

COMMUNITY CARE NETWORK NEXT
GENERATION: ONE TRILLION
DOLLARS OF OVERSIGHT

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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COMMUNITY CARE NETWORK NEXT GENERATION: ONE TRILLION DOLLARS OF OVERSIGHT

THURSDAY, JANUARY 22, 2026

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

The committee met, pursuant to notice, at 10:17 a.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Radewagen, Bergman, Miller-Meeks, Van Orden, Luttrell, Self, Barrett, Takano, Brownley, Pappas, Cherfilus-McCormick, McGarvey, Ramirez, Budzinski, Kennedy, Dexter, and Morrison.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

Mr. CHAIRMAN. Good morning. Without objection, the chair may declare a recess at any time. We are expecting votes about 10:30, so odds are we will have to do that.

Before I proceed, I would like to clarify the purpose of this hearing. Article 1 of the Constitution grants Congress the authority over financial matters and the powers to create law governing the executive branch and the responsibilities to oversee the executive—execution of those laws. The committee is neither a stakeholder in this contract, a bidder, nor a regulator. We are the constitutional body responsible for authorizing funding and overseeing the Department of Veterans' Affairs. Our duty does not dismiss—diminish simply because a contract is large, complex, or currently active.

I also want to raise the issue of timelines and timeliness with the testimony for today's hearing. This is the second time this week that we have not received the testimony from U.S. Department of Veterans Affairs (VA) in a timely manner. It is incredibly frustrating for staff and members to try to prepare for a hearing without having testimony to review prior to the hearing. If this were not such an incredibly important hearing, I would consider preventing VA from testifying today. However, given the importance of this hearing and the need for this committee to conduct critical oversight over this contract, I plan to proceed for the hearing, but rest assured that I will not be forgiving in the future.

Now, I want to thank Mr. Richard Topping for being here today. Mr. Topping is a VA assistant secretary for Management and chief financial officer (CFO). Before VA has—before he has—was chief

legal officer for CareSource, which is a Medicaid management care organization. He was also president of CareSource Military and Veterans, which is a piloting competitive health plan for TRICARE. More importantly, Mr. Topping is also a veteran, an Army veteran, but we will have to excuse him for that. This is the whole jarhead thing. I cannot help it. I believe the background makes him a good fit to lead the Trump administration's effort to manage VA's Community Care Next Generation contract.

However, this contract is going to cost the American taxpayer an estimated \$1 trillion. I want to make sure this money goes where it needs to go, improving health care access for veterans nationwide, no matter who at the VA is in charge. This hearing is the beginning of the conversation between VA and Congress to ensure this contract will maximize health care access and choice for veterans.

The Community Care Next Generation contract, or CCN Next Gen, is one of the largest government contracts in the Nation's history. It is also a unique type of Indefinite Delivery, Indefinite Quantity (IDIQ) contract being used to purchase health care. I am sure that Mr. Topping will explain that in detail in his testimony. Long story short, this is a revolutionary idea. If done properly, this contract would allow unprecedented flexibility for VA to award contracts and task orders that would leverage competition for the benefit of our veterans. It is an ambitious idea. If it works, it may be one of the most important innovations in government-run health care programs.

Unlike the first generation, CCN Next Gen would all—would award multiple contracts at the outset. Rather than being stuck with just one contractor, this will allow different contractors to compete for new task orders. As I understand it, the idea that the VA would be able to leverage new ideas and innovation for the benefit of the veterans. This contract structure would also provide a way to off-ramp poor-performing contractors.

CCN Next Gen will also feature Value-Based Care, or VBC, at a base requirement. VBC has long been an effective way for health systems to control cost while promoting quality care. It is a concept that is fully vetted and tested by Medicare, and it is long overdue in health care access for veterans in the communities where they live. I am glad that we will be able to—that we will be paying providers for the health care they deliver rather than services they bill.

Another new feature of this contract is utilization management, or UM. This is an important cost control tool, but it is also sometimes seen as a burden placed on providers and patients. One example of UM is the dreaded prior authorization. Now, without it, payers would have no way to stop unnecessary spending. With it, some doctors have to move heaven and earth to get the right treatment for their patient. Needless to say, we are interested know how VA plans to strike the proper balance that ensures veterans receive the care they need and deserve while also preserving and maintaining programs integrity.

VBC and UM are only two of the many new features of the CCN Next Gen contract.

I bring up these two because they are both rich in opportunity and in need of congressional oversight. Neither of these are new concepts in American health care, but they are new to the VA. I want to know how well VA is preparing to implement these features in the Community Care Program. Having Mr. Topping at the helm does give me confidence, but as a great man once said, trust but verify. I want assurance backed with details and explanations that VA will make every effort to ensure that the real world execution matches the vision. I need to know that VA will innovate where necessary and lean on existing resources and expertise. For instance, the Department of War is constantly managing complex contracts, and the U.S. Department of Health and Human Services (HHS) has whole divisions dedicated to payment policies. There will be new ground that VA must break, and let us not reinvent the wheel.

Mr. Topping, we are all eager to hear how you will be bringing this together for the millions of veterans in VA services. We are eager to hear what your team has been working on, from the CFO and all the way down to the contracting officer. Also, we are eager to hear in details how you implement—how you will implement such a complex system and bring veterans care into the next generation. As I understand it, there are some topics that VA will choose not to get into. I understand the VA finds it unprecedented to hold a hearing on an active contract solicitation. I appreciate the sensitivity of the contract, but it is also unprecedented to avoid Congress's oversight of \$1 trillion of spending.

My staff and the ranking member's staff have been told that some topics are off limits because of the sensitive nature of the contract and solicitations. We will have—we have tried to create a venue in which VA would feel comfortable to speak candidly to our members, but unfortunately, VA failed to assure us of such candor. As such, we are not able to close portions of this hearing for more candid conversation.

I would also like to thank the Ranking Member Takano and his staff for working with us to exercise this oversight. Mr. Takano, I assure you this hearing is only the beginning of congressional oversight.

Community care is an extension of VA care. It should go without saying that VA must get this right. When veterans call my committee, they want to know how they can access their earned health benefits at VA. They do not ask contracts what VA is used to provide the care. That is the core of the Next Generation contract and why we must have this hearing. We must deliver modern health care access and choice to our veterans without run around—running around or red tape. Veterans have been enrolled in VA at unprecedented rates in every part of this country. Community care is the only way that VA can keep up with this mission. It is the best way we have to get health care to the veterans with the right treatment, at the right time, at the right place. If we do not do our due diligence to maintain and improve community care, we dishonor the memory of the countless veterans who have lingered on a secret wait list at the VA medical centers without receiving the care they earned. Let me say that again. We must get this right.

Before turning to the ranking member, I would also like to take a moment to thank Representative Brownley for her years of service to this committee. You have done amazing work on Health Committee, Health Subcommittee relating to suicide prevention and also improving services for women veterans. I want to say how thankful we are. Thank you. I know you have the rest of the session, but I hope you enjoy retirement and that life is better on the outside for you in the future. Yes, yes.

With that, Ranking Member, I now recognize you for your opening statement.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Thank you, Mr. Chairman. As you mentioned, your—the very beginning of your opening comments, you referred to the untimeliness of the testimony from VA that was due at 10 a.m. on Tuesday. We did not receive the testimony until 6 p.m. last night. I advise the VA witnesses to review on YouTube, and I will have my staff look it up and send it to you, the reaction of Republican—of the Republican chairman of the Judiciary Committee from the State of Wisconsin, James Sensenbrenner’s reaction when testimony arrived late. He canceled the hearing.

We are reviewing a contract of enormous proportions, historic proportions. You gave our committee staff way less time than they were owed under the—under this—under our committee rules. I, if I were its chair, I would have postponed the hearing because we need to review your testimony and prepare the questions for this committee. It is inexcusable. This should never happen again. I want to reiterate that. It will not happen again, or I will lodge an even larger protest with the chairman. This is disrespect to Congress, and I, in my opinion, we are showing way too much deference to the administration in this case. We represent the American people, and this is a near-trillion-dollar contract. Enormous disrespect. Get your testimony here on time, especially when we are reviewing a trillion dollars.

Thank you, Chairman Bost, for yielding. As I said, nearly a trillion dollars. I must admit I am a bit taken aback hearing our Republican colleagues speak positively about the government spending such a large sum. Although, in the chairman’s words, he showed some concern, actually a great deal of concern, about the amount of money that we are talking about spending here.

To put it in perspective, the \$700 billion ceiling on this contract for VA community care is equivalent to what President Trump offered Denmark to purchase Greenland. Just as I believe the president is unnecessarily agitating our most important allies, I fear VA’s plans for Community Care Network Next Generation contract will put the agency on an unsustainable course, barreling toward privatization, hollowing out direct care. I believe as my colleagues will go through the questioning, we are going to look at what appears to be an unsustainable trend in the increase in spending in the community care accounts. I am willing to pay any price for veterans to receive every benefit they deserve, including access to high-quality health care.

When we passed the largest expansion of veterans benefits in history, the Sergeant First Class Heath Robinson Honoring our

Promise to Address Comprehensive Toxics (PACT) Act, we knew more veterans would use VA services and that we would need to invest in VA to pay for the costs of war. VA is the best place for veterans to receive care. Throughout the chaos of the last year, my Democratic colleagues and I have loudly voiced our concerns about VA's future. VA's future is dependent on its people. VA is understaffed. VA is understaffed. If we walked into any VA facility in the country right now, I guarantee that the director would tell us their number one concern is understaffing. It is difficult for me to sit here and discuss this enormous contract for community care, which is one of the, if not the largest, procurement in VA's history, when we have not seen this administration make similar investments in VA direct care itself.

Instead, every headline we read, every whistleblower email we receive, every veteran perspective shared at our town halls is about cuts and how those cuts are impacting veterans' ability to receive the VA care they know, love, and rely on. Secretary Collins proudly carried out the performance—the performative Office of Management and Budget (OMB) decree to illegally terminate probationary employees, only to be ordered by the courts to reinstate them. He oversaw and encouraged the departure of nearly 40,000 employees last year, including thousands who vacated frontline veteran-facing positions. Now we are anticipating the impact of his directive to cut nearly 30,000 positions from VA's roles. There have been no hiring incentives, no investments in VA itself under Secretary Collins, only cuts.

Yet today, VA comes before us with a grand vision to continue to grow community care. VA has tripled how much it spends annually on community care since 2018. This Request for Proposal (RFP), valued at nearly a trillion dollars over 10 years, would continue the exponential, out of control, unsustainable growth of Community Care. You wonder why I am ticked off that you come here and bring your testimony, and give it the—submit it at 6 p.m. last night.

Now, we have here, behind me, a poster. According to VA's own data, the number of individual veterans using community care increased by only 34 percent between 2021 and 2024. However, during that same period, expenditures for community care grew a whopping 67 percent from \$19.7 billion in 2021 to \$32.9 billion in 2024. This far outpaces the growth of health care costs for civilians also receiving care in the private sector. Civilians also know that the cost of health care rises faster than regular inflation. VA health Care is growing faster than civilian health care.

We should all be asking ourselves why? Why did the cost of community care so drastically outpace the number of veterans using it? What controls is VA putting in place in the next generation of this contract to contain those costs? Sadly, I fear the answer to that question will disappoint us. If we divide the \$700 billion ceiling for the contract over its 10 year span, that leaves us with VA averaging about \$70 billion in annual spend on community care going forward, which is over double what VA is spending today.

Again, what is the justification for this rapid growth? VA's testimony today will claim that it is implementing cost containment—a cost containment framework. It expects to reduce community care

spending by \$54 billion over the next decade. Even if that speculative cost savings pans out, this RFP still estimates VA will spend \$30 billion more a year over the course of the new contract than it is spending now. I am sorry, this is not cost containment, it is cost explosion.

While this RFP is lengthy and dense, it provides little detail as to how the new structure will address the issue I believe is most important when we evaluate community care, and that is the quality of care veterans receive outside of VA. The patient experience is tantamount. I fear this RFP does not adequately address persistent issues veterans face when receiving care in the community.

When asked how VA will oversee contracts of this magnitude, Mr. Topping indicated that VA may procure contractors to perform that oversight. Procure contractors to perform. We are going to get contractors to oversee a contract. This is a recipe for disaster. Oversight of contracts is an inherently governmental function. An outsourcing that function to the private sector will leave this behemoth of an acquisition vulnerable to waste, fraud, and abuse.

VA has historically struggled with contract oversight due to lack of staffing. In 2024, VA had only half the staff it said it needed to oversee community care contracts. We have no reason to believe that VA staffing levels have improved, considering the mass departure of employees, experienced employees last year through the deferred resignation program, voluntary early retirement, and natural attrition, coupled with the consequences of governmentwide hiring.

In addition to leaving the contractors to oversee themselves, this RFP leaves open the door for the insurance companies we expect to bid to enrich themselves beyond the cost of the contract. Insurance companies have been on—insurance companies have been on acquisition sprees, vertically integrating and buying up hospitals, clinics, pharmacies, and other parts of the healthcare supply chain across the country. This trend toward consolidation is increasing care costs and diminishing patient access.

Now, what does this mean for veterans? It means that when veterans need care in the community, they are going to have fewer choices. Perhaps an insurance company that wins a CCN Next Gen contract chooses to create a network of only of providers whose practices that insurance company—that the insurance company owns. Nothing in this RFP prevents that from happening.

I fear this RFP does nothing to guard against the issues VA experience with the current third-party administrators who won the contract during Donald Trump's first term. The third-party administrators failed to coordinate network adequacy with the 172 VA medical centers nationwide. As a consequence, we have networks that are not reflective of demand, and wait times for community care often exceed those of VA. Let me repeat that. Community care often—the wait times for community care often exceeds those of VA because of the insufficient contract that was approved during the first Donald Trump administration.

We have heard complaints that there are providers who are currently considered in network for the CCN who are not actually accepting veteran patients. The current third-party administrators only grew the provider network by 7,000 providers between 2021

and 2024. That is a paltry 4 percent growth in the supposed quote-unquote choice veterans are promised for care in the community. Additionally, nothing in this RFP requires the contractors to build a network of only of providers who have the same level of training as VA providers, including on veteran cultural competence. We had no way to ensure that veterans were going to see a culturally competent provider in the community because there was no way to ensure that those community providers would undergo that level of training or certification. This will invariably lead to worse patient outcomes and a negative experience for many of the veterans who have complex medical needs directly related to their military experience.

Chairman Bost, I hope that we can work together to develop a robust oversight plan, and I am glad to hear that this is the first of hearings that we expect to have regarding oversight of community care. We need to work together to develop a robust oversight plan with a regular cadence of required briefings and hearings with VA. As this contract is executed and hopefully with testimony that arrives on time, we must chart a path forward that adequately balances investments of VA care and community care.

We were given little opportunity to prepare for this procurement as VA posted this RFP in December with absolutely no heads up to Congress. My staff repeatedly asked VA for briefings on plans for the CCN Next Gen contract to 2025, but those requests were never fulfilled. We were ignored, and I am offended. Those requests were never fulfilled. We, the members of this committee, who have a constitutional oversight responsibility of VA, found out about a nearly trillion-dollar contract competition at the same time as the general public. This is unacceptable. We did not receive testimony for today's hearing as I said until 6 p.m. last night, giving us little opportunity to review it prior to this hearing. VA has done nothing leading up to this hearing to inspire confidence or trust in this process.

In closing, like signing a bad mortgage contract or opening the credit card without reading the fine print, rushing into this huge taxpayer investment is a recipe for financial disaster. The contract terms alone lock VA into a long-term commitment with very little certainty about whether this contract will improve veterans' access or outcomes. When confronted with a deal that sounds too good to be true, it is important to take a step back and not jump headfirst into a rushed, untested, costly proposal. Until we see a plan that reinvests in VA, VA direct care, not just private contractors, and until oversight is restored, this process cannot earn the trust of this committee or the veterans we serve.

With that, I will yield back.

Mr. CHAIRMAN. I thank the Ranking Member for his opening statement and yielding back.

Ladies and gentlemen, a vote has been called in the House. The committee will stand in recess, subject to the call of the chair. It is my intent that we expect to be back 10 minutes after the final vote. At that, we are in recess.

[Recess]

Mr. CHAIRMAN. Committee will come back to order. Sorry for the interruption. Kind of what we do around here.

As mentioned earlier, joining us today is the Department of Veterans' Affairs. Mr.—the Department of Veteran Affairs, Mr. Topping.

Mr. Topping, you are now recognized for 5 minutes to present your opening statement.

STATEMENT OF RICHARD TOPPING

Mr. TOPPING. Mr. Chairman, thanks for having me. Thanks for having us on this very busy day in Congress. Certainly, I hear you on the delay on the testimony getting to you all last night. In my short time at VA, I have found it is actually easier to fix CCN than it is to get testimony approved through the process. I own the delay, and we will do a better time next time, sir.

Mr. TAKANO. Parliamentary inquiry. Mr. Chairman, is not it customary that we swear on the witnesses?

Mr. CHAIRMAN. It is. If the witnesses will rise. Raise your right hand, please. Do you say—I do not have the script in front of me. You got it? I think I can do it off, but let us do it anyway.

[Witnesses sworn.]

Mr. CHAIRMAN. The witness answered in the affirmative. Now you can open.

Mr. TOPPING. Thank you. Mr. Chairman, Ranking Member, distinguished members of the committee, thank you for the opportunity to discuss Veterans Community Care Program and the Community Care Next Gen contract procurement. I am accompanied today by Ms. Alicia Skolrood, executive director of External Integrated Networks, Office of Integrated Veteran Care, Veterans Health Administration (VHA).

VA has long been recognized for the world-class care we provide to veterans across our more than 1,500 medical facilities. In addition to the Direct Care System, VA has also been a purchaser of healthcare since before the World War II era. As a healthcare payer, VA partners with local hospitals, doctors, and other healthcare providers to ensure that veterans have access to the care they need, where and when they need it. Caring for veterans is about more than operating hospitals. It is about supporting veterans' physical and mental health and wellness, their families, caregivers, and leveraging community services beyond the walls of our facilities.

Recognizing the key role that purchase care plays in VA's ability to provide for veterans health and wellness, President Trump and Congress passed the bipartisan John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, which expanded access and choice for veterans and reinforced veterans mission as both a health care provider and payer. Today, VA is the largest single health care provider through our hospitals and our clinics, our 1,700 sites of care, and the fourth largest healthcare payer.

In Fiscal Year 2025, 41.8 percent of all VA health care appointments were in the community. Next Gen is VA's first major procurement effort to support this program. It is our opportunity to increase competition, upgrade and modernize the provider network, enhance services to ensure that veterans receive the very best

health care possible, whether they are at a VA facility or in their community from a local healthcare provider.

We did not design Next Gen alone. We talked to our veterans, who overwhelmingly want the flexibility to choose between direct care and community care based on medical interest, availability, and convenience. We talk to our government partners. The Departments of Health and Human Services and of War have decades of experience and data on improving healthcare quality, reducing costs, and aligning incentives for better health and wellness. We talk to industry, which is constantly innovating with new delivery models, leveraging data analytics, striving to be consumer-oriented while tackling costs that remain too high.

Combining VA's history, the data, this external input, VA successfully issued the CCN Next Gen Request for proposals on December 15th, 2025. We are leading the Nation with an innovative 10-year multiple award indefinite delivery/indefinite quantity contract vehicle, which has several key advantages over traditional Federal healthcare contracts.

First, the IDIQ drives and delivers competition and flexibility by allowing both national and regional health plans to successfully bid and be awarded a spot on the IDIQ. This is the best of both worlds. We will have vendors with national reach and efficiencies of scale, but also regional health plans with unique capabilities that are locally adaptable to serve our veterans.

Second, through the use of multiple rounds of task orders, this allows VA to iteratively adapt Next Gen to meet veterans' changing needs over time, changing demographics and infrastructure, and to improve VA sophistication to manage the program over the 10 year performance period of the contract.

The IDIQ is the how of this procurement, but the most exciting part of CCN Next Gen is the what. Next Gen is designed on five pillars: quality, value, alternative payments, utilization management, and program integrity.

VA will implement a comprehensive quality program for community care providers based on nationally recognized measures for the Agency for Healthcare Research and Quality and the Healthcare Effectiveness Data and Information Set (HEDIS). Contractors will track patient safety events, identify veterans at risk of avoidable visits and readmissions through predictive analytics, and, while respecting their choice, guide veterans toward higher performing providers.

Next Gen will modernize how VA pays its contractors for the care furnished to veterans by implementing value-based payment models. We will begin with episode-based payments for lower extremity joint replacements. As we gain the data and the expertise to manage alternative payments, we will introduce at least three additional models over the performance period of the contract to continually improve care. These models will shift payment away from volume and toward outcomes and total cost of care, which aligns contractor incentives with veterans' health and system sustainability.

We will introduce utilization management. This includes active management of inpatient admissions, emergency department use, concurrent hospital reviews, high cost drugs administered in clin-

ical settings. This will reduce unnecessary hospitalizations and inappropriate care while protecting veterans' access to medically necessary services.

Next Gen will include a program integrity function to ensure that VA resources are protected and maximized. We will identify providers at high risk of improper billing—improper billing, formalize oversight processes, expand data and technology for improper payment detection, use independent audits, and ensure veterans receive what VA is paying for.

Next Gen also changes how VA pays our contractors to incentivize performance and outcomes. Next Gen will incorporate incentives and disincentives based on the total cost of care, quality, performance, value based adoption, and payment integrity. Ultimately, contractors who achieve VA's quality targets while reducing our costs will share the value of—will share in the value that they create for VA and our veterans.

Speaking of costs, along with our improved care for veterans, Next Gen provides real savings for taxpayers. Next Gen's actuarial estimates based on independently verifiable data show significant savings of 8 to 14 percent over the life of the contract. These savings range from a low-end estimate of \$54 billion to a high-end estimate of \$100 billion over the life of the contract. These are gained—these savings are gained by fewer unnecessary hospitalizations, improved management of high-cost services and drugs, improved quality, and stronger fraud prevention and payment controls.

Mr. Chairman, Next Gen is leading the way in how Federal health care programs can be designed, procured, and operated. I appreciate the opportunity to share this information with you and the committee and look forward to answering any questions you may have. Thank you, sir.

[THE PREPARED STATEMENT OF RICHARD TOPPING APPEARS IN THE APPENDIX]

Mr. CHAIRMAN. We are going to now go to questions.

I will recognize myself for 5 minutes.

Mr. Topping, the community ambulance services have shared that there is no way to know when a patient is a veteran. I would like to see if the Next Gen addresses this for all providers with limited claim windows? How will VA help the community providers' experience in a case where they do have a short claim window for filing? Is there a process by which that will be part of this?

