NON-VA CARE: AN INTEGRATED SOLUTION FOR VETERAN ACCESS

HEARING

BEFORE THE

OF THE

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

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CONTENTS

NON-VA CARE: AN INTEGRATED SOLUTION FOR VETERAN ACCESS

Thursday, June 18, 2014

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

The committee met, pursuant to notice, at 9:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

NON–VA CARE: AN INTEGRATED
SOLUTION FOR VETERAN ACCESS
Wednesday, June 18, 2014
House of Representatives
Committee on Veterans' Affairs
Washington, D.C.

The committee met, pursuant to notice, at 10:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller
[chairman of the committee] presiding.
Present:Representatives Miller, Lamborn, Bilirakis,
Roe, Flores, Denham, Runyan, Benishek, Huelskamp, Coffman,
Wenstrup, Jolly, Michaud, Brown, Takano, Brownley, Titus,
Kirkpatrick, Ruiz, McLeod, Kuster, O'Rourke, and Walz.

The *Chairman.* Good morning, the committee will come to order. Welcome to today's full committee oversight hearing Non-VA Care, an Integrated Solution for Veteran Access.

As we all know last week the Department of Veterans Affairs released the results of an internal access audit which found that more than 57,000 veterans have been waiting 90 days or more for their first VA medical appointment, and 64,000 veterans who have enrolled in the VA healthcare system over the last decade never received the appointment that they requested.

To summarize, that is 121,000 veterans who have not been provided the care they have earned and the care that they deserve.

It is unfathomable to me, and I am sure to the rest of this committee, that tens of thousands of veterans have been left without the healthcare they need for weeks, months, and in some cases years, especially considering that VA has broad, well-established, and long-standing authority to defer veterans to non-VA providers to receive needed care.

Providing our veterans with timely accessible and high quality care regardless of whether or not it is provided in a VA medical fa-

cility or through a private sector provider should be VA's ultimate goal. After all isn't non-VA care not preferable to know VA care? Particularly to a veteran who may be suffering and in pain and unable to receive an appointment with a VA provider for weeks, for months, or for even years. To me, and I know to many of our veterans as well, the answer to that question is a no-brainer to everyone but apparently the Department of Veterans Affairs.

By allowing 121,000 veterans to languish on VA waiting lists VA has made it disturbingly clear that it is unwilling to utilize existing non-VA care authority when, where, and to the extent that it should to insure access to care for veteran patients. Unfortunately thousands of veterans have paid the price. Some even have paid the price with their lives.

We cannot, and beginning now, we will not allow VA to continue to prioritize what may be right for the VA healthcare system, providing care to veterans at VA facilities first and foremost over what is being right for our veterans, and that is receiving timely access to needed healthcare in the most convenient an accessible manner possible.

To be clear, I am in no way advocating for the dismantling of the VA healthcare system as some know it today.

As one of our witnesses, Health Net federal services says in their testimony this morning, "The purpose of non-VA care is to augment VA capacity and capabilities, not to replace them; however, excuses, generalities can no longer be considered as sufficient reason not to provide a veteran waiting for a VA appointment or residing far from a VA medical facility with an authorization to receive care from a non-VA provider should that veteran choose to do so."

Faced with this crisis the simple fact of life is that giving access to non-VA care is quicker than hiring new VA staff and building new VA facilities. Where cultural and structural barriers prevent VA from insuring access to care for veterans through non-VA providers those barriers most be removed.

VA stove pipes must be broken and bureaucratic insularity must be banished. To do anything less would be to dishonor the service and sacrifice of our veterans yesterday, today, and tomorrow.

STATEMENT OF THE HON. JEFF MILLER, CHAIRMAN

House Committee on Veterans' Affairs
"Non-VA Care: An Integrated Solution for Veteran Access"
June 18, 2014

Good morning. The Committee will come to order.

Welcome to today's Full Committee oversight hearing, "Non-VA Care: An Integrated Solution for Veteran Access."

As we all know, last week the Department of Veterans Affairs (VA) released the results of an internal access audit, which found that more than fifty-seven thousand veterans have been waiting ninety days or more for their first VA medical appointment and sixty-four thousand veterans who have enrolled in the VA healthcare system over the last decade never received the appointment they requested.

To summarize, that is one-hundred and twenty-one thousand veterans who have not been provided the care they have earned and deserve.

It is unfathomable to me that tens of thousands of veterans have been left without the health care they need for weeks, months, and – in some cases – years.

Delays in care of this length and magnitude are particularly hard to comprehend considering that VA has broad, well-established, and long-standing authority to refer veterans to non-VA providers to receive needed care.

Providing our veterans with timely, accessible, and high-quality care – regardless of whether or not such care is provided in a VA medical facility or through a private sector provider - should be VA's ultimate goal.

After all, isn't non-VA care not preferable to no VA care at all?

Particularly to a veteran who may be suffering and in pain and unable to receive an appointment with a VA provider for weeks or months or years?

To me – and, I know, to many of our veterans as well – the answer to that question is a no-brainer to everyone but, apparently, the Department of Veterans Affairs.

By allowing one-hundred and twenty-one thousand veterans to languish on VA waiting lists, VA has made it disturbingly clear that it is unwilling to utilize existing non-VA care authority when, where, and to the extent that it should to ensure access to care for veteran patients.

Unfortunately, thousands of veterans have paid the price – some with their lives – for that unwillingness.

We cannot and, beginning now, we will not allow VA to continue to prioritize what may be right for the VA health care system – providing care to veterans at VA facilities, first and foremost – over what is be right for our veterans – receiving timely access to needed health care in the most convenient and accessible manner possible.

To be clear, I am in no way advocating for the dismantling of the VA health care system as we know it.

As one of our witnesses, Health Net Federal Services, says in their testimony this morning –

"[t]he purpose of [non-VA care] is to augment VA capacity and capabilities, not to replace them."

However, excuses and generalities can no longer be considered a sufficient reason not to provide a veteran waiting for a VA appointment or residing far from a VA medical facility with an authorization to receive care from a non-VA provider, should that veteran choose.

Faced with this crisis, the simple fact of life is that giving access to non-VA care is quicker than hiring new VA staff and building new VA facilities.

Where cultural and structural barriers prevent VA from ensuring access to care for veterans through non-VA providers, those barriers must be removed.

VA stovepipes must be broken and bureaucratic insularity must be banished.

To do anything less would be to dishonor the service and sacrifice of our veterans yesterday, today, and tomorrow.

With that I yield to the ranking member, Mr. Michaud, for any opening statement he may have.

OPENING STATEMENT OF THE HON. Mike Michaud, Ranking Member

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Non-VA care has been a priority topic of this committee for many years. Fee-based care, vouchers, contract care, and even privatizations have been discussed often. With the VA's current difficulties in providing timely access to care these discussions understandably have risen to the surface again.

We know that there are concerns with insuring VA conduct proper coordination and continuity of care with non-VA providers. I believe we need to strike a balance between access and continuity of care. Unless we and Congress are willing to write a blank check to VA we also need to be conscience of cost effectiveness. Anecdotal evidence indicate that VA managers pursue for cost savings may have overly restricted use of non-VA care. As GAO pointed out we need to insure VA is taking steps to track their cost and be a good steward of taxpayers' dollars.

Last year the VA spent almost $5 billion or approximately 10 percent of their healthcare budget to private providers; however, only half of this amount was for reimbursing emergency care. While this may be freeing up capacity in the emergency room it is not clear this is helping the access issue.

Improving access requires a multi-prong approach as the hearing title states, non-VA care must be part of an integrated solution.

In the short term we need to be part of other initiatives VA is putting in place to address the backlog, including overtime, additional clinic hours, and hiring additional providers.

We have a number of existing models at the local level that are providing good care for our veterans who for various reasons can't make it to VA facilities. In Maine many of my constituents in Aroostook County face a several hundred mile round trip drive with 600 miles round trip often through ice and snow to Togus VA Medical Center. That is why I was proud to sponsor and create the ARCH program to bring the program to the State of Maine. The program has been overwhelmingly positive. Veterans in northern Maine are receiving their care at Cary Medical Center in Caribou and I am constantly being told by my veterans that things are working out extremely well.

And I want to thank Kris Doody from Cary Medical Center for being here this morning, look forward to your testimony this morning, and it is because of that collaborative effort that you have done to make sure that our veterans get access closer to home.

The chairman's bipartisan bill H.R. 4810 covers primary care, and I was happy to support this effort to address the shortfall in VA, but we also have to look at access to specialty care. Patient Centered Community Care or PC3s was originally developed to respond to specialty consultant backlog. While the initial start was slow a steady increase in authorization noted by the witnesses today is encouraging with transparency now provided by acting secretary Gibson hopefully we will see the wait times for specialty care quickly decline. We need to insure that VA is making full use of these tools across their network.

There are many things to be considered here today, and I caution that our final solutions need to insure that reimbursement rates are adequate to sustain a robust provider network.

As I mentioned last week we all work for the veterans. Throughout these conversations we need to keep in mind the needs of those that we owe so much to. Their well meaning, the work that we do here in this committee have to keep veterans as a top priority. This is an opportunity for us really to improve access to healthcare in our veterans across the country, and I look forward to hear thing panel this morning.

With that, Mr. Chairman, I yield back the balance of my time.

The *Chairman.* Thank you very much for your comments.

Joining us on our first panel today, Mr. David McIntyre Jr., the president and chief executive officer of TriWest Healthcare Alliance, Admiral Thomas Carrato, president of Health Net Federal Services, and as had already been introduced, Ms. Kris Doody, the chief executive officer of Cary Medical Center. Thank you all for being with us today.

Mr. McIntyre, you may proceed with your statement.

STATEMENT OF DAVID J. MCINTYRE JR.

Mr. MCINTYRE. Thank you.

Mr. Chairman, Ranking Member Michaud, and distinguished members of the committee, thank you for the opportunity to appear before you this morning and discuss the critical topic of access to healthcare for our nation's veterans, and particularly the use of non-VA care as part of an integrated solution.

I would ask that my complete written statement be accepted and entered into the record.

The *Chairman.* Without objection all of your statements will be entered into the record.

Mr. MCINTYRE. Thank you, sir.

I would like to begin by acknowledging the members of the committee whose constituents were privileged to serve alone side the dedicated staff and providers of VA. We could not imagine a greater honor or privilege than the work in which we find ourselves currently engaged.

Mr. Chairman and members of the distinguished committee we had the amazing privilege of serving at the side of the Defense Department for nearly 18 years as a corporation, providing them a relief value in 16 states that was both efficient and effective in delivering the care that they were unable to deliver themselves. And now we find ourselves engaged in a similar mission at the side of the Department of Veterans Affairs in part or all of 28 states in the Pacific.

All of us associated with TriWest consider it an awesome privilege and to be engaged in this work through the VA's new program called Patient Centered Community Care, or VA PC3 for short.

Of course VA PC3 had just stood up when we all started to gain knowledge of the clusters of backlog care. I am pleased however to say that together as a team we and VA leaders from central office and the facilities in our geographic areas of responsibility are lean-

ing all the way forward at each others side to address this critical need in a collaborative and constructive fashion.

If you will permit me I would like to talk for a moment about Phoenix, Arizona as an example of what is going on.

While we are all focused on the sites across our regions of responsibility we all know of the serious issues that became public in Arizona, Phoenix in particular, a location that happens to be the hometown for the corporation that I am privileged to lead.

Mr. Chairman, when the situation in Phoenix came to light we quickly began coordinating with VA to obtain detailed information regarding the backlogs in specialty care in order to learn where we might be able to be of assistance. We did the same for the rest of the sites in our regions of responsibility.

We then took that specific information and plugged it into an analytical model that we had constructed in the days prior to analyze the backlog against the capacity of the network that we were responsible for constructing to determine by 15-day increment what we would be able to do market by market and specialty by specialty to come to the assistance of the VA.

I am pleased to say that in Phoenix, Arizona the vast majority of the backlog will be able to be handled in a two-week period of time. Of course you have got appointing on the front end, you have got a variety of other responsibilities, so our commitment to Phoenix is that within 30 days of the receipt of a need for appointment in specialty care that we will have finished the work together with the providers in the community.

That will be done properly and it will also be done at a discount against the fee structure, because the 4200 providers in Maricopa County have come to the table with that commitment.

So you will have an appointment scheduled, the medical documentation will get back from the provider and into the veterans' medical record, which is part of VA PC3, and the provider will get paid on time.

We started to receive the volume of that care coming our direction and they tell us that it will rise to 3- to 400 per day coming our direction.

We have done similar analysis market by market, and the pictures of it differ depending on the market and the saturation of networks in those particular areas.

In addition to be able to handle that demand we have increased the front line staff to be able to receive the appointment requests and be able to manage the work. We have actually tripled our staff in that category in the last several weeks. They are finishing their training now and we have 300 people on the front lines ready to receive care and the care requests going forward.

Mr. Chairman and members of the committee you should expect from all of us candor, openness, and collaboration, because this really is designed to be a team lift and to make sure that we are completing each others' sentences as we go forward and make sure that those that have served this nation get what they have earned and what they are entitled to.

It is our privilege to be here today, it is our awesome privilege and honor to do this work at the side of VA. This is a brand new program. We are tweaking and turning the pieces that need to be

turned, and we look forward to being a collaborative partner with the providers in the community, with this committee, and also with the VA to deliver on the responsibilities that this nation has to those that have sacrificed so much for our freedoms.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF DAVID J. MCINTYRE JR.

Mr. Chairman, Ranking Member Michaud, and distinguished members of the Committee, thank you very much for the opportunity to appear before you this morning to discuss the critical topic of access to health care for our nation's Veterans – and, in particular, the use of non-VA care.

Our History

For 18 years, I have had the distinct privilege of leading a company whose sole mission is standing alongside the federal government in serving the health care needs of those who served this country in uniform and their families. In 1996, a group of non-profit health plans and university health systems came together and founded TriWest Healthcare Alliance. Our initial mission was to serve the Department of Defense (DoD) in bringing up the first TRICARE contract in what were then Regions 7 and 8. And while today TRICARE is recognized as a cherished benefit for our Service members and their eligible family members, it took many years of hard work, focus, and most importantly partnership between the contractor community and DoD's health care system to mature to this point. I am proud of the role TriWest played, along with our colleagues in the contractor community, in the implementation, maturation, and improvement of that program during our years of service in support of the Defense Department. And, I am even more proud today to have the privilege of bringing that same focus and intensity to the side of the Department of Veterans Affairs (VA) through their new Patient Centered Community Care (PC3) program.

In addition, we have the privilege of serving the United States Marine Corps as the worldwide operator of the DSTRESS stress and suicide-prevention contact center and the back-up to the Sexual Assault Prevention and Response (SAPR) line. We also serve the United State Air Force by providing appointing service in three Military Treatment Facilities in the Continental United States.

Awarded PC3 Contracts for Regions 3, 5, and 6

On September 4, 2013, TriWest was awarded a contract to serve VA in implementing their brand new PC3 program. I want to say what an honor and privilege it is to be entrusted to serve alongside VA in caring for our Nation's most deserving citizens... its Veterans! Each and every member of the TriWest family feels privileged to be of service to our nation's Veterans – from the Chairman of our Board (who is the President and CEO of Blue Cross Blue Shield of Arizona) and the rest of our 11 owners, to our senior executives, to all of our employees.

Working with VA on implementing this new program is in many ways a return to our earliest days. We find ourselves partnering each and every day with a group of dedicated public servants,

working long hours to deliver the promise of access to quality health care to a deserving population. We knew standing up a new program would be challenging and consuming. But, we also knew that success in meeting the challenge meant we would have the honor of playing a part in ensuring our nation's Veterans received the care they've earned through their service and sacrifice. Because of this, we embrace the opportunity to again lean all the way forward.

Our Network, Our Focus and Our Commitment

As I just indicated, TriWest provides a diverse set of services to our military and VA clients. At our core, though, TriWest is a company that builds and maintains networks of health care providers, who agree to render care to the deserving beneficiaries we are privileged to serve at a reasonable price for the taxpayer. We then pay those providers on behalf of customers quickly and accurately while focusing intently on professional, fair dealing as the keys to maintaining that network of high quality clinicians.

Today, through the TriWest network, we provide Veterans with access to nearly 70,000 specialty providers and facilities throughout VA's Regions 3, 5, and 6 and are continuing to grow those numbers each and every day as we learn more about their health care needs. Right now, the network available in our native territory, which consists largely of the Western and Midwestern states, contain more robust availability due to how much we knew about that market and our historical presence in that area supporting the DoD. However, we have been engaging the provider community throughout the Southern and Eastern parts of the PC3 Regions for many months now and are finding providers of all types willing to come forward and serve this most deserving population. We have committed to VA that our network will be available within the access standards as well as credentialed and checked against all of VA's specialized quality requirements.

PC3: Our Tasks and Our Team

Under the terms of our contract with VA to administer the PC3 program, TriWest is responsible for:

Building a network of providers – This includes executing all contracts either in-house or in conjunction with our network subcontractors (who are indigenous to their territories of operation), verifying all licensure, certifications, and specialty designations as well as completing all credentialing work. In addition, our contract with VA contains a number of unique requirements for certain specialties and subspecialties that are needed by Veterans. It is our job to ensure those requirements are met.

Making appointments for our Veterans; ensuring they see the doctor – For each authorization TriWest receives, our staff reaches out and attempts to make contact with the Veteran to ascertain their preferred time and date of appointment. We then identify a network provider within the standards set forth in our contract and reach out to that provider and make an appointment before circling back with the Veteran to confirm. In addition, TriWest makes efforts to ascertain the Veteran's preferred communication method so that 48 hours prior to the appointment, we can send a reminder – lessening the potential for missed appointments and resulting in

the delivery of the needed care. Afterwards, we confirm that the appointment occurred.

In those instances in which we cannot reach a Veteran within three days to make an appointment, our contract requires that we make an appointment for the Veteran and send a letter to him or her with the appointment information. We have noticed a not insignificant higher percentage of missed appointments when using the letter method, and have discussed this matter with VA officials.

Following-up after appointments to retrieve medical documentation to return it to VA – Ensuring that a Veteran receives timely access to a high quality health care provider is certainly the most important element of the program. However, following the delivery of health care it is important to make sure that a report from the provider rendering the care gets returned to the Veteran's home VA facility in a timely fashion so that it may be placed in the medical record of the Veteran. And, it is our responsibility to ensure that such occurs. This helps make certain that any findings, recommended treatments, or other important clinical services can occur with full knowledge of the episode of care that occurred in the community.

Paying the providers' claims – As I mentioned earlier, TriWest knows that without our providers, we cannot deliver care through the PC3 program. We realize that sometimes the federal reimbursement rates aren't always the most attractive rate in the marketplace. However, we have learned that timely and accurate payment of claims goes a long way towards ensuring that a provider stays in the network and continues to see our deserving Veterans. Our providers are patriotic and dedicated. But, we do need to recognize their professional value by paying them on time.

