Date	Receipt date -> accept date (Average # days from date we receive VA referral, to beginning to obtain Veteran preferences/opt in)	Accept date -> auth create date (Average # days it takes on average to reach Veteran and obtain their preferences/opt in)	Average # days from obtaining preferences, to beginning scheduling appointment	Auth create date -> scheduling date (Average # days it takes to schedule the appointment)	Scheduling date -> initial appointment date (Average # of additional days from scheduling the appointment to the actual appointment date)	Average Life Cycle
1/1/16-4/30/16	1.68 days	2.85 days	0 days (we do not measure this; the auth is auto-routed for scheduling)	6.78 days	10.54 days	21.85 days
12/1/16-12/31/16	.28 days	2.07 days		4.41 days	11.21 days	17.97 days

Claims Processing

If community providers are asked to provide care that VA is unable to provide itself, it is critical that they get reimbursed for the services they provide on a timely and accurate basis. Unfortunately, the early struggles in TRICARE have somewhat repeated themselves with this work in support of VA.

At the start of TRICARE it became apparent that DoD had not had a good history of paying provider claims prior to when the network was built and brought to the side of the DoD direct care system to provide access to care when DoD was unable to meet the needs of TRICARE beneficiaries themselves. Early on in that work it became apparent that DoD was challenged in setting up the necessary systems and processes to enable us to pay the providers on an accurate and timely basis. And it took three years to get our arms wrapped around it and get it completely fixed. The result of that work, though, is that TRICARE contractors are processing quickly and accurately and DoD is rapidly reimbursing them for the claims they pay providers on their behalf. DoD then subsequently audits the accuracy of claims payment on the back end. But getting to that solid place of performance was very painful and was frustrating to the provider community as they thought that things would magically get better when we arrived.

In this work with VA, history has unfortunately somewhat repeated itself.

First, when we began to set up the provider network we heard from provider after provider who had not been paid timely or accurately for the services purchased from them directly by VA over the years. As we would soon discover, this was not the experience of only a few. In fact, some providers are still owed vast sums of money for services that had been ordered and were to be paid for directly by VA. They expected that it would be different with us coming onto the scene, yet some of the same gaps early on drove a repeat of their prior experience with VA. Fortunately, that is now starting to turn.

Second, VA set up this work in a fashion that had them re-adjudicating each claim we paid on its behalf, rather than reimbursing us for the claims that we paid to providers for the care authorized by VA and then performing audits for accuracy. And, what's more, they did not provide us with the rules logic so that we could map our processing system to match the way in which they wanted us process claims, nor did VA establish a process to review and resolve those claims that VA rejected. Instead, VA allowed them to stack in a queue with no process for resolution,, just as we learned has been the experience of many providers across the country prior to us engaging in this work.

Third, they started with the work being processed manually by each VISN, which led to a very inconsistent performance picture in that there was inconsistency in approach, staffing, and performance.

The difficulty of having to set up the programming of our own systems in such short order added to these complications, as did the lack of maturity in the work, which was new to all of us.

In January 2016, I brought the challenges of this issue to then Secretary McDonald, Deputy Secretary Gibson, and UnderSecretary for Health Shulkin, and Dr. Baligh Yehia, and we began the collaborative work to rectify the issues. Frankly, a lot of progress was being made quickly with the result being that we were successfully working down what had become a massive accounts receivable. In fact, nearly a year ago, we had reached a place where we were processing within 20 days against the 30 day standard. And, then in the Summer, with no forewarning to VA, HealthNet dropped 500,000 claims in VA's lap on a single day looking for reimbursement. Needless to say, with limited staff within VA and the aging of the dates of service for those claims, VA's ability to process our invoices came to a dead stop. And, by the Fall, our performance had nosedived to nearly 65 days to process and pay providers and VA again had built up a massive accounts receivable with TriWest.

In mid-October, I reached out to the same leaders in VA and they agreed to again roll up their sleeves in search of a solution that would solve the underlying issues while eliminating our accounts receivable so that we could get back to timely processing and payment of provider claims. While it has not been a journey without complication, I am pleased to report that as a result of the hard work and focus of the entire team, and a \$45 million capital infusion by our non-profit owners, that we are nearly complete with the execution of all of the pieces of that November 5 agreement and are now back to processing and paying nearly all clean claims within 30 days.

There are three things I believe, however, that still need resolution.