Mr. TOPPING. Thank you, Mr. Chairman. First of all, the claim window is 6 months, and as you know, we have got proposed legislation in the Access Act that would expand that to 12 months, which would match how Medicare does this. There is a window in which a provider who provides a service can bill VA after they determine veteran status after the fact. Part of how we intend to design and manage this network and the capability to verify eligibility enrollment, these will be addressed through this. Our ability for a provider, a network provider, an ambulance provider, an emergency service to then be able to bill VA for the cost of that covered care again on the agreed payment schedule, absolutely. Those are the types of things we are tackling in this reprocurement, sir.

Mr. CHAIRMAN. Okay, so what accounts are—will the fund—will fund the CCN Next Gen?

Mr. TOPPING. CCN Next Gen, sir, has a direct appropriation. One of the things that we are doing at VA is not just the purchase cost of care and accounting for that as a program cost, but also the administrative cost. There are three costs that go to our inputs on community care. One is the administrative cost for the agency to administer our internal program management costs. We are organizing those directly to this program. Second is the cost that we then pay to our health plan partners and our vendors to manage this network. The third are the purchase cost of care that the providers are paid who directly provide the service to the veterans.

Mr. CHAIRMAN. Is it the intent or any anticipation that you will be using the toxic exposure funds resources for the community care?

Mr. TOPPING. Sir, we are going to maximize the resources available to us to ensure that the veterans get the care that they have earned, that they deserve, that they are eligible for under this program. We intend to do so in a way that maximizes our efficiency so that we get the highest quality, lowest cost care. We will reuse the resources that Congress has afforded us to do so.

Mr. CHAIRMAN. Okay. The Next Gen contract would include many features that are found in Medicare and other programs. How deep is your ongoing engagement with other agencies to help implement the new community care system?

Mr. TOPPING. Number one, this year we partnered a program where we are working with Centers for Medicare and Medicaid Services (CMS) on improper payments and overpayments. For the first time, VA has partnered with CMS on payment because we have got veterans who move between our systems and their systems. We have begun that work on how our systems collaborate and work together.

Second, as VA builds out its program management capability, what we are talking about today is the program design of CCN Next Gen. What comes next for VA is program management, our ability to operate this program. We are going to use the models that we see in other places in government. For example, the Center for Medicare, which provides a framework for how VA would manage and operate a program of this size. There are State models. We will incorporate the best of both to bring in how VA is organized, how VA manages this, how we use ingest and action data for the outcomes that we are seeking in this program.

Mr. CHAIRMAN. Yes, my big fear would be that you would not pay attention to mistakes that Medicare has made over the years, and get on the right track right off the start, and take advantage of someone that has already got a system in place.

Mr. TOPPING. Absolutely. When we talk to CMS, and same deal when we talk to Department of War, our colleagues at the Defense Health Agency, is what were their lessons learned? What works, what has not? The five pillars that we are introducing in this program are tried and true methods. These are tools that have been used in other programs and in some cases for decades. We are importing what we know works. We have looked at the lessons. Some have been good, some have not. We have brought those in our pro-

gram. This is a program that takes what has worked elsewhere. Again, we are the fourth largest payer program, but we are not the only and HHS operates the top three. We have looked at their successes, their failures, gotten their input, and we have done the same with industry. We did not just say what is government's view on this. We went and talked to industry and said you tell us how this has worked. You tell us where you have been successful, where you have been not. What have your pain points been? We have incorporated that and built that into this program design.

Mr. CHAIRMAN. Well, I am telling you, before I yield back, I want to let you know that we do not—this—as I said in my opening, this is just the first of many meetings. We need to keep you here on a regular basis, talking to this committee, so we can watch this process. We have had other things that VA has done that they go off on their own, and we do not get the oversight that we need. I want the commitment from you that you will—we can do that.

Mr. TOPPING. Mr. Chairman, anytime you will have me to come back and talk about Next Gen, I will come.

Mr. CHAIRMAN. Okay, thank you very much. I yield back.

I recognize the Ranking Member for his 5 minutes.

Mr. TAKANO. I will expect prompt answers from my staff from you as well. I cannot have delays in, and I do not ever want to see a major program announced at the same time the public hears it. Do I have a commitment from you on that?

Mr. TOPPING. Yes, sir, you do.

Mr. TAKANO. Thank you. Community care spending is out of control across multiple administrations. I have raised concerns about how much spending is going into the community care account at the expense of direct VA-provided care. Underscoring these concerns are VA—underscoring these concerns are VA's transfers so far this Fiscal Year of over \$2 billion into the community care account. Mr. Topping, from what account did you transfer the \$2 billion?

Mr. TOPPING. Ranking Member, there have been no transfers this year into the community care account.

Mr. TAKANO. There have been no transfers? That is what—that is your answer?

Mr. TOPPING. Correct. Yes, sir.

Mr. TAKANO. Okay. You stand by that? You are under oath.

Mr. TOPPING. Yes, sir. There have been no transfers this year. In Fiscal Year 2026, there have been no transfers.

Mr. TAKANO. In Fiscal Year 2025, we are talking about.

Mr. TOPPING. Yes, sir. In Fiscal Year 2025, there were transfers.

Mr. TAKANO. From what accounts were the \$2 billion transferred?

Mr. TOPPING. As I recall, sir, I think it came from Medical Support and Compliance, and there was a transfer of one—I forget the exact number—but I believe the transfer is \$1.3, \$1.4 billion into the account.

Mr. TAKANO. Can you make sure that you get us the accounts that that money was transferred in Fiscal Year 2025, the \$2 billion?

Mr. TOPPING. Yes, sir.

Mr. TAKANO. Thank you. VA requested \$48 billion in mandatory and discretionary funding for community care for Fiscal Year 2026, and that is what you received. As of now, VA—will VA need to transfer more money into the community care account before the end of Fiscal Year 2026?

Mr. TOPPING. I am sorry, sir, was that a question as to whether we will need to transfer?

Mr. TAKANO. As of right now, will VA need to transfer more money into the community care account before the end of this Fiscal Year of 2026?

Mr. TOPPING. Sir, as of right now, my financial cost estimates, along with my spending to date, again, understanding that there is both a data and a claim lag. As of right now—

Mr. TAKANO. My time is short. Just answer the question.

Mr. TOPPING. Sir, as of right now, my data does not show that.

Mr. TAKANO. Okay, so the answer is no, you will not. You are telling me that you do not need to—that you—that you are saying you have sufficient funding from your \$48 billion Fiscal Year 2026 appropriation, and you do not plan to ask for any more money, right?

Mr. TOPPING. Representative, as of right now, my appropriation for Fiscal Year 2026—

Mr. TAKANO. It is a simple question. Yes or no?

Mr. TOPPING. Sir, my appropriation is \$50.174 billion, \$206 million. That is the appropriation, and, sir, that is the budget that I am managing too.

Mr. TAKANO. Well, I asked you about a \$48 billion Fiscal Year 2026 appropriation to the community care account. You do not plan to ask for any more money than that?

Mr. TOPPING. Sir, the number is \$50.174 billion, \$206 million.

Mr. TAKANO. All right. Okay. Well, so you do not plan to ask for any more money for that account?

Mr. TOPPING. No, sir. At this time, my data does not show that I will need to do that. No, I do not, sir.

Mr. TAKANO. Okay. Well, Ms. Skolrood, contractors are required to self-report conflicts of interest, even though many insurers own clinics and provider networks. How will VA independently detect and prevent contractors from steering veterans to affiliated providers for profit?

Ms. SKOLROOD. Thank you very much for that question. Our Third Party Administrators (TPA) do not steer our veterans to providers. Those decisions are made by the veterans.

Mr. TAKANO. Well, how would you know that? You just claim that our TPAs do not do that. Is there—how is VA going to hold our TPAs accountable?

Ms. SKOLROOD. They do not have the opportunity to do that. That is not how a veteran gets to the community provider. The veteran gets to the community provider either by choice, because they have selected them. Now, the network is built by the TPAs. That we control via our credentialing process, our accreditation process, and our assessment of the provider's quality abilities.

Mr. TAKANO. You are going to represent to me in this committee that every clinic, every provider, you know, is not owned by the TPA?

Ms. SKOLROOD. I am not representing that at all, sir.

Mr. TAKANO. Well, then, how is it that you are able to answer my question and the way that you have answered it? You know, how will VA independently detect and prevent contractors from steering veterans into affiliated providers for profit? If you cannot figure that out, you cannot tell me that.

Mr. TOPPING. Ranking Member, the way the system currently works, VA controls the clinical referral, and VA controls the placement with the community provider. The TP, the vendor does not control the steerage. VA does. These are people.

Mr. TAKANO. You are not really answering my question. You are evading the question. You are avoiding the intent of my question. You are not able to answer how TPAs avoid this conflict of interest. You do not—there is no—I do not—you are not answering. You are not talking about any enforcement mechanisms beyond simply trusting contractors to disclose conflicts.

Mr. TOPPING. TPA—

Mr. TAKANO. I would suggest, sir, that is a huge flaw in the assumptions that you are bringing forward to us.

My time is up. I yield back.

Mr. CHAIRMAN. Representative Radewagen, you are not recognized for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairman Bost and Ranking Member Takano, for holding this hearing today. Thank you to the witnesses for your testimony, for your appearance.

Mr. Topping, what was the contract type for the First Generation of contracts? What is the contract type for the Next Generation? What is the significance of the difference for veterans?

Mr. TOPPING. Thank you for the question, Representative. The First Gen contracts were direct sole source contracts to the award-ees. There are two vendors under the current Next Gen contracts that operate those exclusively. The difference with Next Gen being an IDIQ is that the government will have the ability to bring on multiple vendors and multiple contractors. Those contractors can then compete across the life of the contract for different task orders. That allows VA to change program design, to learn from mistakes, to increase our capabilities and capacities, to innovate and evolve the program over time. The difference will be we picked a program, we awarded contracts, and that is what we have had for the past contract. What we are able to do under the IDIQ and why this is so unique and so different is it allows us the flexibility to pick, innovate, and for vendors to compete and improve continually across the life of the contract.

Ms. RADEWAGEN. Mr. Topping, does VA believe it needs any additional legislative or regulatory authority to act on the Next Generation contract?

Mr. TOPPING. Ma'am, at this time, we do not. We believe we have it. However, as we go through this process, engage with the oversight of this committee, stay engaged, making sure we report as we may or may not need additional authorities, we intend to come to this committee and work with you and your staff to ensure that we have it.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back the balance of my time. Thank you.

Mr. CHAIRMAN. Representative Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. I apologize. My staff was just telling me I have a vote in another committee, but I will take my time.

Thank you to the both of you for being here today. I have to say that, you know, everything you have said in your opening comments with regards to your stated goals, I agree with. You know, and if you succeed in raising and having higher quality of care with less resources, I will be the first to commend you. Honestly. Honestly.

When I review the one trillion dollar contract that you have put forward, I am just absolutely not convinced that you can succeed in those goals. Better quality, less resources. Over the last decade, community care continues to increase exponentially. I think we can agree on that. Turning VA, I think more into a payer system rather than a provider of healthcare. It seems that the Next Gen contract is not. It is clear to me, let me just say, that you are not shutting down and the contract's not shutting down VA facilities whatsoever. It does not require, in my opinion, any kind of important oversight like requiring prior authorization to receive care in the community. It seems to me, based on what you are saying, that competition is the oversight piece within the contract. If people cannot compete, they are out. If they can compete, they are in, and they will be doing a good job.

Do you agree with that assessment in the simplest terms, that you believe that competition is the—is the main component for oversight?

Mr. TOPPING. Thank you, Representative. I believe the main component of this contract and why this is different is this gives VA the tools, and again, tried and true tools, the five tools we are going to use. This gives us the tools to hold our contractors accountable. Our ability under the IDIQ to off-ramp non-performing contractors, that is what I believe is different about this. I do not believe that the competition is what is going to drive the outcomes. I believe VA's management is what is going to drive the outcomes. The competition is a tool that allows us to ensure that only vendors that are achieving our expectations for them are hitting those quality scores, are achieving the cost savings, and doing it in a way that VA oversight agrees with and is consistent with our values. That is what we are able to do in this, and that is what is different. We do not have that ability under the current contract.

Ms. BROWNLEY. You know, your first point of control, if you will, and using your words, that would be a prior authorization, whether, you know, it is appropriate for the veteran to go into the community or not. I believe what you are proposing is that a veteran just can go into the community, and these other tools that you have can control that?

Mr. TOPPING. Well, let us—let us talk about the utilization management part of this program and prior authorization, which is one part of that, and had been one part of UM used differently over time. Fundamentally, what UM is, and UM has been around for 30 or 40 years, it says that for any given diagnosis, there is a finite universe of treatments to treat that diagnosis. For example, when we send a veteran to the community for Post-Traumatic Stress Dis-

order (PTSD) could, you know, could be, could be therapy, could be medication, could be psychiatric care. It is not a knee replacement. A knee replacement is not responsive to that veteran's need. What UM allows us to do is package this up and know that we ensure that veterans are receiving the care that is responsive to and therapeutic to the diagnosis. That is how we are going to use that tool in this contract.

Ms. BROWNLEY. You said in your testimony that you have talked to many with regards to this new proposal, new system within the VA, and you said you talked to industry. I am curious to know how much engagement you have had with veterans across the country.

Mr. TOPPING. Ma'am, we have been very engaged with veterans, both through our Veterans Service Organization (VSO) groups, through our individual outreach, through the Request for Information (RFI) feedback that we have had. We have been engaged with veterans who are the users of this system. They are the end state. The goal of this is ensuring that our veterans are best served. They are our customers and so that is why we are doing this.

Ms. BROWNLEY. Can you—my time is limited and it is almost over. Can you just give me a list of the VSOs that are supporting this program? Can you name them now for me?

Mr. TOPPING. Ma'am, I can take that and bring you the list.

Ms. BROWNLEY. Thank you. I yield back.

Mr. CHAIRMAN. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. It has been interesting to sit here and listen. I have got a lot of prepared questions in front of me, and I will get to some of them. As I listen, I recall the MISSION Act of 2018, which started this ball in motion. Okay. The point is, has there been any lessons learned that have been tabulated by the VA since that time? Maybe, you know, by your predecessors or whatever, that when we implement anything, the ability, you know, in the military, no battle plan survives first contact because the plan is the plan until you put it into kinetics, and then it is modified.

We could talk for hours, and maybe the time is right now. As a follow on, I would suggest to have a closed meeting with our committee where there is no cameras, just to really get, because you cannot cover this, and a dialog that involves honesty. Is there anything that has appeared to you that has become redundant, that is necessary? The redundancy is necessary, or the opposite is that it is unnecessary, the redundancy that you put into place? Okay, any—anything pop out in your—as you look at what you have seen and what you are trying to do, do you try to evaluate, do we need to continue to do this step? Does it add value?

Mr. TOPPING. General, thank you for the question. I think so, absolutely. As we look back on lessons learned and some of the—and some of the issues that we had, the prior contract was not designed to be a program of the size, scope, and scale that it now is, serving 9.1 million veterans literally wherever they live. Our ability to make sure that this program is sustainable, but also achieving the outcomes and access that we are looking for—for our veterans has been our guide stone in this.

Mr. BERGMAN. Has there been anything that is just—that you could give us a data point, and if the answer is none, okay. Is there anything that, since trying to implement this and get everything up and running that you have said, absolutely, this is a waste of time and money. It is not adding value to the veterans. Has there been any list of things so that people could say, well, did not see that coming, but okay, it makes sense. I think as a committee, we want to hear confidence in your ability at the Veterans' Administration to create this and to keep it going, to make the necessary change, to stop doing stuff and not let bureaucrats and contracts that, you know, a reason to not do something that you know deep down because that—but that is—that is a unit that is in the military. It is within the unit to make changes that they see because they are right in the middle of the fight.

Mr. TOPPING. Representative, so three things. One, this program has been unmanaged since its inception. None of the tools, none of the controls that we are talking about introducing here have been available for. VA had no ability to manage this program, to drive quality, to focus on the outcomes for veterans, to focus on cost. We have now got the ability to do that in this contract. That is number one.

Number two, the way we designed this unmanaged program made it very difficult for industry to partner with us. It made it very difficult for community providers to serve our veterans. Made it difficult for our TPAs because it did not operate like any other payer program, which made it one off anomalies that made it difficult to be part of this.

Then third, and I think most importantly, and this is the one that VA owns, that we are working on together, is our program management, for this was not built to run a payer program. We are focused. The program design is—

Mr. BERGMAN. I hate to cut you short, but my time is running. I would suggest to you that under Secretary Collins' leadership, we have seen the reorganization of the Veterans Integrated Service Networks (VISN) and how they are set up. What I would like to see is, in that, the already existing and announced VISN reorganization plan, how that will affect, or maybe no effect, no effect on your ability to do what you are tasked to do. With that, I yield back.

Mr. CHAIRMAN. Mr. McGarvey.

Mr. MCGARVEY. Thank you, Mr. Chairman. Appreciate you all being here. I mean, look, my focus is the veterans. It is the focus of this committee. It is my focus. We have to do what is best for our veterans. They put on a uniform, they served, they sacrificed for us, and we promised we would take care of them.

When I think about this, I want our veterans who need it and want it to get their care through the VA. I know the VA cannot necessarily provide every single service available. We got to have a VA that functions. When we are here talking about these community care networks right now. I want to talk about what it looks like in Kentucky because in Kentucky, we have a lot of veterans, and we have a lot of veterans in rural areas. We cannot look at this in a vacuum in this hearing. This year, the Trump administration, last year, the Trump administration passed a bill they refer to as

The One Big Beautiful Bill. Well, the Kentucky Hospital Association, which is not exactly some flaming liberal organization, has predicted that 35 rural hospitals in Kentucky could close because of the funding cuts that are going to come through this. This means our veterans, our men and women who served, who are already in health care deserts, 41 counties in Kentucky, do not have an obstetrician-gynecologist (OBGYN) right now. This is going to get worse with what is coming in these funding cuts. The system cannot continue like this.

My concern is that when we think about community care filling the gaps, we have to look in places like mine, where community care is already struggling, and it is expected to get worse. Again, I understand we cannot rely on the VA for everything, but thinking that community care is a silver bullet, I do not think is the solution either to what we are looking at.

What happens to veterans when these community care network contractors build networks that look adequate on paper but do not reflect real provider capacity? Let us get the Washington speak out of this. Looks good on paper, but our vets are not going to be able go to the doctor. Right? That is what we are worried about here. These are some of the questions we have to ask ourselves about this because of the promise, the legal and moral promise we have made to our veterans to take care of them.

Mr. Topping, I am going start with you. What safeguards are in place right now to prevent a lot of these large national insurers, you know, the big companies we are talking about, from bypassing rural providers because they are less profitable to contract with?

Mr. TOPPING. Thank you so much for that question. Number—so number one, I think there is three things in there that I want to hit. Number one, community care is one tool that VA has to serve our veterans. We talk about this being a trillion-dollar, 10-year contract, and it is. At the same time, we are going to spend \$2 trillion in direct care during that same timeframe. These are two tools. We have our facilities. We opened 25 new facilities last year. We have got five more coming on. That is 30. We have invested \$800 million in infrastructure under Secretary Collins' leadership. We are engaged on that part of this as well. That is number one.

Number two, network adequacy in rural areas. Rural veterans disproportionately rely on community care. It is more important for rural veterans in Kentucky and other states to ensure that we have got the providers and the adequacy. Our work here is complementary to what we are doing in rural health in America because we are one more payer, and we are going to manage this like a payer. This creates predictability for those hospitals, those rural hospitals, those providers to participate in this program and be with us. Back to if we have got a national company who is looking at this nationally they have 50 states, 25 states, one of the major, the key change in this on using IDIQ again, VA is going first. One of the innovations on this is if we cannot get the coverage we need in Kentucky, we can bring in a Kentucky provider to support VA in Kentucky. We can do that. We can off-ramp a national that is not meeting the needs and bring in a local company that knows Kentucky, that knows the rural areas, knows the urban areas, and we

can use their network to serve our veterans. The flexibility under this program is unique and——

Mr. MCGARVEY. I am just going to interrupt you there because, like, look, this is a perfect example of okay, that all sounds great. I trust this committee to have veterans' interests first and foremost. I do not trust big insurance companies to take care of anybody. The sole thing that motivates them is profit. It is not people, and it is certainly not our veterans. You can talk about \$1 trillion and \$2 trillion, and those are really big numbers that you can paper over in front of this committee. Until we are looking at those contracts and we are looking at those numbers, those are just assurances. We have the right to be skeptical when we are talking about private insurance companies taking care of people, because right now, they do not.

I want to go to the next question. Many of these CCN bidders are vertically integrated insurers. That means again, let us take the fancy. They own doctors' practices. Their motive is profit. What they want to do is make the most profit. How is the VA going to prevent these companies from steering veterans into their own facilities to maximize profits? You talk about what is going on the ground. I look at what is going on in their books because I think that is what they care about.

Mr. TOPPING. Representative, that is a fair question. I go back to what I said earlier. The vendors, our health plan partners on this, a) do not make the clinical referral from the Direct Care System to community care. VA does that. They do not make the referral to the provider. VA determines that. They do not determine eligibility. VA drives where and how our veterans respond, receive care, and the whole, you know, going back to the pillars that we are using, including quality, we want to know what we are buying. We want to steer our veterans to the highest quality, lowest cost providers. Again, that is a goal that is not unique to VA. It is new to us. We are bringing this into this program. We are going to make those determinations. Our vendors, our health plan partners on this, do not drive that. VA does. We own our veterans, and we are accountable for their care.

Mr. MCGARVEY. Yes. Thank you. I am out of time. Mr. Chairman, thank you for letting that go on. I just will—I just will say again, our focus is not on VA versus primary or community care. Our focus is on the veterans and what is best for them. I really want to continue working with you on this. Thank you.

Mr. CHAIRMAN. Representative Van Orden, you are recognized for 5 minutes.

Mr. VAN ORDEN. Mr. Topping, there are very few occasions where Mr. Takano and I agree. This is one of them. How big is your staff? Is it more than one?

Mr. TOPPING. Sir, to support me on this, I have two.

Mr. VAN ORDEN. Okay, well, I have one. My—he goes by Dutch. His real name is Clark. He puts together these awesome binders for me. It has got everybody's bios and stuff in there and everything. Then this morning, he had to hand me this. You know what this is? This is your testimony. This should be in here, but it is not because you did not provide it until last night. We are not putting up with that. It does not matter who is in the White House. Sec-

retary Collins, I think, is awesome. He is doing great. I love Donald Trump. We are not going to put up with that. Period. Just never do that again. It is unacceptable. I agree with Mr. Takano on this. I also agree with Mr. McGarvey, who went out skateboarding or something right now, about this vertical integration of insurance companies.

Okay, so here is the issue. I think I am the only member of this committee that is actually used community care. I get all my health care through the VA system. Community care is part of the VA system. It is. I have had tremendous experiences with community care for dental stuff and orthopedics, because I am old and whatnot. Here is what I hear from my veterans. The bureaucracy at the VA tries to slow-roll community care. One of the things that they have come up with is very innovative. Within like 45 minutes, you are supposed to go to the VA. If you are outside of the 45 minutes, they have created all these Community-Based Outpatient Clinics (CBOC) everywhere so that more and more people are within this 45-minute radius, so then they do not have to be referred to community care.