To accomplish all of this work, we rely on our dedicated team who work either in our corporate headquarters in Phoenix, AZ or our call center located in Puyallup, WA. In fact, I am pleased to tell the Committee that in an effort to be certain we are ready and able to assist VA in working down their identified backlogs for care, we recently doubled our front-line staff with the hiring of 100 new employees. They will be joined by another 100 or so next week. All of them will be trained and ready to serve VA and our nation's Veterans in the very near future, giving us the ability to meet the coming demand from the clusters of backlogs across our geographic area of responsibility.

Non-VA Care and the First Five Months of PC3

Implementation work "behind the scenes"

As noted earlier, TriWest was awarded the PC3 contract on September 4, 2013 and we officially began implementation of the program on September 26, 2013. Most of the early work consisted of "behind the scenes" efforts in coordination and cooperation with VA. Under our implementation plan, we would begin direct services to Veterans in Region 5 January 2, 2014 while rolling-out services to Regions 3 and 6 on April 1, 2014.

I would like to say at this time that I regret that our implementation schedule in Region 3 needed to be pushed back from the original April 1 date to allow for a phased implementation through June 30 to allow more time to ensure that we had the right pro-

viders available to VA when authorizations for care were sent to us. We had a robust network in many places throughout the Region; however, we expected to have many more providers than we did in some of the geographically diverse places to serve VA's needs. Since that time, we have been working around the clock to sign up additional network providers. And, as we do so, we are constantly updating VA on a location-by-location and service-by-service basis so that local officials know what is available. We expect to be at or near completion of our initial building goals by July 1, 2014. And, in the midst of it all, we have now been working to address the clusters of backlogged care that have materialized . . . making the challenge a bit more complicated.

During our "behind the scenes" implementation TriWest worked simultaneously on a number of initiatives, including:

Ramping up our network building – While TriWest maintained a sizable network from our previous TRICARE work, upon award of the PC3 contract, we began in earnest the work required to amend those contracts to meet all of VA's standards.

Developing our TriWest/VA portal – This interactive portal system is used by VA employees to enter authorizations for care; track when care has been scheduled or provided; and monitor the return of medical documentation related to an appointment in the network. The portal is also used by TriWest staff to upload medical documentation in .pdf format for return to VA and also to enter Secondary Authorization Requests, which VA can then consider and approve for service in the network or appoint to its own facilities.

Developing our TriWest Provider Portal – This interactive portal allows network providers who see Veterans under the PC3 program to view authorizations; upload medical documentation; confirm appointment timeliness; and make a Secondary Authorization Request.

Standing up our contact center operations – In a short period of time we had to acquire building space, bring in Information Technology (IT) services, and hire the staff that would begin serving Veterans in Region 5 on January 2, 2014.

Training hundreds of TriWest and VA staff – The PC3 program was not only new to TriWest and our recently-hired staff, but many aspects of it were also new to employees of the non-VA Care Coordination offices in VA Medical Centers (VAMC) all across the Regions. Working closely with our VA team colleagues in the Project Management Office, we provided unique user names and passwords for all of the VA staff at facilities across Region 5 and trained them of the use of the portal.

Conducting Site Visits – On these visits, which were coordinated and led by our VA Project Management Office colleagues, we introduced ourselves and worked to educate VAMC staff and leadership on the elements of the PC3 contract and the tools we had and how TriWest would interact with them to serve Veterans.

Start of direct care delivery

On January 2, 2014, fewer than four months after award, we went live and began direct services to Veterans throughout Region 5. Not surprisingly, as a new program, PC3 started slow. During

the first few months, we were receiving on average about 100 authorizations each day from the VAMCs we serve; although the daily number fluctuated from between 30–150 each day. That workload translated into about 2,000 authorizations for care during the month of January. I can state, unequivocally, that slow initial start is now a very distant memory for all of us in our geographic area of responsibility . . . TriWest and VA team alike . . . in spite of the short timeframe since we started delivering services.

In February, workload inched up slightly from 2,000 to about 2,500 for the month. For the month of May, we received 10,000 authorizations for care – a quadrupling of the monthly volume in just three months. And we expect the growth to continue. I will talk shortly about how we are preparing for that growth.

Perhaps, as to be expected with any new program, not everything has gone according to plan during the first couple of months. First, as noted above, we know that despite our best efforts, not all of our network was ready in all of the places where we needed to have it in order to best serve VA's and Veterans' needs. The reasons are varied and several-fold: immaturity of data, complexity of contract requirements, Medicare-based reimbursements rates, VA's continued provider engagement separate and distinct from the PC3 program; and lack of clarity of all of the places in which care was going to be needed and the volume of such care . . . exacerbated a bit by the current clusters of backlogged care. But, whatever the reasons, they are only reasons and not excuses. It is our job to have services available and we will meet that expectation. And, I am pleased to state that in spite of these initial challenges, together we are gaining on it.

As you might expect, in a personnel-intense program, the rapid increase in workload from February to May led to some delays in appointing Veterans within the desired timeliness standards. Fortunately, as I noted earlier, in less than one month, we have been able to hire nearly 100 new staff. That growth in staffing has substantially cured those challenges. And, we will be adding another 100 this next week. That said, I would be remiss if I did not note that while TriWest certainly welcomes the rapid growth in the use of the PC3 program, the Indefinite Delivery/Indefinite Quantity (IDIQ) contract design can present some unique challenges when such a rapid and voluminous change in demand comes into play.

From a taxpayer-centric approach, VA does not wish to pay for services until after they are ordered. This is certainly understandable. And, with this contract design they do not have to. Yet, paying in arrears with little information on projected ordering volumes means TriWest is estimating the need for physical space and staff with little information or experience on all sides. As such, rapid growth could – and did for a bit – overwhelm TriWest's infrastructure and staff that was built without foreknowledge of the clusters of backlogged care that existed. But, together, we, and the VA team in our geographic areas of responsibility, are persevering and I believe that we have prognosticated well enough to have a reasonable probability of positioning ourselves to successfully meet the demand when it arrives.

Please know that I am in no way advocating for a change in contract design. I am only noting the importance of sharing informa-

tion between VA and the PC3 contractors in a design like this so that we can reasonably predict the workload we will be facing in advance and be better prepared to respond to it. And, I am pleased to report that VA has done a very solid job of responding to that need once we all got visibility of the clusters of backlogged demand for care.

I would also like to note that we have received a lot of feedback on our TriWest/VA Portal interface tool from VA staff and our Contracting Officer. We have listened and made substantial upgrades and improvements in recent months. These changes will not only enhance productivity and efficiency inside TriWest and VA, but they will also provide valuable data tools for all of us to use in monitoring our progress and the experience of receiving care through the PC3 program.

Finally, Mr. Chairman, I would like to spend a minute discussing how TriWest is partnering with the VA team to address the current access challenges faced by many of the VAMCs in our areas of geographic responsibility.

VA has discussed publicly its Access to Care Initiative. But, before the initiative even had a name, our colleagues in many VAMCs around the Regions we serve were reaching out to us to see if we could help, and if so, where and how fast. Our company is headquartered Phoenix AZ. And, while I realize much remains to be learned and understood about actions that occurred in Phoenix, I can say without hesitation that the leadership there today, their superiors, and the Program Management Office, have been collaborating with us each and every day to hone a model of partnering to work down the specialty care backlogs as quickly as possible. They have identifying their needs for assistance so that we can reasonably identify the capacity of the providers in our network to handle the care. And, indeed, the analysis of demand against capacity has been conducted there and for most of the places with backlogs across our entire service area. And, to ensure that we can handle the demand in Phoenix, my team and I have spoken with many leaders of large practices and facilities across Maricopa County. And, as you would expect, they are committed to leaning forward to help serve their fellow citizens. In fact, we expect to be receiving between 300–400 authorizations of care a day from the Phoenix VAMC and are prepared, along with our provider network, to handle them all within the access standards required in our contract.

In addition, just this past week, we began getting some of the authorizations for services needed to provide a special type of cognitive behavioral therapy. One of VA's Psychology Chiefs is in direct communication with our head of Behavioral Health Services, who happens to be a Veteran himself. They are matching caseloads with network providers' schedules and specialties so we can place Veterans with care in the community as quickly as possible with the right type of provider for their needs.

I know Members of the Arizona Congressional delegation are rightly looking for accountability for the past, but they are also focusing intently on solutions for tomorrow—both long term and those that are available quickly to help Arizona Veterans. TriWest takes very seriously our obligation and privilege to do our part for

the short term as well as over the long term. I am hopeful that the tools we have developed and this model of information sharing and collaboration becomes one that we can use not only in Arizona but all across our Region to assist where and when we can. And, indeed, that is exactly what is underway.

Remaining Committed and Focused

Mr. Chairman, and members of the Committee. I hope I have made clear in my comments today that TriWest is very committed to and indeed is working tirelessly alongside VA to successfully execute a program that was designed to provide Veterans with timely access to specialty care from community providers and community facilities when asked to do so by VA Medical Centers because they are unable to meet the need. We are growing our staff and we are collectively beginning to smooth-out the rougher edges of our operations under this new program. We are adding scores of new providers every day to our network. And, most importantly, we are communicating with our VA partners every single day to understand their needs community-by-community and Veteran-by-Veteran.

We have found a tremendously dedicated VA Management Team overseeing this contract and matching our work hours, focus, and intensity every step of the way. I don't think either of us believe that the other is perfect nor did we all think that we would be tested in this way. But, I want you and the rest of our fellow citizens to know that we have encountered a VA team that has nothing but the interests of our Veterans at heart, and I hope they know and believe the same thing about TriWest.

Working together, and armed with an open and honest dialogue between us, and an intensity to match the amazing service and sacrifice of our collective customer, I'm confident our Veterans will receive the timely, quality care they deserve.

Thank you. I will now be pleased to answer any questions that Committee members may have.

The *Chairman.* Thank you very much.

Admiral, you are recognized for five minutes.

STATEMENT OF ADMIRAL THOMAS CARRATO

Admiral *Carrato.* Chairman Miller, Ranking Member Michaud, and members of the committee, thank you for the opportunity to testify on the role that non-VA care, specifically the Patient Centered Community Care program, can play in increasing veterans' access to care through the VA.

In May of 2012 I had the opportunity to testify before this committee to discuss some ideas around increasing veteran access to healthcare services. At that time I had made three specific recommendations that apply more broadly to access to healthcare services.

First augment VA medical center capacity by using short term solutions, such as use of contracted standby capacity that is delivered when and where assistance is needed.

Second, VA could expand use of telephonic and web-based tools that offer the opportunity to reach deeper into the veteran population and to serve those in very rural or remote areas.

The third recommendation was to use a network of community-based providers that would augment VA's capacity and capability.

Since the focus of this hearing is non-VA care I will focus today on the last of my three recommendations, using a network of community-based providers. This is exactly what PC3 is designed to do, augment VA's ability to ensure needed specialty care is available to veterans when a local VA medical center cannot readily provide the needed care due to lack of specialists, long wait times, or geographic inaccessibility.

Health Net was awarded a contract to provide VA with specialty care networks in three of the six PC3 regions. We began implementation of PC3 in our regions in January and completed implementation on April 1st of 2014.

Today our provider network consists of approximately 39,000 providers and continues to grow. Our network has full accreditation demonstrating excellence and meeting key quality benchmarks in the healthcare industry.

From program inception through today VA has provided Health Net with over 31,000 authorizations for care in 71 specialty areas.

PC3 provides many benefits to veterans and VA. The PC3 program is positioned to effectively augment VA's capacity to ensure veteran access to care and do it in a way that facilitates the delivery of integrated care. It is a program that ensures high clinical quality, access within standards, provides patient tracking and follow up, and insures the return of medical documentation to VA. These features are not necessarily present in other non-VA care options or are not as robust and proven.

PC3 is also convenient for veterans. Upon receipt of an authorization we contact the veteran to schedule an appointment, provide an appointment reminder to the veteran in writing, and then follow up to ensures the appointment occurred. Veterans are not left to find qualified quality providers on their own. We believe PC3 is well positioned to help ensure our veterans receive timely, consistent, and integrated access to care.

PC3 is a funded, up and running, nationwide program built upon a consistent set of requirements; however, it is still a very new program, and as such it is essential that lessons learned and identified enhancements are adopted to increase the program's effectiveness.

We look forward to continued collaboration with the VA to help ensure that our veterans have ready access to the healthcare services they need.

Thank you for your time and I am prepared to answer any questions that you might have.

PREPARED STATEMENT OF ADMIRAL THOMAS CARRATO

A Partnership History

Chairman Miller, Ranking Member Michaud and Members of the Committee, I appreciate the opportunity to testify on Health Net Federal Services' implementation and administration to date of the Department of Veterans Affairs' (VA) new non-VA care initiative, the Patient-Centered Community Care (PC3) program.

Health Net is proud to be one of the largest and longest serving health care administrators of government and military health care

programs for the Department of Defense (DoD) and Department of Veterans Affairs (VA). Health Net, Inc.'s health plans and government contracts subsidiaries provide health benefits to more than five million eligible individuals across the country through group, individual, Medicare, Medicaid, TRICARE, and VA programs.

For over 25 years, in partnership with DoD, Health Net has served as a Managed Care Support Contractor in the TRICARE Program. Currently, as the TRICARE North Region contractor, we provide health care and administrative support services for three million active duty family members, military retirees and their dependents in 23 states. We also deliver a broad range of customized behavioral health and wellness services to military service members and their families, including Guardsmen and reservists. These services include the worldwide Military and Family Life Counseling (MFLC) program providing non-medical, short-term, problem solving counseling, rapid response counseling to deploying units, victim advocacy services, and reintegration counseling.

As an established partner of VA, Health Net has collaborated in supporting Veterans' physical and behavioral health care needs through Community Based Outpatient Clinics (CBOCs) and the Rural Mental Health Program. We also support VA by applying sound business practices to achieve greater efficiency in claims auditing and recovery, and previously through claims re-pricing. The monies recovered through these programs are available to provide or enhance services to our nation's Veterans.

It is from this long-standing commitment to supporting service members, Veterans, and their families that we offer our thoughts on PC3 and its role as an important component toward improving Veterans' timely access to care, supporting coordination of care, and ensuring quality of non-VA care. PC3, ultimately, supports greater integration of non-VA care services with the care provided to Veterans at a VA Medical Center (VAMC) or CBOC.

Building Upon Lessons Learned

In developing approaches to ensure Veterans have access to quality, coordinated care, VA has previously implemented pilot programs, such as Healthcare Effectiveness through Resource Optimization (HERO) in 2008, VA Rural Mental Health Program in 2010, and Project Access to Care Received Closer to Home (ARCH) in 2011. PC3 grew out of these pilot programs and was designed based on lessons learned from them, as well as input from and collaboration with, key industry and legislative stakeholders, including Veteran Service Organizations and Members of Congress.

In-Place, Integrated Solution

PC3 has been designed as an integrated solution that ensures a clinical quality baseline, supports care coordination, and provides timely access to care for Veterans. PC3 contracts have been constructed to enhance VA care delivery by augmenting VA's ability to provide inpatient and outpatient specialty care and behavioral health care for enrolled Veterans when the local VA Medical Center (VAMC): (1) lacks available specialists; (2) has a long wait time; or, (3) is an extraordinary distance from the Veteran's home. The purpose of PC3 is to augment VA capacity and capabilities, not to

replace them. To this end, specialty care can be provided on either an inpatient or outpatient basis and includes mental health.

The most important goal of PC3 is to ensure Veterans have timely access to high quality, coordinated care. Health Net's PC3 appointment schedulers work collaboratively with Veterans to schedule appointments that meet their schedules and follow PC3 standards and industry best practices. Health Net conducts follow-up with providers to ensure that Veterans complete their appointments. When there is an issue with an appointment, we find out why and attempt to reschedule. Health Net's PC3 staff collects and returns completed medical documentation to VA, which ensures VA has timely and complete patient care information to include in the Veterans' computerized patient record within VistA (Veterans Health Information Systems and Technology Architecture). The result of this careful process is delivery of integrated health care services in a manner that is convenient for Veterans.

PC3 contracts deliver significant benefits to Veterans and VA through:

- ✓ *Enhanced Access to Care: Veterans are seen quickly and within required commute times.*
- ✓ *Convenience to Veterans: Upon receipt of an authorization from a VAMC, appointment schedulers reach out to Veterans and work with them to schedule appointments that best meet their needs.*
- ✓ *Improved Care Coordination: Medical documentation is returned to the VA in a secure and timely manner.*
- ✓ *Quality Care: Health Net's provider network is URAC accredited and all providers comply with PC3 clinical quality requirements.*
- ✓ *Improved Efficiency and Accountability: PC3 contracts help VAMCs manage high volumes of care. They consolidate the complex, diverse work of managing many providers into a single contract.*

Standing Up PC3

Following a competitive bidding process, Health Net Federal Services was awarded a contract for three of the six PC3 regions (see Figure 1). The regions supported by Health Net contain all or part of 37 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Within the three regions are 13 of VA's 21 Veterans Integrated Service Networks (VISNs) and 91 Veterans Affairs Medical Centers (VAMCs). Implementation started shortly after the contract was awarded on September 23, 2013. The first VAMCs in Health Net regions went live on January 6, 2014. Implementation of the remaining VAMCs was completed on April 1, 2014. From program inception through June 9, 2014, VA has provided Health Net with approximately 28,000 authorizations for care in 71 specialty areas. The top five areas of specialty care authorized include: optometry, physical therapy, gastroenterology (to include colonoscopy), audiology, and podiatry. PC3 is not a mandatory program, thus, utilization across the 91 VAMCs and 13 VISNs has varied significantly. For example, as of June 9, 2014, three VISNs provided almost 60 percent of total authorizations to Health Net.

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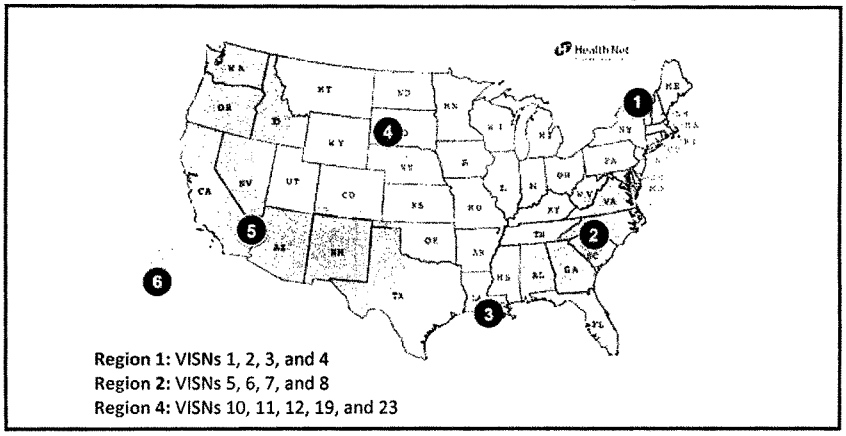
Figure 1: Health Net Federal Services' Contracted PC3 Regions 1, 2 and 4



Improving Timely Access to Care

PC3 includes strict timelines to make sure that appointments are scheduled and executed quickly. These requirements help reduce wait-times and ensure that Veterans are able to see a physician in a timely manner. We are committed to meeting the contract requirements for scheduling routine appointments within five days of receiving an authorization and scheduling care to occur within 30 days. Urgent authorizations have an even higher standard: appointments are made within 48 hours of receiving an authorization. Our PC3 appointment schedulers always attempt to contact Veterans in order to collaboratively find appointment times that are convenient for Veterans. Distance as well as travel time are considered when offering the Veteran an appointment with providers within VA-defined distance standards. Veterans are called to schedule the appointment and the provider is contacted after the appointment to make sure the Veteran attended the appointment. If the Veteran did not attend the appointment, Health Net ensures the Veteran is contacted to reschedule the appointment.

