

Department of Veterans Affairs (VA)
Questions for the Record Submitted to
Mr. Richard Topping
Assistant Secretary for Management and Chief Financial Officer;
Ms. Alicia Skolrood
Executive Director, Integrated External Networks, Office of Integrated Veteran
Care, Veterans Health Administration
From the Committee on Veterans' Affairs
United States House of Representatives
"Community Care Network Next Generation: One Trillion Dollars of Oversight"

January 22, 2026

Questions for the record from Ranking Member Mark Takano:

Question 1: What are the specific drivers of increased costs in community care? Please provide the specific data you have on utilization, pharmacy, provider reimbursements and other factors.

VA Response: The key drivers of increased costs in the community care are as follows:

- Expanded Veteran eligibility for community care services resulting in more patients choosing to receive community care:
 - Numerous laws, including the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 and the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, increased Veteran eligibility for health care, including community care.
 - As a result, nearly 3.3 million Veterans were referred to community care in fiscal year (FY) 2025, an increase of 61% from the nearly 2.1 million Veterans in FY 2019.
- Increased reliance on VA, in particular community care, for health care services:
 - Beyond the growth in number of Veterans receiving community care, Veterans are choosing to receive a larger percentage of their care through community care.
 - VA has created more than 10.0 million community care referrals in FY 2025, an increase of 106% from the 4.9 million referrals in FY 2019.

Question 2: How will VA measure success or failure of CCN Next Gen in terms of access and health outcomes? If community care results in longer wait times or lower quality than VA care, what accountability exists?

VA Response: VA evaluates the success of the Community Care Network (CCN) Next Gen program through rigorous performance standards focused on access, quality, and accountability. Although CCN Next Gen may apply slightly different methodologies to assess access, the core requirements, such as appointment wait times and drive-time

limits, are fundamentally aligned. Additionally, health outcomes are tracked through nationally recognized clinical quality indicators, patient safety metrics, readmission rates, and Veteran experience surveys.

VA monitors contractor performance through data surveillance and oversight activities, including the Quality Assurance Surveillance Plan (QASP). When issues are identified, contractors are asked to implement quality improvement or corrective action plans. VA may use financial remedies or request provider removal when necessary and will continue to oversee compliance through audits and performance reviews.

Question 3: Are there outcome-based performance metrics and consequences, or will VA pay contractors regardless of results?

VA Response: The contract structure allows VA to use performance incentives/disincentives and formal oversight tools (QASP, Contractor Performance Assessment Reporting System (CPARS)) to address contractor performance.

Question 4: CCN Next Gen transfers administration of veterans' care to large insurance companies whose fiduciary duty is to shareholders. What concrete protections ensure these contractors prioritize veterans' health over profits?

VA Response: Under CCN Next Gen, VA retains the responsibility for administration of Veterans' care and continues VA's practice of contracting with a third-party administrator (TPA) to create and maintain a network of providers. Protections reflected in the solicitation include:

- QASP/CPARS oversight and off-ramping authority for performance, responsiveness, or integrity concerns.
- Strict privacy and cybersecurity requirements with breach liquidated damages (Health Insurance Portability and Accountability Act, Federal Information Security Modernization, National Institute of Standards and Technology).
- Service Contract Labor Standards compliance for service employees,
- VA inspection/acceptance prior to payment and invoice controls via electronic submission.
- Authority to impose incentives/disincentives and task order remedies.

These mechanisms align contractor behavior with VA's standards and patient care priorities.

Question 5: At the hearing, Ms. Skolrood indicated that VA schedulers do not have any visibility into which network providers are owned by the existing third-party administrators, and therefore, VA's decision to refer veterans to specific providers cannot take into account whether the veteran is being referred to a provider with a financial relationship with the third-party administrator. What assurances can you provide that the proposed contract will include mechanisms of enforcement and tools to ensure VA can prevent third-party administrators from creating a network of providers that would financially benefit them?

VA Response: VA acknowledges concerns about potential financial relationships between TPAs and network providers. Under the proposed contract, TPAs may add providers only if they maintain all VA credentialing, quality, and safety requirements. TPAs may include their own providers as long as those providers meet VA's standards and support Veterans' access to timely, high-quality care. VA maintains oversight of network development and participates in the credentialing committees and peer-review committees to ensure provider selection aligns with Veterans' needs. VA and Veterans decide which providers will provide care from among network providers, not the TPAs.

Question 6: On January 21, 2026, VA provided answers to questions Committee staff sent on January 7, 2026, about community care spending. The numbers VA provided are alarming. While VA experienced a 34 percent increase in patients receiving community care, its spending on that care increased 67 percent. Please identify the procurement terms for the new contract that will bring this spending down to a sustainable level. Please also identify what specific incentive or care quality will guide bringing this under control.