We are talking about—it is 1, 2, 3, 6—it is 1 with 12 zeros after it is what we are talking about. I really am interested to know how much of this, you know, one with 12 zeros behind it, the VA is going to be spending to create these CBOCs, to, in my opinion, intentionally exclude the veteran's ability to seek community care. I know you do not have that answer. I am not trying to—I am not going to punk you here. I know you do not have that answer, but we need to have that answer. As my colleague Mr. McGarvey said, this ain't about the VA, dude. It is not about the bureaucracy. It is about the veteran. If our veterans are not getting timely, high-quality health care, there is a problem when we are talking about spending a trillion dollars on this. I want to implore you, I will implore you to make sure that you are focusing a trillion dollars to make sure that our veterans' health care is a trillion times better, not that we create a trillion more bureaucratic positions.

What is the average time from the request for health care that is unavailable at the VA to the point where the veteran is referred to and treated in the community care system?

Mr. TOPPING. Representative, there is a range of times depending on location, and those range all the way from 4 days up to 54 days, depending on where it is and what the service is.

Mr. VAN ORDEN. Okay. Do you think that a veteran waiting 54 days to get healthcare is acceptable?

Mr. TOPPING. I do not.

Mr. VAN ORDEN. Okay, then, how are we fixing that, sir?

Mr. TOPPING. Through the proposal around Next Gen and how we intend to bid and run this program. Sir, I want to go back to, I want to go back to one of the points I think you made that is critical about CBOCS and referrals, and community care. I think that is incredibly important. Number one, Secretary Collins has made clear we are investing in infrastructure, we are opening facilities, and that is so that there is more direct care capacity for veterans. Absolutely, we are doing that. The other thing that Secretary Collins said is we are very well aware that in the last administration, bureaucratic impediments were thrown up to prevent veterans

from going to the community if they wanted to, even if it was a continuity—

Mr. VAN ORDEN. I experienced that firsthand.

Mr. TOPPING. What Secretary Collins introduced last spring is the best medical interest. Best medical interest allows the veteran, with the provider, not the bureaucrat, not the referral, but the provider and the veteran to make, to determine whether the veteran should go to the community, and then that allows that, sir.

Mr. VAN ORDEN. What percentage of veterans that should be eligible for community care are turned down or pushed into the more than four 50 day window?

Mr. TOPPING. Sir, I will have to take that and bring you back that data.

Mr. VAN ORDEN. I would really appreciate that answer. Listen, man, I got a tremendous amount of confidence in Doug. He is a personal friend of mine. He is a chaplain. He is a good man. He is a veteran. I know that you serve in the Army. Sorry about that. Mike is right. We expect—we do not expect good things from you. We expect great things from you. We will hold you accountable regardless of who is in the White House. Is that clear?

Mr. TOPPING. Yes, sir.

Mr. VAN ORDEN. Very well. I yield back.

Mr. CHAIRMAN. Congressman Ramirez, you are recognized.

Ms. RAMIREZ. Thank you, Chairman. Well, it has been a year. It has been a very long year. I have been really thinking about the work that we do here. I want to talk a little bit about a recap. Since the Secretary stepped into leadership, the VA has eliminated diversity, equity, and inclusion initiatives. It has allowed Department of Government Efficiency (DOGE) access to VA's data. It has made it its mission to help reduce the VA workforce by 30,000 employees by the end of 2025. It has also doubled down, removing 35,000 healthcare positions this month, according to an internal memo, according to VA staffers and congressional aids.

I got to say, folks, it is hard to believe that Secretary Collins gives a damn about veterans when he is actively undermining the mission of the VA. You cannot say you serve veterans when their doctor appointments are being delayed and canceled due to staffing shortages. You cannot say you serve veterans when you repeatedly attack the VA workforce. Who actually serves our veterans? Today, we are going to talk about the Community Care Network Next Generation contracts. Well, Collins tears down the VA with one hand. He then doles out the pieces to corporate interests, with the other enriching them, while veterans are going to go unserved and uncared for. In his actions, we see exactly who Secretary Collins really serves. Driving the VA toward privatization we know only serves corporate interests, and it puts profits over veterans.

I want to get into some of these questions. Despite the VA's severe staffing shortage, the Next Gen contract structure introduces significant oversight complexity. The VA is planning to establish a bench of contractors through this 10-year indefinite delivery, indefinite quantity multi-award contract model. Contractors on the base IDIQ will compete on task orders that the VA will have many layers of contractor activity to oversee.

Mr. Topping, given that the VA is down to down 30,000 employees with the plan to get rid of 35,000 more positions, it is really hard for me not to wonder who exactly you plan on having oversee this contractor activity. Because, according to a U.S. Government Accountability Office (GAO) report released in August 2024, the VHS Office of Integrated External Networks, which is involved in oversight of the contracts, was staffed at 57 percent of its authorized level as of February 2024. At the same time, the Contracts Management and Performance Team within that office was staffed at about 50 percent of the authorized level. Committee staff asked for updated staffing numbers during our recent briefing with you on the CNN Next Gen procurement, but the VA has yet to provide those to the committee.

Mr. Topping, here is my question. How do you anticipate meeting its contract oversight and execution obligations, particularly given the President's ongoing limitations on hiring?

Mr. TOPPING. Representative, thanks for the question and the chance to set the record straight on—on this. Let us talk about staffing. VA is appropriated for 455,000 employees. Our operational strength is 447,000 employees. That is a delta of 8,067, actually. That is the delta. 5,000 of those are clinicians in the clinical setting. In VHA, we are working to fill those to ensure that we are fully staffed. There is an 8,000 employee difference, not 35,000. This garbage story from the Washington Post about 35,000 positions being cut it is not true. The Post reached out to us, to my staff—

Ms. RAMIREZ. Mr. Topping, I want to really specifically come back to CCN contract oversight, and I want to just do a follow-up question because I know we have limited time here. How many positions, so let us go specifically here, are currently authorized for CCN contract oversight and execution? Number two, do you intend to increase the number of authorized positions for the Next Gen?

Mr. TOPPING. We will build the program management capabilities necessary to manage a contract—

Ms. RAMIREZ. Do you have a number of how many you are going to authorize?

Mr. TOPPING. I do not have a number yet because we have not built it yet. We are in the process of doing that. What we are—what we are bringing to you today for your oversight is the design of CCN Next Gen, program management is the next. Again, I say what I said earlier, this is not unique to VA. We have the Center for Medicare, CMS does this. We are not the only ones to manage a program like this. We will look at best practice, best structure. We will bring those to VA. It is not just the Federal level.

Ms. RAMIREZ. As you are looking at this best practice, let me ask you a follow-up question. As you are doing the planning, tell me a little bit about how you are considering what percentage of the currently authorized contract oversight positions you already have available to be filled.

Mr. TOPPING. The way we manage the current contract, which is an unmanaged contract and very different from what Next Gen is, is not the same as we are going to program management and design the new one. We will design program management inside VA to match the—

Ms. RAMIREZ. Mr. Topping, my time is up, but I definitely want to make sure that we have a follow-up on these staffing numbers that it seems like you have a number, and we have another based on the memos that we have seen. We will follow up. Thank you.

Mr. CHAIRMAN. Representative Self, you are recognized for 5 minutes.

Mr. SELF. Thank you, Mr. Chairman. I have got questions on kind of going forward on this because IDIQ in some government contracts are the race to the bottom.

Let us just be honest. When you—and I understand we have been told that you are going to have a vendor that might have the capability, might submit the capability, but you will not use the services currently, but you might get to them later. Is that not going to make first of all, their submission more expensive? You are going to have them in a contract that you may or may not be paying them for. Then you might limit the numbers of vendors, too, because that requires a vendor to have a wider range of services. Can you address that? It looks to me like you might be limiting to the larger vendors who are going to be able to meet that requirement.

Mr. TOPPING. Representative, we are very much intentionally not limiting the large vendors. The intention and the ability to use the IDIQ is to open this up to competition to non-large vendors, but to those who might bring regional capabilities, regional capacity that would not be able to operate on a national or semi-national scale. We want those vendors on the vehicle. They will incur a cost to bid and—and be awarded a spot on the vehicle. Once they do that, the vendors who are on the vehicle with us, large and small, have a seat at the table with VA, with our program management team to design those next task orders. There are two initial task orders in the initial award. Those look a lot like what we have now, large regional. We are going to immediately partner with the vendors on the vehicle to—to begin to build the next, more regional, more adaptable, more local models in our task orders.

Mr. SELF. You have already heard our concern about \$1 trillion. These are inputs. This committee, and particularly me, are always concerned about the VA. I want to give you the, and you have got it, the range to run on. These are inputs, outputs. How are you going to identify to off-ramp vendors who are not participating? This is where the rubber meets the road. How are you going to make sure you have an efficient process to do this?

Mr. TOPPING. The vendor oversight process, the contract requirements will be spelled out. Those will be very specific. Unlike in the current program, where really all we can do is bicker about that, all we can do is litigate that, and the only remedy is the ultimate remedy, which is termination or replacement, our ability for vendors who do—do not meet our technical requirements or even our value requirements and how they are serving our vendors. We have, the government has the ability to off-ramp that vendor off that contract.

Mr. SELF. Who is that person who has that decision-making authority to make the decision you are now off-ramped?

Mr. TOPPING. That is the Department of Veterans' Affairs and the Program Management team.

Mr. SELF. What level is that?

Mr. TOPPING. That would be inside the agency and the lead program for this office.

Mr. SELF. Okay, that is a little nebulous. Look, 40 percent of care is now under community care, right? This is a rhetorical question. Once we get over 50 percent, you are going to hear the privatization argument ramp up. Then right now we know—we know that veterans get the private coverage. More of them say they are in good health than the veterans who get care in the big VA. I am concerned about the future here because once we get over 50 percent and you start hearing this argument about privatization, you have privatized care, how then are we going—is the VA then going to be expensive, specialized care only? Give me your vision for the future and basically in 10 years, what does the success of this program look like if we go over 50 percent of care is given by community care is provided by community care providers?

Mr. TOPPING. Representative, Secretary Collins has been very clear. We are not privatizing the VA. We are investing in the Direct Care System, and we are investing in the Community Care Program. We want veterans to have the choice where he or she receives the care, and if they prefer direct care, we want them to have the access to that and the world-class care they get there. If they choose the community, we want them to have access to that as well, too.

What this program looks like 10 years from now, and where we are moving to, and we are starting with where we are, we will progress through this as task orders again with the vendors on the vehicle, is we ultimately want to be focused on paying for the highest quality cost, the highest quality care that we can receive. That is based on agreed upon measurements and metrics, our data, and our ability to action that for the lowest possible cost of care. That is what success looks like. Ultimately, that the veteran can choose where he or she receives or wants to receive his or her care.

Mr. SELF. I have more questions, but my time is up. I yield back, Mr. Chairman.

Mr. CHAIRMAN. Dr. Dexter, you are recognized. Dr. Dexter.

Ms. DEXTER. Thank you, Mr. Chair. I love and thank you, Mr. Topping. I love hearing that you want to pay for the highest quality care veterans can receive. I think we all want that. I would like to ask first, which healthcare organizations in the U.S., either government, nonprofit, or for-profit, have utilized this indefinite delivery/indefinite quantity, IDIQ, contract structure you are proposing?

Mr. TOPPING. Representative, VA uses IDIQs and uses them in multiple areas and multiple spaces. This is the first time for a healthcare contract that VA is using this. This is used outside of our agency and other parts of government as well, too. The IDIQ is a vehicle which allows the government to buy services, and if it does not know up front exactly what it needs and when, but can pick a stable of vendors that we know are capable of delivering that. That is the use of the IDIQ. The model of an IDIQ is not new, not new to VA, not new to government.

Ms. DEXTER. I do want—

Mr. TOPPING. It is new to healthcare.

Ms. DEXTER [continuing]. to get through a lot of questions, so I appreciate that. I think I understand it is not new, but I think that we all have concerns with some of those well-vetted vendors, that there have been misuse of Federal dollars that should have been taking care of veterans, and may have been misbuilt, let us say. For our committee to do effective oversight, I would like to see a list after this hearing of those entities in any market research VA has conducted on those organizations that we are considering using this contract. Based on your testimony, it seems contractors alone will propose and pilot alternative payment models to test on the veteran population. How, how does the VA plan to evaluate these care models, especially related to quality outcomes, when they are being offered outside the Direct Care System?

Mr. TOPPING. VA will make the determination on which models we use. VA will drive this. VA will make the ultimate decision. What we do want to do, and again, this goes back to the IDIQ vehicle, is we want different vendors with different capabilities, and they will be regional. We understand that. We want these vendor partners to come in and make proposals based on what they have used and what has been successful in their network in their areas. Those will be different in different parts of the country. What we are going to be able to do in terms of value-based care in the upper Midwest, largely rural, where you have got potentially, you know, limited providers, versus what we could do in metro DC very different. That is why we want them to bring the proposals, but we will make the decision.

Ms. DEXTER. I appreciate that, and I think it all sounds fantastic, but really putting it into practice has been extraordinarily difficult. I come from a healthcare organization. I know this very well. I just want to use as an example my team sent a letter to Secretary Collins on September 22d, asking for what was required by Congress in December 2022 for the VA to develop a plan to ensure veterans are informed of expected wait times at VAs and in the community. That was over 3 years ago. We asked for that information, and our team has been reminding folks weekly since September that we are waiting for that information and still have not gotten an answer. I find it hard to believe that we are still waiting for just how long does it take for a veteran to get an appointment in the community, over 3 years from when Congress said it should be, so that we actually have the capacity to have appropriate oversight and transparency for outcomes for our veterans if we cannot even tell when they are getting appointments. I would love your response to that.

Mr. TOPPING. Representative, let me take that. I have not seen the letter. I am not aware of the ask. Let me take that and come back to you.

Ms. DEXTER. Mr. Chair, if I may ask to submit into the record the letter dated September 22d, 2025. It will be available for all. I also want to just—

Mr. CHAIRMAN. Without objection.

Ms. DEXTER. Thank you, sir. I appreciate that.

You noted in your testimony also that the VA will implement comprehensive quality programs for community providers based on nationally recognized measures that will “ensure veterans are not simply referred to any available provider but to those dem-

onstrating strong outcomes and safe, high-quality care.” Again, I share this goal. However, given that vertically integrated health care entities often restrict patient visits to their own providers, how can you clarify any guardrails that will be in place to ensure that veterans in the community care programs will be referred to providers with highest quality outcomes rather than just those preferred by any contractor?

Mr. TOPPING. Representative, number one, we are using healthcare research and quality data. You have seen and you have worked with those. HEDIS, you have seen, and you have worked with those. These are well-known, well-understood by both payers and providers. We are using the metrics that the industry understands. We are going to measure to those. Where we set the goals and the outcomes and the requirements, VA will determine that. All that is to say, too, and I think probably this is the fourth time I have said it here today, too, the plans will not determine where the veteran goes. We will make the referral. We will determine where the veteran receives the care. We want our veterans to go to those providers that can provide the highest quality at the lowest cost. The intent of this program and the tools that we have built into it enable us to do that.

Ms. DEXTER. I will follow up on that because I worry that in the actual delivery systems, the VA is not going to have the level of engagement to actually be able to direct those visits. We know that those vertically integrated systems are already shunting lower-paying patients to different outcomes. I am concerned that you actually can deliver on that, and would love to understand some details on that and follow up.

Thank you, Mr. Chair. I apologize. I yield back.

Mr. CHAIRMAN. Representative Barrett, you are recognized for 5 minutes.

Mr. BARRETT. Thank you, Mr. Chairman. Appreciate it. Thank you for being here today, and thank you for your testimony. Obviously, it is of high interest to this committee the amount of investment and commitment that we have for a contract of this nature. I do want to start by just kind of reminding folks of before we had community care options available to veterans, what that looked like.

I was early in my tenure in the State legislature in Michigan, I heard testimony from a veteran in Michigan who had a hip replacement done at a VA hospital several hours from his home, probably 3 hours away. They prescribed him physical therapy, as is expected and normal after that. He could not get physical therapy at the clinic 2 miles from his house, because he was technically in an area that had a VA facility within a commutable range. They did not offer physical therapy at that place. They wanted him to go back to the hospital. He had the—the hip replacement two or 3 hours from his home. Entirely impractical.

Obviously, changes needed to be made. I think one of the lessons learned post-9/11 is that the VA was not really set up for the wave of veterans that came home off the battlefields in Iraq and Afghanistan, and the unique circumstances that they were facing. I think reminding us of why we are here and why community care can work for veterans is important for things that they need. Obvi-

ously, we need the VA for very, very important things as well. This is not an either-or thing. It is a both thing. I think we can acknowledge that as well. It does not need to be one at the expense of the other. They can work in concert with one another.

I have the privilege of chairing the technology modernization subcommittee on this committee. One of the things we are really investing heavily in is this Electronic Health Record Modernization (EHRM) that is coming. I guess what I would like to hear from you is, as we roll that out, are we going to see a better integration with community care for veterans as they move portability, their electronic health records? Veterans like me who go to a VA hospital for part of my care, but also take care in my community for things that I feel I can realistically get there, but there is not a way of sharing those records. I had the same back X-ray no less than three times because one was within the VA, then to my primary care at the VA, then to the place they referred me to. They cannot even share an X-ray scan between one another. Are we going to see a benefit of that coming? Is that contemplated under this contract, and how do you see that performing?

Mr. TOPPING. Representative, let me answer both those questions. One about the constituent that you had that had surgery in one place referred to the other.

Mr. BARRETT. This was long ago, so it is not current.

Mr. TOPPING. Could have been long ago, but I am sure there may be other stories out there like that, too. This was when Secretary Collins introduced best medical interest; this is exactly the type of thing he wanted to tackle. Where you have got for a veteran, where the quality of care, but also continuity and convenience makes sense, the veteran should be able to drive that, not their bureaucracy. That is the intent of that change. Absolutely, the impacts both direct care and community care that is part of it.

In terms of portability and the ability for our electronic medical system to speak to—to work with compatibility, one of the things that under the current contract that has really been unfunctional is we do not have an easy way for providers to transmit records. We have the same challenges with claims which really should not even be there. We have the same, very much a problem with provider record transmission. Yet, there are easy and commercially available exchanges that every other provider does this. Different providers from different systems move claims, move records all day, every day. The new contract requires the use of commercially available and compatible systems. The new system that VA is implementing, again Veterans Health Information Systems and Technology Architecture (VistA) is homegrown 30 years.

Mr. BARRETT. Mm-hmm.

Mr. TOPPING. The new system does have the ability to do that. It can ingest those records and then populate it through the new system.

Mr. BARRETT. Very good. I do not want to cut you off, but I do want to move to the second part of that, which is I have seen through the electronic health record program just how these contracts can balloon into a cost that is way beyond what is initially advertised. You know, we get into one of these contracts, and we are too far into it to really claw back or pivot or change or make

adjustments to that. What accountability measures can you assure us of so that, as we go through this process, knowing that contractors are going to try and charge us, nickel and dime us every change order along the way, and everything else? How are we going to extract the best value for the taxpayers and for the outcomes for veterans to know that we are not going to have a contract swallowed up into something that is unmanageable, and 5 or 10 years from now, we are in a position where this thing is ballooned completely out of control?

Mr. TOPPING. Representative, one thing, again, the IDIQ gives us the flex—the flexibility to bring in, choose, and swap between different vendors in the program to change the program as we go. That is what is novel about that. That is what is exciting about this. That is what gives us those tools and our ability to do that. We do not get swallowed up on this because we have time as we go across.

Then ultimately, the cost of care and community care is not the administrative cost of the program. It is not what it costs VA to operate it. It is not even what we pay our health plan partners. It is the cost of purchased care. We want those health plan providers to have skin in the game in lowering our cost of care. Ultimately, where this contract does go is we are paying for quality. If they hit our targets, they hit our scores, and they save money for us, they will share in those savings. That is how we drive and pull down the cost of care in this.

Mr. CHAIRMAN. Representative Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman. Today's hearing on Community Care Network Generation requires clarity about what the program is and what it is not. Community care was meant to supplement VA health care when timely care is not available. It was never meant or intended to replace the VA or be a vehicle for privatization.

Veterans are a unique patient population with complex service-connected needs from combat injuries to toxic exposures that the VA was specifically built to treat through coordinated, holistic, and specialized care. Shifting more care into fragmented, private systems risks quality, continuity, and outcomes. This model is also unworkable. CCN Next Gen demands strong oversight, yet this administration has cut tens of thousands of VA staff and failed to fill vacancies, including staff responsible for overseeing these contracts. You cannot howl about the workforce and expect the system to function effectively. We all know that. Billions will flow to contractors with limited accountability. When care fails or becomes fractured, veterans will pay the price. Veterans kept their promise to our country. We should be strengthening the VA and not hollowing it out.

I am a healthcare practitioner myself, an occupational therapist. I was trained to look at the whole patient: function, recovery, long-term outcomes, and continuity across providers. The CCN Next Gen RFP provides extensive detail on contract structure and payment, but very little on requirements for clinical quality, continuity of care, or experience treating high-risk veterans.

My question, Mr. Topping, is where in the RFP have you set specific quality of care metrics for community providers to meet?

Mr. TOPPING. Representative, thanks. Good to see you again. Number one, Community Care Next Gen is a supplement to the Direct Care System and the things that VA does well and VA does uniquely. Again, this is a trillion-dollar over 10 program, but our direct care is 2 trillion over 10. This is 1/3. That is 2/3. We are investing in those. We are opening new facilities. We have invested \$800 million last year alone. We are investing in our direct care capabilities. For veterans who either need to go to VA for direct care because it is a unique capability that VA has or who choose to go, that they have that ability and they have that choice, we are investing in that.

Second, how quality will be measured, again, we are using standard industry metrics for this. These are not unique to VA. These are not unique to providers. We are focusing on HEDIs, we are focusing on the types of scores and measures that make a difference, that we know providers are used to working to a measure. We are going to use that as we then determine who and how and under these contracts, whether we are meeting the requirements that we are setting out for them. These—so that is contemplated and included in this program.

Mr. KENNEDY. I understand the goal. The goal should be the golden standard of care, the top quality care for our veterans. I believe we all should aspire to hit that goal. If the quality care standards are not put into the contracts, they are not clearly defined. Is not it fair to say that the quality and the continuity of care are not being prioritized in the contract?

Mr. TOPPING. Representative, they will be included in the contract. We have identified what our mandatory quality requirements are and what our scores are. They are mandatory and optional, but we have already identified those, and those will be in the contract, and they will be required.

Mr. KENNEDY. Well, it seems to me the oversight of these contracts, though are going to be left onto the contractors themselves, that the quality of care is going to be left to a standard like they are policing themselves when it comes to quality of care. Like the fox watching the hen house. You know, how do we assure our veterans and this committee and Congress and the people that veterans are going to be provided that golden standard of care if we do not provide for the proper oversight of those contracts?