Supporting Coordination of Care

The PC3 program achieves care coordination by requiring that medical documentation is returned to VA. In PC3, we collect documentation from the provider, image it into in our workflow management system (iDocs), and transfer it electronically to VA (within 14 days for outpatient care and 30 days for inpatient care) for inclusion in the Veteran's electronic health record. In collaboration with DOMA Technologies, a Veteran Owned Small Business, we tailored iDocs for PC3 to provide transparency and ready access to information by VA. The iDocs system provides VA users with secure, role based access to key information and provides transparent access to information. The same system is accessed by both VA and Health Net users. VA users can track the authorization as it progresses through a seven step process that

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Ensuring Quality of Non-VA Care

Ensuring quality is an important component of PC3. Network providers must meet strict, VA-mandated clinical quality requirements to be accepted into the PC3 network which includes the Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC). In addition, Health Net's network is URAC accredited. URAC accreditation is a symbol of excellence and provides key quality benchmarks in the health care industry. Health Net meets URAC's nationally recognized standards of quality and operational integrity for network management, provider credentialing, quality management and improvement, and consumer protection. We currently have over 60,000 providers in the PC3 network across all three regions and continue to grow the network based on the needs of each VAMC. Primary care is not available through PC3, so all of the network providers are specialty providers. To further support our focus on quality in relation to patient safety and patient clin-

ical issues, we have an Oversight Committee and a Peer Review Committee, and a comprehensive Quality Assurance Surveillance Plan (QASP) that is aligned with specific contract performance objectives.

The Path Forward

We believe PC3 has tremendous potential to help VA deliver timely, coordinated, and convenient care to Veterans. PC3 is still a very new program. As with any new program, no matter how well the program requirements and design have been developed, areas for enhancement become apparent in the early stages the program. In order to ensure the success and long-term viability of a new program, all parties need to be able to bring forward recommendations for refinement and be willing to make appropriate corrections or modifications to ensure the program is effective in achieving its goals and objectives. We are committed to doing this and have already adopted a number of enhancements to make the program more effective and more responsive to Veteran and VAMC needs. We also are participating in frequent collaborative discussions with the VA Program Management Office around some potential VA refinements to the program.

As mentioned earlier, PC3 is not a mandatory program. As an in-place program which addresses access, care coordination, and quality, PC3 is an integral part of the solution to effectively care for our nation's Veterans. To fully leverage the capabilities of PC3, full adoption is essential.

We stand ready to support Acting Secretary Gibson on the Accelerating Access to Care Initiative. We look forward to continuing our collaborative relationship with VA and to serving as a resource to this committee and to Congress on ways in which the highest quality care can be delivered to our nation's Veterans. Thank you and I am available to answer any questions you may have.

Background on Health Net, Inc.

Health Net, Inc. (Health Net) is one of the nation's largest publicly traded managed health care companies and is currently ranked #254 on the 2014 Fortune 500. Health Net's government services division is one of the largest and longest performing administrators of government and military health care programs. Our health plans and government contracts subsidiaries provide health benefits to more than five million individuals across the country through DoD and VA, as well as group, individual, Medicare, and Medicaid programs. As a leader in behavioral health, Health Net provides behavioral health benefits to approximately five million individuals across the U.S. and internationally through its subsidiaries, MHN, Inc. and MHN Government Services.

Health Net Federal Services manages several large contracts for the government operations division of Health Net, Inc. and is proud to be one of the largest and longest serving health care administrators of government and military health care programs for the DoD and VA.

In partnership with DoD, Health Net Federal Services serves as the Managed Care Support Contractor for the TRICARE North Region, providing managed care services for three million active duty family members, military retirees, and dependents in 23 states. In

collaboration with VA, Health Net Federal Services has supported the physical and behavioral health needs of Veterans through CBOCs and the Rural Mental Health Program. Additionally, Health Net Federal Services also supports VA by applying sound business practices to achieve greater efficiency in claims auditing and recovery.

Our affiliate, MHN Government Services, delivers a broad range of customized behavioral health and wellness services to military service members, their families, and Veterans. These services include military family counseling, financial counseling, rapid response counseling to deploying units, victim advocacy services, and reintegration counseling.

The *Chairman.* Thank you very much Admiral.

Ms. Doody, you are recognized for five minutes.

STATEMENT OF KRIS DOODY

Ms. DOODY. Thank you.

Good morning, Committee Chairman Miller, members of the committee, and own congressman and ranking minority member, Mike Michaud.

When I testified to the Veterans Affairs House Subcommittee September 2012 I was pleased to report the good news about Project ARCH at Cary Medical Center, our community hospital in Caribou, Maine.

Now, in June of 2014 I am delighted to inform you that the good news just keeps getting better.

The original goals of Project ARCH were to expand access to eligible veterans for healthcare services, including specialty care and hospitalization, close to home.

Now, after nearly three years of working with Project ARCH we can confirm that not only can we deliver on these goals but we can go beyond.

Over the past three years Cary Medical Center, working together with VA Project ARCH staff, have enrolled some 1,400 Veterans who have experienced more than 3,000 consults at our hospital. If we assume that these same veterans would have sought out VA care at Togus, our single VA hospital in Maine, hundreds of miles away from Caribou, travel costs alone could have exceeded $600,000.

But the benefits of Project ARCH go well beyond travel savings, we are saving lives and improving quality of life for our Veterans in Northern Maine.

Listen to what Peter Miesburger, U.S. Air Force Retired, had to say about Project ARCH. As Peter explains, "It is the best thing since peanut butter."

Peter is a 77-year-old Korean War Veteran. He suffered a broken hip on January 30th when he fell at his home in Caribou, but, thanks to Project ARCH he did not have to worry about a 250-mile ambulance ride.

"It was miserable outside, snowing, cold, a typical northern Maine winter day," Peter said, a former air force firefighter who retired in 1974. "God only knows what would have happened," he said.

Such trips have been the standard procedure for veterans in northern Maine, and given the unpredictable weather conditions six months out of the year those trips would be life-threatening.

John Wallace is an army veteran and at 67 had been suffering with a bad knee ever since he jumped out of a helicopter in Vietnam. Project ARCH encouraged him to seek treatment and he successfully had arthroscopic knee surgery to alleviate his chronic knee pain. "I am feeling great, although my knee can still predict the weather," he said. "Any veteran you talk to up here, we are all been very happy with the results."

These are just two of hundreds of examples of how bringing care closer to the home of veterans near family and friends in familiar surroundings can make a difference.

Veterans are also taking advantage of preventative care such as colonoscopies and mammograms.

Key to the success of Project ARCH at Cary Medical Center has been the long-term relationship that we have built with VA healthcare and in particular with Maine's Togus Veterans Hospital.

VA Togus, with support from Cary, opened a VA community-based outpatient clinic, or CBOC, the first in our nation, some 27 years ago. The clinic provides primary care in Veterans living in Aroostook County, Maine.

Having the ability to work with the clinic and Togus has allowed veterans to remain in the VA healthcare system. This is important to veterans who overwhelmingly endorse VA healthcare when they have the chance to experience it.

While we can speak to the remarkable success of our experience with Project ARCH we have also faced challenges. Being a rural, community hospital, we struggle with the 14-day rule. This requirement of the VA to have veterans seen by a specialist within 14 calendar days of authorization is simply not realistic. We have however, dramatically reduced wait times, and because we are flexible are able to respond to unique circumstances, such as urgent or emergent care.

The volume generated by Project ARCH has now allowed us to recruit a second full-time orthopedic surgeon and two full-time oncologists, a great benefit for not only the veterans but to our community.

We recognize that Project ARCH is a Pilot. Some have said that the results that we present are anecdotal and that with only five locations across the nation are not high enough numbers to make any predictions for a national expansion. We respectfully disagree.

We believe that Project ARCH has tremendous potential to save the lives of our nation's honorable and courageous veterans, save millions of dollars, and ultimately advance the health status of millions of veterans nationwide.

We urge Congress to extend Project ARCH to expand the program in other rural areas of our country where veterans live hundreds of miles from the nearest VA facility.

Project ARCH is working. Ask our veterans in northern Maine. There is no doubt that veterans living in remote, frontier areas of our country are at a tremendous disadvantage when it comes to accessing care. Even with access to care closer to home veterans must

be made aware of the options and after years of staying in the shadows they must be encouraged to come forward.

It takes time and effort to build the trust of veterans, many of whom have never approached the VA for healthcare. At Cary Medical Center we have made this a top priority and we have demonstrated that when treated with respect, gratitude, and compassion the veterans' community will not only respond but they will create an unbreakable bond and reach out to their comrades who may be in need of care.

We truly believe that the system we have built at Cary Medical Center and our relationship with VA healthcare in Togus is a model for the nation. We would love nothing more than to share our success and model with other rural areas of America.

Thank you so much for this opportunity to present this urgent request for the extension of Project ARCH. It is just the right thing to do.

Thank you, sir.

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We recognize that Project ARCH is a 'Pilot'. Some have said that the results we are presenting are anecdotal or that with only five locations across the nation the numbers are not high enough to make any predictions for a national expansion. We respectfully disagree. We believe that Project ARCH has tremendous potential to save the lives of our nation's honorable and courageous Veterans, save millions of dollars, and, ultimately advance the health status of millions of Veterans nationwide. We urge congress to extend Project ARCH to expand the program in other rural areas of our country where Veterans live hundreds of miles from the nearest VA facility.

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The *Chairman.* Thank you very much to all of our witnesses. We will do a five-minute round of questions.

If we can go to your testimony, Ms. Doody, you said in your closing comments that some have said that the results of ARCH we are presenting are anecdotal. Who is saying that they are just anecdotal?

Ms. DOODY. Just comments that I have heard and reviewing newspaper articles because they have heard from veterans.

The *Chairman.* I guess the question is who is making those comments? Are they part of the status quo, they don't want to see ARCH succeed? We are trying to find out who in fact doesn't like this pilot program.

Ms. DOODY. I don't know if I can answer who does not like this program, I think there has been a number of folk ins the State of Maine who would like to see this program extended and succeed into the future, and comments that I have heard is that it is anecdotal because I cannot get specific information from Altarum who was the company that was contracted to do the review of Project ARCH.

So again, I can only tell information from individual veterans as opposed to a summary of key indicators.

The *Chairman.* Okay. Thanks.

To all of you, almost a month ago VA began implementing the accelerated care access to care initiative and as part of the effort VA stated, "Where VA cannot quickly increase capacity VA is increasing the use of care in the community through non-VA care."

And so what I would like to hear from you, if you could in a very succinct way if possible, what, if any, communication did you receive from VA on this initiative?

Admiral *Carrato.* I can start.

We have been working since we began implementation very closely with the program management office at VA and we have had close collaboration with them. We have seen some increase in authorizations from certain places. There is not uniformity across the system. In fact 3 VISNs account for about 60 percent of the authorizations we see.

So it is a continuing, ongoing collaborative conversation that will continue, but it is clear that the program office sees PC3 as part of a solution to the issue.

The *Chairman.* Mr. McIntyre?

Mr. MCINTYRE. Sir, with regard to the communication side of things the communication was swift, it was completely engaged, it was reached to on both sides of the street with us reaching to them and them reaching to us. It followed on what we were seeing with some clustered backlogs that were showing up before everything became public around Phoenix and then what followed after that.

Since that time and the analysis that we have collectively done in our geographic areas of responsibility there have been meetings directly will every VISN director that I have been involved in, that the program office has been involved in, and other underneath each VISN has been every VA medical center engaged in the same thing, and we now have all the information that we believe we need and they have what they need from us to be able to determine what our capacities look like to be able to help them so that as they decide what levers they will pull that they know what their options are in the community so that they can make informed decisions going forward.

I will use Phoenix as an example. Complete engagement in that market from the acting director, the acting VISN director, the staff at the local level, and the delegation in Arizona completely involved across the board, and we have a collaborative relationship with the providers in the community, all of whom have stepped up and said we will take whatever we can take and need to take to expand out our schedules to be able to meet the need of our fellow citizens.

The *Chairman.* Really quickly, because my time is about to expire for both TriWest and Health Net. What reception have you received from VA medical center staff throughout the implementation of PC3? In other words, are the staff at the VA medical centers aware and willing to properly utilize the PC3 program?

Mr. MCINTYRE. You know, with any new program there is always fits and starts. I think if you measured it at this point the engagement is strong, it is thorough. Is it at the same level of maturity at every sight, the answer would be no. But those sites where we are having struggles we are identifying those issues to the program office and they are working those issues effectively.

The *Chairman.* Admiral?

Admiral *Carrato.* Yeah, echo most of what Mr. McIntyre said.

I think the one lingering issue that we are facing as we are continuing to grow our network is that at some locations the VA medical centers have direct contracts with providers, and when we are talking to those same multi-specialty groups or health systems they say, well we have a contract with the VA medical center and we are really not being encouraged to use PC3 or to enter into those negotiations fully.

So that is, getting a lot better, the communication is lot better, but that is one issue that continues to linger.

The *Chairman.* Thank you, sir.

Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman. And once again I would like to thank the panel.

Ms. Doody, the VA said in their testimony that the expiration of the ARCH contract individual transition plans for each veteran participating in the ARCH program is being created. Has Cary been involved in that transition plan for each veteran?

Ms. DOODY. Yes, we have, congressman. We have begun to discussions with our project officers as well as members of the VA and looking at how many appointments are scheduled out into the fall of 2014 and then what will occur next in trying to assure that the veterans are receiving the care prior to the expiration of ARCH.

Mr. MICHAUD. Okay. And what are your concerns with the expiration of the ARCH contract?

Ms. DOODY. Well obviously Project ARCH from our perspective as well as the VA in Maine has been very successful, and we recognize although it is been a different arrangement than PC3 because it is a direct relationship with VA, Togus, and Maine, although contract with the VA health system at a federal level, it has been very successful and we recognize that it could potentially be a model for the nation in a VA hospital working directly with a community hospital within a state.

Mr. MICHAUD. Thank you. Yes, I remember when we put forward the program VA actually was opposed to it.

Ms. DOODY. Yes.

Mr. MICHAUD. As a matter of fact this was supposed to be a VISN-wide program and when the VA got done with their rule making it narrowed it down substantially. So I am glad to see that it has worked out well.

Did Cary Medical pass on the bidding contract for the PC3 program?

Ms. DOODY. No, we did not pass. We have had some contact negotiation—contract negotiation with Health Net who would be our provider in our region, but we have not reached agreement.

Mr. MICHAUD. And what is your concern with the PC3? I am hearing concerns about reimbursement rates.

Ms. DOODY. Yes, we have not reached agreement on reimbursement rates, which obviously I have to be financially responsible to my organization, so we have not been able to reach agreement at this time.

Mr. MICHAUD. Okay. And this question is for—well, actually, Mr. McIntyre and Carrato, I know that the PC3 program has only been fully implemented recently. Can you explain what about the access to rural or highly rural areas has been? Have either of you experienced problems?

Admiral *Carrato.* Certainly in highly rural areas it can be challenging to develop a network of providers, and part of that reason is that there are medically underserved areas in this nation as you well know, and the VA in defining the requirements for PC3 recognized that, they defined areas as urban, rural, and very rural.

There are also shortages of certain medical specialties regardless if you are rural or urban. But we have very good experience with other large federal programs in developing networks in rural areas and so far we have been fairly successful.

As I mentioned in my statement we are continuing to grow our network. There are challenges, but we do have ways to address those.

Mr. MCINTYRE. I would associate myself with Mr. Carrato's remarks, but use as an example the work that we finished last night in Prescott in Flagstaff, Arizona, which is a place where we have commonly identified the fact that we need to take care closer to home. We signed a contract last night at 10 o'clock.

And so, you know, the community I think is now recognizing the need to step forward and everybody wants to try and do the right thing on the provider side, and certainly that is true for the corporations that we both represent.

This is a big lift, it is a large geographic space, and making sure that we are talking together both Congress as well as the VA and ourselves to identify where the pockets of veterans are that we need to make sure that there is particularly strong lift on the private sector side is very, very valuable to making sure that we get the job done right.

If there is a silver lining to the backlogs and the clusters is it is going force that dialogue and it is going to help us identify where those shortfalls are that cause particular problems against the direct care system.

What has been striking to me is that if you look just at Phoenix, Arizona as one example some of the backlogs represent 10 to 15 times what you would expect in monthly average appointments that have to be made downtown.

And so that engaged conversation back and forth and the expectation of all of us that we figure out what that is about and what the long-term needs are going to look like will help both ourselves and Health Net figure out how to make sure that the capacity downtown will match ultimately what the demand is whether it is rural, highly rural, or urban.

The *Chairman.* Dr. Roe, you are recognized.

Mr. ROE. Thank you.

Ms. Doody, we have a solution for your 77-year-old veteran with six months of bad weather. Move to Tennessee.

Ms. DOODY. I am not sure he would take you up on it, sir.

Mr. ROE. Well we can fix that problem.

Really fascinating. I have read all of the testimony and one of the things we talked about last week was process, and part of the process of getting a veteran to non-VA care can be—there is—I saw the GAO about how the providers see someone and then refers that person to somebody else in the VA who then decides, and then there is a request from the VA.

How long does all of that take before the—because the PC3 program looks like it is one—once it is up and working well would work extremely well and you are seeing the providers across the country step up.

We had five veterans in my medical practice in one office and we are more than willing to step up and help take care of our fellow veterans. And you are looking at healthcare for only six million veterans in the country out of the 22 million or so of us that are veterans. That is not a big lift, we can do that.

So how long does this take? Do you know by the time they get to you how much time is wasted doing that?

Mr. MCINTYRE. Dr. Roe, I think that the VA probably would be better able to answer the first component of process, and that is what happens within the VA before the request for authorization for care actually gets to us, and they are refining those processes and that is what is referred to as NVCC, and that is their part of the process.

They then contact us and say retired Sergeant Jones needs care, he has got a cardiac problem, he is in the following market, can you place him with a cardiologist?

Then it is our responsibility to make sure that we contact a cardiologist that is in the network, make sure that retired Sergeant

Jones gets placed in that provider's calendar, the service gets rendered, we then get the medical documentation, get it back to the VA, and pay the doctor for the service. That is the part of the process we do.

Mr. ROE. How does the information get from the VA to the doctor?