First, we believe that VA should not be in the claims processing business when they have private sector organizations paying the providers in their own networks for the care that is rendered in the community. Like TRICARE and Medicare Risk,

claims should be paid by the entity that built the network and then VA should audit the contractors for compliance on the back end.

Second, the antiquated process of having to estimate the nature of the encounter and the cost of every unit of care for a Veteran before he or she leaves the VA medical center for that care in the community and then reconciling it on the back end needs to come to an end. It is inefficient, ineffective, costly and slows the ability of the Veteran to get to the care they need.

And third, the turnaround for VA payment of claims invoices for contractors should be no more than 7 days. We are in effect functioning as the bank for VA. In a perfect world we would be drawing from an account they have established, but if that can't be made to happen then we should be reimbursed in more than 7 days.

While work still remains, I would be remiss if I did not compliment the team at VA. They are focused, led by a hands on Secretary and team underneath him (just as was the case prior to him stepping up into his new role), who are collaboratively attempting to resolve the issues that have been complicating our ability to achieve the success we all desire.

And, while we still have work to do, just as we did at this juncture in the early days of TRICARE, I am pleased to report that we have now processed and paid in excess of 6.5 million claims (455,000 in the month of January alone) and are again honoring our obligation to pay providers on a timely basis as VA is doing in reimbursing us for those payments.

Streamlined Processes and Procedures for Accessing Care

TriWest has worked collaboratively with VA to address a number of operational gaps that have been identified and needed adjustments are being made around five core initiatives which Dr. Yehia and his team at VA have led since January 2016:

- *Simplifying the Referral/Authorization Process:*
Transmitting packages to the contractor through a portal and scheduling an appointment using the Veteran's preferences is a complicated process which results in work duplication and care delivery delays. We are working closely with VA to streamline the process, with a goal of implementing an automated process that is easy to understand and complete.
- *Decrease Returned Authorizations/Make the Capturing of Return Reasons More Accurate:* Authorizations are returned for several reasons, such as when no network provider is available; the Veteran declined the appointment or distance; we are unable to reach the Veteran; VA requested the authorization be returned due to inactivity or other reasons; or the authorization is a duplicate. We have worked with VA to refine and expand return reasons from the very limited number of options from which to choose to a broader set so that we can analyze the gaps by category and track performance in remediating them. In addition, we have embedded staff in over 40 VAMCs to facilitate better coordination between VA and us; continued to focus on training staff on return reasons and the return process; and spent a massive amount of money to re-tailor our network to ensure that it is sized to meet the actual needs of each VAMC in our area of responsibility. These initiatives are indeed producing success and the number of returns continues to be on the decline.
- *Improve Customer Service:* TriWest has improved customer service for Veterans by developing an entirely new Customer Relationship Management (CRM) System that is customized to this work, assisting in the delivery of effective and efficient customer service encounters through an improvement in the user interface and the ability to document outbound and inbound calls with Veterans. We also have implemented a Behavioral Analytics Call Monitoring System which helps improve staff interactions with customers, VA staff, providers and Veterans alike.
- *Improve Process Efficiency:* TriWest's VA portal is the medium through TriWest and VA staff order and track health care services in the community for Veterans, as well move information and data/information relevant to the provider and needed back in the hands of the VA provider and the medical record of the Veteran. To improve the overall process, TriWest solicited feedback on our initial VA Portal from VAMCs. Based on VA feedback, a new redesigned portal was rolled out in July 2015, bringing streamlined processes, which increased portal utilization and improved the efficiency and effectiveness for both VAMCs and TriWest.

The pace of identifying gaps and resolving them necessarily remains aggressive between our company and VA, so that we can speed the needed changes to Veterans that reside in our area of responsibility in our collective quest to enable the Veterans Choice Program to achieve its potential and enhance access to care for Vet-

erans thus enabling VA to fulfill its mandate to care for those who have borne the price of the battle.

Continuing to Pursue the "Art of the Possible"

Mr. Chairman, I believe the Choice program is working in our geographic area of responsibility. Having said that, though, we are not finished with the refinement of the program and are in the midst of developing or testing a series of prototypes and pilots to explore that which will be most effective in further improving the program.

First, we are launching a self-appointing pilot this month in Tennessee that will leverage common technology on smart phones to allow Veterans, under controlled circumstances, to self-appoint with certain categories of providers. This is aimed at increasing efficiency for Veterans in gaining access to the care they need. We expect it to be very successful and will be looking to quickly expand it across our geographic area of responsibility once we have proof of concept.