Mr. TOPPING. Representative, we will manage our vendors. We are accountable to our veterans for the care they receive. We are accountable to you as Congress. We will manage the vendors. This is our program. Our vendors will operate this as our partners on agreed-upon terms and requirements. Again, we have the ability to off-ramp vendors who do not meet our requirements, do not match our values.

Mr. KENNEDY. Will they be self-policing their own contracts—

Mr. TOPPING. No.

Kennedy—for quality of care? There will be oversight?

Mr. TOPPING. Yes, sir.

Mr. KENNEDY. How is that oversight provided in the contract? How is that outlined?

Mr. TOPPING. We will manage that. The requirements will be in the contract. We will manage that through our program office.

Again, the IDIQ gives us the ability to off-ramp vendors who do not meet those requirements. Those will be required. We will manage that, and we will be accountable for their performance.

Mr. KENNEDY. Well, just short on time here. Mr. Chairman, I will yield back.

Mr. CHAIRMAN. Thank you. Representative Cherfilus-McCormick, you are recognized for 5 minutes.

Ms. CHERFILUS-McCORMICK. Thank you so much, Mr. Chairman. Thank you for being here and answering these questions. You know, the possibility that our veterans could have access to care wherever they live is actually, I think, our shared goal. However, the VA does not have a good history of implementing any kind of technology modernization. I love what you are saying, but I think the scrutiny is coming because of VA's history. Looking at that, I want to dive into what mechanisms were used in determining to go with Next Gen as far as acquisition.

Mr. TOPPING. Representative, so in terms of the contract vehicle or in terms of the technology that we are going to use to administer the——

Ms. CHERFILUS-McCORMICK. The decision-making process.

Mr. TOPPING. The decision-making process around CCN and to use the IDIQ vehicle was to introduce flexibility and competition. Then the choice to use the 5 pillars were based on we know that those are controls that exist in every other healthcare program that have been successful. We know that we can leverage those to get to the outcomes that we are looking for. We made those choices based on that. Then our next step on this, too——

Ms. CHERFILUS-McCORMICK. Well, I want to interrupt you real quick because what I am looking at is the price point and what the decision-making behind the acquisition. For example, as a mission-critical, highly complex, and high-dollar value acquisition, Next Gen clearly qualifies as a major acquisitions program under VA's acquisition lifestyle framework. Could we go into the framework that you used in choosing Next Gen?

Mr. TOPPING. Representative, I am not—I am not sure I clearly understand the question. The framework that we chose were based on what are the outcomes we are trying to achieve for our veterans. Ultimately, what we want is veterans to have choice, we want veterans to receive high-quality care, and we want taxpayers to get the best value for that care. That was the framework that we—that we choose.

Ms. CHERFILUS-McCORMICK. Would Ms. Skolrood be able to answer that question? I know you do the financial parts of it.

Ms. SKOLROOD. We did follow the acquisition lifestyle framework. That was—that have been—I have learned a lot about that in the last year and a half since I have been with the Federal Government and the VA, and we followed and worked closely with SAC, the Strategic Acquisition Office, and you know have followed that process as it is laid out.

Ms. CHERFILUS-McCORMICK. Have you already had the acquisition decision events A and B?

Ms. SKOLROOD. I am not familiar enough with it to speak to those details, but I know that we can provide you that information.

Ms. CHERFILUS-McCORMICK. That would be excellent. We want to know also who was provided or who was actually a part of those decision-making. Like I said, the extra scrutiny is because the VA has not been successful in implementation. We want to make sure that a lot of the failures we had in the past are not being repeated.

In addition to that, I have heard you say several times that we are looking at best practices, even with CMS. There is a unique culture within the VA that has caused the VA's transition to different types of technology unsuccessful. One of the things that, you know, the last 5 years we have been doing this, I have learned, is the presumptions that we make in private industry or in other government sentences—other government settings do not necessarily apply here in the VA. As we are going forward, we do want to get more data and more information as implementation goes on. This process of flying, building the plane while flying it, has not led to success.

Do you know offhand any safeguards of reporting that are going to be present? As we see the implementation, we are knowing wait times, for example. Do you have any of that lined up?

Ms. SKOLROOD. We do. We have an extensive implementation team that has already began meeting. We have over, well over 200 team members throughout the VA that are participating in that. Right now, the primary—the primary focus of that team, once we have—we have created the infrastructure and the work streams that will oversee the implementation, the predominant thing of importance right now is care coordination.

Ms. CHERFILUS-McCORMICK. Yes.

Ms. SKOLROOD. If we were to select a provider, a TPA, when we select a TPA, it will be very important that veterans who are getting care currently in the field, in the community, that those referrals, that all of that is hand—hand by hand, one by one, transferred over to community, to the other provider.

Ms. CHERFILUS-McCORMICK. As I am running out of time, I just want to make sure that when we have another opportunity to convene, that we can actually have all that information in front of us.

Ms. SKOLROOD. Absolutely.

Ms. CHERFILUS-McCORMICK. That as we are doing the oversight process, we can work together to make sure that this is actually successful. As I mentioned, too many projects that we have spent a smaller amount of money on have failed. That ends up hurting our veterans. It ends up hurting our finances as we are funding it, and it hurts everybody, all across the board. We are like 10 years in trying to get it right. The goal is to get it right as much as we can and spend the least amount. Flying the plane while building it has historically caused failure, and we want to make sure we prevent that.

Thank you so much. I yield back.

Mr. CHAIRMAN. Dr. Morrison, you are recognized for 5 minutes.

Ms. MORRISON. Thank you, Mr. Chair. Health care workers are increasingly facing burnout. I hear about the administrative burden my physician colleagues are facing with an alarming frequency. A major part of what compelled me to serve in Congress was my firsthand experience as a doctor, seeing how difficult navigating our healthcare system can be. It is one of the reasons I

fought so fiercely in my home State of Minnesota to pass legislation that reduces this burden. It is why I have serious concerns with the significant changes that have been proposed to VA's Community Care Network. The focus should be on delivering the best care for our veterans, prioritizing their needs and access to care. I am sure you agree.

Mr. Topping, the CCN Next Gen contract will include incentives and disincentives to be implemented over the life of the contract. The incentive and disincentive plan for the East Region task force only identified two performance objectives, both of which seem concerningly easily attainable. The first incentive VA lists is adverse credit reporting. That is ensuring veterans are correctly billed for copays and not improperly billed for services to avoid having unpaid bills being sent to collections.

It is my understanding that among the pressing concerns with vulnerabilities in the CCN, this has not been an issue in the Community Care Program under the current structure. My colleagues that have served on this committee for longer than I have shared that they cannot remember the last time a veteran reached out, sharing that their community care claim was sent to collections. I am having a difficult time understanding the logic between tying incentive payments to metric contractors that will ease—that will easily be able to achieve.

Mr. Topping, briefly, how does small, easily achieved incentives protect the quality of care veterans receive and safeguard taxpayer dollars?

Mr. TOPPING. Representative, thanks for that question. Again, the purpose and the intent of this contract is to be iterative and for us to be able to scale and evolve over time. Adverse credit reporting is a proxy for whether or not these TPAs are doing their job, which is processing and paying for claims. That is the number one thing they are supposed to do, is to ensure that our veterans do not receive bills for the services they have provided. This has been a management issue inside VA, and this is an easy, clear metric that they can manage too and that we can manage and report on, to ensure that they are doing their number one task, which is paying and managing claims. That is number one.

The second thing we chose is the inclusion of value based—value based contract provisions in their network. You can see that it starts with a zero and ratchets up over time. The reason why we have done that is value based is a key component, a key control in this contract to ensure that we can pay differently for the quality that we want and with the integrity that we are looking for. This ratchets up over time, the ability to ensure that they are—that we have these in the provider network. Then what we intend to do is then drive the requirements on what we want out of VBR. It is ensuring that the infrastructure is in place.

Last, the lower extremity joint replacement, this is already a procedure and a process that VA has. We use this in the community. This is a well-known bundled payment. We are starting with where we know we can manage, we can be effective, we can provide the oversight, and we know industry can deliver.

Ms. MORRISON. Would you—

Mr. TOPPING. These are our starting points.

Ms. MORRISON. I am sorry to interrupt, sir. Would you be willing to commit to working with us to implement meaningful guardrails that can prevent these incentives from becoming mechanisms that will actually be used to just drive excessive money to health insurance companies and payers that will be awarded these contracts?

Mr. TOPPING. Absolutely, yes, Representative. We share that with you.

Ms. MORRISON. Fantastic. It is my understanding that VA anticipates it will take until Fiscal Year 2028 for full healthcare delivery under the CCN Next Gen contracts. What is VA's plan to bridge the current CCN contracts and services until the Next Gen contractors are in place and able to provide the full spectrum of care needed in Fiscal Year 2028?

Mr. TOPPING. Representative, we would love to have no bridge. We would love to implement the new contracts as soon as we can, on time. To the extent a bridge is needed, when that comes and that goes through the acquisition and contract office process, to the extent a bridge is needed, we will implement that at the time. Our goal is to get this done, get this bid, get this right, and get these awarded, and to begin to manage and operate this program as soon as possible.

Ms. MORRISON. How will you ensure proper continuity of care for veterans during this transition?

Ms. SKOLROOD. Thank you for the question. That goes to what we were talking about a few minutes ago, our implementation team. Right now, our primary focus and the priority for the work stream is care coordination. These things occur in industry not infrequently, where a TPA changes. There is a process in place to make sure that that care coordination is—is done very well. We are pulling again from industry expertise to make sure we are thinking of every single avenue that we need to, to make sure that no veteran falls through the crack during—during that transition.

Ms. MORRISON. Thank you very much. Mr. Chair, I see my time has expired. I yield back.

Mr. CHAIRMAN. Thank you. Representative Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman and Community Care Takano, for holding this hearing. One of the major limitations of the current Community Care Program is that there are about four, five different ways for providers to return medical records, ranging from faxing copies to participating in electronic health information exchange. Many of the existing mechanisms rely on manual retrieval of records and importation into VA's electronic health record, which is both time-consuming and lacking in true interoperability. Most records never make it back to the VA, which limits our ability to monitor the quality of care veterans are receiving in the community.

My question, Mr. Topping, is to what extent does the CCN Next Gen request for proposals address the technology needed to facilitate the return of medical documentation to the VA from network providers? Then, as a second question, what challenges do you anticipate in getting that information to the VA?

Mr. TOPPING. The first challenge on medical records, which is well known at this point and documented, is driven in part by the

fact that VA still uses an EHRM that is homegrown, at about 30—30 plus years old. We are transitioning on a very aggressive schedule. Secretary Collins has been clear that his expectation is this will be done. This is being led by the Deputy Secretary. We are transitioning to a new EHRM that has these capabilities. Currently, for a provider to share records with VA and for those to then get into the VistaA system, it is a manual process, and that is unacceptable.

Under the HRM system and in this contract, we are requiring the use of commercial exchanges. We are going to transfer medical records, share medical records in the same way the rest of industry does. The providers can use the systems they already have. They will be in exchange, and then we can bring those records into our system going forward as part of, part of our EHRM implementation.

Ms. BUDZINSKI. I serve as the Ranking Member on the Tech Modernization Subcommittee. Definitely very much tracking this EHRM implementation as it has been going. This is going to be a big process. What you are saying is that, through the manual process, that is how manually we will be able to have to, until EHRM is fully implemented, it will be a manual process in ensuring that community care records get back to the VA?

Mr. TOPPING. We will likely during this transition between now and when EHRM will be completed. It is a completely electronic process, straight data exchange from the provider through the exchange to our new system. That is fairly straightforward in the way that the rest of industry operates. We will still, while we have VistaA, likely have to take from the exchange, and there will likely be a process by which we will then have to pull those records in. That will continue. That is part of the goal on EHRM, ensuring that we do not have to do that going forward.

Ms. BUDZINSKI. There is—

Mr. TOPPING. It will be a bridge.

Ms. BUDZINSKI. There is a commitment that those records will get to the VA. Is there, you know, returning of these medical records, would there be a condition of payment? You know, maybe if they do not return those payments to or they do not return those records to the VA, would there be some kind of, you know, condition on payment to the vendor if they do not receive it?

Ms. SKOLROOD. Thank you for that question. We are not linking payment to the vendor directly to the return of medical records. However, we have put into the Next Gen contracts more of responsibility on the TPA to ensure that their providers are compliant with the rules. The contracts that the TPAs have with the providers must include the return of medical records. We also—we have also streamlined the way in which we will receive those medical records, so the fax, the phone in all of that, we have streamlined what the expectation—expectation is for return of those.

Ms. BUDZINSKI. Okay. If there, I mean, if you are—if you are taking kind of payment off the table, is there—will there be a process in place to just ensure when you see there is that gap, records are not being, I mean, it is just important—

Ms. SKOLROOD. Absolutely.

Ms. BUDZINSKI [continuing]. that the VA be the place where all that is housed.

Ms. SKOLROOD. Absolutely. We also are utilizing that as a—as a data point for our preferred provider program. If we have a provider who is not—who is not doing that, then they can lose designation as a preferred provider.

Ms. BUDZINSKI. Okay. This might go to my next question. Is it the VA's expectation that contractors will provide a system that will be truly interoperable with VA's electronic health records, both VistA and Oracle? I think you have answered that question, but just anything further to elaborate on that point?

Mr. TOPPING. Yes.

Ms. SKOLROOD. Yes.

Ms. BUDZINSKI. Okay. One other thing I just want to ask really quickly about the RFP. It includes optional line items related to the development of software processes. Could you just quickly say to what extent do you think the VA sees development of Information Technology (IT) systems and software is a part of this effort?

Ms. SKOLROOD. Thank you for that question. The intent of the IDIQ is to be broad. That should again, so that we are nimble. Should we come to a point in time where that makes sense and we need that, then we can utilize the multi-award IDIQ and issue a topper for that particular need, whatever it may be.

Ms. BUDZINSKI. Would that be an additional cost in addition to the trillion if you do decide that you need it?

Mr. TOPPING. The cost—the cost for the technology requirements for the management of this program—so let me first go back to the program management part of this, which VA is now focused on our ability to manage these contracts. We are building that, and that includes a technology build. We are getting ready to focus on a \$300 million acquisition around that to ensure we have the capability to do that. That is number one, making sure that we have the resources, make sure we have got the team, the capabilities, and the resources to do that.

How that then fits in with the network and our providers is that we want to be as plug-and-play as possible. We are the fourth largest payer, but we are one of the payers. These providers also work with Medicare, they work with Medicaid, they work with Tricare. We want our system to be complementary to work that they are doing with the most interoperability as possible. Those have been our focus, and that is a commitment to it. Both a financial commitment and a management focus on the build.

Ms. BUDZINSKI. Okay. Thank you for the extra time, Mr. Chairman. I yield back.

Mr. CHAIRMAN. I am going to explain to the audience, the panel, and the members what the intent of the chair is at the request of the Ranking Member. He does want to ask one more 5-minute, we are going to grant him that opportunity, and then one on our side for Keith, or for Self, instead of doing a second round, because we have got another panel we are trying to get to. Are you all right with that?

Well, what I am trying to do is get to the second panel as fast as possible. That is why I said we were—we will just go over here to everybody that is here.

Mr. TAKANO. Okay.

Mr. CHAIRMAN. So——

Mr. TAKANO. Appreciate it.

Mr. CHAIRMAN. You are recognized.

Mr. SELF. Thank you, Mr. Chairman. Mr. Topping, you have—you have given us the mantra several times. I am trying to get to the details. I do not think you answered Mr. Barrett's question about do you have a plan. Can you assure Congress that the \$1.049 trillion is the final cost for this program? In the VA, we find they come back for more money almost every time. I think that is what Mr. Barrett was asking, and I would ask you directly how will you manage that in this managed program, so that when you reach that—that end dollar, what are you going to do to make sure you do not come back for open-ended funding from Congress?

Mr. TOPPING. Representative, there are three things that drive, ultimately, you know, our VA's on cost. Number one are the original cost estimates, which tend to be inaccurate. The reasons why they are inaccurate are there are things that are not in the model. For example, congressional changes, congressional intent, larger demographic shifts. There are things that we cannot quantify in a 10 year model, in our enrollee healthcare cost model, that make the model sometimes inaccurate. That is number one.

Number two, by design, the VA system cost shifts. Veterans and their care, they can go from direct care to community and back again. Our system, in terms of letting the veteran choose where he or she receives care, is designed to shift that cost and that care. That is number two.

Then number three, both of those programs, both the Direct Care System and the Community Care Program, up until now have been completely unmanaged. We have had no tools, no levers, no capabilities to manage those costs, to make adjustments. What CCN Next Gen does on community care is it gives us program integrity, it gives us quality, gives us value based care, gives us utilization management, and it gives us alternative payments. It allows us to use those tools and levers to begin to be accountable for those costs and to pull those levers.

For the first time, and in the cost estimates I provided this committee, where we show savings of 8 to 14 percent over 10 years, \$54 to \$100 billion, those cost estimates are not based on VA data. Those cost estimates are based on CMS data on these tools used in other programs over the past 10 years. It is verified data. I believe those numbers and those projections are accurate and as accurate as they can be. I believe we can come back to you on time and on budget.

Mr. SELF. Okay. IDIQ contracts have a habit of not being solid. Veterans, the population between 2004 and 2024, I think, decreased by 30 percent. The enrollees have been stable, the way I understand it, but the population has gone down by 30 percent over those last 10 years. As the population goes down, we are losing, obviously, our World War II vets and our Korean vets in great numbers. Frankly, we are not—we are not in any active conflicts now. I think that will change. Your transition plan, I believe that you do have a transition plan over 2 years because you have got like \$425 million over 2 years for implementation. I assume you

are having a soft opening, which people would call a soft opening. You roll it out over time.

Question, do you have community care—and this may be something I just do not know. VISN boundaries have been sacrosanct heretofore. Is this—is this—under this contract going to be different? El Paso, Texas, for instance, is at a VISN boundary. Can you speak to that under this contract?

Mr. TOPPING. Representative, yes, and no. Yes, we are going to have VISN boundaries. This is part of the VHA restructure in which we are moving from 18 business to 5, plus with health service areas as well. Our regions match those. However, under the IDIQ and bringing in regional vendors, our intent is that those regions can then be broken up further, redesigned. We could have partnerships in those regions. What we want to be able to do is match the care we can deliver, what we are paying for, and what we are achieving, and what we need. We want to be able to match to the region in which we need to deliver it. There is flexibility for us to do that. We will use the same regions, we will have the same boundaries, but we do have the ability to be flexible based on the needs of the veteran.

Mr. SELF. Cross VISN boundaries. You have that flexibility?

Mr. TOPPING. Yes, sir, we do.

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

Mr. CHAIRMAN. Ranking Member, you are recognized for 5.

Mr. TAKANO. Oh, you can go. You can go.

Mr. CHAIRMAN. Okay, go ahead.

Ms. BROWNLEY. Trouble hearing you today, Mr. Chairman. Thank you for the opportunity. Just a couple of last questions here. I—earlier you told the Ranking Member that VA will not require any transfers to the Community Care account for Fiscal Year 2026. I just want to make sure that that is absolutely correct.

Mr. TOPPING. Representative, I want to be a little hedgy on that. What—and what I said and which is what I have right now is my data right now, my utilization data, my cost data, understanding that there is a data lag and there is a claims lag, providers can bill me 6 months after the fact. The data that I have right now shows that our appropriation for Fiscal Year 2026 is accurate, and that is the number that we need. That is what we are managing, too.

Ms. BROWNLEY. Okay. I also want to just confirm that you have not had any discussions with our Appropriations Committee counterparts about possible transfers. I just want to make sure we are absolutely clear on this. If you can answer that, please.

Mr. TOPPING. Representative, I always have conversations with our appropriators. They are—they are my best friends as the CFO, making sure they know what I am managing, managing to, where I see risk, where I see opportunity, and making sure they know. I have got maximum flexibility to meet the aids—needs of the agency. Coordinate with them and frequently—

Ms. BROWNLEY. Let me re-ask. Let me re-ask the question in a different way. What you just told us about transfers in 2026 is the same thing that you have said to the Appropriations folks in your ongoing conversations?

Mr. TOPPING. In my ongoing conversation, it was, this is the data I have. This is the number we have. This is what we are managing,

too. I want—but I want all of my appropriators to know that as we manage this, we want to ensure that we have the resources we need to meet the mission and care for the veterans. Those are the conversations I have had with my appropriators.

Ms. BROWNLEY. Okay, thank you. One last question. I think the—when your plan, this new plan will be fully operational, will be in 2028, is that correct?

Mr. TOPPING. Yes, ma'am.

Ms. BROWNLEY. Okay. In 2028, we are going to have a new administration. What that administration looks like, we do not know. Right? My concern is, while we are working really hard on this new delivery system, if you will, for community care, how are we—what are you doing to ensure that we, under the current system is delivering high-quality—high-quality care and timely care to our veterans? That is my concern, because I do not want to be talking about something that may or may not happen, and meanwhile, our veterans are getting less care.

Every veteran that I speak to, almost every veteran I speak to, prefers to get their health care within the VA. I am, you know, I have always advocated for community care. It is necessary to provide care to all of our veterans across our country in terms of everything that they need for their health care and mental health care. I am not against community care. I want to be clear on that. I just want to make sure that we are providing the high quality care and that we have the ability today. I worry about all of the cuts and vacancies that are in the VA that we do not have the ability to provide the care, the high-quality care that we need. I need some insurances—assurances from you on how you are handling that.

Mr. TOPPING. Representative, so as a veteran who uses both direct and community care and also prefers direct care when I can get it and community care when I cannot, I share your interest in that too. The system that we have in place today, both with direct community, is a system that we have and we will operate until this contract is live. The tools that we have, the limitations that we have, those exist today. Today, the team that has focused on serving veterans through this program continues to focus on ensuring—

Ms. BROWNLEY. Okay.

Mr. TOPPING. they get what they need, when they need it.

Ms. BROWNLEY. As we go through, you know, 2026, 2027, and 2028, so when there are vacancies that occur, you are going to fill those vacancies? You are not going to say, oh, I can now take those resources and make some kind of investment in the new system versus the existing system?

Mr. TOPPING. VA has a huge investment in Next Gen, getting this right, and being accountable for it. As we build the program management team and the design of that team, we will resource that to ensure that it is staffed appropriately, that it is got the right technology, that it is got the right tools, that they can manage this contract, and we can be accountable for these outcomes to you and to our veterans.

Ms. BROWNLEY. Okay. It sounds to me like you may indeed, if there are folks that leave the VA, there are vacancies there, that

you may use those resources for the new system versus the old system.

Mr. TOPPING. We want to ensure that the program management capabilities of VA can manage this program. The program we have today, we want to manage that as best as we can, as effective as we can. We are excited about these new tools, these new capabilities for better outcomes, better cost as we move forward.