Mr. MCINTYRE. On our end the way it works is that the VA provides us with the medical documentation and medical record information that we need, then we engage with that provider because they are in the network. We move that information to the cardiologist that the retired sergeant would be seeing, they deliver the work, then we grab the medical documentation back, provide it back to the VA, and pay the doctor.

I will tell you that in Phoenix, by way of example, where we have had very deep conversation together, the director of the facility said, you know, we didn't do those parts of this process very well, and while we all understand the fact that there needs to be sufficient supply downtown to take care of those that can't be cared for in the system, releasing people into the marketplace in an unstructured way carries with it the risk that the provider does not get what they need.

At the end of the day the provider might not even get paid, and our job is to make sure that there is sufficient supply, we take care of the provider so that the provider will take the call the next time we call them.

Mr. ROE. I think that is absolutely essential or they won't take the call the next time.

Mr. MCINTYRE. Yes, sir. You know that well.

Mr. ROE. I know that very well.

And, you know, there are systems out there now that are set up among primary—I know this is just specialty care, but this could be extended as you have done Ms. Doody in Maine to primary care, and there are multitudes of primary care groups out there that are ACL approved by Medicare that already meet the metrics of quality, not quantity, we talked about that, that you don't have to reinvent the wheel. Those metrics are out there already and I think this could be extended to primary care, and as you said to augment the VA, not the replace the VA, and to help them get through these bumps.

I said everyone knows when you have more patients to see that you can see in a day. Every doctor has had that situation where he needs some help, and every hospital. Ms. Doody has to worry about staffing up her facility.

So would that will applicability to the primary care, your PC3 programs?

Mr. MCINTYRE. Yes, sir, and I would say that as people look at what portion of primary care cannot be handled in the direct system that it is important to also remember that the panel of primary care providers in the private sector needs to be loosely integrated with the specialty care network, or as you know as a provider you are going to end up with people getting trapped in one lane and not being able to seamlessly crosswalk to the other and we will have a complete mess.

If I were king for a day you would add primary care into the VA PC3 contracts, expect those like us that are required to build these to get that put in place and make that part of the downtown system work probably.

Mr. ROE. My time has expired, but Ms. Doody, I think the ARCH program you set up is exemplary and I wanted to commend you for that.

Ms. DOODY. Thank you very much, sir. I will share that with our local veterans.

Mr. ROE. I yield back.

The *Chairman.* Thank you, Dr. Roe.

Ms. Kuster as a reward for being here when the gavel dropped you are recognized for five minutes.

Ms. KUSTER. Thank you so much, Mr. Chairman, and thank you to all of you for appearing before us today.

I am from New Hampshire where we are beginning to get into the process of private care in the community at Concord Hospital, which is in my hometown, and I am very pleased to report that the hospital is very pleased with their relationship, but most importantly the veterans are very pleased with the relationship.

And so my questions today really have to do with how we can expand this to meet other parts of the country that—I know I frequently refer to my good colleague here, Beto O'Rourke with El Paso and the long, long distances that people have to travel.

For us in the northern part of the state we have the very good news of opening new clinics on the Canadian border towns of Berlin and Colebrook, New Hampshire. We have the same problem that you have in Maine with six months of challenging weather, although it is very beautiful.

And so my question is what could we be doing to extend this—these arrangements for community-based care beyond where we are now and meet the needs of our veterans throughout the country?

Ms. DOODY. I can take that.

Mr. MCINTYRE. You want to take that?

Ms. DOODY. Yes. I think we need to be looking at models of care such at what we have done in Caribou, Maine as a model for the nation and look at what has worked well. And we have also experienced some growth pains along the way.

The discussion earlier about how to condense time from when the patient is seen in the primary care office till they are actually seen by a specialist. We have worked through a number of the issues and we actually have an ARCH case manager from the VA alone side the VA—excuse me—a case manager for Cary Medical Center, their offices are side by side so they work very well together and they work very timely for our veterans.

So I think what we should do as a nation is look at what is working well and replicate that in other parts of our country, and I think Project ARCH is one of those opportunities.

Ms. KUSTER. And you have talked about the coordination of care, I think that is extremely important.

One of my concerns is there was reference to the return of medical documentation to the VA and making sure—we have had testimony here in a previous hearing about opiate use and high dosages

and our veterans not getting the word when they change medication—pain medication, they continue to take previous medication and then we have had medical problems from that. So the coordination of care is a concern of mine.

I also want to address the issue in your experience in the community care around scheduling. Obviously that is the crux of the matter. We have had testimony about using software from 1985. No wonder they are is a problem. But I would love to learn more about in the community care model.

We had testimony last week that the VA experiences a 50 percent no show in some circumstances. Obviously that is not acceptable in the private sector, it is not acceptable frankly from my perspective in the public sector, but what are some of the techniques that you use and does that include—I learned this morning about the DoD has a patient portal where the patient can literally go online, schedule an appointment, refill a prescription, actually take—take control of their own access to healthcare in a way that is convenient and timely to them. And if you could comment on the types of scheduling that you use and the effectiveness and how we could learn from that.

Admiral *Carrato.* Okay. Let me just comment briefly on your first question——

Ms. KUSTER. Sure.

Admiral *Carrato.* —about how can we expand the program nationwide.

With the Patient Centered Community Care Program, PC3, it is currently funded, it is currently nationwide, in fact it reaches to the Philippines and the Virgin Islands and Puerto Rico.

Ms. KUSTER. Yeah.

Admiral *Carrato.* And I think just to pick up on a comment that Mr. McIntyre said that we need to learn lessons, borrow from some of the pilots like ARCH, and to his comment about adding—potentially adding primary care to PC3. I think that could be helpful.

In terms of scheduling our responsibility for scheduling appointments is with our network providers, so we have a call center that receives the authorization from the VA, we then reach out to the veteran and the provider and try and get a match on when an appointment would be convenient. The veteran also has the ability to reschedule the appointment.

Ms. KUSTER. Yeah.

Admiral *Carrato.* I think the DoD portal you are talking about really is focused on their direct care system and scheduling appointments within the military treatment facilities.

So in the PC3 program we are focused on scheduling appointments downtown. And so far it is working fairly well.

In terms of——

Ms. KUSTER. Do you have a reminder system——

Admiral *Carrato.* We do.

Ms. KUSTER. I am sorry my time is limited, in fact I have gone over.

Admiral *Carrato.* Yeah, we reach out with a letter to the veteran and if they don't show we do follow up.

Just quickly on no-show rates. Our no-show rate is running about ten percent in the PC3 program. Just a benchmark in the——

Ms. KUSTER. It is a very helpful benchmark.

Admiral *Carrato.* —program, TRICARE program, which I am familiar with, it is about a 30 percent no-show rates.

Ms. KUSTER. Thank you very much.

The *Chairman.* Thank you, Ms. Kuster.

Mr. Flores for five minutes.

Mr. FLORES. Thank you, Mr. Chairman.

I want to thank each of you for your commitment to care for our veterans as well as your organizations as a whole.

I also want to brag about the physicians in Texas for a minute if I can, I am going read a couple of excerpts from a press release that came out yesterday.

It says, "The Texas Medical Association of Physicians are stepping up to care for U.S. veterans awaiting healthcare in the U.S. Department of Veterans Affairs system."

"TMA this week invited private physicians across Texas to enroll in a TMA registry if they are willing to see veterans in their offices TMA will share this registry with community groups that work with Texas veterans and with medical directors of VA facilities in Texas."

"American's veterans need healthcare so TMA wants to create a system to connect in with Texas physicians who want to help," said Austin I. King M.D., TMA'S president, who has already enrolled his practice to care for veterans.

He noted other physicians can do so too my checking the I am willing to serve veterans box in TMA's online enrollment form.

"I am saddened that our veterans have been forced to wait for the healthcare they need and deserve, so until the VA can solve this problem I, like many other Texas veterans, want to help care for them."

And I want to thank the TMA and Texas physicians for what they are doing.

I have a fairly simple question, and I think Ms. Doody you touched upon it, but if I could get feedback from each of you that would be great.

What has been the preliminary feedback that our veterans have said about healthcare outside the VA versus healthcare in the VA? And in particular are any veterans weary of outside VA healthcare?

Mr. McIntyre, let us start with you.

Mr. MCINTYRE. Sir, I believe that the feedback has been strong and that the complaints are very, very nominal.

The issue is to make sure that people get placed timely, that the providers that we have in our networks are solid providers like the ones you are talking about from the great State of Texas which we are privileged to serve and I look forward to a conversation with the Texas Medical Association about where they can go to actually sign up, because we are that place as is Health Net.

And then lastly, you know, I think the providers really are leaning forward and the experience that they are going to find on the beneficiary side is very similar to those that were found with those that were serving in the guard and reserve during the time of the

conflicts that we have been through where you had community providers stepping up at the side of the Defense Department through our two organizations to provide services that couldn't be done directly by the DoD, and comments were very positive and very high as a supplement to the Defense Department just as they would be to the VA.

Mr. FLORES. Okay, thank you.

Admiral Carrato?

Admiral *Carrato.* Yeah, again, echoing what Mr. McIntyre said, the feedback we are getting from veterans on the community care that they are receiving is very positive.

Like Mr. McIntyre I review our—any grievances, appeals that we get in just to see how things are going. Very few. So I think it is a positive experience.

Mr. FLORES. Ms. Doody you talked about it in your testimony, do you have any expansive comments you would like to add?

Ms. DOODY. I too would just echo my colleagues. The feedback has just been phenomenal from the veterans. Caribou is their home and they know the providers, they know the hospital, they know the people who work in the hospital, so the feedback has been just exceptional, but at the same time they widely support the VA healthcare system and VA Togus.

Mr. FLORES. Okay. I thank each of you for your feedback. The rest of my questions I will submit for the record and we can get to those later on.

Mr. Chairman, I yield back the balance of my time.

The *Chairman.* Thank you, Mr. Flores.

Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke.* Thank you, Mr. Chairman.

I guess my first question is hopefully a big or bigger picture question. You know, given the proportion of the failure at the VA I would love to know your thoughts on what the logical conclusion or extension of this current strategy is.

In other words I get asked a lot at home why have the VA at all? Why not privatize that care? The private sector could do it better. What is missing in the VA is competition. Our veterans deserve the very best, let us not keep them in this institution that is not working.

From veterans almost to a person I hear if I get in the VA I love the care, I am treated very, very well, the outcomes are great, don't touch the VA.

So what do you do best and what does the VA do best and five years down the road after we get out of this current crisis what will this look like?

Mr. MCINTYRE. That is a great question and it is an honor to serve El Paso where I spent part of my childhood when my dad was in the army as a doc.

I will tell you that I hope it does not take five years, and I think everybody else would echo that statement.

My belief is that the first phase is to make sure that the program that the VA has invested taxpayer money in, VA PC3, is put in place, is matured, that the processes on the VA side are matured, that our processes are matured, and that together we are identifying where those pockets of veterans are that might not otherwise

be able to get what they need in a complete capacity through the direct VA system because they lack the capacity to deliver on all the needs, and that the VA system—yes, sir.

Mr. *O'Rourke.* I am sorry to interrupt you but I do want to understand what you think beyond taking care of capacity issues when the VA is not able to see someone in a reasonable period of time. Are there specific kinds of care that you all would be better equipped to take care of?

For example, I often think the VA is or should be better at handling PTSD or the after effects of traumatic brain injury because they see so many people like that as opposed to your typical health system or hospital. Maybe that is a VA Center of Excellence.

Is there something on the outside that we should just move all appointments or consults or procedures in a given area over to the private sector or let the private sector compete for?

Mr. MCINTYRE. Great question. My personal view is that it is too early to ask that question. Or to answer it probably a better way to put it. It is early to ask it, it is right to ask it, you are looking over the horizon line, but that we first need to get the pieces plugged together and then there needs to be a make by decision category by category and facility by facility to look at what is best done with taxpayer funds.

Is it best to have the direct system provide care for four veterans in a particular category? Is that really necessary? Or should we buy that on the outside because it is more efficient and more effective?

I believe that we are going to be in a place within the next six to nine months to start asking in earnest that question which you have asked on our end and being able to collaborate with the VA to help them understand what the downtown capacity looks like and then They in a position to make those decisions. We saw that happen in the Defense Department with TRICARE a long time ago.

In Phoenix, Arizona there is no hospital anymore in the air force, it is a clinic, and the reason why it is a clinic is that the air force stepped back, asked the very question you are asking, and ultimately decided we need a platform for delivery, so don't dismantle it entirely, but it made sense in Phoenix to go to a clinic. In other communities there are still air force hospitals.

And so I think once we get our piece of this plugged in and it is matured then those questions will be able to be start—start to be able to be answered.

Mr. *O'Rourke.* It also shows you how serious the situation is and the attention that is been drawn to it.

You know, I have been on this committee for a year and a half now, this is my first year in Congress, but I have never been approached by a lobbyist. On my way into a meeting today I was who represents providers in the private sector in El Paso and said, we have a hard time getting paid, it takes us a year sometimes. We want to see these veterans who are not able to be seen by the VA, but it is going to be really hard to do this if we don't get paid. You know, my client, you know, wants to work with you to see how that is done.

I only have 15 seconds so very quickly is payment a problem, and if you could all just answer very briefly.

Mr. MCINTYRE. We paid quickly, we pay to 99 percent plus accuracy as we did it in TRICARE, and I will look forward to talking to that lobbyist before we leave today.

Mr. *O'Rourke.* Great.

Mr. Carrato, just really quickly.

Admiral *Carrato.* On the claims payment issue?

Mr. *O'Rourke.* Yes.

Admiral *Carrato.* Yeah, I think that is one of the things that providers like is that we—our two organizations pay very quickly, accurately, and that is one of the benefits of joining our network.

Mr. *O'Rourke.* Ms. Doody very quickly.

Ms. DOODY. Yes, actually obviously they are speaking on behalf as their role as insurance providers. Having a direct relationship with the VA there is an issue with prompt payment.

Mr. *O'Rourke.* Okay. We would love to follow up with you on that.

Ms. DOODY. Absolutely.

Mr. *O'Rourke.* Mr. Chairman, I yield back.

The *Chairman.* Yeah, and thank you for clarifying that because I think the question is VA's prompt payment, not the providers.

Mr. Denham, you are recognized for five minutes.

Mr. DENHAM. Thank you, Mr. Chairman.

Mr. McIntyre, I am sure you have seen reports over the last few weeks of several different pieces of legislation that would address these backlogs. I know the chairman has a bill, I have a bill, I know there are several others out there. But basically if the VA can't meet its own goals, its own guidelines then we believe that they should be immediately outsourcing that care so that our veterans get immediate care.

So my question to you is what are you doing to prepare for a possible increase?

Mr. MCINTYRE. We are already seeing an increase. Our care demand went from 2,000 in the first month to 10,000 in May, so that would start January through May, a 4-, 5-fold increase, and we are expecting a lot more demand coming our direction based on the backlogs and that is why we tripled our front line staff is to be able to handle that demand. The flow levers are put in place to be able to make that work.

The notion that someone can go somewhere if we don't individually or collectively meet the requirements is probably going to be a very effective cross pressure on all of us to stay focused on what we need to do together to make sure that people get what they need within the time frames and the specifications of what is necessary viewed by this committee and by the administration.

Mr. DENHAM. Is there anything that you are lacking now or anything that you need to prepare for the future?

Mr. MCINTYRE. No.

Mr. DENHAM. And across the entire nation can you describe in greater detail the efforts that we would need to increase provider ship?

Mr. MCINTYRE. I go back to what happened 18 years ago at the start of TRICARE and then I look at what happened at the start of the conflicts we are currently engaged in.

A former member of Congress who was then governor of Idaho, Dirk Kemp throne, called me and said, can you come to Idaho? I said, why? He said, you know we are getting ready to deploy the largest portion of a population as a guard unit of any state. I want to ask every lawyer to come to the table and take two of their fellow citizens. Every doctor to do the same thing. You know what happened? The network grew from 700 providers in Idaho to 1500 in one month, because every community provider was willing to step up and just take a few.

One of the very effective things all of you could do to be helpful to all of us, including the VA, but also to veterans, is when you see providers say will you take a couple? And at the end of the day let us make sure that we have got a way to catch those folks as they come our direction and make sure that they are in the network so that we really can meet the demand regardless of where a veteran lives. So if they live out in that really rural community then we have got the ability to meet their needs, and together we should be able to solve the same problem that got solved in Idaho as it related to the guard that was getting ready to deploy. They had a full network when they were gone for their families, and when they came back the same thing.

Mr. DENHAM. As we have seen that provider network expand has there been an issue with participation rates due the reimbursement?

Mr. MCINTYRE. You know we are——

Mr. DENHAM. Both by reimbursement rates as well as Mr. O'Rourke said the timing to get repaid?

Mr. MCINTYRE. We are doing a pretty good job of being able to sign up providers. Like Admiral Carrato said, there is a challenge from time to time because some who may not really understand the implications could say to someone, you know, you don't really have to sign up with this we will just do this contract directly that we currently have in place. Eventually those contracts won't exist anymore and there needs to be a network sitting on the back end. But the folks in the VA are working those issues.

We have found that for the most part providers are willing to step up, because as Tom said, we do pay on time, and in our case we have over 60,000 providers already signed up, we are working on a few areas to complete still as we move forward, and we are getting a discount against the VA structure in terms of fees with high quality providers. So that means that more veterans can get care and that the care is high quality. So we have stretched the VA budget.

Mr. DENHAM. And are you working with now or have you worked with in the past public hospitals?

Mr. MCINTYRE. Absolutely. In fact in many of the locations that we are in, public hospitals that are in, I will tell you the fastest network contract we have ever done was done in Phoenix two weeks ago, it took five days from the start of a conversation between the CEO and myself and Maricopa County and we had a signed contract five days later and they are now part of the delivery system, and that gets replicated across the board.

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

The *Chairman.* Thank you, Mr. Denham.

Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank the panelists for being here this morning.

Mr. McIntyre, I wanted to ask you a question. Do you track your wait times?

Mr. MCINTYRE. Absolutely.

Ms. BROWNLEY. And how do you report those wait times to the VA?

Mr. MCINTYRE. Yes. We track the information collectively about where we sit with regard to the appointing responsibility that we have and what that looks like location by location. As I said, we started with 2,000 authorization requests in January.

If you look at what happened from April to May, we went from 6,500 to 10,000 in one month. And one of the reasons why we have added so many line staff in the last two weeks is that we were concerned about the volume that was coming at us because we started to struggle a bit with that.

We wanted to get in front of that issue and then also prognosticate forward so that we would be prepared for the clusters of backlogs that would be coming at us. And we are now prepared to handle whatever those volumes are that we are going to have to deal with.

Ms. BROWNLEY. So what is your average wait time would you say?

Mr. MCINTYRE. Our average wait time right now is about seven days to get someone to an appointment. And that is two days beyond where we want to be because our responsibility is to be at five days and we are digging out of the challenge of going through a five-fold increase in three months.

Ms. BROWNLEY. Thank you.