Second, with a desire to enhance access to needed behavioral health services in order to give VA the enhanced access to these critical services it needs, we are moving beyond simply appointing to our substantial behavioral health network numbering more than 25,000 providers. We have invested in and are training our behavioral health providers in evidenced-based therapies that are known to be maximally effective in meeting the needs of Veterans. And, we have designed and deployed a tele-behavioral health platform to connect community behavioral health providers with Veterans in need of counseling, who desire the use of this tested modality of care delivery. The initial rollout of this initiative is in Phoenix and San Diego, with geographic expansion to come soon as this is now taking hold.

Third, in an effort to ensure that those who are presenting themselves in VA Medical Center Emergency Rooms, where there is a lack of inpatient mental health beds to meet the needs of Veterans, we and VA just designed and deployed a pilot program in Wichita, KS that has us placing the Veteran in an inpatient bed in one of our nearby behavioral health network providers rather than letting them wander out the front door without receiving services and putting their life at risk. This pilot builds on a similar one we conducted in Phoenix, which was very successful in eliminating suicides of this category.

Fourth, we are testing whether it is possible to provide Veterans with ready access to lab and radiology services in the community in which they reside, drawing from our extensive network, rather than forcing them to drive great distances to a VAMC for such services. This pilot will start soon in support of the VA community based outpatient clinics in Show Low, Arizona and just north of Los Angeles, California.

Fifth, to enhance access to primary needed primary care services, particularly in the evenings and on the weekend for a Veteran suffering from an ailment such as a sinus infection, they will be able to go to a convenience clinic to receive their care, like those in the private sector, rather than waiting for the VA facility to have an available appointment. This pilot, which we and VA have been developing, will start to be tested in Phoenix, Arizona in the next couple of weeks.

Sixth, leveraging a network that includes more than 50,000 primary care providers, there are communities within our area of responsibility where VA is evaluating whether it makes sense to leverage that network versus operating or contracting for community based outpatient clinic services. In many areas, VA operates community-based outpatient clinics that are staffed by either a single provider or a part-time provider. These small clinics create continuity of care and access issues; not an ideal situation. There are also other areas where the demand just does not seem to justify the existence of the site when care is otherwise available in the network. A test is underway in a couple of communities across our geographic area of responsibility for making primary care available in the zip code in which the Veteran resides rather than making them travel to a sparsely used and staffed CBOC that is far from where they reside. In the long term, I wonder whether the VA ought not to simply leverage the network they already paid for and provide access to primary care in all zip codes but those where the density truly justifies the investment. It would be more cost effective for taxpayers and convenient for Veterans.

Lastly, in a constant effort to improve the performance of the program for Veterans and providers, VA and TriWest are in the process of launching a prototype that leverages network providers who are high-performing through a process that will enable the community based outpatient clinic and community providers to serve the Veterans right in Harlingen, Texas rather than having to drive 5 hours each way to San Antonio or go without needed care. I believe this model will stand as one of the models that should be replicated across communities with similar attributes in order to provide Veterans will access to a collaborative approach that

fully leverages the best of both VA and the community providers to meet the needs of Veterans in the most efficient manner possible. At the end of the day, the key outcomes for Veterans will be an expedited process that will offer same day authorizations for community care appointments, electronic filing and payment of all claims, and digital sharing of medical records between community providers and VA.

Mr. Chairman, it goes without saying that we are in the midst of a major reform of VA health care. We collectively have an opportunity to enhance access and make the health care delivery model more efficient and effective. I believe doing so will necessitate leveraging the best of both the public and private sectors, and we are excited about the framework defined in Secretary Shulkin's 10 Point Plan and are looking forward to learning of his specific thoughts with regard to Choice 2.0. We count it a privilege to be involved in this critical effort to enhance access to care for Veterans and will continue to push ourselves at the side of you, the rest of your colleagues in Congress and VA in attempt to achieve the optimal state of operation. A strong public-private partnership that builds on what VA does best and leverages private sector provider networks and best practices will foster innovation. It also, if configured correctly, will provide accountability and transparency, both of which are essential for regaining Veterans trust of the system. Know that we look forward to continuing to work together for the betterment of VA health care, alongside VA and Congress, and to doing whatever it takes to make sure Veterans receive needed health care promptly and easily.