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

Mr. CHAIRMAN. You are recognized for 5 minutes.

Mr. TAKANO. Thank you. I want to take this opportunity to clarify this issue over referrals from the VA—and TPA's ability. This is a problem of the vertical, the challenge of vertical integration of the healthcare industry. Third-party administrators build. Currently, they build the network, right? They build the CCN network. Is that my understanding? That's what—that is what part of their job is, right?

Mr. TOPPING. Yes, Ranking Member.

Mr. TAKANO. If they pick and choose which providers are part of those networks, we are presented with an issue. If those networks are full of providers that the third-party administrators own themselves because of the vertical integration, it does not matter that the VA is doing the referrals. They have set—the situation that we have set up structurally, is that they are, in a sense, going to be able to have veterans referred to providers in the networks that they already own. Do you follow what I am trying to say here?

Mr. TOPPING. Yes, sir.

Mr. TAKANO. You have not given us any assurance that you are preventing this scenario under the current contracts or that you will prevent it under future contracts. How will—how will your proposed contract deal with the scenario I just presented to you?

Mr. TOPPING. Sir, so the goal is to ensure—

Mr. TAKANO. No, no, I do not want to know the goal. What mechanisms, what manner of enforcement, what ways, what—what tools will you have in the contract to prevent what I just described?

Mr. TOPPING. The mechanism is ensuring that VA has the authority to make the referral and determine where the veteran receives the care.

Mr. TAKANO. I just showed you how the referral—what good is VA's authority to refer when they have—when they refer, all they are going to be able to do is refer, the TPA refers them into providers that they already own?

Mr. TOPPING. The referral and the placement VA owns that. VA is accountable for the veterans' care. The TPA does—the TPA does not have the authority to steer veterans into a provider that the veteran and or the VA does not choose. The issue is not vertical providers owned by payers. In some cases, that might be the highest quality, lowest cost care. That is something that VA would benefit from in our veterans were . Well, what we want to do is, regardless of who owns a provider, ensuring that the veterans go to the highest quality, lowest cost provider. VA controls the steerage. VA places the patient. They belong to us. We make those decisions. VA will place the veteran.

Mr. TAKANO. Well, does the VA—do the VA schedulers have any visibility into which network providers are owned by the TPA?

Ms. SKOLROOD. Currently, to my knowledge, they do not. I think that is something we can take back and contemplate. We have talked a little bit about preferred providers, and that is something that we are building in a more robust way in Next Gen.

Mr. TAKANO. Yes, well, so this is a major flaw in the current system and one which leads to some self-dealing by the third-party administrators. They put the network together and say they have set up VA with a limitation, and if the VA has no visibility into where the veteran is referred to, you can see the conflict right there.

Ms. SKOLROOD. Again, the VA is the one who makes that decision. As we select preferred providers—

Mr. TAKANO. VA is making a very limited decision. Right? You are making it sound like they have this choice, but there is none. The VA does not have a choice here. The TPA has been able to set it up to their benefit.

Mr. TOPPING. Sir, so that is not true. Under Next Gen, VA does have the choice because we have the quality—

Mr. TAKANO. I am sorry. I am interested in knowing more about that, but I need to get to another question. I want to know more if you would get back to me about how, under Next Gen, we prevent this situation. I have no assurance that this current flaw is going to be prevented in Next Gen. If community care is VA care, then the knowledge and skills of the providers should be equivalent. If that—if that representation—if that—we are going to represent community care as VA care. Well, currently, suicide prevention training to bring the knowledge of CCN providers to equivalent VA standards. Currently, that is voluntary, right? That is not something that VA can insist that CCN providers get or do in order to be able to treat our patients, is that right?

Mr. TOPPING. We want to ensure that all network providers—

Mr. TAKANO. Well, just to answer the question. Do you know if that is true or not? Now I can tell you it is not. If it is voluntary. It is voluntary. VA cannot insist that they do—that our providers, the CCN providers, must go through suicide prevention training equivalent to VA providers. Do you know why?

Mr. TOPPING. Ranking Member, we want to ensure that all of our providers—

Mr. TAKANO. Do you know why?

Mr. TOPPING [continuing]. have the training—

Mr. TAKANO. Do you know why?

Mr. TOPPING [continuing]. and skill set—

Mr. TAKANO. You do not. You do not know why? The answer is you do not know. The answer is that, my understanding is that third-party administrators have resisted in negotiations with VA the requirement that VA be able to insist that CCN providers receive trainings like suicide prevention because it would be too hard to recruit for their network. They have that power to push back on VA. VA should be able to insist that all CCN providers are trained to equivalent standards that are within VA direct care. Do not you think that—do not you think that is a reasonable level of standard in?

Ms. SKOLROOD. In Next Gen, we do have the requirement that certain training that we require will be required of providers, and the TPAs have responsibility to ensure that that happens. I will say we can put in the contract that all physicians must wear purple shirts on Tuesdays. That does limit our ability to build a robust network. I do not like the word—

Mr. TAKANO. You just parroted what I just said. Right?

Ms. SKOLROOD. Right.

Mr. TAKANO. The reason why—the reason why that this is not a requirement and is not enforceable is—is exactly what you just said.

Ms. SKOLROOD. It is enforceable.

Mr. TAKANO. It impairs the ability—it impairs the ability of the third-party administrator to recruit and build out their network. That is basically yes.

Ms. SKOLROOD. No. In Next Gen—

Mr. TAKANO. No?

Ms. SKOLROOD. In Next Gen, we do have the requirement. We have to—we have to understand and identify that that is a risk. That is absolutely a risk. As we require more and more providers in the network to do things specific to what the VA needs and wants for our veterans, it will impact potentially the network. That is—that is our problem, and that is our TPA's problem. We then have to address it. We have to then build not an adequate network, but a robust network that meets the needs of—

Mr. TAKANO. I can tell you it is a huge frustration of mine that the CCN providers we have now, we have not been able to get them to do suicide prevention training, which is one of the biggest, biggest challenges we have at VA.

Ms. SKOLROOD. Absolutely.

Mr. TAKANO. You have not given me any clear answer that Next Gen is really going to solve this problem.

I yield back.

Mr. CHAIRMAN. Thank you. On behalf of the committee, I want to thank you for your testimony for joining us here today. You are now excused because we do have another—we will wait a few seconds and get the second panel up. Thank you for being here.

We want to welcome everyone and thank the next panel for being here.

On our second panel, we have Mr. John Vick, executive director of Concerned Veterans for America (CVA), and Dr. Rachel Madley, Ph.D., director of policy and advocacy at the Center for Health and Democracy. Thank you once again for being here and attending today.

I would like to, if each one of you would rise and raise your right hand.

[Witnesses sworn.]

Mr. CHAIRMAN. Let the record reflect that both witnesses answered in the affirmative.

Mr. Vick, you are now recognized for 5 minutes.

STATEMENT OF JOHN VICK

Mr. VICK. Thank you, Chairman, Boss, Ranking Member Takano, and members of the committee for the opportunity to testify today

at today's oversight hearing on the future of the Veterans Community Care Program on behalf of Concerned Veterans for America. CVA is a Grassroots network of thousands of vets, family members, and patriotic citizens that advocates for and defense policies to preserve freedom and prosperity for all Americans. Our organization builds engaged communities of vets, elevating their unique experiences and perspectives to help improve American lives. We believe that strong and healthy vets make for strong and healthy American communities.

While CVA is focused on many issues, since its establishment over 14 years ago, the organization has consistently fought to empower vets to be at the center of their health care journey. Excuse me. As an enlisted Marine and later as a Navy Officer and now as executive director for CVA, I know a lot of veterans. I have seen how the ability or inability to access quality and timely health care has profoundly impacted the lives of those that I have served with. That is why we advocate for choice and accountability.

CVA helped elevate the voices of veteran VA whistleblowers who revealed that veterans had died while waiting for care on secret wait lists during the Phoenix VA scandal of 2014. CVA helped shape and support the 2018 MISSION Act, which passed with overwhelming bipartisan support and created the Veterans Community Care Program that we are talking about today. Community care now accounts for about 40 percent of overall VA health care, and that is growing, which is a testament to both veterans' preferences and to this committee's willingness to tackle tough problems on their behalf.

CVA's view of veterans' healthcare is simple. At all times, veterans should have the choice of seeking care either at a VA facility or a community care provider, depending on which best meets their needs. It is the same choice that the congressional staffers get sitting behind you, and it is the same choice that the CVA staffers get sitting behind me somewhere back there. It is also the same model that our retired military and civilians are able to use.

The Community Care Network's Next Gen contract offers an important investment in sustaining the hard-won health care choices of the VA MISSION Act and ensuring that veterans have quality choices to choose from. At the same time, Members of Congress and policymakers at the VA will need to work together to ensure that the Next Gen contract is carefully and efficiently managed to limit the potential for waste, fraud, and abuse. This contract should empower the thousands of incredible people at the Department of Veterans' Affairs who truly want to be a partner in getting veterans the care that they need as soon as they can get it. Veterans need these community care options.

Here in DC alone, the consequences of pushing veterans away from community care and toward sole reliance on the VA or would be disastrous. As of January 20, 2026, new patient wait times for primary care at the Washington VA Medical Center were at over 35 days, according to the VA's own wait time tracking tool. This is well over the 20-day wait standard for non-specialty treatment in the community. The same query found new patient wait times of 62 days for dental care, 66 days for OBGYN treatment, 65 days for podiatry appointments, and 56 days for oncology appointments.

That last one is for cancer. Mental health availability in DC is actually pretty decent at about 8 days, but up the road in Baltimore, it is 26 days, Phoenix is 39 days, and Los Angeles is 55 days. People that are finally ready to get mental health care treatment often just do not last that long.

Rural veterans that volunteer for CVA often report the additional burden of onerous travel requirements to VHA facilities, sometimes hours away and across State lines for an appointment that took too long to get in the first place. That is why over 84 percent of veterans enrollees at VHA rely on supplemental insurance outside the VA, such as Medicare, Medicaid, Tricare, or some other private insurance. Unsurprisingly, the veterans that have other insurance also report being healthier, about 44 percent. We should embrace what works.

Protecting and expanding community care options is not about privatizing or otherwise eliminating the VA, so that—that so many veterans do rely upon. I myself utilize VA in addition to my other health insurance. This is about making VA a better partner to veterans and all the folks that treatment—that treat them. Congress and the Department of Veterans' Affairs should protect and expand our veterans' treatment options and thereby prioritize dignity and agency, and how each of us cares for our minds and our bodies.

Thank you again for having me today. I will try my best to answer your questions.

[THE PREPARED STATEMENT OF JOHN VICK APPEARS IN THE APPENDIX]

Mr. CHAIRMAN. Dr. Madley, you are now recognized for 5 minutes.

STATEMENT OF RACHEL MADLEY

Dr. MADLEY. Chairman Bost, Ranking Member Takano, members of the committee, thank you for the opportunity to testify.

The Veterans Community Care Program and the proposed Community Care Network, or CCN, Next Generation Initiative represent a significant shift toward veterans receiving care in the private sector rather than through the VA. This expansion is based on the assumptions that private sector care is higher quality and more efficient and that private contractors will prioritize veterans over profits. The evidence does not support these assumptions. This pattern is familiar across Federal healthcare programs. Privatization is often promised as a way to improve care and lower costs, but in practice, it frequently leads to higher spending, worse patient outcomes, and increased corporate profits.

The Community Care Program was created under the 2018 VA MISSION Act and is currently administered through contracts with TriWest Healthcare Alliance and Optum Serve. These contractors build provider networks and process claims for veterans receiving private sector care. The VA is now seeking contractors for CCN Next Generation, an expanded program projected to cost up to \$1 trillion over the next decade.

This proposal dramatically expands a model that has already shown serious weaknesses. Experience with current contractors raises red flags. The VA Office of the Inspector General, or OIG, found that Optum Serve and TriWest billed the VA nearly \$1 bil-

lion more for dental services than they reimbursed community care providers between 2020 and 2024. While permitted due to a gap in contracts, this practice highlights the risks of relying on private-driven intermediaries to administer public health programs.

These issues mirror well-documented failures in the private Medicare Advantage (MA) program. Insurers have marketed Medicare Advantage plans to veterans who primarily rely on VA care and use little or no Medicare services. Yet the government still pays MA insurers the full amount. In 2020 alone, taxpayers paid more than \$1.3 billion to insurers for veterans enrolled in MA who used no Medicare services that year. UnitedHealth Group, the parent of both Optum Serve and UnitedHealthcare and MA Plan, directly benefits from this duplication. These behaviors demonstrate that private company incentives are misaligned with the goals of the VA to care for those who served and used tax dollars efficiently.

A substantial body of research shows that VA care frequently matches or outperforms private sector care. A comprehensive review published by the VA in 2024 found that most studies show VA care is equal to or better than community care, and no studies found better patient experience in the private sector. Many private providers also lack military cultural competency, particularly in mental health care.

Access problems further undermine community care. The OIG found that community care contractors failed to maintain adequate provider networks, with VA staff repeatedly reporting that many listed providers were not actually accepting VA patients.

The VA also delivers care more efficiently. Studies show shorter wait times for many specialties within the VA, and VA clinicians are less likely to deliver low-value, high-cost care. Administrative efficiency is another key advantage the VA—another key advantage. The VA employs far fewer administrative staff than private health systems, mirroring traditional Medicare’s substantially lower overhead costs. Proposed increases in community care funding are paired with reductions in funding for direct VA care, weakening the VHA’s role as an emergency backstop training system and research leader. Expanding community care without fixing existing problems risks scaling these issues.

CCN Next Generation also imports Medicare Advantage-style payment models, including capitation, risk adjustment, and shared savings incentives that allow contractors to retain up to 50 percent of savings from providing less medical care. In this context, these mechanisms have consistently led to care rationing and upcoding, raising costs while harming patients. In Medicare Advantage, insurers are overpaid by \$84 billion each year due to their gaming of the very risk adjustment system proposed for these community care models.

Instead of this community care expansion, the VA should reinvest the proposed increased CCN funding into expanding VA capacity by modernizing facilities and building additional facilities where needed, as well as hiring additional clinicians. When veterans do require specialized care unavailable within the VA, traditional Medicare should administer that care using its efficient claim system to reduce overhead costs and protect both veterans and taxpayers.

Thank you for the opportunity to testify, and I look forward to taking your questions.

[THE PREPARED STATEMENT OF RACHEL MADLEY APPEARS IN THE APPENDIX]

Mr. CHAIRMAN. Thank you. I now recognize myself for 5 minutes.

Mr. VICK. Going forward, how can VA maximize veteran input in major contract actions such as this one?

Mr. VICK. Thank you, Mr. Chairman. Notably, according to the VA, a VA survey in 2022, which is the last year that the survey was conducted, 83 percent of veterans are satisfied with community care versus 69 percent for their VHA experiences. I do believe that, you know, whereas VA does play a critical role in any future administration, of VA plays a critical role in contractor accountability, in all VA accountability. I would love to see a time when VA accountability did not mean all of the oversight things that you guys do that we do and also, but rather meant like VA being accountable for patient outcomes, no matter where those patients get their care. I do think a critical component of that, too, is surveying the people that are getting the care and following up on what their health care outcomes are, not just how much we spend.

Mr. CHAIRMAN. What are some of the opportunities you see for expanding, improving, and delivery of health care with this Next Generation contract structure?

Mr. VICK. Yes, well, I think it is going to be critical to expand the pool of people that can treat veterans. You know, it is always seemed crazy to me and I have used the VA in my life and I have used—I am also a military reservist, so I also have access to TriCare. I have had multiple different kinds of insurance, and I have used them all over the country. It always seemed crazy to me that I was not able to necessarily go to the same doctor that the rest of my family used. I think that if you can expand the pool of people that can treat our veterans, and you are layering that into the feedback that veterans give on what works best for them. By the way, some of them absolutely prefer going to a VHA facility. If you can track accountability for the outcomes, expand this pool, and I think most importantly, when somebody does underperform, whether it is something like electronic health records and not getting records back on care, not making it possible to have a solid continuum of care, being able to off-ramp those contractors efficiently without a bunch of red tape, that is critical.

Mr. CHAIRMAN. Also, what are some important things VA to keep—do you think VA should keep in mind when they are evaluating proposals on these contracts to ensure the benefits are best for the veterans?

Mr. VICK. I think past performance, you know, one of the things that community care does is lean into the existing healthcare infrastructure. You know, unlike the VA system, which, you know, some of these facilities were built decades ago when populations existed in different places and where specialty care existed in different parts of the system, the private health care industry, for instance, in Orlando, where I—where I call home, it mirrors exactly what the local community needs, right? I think that being able to match that for veterans, right, and finding out exactly how to streamline

service delivery directly to the vet, that is the most important thing to do.

Mr. CHAIRMAN. I have no more questions. Ranking Member, you are recognized for 5 minutes.

Mr. TAKANO. Thank you. Thank you for the patience of our witnesses for staying till this—tell their—till this time. I am sorry that the VA witnesses have left and are not going to benefit from the answers that you are going to—they could use your expertise, frankly.

You have testified, Dr. Madley, that CCN Next Gen leaves open the door to gaming and misuse of taxpayer funds. What specific flaws in the RFP create these risks, and what changes are needed to protect veterans and taxpayers?

Dr. MADLEY. Thank you for that question, Ranking Member. One of the biggest flaws is the incorporation of what is called value-based care models. In this case is use of capitated payments and risk scoring of veterans, where the contractors will be running these models, that—and they get to keep any 50 percent of any savings that they are able to get. And now——

Mr. TAKANO. It is a Medicare Advantage model?

Dr. MADLEY. Exactly.

Mr. TAKANO. Capitated payments. They actually benefit by—by withholding care.

Dr. MADLEY. Exactly. When the lower extremity joint replacement model that is being prescribed for contractors here was run in CMS, it was actually found that safety net hospitals were unable to achieve savings because they had more complex, more vulnerable patients who needed more care. That savings is often coming from not providing needed care.

Mr. TAKANO. Are these safety net hospitals, are they located in rural areas? I mean, rural areas, I know that hospitals are under tremendous pressure because of the cuts in Medicaid.

Dr. MADLEY. It was in both rural and urban areas. Those safety net hospitals, and this is mirrored in the CCN Next Gen documents, were then forced to repay CMS the money that they over-spent.

Mr. TAKANO. I am just incredulous. Capitated payments on them along the lines of Medicare Advantage. VA is going to do the same thing to our veterans?

Dr. MADLEY. Yes, and it is also importing the risk adjustment system that bipartisan Members of Congress have raised red flags about because it leads to upcoding of these patients and making them look sicker, meaning that they get higher payments from the government.

Mr. TAKANO. Okay, so profit incentives are often in conflict with care quality. How do those incentives manifest under the CCN Next Gen, and how are VA safeguards sufficient to counteract? We kind of already covered it, but maybe you can sum it up real quick.

Dr. MADLEY. Definitely. The way these contracts involve incentive payments means that contractors who do enact these value-based care models, and they are required to implement four, get to keep 50 percent of the savings that they generate. That savings comes from lowering costs, which comes from providing less care.

Mr. TAKANO. We are going to incentivize private providers to increase their profit margins for their shareholders and for their executives by potentially denying care to veterans. This is incredible. This is a beautiful—well, whatever.

Dr. Madley and Dr. Vick, I am going to ask you both this question. Who are your major donors to your organizations? Dr. Madley, I start with you first.

Dr. MADLEY. We are funded by grants from philanthropic organizations such as Arnold Ventures, as well as small-dollar donations from supporters who want more affordable health care.

Mr. TAKANO. Mr. Vick.

Mr. VICK. I do not work in donor development. CVA has about 40 full-time staff. The donors that I am mostly concerned with are literally thousands of volunteers—

Mr. TAKANO. Oh, come on. Mr. Vick, CVA is a 501(c)(4), not a (c)(3), unlike the person sitting next to you, which means it is political and it does not publicly disclose donors. Will you commit today to provide the committee a confidential list of CVA's top donors over the last 5 years?

Mr. VICK. I would not be able to do that. We respect donor privacy.

Mr. TAKANO. You can, and you are not. You are here today asking Congress to allocate large amounts of veteran health care spending without telling veterans or taxpayers who is paying for your advocacy, is that correct?

Mr. VICK. I advocate for the thousands of Grassroots volunteers.

Mr. TAKANO. I am correct. I am correct. You are here—Grassroots my—your organization is paid for by—it is not paid for by those folks. That is not the majority of who funds you. Who funds you are donors that are very much interested in certain outcomes. Do any of CVA's donors, major partners, or board affiliates have financial interests in healthcare delivery, insurance, managed care, or provider networks related to VA community care?

Mr. VICK. I am unable to answer that question. I do not know.

Mr. TAKANO. Well, so you cannot answer the question, but I am sure that this will come out in due course. Is Concerned Veterans for America currently affiliated with Americans for Prosperity (AFP) and governance, staffing, shared services, or funding streams?

Mr. VICK. AFP is a sister organization of us. Yes.

Mr. TAKANO. Say again?

Mr. VICK. A sister organization.

Mr. TAKANO. A sister organization. Is your political arm branded CVA Action, registered as a service mark of Americans for Prosperity for Action?

Mr. VICK. I have to get that answer back to you.

Mr. TAKANO. Okay, so when CVA engages in advocacy and political equity, is it fair to say it is operating as—

Mr. CHAIRMAN. The gentleman's time has expired.

Mr. TAKANO [continuing]. AFP organizational ecosystem? The answer is yes.

Mr. CHAIRMAN. Okay.

Mr. TAKANO. Thank you, and I yield back.

Mr. CHAIRMAN. Thank you. Just for the record, the Center for Health and Democracy is a (c)(3) but also a (c)(4). They are both. They are both.

Any rate, Ms. Brownley.

Ms. BROWNLEY. Dr. Madley, is that true?

Dr. MADLEY. We have a (c)(4) arm as well as a (c)(3) arm.

Ms. BROWNLEY. Your (c)(4) arm is involved in?

Dr. MADLEY. Advocating for policies to lower health care costs and bring more transparency to insurance companies.

Ms. BROWNLEY. Thank you. Thank you.

Mr. VICK, first, let me just say thank you for your service. I do not dispute any of the facts that you stated in your testimony. I just disagree with how we solve some of these issues. I think, do you consider yourself a VSO?

Mr. VICK. We are Veterans of Foreign Wars. We also are—there is also CVA foundation, which is a (c)(3), which is wholly involved in educational programming. The reason why it is called Concerned Veterans for America is because we advocate for things that benefit all Americans. Right? And so,—

Ms. BROWNLEY. They advocate for all veterans?

Mr. VICK. We advocate for things that matter to all Americans, but we also get into veterans' issues as well.

Ms. BROWNLEY. For all Americans. I see.

Mr. VICK. Yes.