And so your measurement for success on wait time is five days then?

Mr. MCINTYRE. Our responsibility is to take an authorization for care request from the VA for a particular veteran and in five days have that veteran appointed with a network provider to be seen within 30 days for care.

So I talked about our wait time. That is against a five-day appointing standard. In some markets, there are not enough providers to actually deliver care against the demand that currently exists given the backlogs.

And so we have been able to help the VA understand market by market what that will look like as they make decisions about how to handle the backlogs.

Ms. BROWNLEY. So do you have that? Is that published, something that we can review to see what the wait times are from city to city, region by region?

Mr. MCINTYRE. Be glad to sit with you and have a conversation about things that would relate to the markets that we serve.

Ms. BROWNLEY. Thank you.

And what about transportation? How does TriWest coordinate transportation and reimbursement to our veterans?

Mr. MCINTYRE. We are not responsible for transportation directly. I will tell you that if you look to some of the markets we

are in where transportation is a greater challenge, we will engage directly with the VSO community and others that do transportation support. The VA has a structure through which they reimburse for transportation.

One of the challenges we all faced in the community in Arizona where not only do we have a furnace of a backlog that we are all dealing with, but it is also hot right now, was how do we set up a transportation infrastructure across the city so that as veterans are going to get care that we don't find them expiring at a bus stop waiting for a bus to get to where they need to get.

So the VSOs have stepped up in the community, interlinked how that is going to work and they will get a voucher if they are unable to get to where they need to be in an easy fashion. And our appointing staff will be educated about how they get to that voucher so that they will all be able to get what they need.

Ms. BROWNLEY. Thank you.

And in terms of reimbursements, is TriWest being reimbursed at Medicare rates by the VA?

Mr. MCINTYRE. We are paid an administrative fee to do the work that we do when the work shows up. That is how we get paid. And we are also responsible for making sure that we can build a network that has got the right quality in it, the right breadth and the right depth, and on the reimbursement rate to get providers signed up at or below the fee schedule.

And that is an important piece because at the end of the day, if you can find providers that are willing to step up and take a few of their fellow citizens and are willing to do that at a little bit less than the fee schedule at its maximum level, that allows more people to get cared for in a finite budget. And that is what we are doing.

And as I said and as Admiral Carrato said, we have fairly large networks built and others are being added. We did that work in the Defense Department community and we are doing it now. And we cross-leverage as a company the relationship of a lot of nonprofit Blue Cross Blue Shield plans and two university hospital systems with own our company. And that way, we are able to maximize the taxpayer dollar while delivering the highest quality access to care.

Ms. BROWNLEY. Thank you.

My time has expired. I yield back.

Mr. MICHAUD. Mr. Chairman, so yes or no, are you being reimbursed at the Medicare rates? Yes or no?

Mr. MCINTYRE. Yes.

Mr. MICHAUD. Okay. Thank you.

Mr. BILIRAKIS. [Presiding] No problem.

Mr. Runyan, you are recognized for five minutes.

Mr. RUNYAN. Thank you, Mr. Chairman.

And I want to talk a little bit about expectations because I know, Mrs. Doody, you said in your testimony that 14 days is unrealistic and I think Mr. McIntyre just kind of backed that up with how he answered the previous question.

Two questions. In normal operating procedure, what is the expectation and this in this crisis with what we know with the data that we can get from the VA, which I think most people agree we can't really trust a lot of it right now, what would—obviously that data

would be higher with a higher volume, but all three of you, can you kind of set what those expectations may be?

Ms. DOODY. Absolutely, sir. And I am sharing again from my experience with Project ARCH in my hospital.

When I say it is unrealistic, meaning a rural community with a limited number of providers, as both Mr. McIntyre and Mr. Carrato have stated, just a physician going on vacation is going to impact that 14-day window.

Also, if we have a physician who leaves in a certain specialty, that extends that 14-day opportunity to get the patient in to be seen, and it is just not realistic for that to occur.

What we are seeing is we are able to get the patients in in a lot of very busy specialties, primarily orthopedic surgery, which is probably similar in a lot of other markets that these gentlemen are in. That is where the demand is the highest for some of our aging veterans, and we are able to get them in within 30 days.

And, interestingly, the previous indicator in looking at getting a patient in to be seen by a provider was at the 30-day window. And from understanding doing research, the majority of the VA facilities were able to get the veteran in and be seen by a provider within the 30 days.

So I think going forward, that is something that really should be investigated and see if that is another opportunity for our veterans to be seen in a timely manner.

There are probably some areas or some parts of the country that veterans can be seen within 14 days because of the supply of physicians, but I would highly recommend that you investigate in rural communities, it is probably not realistic. And, again, that is from my experience for the last three years.

Mr. RUNYAN. The other two of you agree with——

Admiral *Carrato.* Yeah, I think that is pretty consistent. You know, our requirement, as David mentioned, is for routine appointments within 30 days. For urgent appointments, 48 hours. But, again, depending on the specialty, depending on the geographic location, you can get some routine appointments in quicker than 14 days. Some may go a bit beyond 30 days.

The other factor is, you know, veteran choice. You know, it may not be convenient to have that scheduled appointment, you know, at two o'clock on Wednesday. They may want it a different day of the week. And that sometimes can impact when a routine appointment is scheduled and agreed to.

But I think 30 days for routine appointments is a fair benchmark.

Mr. RUNYAN. Thank you.

Chairman, I yield back.

Mr. BILIRAKIS. Thank you, Mr. Runyan.

I will recognize Mr. Walz now for five minutes.

Mr. WALZ. Thank you, Mr. Chairman.

And, again, thank each of you for coming and providing expertise and a perspective, one to educate us and to the country on we are identifying, we are getting a diagnosis, and now the prescription for what happened.

I am grateful for that and this is a very important piece of this. And we have an opportunity to move this forward for decades to come.

Mr. McIntyre, in full disclosure to everyone and on my last deployment, my family was covered under TRICARE Prime Remote that was administrated by TriWest. And my wife to this day claims it was the best service she ever got. So I tell you that in just understanding and seeing this from a deployed national guardsman on the implications of having private insurance, switching over to TRICARE, and then seeing how that was administrated. It was seamless and I am grateful for that.

Mr. MCINTYRE. Sir, we are not perfect. We were honored to serve your family. I didn't even know we were doing that, but we were honored to do it.

And our belief is that not five years from now but a few months from now, we will be in that same zone of seamless operation and then we will be asking the kinds of questions of ourselves that your colleagues and others are asking and be able to mature this program the way we matured TRICARE.

Mr. WALZ. Well, it gives me a perspective, you know, small, limited, and extrapolating from that, we have to be careful. But I think Mr. O'Rourke's and other questions are being answered of how we go forward.

I asked a witness last week who is making a case and I think what we are hearing from this, and this is fair to say, that as the public heard this and they were rightfully appalled by what happened, the knee jerk reaction to give them a card and let them go anywhere.

This witness made the case is why is there an intermediary, why is there a VA or a TriWest or a Health Net in the middle. Why can't they just go do this themselves. How would you respond to this? This witness made the case that it is an ineffective bureaucracy that can never be fixed and putting another one in there, give control to the veteran and you can see the appeal of this theoretically.

My question to you is, what is your take on that and flesh out the details of what that means if that were the case?

Mr. MCINTYRE. My hope is personally that the use of such a card will not be necessary and that if we collectively including Congress have an understanding of what the realities are that veterans face and the ability to customize this program and the VA architecture that at the end of the day, we will retool the system so that it is ready for the return of veterans who have served in these two conflicts.

And what you refer to on the guard side is an initiative that we did as a company that was singularly done. It was done at our own expense and it was started at the encouragement of a former colleague of all of yours, Dirk Kempthorne.

And we then stepped back and said if that works in Idaho, we can do that everywhere. And so we reached out to doctors all over the 21 states that we were responsible for at the time. And what we found was most were willing to take a couple of their fellow citizens.

And so if we know what the mapping looks like, I would say from primary care all the way through the most specialized specialty care, we should together be able to have a platform that works effectively on the VA side from a direct delivery system and downtown.

Mr. WALZ. That is the hybrid, the best of both worlds.

Admiral, do you concur with that?

Admiral *Carrato.* I do. I think, you know, having a card which would provide the veteran with unfettered access to providers may sound attractive to some, but I have seen that in some systems. I think what we really need to do is make sure that we build an integrated, coordinated system.

As I mentioned, our network and TriWest's network, we fully credential the providers. We know who the quality providers are. We have a URAC accredited network. I think the key is to make sure that we augment the VA brick and mortar and it is a local decision. There are some that specialize in TBI, prosthetics.

But I think using the private sector to augment that capability and deliver a truly integrated, coordinated healthcare experience for the veteran is what we need.

Mr. WALZ. Ms. Doody, does that make sense? And you are appealing from an area that is my wheelhouse, the rural areas and the rural veterans. But the card doesn't do you any good if there is no one there to provide the care.

Ms. DOODY. Absolutely, sir. And I agree with my colleagues. We are here. Both of these programs, whether it is TRICARE and Health Net or what we are doing with Project ARCH, this is to augment the care that the VA healthcare provides. It is not to replace it.

Mr. WALZ. Very good. Well, I thank you all for being here.

I yield back.

Mr. BILIRAKIS. Thank you, Mr. Walz.

Now I will recognize Mr. Huelskamp for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

Gentlemen and ma'am, appreciate you being here.

The first question I would have would be for Ms. Doody and trying to understand the Cary Medical Center. That is a hospital that serves not only veterans but other patients as well, is that——

Ms. DOODY. That is correct, sir.

Mr. HUELSKAMP. And you obviously do receive Medicare?

Ms. DOODY. Yes, I do.

Mr. HUELSKAMP. What is the average reimbursement time from Medicare for those services?

Ms. DOODY. Medicare would be timely. We would probably see reimbursement from Medicare probably within 30 days if not less.

Mr. HUELSKAMP. Okay. And currently from the VA for services that we discussed here, how long?

Ms. DOODY. That can extend out for months if not years.

Mr. HUELSKAMP. Months if not years?

Ms. DOODY. Yes. There is a prompt payment issue with the VA.

Mr. HUELSKAMP. Okay. Issue on scheduling appointments with Medicare patients, who schedules their appointments?

Ms. DOODY. Our individual office staff.

Mr. HUELSKAMP. Okay. So there is no intermediary that——

Ms. DOODY. No.

Mr. HUELSKAMP. —schedules appointments? But for the veterans, who schedules their appointments?

Ms. DOODY. We have the exact same model in place for the veterans, so there is no intermediary. We work directly with the veteran and our office staff.

In fact, as I mentioned earlier, we are fortunate with this program to have the case managers associated with ARCH, the VA facility, and our case managers working side by side. And they are actually physically located at the offices. So they are physically present when the veteran is seen and they can schedule the patient right then.

Mr. HUELSKAMP. So the veteran shows up and there is no release from the VA to go into the ARCH Project?

Ms. DOODY. Yes. The VA has to provide authorization. And, again, it is the case manager with the VA that reviews that information from the primary care provider, does the authorization and forwards it on to our case managers. And that happens very timely. That does not take days or weeks. That sometimes can take hours.

Mr. HUELSKAMP. The authorization for each visit or how often does VA have to step back in? Obviously in Medicare, that doesn't occur?

Ms. DOODY. That is correct.

Mr. HUELSKAMP. But the VA does have to preauthorize. Describe a little bit more how extensive that is. I am hearing from doctors that every time they want to prescribe, they have to get authorization every single time. Is that not accurate?

Ms. DOODY. That is very accurate. There can be multiple authorizations involved with a single visit. And what is difficult being in a non-VA facility when our provider—I am also a nurse, so knowing the history of how this works for our patients.

When a patient is seen by a physician, the physician does diagnosing. And to diagnose, they have to receive laboratory or ancillary results back. Well, they will order those results with the intent of receiving those results back to get a diagnosis. They again have to go back to get authorization from the VA before we can go forward with that testing. So there are multiple authorizations involved.

Mr. HUELSKAMP. Thank you.

And, gentlemen here, is this the same type authorization requirements that you are going through the VA at certain levels for nearly every one of these type of services?

Mr. MCINTYRE. There certainly are requirements that we have to meet from an authorization perspective. And we have been in the conversation since we started the program a couple of months ago on the VA PC3 side to give the VA feedback on where there are opportunities for refinement.

And in some cases, those pieces of refinement have already been done. In other cases, things are under analysis.

Mr. HUELSKAMP. How does that compare to TRICARE? And both you gentlemen, if I understand your companies, they are heavily involved in TRICARE as well. And describe quickly, if you could, how that compares.

Mr. MCINTYRE. If you go back 18 years to the start of TRICARE, it was similar.

Mr. HUELSKAMP. What about today?

Mr. MCINTYRE. Today it would be much more seamless in terms of how things operate.

Mr. HUELSKAMP. And certainly Medicare is much more seamless——

Ms. DOODY. Yes.

Mr. HUELSKAMP. —in terms of preauthorization. But a little more questions on the PC3. So you keep talking about how if providers would pick a couple veterans. What is wrong with letting the veterans pick a couple providers? That is how the Medicare system works and that is what I am confused here.

In Medicare and rural areas, there is a capacity problem. In my district, they are looking for patients. I just talked with the head of the Kansas Hospital Association. They are begging for patients and the VA won't give them patients or they make it incredibly burdensome. We have to create a special project called ARCH just for one community and have got 70 hospitals that have capacity issues and they don't have enough patients.

And they are not asking for a middle man. They are asking for letting the veteran pick to come in. They would be happy to serve them because they are waiting for reimbursement, but that becomes the problem whether they wait a year or 14 days for Medicare.

And so if you are going to tell these folks that you are going to wait a year going through this cumbersome system, they are going to say, well—you know, veterans are saying, wait, they are going to pick Medicare over this particular system.

Mr. MCINTYRE. On the private sector side through VA PC3, the payment rates are such—payment timeliness is such that we are paying within less than 30 days.

Mr. HUELSKAMP. I appreciate that.

Only a short time. One last thing with Ms. Doody. We have heard rumors that the national director of ARCH is beginning to ask folks like yourself to begin informing veterans that the program will be ended.

Have they actually told you that, actually spread that message to our veterans?

Ms. DOODY. No, I have not, sir.

Mr. HUELSKAMP. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

Dr. Ruiz, you are recognized for five minutes.

Mr. RUIZ. Thank you very much, and thank you for being here today.

In an effort to ensure veterans in my district and across the country receive the care that they have earned and need and when they need it, I have sought input from my veterans' advisory board and I have listened to veterans throughout my district during our veterans' initiative this past summer.

The things that they were most concerned about include issues in regards to getting their medications in a timely manner that isn't so cumbersome for them, how medical records can be obtained

in a more timely manner, particularly on the nights and weekends, by non-VA providers, and how to overcome bureaucratic red tape preventing VA healthcare systems from partnering with federally qualified health centers.

So my first question is, how can we ensure that non-VA providers have access to veterans' medical records on nights and weekends and also get them faster?

When I did my overnight shifts in the emergency department, it was very difficult to get the EKGs or the medical records from a veteran that I needed to make decisions at that moment.

So how do you address that issue and what can we do to ensure that those medical records are received by the non-VA providers?

Ms. DOODY. I can tell you from our experience through Project ARCH we have access. It is read only. We are not able to input data into the VA record, but we have access to that information at our hospital. So that has helped with the continuity of care as you describe.

As it relates to veterans receiving that information, again, with the close relationship of our case managers, we are able to get the information back to our veterans in a timely manner. In fact, we have to report that to the VA as part of Project ARCH.

And also the information goes back to the Veterans Administration as soon as we receive it as a private hospital. It goes back to the VA, so the VA healthcare providers, whether it is the primary care or other specialists, are able to see the work that we do as a hospital and that gets inputted into their electronic medical record.

Mr. RUIZ. Do the physicians input it into their system or do you input into yours, make copies, put it in electronic form, PDF or something, and send it back? How does that work?

Ms. DOODY. Well, that actually from my point of view is an opportunity for improvement between the VA and the private hospital. We do have an electronic medical record and, as you know, the VA has an electronic medical record, but we have to print hard copies for the VA to insert into their record because we do not have access to put that information in. And we should.

Where technology is today as it relates to electronic medical records, we should be making that seamless and a lot more timely for veterans in veterans' hospitals and community hospitals.

Mr. RUIZ. Okay.

Admiral *Carrato.* And a similar answer. For routine appointments, we are able to provide the medical records from the VA to the provider. I think evenings or weekends or emergency, it might be good for us to have access at some point to the VistA system so we could take a look at that. And those conversations are going on.

And I think the electronic interface, I know there are some demonstration sites, the VLER program, that is looking at how do they capture all the medical records in a unified system. I think continuing to move forward on that.

Mr. RUIZ. In the sake of time, I am going to go to my next questions. What are the obstacles and how can we overcome them in order to open care for our veterans in federally qualified health centers?

You mentioned before that we have issues in rural areas because of lack of physicians, because of transportation, because of these other issues that the FQHCs are designed to address.

How can we open up care with FQHCs?

Admiral *Carrato.* I have had ongoing conversations with the national association representing the federally qualified healthcare centers. The issue with PC3 is it is largely specialty care and the capability of the federally qualified healthcare centers is principally primary healthcare.

So we have been looking for some opportunities. They are part of my TRICARE network, but, again, the lack of the requirement for specialty care really is a matchmaker capability.

Mr. RUIZ. In terms of prescriptions, I have veterans that tell me it takes too long for them to drive all the way about an hour and a half, two hours to the VA hospital, pick up their prescriptions. Sometimes they run out of their prescriptions before it is due.

What are the obstacles in them being able to go to a pharmacy or go to another local clinic or hospital to use their formula?

Admiral *Carrato.* You know, I will have to respond to the record for you on that one. I don't have an answer.

Mr. RUIZ. Okay.

Ms. DOODY. From my experience in working with local veterans, we have a VA clinic that houses primary care providers for veterans, so they have access locally to talk with veteran providers. But a number of our rural veterans also use a mail order pharmacy, so that may be an opportunity for, you know, local veterans.

Mr. MCINTYRE. We have set up a process in the pharmacy area where script can be provided on a short-term basis and then it is backfilled by the VA. But I think some stepping back to figure out how do we take the feedback that you are getting, particularly as a provider of care in your career before you came here, and determine between ourselves, both of our organizations and the VA, how can we make that work in a more seamless way when we look through the lens that you have got. I think that that would be very constructive.

Mr. RUIZ. Well, the lens that I have that should be the lens for the care to our veterans is to put veterans first, to put patients first, to be a veteran-centered center of excellence and look through the lens of our veterans, not my lens, but the lens of the veterans, and their experiences and what we can do to address their needs.

Mr. MCINTYRE. You bet.

Mr. RUIZ. Thank you.

I yield my time.

Mr. BILIRAKIS. Thank you very much.

I will recognize myself for five minutes.

Why don't I follow-up on that question with regard to prescriptions. What percentage of veterans use a mail order pharmacy and are they pleased with it by and large?