Conclusion

Mr. Chairman, I hope my testimony has provided some useful information on the status of the Choice Program in TriWest Healthcare Alliance's area of responsibility, as well as what I believe to be the "art of the possible." I also hope this testimony and the progress that we have made since the necessarily very rapid design and start-up of the program has demonstrated the steadfast commitment of TriWest's leadership, owners and 3,000 employees to push ourselves in the quest to bring optimal performance and access to enable VA to be able to optimally serve those who have served. It is an honor and awesome privilege to work every day to provide access to care for those who have served this nation in uniform. We have always stood ready to implement VA health care needs within record speed and record time, and will continue to remain dedicated to this critical task, as you and your colleagues challenge all of us to continue to raise the bar in support of our nation's Veterans. We and our non-profit owners look forward to continuing to be a large part of the formula for future success in assisting VA in delivering on its responsibilities to our heroes on behalf of a grateful nation!

TRIWEST ATTACHMENT

TRIWEST HEALTH CARE ALLIANCE RESPONSE TO VA OIG REPORT

TriWest Healthcare Alliance respects the Department of Veterans Affairs (VA) Office of Inspector General (OIG) review of the Veterans Choice Program (VCP) in its report dated January 30, 2017, and supports its recommendations to improve the program. In fact, we have been working closely in support of VA to address many of the items in this report. Given the fact that the OIG review of VCP in this analysis only covered the period up to September 2015, the report does not reflect the current state of the program. In fact, over the past 16 months, VA and Congress have worked together to successfully adopt and implement several important improvements to the program that have resulted in significant progress for Veterans and increased their access to care in the community. TriWest has proactively worked alongside VA to execute these program changes.

While there were predictably real challenges associated with setting up a program of this size and scope in only 90 days (with little over 30 days for the Choice contractors), our partnership with VA and the 180,000 community health care providers in our 28-state area of responsibility has now connected Veterans with over 4.1 million total medical appointments since January 2015. That's real progress for our nation's Veterans. In fact, TriWest has now served over 800,000 Veterans and is now receiving over 100,000 Choice requests for care each month. And, across all categories of care, the average number of days to make an appointment with a community care provider is 3 days. Today, less than 2% of the care requests are being returned due to lack of a network provider of the specialty type needed. Further, TriWest is now processing and paying claims within 30 days for those receiving care through the network.

As we look back on the launch of VCP two years ago, the program today provides VA more elasticity to meet the ever-growing demand for care. Because of the very

focused leadership of Congress and VA to recognize and resolve policy gaps during this implementation and early refinement phase, Veterans' access to needed community care has significantly grown over the past 16 months.

But the mission is not complete. As the Veterans Choice Program continues to grow and more and more Veterans receive care in the community, TriWest will continue to work closely with VA, Congress, and community health care providers to refine and strengthen the program, enhance the Veteran and provider experience, and ensure Veterans have greater access to high-quality care closer to home.

Below is a snapshot of TriWest's operational growth from the start of the Veterans Choice Program.

Network:

- VA OIG's report cites inadequate provider networks immediately following the 90-day implementation timeline to stand up the Veterans Choice Program. At the time (November 2014), TriWest's network consisted of approximately 90,000 community health care providers.
- Since that time, TriWest has worked directly with every VA medical center in our 28-state geographic area of responsibility to assess demand for care, and has tailored the network accordingly. Now, TriWest's customized and tailored network is comprised of approximately 180,000 providers, more than doubling since January 2015.
- Since the end of the VAOIG analysis in September 2015, TriWest has grown its network by 32%, increasing from 135,000 to over 179,000 unique providers, to meet the growing demand of the program (IG Recommendation #2 and #6).
- Using our innovative Demand Capacity Tool to refine and strengthen our network since 2015, TriWest's community providers meet Veterans' appointment scheduling needs in each local service area. Beginning in July 2015, TriWest's executive leaders met with every Veterans Integrated Service Network (VISN) and VAMC director to learn exactly what type of network they needed. Today, less than 2% of the care requests are being returned due to lack of a network provider of the specialty type needed.