Ms. BROWNLEY. It is hard to kind of reconcile, you know, the political side of your organization that is supporting—supporting candidates here in Congress, you know, making campaign contributions, supporting their campaigns, and so forth, who are advocating for X, Y, and Z. That might not be what all Americans support. You know, I have trouble sort of reconciling how you can represent all Americans when all Americans may not have—have the same point of view as you do.

Mr. VICK. For sure, all Americans definitely do not have the same points of view. For me, the reason why I am passionate about this, especially talking about healthcare choice, I talk to veterans all over the country. I get emotional about it when I talk about it sometimes, is because for me, it is a matter of human dignity. I do believe that any government-sponsored, you know, healthcare subsidized program, there is problems with it. We face it with Medicare, with Medicaid, we face it with TriCare, a lot of different things. I think that that is always going to be an accountability piece, and CVA will always be there to talk about the accountability piece, too, in as nonpartisan a way as we possibly can. I really do believe that if we make VA a prime partner in this service delivery journey for veterans, that we are going to have better healthcare outcomes. We definitely have to have accountability in it.

Ms. BROWNLEY. Have you been at the table for all of the planning of this Next Gen proposal on the VA?

Mr. VICK. Not all the planning. I do not—I do not work for VA. So—

Ms. BROWNLEY. No, I understand, but I am just wondering if you or someone else in CVA has had a seat at the table.

Mr. VICK. No, not, not directly. I do not believe so. I take a lot of meetings with Members of Congress. We do talk to—had a chance to sit down and chat with Secretary Collins one time, so that was pretty neat.

Ms. BROWNLEY. You have never come to my office. I will just say that.

Mr. VICK. I can commit that we absolutely will come.

Ms. BROWNLEY. Okay. Well, I have been on the committee for 14 years, and you have never knocked on my door. Anyway.

Dr. Madley, you know, you just talked about with the Ranking Member some of the issues with regards to financial incentives conflicting with quality healthcare. I want to ask you, based on everything that you have heard today and testimony and what the VA is proposing, I do not know if you have had a chance to really study the contract and so forth, but do you see other ways in which contractors will be more profitable based on this new contract?

Dr. MADLEY. Thank you for the question, Congresswoman. I do see, aside from the alternative payment models, the ability for contractors who run integrated healthcare systems.

Ms. BROWNLEY. I am sorry. Integrated what?

Dr. MADLEY. Integrated healthcare systems.

Ms. BROWNLEY. Uh-huh.

Dr. MADLEY. That is, they have an insurance arm, that they then have a provider arm, sometimes a Pharmacy Benefits Management (PBM) arm, and so on. In the design of the networks, contractors are responsible for choosing providers who will be in the networks. This was talked about at length with the witnesses from the VA. To my knowledge, reading the contract documents and hearing the testimony, there is no way for the VA to prevent a contractor from creating a network that is disproportionately made of providers that that contractor owns. I will just say that there is evidence in the commercial market of insurers who own providers treating those affiliated providers very differently. For example, UnitedHealthcare pays Optum providers, which are providers that they own up to 61 percent more than non-affiliated providers in the same network. Optum Serve is currently a contractor for the community care program right now. We have—we have seen this evidence, and there are no requirements as of now in the VA documents that would prevent it from happening.

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

Mr. CHAIRMAN. Dr. Dexter, you are recognized by minute.

Ms. DEXTER. Thank you very much, Mr. Chair, and thank you to our witnesses for coming. One thing I just wanted to respond to, Mr. Vick, is you are talking about waiting times at the VA. I used to practice in the VA. I know many who still do. I have been told by several, not just at one VA, that a lot of the administrative staff that were scheduling and screening patients for appointments have actually been let go, fired. They are having a hard time filling their appointments. I just would elevate the need for us to actually staff our VAs so that we can actually deliver on the care, even when doctors are sitting there with unfilled spots.

Also, I, having worked at a VA, I will just push back on the concerns about driving many hours to VA facilities. I had a lot of patients that would rather wait to go to a VA or would drive long dis-

tances to go to a direct care facility. I do want us to have a balanced perspective on the fact of the matter is the veterans should have a choice, and they should have transparency so that they can decide, which we do not have right now. I brought that up earlier, so I will not wax poetic about that. I do have very significant concerns about the promises we are hearing from community care providers versus what reality is. The fact of the matter is, as Dr. Madley has raised, that they can make a lot of money off of veteran contracts and not necessarily deliver because we are not great at holding them accountable.

As a member of this committee, Dr. Madley, I take really seriously, as I understand many of us do, my role to steward our taxpayer dollars. As you cited in your testimony, there have been instances, for example, over \$900 million in overpayments for dental services to Optum and TriWest. That appears to be a waste of taxpayer dollars in the community care program. Would you like to comment further on that at all?

Dr. MADLEY. Thank you for that question. Yes, the overpayments to the dental providers, as it was explained from the third-party administrators, were due to the contracts not having language essentially that said they could not do that. I think it really illustrates, as I said in my testimony, how oftentimes private contractors have incentives and fiduciary responsibility to their shareholders. That is fundamentally misaligned with what the VA and what the Community Care Program is trying to do, which is trying to provide care for our veterans and use our taxpayer dollars efficiently. I think it is a very good illustration. Due to the fact that we have not been able to conduct as much oversight on these contractors, there is probably a lot more examples of that happening, and those misaligned incentives leading to wasting money.

Ms. DEXTER. I will just follow up on that that I think it is a similar issue to the training that provider network or providers in networks are being asked to have the same level of training that our veteran providers do. I will just say, as somebody who vehemently was against more mandates for my education, as a physician who has a lot of time being used for other administrative issues, I absolutely, as a professional, agree with that. You know that you are going to limit the networks if you are demanding that, because doctors, nurse practitioners, and others are already overstretched. It is irrational for us to think that we are going to have robust networks and have all these requirements. It is simply not the case that we can get to the same level of quality for out-of-network community care providers as we do for people who take care of veterans every day. We were motivated to want to know about the impacts of exposures and toxins.

Which is another thing I wanted to follow up with you about. How do you see, Dr. Madley, the ability for community care providers to have the level of understanding of veteran exposures and other diseases are airborne divisions who have many, many joint replacement issues and skeletal issues? How can we provide transparency and accountability for quality and service in these contracts? What can we do better?

Dr. MADLEY. That is a great question. I would recommend first making sure that the contractors have to maintain accurate net-

work data. In that listing of the providers within the community care network, I would recommend adding in which providers have fully completed the training, such as suicide prevention training, opioid prescribing training, and things like that that VA clinicians have gone through. Now, with the contractors that were used in the First Generation of this, they were not able to keep their provider network data up to date. Again, going with similar contractors this time, they will likely not be able to provide that data. How can we find contractors who are motivated to be able to keep that accurate data? I would recommend that.

Ms. DEXTER. I will just raise up, Mr. Chair, what you stated at the beginning that we need to trust but verify—

Mr. CHAIRMAN. Mm-hmm.

Ms. DEXTER [continuing]. someone great, per your words, said that. I do not think that we have established the mechanisms here in government to do that. I certainly would argue that contractors overseeing contractors is probably not the right way. I know that this is a bipartisan issue and I very much hope that we will continue to—

Mr. CHAIRMAN. As I said at the very beginning, we—this is the beginning.

Ms. DEXTER. Right.

Mr. CHAIRMAN. The beginning.

Ms. DEXTER. No, I very much appreciate that, and I know my time has run out. I will yield back. Thank you.

Mr. CHAIRMAN. Well, let me tell you, rest assured, all of our—all of everybody on this committee I know wants to help the veterans and make sure they realize that they get the best benefits they possibly can and the best places they possibly can.

On behalf of the committee, I want to again say thank you to the witnesses and members who are being here—for being here today. I look forward to working with you to address the issues facing our veterans.

Now, the committee's written statements, the complete written statements of today's witnesses, will be entered into the hearing record, and I ask unanimous consent. Do you need to be—no. Okay.

All right. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks, including extraneous material into the record. Hearing no objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 1:44 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Richard Topping

Mr. Chairman, Ranking Member, and distinguished Members of the Committee, thank you for the opportunity to discuss the Veterans Community Care Program (VCCP) and the Community Care Network (CCN) Next Generation (Next Gen) contract procurement. I am accompanied today by Ms. Alicia Skolrood, Executive Director of Integrated External Networks, Office of Integrated Veteran Care, Veterans Health Administration.

VA has long been recognized for the world-class health care we provide to Veterans across more than 1,500 medical facilities. In addition to the direct care system, VA has also been a purchaser of health care since before the World War II era. As a health care payer, VA partners with local hospitals, doctors, and other health care providers to ensure that Veterans have access to the care they need, where and when they need it. Caring for Veterans is about more than operating hospitals. It is about supporting Veterans' physical and mental health and wellness, their families and caregivers, and leveraging community services beyond the walls of our facilities.

Recognizing the key role that purchased care plays in VA's ability to provide for Veterans' health and wellness, President Trump and Congress passed the bipartisan VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115–182). The VA MISSION Act expanded access and choice for Veterans and reinforced VA's mission as both a health care provider and payer. Today, VA is the country's largest single health care provider through our hospitals and clinics, and the fourth largest health care payer through VCCP. In Fiscal Year 2025, 41.8 percent all health care appointments Veterans booked with VA were in the community. CCN Next Gen is VA's first major procurement effort to support this program since shortly after enactment of the VA MISSION Act, when the legacy CCN contracts were awarded in 2018. CCN Next Gen is our opportunity to increase competition, upgrade, and modernize the provider network, and enhance services to ensure that Veterans receive the very best health care possible, whether at a VA facility or in their community from a local health care provider.

Fortunately, VA has had significant input and support in designing CCN Next Gen. We talked directly with our Veterans. We asked what they need and want from community care, and how the program can best serve them. Veterans overwhelmingly want choice. They want the flexibility to choose between direct care and VCCP based on best medical interest, availability, and convenience. Most importantly, Veterans want health care choices that meet them where they are.

We talked to other Government Agencies. The Department of Health and Human Services (HHS) operates the country's three largest payer programs. HHS brings decades of experience and data on improving health care quality, reducing costs, and aligning incentives for better health and wellness. The Department of War (DOW) also operates both a direct care system and a payer program, with expertise in managing capacity and access across both while maintaining an overall focus on quality and cost. HHS and DOW both have insights into what works, what does not work, and where VA can have maximum impact by leveraging lessons already learned.

We engaged with industry leaders. Non-VA hospitals and insurers are constantly innovating in the health care marketplace. They are experimenting with new delivery models, leveraging data and analytics, striving to be consumer-oriented, and tackling costs that remain too high. Industry has provided VA with a roadmap of successes and failures and how VA might capture the best of the innovation in health care and apply them to VA's model for the benefit of our Veterans.

By combining VA's history as a health care payer with the improvements made by the VA MISSION Act, incorporating Veterans' needs and demographics, and leveraging external innovation, VA successfully issued the CCN Next Gen Request for Proposals on December 15, 2025. VA is leading the Nation with an innovative 10-year, multiple award Indefinite Delivery Indefinite Quantity (IDIQ) contract ve-

hicle which has several key advantages over traditional Federal health care contracts.

First, this approach allows VA to make multiple awards to offerors that meet our requirements, but vary in size, capabilities, and regional presence. Under a traditional Federal health care procurement model, only the largest national third-party administrators (TPA) would have the scale to propose on CCN Next Gen. However, with the multiple award IDIQ, VA expects responsive proposals from regional health plans that have unique capabilities that are locally adaptable.

Second, the multiple-award structure enables VA to iteratively adapt CCN Next Gen to meet Veterans' changing needs over time and to match VA's increasing sophistication to manage the program. Over the 10-year performance period of the contract, VA can issue multiple rounds of task orders for which contractors can compete. Our initial task orders will resemble current CCN operations: large, fee-for-service TPAs with expanded requirements from legacy CCN contracts, and incentives and penalties tied to that performance. However, immediately after issuing these initial task orders, VA will begin designing the second round of task orders. The second round of task orders will be more regional and increase both the requirements and the opportunities for the vendors. The sequential use of task orders will give industry the opportunity to adapt its capabilities to better serve Veterans, but it will also allow VA to improve and enhance our internal program management capabilities.

Third, by allowing for multiple contractors to compete for multiple rounds of varied task orders, CCN Next Gen will ensure continuous competition over the performance period of the contract. Contractors who fail to perform may be off-ramped, task orders can be modified, and more sophisticated requirements may be introduced. The design of the multiple award IDIQ allows ongoing quality and performance improvement between VA and our contractors.

The IDIQ is the *how* of this procurement, but the most exciting part of CCN Next Gen is the *what*. CCN Next Gen will be a dramatic modernization of the current CCN contracts. It will begin with the recognition that VA must have the tools and capabilities to drive outcomes, ensure quality, and manage costs effectively. CCN Next Gen is designed on five pillars: Quality, Value, Alternative Payments, Utilization Management, and Program integrity.

VA will implement comprehensive quality programs for community providers based on nationally recognized measures from the Agency for Healthcare Research and Quality (AHRQ) and the Healthcare Effectiveness Data and Information Set (HEDIS). Contractors will track patient safety events, identify Veterans at risk of avoidable emergency visits and readmissions through predictive analytics, and, while respecting their choice, guide Veterans toward high-performing providers using data-driven algorithms. This program ensures that Veterans are not simply referred to any available provider, but to those demonstrating strong outcomes and safe, high-quality care.

CCN Next Gen will modernize how VA pays its contractors for the care furnished to Veterans by implementing value-based payment models. Based on existing needs and capabilities, VA will begin with episode-based payments for lower-extremity joint replacements. As we gain the data and expertise to manage alternative payments, we will introduce at least three increasingly sophisticated models over the performance period of the contract. These models will shift payment away from volume and toward outcomes and total cost of care, aligning contractor incentives with Veteran health and system sustainability.

CCN Next Gen's care coordination incorporates utilization management processes proven in other payer programs and aligned with industry standards. This includes active management of inpatient admissions, emergency department use, concurrent hospital reviews, and high-cost drugs administered in clinical settings. VA will measure and report performance, benchmark results, and drive continuous improvement. These measures are designed to reduce unnecessary hospitalization and inappropriate care while protecting Veterans' access to medically necessary services.

CCN Next Gen will include a full program integrity function to ensure that VA resources are protected and maximized. Contractors will maintain compliance committees, appoint dedicated compliance officers, and operate Special Investigations Units to detect and investigate fraud, waste, and abuse. They will identify providers at higher risk of improper billing, formalize oversight processes, expand data and technology for improper payment detection, and submit to independent audits. This shifts VA from a system that paid bills after-the-fact to one that actively prevents and detects abuse.

The last exciting innovation in CCN Next Gen is how VA will manage its contractual relationship with contractors. VCCP's ultimate goal is to provide the highest quality care for Veterans at the lowest cost to taxpayers. Achieving this outcome de-

depends equally on the agency and industry. CCN Next Gen will be a contractual relationship with contractors, leveraging all VA and industry brings, in the service of our Veterans. Historically, VA's approach, like most Government Agencies, has been to try to predict the next several years, compete it, award it, and then manage it. CCN Next Gen will allow VA to gain the information needed during the contractors' performance on capacity, capabilities, regional adaptations, innovation, and pricing and to do so continuously through the task order formation and issuance process.

CCN Next Gen will change how VA pays our contractors to incentivize performance and outcomes. CCN Next Gen will incorporate incentives and disincentives based on the total cost of care, quality performance, value-based care adoption, and payment integrity. Contractors may earn up to 2.25 percent in incentive payments or be subject to disincentives of up to 3 percent of administrative fees if they fail to meet contract requirements. This ensures that contractors have "skin in the game" and remain accountable for how well they serve Veterans and manage taxpayer dollars. Ultimately, contractors who achieve VA quality targets, while reducing costs, will share in the value they create for VA and for Veterans.

Taken together, the payment changes included in CCN Next Gen will be significant. We will change how contractors pay community health care providers by introducing value-based care and require alternative payment models that align with evolving industry standards. We will also change how VA pays our contractors, introducing incentives and disincentives that move away from fixed administrative costs. These payment changes align VA with contractors and with our community providers.

Our actuarial analysis of the CCN Next Gen program design changes, along with these payment changes, estimate significant savings of 8–14 percent over the life of the contracts. Under conservative assumptions, the cost-containment framework is expected to reduce community care spending by approximately \$54 billion over the next decade. Under stronger performance scenarios, the cost-containment framework's estimated reduction could approach \$100 billion. These savings will be driven by fewer unnecessary hospitalizations, improved management of high-cost services and drugs, improved quality, and stronger fraud and payment controls.

Mr. Chairman, CCN Next Gen is leading the way in how Federal health care programs can be designed, procured, and operated. I appreciate the opportunity to share this information and look forward to answering any questions you or the other Members of the Committee may have.

Prepared Statement of John Vick



Statement of

**John Vick,
Executive Director, Concerned Veterans for America**

before the

House Committee on Veterans Affairs

concerning

“Community Care Network Next Generation: One Trillion Dollars of Oversight”

January 22, 2025

Thank you, Chairman Bost, Ranking Member Takano, and Members of the Committee for the opportunity to testify at today's full committee oversight hearing on the future of the Veterans' Community Care Program on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans, family members, and patriotic citizens that advocates for and defends policies to preserve freedom and prosperity for all Americans. Our organization builds engaged communities of veterans, elevating their unique experiences and perspectives to help improve American lives.

CVA's History with Community Care

While CVA has focused on several issues since its establishment over 14 years ago, our organization has consistently fought to empower veterans to be at the center of their health care experience, not an agency's bureaucracy. As a Navy and Marine Corps veteran, I have seen how the ability or inability to access quality and timely health care has profoundly impacted the lives of those I served with.

Organizationally, CVA helped elevate the voices of VA whistleblowers who revealed that veterans had died while waiting for care on secret wait lists during the Phoenix VA scandal of 2014, underscoring the need for additional options outside of care at VHA facilities. In the aftermath of Phoenix, CVA also supported early reform efforts like the Veterans Access, Choice, and Accountability Act of 2014, which created the first options for veterans to choose to use their health benefits at independent providers.

These early efforts culminated in the VA MISSION Act of 2018, which CVA helped shape and support in Congress. The legislation passed with overwhelming bipartisan support, incorporating many of the recommendations of CVA's 2015 Fixing Veterans' Health Care Task Force, including creating the Veterans Community Care Program (VCCP) under discussion today.¹ By consolidating existing choice programs into an easier-to-use VCCP and simplifying access standards, the MISSION Act has been a game-changer for millions of veterans' access to timely and quality care.

CVA's view of veterans' health care is simple: at all times, veterans should have the choice of seeking care either at a VA facility or a community care provider depending on which best meets their needs. This is the same model our retired military and civilians are able to use. To the extent the VA molds itself into a socialized health care system by limiting the progress that has been made to add choices for veterans, the more dysfunction we are likely to continue to see.

The Community Care Network's Next Generation contract offers an important investment in sustaining the hard-won health care choices of the VA MISSION Act and ensuring that veterans have quality choices to choose from. At the same time, Members of Congress and policymakers at the VA will need to work together to ensure the Next Generation contract is carefully and efficiently managed to limit the potential for waste, fraud, and abuse.

¹ "Fixing Veterans Health Care: A Bipartisan Policy Task Force," *Concerned Veterans for America*, 2015. <https://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>

The VA's Own Surveys Have Shown Veterans Are Satisfied with Community Care

While the VA no longer publishes this data in its annual budget request, the agency's satisfaction survey in FY 2022 (the final year the comparison was available) found that 83% of veterans were satisfied overall with their community care experiences, compared to only 69% with their VHA experiences.² The roughly 40% of enrollees who use community care each year is ample evidence for the revealed preferences of veterans for additional treatment choices besides VHA direct care facilities.³

Veterans Need Community Care Options

Here in D.C. alone, the consequences of pushing veterans away from community care towards reliance only on direct care facilities through the Veterans' Health Administration (VHA) would be disastrous. As of January 20th, 2026, new patient wait times for primary care at the Washington VA Medical Center were over 35 days, according to the VA's wait time tracking tool.⁴ This is well over the 20 day wait time access standard that currently qualifies veterans for community care to access non-specialty treatment. The same query found new patient wait times of 56 days for oncology appointments, 62 days for dental care, 66 days for OB/GYN treatment or pain medicine appointments, 65 days podiatry appointments, and over 73 days for urology exams.⁵ By contrast, the community care access standard for mental health or other specialty treatment is 28 days.

These are unacceptable wait times, yet they illustrate the abysmal delays veterans can face if given no other option but whenever the nearest VHA facility is available. In CVA's experience with its own activists, rural veterans face similar hurdles, too often being referred to VHA appointments hours away, sometimes across state lines, regardless of stated community care access standards. The prospect of these wait times and drive times to VHA appointments is one reason why over 84% of veteran enrollees rely on supplemental insurance besides the VA, such as Medicare, TRICARE, private insurance, or Medicaid.⁶

Evidence suggests that access to alternatives to sole reliance on VA care is associated with positive impacts on veterans' health, which is why community care remains crucial. A July 2023 JAMA Network Study found that "VA enrollees with private coverage were the most likely (44.0%) to report being in good health. Veterans who received all care through the VA were the most likely to report poor health (33.3%)."⁷ This association should not be surprising given the importance of timely treatment, made easier by a variety of options, for effective preventative

² "Performance Summary," Department of Veterans Affairs FY 2022 Budget Submission, Vol. I: Supplemental Information, page 24.

³ <https://department.va.gov/administrations-and-offices/management/archived-plans-and-reports/>

⁴ "VA to improve health care choice and quality for Veterans with new community care contracts," Department of Veterans Affairs Press Room, December 15, 2025. <https://news.va.gov/press-room/va-to-improve-health-care-choice-and-quality-for-veterans-with-new-community-care-contracts/>

⁵ "Washington VA Medical Center: Wait Times," Accesstocare.va.gov, Department of Veterans Affairs, January 20, 2026. <https://www.accesstocare.va.gov/FacilityPerformanceData/FacilityDataResults?LocationText=District%20of%20Columbia,%20United%20States&Radius=50&UserLatitude=-1&UserLongitude=-1&f=688&sd=99&sc=10>

⁶ Ibid.

⁷ FY 2026 VA Budget Request, Vol. II: Medical Programs," Department of Veterans Affairs, March 2025, page 316.

<https://department.va.gov/wp-content/uploads/2025/06/2026-Volume-2-Medical-Programs.pdf>

⁸ Liam Rose, et. al. "Association Between Self-Reported Health and Reliance on Veterans Affairs for Health Care Among Veterans Affairs Enrollees," JAMA Network, July 17, 2023. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807342>

care.

Community care is a source of savings and sustainability for the VA

Contrary to opponents' claims, community care is a source of savings, not out-of-control costs. Honoring our nation's promise to those who served requires responsibly managing the use of available resources to provide the best access to care possible. However, historically inflexible VA staffing trends have been larger drivers of cost than community care.