VA Response: Several cost control mechanisms are included in the CCN Next Gen contracts:

1. Utilization Management – Utilization management applies evidence-based clinical criteria, standardized diagnosis and procedure codes, and decision-support tools to guide appropriate referrals, admission, and post-acute care decisions. VA uses industry standard approaches, including utilization management for outpatient and inpatient care. Low-complexity requests are automated, while higher-risk or clinically complex cases are escalated for VA clinician review, preserving clinical oversight and Veteran-specific decision making.
2. Value-Based Care (VBC) and Alternative Payment Models (APMs) – VBC and APMs support cost containment and quality of Veteran care by shifting payment away from volume and toward quality, efficiency, and improved outcomes. Evidence from the private sector demonstrates that carefully selected APMs can reduce unnecessary utilization, limit variation in care delivery, and lower total cost of care while maintaining or improving quality. CCN Next Gen applies these models in a controlled manner to preserve VA oversight and alignment with program objectives, while increasing expectations for performance and efficiency over time. The Lower Extremity Joint Replacement bundled payment model is the initial APM and is using a successful model implemented by Centers for Medicare and Medicaid Services (CMS). Additionally, within the first 3 years after health care delivery, TPAs must propose three additional APMs. These proposals are subject to VA review and approval, allowing VA to align APM selection with program priorities and the evolving clinical profile of the Veteran population. Following VA approval, the Contractors must implement these APMs, and VA will monitor APM performance using defined quality, utilization, and cost metrics to assess impact on outcomes and spending.

3. Program and Payment integrity – VA will modernize systems, upgrade data analytics tools, and increase auditing efforts to better identify program risks and vulnerabilities and claims payment policies.
4. Claims payment – Reimbursement of claims accounts for the majority of community care spending. VA controls costs through a structured reimbursement hierarchy. When Medicare rates exist, VA reimburses up to the locality-adjusted Medicare maximum. If no Medicare rate applies, VA uses the VA Fee Schedule or Alaska Fee Schedule; otherwise, reimbursement is set at 50% of billed charges.
5. Administrative Services Payment Methodology – By improving alignment with commercial practices, CCN Next Gen administrative services payment methodology covers all administrative activities required to build, maintain, and report on the medical and dental networks, and is based on the entire Veteran population. This approach aligns with commercial per-member-per-month reimbursement methodologies and is an improvement over the current (legacy) contract that used a methodology based on Veterans utilization. The legacy method was less predictable and imposed greater risk on the contractors. By eliminating cash flow volatility, CCN Next Gen can avoid the risk premium contractors typically embed in their rate to hedge against unpredictable reimbursements. This payment approach should drive lower proposed prices and greater competition.

Question 6A: Mr. Topping, VA concurred with a 2024 GAO recommendation that the Department undertake a formal “lessons learned” process to inform VA’s plans for the next generation of CCN contracts. Did VA formally complete these lessons learned process? Is so, please provide some examples of changes you are making under CCN Next Gen that will address the problems identified through the lessons learned process.

VA Response: VA agreed with the Government Accountability Office’s (GAO) recommendation and has completed a formal lessons-learned process. The insights from that review are directly informing CCN Next Gen, including clearer performance requirements, stronger oversight mechanisms, and improved provider network management. These changes are designed to address the issues identified and strengthen contract execution going forward.

Question 7: GAO found in 2024 that staffing shortages in your office contributed to poor oversight of the current CCN contracts. How many employees will you need to conduct proper oversight of the CCN Next Gen contracts? Has the department authorized all of those positions? What is the current vacancy rate, and how will you ensure you achieve full staffing, in light of VA’s ongoing staffing cuts?

VA Response: GAO’s findings highlight the importance of having adequate staffing for CCN Next Gen oversight. While we do have vacancies, we are prioritizing roles and using targeted hiring strategies to reach the staffing levels required.

Questions for the Record from Representative Delia Ramirez:

Question 1: How does VA anticipate meeting its contract oversight and execution obligations, particularly given the Trump administration's ongoing limitations on hiring?

VA Response: VA remains committed to meeting its contract oversight and execution responsibilities. Legacy Integrated External Networks (IEN), which administers CCN contract oversight, employs 101 staff supporting CCN oversight — down from 339 as of January 1, 2025, and 310 as of September 1, 2025. VA is prioritizing the 185 positions authorized for dedicated CCN contract oversight and streamlining internal processes to close this gap while operating within current hiring constraints.

Question 2: How many positions are currently authorized for CCN contract oversight and execution? Do you intend to increase the number of authorized positions for NextGen?

VA Response: Within legacy IEN, 511 positions are authorized to support CCN oversight broadly, of which 185 positions are authorized to provide dedicated CCN contract oversight. As VA transitions to CCN Next Gen, we are assessing whether these authorized levels are sufficient for the expanded program and will adjust staffing plans accordingly.

Question 3: What percentage of the currently authorized contract oversight and execution positions are filled?

VA Response: Of the 511 positions authorized to support CCN oversight broadly, 101 are currently filled (approximately 20%).

Question 4: How many of these positions were made vacant in 2025, following the Trump administration's attempts to downsize the federal workforce, through the deferred resignation program and voluntary early retirement?

VA Response:

During calendar year 2025, 13 employees supporting CCN oversight took Veterans Equitable Resource Allocation (VERA) or the deferred resignation program (DRP). This figure reflects VERA/DRP separations only. Overall staffing supporting broad CCN oversight declined from 339 (January 1, 2025) to 310 (September 1, 2025) to 101 currently, a decline attributable to a combination of VERA/DRP, RIF, attrition, and non-conversion of term appointments. We are actively prioritizing the positions essential for effective CCN oversight and execution.

Question 5: Do you [Mr. Richard Topping] agree that contractor oversight is an inherently governmental function and that it is essential to ensure you have a robust, fully staffed workforce for CCN NextGen contract management?

VA Response: Yes.

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