Appointments/Program Demand (IG Recommendation #2):

- TriWest has scheduled over 4.1 million total appointments (including initial and follow up care) since the start of the Choice Program. Without the Choice Act, those appointment requests would have increased appointment wait times at VA hospitals and clinics for all Veterans using VA care.
- 95% of all appointments are scheduled within 5 business days of authorization.
- The report cites that at the onset of the Choice program, the time from a Veteran opting in to receive care through the Choice program to the first completed appointment took an average of 48 days - 18 days longer than VHA's 30-day standard. Now, as a result of streamlined processes, and TriWest's staff of more than 3,000, the average number of days to the first completed appointment with a network provider is 14 days, a decrease of 33% from the 2015 annual wait time average.
- TriWest has worked diligently to address scheduling issues over the past two years. Now, as the result of a dedicated quality improvement initiative, TriWest schedules appointments with the correct provider the first time, 98% of the time.
- Since August 2015, the number of care requests TriWest receives on a monthly basis has increased by 120%. Today, TriWest receives nearly 110,000 authorizations for Veteran care in the community, compared to 50,000 authorizations in August 2015. Program usage continues to grow as the program matures and enhances access to care for Veterans.
- Over 800,000 unique Veterans across TriWest's 28-state territory have received care from a community care provider under the Choice program.

Customer Service:

- Since the fall of 2015, TriWest has opened or expanded from 2 to 10 operations centers, at least one per VISN. Our volume of calls has more than tripled since the beginning of 2015; with our staff responding to over 800,000 calls per month, with an average speed to answer below 30 seconds.

Claims Processing (IG Recommendation #5):

TriWest understands the importance of paying community providers on a timely manner, and has gone to great lengths to make the provider claims submission process easier for providers and ensure claims are paid to providers on a timely basis.

- The number of claims received each month has grown from 114,000 in September 2015 to over 420,000 in December 2016. That represents an increase in volume of 268% since the analysis period covered by the OIG report.
- During that same period of time, since September 2015, the average days TriWest is taking to process claims has overall averaged 25 days. In recent months, paying claims on a timely basis became complicated by the volume moving through the system. Through the effort of both TriWest and VA, the issues have been resolved, payments have been made, and a long-term fix has been put in place. Today, all claims have been brought current through additional resources from VA and TriWest (including \$45 million from TriWest's company's non-profit owners) in order to decrease the backlog and honor our commitment to provide timely and accurate payment to providers.
- The average number of days from receipt of the claim to it actually being paid to the provider is currently down from a high of 65 days (when we and VA started to aggressively confront the backlog that has built up through October 2016) to now processing and paying claims within 30 days for those receiving care through the network.

Streamlined Processes and Procedures for Accessing Care (Recommendation #1):

TriWest has worked at VA's side on several initiatives to streamline processes and procedures and help improve the PC3/VCP programs, including:

- *New CRM:* TriWest has improved customer service for Veterans by investing in an entire new Customer Relationship Management (CRM) System to help deliver effective and efficient customer service encounters. The system also brings improvements to the user interface and the ability to document outbound and inbound calls with Veterans - all aimed at improving customer service.
- *VA Portal:* TriWest solicited feedback on the then-existing VA Portal from VAMCs. This system is the way TriWest and VA staff order and track health care services between the two organizations. Based on VA feedback, a new redesigned portal was rolled out in July 2015, bringing streamlined processes, which increased portal utilization and improved efficiency for both VAMCs and TriWest.
- *Embedded Staff in VAMCs:* In 2015, TriWest worked with VA to begin to embed cells of staff within a multitude of VAMCs. Veterans accessing VAMCs with embedded TriWest staff are educated in-person about program benefits and receive customer service quickly; TriWest works directly alongside VA staff to help coordinate Veteran care. Today, TriWest has embedded cells of staff in over 40 VAMC locations within our geographic area of operations, providing better daily coordination at a personal level.
- *Top Priorities Workgroups:* TriWest collaborated with VA to initiate workgroups to develop solutions for VA's Top 5 Priorities-improving customer service, improving visibility into the network, reducing returned authorizations, getting the right provider every time, and simplifying the referral process. As a result of these meetings, we jointly developed a detailed plan of action and timelines to address and execute plans to address each of these five priorities.
- *Tele-Behavioral Health (Tele-BH) Pilots:* In October 2016, TriWest implemented state-of-the-art, tele-behavioral health pilots in support of VA's same day behavioral health access initiative. As a result, Veterans in several states are experiencing increased access to BH care, including in rural areas. The pilot is being expanding to multiple states throughout our geographic areas of our responsibility.