The VA-commissioned "Red Team" report, internally released March 30, 2024, painted community care as an untenable source of cost-growth, focusing on the increased popularity of community treatment overtime to recommend further restricting access (community care now accounts for roughly 40% of the VA's patient workload).⁸ However, in emails obtained via Freedom of Information Act request, VA staff noted to report authors that in the past five years, only 15% of the agency's increased spending was due to community care.⁹ In contrast, direct care costs and staffing accounted for 74% of increased VA spending.¹⁰

Members of this committee are right to be concerned about the sustainability of America's promise to those who have served. CVA would highlight the fact that the Department of Veterans Affairs increased its budget over four-fold in inflation-adjusted terms between FY 2004 and FY 2024 alone, while the overall number of enrollees remained largely stable and the overall population of veterans declined over 30% in the same time period.¹¹ Despite these factors, the Biden-era VA expanded its staff by nearly 80,000 full-time equivalents from 395,000 to 472,000 between FY 2020 and FY 2024.¹² To ensure it can continue to meet its obligations, the VA should follow similar industry practices as private health systems and adjust its VHA staffing overtime to reflect the growing popularity of community care among veterans.

We know the agency has focused on staffing when conditions have called for doing so previously. In the latter half of the 1990s, then-Undersecretary of Health Kenneth Kizer oversaw a reduction in over 25,000 VA staff and the merging of dozens of underutilized facilities to concentrate resources on efficiently serving veterans. Undersecretary Kizer paired these right-sizing efforts with opening lower cost community-based-outpatient clinics across the country, treating over 24% more veterans and decreasing wait times, all without major budget growth.¹³

⁸ "Empower Oversight Obtains VA Red Team Report on Community Care," Empower Oversight, April 30, 2024. <https://empowr.us/empower-oversight-obtains-va-red-team-report-on-community-care/>

⁹ See: FOIA Production for Americans for Prosperity Foundation, October 24, 2014, page 3. <https://americansforprosperityfoundation.org/wp-content/uploads/2024/10/24-14214-E.pdf>

¹⁰ Ibid.

¹¹ Data Tables for Historical VA Budgets in 2025 Dollars, "At last of Military Compensation, 2024," Congressional Budget Office. January 30, 2025. <https://www.cbo.gov/publication/60886>; Appendix A in "Department of Veterans Affairs FY 2024 Appropriations," Congressional Research Service, May 1, 2024. <https://crsreports.congress.gov/product/pdf/R/R48056>

¹² VA MISSION Act Section 505 Data – Annual Reports FY 2024 - FY 2019, U.S. Department of Veterans Affairs. <https://www.va.gov/employee/va-mission-act-section-505-data/>

¹³ For more on VA staff right-sizing in the 1990s, see: Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans' Health Care System," Annual Review of Public Health, Vol. 30. December 15, 2008, Pgs. 313-339. <https://www.annualreviews.org/content/journals/10.1146/annurev.publhealth.29.020907.090940>; Brian Friel, "VA considers more layoffs, buyouts," Government Executive, April 14, 1999. <https://www.govexec.com/federal-news/1999/04/va-considers-more-layoffs-buyouts/2787/>; "Final Report of the Commission on Care," Commission on Care, June 30, 2016, pgs. 213-215, https://permanent.fdlp.gov/gpo69908/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

Finally, the VHA's astronomical cost-per-patient rates, which numbered upwards of \$21,000 on average, according to the most recent FY 2024 actuals, dwarf choice-friendly alternatives.¹⁴ TRICARE Select and TRICARE for LIFE, which allow active duty and military retiree patients to use their health benefits at private sector providers without Department of War pre-approval, cost roughly one-half to one-quarter the amount per-beneficiary, while empowering patients with more choices, not less. By comparison, a rough per-patient cost approximation of Kaiser Permanente's per-patient costs, based on 2024 operating expenses and total patients suggests an average of \$9,000 per beneficiary.¹⁵ Offering patients more access to systems that typically serve their needs more efficiently should save, not drain VA resources.

The Next-Gen Contract Promotes a Robust Health Care Marketplace

The community care network is only as beneficial to veterans as the choices it is able to offer them. Crucially, the Next-Gen contract promotes the sort of competition that will expand veterans' health care options further through its "indefinite delivery/indefinite quantity" structure. This system removes upper bounds on the numbers of health plans that can be approved to compete to serve veterans.¹⁶ Allowing for many health plans to provide offerings to veterans at once will improve third-party administrators' transparency incentives as Congress and the Department oversee their performance and compliance.

Policy Solutions

Codify Community Care Access Standards:

The VA's prior failure to follow the implementing regulations of the MISSION Act require firmer action by Congress. In 2019, the VA wrote the implementing regulations determining veterans' eligibility rules, or access standards, for community care. These access standards specify that when wait times at Veterans Health Administration (VHA) facilities exceed 20 days or a 30-minute drive from the veterans' residence for primary or mental health care, and 28 days or a 60-minute drive for specialty care, veterans are eligible for a community care referral.¹⁷ The regulations also allow a veteran's VHA clinician to refer them to community care, regardless of wait or drive time, if he or she determines that doing so is in the veteran's best medical interest.

Over the past four years, the VA repeatedly chose to ignore these rules and even issue contradictory internal guidance. VA training documents recommended that schedulers not inform veterans of their community care eligibility unless veterans directly asked for it.¹⁸ On top of this, VA scheduling scripts instructed employees to actively try to dissuade veterans from choosing

¹⁴ "TRICARE vs. VA Health Care, Cost Estimates: FY 2026 Budget," Concerned Veterans for America, 2025 (see document submission); U.S. Department of Veterans Affairs FY 2026 Budget Submission, Department of Defense FY 2026 Budget Submission: Defense Health Program; Congressional Budget Office February 2024 Baseline Projection: Department of Defense Medicare Eligible Retiree Health Care Fund.

¹⁵ "Fast Facts," Kaiser Permanente, <https://about.kaiserpermanente.org/who-we-are/fast-facts>; Dave Muoio, "Kaiser Permanente Clears \$115B revenue in 2024 thanks to Riant Health additions," Fierce Healthcare, February 10, 2025, <https://www.fiercehealthcare.com/providers/kaiser-permanente-clears-115b-revenue-2024-riant-health-additions#:~:text=Kaiser%20considered%20this%20a%20%F2%80%9Cmodest,%F2%80%9Cleading%20Dodge%20technologies,%F2%80%9D>

¹⁶ "VA to improve health care choice and quality for Veterans with new community care contracts," Department of Veterans Affairs Press Room, December 15, 2025, <https://news.va.gov/press-room/va-to-improve-health-care-choice-and-quality-for-veterans-with-new-community-care-contracts/>

¹⁷ CFR § 17.4040

¹⁸ "Unless the patient requests to review their other eligibility, no additional [community care] eligibility is required to be reviewed other than wait time." See: "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet," *Department of Veterans Affairs*, October 28, 2020, pg. 2, <https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf>

community care instead of VHA facilities.¹⁹ Veterans who knew about and wanted community care nevertheless faced a variety of obstacles for access.

FOIA-obtained VA training documents revealed that officials added an additional approval layer for community care requests. Despite appearing nowhere in the MISSION Act or its implementing regulations, the VA created a new standard for determining whether a veteran's community care request was "clinically appropriate," which in practice functioned as an additional opportunity to improperly deny referrals despite no legal basis for the VA to do so.²⁰

What's more, the VA allowed its administrators to overturn clinicians' assessment of a veteran's "best medical interest" for community care referrals.²¹ VA internal guidance even created carveouts where wait time access standards were simply ignored for scheduling purposes without the veteran's consent.²²

Fortunately, legislation such as **H.R. 740, the Veterans' ACCESS Act**, which has been reported by this Committee, would write community care access standards into law, putting an end to blatant wait-time manipulation and rogue scheduling. The Next-Gen contract needs the guarantees that codified access standards create to attract as many providers and third-party administrators as possible.

Pursue Full Choice:

While Congress should codify community care protections via the Veterans' ACCESS Act, the best way to remove opportunities for the VA administrative meddling that harms veterans is to end the VHA's role as a gatekeeper for whether a veteran can choose to go to the VA or a community care provider to begin with. **H.R. 71, the Veterans Health Care Freedom Act**, sponsored by Rep. Andy Biggs, would create a "full choice" pilot program, allowing veterans to seek either VHA or community care without VA preapproval over a three-year trial in at least four VISNs.²³ This legislation would give veterans' health benefits the same user-friendliness veterans enjoy in other contexts like the VA Home Loan or GI Bill, where their choice as consumers comes first.

Conclusion: Embrace What Works

Protecting and expanding community care options is not about "privatizing" or otherwise eliminating the VA that so many veterans appreciate. It's about treating veterans like adults and

¹⁹ "Referral Coordination Initiative Implementation Guidebook," Veterans Health Administration, *Department of Veterans Affairs*, March 10, 2021. <https://americansforprosperity.org/wp-content/uploads/2021/09/Referral-Coordination-Initiative-Guidebook.pdf#page=62>

²⁰ VA training flowcharts obtained via FOIA: https://americansforprosperity.org/wp-content/uploads/2022/01/21-06268-F-Responsive_Records_1-Part-1.pdf#page=347

²¹ Jill Castellano, "The Mission Act is supposed to help US veterans get health care outside the VA. For some, it's not working," *USA Today*, November 1, 2021. <https://www.usatoday.com/in-depth/news/investigations/2021/11/01/mission-act-aid-veterans-healthcare-va-isnt-letting-1/8561618002/>

²² For example, the VA's internal community guidebook, obtained via FOIA, included directives such as "For Veterans with a Return to Clinic order with CID greater than 20/28 days, the wait time standard is considered waived." This guidance is in direct contravention to MISSION Act eligibility access standards, under which only a veteran can waive community care wait time standards. "Office of Community Care Field Guidebook," Veterans Health Administration, *Department of Veterans Affairs*, August 21, 2021. https://americansforprosperity.org/wp-content/uploads/2022/01/21-06268-F-Responsive_Records_1-Part-1.pdf#page=198

²³ "Blackburn, Colleagues, Introduce Veterans Health Care Freedom Act," Senator Marsha Blackburn, January 24, 2025. <https://www.blackburn.senate.gov/2025/1/issues/veterans/blackburn-colleagues-introduce-veterans-health-care-freedom-act>

giving them the same options policymakers extend them elsewhere. When veterans are able to choose the care that best meets their needs, as military retirees can, they are more able to live fuller lives and pursue their goals, benefitting American communities through their leadership in the process. Congress and the Department of Veterans Affairs should protect and expand our veterans' treatment options, putting them in their health care driver's seat.

Sincerely,

A handwritten signature in blue ink that reads "John Vick". The signature is written in a cursive, flowing style.

John Vick
Executive Director
Concerned Veterans for America
JVick@cv4a.org

Prepared Statement of Rachel Madley

Testimony for the Record
Submitted to the
U.S. House of Representatives Committee on Veterans Affairs
for the Hearing
**“Community Care Network Next Generation: One Trillion Dollars of
Oversight.”**
January 22, 2026
Rachel Madley, PhD
Executive Director, Center for Health and Democracy

The Veterans Community Care Program (VCCP) and the proposed expanded Community Care Network (CCN) Next Generation represent a shift of funding from direct care provided by Veterans Health Administration (VHA) clinicians to care in the private sector that results in worse or no better patient outcomes at higher costs, partially due to the actions of the private insurance companies chosen as stewards of the program.

The proposed expansion of the use of private medical care for veterans poses a serious risk to their health and the financial well-being of the VHA. The accelerating shift from public sector care delivered at the VHA to care in private facilities is based on assumptions not supported by the evidence that the private health care sector, specifically private insurers, can provide better care more efficiently than the public sector and that private companies chosen as contractors for the VCCP will prioritize veterans over the desire of their shareholders to increase profits.

This mirrors the trend in other federal health care programs where taxpayer dollars are paid to private corporations to administer these previously trusted public health programs. The results have included decreased trust in public health programs, poor patient experiences, and increased profit for private corporations. Instead of increasing funding for private contractors and care, the Department of Veterans Affairs (VA) should invest in expanding VHA facilities, hiring more staff, and utilizing the traditional Medicare program to process the small amount of claims for veterans who need highly specialized care only found in the private sector.

How the VCCP currently operates

The current VCCP was authorized and established by the VA MISSION Act, which was passed by Congress in 2018. Prior to this, the VHA was in the midst of both increasing veterans' access to care outside the VA and increasing their capacity for direct care through hiring more medical staff under the Choice Act.¹ After passage of the VA MISSION Act, the VHA contracted with TriWest Healthcare Alliance and OptumServe to develop networks of providers outside the VA that veterans could see and to process claims and payments to those providers. The VA has released a Request for Proposals for prospective contractors for the next iteration of the VCCP called the CCN Next Generation. These contracts represent an expansion of the VCCP with a total cost of up to \$1 trillion dollars over the next ten years. The continuation and expansion of the VCCP is predicated on the assumptions that the private sector provides better medical care than the public sector and that the private sector provides care more efficiently than the public sector.

¹Congressional Budget Office, "Funding for Department of Veterans Affairs Health Care," December 2023, https://www.cbo.gov/publication/57583#_idTextAnchor003.

Private contractors have financial incentives that conflict with the goal of high quality care for lower costs when administering public health programs

The performance record of private companies administering the VCCP demonstrates concerning profit-maximization practices that pose financial risks to the VA and taxpayers. A prominent example of such behavior was identified by the VA Office of Inspector General (OIG) in its February 2025 report, which found that OptumServe and TriWest billed the VHA nearly \$1 billion more for dental services delivered by community care providers between FY2020 and May 2024 than they reimbursed the providers. Specifically, when a veteran received dental care from a CCN provider, OptumServe or TriWest charged the VHA in excess of the reimbursement paid to the provider and retained the difference. Although this overbilling was enabled by a contractual gap that did not explicitly prohibit charging the VHA more than the amount reimbursed to providers, this raises concerns about whether contractor motivations align with VA's mission in a public-private partnership.

In another example of profit maximization behavior by private companies involved in the VA and other federal health programs, Medicare Advantage (MA) plans that enroll veterans collect the full capitated payment from the government for the expected medical costs of that enrollee. However, veterans eligible for care at the VA rarely or never use any Medicare services. Companies administering MA plans not only fail to report this trend to the government, they have begun actively advertising their plans to veterans. In 2023, there were nearly 200 veteran MA affinity plans, many of which exclude prescription drug coverage, which experts conclude is to specifically attract veterans who use VHA care.² This results in immense wasteful spending with the federal government paying over \$1.3 billion in 2020 to private insurers running MA plans for VHA enrollees who did not use any Medicare services in that year.³ In the context of VCCP contractors, UnitedHealth Group, the parent company of VCCP contractor OptumServe and MA provider UnitedHealthcare is duplicatively billing the government by requiring payment for a VHA enrollee who has a United MA plan and uses VCCP. Not only is this extracting additional revenue from the government, it raises serious questions about alignment with the VA's interests and stewardship of taxpayer dollars.

Unfortunately, this profit maximization behavior appears in other federal health programs, such as MA. Multiple independent researchers and government organizations, including the Committee for a Responsible Federal Budget and the Medicare Payment Advisory Commission, have identified that insurance corporations running MA plans receive roughly \$84 billion in overpayments every year.^{4,5} These excessive payments result from well-documented financial

²Susan H. Busch et al., "Medicare Advantage Plans That Target Veterans," JAMA Health Forum, 2024, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831837>.

³Richard G. Frank et al., "Medicare Advantage and VA Enrollees' Use of Services," Health Affairs, 2024, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00302>.

⁴Committee for a Responsible Federal Budget, "Medicare Advantage Will Be Overpaid by \$1.2 Trillion," 2024, <https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion>.

⁵Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2025,

behaviors like upcoding, or adding more diagnosis codes to an enrollee's chart to make them appear sicker thus garnering a higher payment from the government, and favorable selection, or the enrollment of healthier people into MA plans due to obstacles to care in those plans. Private insurers have built extensive tools to capture as much money from the government as possible in the MA program including data mining and chart reviews to find diagnoses doctors did not make for a patient, sending providers to seniors' homes to ask questions and uncover new diagnoses (which the seniors are then never treated for), and paying physicians to add more codes to charts.⁶

In MA, companies administering the plans have erected barriers to care to aid in maximizing their revenue and profits. The most frequent obstacle is prior authorization, in which insurers require a request to be submitted to them, reviewed by insurance employees, and approved before certain services prescribed by the patient's provider are delivered. Differences in prior authorization requirements further illustrate how financial incentives shape program design. In traditional Medicare, which has no profit motive, 52 outpatient medical services and durable medical equipment products require prior authorization and the decisions made on these authorization requests are more than 98 percent accurate.^{7,8} In contrast, MA plans require prior authorization for hundreds, sometimes over one thousand medical services and tests, and over 80 percent of the decisions MA plans make are overturned once appealed.⁹ As prior authorization has become an obstacle for needed care, many patients and providers have called on insurance companies to remove this barrier. However, prior authorizations are a profit maximization behavior, and companies have not stopped it. In fact, in 2022 CVS "'de-prioritized' a plan to reduce the overall volume of prior authorizations, concluding that the impact on lost savings to the company was 'too large to move forward.'"¹⁰

Finally, private companies that receive federal and state tax dollars for Affordable Care Act (ACA) premium subsidies and to administer Medicare, Medicaid, and VHA have recently raised their premiums and often push for higher payment from the government citing increased medical costs. At the same time, these companies spend billions of dollars on repurchasing stock, which enriches shareholders and increases executive compensation packages. Specifically, the seven largest for-profit insurers, including UnitedHealth Group which owns VCCP contractor

⁶https://www.medpac.gov/wp-content/uploads/2025/03/March_2025_MedPAC_Report_Press_Release_SEC.pdf.

⁷Charles E. Grassley, "How UnitedHealth Group Puts the Risk in Medicare Advantage Risk Adjustment," January 2026, <https://www.grassley.senate.gov/news/news-releases/grassley-report-details-unitedhealths-record-of-appearing-to-game-the-medicare-advantage-system-turning-risk-adjustment-into-its-own-business>

⁸Centers for Medicare & Medicaid Services, "Outpatient Department Services That Require Prior Authorization," 2023, <https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf>.

⁹Centers for Medicare & Medicaid Services, "Pre-Claim Review Program Statistics FY 2023," 2023, <https://www.cms.gov/files/document/pre-claim-review-program-statistics-document-fy-23.pdf>.

¹⁰Meredith Freed et al., "Nearly 50 Million Prior Authorization Requests Were Sent to Medicare Advantage Insurers in 2023," KFF, 2024, <https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-jn-2023/>.

¹¹U.S. Senate Permanent Subcommittee on Investigations, "Medicare Advantage Prior Authorization and Denials," Majority Staff Report, October 17, 2024, <https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf>.

OptumServe, spent \$146 billion repurchasing their own stock from 2014-2024 while raising ACA plan premiums by almost 100% during that time.¹¹

Evidence does not show superior care in the private sector compared to the VA

Medical care provided by the VA results in better patient outcomes in many situations compared to care received at private facilities and hospitals. For example, a peer-reviewed medical research paper found a 46% reduction in 28-day mortality for senior veterans experiencing medical emergencies who were treated at VA medical centers compared to those treated at private medical facilities.¹² Another study showed that veterans in the intensive care unit (ICU) at VA medical centers had lower rates of mortality than veterans in the ICU at hospitals in the CCN.¹³ In surgical settings, researchers found that patients undergoing surgery at VA medical centers had a 40% lower adjusted risk of mortality than in the private sector.¹⁴ There are many other studies that find similar trends when comparing VA care to private sector care.

The VA Health Systems Research and Development Service (HSRD) maintains a systemic review of VA versus non-VA Quality of Care, which is updated periodically and takes into account all relevant studies comparing VA and private sector care. In the last public update in October 2024, the VA found that “most published studies of comparisons of quality of care show that veterans getting care from VA get the same or better quality care than veterans getting community care or the general public getting non-VA care.” Additionally, the VA researchers state that they “did not identify any study that found that patient experience was better in community care.”¹⁵ Additionally, many providers such as mental health providers are not trained and do not have military cultural competency to provide the mental health care that many veterans need.¹⁶

In addition to worse patient outcomes in many situations, the VCCP exhibited issues maintaining adequate CCNs for veterans to get the care they needed. In 2024, the OIG determined that the two VCCP contractors, OptumServe and TriWest, failed to maintain adequate provider networks to meet veterans’ community care needs. The OIG could only verify that OptumServe and TriWest had substantively discussed CCN network adequacy requirements, as was required by their contracts, with three of the 172 VA medical centers nationwide. Moreover, VA facility staff

¹¹ Healthcare Uncovered, “Where Do Our Health Insurance Premiums Really Go?” 2024,

<https://healthcareuncovered.substack.com/p/where-do-our-health-insurance-premiums>.

¹² David C. Chan et al., “Outcomes for Veterans Treated in VA Versus Non-VA Hospitals,” *Journal of General Internal Medicine*, 2024, <https://pmc.ncbi.nlm.nih.gov/articles/PMC11735001/>.

¹³ JAMA Health Forum, “ICU Outcomes at VA and Community Hospitals,” 2024,

<https://jamanetwork.com/journals/jama-health-forum/fullarticle/2842406>

¹⁴ JAMA Surgery, “Surgical Outcomes in VA vs Private Sector,” 2022,

<https://jamanetwork.com/journals/jamasurgery/fullarticle/2787614>.

¹⁵ VA Health Services Research & Development, “Systematic Review of VA Versus Non-VA Quality of Care,” October 2024,

<https://www.hsrd.research.va.gov/publications/esp/quality-of-care-review.pdf>.

¹⁶ Rajeev Ramchand et al., “Mental Health Care for Veterans: Barriers and Cultural Competence,” RAND Corporation, 2015,

https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR806/RAND_RR806.pdf.

reported that many providers listed in the CCN database were not, in practice, accepting VA patients. These deficiencies persisted despite contractual requirements obligating OptumServe and TriWest to “always maintain a network of providers and practitioners that will extend across the entirety of each CCN region and must always be sufficient in numbers and types of providers.” VHA facility leadership and staff further reported that OptumServe and TriWest frequently denied requests to expand network capacity, asserting that sufficient access already existed; assertions based on inaccurate provider network data that the contractors had not corrected.¹⁷

As a larger shift from veterans receiving direct care at the VA to care in the private sector is being proposed, it is imperative to consider the wealth of research that demonstrates that at best, patient care is equivalent in the private sector and at worst, patient outcomes are significantly worse in the private sector than the VA. Further, it is imperative to review the performance of the first iteration of VCCP contracts in which the contractors failed to maintain adequate provider networks for veterans.