Ms. DOODY. I could only tell you from limited feedback that I have received from veterans. The majority of the veterans that I work with or have been in contact with use the mail order pharmacy since we are in rural northern Maine and the feedback has been positive.

Mr. BILIRAKIS. Very good. Thank you.

Mr. McIntyre, to assist the VA in working down their identified backlog for care, it is my understanding that TriWest will hire an additional 100 employees and an additional 100 the following week.

What kind of system do you have in place to monitor the effectiveness of their training and ensure these employees are properly scheduling appointments and processing claims?

Mr. MCINTYRE. We already have 100 people in process doing that work. We took our training programs, looked at them through the other set of lenses backwards to figure out what refinements we could make to shorten the training. Those folks are in the process of doing the easiest part of a plan as they get spooled up to be able to do this. And we will be measuring their performance just like we measure every other staff person's performance in that critical work.

Mr. BILIRAKIS. Well, what is your policy as far as disciplining or reprimanding an employee for not doing their job, improper scheduling or processing claims? Do you have a policy in place?

Mr. MCINTYRE. You bet. We monitor very carefully where gaps are in performance. We put people on corrective action plans. If the issues that they worked on are viewed as a problem that can't be corrected with counseling, then we will release them on the spot.

And we found a very dedicated workforce that together with all of us wants to be able to serve veterans just as is true for the providers in our networks.

Mr. BILIRAKIS. Thank you.

A question for Mr. McIntyre and then Mr. Carrato as well. In both your testimonies, you mentioned that with any new program, no matter how well the design and preparation, areas of enhancement will be detected in early stages. So areas of enhancement, I will say it again, will be detected in the early stages.

Can you share with this committee some of those challenges?

Mr. MCINTYRE. What we have discovered is the fact that there needs to change some of the authorization processes that were being discussed previously. Those have been put on the table, the notion of making sure that we refine how we actually do physical appointing with the veterans to make sure that we are dropping the no-show rate even further and the way in which people come to understand the program itself and how it executes because that has changed both for the veteran but also for the VA medical center staff themselves.

Mr. BILIRAKIS. Mr. Carrato.

Admiral *Carrato.* Yeah, a couple of things. One is I do think we need to continually educate the VAMC staff on the benefits of the program. Mr. McIntyre alluded to some issues that our network providers bring to us and that is not unusual that the authorization requirement is one.

The other issue that we have discovered and we are talking to the VA about is the requirement that all care go to network providers. In some situations, as an example, you don't know what anesthesiologist is going to scrub for surgery on a given day. And that anesthesiologist may not be a network provider.

So I think some allowance for a percentage of non-network providers to support our veterans. This really is the only program that I support that has a requirement for 100 percent network pro-

viders. There is always an allowance for some non-net providers. And I think that would actually increase our ability to serve our veterans.

Mr. BILIRAKIS. Very good. One last question for you, sir.

What kind of information does VA share and/or what information do you have access to regarding the veterans' process within the PC3 program?

Admiral *Carrato.* Regarding the veterans' process within the P——

Mr. BILIRAKIS. Yeah, correct. Correct.

Admiral *Carrato.* —the internal VA process? There is sharing of that information and we are having ongoing conversations because I think the intent on all parties is to improve processes and particularly those that are impacting access to timely care.

Mr. MCINTYRE. I would echo the same.

Mr. BILIRAKIS. Thank you very much. Appreciate it.

And now I will recognize Ms. Negrete McLeod. You are recognized for five minutes, ma'am. Thank you.

Mrs. *Negrete McLeod.* Thank you, Mr. Chair.

I think what I have gotten out of this is that your programs are going well. However, if we are going to allow veterans to go outside and get other providers and the reimbursement rate is so long in coming back to them, who is going to want to provide services if the reimburse rate is so long in taking to get back to the provider?

Admiral *Carrato.* Well, in the program, the Patient-Centered Community Care program, we directly reimburse our network providers and we reimburse in 30 days or less.

Mrs. *Negrete McLeod.* Well, yes. But you are part of a network. But if we are going to move that forward that veterans can go outside of the VA to get services, if the providers don't belong to you, what is going to incentivize those other people to take any other patients if the reimbursement period is so long to get reimbursement?

Admiral *Carrato.* Yeah, I think that is a fair question. And that is one of the things we hear from providers when they join our network. And one of the reasons they like to join our network is that we pay promptly.

I think that is an issue that needs to be addressed by the VA which is prompt payment to providers. That is still an issue. I think there are solutions that could be brought to bear.

You know, one could be that, you know, we could have, you know, permission to reimburse non-network providers, but I think there are a variety of things that could be done to increase the timeliness of——

Mrs. *Negrete McLeod.* Because it is one thing in philosophy to say we are going to provider services outside, but if there is no providers, then it is just an empty promise that we are going to do.

Admiral *Carrato.* Correct. Correct.

Mrs. *Negrete McLeod.* Thank you.

Mr. BILIRAKIS. Yield back?

Mrs. Negrete McLeod.* Yes.

Mr. BILIRAKIS. Okay. Very good.

Okay. I will recognize Mr. Jolly for five minutes.

We are getting there, Ms. Brown. You are next.

Mr. JOLLY. Thank you.

I actually just have a very general question. And if you don't have enough information to answer, that is fine.

Yesterday in my district office, I hosted about 300 people. We had what I call a veterans' intake day for folks to come in, express their concerns and their compliments. And so I think everybody here has expressed, you know, we got great compliments, people who want to stay in the VA system, absolutely, and they never want to step outside of it.

But then we also heard from those who do want to step outside of it. My primary takeaway from that event is we need to do even more in providing the veteran choice is the bottom line. The question, though, is how do we do that in a way that is fiscally responsible.

And so my question for you generally, and, again, if you don't have enough information, that is certainly fine, in your roles supporting non-VA care, can you give either an assessment, if you have technical information or if it is just a working opinion, on the cost effectiveness compared to traditional care, realizing that we have hard infrastructure costs within our VA system that aren't reflected when you go to non-VA?

We can look at all sorts of data. I am somebody who thinks typically data is manipulated to get whatever outcome or position we want to finally be able to support.

But can you give an opinion or assessment on the cost effectiveness of non-VA care versus within the VA?

Ms. DOODY. I can tell you from our experience with Project ARCH, and I wish I could give you specific numbers, sir, the company Altarum who was contracted to collect this information, and my understanding is they are going to report back to you folks in 2015, are looking at the cost of care per veteran.

From my understanding, it is less than if they would have gone to a VA facility for certain procedures. And so, again, it is anecdotal. It may be geographic. I can't comment on the other regions or other states in our Nation, but also just limiting the amount of mileage, the traveling that the veteran would have to do traveling to a VA hospital to receive care is a savings to the system also.

The veterans have also expressed, which I think is something that needs to be considered going forward, is there are times that they have not sought preventative care because they did not want to drive the extra miles to receive a colonoscopy or have a mammogram.

And I think that is something we need to consider because those diagnoses that may be missed because a veteran has not received preventative care is very costly to our system.

Admiral *Carrato.* I would say with PC3, it is a tough comparison comparing the care delivered in the VA brick and mortar to network care. But with PC3, the starting point for our reimbursement is, you know, Medicare levels and we have been successful in getting discounts from some of our providers.

So I think if you compare PC3 care to other non-VA care, I think it will prove to be cost effective. But, again, it is pretty early to reach any conclusion.

Mr. JOLLY. Sure.

Mr. MCINTYRE. And it is an integrated system in a loosely done way. So the fact of the matter is you need both sides of that puzzle to be able to make this work. And as was discovered by the Defense Department when they started down a similar journey 18 years ago, it is a very effective way to be able to complete the other side of the puzzle. And as Tom said, people are signing up.

The administrative fee that we get paid is very nominal as it should be and we get paid when the work comes our way. We don't get paid before it comes our way. And that is the right way to do it from a taxpayer perspective.

Mr. JOLLY. Very good. Thank you.

Mr. Chairman, I yield back.

Mr. BILIRAKIS. Thank you.

Thank you so much for your patience, Ms. Brown. You are recognized for five minutes.

Ms. BROWN. Thank you.

And let's be clear. I did like your Daddy better.

But let me just say that the reason that I was a little late getting here is because I had guests that flew in from New York, Matthew Hamilton, president and CEO of Columbia Hospital. He is here and a couple of his colleagues.

Why don't you stand up? Stand up, you and it is a couple more people with you. Stand up. Yes, they are here. Thank you.

And the point is there are people all over the country that want to do business with the VA. And they have an international certification. But the question is, how do you do business with VA? And I personally have a hundred percent support of the VA. But I do know that in certain cases that we need to partner outside of the VA to provide a certain amount of services.

Someone spoke about Texas. Texas next to Florida, Texas sent back $95 billion of Medicaid reimbursement. Some of that money would have gone to veterans. Florida sent back $55 billion. And part of that system with our stakeholders is that we have transportation involved for the disabled or for the veteran, part of that Medicaid money that we have sent back to the Federal Government. So it is not just the VA. It is the VA partnering with different organizations and different groups.

And someone mentioned TRICARE and medicine. Let me tell you. My mother is TRICARE, so I know what happened and, you know, that she can go anywhere she wants to in the community.

Well, I went to the corner Walgreens to pick up her medicine and when I drove through, they said $200. So I know it is not no $200. She is TRICARE. I said check again. It came back $13.00 or $15.00. Some people, they would have just tried to pay it or wouldn't have said anything.

So we have got to make sure that we have oversight and make sure that our stakeholders, we are all on the same page because this is all taxpayers' dollars. So it is very important that any system that we put in place that VA have the oversight and make sure that we are getting what we are paying for.

So anyone want to respond to that?

VA has worked with teaching hospitals, different groups. In fact, when the VA built the hospital in Orlando, hopefully one day it will open, but when we built that hospital in Orlando, it has been the

catalyst for the University of Florida, the University of Central Florida, many institutions, and it is a medical complex. And so, you know, it is a team effort. It is not just the VA.

So why don't you respond to that?

Admiral *Carrato.* Well, first I would like to thank you for pointing out Mr. Hamilton and I certainly will reach out to him right after this hearing.

Ms. BROWN. All right. I got his information here.

Admiral *Carrato.* And, yeah, I think you are right. A lot of people are stepping up. I know in Orlando, the Florida Hospital and the Florida Hospital Medical Group have—we have begun those negotiations as a result of the issues they see.

So you are correct. A lot of people want to help. And we want to, as I said, continue to grow our network. So, again, very much appreciate the introduction and I will follow-up after the hearing.

Ms. BROWN. Thank you. Thank you.

So you are operating now out of Florida?

Admiral *Carrato.* Florida with the exception of the Panhandle. We have divided Florida.

Ms. BROWN. I don't know whether the Panhandle is really Florida, but if you say so.

Admiral *Carrato.* Well, that is why Mr. McIntyre has the Panhandle.

Mr. MCINTYRE. That must be because the chairman is not here.

Ms. BROWN. It is the chairman. I take that back. The Panhandle is Florida. In fact, the people from Miami say if you are not in Miami, it is all Panhandle.

But on the prescription, basically the 90 days, it works. The veterans like it. And if you are going to work with the local pharmacies, it is very important that you have the oversight because, like I said, I went through and she said $200 without skipping a beat. And I knew that was not the case. So it is very important that we have the oversight in the system.

Ms. DOODY. Absolutely. Your comment about this being a team effort, and I can tell you from our experience with VA Togus in Maine, we are a team in providing healthcare services to our veterans in northern Maine.

In fact, one of the models that we—as part of our model which we started many years ago, the administration from VA Togus based out of Augusta comes to Caribou and we host town hall meetings with our local veterans which has helped expand services for our veterans and it has been very successful. So we are working very collaboratively with the VA healthcare.

Ms. BROWN. And to my surprise, veterans really like tele-medicine also.

Ms. DOODY. Absolutely.

Ms. BROWN. And so we are going to have a hearing in the next week on how we can expand that program. I was surprised because I would not have liked it. But when I visited with several of the veterans' organizations and groups, they like it.

Ms. DOODY. Absolutely, ma'am. And from our experience in rural parts of our country, tele-medicine is a wonderful option and it has been very successful. We have been doing it for in excess of ten

years and our local veterans are very appreciative of even that opportunity because they know it is another opportunity for access.

Ms. BROWN. Thank you very much.

Mr. Chairman, Chet Edwards, former Member of Congress, is in the audience and he has worked so many years with the veterans.

Why don't you stand up, too?

Mr. BILIRAKIS. Absolutely.

Ms. BROWN. Stand up. Let's give him a hand. Thank you so much for being here.

Mr. BILIRAKIS. Welcome, welcome, welcome.

Ms. BROWN. Stand up so they can see you. All right. Thank you.

Mr. BILIRAKIS. Welcome.

Ms. BROWN. Thank you.

All right. I yield back the balance of my time.

Mr. BILIRAKIS. I gave you an extra minute just for the record.

Okay. Any further questions? Any further questions? Yes, we have Ms. Titus.

You are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman. I appreciate it.

As I have sat here and listened to all of you talk about some of the issues affecting non-VA care, it seems to me we can kind of sum them up with three.

One, lack of providers which I talk about all the time. I represent Las Vegas. Now, there is a national lack of providers, especially in primary care, but we certainly have one in Las Vegas. So as we push veterans out of the VA and into the private sector, I don't want that to be a push to the airport because they don't have any doctor to see them at home.

The Idaho approach 20 years ago of having a doctor step up and take on two veterans is great, but a bit idealistic in today's world.

The second issue is the reimbursement. Now, we have kind of talked about this, but the GAO report that we are going to be discussing in the next panel shows that it is slower, absolutely is slower than the private sector or other federal payers for healthcare. And the Federation of American Hospitals said that the unreimbursed claims often exceed 50 to 90 days, so we can't ignore that as a problem.

The third thing is in that same report, we see that the VA has insufficient data to judge the timeliness and the cost effectiveness of non-VA care. You confirm that you can't talk about the cost effectiveness. There is just not enough data there yet. You think it is working pretty well, but we don't have any hard figures.

And we also know that CBO has been kind of unable to assess the cost going forward and nobody is talking about how to pay for it, yet we are moving pell-mell towards more veterans using this kind of non-VA care.

Now, it is not that I am opposed to that, but I want us to do it right or else we will be having hearings five years from now talking about all the problems with non-VA care.

Now, to hear you all talk about it, you are not having any problems, things are working great under your networks, but we know that is not true either. I mean, there are problems out there and we need to be serious about how to address them from the beginning.

Now, as I understand it, you all are just kind of like the middle man like Sallie Mae and Medicare Advantage where you have a contract to provide a service. That is fine.

But as you push more people out into the private sector, do you see your kind of business growing? Is your network going to cover more areas or more new networks and competition going to come on to be part of this new system that we are going to be creating?

Mr. MCINTYRE. Ma'am, if I might, thank you for your service, and we have the privilege of serving Las Vegas——

Ms. TITUS. I know you do.

Mr. MCINTYRE. —among a number of other places in TRICARE. And in TRICARE, there were a lot of providers who stepped up and said I will take a few. And we are finding the same thing in the VA work.

And what I will tell you is the way that that worked around Nellis, the way that worked with the other places in Nevada is that the care that couldn't be rendered directly by the Defense Department was taken care of by the providers downtown.

And we have been into this work since January 2nd following a 90-day startup. And what I will tell you is——

Ms. TITUS. Which was pushed back, right?

Mr. MCINTYRE. I am sorry?

Ms. TITUS. Didn't you have to push that deadline back?

Mr. MCINTYRE. No. In Nevada, we started on January 2nd and after a 90-day startup and we have a lot of providers in Las Vegas that have stepped up that said they will be helpful in taking care of the veterans in that community.

Now, we have some backlogs in that space, a lot of backlogs in gastroenterology. Guess what? There a lot of those providers in Las Vegas that have a lot of extra capacity because of the size of that community. And so them being able to digest that entire backlog in a 15 to 30-day period is very, very difficult to be able to do.

And so we have been involved in a conversation with the gastroenterology community in Las Vegas by way of example for here is what we are looking at volume wise. We would like your help. They have said yes. And how can you open up your calendar to make sure that veterans can fit into the calendar as you are doing your scheduling in your office. And we are doing that a lot of places across the communities that we serve.

On the primary care side, primary care is not done through these contracts today. In primary care in the Defense Department environment, there were providers all over the community in El Paso and beyond in Nevada that stepped up to say we will take a few. I can't fill my entire practice with those that come through this program because the reimbursement rates may not be as high as they might be in some other programs, but I will take a few. And it worked and it will work here.

Ms. TITUS. What about in Ely, Nevada where you don't have a doctor who can step up and take a few?

Mr. MCINTYRE. Well, if you are in Ely, Nevada and there are no providers in that community of a certain specialty type, which is a factual statement, as you know, then you can't deliver the care in that community.

Then the question becomes where is the closest location to Ely to be able to deliver that care? And one of the things that we in the VA are trying to determine as we go through this process is where are the veterans and in what numbers that need to rely on the private sector as a pop-off valve or a relief valve to the direct care system and what is the demand so that we can make sure that those networks match to that.

Ms. TITUS. Is that study ongoing right now? Are you doing a study?

Mr. MCINTYRE. It is not a study. It is not a study. It is an engaged conversation that is going on every day across our geographic space and I am sure the same is true in the Health Net area to share information between both sides of the system to make sure that we identify together where those pockets are where we might need providers that might not have otherwise been known to all of us as we started up this program on January 2nd.

Ms. TITUS. Is there hard data? Are you going to have hard data to show us or is this going to be anecdotal?

Mr. MCINTYRE. I will be glad to come sit down with you and talk about the State of Nevada and the communities in your area that you are responsible for. And I would like to be measured against the same standard that Mr. Walz talked about which was at the end of the day when we got to a place that was at maturity, it won't be five years from now, that the veterans that need care that rely on this program as well as the direct system are getting what they need.

Ms. DOODY. In your comments, ma'am, the—I am sorry. Go ahead. No. Go ahead, please.

Admiral *Carrato.* I was just going to say just in response to your points, claims payment, we are paying in a timely fashion, 30 days or less. Reimbursement, we have been successful in achieving some discounts and we are continuing to grow our network. And as Dave said, part of it is looking where the demand is and matching supply to demand.

In terms of what our organizations do as contractors, we do provide a lot of value. We pay claims timely, as I said. We coordinate care. We have quality oversight. We build networks in accordance with URAC accreditation requirements. So we do deliver value add to our veterans and to their healthcare needs.

Ms. DOODY. And our arrangement, ma'am, is slightly different. It is a direct contract with the hospital without a middle person involved. And we work directly with the VA hospital within our state in coordinating the care for the veteran and what the needs might be.

So it is direct access between the VA and our private hospital. So it is a very different arrangement and there is very open communication between the VA Togus, our hospital in our state, and our hospital.

Ms. TITUS. Thank you, Mr. Chairman.

Mr. BILIRAKIS. You are welcome.