Evidence suggests that the VA and other public programs administer care more efficiently than the private sector

Misconceptions about the efficiency of the public sector, specifically when dealing with health care, have led many to believe that the private sector provides and administers health care with greater efficiency compared to the public sector, when the opposite is true. Within the VA, there is ample evidence that VA medical centers provide more efficient care than private facilities. One of the most important considerations when proposing an expansion of veterans using private providers is the comparison of wait times for appointments in the VA versus private providers. Research funded by the VA HRSD found that when looking at wait times at the Veterans Integrated Service Network (VISN) level, wait times were shorter for VA than for community care.¹⁸ Another study comparing wait times in the VA versus the VCCP for cardiology, gastroenterology, orthopedics, and urology, high volume services for the VCCP, found that mean wait times for appointments at the VA were lower than those for appointments with community providers.¹⁹

When examining the value of care provided at VA medical centers compared to CCN providers, private providers are more frequently providing both low-value and more expensive care, specifically, when treating “clinically insignificant” low-risk prostate cancer. Medical organization guidelines advise treating this diagnosis with attentive surveillance rather than

¹⁷Department of Veterans Affairs, Office of Inspector General, “Provider Network Deficiencies in the Veterans Community Care Program,” Report 23-00876-74, April 2024, <https://www.vaogig.gov/sites/default/files/reports/2024-04/vaogig-23-00876-74.pdf>.

¹⁸VA HRSD, “Wait Times for New Patient Appointments in VA Versus Community Care,” HRSD Publication Brief, 2024, <https://www.hrsd.research.va.gov/research/citations/pubbriefs/articles.cfm?RecordID=1183>.

¹⁹Michael J. O’Shea et al., “Comparison of Wait Times in VA and Community Care,” JAMA Network Open, 2020, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769826>.

aggressive treatments such as surgery. Researchers found that CCN providers were twice as likely to treat these patients with unnecessary and risky surgeries for their cancer than providers at the VA. Providers at the VA pursued the lower-cost, higher-value treatment plan of active surveillance.²⁰ Similarly, another study found that treatment costs over 28 days for senior veterans treated at a VA medical center during an emergency were 21% lower than for veterans treated in private facilities.²¹ In addition, veterans treated at VA facilities were more likely to receive low cost follow-up treatment such as phone calls.

The VA operates with lower administrative overhead than the private health care sector. Data analysis demonstrated that the VHA staff includes significantly less employees in administrative roles compared to the private health care sector. If the private sector were able to use the same efficient staffing pattern as the VHA, there would be nearly one million fewer administrative personnel needed, which would significantly reduce overhead costs.²² This increased efficiency compared to private health care is also seen in Medicare with the administrative costs for traditional Medicare ten times lower than those for private health insurance.²³ The ability of the VA to provide care to veterans quicker and at a lower cost is an important consideration when debating expanding veterans' use of private sector care.

Increasing funding for the VCCP decreases funding for the VHA which provides crucial support to the U.S. health care system

The proposed increase in funding for care in the private sector was paired with a proposed 17.4% decrease in the budget for direct medical care at the VHA. This defunding of the VHA will have effects far beyond care for veterans. The VHA provides immense structural support to the U.S. health care system that often goes unnoticed. Part of the VA's mission, known as the fourth mission is to "improve the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts." During the COVID-19 pandemic, the VA fulfilled this fourth mission by providing over 1 million pieces of personal protective equipment, caring for over 600 non-veteran patients, and sending personnel to over 50 states and territories.²⁴ Reducing funding for the VHA will reduce their capacity to serve as the backstop for the U.S. health care system and ensure the health of all Americans during times of crisis.

²⁰JAMA Network Open, "Management of Low-Risk Prostate Cancer in VA and Community Care," 2023, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810875>.

²¹See note 12 above

²²JAMA Network Open, "Administrative Staffing in VA Versus Private Sector Health Systems," 2024, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814055>.

²³Karen Davis and Amber Willink, "Comparing Apples with Oranges: Administrative Expenses in Medicare Systems," American Journal of Managed Care, 2017,

<https://www.ajmc.com/view/comparing-apples-with-oranges-administrative-expenses-and-finances-in-medicare-systems>.

²⁴Department of Veterans Affairs, "VA's Fourth Mission and COVID-19 Response," 2020, <https://www.va.gov/health/coronavirus/statesupport.asp>.

Another core mission of the VA is to educate medical professionals. The VA has trained almost 70% of physicians in the U.S. at one of their medical centers or clinics. Each year, the VA trains over 120,000 physicians, nurses, psychologists, dentists and other health professionals making it the largest trainer of health care professionals in the country.²⁵ As shortages of health care professionals plague the country, decreasing funding for the largest trainer of medical professionals would greatly exacerbate the shortage.

The VA is also a major medical research hub making discoveries and developments that benefit veterans and the general public. The first laboratory to study cancer tumors was at the Hines VA Hospital in 1932. A VA researcher at the Los Angeles VA Medical Center built the prototype for what would become the CT scanner, a core diagnostic tool in modern medicine. The first successful liver transplant was performed in 1967 at the Denver VA Medical Center. The Million Veterans Program is run by the VA which uses blood samples to examine how health and wellness for veterans is affected by genetics, lifestyle, and military experiences.²⁶ These examples only scratch the surface of the significant research that the VA has done. This research capacity would be in jeopardy with decreased funding for medical care.

Expanding the VCCP with CCN Next Generation without changes scales known failures in the system

The proposed contracts of up to \$1 trillion for the CCN Next Generation initiative run the risk of replicating and amplifying the inefficiencies and poor performance of the private sector outlined above. Specifically, expanding the amount of care veterans get from private providers could decrease quality and outcomes those veterans have based on the research demonstrating that the VA provides higher quality care and better outcomes. Additionally, as funding is increased for VCCP, funding for direct care is decreased which will inhibit the ability for veterans to get the higher quality care offered by the VA.

Increasing the amount of care the veterans get in the private sector will also increase their wait times for appointments, as is demonstrated by studies that found longer wait times for primary and specialty care providers in private facilities compared to the VA. The increased funding for VCCP will not act to lower wait times for veterans in the private sector because the funding from VCCP is very small relative to the size of the private health care market. However, if the money from VCCP were reinvested into increasing VHA's direct care capacity, it would have a much larger impact in decreasing the already shorter VA wait times.

²⁵Department of Veterans Affairs, "VA Medical School Partnerships Benefit Veterans," 2019, <https://news.va.gov/56543/va-medical-school-partnerships-benefit-veterans/>.

²⁶Department of Veterans Affairs, "The Million Veteran Program," 2024, <https://new.express.adobe.com/webpage/D/1t5eyV68Njow>.

Initiating new contracts with private companies to administer the VCCP before identifying how to prevent the profit maximizing pattern of behaviors that those companies have exhibited in the first round of VCCP contracts, as well as in other federal health care programs, poses the risk of more tax dollars being misused by these contractors. Though it is unrealistic to expect zero tax dollars will be misused in contracting relationships, it is reasonable to attempt to remove any possibility of that happening and the proposed CCN Next Generation initiative leaves the door wide open for gaming and misuse of taxpayer dollars.

The safeguards against contractor bad actions in the current documents supporting the CCN Next Generation request for proposals do not adequately safeguard the VHA. For example, the contracts require contractors to report suspected conflicts of interest. However, as insurance companies more frequently consolidate with medical providers, there is an inherent conflict of interest created when asking a prospective contractor to create a provider network that serves the needs of the veterans and schedule appointments with private providers. In this case, an insurer that is the contractor for this program would likely be creating a network from providers they own and do not own and also scheduling patients with providers they own and do not own. This creates the potential for steering veterans to providers that the contractor owns, rather than the best provider for them. This differential treatment of affiliated providers and non-affiliated providers has already been uncovered in the commercial market.²⁷ This issue could get a foothold in the VCCP based on the current request for proposals, and potentially already has since OptumServe, a current VCCP contractor owns significant medical providers and has a record treating affiliated providers differently than non-affiliated providers.²⁸

In addition to amplifying existing problems with the VCCP contractors, the proposal for CCN Next Generation will import new problems from the current Medicare and MA programs into VCCP. In the attachments in the RFP labeled “Attachment 1 - CCN Next Gen - Medical East TOPR PWS” and “Attachment 1 - CCN Next Gen - Medical West TOPR PWS” the VA describes requirements for contractors in CCN Next Generation to implement four “value based care” models, including the lower extremity joint replacement (LEJR) advanced payment model.²⁹ Value based care models have the potential to provide promising results, if conducted under the right conditions, including operating in a not-for-profit health care system and being fully provider led. Under the wrong circumstances, these models can lead to rationing care and profiteering. The VCCP contractors required to implement value based care models, who are likely to be private corporations, will be operating with opposing objectives to 1) increase profits for shareholders, and often secondary to that objective 2) provide quality care at lower costs.

²⁷Erin C. Fuse Brown et al., “Differential Treatment of Affiliated and Non-Affiliated Providers,” *Health Affairs*, 2025, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155>.

²⁸Ibid.

²⁹Department of Veterans Affairs, “CCN Next Generation Request for Proposals,” SAM.gov, 2025, <https://sam.gov/workspace/contract/opp/7b2734002e4048bfa2ac4cc5b0479930/view>.

Most value based care models have failed to save money and the most prominent, the Medicare Shared Savings Program (MSSP) led to an increase in government spending.^{30,31}

Aside from failing to save money, value based care models often include capitated payments, or lump sum payments for all the care a person may need in a definite time frame or for a particular condition. Research shows that capitated payments in these settings can lead to rationing of needed medical care. For example, in primary care, full capitation of payments for a patient can lead to rationing of care for preventive services.³² Rationing of care is also a risk in capitation payments for specific conditions or procedures, like the proposed VCCP LEJR model, potentially leading to providing less care or avoiding caring for sicker patients in the absence of risk scoring, which has its own flaws.³³ Finally, in the MA program where insurers are paid a lump sum for all care an enrollee may need in a year, care is rationed by limiting the providers patients can see and delaying and denying needed medical care.^{34,35} Introducing value based care models with capitation, like the LEJR model, without addressing the trend of care rationing in these models poses immense risk to the health of veterans across the country.

Many value based care models utilize risk adjustment, including the LEJR model that the request for proposals requires contractors to implement in VCCP. Risk adjustment works by assigning a risk score to each patient based on their health status and then adjusting the payment made to contractors based on that risk score. For example, a person with average health would receive a risk score of 1. A person who has a chronic illness would be assigned a higher risk score, say 1.2. The payment a contractor receives for this patient would be the baseline price multiplied by 1.2, resulting in a 20 percent increase in payment. This method, required by the LEJR model and many other value based care models, replicates the risk scoring from the MA program and imports it into the VCCP. This is an alarming development seeing as risk scoring in MA has been manipulated by private companies to extract taxpayer dollars they did not earn. This manipulation of the risk scoring system in MA is projected to cost the federal government an extra \$600 billion from 2025-2034.³⁶ Replicating this broken risk scoring system in the VCCP poses an existential risk to the fiscal solvency of the VHA. Further, the document titled

³⁰Health Affairs Forefront, "All Do Win? Why Beating Benchmarks Doesn't Mean ACOs Are Reducing Costs," 2023, <https://www.healthaffairs.org/content/forefront/all-do-win-why-beating-benchmarks-doesnt-mean-acos-reducing-costs>,
³¹JAMA Health Forum, "Performance of Accountable Care Organizations in the Medicare Shared Savings Program," 2024, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812611>.

³²Urban Institute, "Primary Care Capitation: Payment Reform in Primary Care," 2016, https://www.urban.org/sites/default/files/2016/06/13/02_primary_care_capitation_2.pdf.

³³Urban Institute, "Bundled Episode Payments in Health Care," 2016, https://www.urban.org/sites/default/files/2016/05/03/06_bundled_episode_payments.pdf.

³⁴KFF, "Medicare Advantage Enrollees' Access to Physicians," 2023, <https://www.kff.org/medicare/medicare-advantage-enrollees-have-access-to-about-half-of-the-physicians-available-to-traditional-medicare-beneficiaries/>.

³⁵Office of Inspector General, HHS, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns," 2022, <https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/>.

³⁶Committee for a Responsible Federal Budget, "Medicare Advantage Will Be Overpaid by \$1.2 Trillion," 2024, <https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion>.

“Attachment W Lower Extremity Joint Replacement LEJR Bundled Payment Model” states that in the LEJR model “participating providers may earn up to 50% of the total savings pool generated when actual episode costs fall below the risk adjusted episode costs” creating a major incentive to ration care and increase risk scores to increase savings.

CCN Next Generation reflects broader trends toward privatized administration of public health programs

The increasing amount of tax dollars and patient care being outsourced from the VHA to the private sector mirrors a larger trend in public health programs. Enrollment in private MA plans has grown from 19% of Medicare beneficiaries in 2007 to 54% in 2025.³⁷ Additionally, the Center for Medicare and Medicaid Innovation recently announced the Wasteful and Inappropriate Service Reduction (WiSeR) Model which will contract with private companies currently involved in administering prior authorization in MA plans to expand prior authorization in traditional Medicare.³⁸ Finally, over recent decades, many states have contracted with private insurers to manage their Medicaid programs. Research found that using private companies to administer the Medicaid program rather than their governments costs the federal government and state governments a total of \$77 billion in 2023.³⁹ The rapidly spreading pattern of outsourcing federal health programs to private companies comes with the promise of better care and lower costs. However, in reality it results in higher costs, worse care, and taxpayer-funded profits for corporations.

Policy recommendations

Re-invest the money proposed for CCN Next Generation into expanding the VHA’s capacity

The original goal of the VCCP, to increase access and decrease travel and wait times for veterans, is more easily attainable through other means than spending \$1 trillion on private contractors. Instead of \$1 trillion for VCCP, the VA should invest most of that money into expanding the capacity of the VHA by building more VA medical centers and hiring more medical staff. To put into perspective the magnitude of money being shifted from the VHA to these private contractors, take the fact that the amount of money set aside for the VCCP could fund the building of roughly 500 new VA medical centers.⁴⁰ VHA does not need that many new medical centers. However, I recommend a bold goal of doubling the number of VA medical

³⁷KFF, “Medicare Advantage Enrollment Update and Key Trends,” 2025,

<https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/>.

³⁸Centers for Medicare & Medicaid Services, “Wasteful and Inappropriate Service Reduction (WiSeR) Model,” 2024,

<https://www.cms.gov/priorities/innovation/innovation-models/wiser>.

³⁹Physicians for a National Health Program, “The Medicaid Managed Care Privatization Blueprint,” 2025,

<https://pnhp.org/system/assets/uploads/2025/00/MedicaidBlueprintFinal.pdf>.

⁴⁰Healthcare Facilities Today, “New VA Center Is One of World’s Most Expensive,” 2022,

<https://www.healthcarefaciliestoday.com/posts/New-VA-Center-Is-One-of-Worlds-Most-Expensive--26631>.

centers over the next ten years and modernizing the existing VA buildings which would leave roughly \$600 billion from the original funding for hiring additional medical staff and for any care veterans need to receive in the community because it is truly specialized or they live in a particularly remote area. Reinvesting money into expanding the capacity of the VHA has provided positive results. For example, researchers found that access to VA care increased from 2014 to 2017 and surpassed access in private facilities in three out of four specialties studied.⁴¹ During the same time period, Congress had appropriated \$5 billion for the VHA to expand capacity and hire more staff.⁴² Investing in the VHA has shown proven results and should be continued.

Use traditional Medicare to process claims for veterans who need care in the private sector

Veterans will likely continue to need specialized care in certain situations, just as some complex diseases in those with private insurance require specialized care. The VCCP should address this need while also safeguarding veterans and taxpayer dollars by using the traditional Medicare infrastructure to administer the VCCP. Rather than utilizing private contractors with demonstrated histories of being poor stewards of the well-being of patients and funding, the VHA should enable all veterans who receive a referral from the VHA to see any provider who accepts Medicare. That provider would then send the claim to Medicare which would pay it and then request reimbursement from the VHA. This policy would capitalize on the efficient, proven structure of the Medicare program. Additionally, the VCCP bases many of its payments to providers on Medicare rates so it would not require increased reimbursements to physicians and would decrease the overhead spending from private contractors. Finally, Medicare is trusted and viewed favorably by 94% of enrollees suggesting that veterans would have positive experiences under this administration of community care.⁴³

⁴¹Michael J. O'Shea et al., "Appointment Wait Times for Specialty Care in the Veterans Health Administration and the Private Sector," JAMA Network Open, 2019,

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917>.

⁴²Congressional Budget Office, "Funding for Department of Veterans Affairs Health Care," 2018,

https://www.cbo.gov/publication/57583#_idTextAnchor003.

⁴³KFF, "Public Attitudes Toward Medicare and Medicaid," 2025,

<https://www.kff.org/health-costs/kff-health-tracking-poll-public-weighs-health-care-spending-and-other-priorities-for-incoming-administration/>.

STATEMENTS FOR THE RECORD

Letter to Douglas Collins from Maxine Dexter

Congress of the United States

Washington, DC 20515

September 22, 2025

The Honorable Douglas Collins
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary Collins:

As members of Congress committed to strengthening veterans' access to high-quality, timely, and coordinated healthcare, we write to urge the Department of Veterans Affairs (VA) to take immediate action to improve transparency and support informed decision-making within VA's community care program.

Under current law, veterans must be offered referrals to community care when VA is unable to meet designated access standards. These include a maximum wait time of 20 days for primary or mental healthcare and 28 days for specialty care and drive time thresholds of 30 minutes for primary or mental healthcare and 60 minutes for specialty care. While these benchmarks are well-intentioned, they do not work in the absence of meaningful, comparative data.

In December 2022, Congress required VA to develop a plan to ensure veterans are informed of expected wait times at VA and in the community. Although VA has issued quarterly reports on its progress towards implementing that plan, VA seems to be no closer to achieving the goal of providing veterans with meaningful, comparative data now than it was in 2022. As a result, veterans continue to accept community referrals without knowing whether they will receive care sooner—or whether their travel burden will be reduced—compared to staying within the VA system. This lack of transparency limits veterans' ability to make fully informed decisions and, in some cases, leads to harmful delays in care.

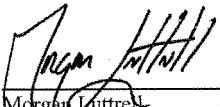
VA has the authority to address this gap through administrative action. Therefore, we respectfully request VA immediately establish an interactive, online self-service platform that allows veterans to compare average wait times and drive times for VA care to average wait times and drive times in the community. Making this information easily accessible to patients is a critical step toward delivering the patient-centered care our veterans deserve.

Thank you for your dedication to those who have served. We look forward to working together to improve access to care for our nation's veterans.

Sincerely,



Maxine Dexter
Member of Congress



Morgan Luttrell
Member of Congress

Questions for the Record Submitted by Abe Hamadeh

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 DEMOCRATIC STAFF DIRECTOR

February 2, 2026

The Honorable Douglas A. Collins
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Mr. Secretary:

Thank you for providing witnesses for the House Committee on Veterans' Affairs Oversight hearing titled, "Community Care Network Next Generation: One Trillion Dollars of Oversight" that was held on January 22, 2026.

As a follow-up to the hearing, Representative Abe Hamadeh has requested Mr. Richard Toppings, Assistant Secretary for Management and Chief Financial Officer, respond to the attached questions for the record.

The Committee requests a written response no later than February 26, 2026, so they may be made part of the record. If you have any questions, please let my staff know.

Sincerely,



MIKE BOST
 Chairman
 House Committee on Veterans' Affairs

Cc: The Honorable Mark Takano, Ranking Member, House Committee on Veterans' Affairs

Enclosures: Questions for the Record submitted by Rep. Abe Hamadeh

Committee on House Veterans Affairs
Full Committee Oversight Hearing
January 22nd, 2026

Questions for the Record for "Veterans Community Care Network Request for Proposals"

Submitted by Rep. HAMADEH

Questions for Mr. Richard F. Topping (Assistant Secretary for Management and Chief Financial Officer, U.S. Department of Veterans Affairs) and Ms. Alicia Skolrood (Executive Director, Integrated External Networks, Office of Integrated Veteran Care, Veterans Health Administration):

1. Please explain the clinical and operational difference, if any, between physical therapy covered under Medicare and medical massage therapy (MMT) provided by qualified professional massage therapists covered under VACCN.¹
2. ² Is MMT provided by qualified professional massage therapists, as defined by VA (and the SEOC), a covered benefit under Medicare?
3. Please explain whether Medicare covers and/or pays for MMT by qualified professional massage therapists under CPT 97124 and post-therapy patient education under CPT 98960.
4. Please explain whether VA covers MMT by qualified professional massage therapists under CPT 97124 and post-therapy patient education under CPT 98960. Please explain how the VA and Third-Party Administrators (TPAs) determine payment amounts for providers of MMT, including by citing specific applicable statutes, regulations, or sub regulatory materials.
 - a. Please explain, including by referencing specific applicable statutes, regulations, or sub-regulatory materials, why Medicare Multiple Procedure Payment Reduction (MPPR) rules should apply to the VACCN MMT program when Medicare does not cover MMT by qualified professional massage therapists.
 - b. Please explain why in 2024, VA added patient education CPT 98960 to its revised SEOC and code list, and published a specific payment rate under the VA fee schedule, if it believed that patient education was not separately payable.
 - c. Please explain how the VA and the TPAs determine payment amounts for MMT providers for treatment at a provider's office, provided at a veteran's home, and provided at a VAMC. Explain the rationale for any differences, or the rationale for paying the same rate if there or no differences.
5. Please identify and explain what notices, if any, the VA gave to providers or the TPAs that it intended to, or would, apply Medicare MPPR rules to MMT services and Medicare bundling rules

¹ provided by qualified professional massage therapists

²

to education services. If there was notification in writing, to either providers or the TPAs, please provide copies of the relevant documents, including if by email.

6. Please provide data showing the number of qualified professional massage therapists (MTs) by state.
 - a. When providing the data, provide the number of MTs that have left the program since June 1, 2025 and the number of MTs that have been added to the program since June 1, 2025 to determine the net number of MTs by state and by TPA to the present.
 - b. When providing the data, ensure MT numbers are distinct from any other providers under CIH[NW1.1], Whole Health, Pain Management, or any other category into which MTs are placed.
7. What data does VA have on outcomes for MMT relative to opioids, other pain medications, ablations, spinal blocks, and other treatments?
8. One of the flexibilities granted during COVID was allowing the third-party administrators to schedule appointments directly with the veteran, upon them receiving a referral to community care.
9. There has been significant discussion regarding medical massage therapists (MMT) reimbursement rates. For example, many community massage therapists have advocated for the VA to maintain or increase payment rates, arguing that current Medicare-based fee schedules are too low for private practices to sustain.

What efforts has the VA taken to resolve a disconnect between VA policy and VA payment regarding MMT provided under the Veterans Community Care Network (VCCN) program?

Specifically, could you explain the application of Medicare reimbursement reduction policies, also known as the MPPR?
10. Under President Biden, President Trump's 2018 bipartisan MISSION Act was routinely violated. Mr. Chair, at this time I ask Unanimous Consent to insert [QUOTE] The Most Alarming Aspects of VA Document Review Staff Memo into the hearing record. [Chair: Without Objection]

Given the deliberate undermining of the MISSION Act during the Biden administration, how has the Administration overcome these obstacles given the mess you inherited?