All right. Now I will recognize—you yield back obviously. Okay. I will recognize Mr.—do you have any questions, Mr. Coffman, for this panel? You are recognized, sir, for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Mr. McIntyre, I am not sure if this was covered, but in your written statement, you reference the experience TriWest brings to bear. As a former TRICARE provider, I just want to say you did a great job in the State of Colorado and I thank you for that.

But what similarities and differences, if any, do you see between the implementation of TRICARE and the implementation to date of PC3? What lessons learned would you like to see VA take from TRICARE and applied to PC3 to improve the provision of care to veteran patients?

Mr. MCINTYRE. I think that the VA on the VA PC3 side has done an admiral job under very, very tight time constraints and then the loading on of the challenges that we have all been talking about today. Those challenges got loaded in as this program started up.

They were in the process of putting in place and maturing their own system, the NVCC care process, which has them standardizing how they put stuff to the marketplace. I think they would all say that that program wasn't entirely at maturity at the time that this all started.

A 90-day startup is a very, very short period. Nine months is short. Ninety days is really short. And I think we stood up. We were wobbling a bit, but we stood up what we needed to do. And I think looking backwards, if they had been given the opportunity to have more than 90 days, they probably would agree that that would make some sense.

But I think by and large, things have gone reasonably well. They studied the TRICARE experience. They studied the implementation of other programs. And they did a pretty good job of designing a system that matches up to a very complicated enterprise.

That unlike the military has differences site by site by site by site. And in the military, you see standardization by and large between the army facilities, between the air force facilities, and between the navy facilities. And you don't find that kind of common consistency, yet the program office and central office have been trying to standardize their process to which this is matched.

Mr. COFFMAN. Let me just start again. The PC3 program is a program whereby under the authorization of the VA, the veterans eligible for VA care can access non-VA providers.

Would either of you also like to comment on the question?

Admiral *Carrato.* On the similarities, sir, of the startup?

Mr. COFFMAN. Sure.

Admiral *Carrato.* I think Dave covered a lot. I agree that the VA did a very good job on defining the requirements for the PC3 program. I think one of the things we are seeing in terms of similarities with a large program, a new program across just such a broad geographic area, there still are lessons to be learned.

I think it is important to listen to our providers and some of the requirements that don't quite fit with the civilian practice of medicine and see how we can address those. And obviously it is important to hear the voice of the veteran as well.

So I think one of the big lessons learned is with the early startup, during that first year, pay attention to those lessons learned and adapt and be flexible in trying to improve the program and make it more efficient for all parties concerned.

Mr. COFFMAN. Ms. Doody.

Ms. DOODY. Yes. From our experience, we started Project ARCH in the fall of 2011 and had to work very closely with the Veterans Administration since this was a new program and also had to learn some of the requirements as it related to the VA. And we also had a very tight time frame. In fact, at the beginning, it was a moving target on when Project ARCH was to go live.

But we were able to pull it off and it is because of excellent relationship with the Veterans Administration. They provided us the support and the direction that we needed to make it happen for the veterans.

And I agree with the comments of my colleagues. We have to listen to the veterans and what is working and what is not working and immediately respond to that.

Mr. COFFMAN. Mr. McIntyre, very quickly. Prior to the recent Phoenix scandal in that hospital, how long did it take for a veteran to try and access an outside provider through the system? Do you have any idea of what that was like?

Mr. MCINTYRE. I don't.

Mr. COFFMAN. Okay.

Mr. MCINTYRE. And that is information that the VA should be able to provide to you.

Mr. COFFMAN. Okay. Any other comments on that specific issue?

Ms. DOODY. No, I am not aware.

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

Mr. BILIRAKIS. Thank you.

Mr. Wenstrup, you are recognized for five minutes.

Mr. WENSTRUP. Thank you very much, Mr. Chairman.

I want to talk about a couple things. I come from a group of 26 doctors, orthopedics and sports medicine, and some of us had military background. And we felt an obligation to take TRICARE even though reimbursement was less and a desire to take TRICARE to take care of our military. So I appreciate what you were saying because I think that there is that appeal.

You do have to monitor whether you are being overrun with it because it is not necessarily great for your bottom line, but you are willing to do that. And that is an appeal that I think we need to make to doctors in America that they will understand and not be chastised if they were to limit that amount but just encourage them to participate.

And I think that would be a great benefit to us today. And I am glad to know that it has been successful. That was the notion within our group.

But I also have a concept here that I would like to get your opinion on. You know, we have doctors that are VA doctors within the walls, but what about our specialists that are out in the community that we refer to? Can we credential them as VA doctors?

And although they probably don't want to learn the VistA system and get into all that, can they send a PDF of all their notes that can get into the VistA system and be accessible and at the same time when they write a prescription to the patients, because they are credentialed through the VA, can they just go get it filled at the VA?

But some ideas along those lines where even though you are not within the walls, you are a VA physician outside the walls.

Mr. MCINTYRE. There certainly is value in the ability to supplement what can be done directly in the system by allowing providers to come in on a case-by-case basis and deliver services. And in some communities, that works.

In Phoenix, Arizona, one of the things that is underway right now is discussion, as there should be, between the VA and some of the local facilities on can you expand our platform and give us the ability to actually make use of your facilities to deliver more care in the other direction because they have enough providers, but they don't have enough OR space. That is always a good idea.

And in Arizona, that has been going on for a long time between the air force and the community, the shrinkage of that hospital to a clinic. And so my guess is there is going to be a lot more of this conversation that goes forward.

And I would like to thank you for your service to this community and really demonstrating the fact that it really does work if folks take a handful of their fellow citizens in these important programs and step up and do the work. And our job is to make it as seamless as we can make it to honor the service of those providers and make sure they get paid on time so that they will take another one or two in the next three or four months.

And that model really does work, so thank you for validating that.

Mr. WENSTRUP. Thank you.

Mr. MCINTYRE. You bet.

Mr. WENSTRUP. Unless someone else has a comment.

Admiral *Carrato.* You know, since you threw out the concept, I will take the bait. And, you know, Dave has talked a lot about TRICARE. And I think the notion of assets moving from the private sector to the VA and the VA to the private sector has been demonstrated to be a very effective component of the TRICARE program.

So if the VA has a service fully staffed with the exception of a technician or a certain provider, the contractor can provide that resource to the VA again to make sure that care is delivered.

By the same token, there is something called external resource sharing. So if there is no OR space in the VA, you don't want the surgeon's skills to degrade, you can get them privileged at a network hospital. So that concept actually works very effectively in the DoD program. And it is a concept that is probably worth exploring within PC3.

Mr. WENSTRUP. I appreciate the open-mindedness as we move forward. Thank you.

Ms. DOODY. And from our experience in Project ARCH and actually your comments about can I use my own prescription pad and can I use some of my own forms, you sound like some of my physicians when we started Project ARCH. I have to be honest with you.

And until we learned some of the forms or requirements of the VA, it was a transition time for our providers, but now it is a way of life. And I will be honest with you. We have actually learned from the VA some best practices that we have incorporated into our own hospital.

Mr. WENSTRUP. Thank you very much. I appreciate your input.

And I yield back.

Mr. BILIRAKIS. Thank you. Thank you very much.

I will ask one last question for TriWest and Health Net. What are the performance measures you track besides and beyond profit?

Mr. MCINTYRE. We have a responsibility to appoint people within a certain time frame. We track that. We track the volume of work that our staff is taking to complete. We track the providers that we are required to have from our perspective based on the demand that we see by facility and the location of veterans.

And we track claims payment on the back end and we track the return of medical documentation back from the provider to the VA to make sure that the medical record when that person ends up back in the VA needing care is going to be complete.

We track about 40 other metrics, but those are the ones that top of mind would probably be most important to making sure that we are staying focused on the very performance of what is going on here.

What I will tell you is this year, our company is paying $29.00 for the privilege of doing this work. And the reason for that is, and I am not complaining because we do that voluntarily, the reason is you pay to build your own infrastructure. And you only get paid for the work as it arrives and that requires advanced investment.

And so we do that willingly and we believe at the end of the day that this program is going to be a good match to the direct delivery system just as TRICARE is to the Defense Department.

Mr. BILIRAKIS. Thank you.

Admiral *Carrato.* Yeah. We are an ISO 9000 certified organization, so we really focus on tracking performance metrics. Dave mentioned some of the more significant ones, but we have a program management review that we conduct monthly where we track all of the metrics that the VA uses to monitor our performance.

And I can tell you that so far, things are going well. We also have a very detailed quality assurance surveillance program that we use. And I think that so far, you know, we have been performing well against those metrics.

Mr. BILIRAKIS. Very good.

Mr. Michaud, anything further?

Mr. MICHAUD. No.

Mr. BILIRAKIS. All right. Well, thank you very much again for your testimony today.

And what we will do is dismiss the first panel and we will call the second panel. I want to welcome the second panel to the witness table.

Joining us on the second panel is Randy Williamson, Mr. Randy Williamson from Health Care, director for the Government Accountability Office, and Mr. Philip Matkovsky, the assistant deputy under secretary for Health for Administrative Operations for the Department of Veterans Affairs. Welcome.

Thank you both for being here today. If you are ready, Mr. Williamson, you are now recognized for five minutes.

If you could check, your mic is on.

Mr. WILLIAMSON. Thank you

STATEMENT OF RANDY WILLIAMSON

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

I am pleased to be here today to discuss our work on VA's programs for delivery of care through non-VA providers. Non-VA providers treat veterans in community hospitals or doctors' offices and VA pays for them using a fee-for-service arrangement. Last year VA spent about $4.8 billion dollars for non-VA provided medical care for more than one million veterans.

Since VA intends to allow more veterans to see non-VA providers due to excessive wait times at some VA facilities, it is important to ensure that non-VA care is reliable, accessible, and efficient. Two recently GAO reports identified numerous weaknesses in VA's management of its non-VA care program, and today, I want to address three broad areas that require VA's attention in this regard.

First, the need to eliminate VA claims processing errors mainly for emergency care provided at non-VA facilities. Second, the need for more focused oversight and reliable data to monitor the non-VA care program. And third, the need for better communication with veterans and non-VA providers about program eligibility and claims processing.

Regarding claims processing errors, at four VA facilities we visited, we found patterns of noncompliance with VA processing requirements. Specifically, we reviewed a sample of 128 claims for emergency care non-VA providers had submitted to these four locations and found that VA had inappropriately denied 20 percent of the claims because VA clerks made mistakes in planning eligibility criteria and were sloppy in their procedures for processing claims.

Moreover, VA did not always notify veterans, as required, that their claims had been denied; therefore, some veterans were likely billed for care that VA should have paid for and those not notified by VA were denied their appeal rights and were unaware they were liable for paying bills for non-VA providers.

Looking forward, we found that VA, both at the national and local levels, does not have effective oversight mechanisms in place to detect claims processing errors or to monitor other important aspects of the non-VA care program. For example, the issue of wait times for appointments in VMACs, which has been a serious and longstanding problem for VA, could be an issue with non-VA providers as well. This is because once a veteran is authorized to use non-VA provider care, VA doesn't track how long a veteran waits to see a non-VA provider. Because VA had virtually no data on this, little is now known about wait times for veterans seeking care outside VA.

Finally, communication between VA and veterans and between VA and non-VA providers is lacking in some respects. We found on our visits to four locations that some veterans do not always understand their eligibility for coverage for emergency care from a non-VA provider and this has resulted in cases where veterans have avoided or delayed seeking emergency care for non-VA providers, sometimes to the veteran's detriment.

For example, a VA official we interviewed described one account involving a veteran experiences chest pains who drove over a hun-

dred miles to a VA facility rather than seeking emergency care at a local non-VA medical facility. In another case, a veteran experiencing chest pains died during the weekend as he waited to seek care until a local veteran CBOC opened on Monday.

Moreover, VA does not conduct any veteran surveys to identify specific gaps in veterans' knowledge and determine how to better target its veteran education efforts. Non-VA hospital administrators and other providers we talked with also cited instances where VA claims processing staff had been unresponsive to the requests and queries about unpaid claims in efforts to move veterans back to VA facilities once their emergency conditions had stabilized as required. In some cases, non-VA providers had difficulty even obtaining a point of contact from the nearest VAMC to answer their questions.

In summary, VA needs to improve the management of its non-VA care program to provide veterans with accessible, reliable and efficient care when they seek care from non-VA providers. VA needs to fully develop and implement a comprehensive strategy and action plan that addresses weaknesses the GAO and others have identified. This includes establishing clear responsibilities and expectation for what needs to be done and holding staff at all levels accountable for implementing the AVA care program, such that veterans are treated fairly and not put in harm's way. This concludes my opening remarks.

Mr. BILIRAKIS. Thank you.

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VA HEALTH CARE

Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care

Statement of Randall B. Williamson
Director, Health Care

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am pleased to be here today to discuss our work on the Department of Veterans Affairs' (VA) delivery of care through its Non-VA Medical Care Program.[1] The majority of veterans enrolled in the VA health care system receive care in VA-operated medical facilities, such as VA medical centers and community-based outpatient clinics.[2] However, VA is authorized to obtain health care services from non-VA providers to help ensure that veterans are provided timely and accessible care.[3] For example, VA may utilize non-VA medical care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or when a veteran would have to travel long distances to obtain care at a VA medical facility. Non-VA providers treat veterans in non-VA facilities, such as physicians' offices or hospitals in the community. Non-VA providers are commonly paid by VA using a fee-for-service arrangement. In fiscal year 2013, VA spent about $4.8 billion on non-VA medical care for more than 1 million veterans, which accounted for about 11.6 percent of VA's total medical services budget for that year.[4]

There are two main non-VA medical care delivery methods—preauthorized care and emergency care—that are approved using two different processes. The first, preauthorized care, is approved in advance by VA facility officials. VA may authorize veterans to seek care from non-VA providers for a number of reasons, including when (1) wait times for appointments at VA facilities exceed VA standards; (2) the distance veterans must travel to VA facilities is impractical for the veteran; and (3) VA facilities do not offer the medical services the veteran needs. Preauthorized care accounts for the majority of spending and utilization

[1]The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

[2]VA's health care system includes 151 VA medical centers. VA also provides care to veterans in VA-operated community-based outpatient clinics, community living centers (nursing homes), residential rehabilitation treatment programs, and comprehensive home care programs.

[3]VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

[4]This percentage reflects final appropriations numbers for VA's total medical services budget after the across-the-board budget rescissions in fiscal year 2013.

(about 60 percent of spending and about 88 percent of utilization) for the Non-VA Medical Care Program. The second, emergency care, is not typically approved in advance by VA facility officials and has certain criteria that must be met in order for VA to approve reimbursement for the non-VA provider.

In response to serious and longstanding problems regarding the timely scheduling of veterans' appointments in VA facilities that have been highlighted in recent congressional oversight hearings, VA has announced its intention to allow additional veterans to be treated through its Non-VA Medical Care Program. With this likely increase in the utilization of non-VA medical care, it is not only important to ensure that veterans will obtain timely treatment from non-VA providers, but also to ensure that non-VA medical care is a reliable and cost-effective means for VA to deliver services. Today, I will address the extent to which (1) VA collects reliable information on wait times and cost-effectiveness of the Non-VA Medical Care Program; (2) VA facilities comply with claims processing requirements for emergency care provided under the Veterans Millennium Health Care and Benefits Act (Millennium Act), and the extent to which VA oversees facilities' claims processing activities; and (3) VA educates veterans about eligibility for Millennium Act emergency care and communicates with non-VA providers about claims processing.[5]

My statement is based on the key findings of two GAO reports that identified weaknesses in VA's management and oversight of its Non-VA Medical Care Program: a March 2014 report entitled *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit,* and a May 2013 report entitled *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement.*[6] For the March 2014 report, which focused on VA's

[5]The Veterans Millennium Health Care and Benefits Act (Millennium Act) authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other eligibility criteria. See Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (codified, as amended, at 38 U.S.C. § 1725).

[6]See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit,* GAO-14-175 (Washington, D.C.: Mar. 6, 2014) and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement,* GAO-13-441 (Washington, D.C.: May 31, 2013).

administration and oversight of Millennium Act emergency care delivered to veterans by non-VA providers, we reviewed the law, its implementing regulations, and applicable VA policies and guidance to identify applicable requirements for processing these claims. We then visited four VA facilities that were selected on the basis of fiscal year 2012 spending totals and geographic location and reviewed VA documents—including 128 Millennium Act emergency care claims that these four facilities had denied in fiscal year 2012. We also interviewed officials from VA, non-VA providers, and veterans service organizations. For the May 2013 report, which focused on VA's management and oversight of non-VA medical care spending and utilization, we reviewed relevant laws and regulations, VA policies, and spending and utilization data on non-VA medical care from fiscal years 2008 through 2012. We also interviewed VA officials and examined the non-VA medical care operations at six selected VA facilities that varied in size, services offered, and geographic location. The results of both of these studies cannot be generalized to all VA facilities, but they illustrate the serious weaknesses in various aspects of the Non-VA Medical Care Program. We have made numerous recommendations to VA in these previous reports, and VA has concurred with all of them. We are not making any new recommendations at this time. In June 2014, in preparation for this statement, we met with VA officials to discuss the status of VA's implementation of action plans to address the recommendations included in these two reports.

The work this statement is based on was conducted in accordance with generally accepted government accounting standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The reports cited provide additional information on our scope and methodology.

Background

Types of Non-VA Medical Care

When veterans obtain care from non-VA providers, the non-VA providers submit claims to VA for payment. See table 1 for a description of the types of non-VA medical care claims processed by VA.

Table 1: Types of Non-VA Medical Care Claims and Relevant Payment Authority

Type of claim	Description and relevant payment authority
Preauthorized care[a]	Services with prior VA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)
Emergency care	Services without VA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash)
Veterans Millennium Health Care and Benefits Act (emergency care for conditions not related to service-connected disabilities)	Services meeting criteria under 38 U.S.C. § 1725
Emergency care for conditions related to service-connected disabilities	Services meeting criteria under 38 U.S.C. § 1728

Source: GAO analysis of VA policies. | GAO-14-696T.

[a]In certain circumstances, emergency care provided by non-VA providers can be deemed preauthorized if the non-VA providers provide notification of a veteran's admission within 72 hours. Emergency care by non-VA providers may also be preauthorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA provider.

Preauthorization Process for Non-VA Medical Care

Preauthorizing non-VA medical care involves a multistep process conducted by the VA facility that regularly serves a veteran.[7] The preauthorization process is initiated by a VA provider who submits a request for non-VA medical care to the VA facility's non-VA medical care unit, which is an administrative department within each VA facility that processes VA providers' non-VA medical care requests and verifies that non-VA medical care is necessary. Once approved by the VA facility's Chief of Staff or his or her designee, the veteran is notified of the approval and can choose any non-VA provider willing to accept VA payment at predetermined rates.[8] (See fig. 1.)

[7]VA uses this same preauthorization process for nonemergency inpatient and outpatient care, dental care, nursing home care, compensation and pension exams, and most pharmacy expenses paid for through the Non-VA Medical Care Program.

[8]VA uses this process to preauthorize non-VA medical care from a number of different types of non-VA providers, including community-based hospitals and Department of Defense medical facilities that collaborate with VA facilities to provide some veterans' care.

Figure 1: VA Facility Process for Preauthorizing Non-VA Medical Care

Source: GAO. | GAO-14-696T

[a]In some VA facilities the non-VA medical care unit may assist veterans in setting up their appointments with the non-VA provider of their choice.

Criteria for VA Coverage of Emergency Care from Non-VA Providers

For claims that are emergent in nature and therefore would not have gone through the traditional VA preauthorization process, VA is authorized to pay claims for emergency care from non-VA providers under certain conditions, which vary depending on whether the care was related to the veteran's service-connected disability.

If a non-VA emergency care claim is related to a veteran's service-connected disability, the following criteria must be met in order for the services to be paid for by VA.

- First, the non-VA emergency care must have been rendered to treat one of the following: (a) a veteran's service-connected disability; (b) a condition that is associated with and aggravating the veteran's service-connected disability; (c) any condition for a veteran who has been rated by VA as permanently and totally disabled due to a service-connected disability; or (d) any condition for a veteran participating in a vocational rehabilitation program who needs care to participate in a course of training.
- Second, the non-VA emergency care must also meet all of these criteria:
  - the claim must be filed within 2 years of the date the care or services were rendered;

- the services were rendered in a medical emergency, as determined using the prudent layperson standard;[9]
- a VA or other federal facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable; and
- the services were needed before the veteran was stable enough to be transferred to a VA or other federal facility and before the VA or other federal facility agreed to accept the transfer.

If a claim for non-VA emergency care is not related to a veteran's service-connected disability, there are different criteria that must be met in order for the services to be paid for by VA. The Millennium Act, which was enacted in 1999, provides a safety net for veterans when they do not have other insurance and need emergency care that is not related to a service-connected disability. Specifically, all of the following criteria must be met for VA to cover Millennium Act claims:

- The claim is not payable under the payment authority for emergency care related to service-connected disabilities.
- The claim must be filed within 90 days of the latest of the following: the date of discharge, date of death, or date that the veteran exhausted, without success, action to obtain payment or reimbursement from a third party.
- The veteran must be enrolled in the VA health care system and have received treatment from a VA clinician within 24 months of the emergency care episode.
- The veteran must be financially liable to the non-VA provider of emergency care.

[9]A medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

- The veteran can have no entitlement to care under a health plan contract (such as Medicare or a private health insurance plan).[10]
- The veteran can have no other contractual or legal recourse against a third party that would in whole extinguish his or her liability to the non-VA provider.[11]
- The services must be rendered in a hospital emergency department or a similar facility providing emergency care to the public.
- The services must be rendered in a medical emergency as determined using the prudent layperson standard.[12]
- A VA or other federal facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable by a prudent layperson.
- The services were rendered before the veteran was stable enough to be transferred to a VA or other federal facility and before the VA or other federal facility agreed to accept the transfer.

Process for Paying Non-VA Medical Care Claims

Regardless of whether a veteran's non-VA medical care was preauthorized or the result of an emergency, the steps for processing payments to non-VA providers are the same. Specifically, the non-VA provider submits a claim to either a Veterans Integrated Service Network (VISN) or a VA facility for payment following the veteran's treatment.[13] In some VISNs, claims processing activities are centralized in a VISN-level department that is responsible for reviewing claims from non-VA providers, obtaining copies of medical records for veterans' non-VA medical care, and approving payment to non-VA providers. In other

[10]The 2010 amendments to the Millennium Act changed the definition of a health plan contract to exclude state laws requiring motor vehicle drivers to have auto insurance as a source of coverage. Act of Feb. 1, 2010, Pub. L. No. 111-137, §1(a)(2),123 Stat. 3495.

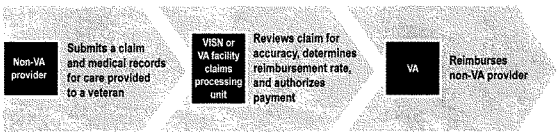
[11]The 2010 amendments to the Millennium Act also authorized VA to pay for treatment when a veteran has recourse against a third party for a portion, but not all, of the veteran's liability. In such cases, VA becomes the secondary payer, such as when auto insurance only partly covers the veteran's liability to the non-VA provider.

[12]38 C.F.R. § 17.1002(b).

[13]VA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA facilities that are within their network. Each VA facility is assigned to a single VISN.

VISNs, these claims-processing activities are decentralized and are the responsibility of individual VA facilities. After VA facility or VISN officials review the claims for accuracy, non-VA providers are reimbursed by VA. (See fig. 2.)

Figure 2: Veterans Integrated Service Network (VISN) or VA Facility Steps for Processing Approved Claims for Non-VA Medical Care



Source: GAO. | GAO-14-696T

To process all claims for non-VA medical care, VA facilities use software called the Fee Basis Claims System (FBCS).[14] FBCS is primarily a system that helps VA facilities administer payments to non-VA providers, as opposed to a system that automatically applies relevant criteria and determines whether claims are eligible for payment. As a result, VA relies on staff in the VISNs and VA facilities that process claims, such as administrative clerks and clinicians (typically nurses), to make decisions about which payment authority applies to the claim and which claims meet the criteria for VA payment.

Notifying Veterans and Non-VA Providers of Denials of Claims for Non-VA Medical Care

If VA denies payment for a claim for non-VA medical care, the Department must provide written notice to the veteran and the claimant (usually, the non-VA provider) regarding the reason for the denial and inform them of their rights to request a reconsideration or to formally appeal the denial. If a veteran or non-VA provider has questions about a denied claim, claims should be reconsidered by a supervisor at the same VISN or VA facility that denied the claim. If the denial decision is upheld,

[14]The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

the veteran or non-VA provider has the right to file an appeal through the Board of Veterans' Appeals.[15]

VA Lacks Critical Data on Wait Times and Cost-Effectiveness of Non-VA Medical Care

Critical data limitations related to the wait times veterans face in obtaining care from non-VA providers and the cost-effectiveness of such services limit VA's efforts to oversee the Non-VA Medical Care Program in an effective manner. Most notably, VA does not collect data on how long veterans must wait to be seen by non-VA providers. We previously reported that the amount of time veterans wait for appointments in VA facilities influenced VA's utilization of non-VA medical care. For example, in our May 2013 report, VA officials from all six facilities we reviewed reported that they routinely referred veterans to non-VA providers to help ensure that veterans receive timely care and their facilities meet performance goals for wait times for VA facility-based care.[16] Officials from one of these VA facilities explained that veterans needing treatment in several specialties—including audiology, cardiology, and ophthalmology—were referred to non-VA providers for this reason.

In fiscal year 2012, VA performance goals for wait times for care in VA facilities called for veterans' primary care appointments to be completed within 7 days of their desired appointment date and veterans' specialty care appointments to be scheduled within 14 days of their desired appointment date. However, since VA did not track wait times for non-VA providers, little was known about how often veterans' wait times for non-VA medical care appointments exceeded VA facility-based appointment wait time goals. Officials from one VA facility we reviewed explained that non-VA providers in their community also faced capacity limitations and may not be able to schedule appointments for veterans any sooner than the VA facility.

Limitations in the way VA collects non-VA medical care data also did not allow the Department to analyze the cost-effectiveness of non-VA medical care provided to veterans. In our May 2013 report, we found that VA

[15]Based in Washington, D.C., the Board of Veterans' Appeals is composed of judges experienced in veterans' law. The Board reviews benefit determinations made by local VA offices and issues final decisions on appeals.

[16]See GAO-13-441. These six facilities were located in Durham and Salisbury, North Carolina; Alexandria, Louisiana; Biloxi, Mississippi; Las Vegas, Nevada; and Loma Linda, California.

lacked a data system to group medical care delivered by non-VA providers by episode of care—a combined total of all care provided to a veteran during a single office visit or inpatient stay.[17] For example, during an office visit to an orthopedic surgeon for a joint replacement evaluation, an X-ray for the affected joint may be ordered, the veteran may be given a blood test, and the veteran may receive a physical evaluation from the orthopedic surgeon. The non-VA provider would submit a claim to VA for the office visit, and separate claims would be submitted by the radiologist that X-rayed the affected joint and the lab that performed the veteran's blood test. However, VA's non-VA medical care data system was not able to link the charges for these three treatments together. We found that this left VA without data for comparing the total non-VA medical care costs for various types of services with the VA facility-based alternative.

Without cost-effectiveness data, VA is unable to efficiently compare VA and non-VA options for delivering care in areas with high utilization and spending for non-VA medical care. Two VA facilities we reviewed had undertaken such assessments, despite the limitations of current data. Officials at one facility reported that they expanded their operating room capacity to reduce their reliance on non-VA surgical services, saving an estimated $18 million annually in non-VA medical care costs. Similarly, officials from the second facility reported that they were able to reduce their reliance on non-VA medical care by hiring additional VA staff and purchasing additional equipment to perform pulmonary function tests, an effort that reduced related non-VA medical care costs by about $112,000 between fiscal years 2010 and 2012. The lack of non-VA medical care data available on an episode of care basis also prevents VA from efficiently assessing the appropriateness of non-VA provider reimbursement. Specifically, VA officials cannot conduct retrospective reviews of VA facilities' claims to determine if the appropriate rate was applied for the care provided by non-VA providers.

To help VA address these concerns, we made two recommendations in our May 2013 report that directed VA to (1) analyze the amount of time

[17]In March 2013, VA officials told us that for inpatient claims they could construct a program to group inpatient and inpatient ancillary claims together by linking all the records of individual services provided to veterans during a particular date range. However, this method relies on correct data entry by VISNs and VA facilities into FBCS and correct information to be furnished by non-VA providers. VA officials acknowledged that there is no way to link outpatient services together to create a record of a single outpatient episode of care.

veterans wait to see non-VA providers and apply the same wait time goals to non-VA medical care that have been used to assess VA facility-based wait times, and (2) establish a mechanism for analyzing the episode of care costs for non-VA medical care. VA concurred with these recommendations. In June 2014, we discussed VA's progress in implementing these recommendations with VA officials. These officials indicated that the Department anticipated being able to track some wait time information for veterans seen by non-VA providers that VA contracts with under its new Patient Centered Community Care (PCCC) initiative in the near term.[18] However, wait time information for all non-VA medical care will not be readily available until VA completes a redesign of its claims processing system, which is expected to occur in fiscal year 2016. With respect to establishing a mechanism to analyze the episode of care costs for non-VA medical care, VA officials explained that they are in the process of fully implementing this recommendation by (1) improving existing data systems to systematically audit claims that include billing codes typically included in bundled payments while the claims are in a pre-payment status and to require VA facilities to review these claims prior to payment, and by (2) making improvements to its Non-VA Medical Care Program data that would allow all non-VA medical care data to be analyzed on an episode of care basis. However, VA officials did not provide a time frame for when all non-VA medical care would be routinely analyzed by episode of care.

[18]Under PCCC, VA facilities have the ability to purchase non-VA medical care through contracted non-VA providers when they cannot readily provide the needed care due to geographic inaccessibility or limited capacity. VA has awarded two PCCC contracts, one to Health Net Federal Services, LLC, and another to TriWest Health Alliance Corporation. Under these contracts, these companies are setting up networks in six regions covering the entire country.

Selected VA Facilities Failed to Comply with Applicable Millennium Act Claims Processing Requirements, and Weaknesses Were Identified in VA's Oversight of Claims Processing Activities

In March 2014, we reported that four VA facilities we visited had patterns of noncompliance with VA claims processing requirements, which led to the inappropriate denial of some Millennium Act emergency care claims and the failure to notify some veterans that their claims had been denied.[19] We also found that VA's existing oversight mechanisms for non-VA medical care claims processing were not sufficiently focused on whether VA facilities were inappropriately approving or denying claims.

Selected VA Facilities Frequently Did Not Comply with Claims Processing Requirements, Which Led to the Inappropriate Denial of Claims

For our March 2014 report, we examined a sample of 128 Millennium Act emergency care claims that the four VA facilities we visited had denied in fiscal year 2012 and found 66 instances of noncompliance with VA policy requirements. We determined that about 20 percent of the claims we examined had been denied inappropriately, and almost 65 percent of the claims we examined lacked documentation showing that the veteran was notified that their claim was denied. As a result of our review, these four VA facilities reconsidered and paid 25 claims that they had inappropriately denied.

We found that there are no automated processes for determining whether a claim for non-VA medical care meets criteria for payment or ensuring that veterans are notified when a claim is denied; instead these processes rely on the judgment of VA staff reviewing each claim and adherence to VA policies. There are a number of steps in the claims review process that were susceptible to errors that could lead to inappropriate denials of non-VA medical care claims. For example, we found nine instances where VA staff incorrectly determined that non-VA medical care was not preauthorized when, in fact, a VA clinician had

[19]See GAO-14-175. We visited the North Texas VA Health Care System; the Washington, D.C., VA medical center; the White River Junction VA medical center; and the Black Hills VA Health Care System.

referred the veteran to the non-VA provider.[20] In addition, VA policy states that VA must notify veterans in writing about denied claims and their appeal rights. However, we found that one facility we visited could not produce documentation of veteran notification for any of the 30 denied claims we reviewed. We concluded that when veterans are not informed that their claims for non-VA medical care have been denied, and VA has inappropriately denied the claims, then veterans could become financially liable for care that VA should have covered. Under such circumstances, veterans' credit ratings may be negatively affected, and they may face personal financial hardships if they are unable to pay the bills they receive from non-VA providers.

These findings from our March 2014 report raise concerns about compliance with claims processing requirements at other VA facilities nationwide. To help VA address these concerns, we made six recommendations aimed at improving VA's processing of non-VA medical care claims, specifically Millennium Act emergency care claims. These recommendations directed the Department to establish or clarify its policies or take other actions to improve VA facilities' compliance with existing policy requirements. VA concurred with these six recommendations. Based on discussions with VA officials in June 2014 to obtain information about the status of their planned actions for implementing these recommendations, we believe that VA is making progress on the implementation of three of the six recommendations. However, VA needs to take additional steps to revise its policies on claims processing roles and responsibilities in order to address our remaining three recommendations.

Weaknesses Found in VA's Oversight of Non-VA Medical Care Claims Processing

One of VA's primary methods for monitoring its facilities' compliance with applicable requirements for processing non-VA medical care claims is field assistance visits. In fiscal year 2013, VA conducted these visits at 30 out of 140 VA facilities that processed non-VA medical care claims. These 30 facilities were selected for review by VA based on their claims

[20]In eight of these nine instances, VA clinicians did not properly document their referrals in VA's electronic medical record, as required by VA policy. As a result, non-VA medical care unit staff were not alerted to create authorizations in FBCS, which is a necessary step for the payment of preauthorized non-VA medical care claims. In the remaining instance, staff who processed the claim did not have access to any authorizations in FBCS that had been issued by other VA facilities and did not know that a VA clinician from a different VA facility had referred the veteran to the non-VA provider.

processing timeliness. However, we reported in March 2014 that the criteria VA used to select facilities for review may not direct VA to the facilities most in need of a field assistance visit because VA does not take into account the accuracy of claims processing activity. Moreover, we found that the checklist VA uses for its field assistance visits does not examine all practices that could lead VA facilities to inappropriately deny claims.[21] Further, VA does not hold facilities accountable for correcting deficiencies identified during these visits, and it does not validate facilities' self-reported corrections to address field assistance visit deficiencies. According to VA officials, these visits are meant to be consultative in nature and assist facilities in improving their non-VA medical care claims processing. However, we found weaknesses in VA's reliance on facilities' self-reported actions when we reviewed the Department's fiscal year 2012 and 2013 field assistance visit data and found unresolved problems in fiscal year 2013 that originated in fiscal year 2012.[22]

Further, VA implemented automated processes for auditing approved non-VA medical care claims to ensure that VA facilities apply the correct payment rates and no duplicate versions of the claims were previously paid. However, VA has no systematic process for auditing claims to ensure that they were appropriately approved or denied. VA officials stated that they recommend, but do not require, that managers of non-VA medical care claims processing units at VA facilities audit samples of processed claims—including both approved and denied claims—to determine whether staff processed claims appropriately. However, we found that VA does not know how many facilities conduct such audits, and none of the four VA facilities we visited reported conducting such audits.

[21]For example, VA's checklist does not examine VA facilities' practices for determining whether veterans are enrolled at a different VA facility and whether they have been seen by providers at another VA facility in the last 24 months—a critical criteria for determining whether veterans are eligible for Millennium Act emergency care coverage.

[22]For example, when we reviewed these data, we found that one VA facility had been cited in fiscal year 2012 because it was not entering authorizations for referrals to non-VA providers in a timely fashion into FBCS—a practice that could lead to the inappropriate denial of claims. When we reviewed VA's fiscal year 2013 field assistance visit data for this facility, we noted that VA observed this same deficiency again that year, even though facility officials had reported after the previous year's visit that the problem had been resolved.

In our March 2014 report, we concluded that ensuring VA facilities correct deficiencies identified during field assistance visits and conduct systematic audits of the accuracy of claims processing decisions would provide necessary transparency and stability to the Non-VA Medical Care Program. To help VA address these issues, we made three recommendations aimed at revising the scope of the field assistance visits, ensuring deficiencies identified during these visits are corrected, and instituting systematic audits of the appropriateness of claims processing decisions. VA concurred with these recommendations and detailed its plans to address them. In June 2014, VA officials detailed the Department's progress implementing these recommendations. However, we do not believe the Department's actions have sufficiently addressed these recommendations. To fully implement these three recommendations, VA needs to ensure field assistance visits include a review of a sample of processed claims in order to determine whether staff are complying with applicable requirements for claims processing and needs to establish systematic audits of claims processing decisions, among other things.

Veterans Lack Knowledge about Millennium Act Emergency Care Eligibility, and Selected Non-VA Providers Have Reported Communication Challenges with VA

In March 2014, we found that despite VA's communication efforts with veterans and non-VA providers, knowledge gaps exist for veterans about eligibility for Millennium Act emergency care, and communication weaknesses exist between VA and non-VA providers.[23]

[23]GAO-14-175.

Veterans Lack Knowledge about Eligibility for Coverage of Millennium Act Emergency Care

In March 2014, we reported that veterans may still be unaware of the criteria that must be met in order for VA to pay claims for non-VA medical care; specifically, Millennium Act emergency care. VA primarily educates veterans about their eligibility for non-VA medical care through patient orientation sessions and written materials, such as the Veteran Health Benefits Handbook. However, VA patient benefits and enrollment officials at two of the four VA facilities we visited said that patient orientation sessions were generally not well-attended. Also, written materials we reviewed did not always provide a complete listing of all criteria that must be met for Millennium Act emergency care claims to be covered, which may create confusion about whether veterans should seek treatment from a VA facility or a non-VA provider in the event of an emergency. VA officials said that the primary intent of the written materials was to communicate the importance of promptly seeking care and to discourage veterans from delaying care by bypassing non-VA providers in the event of an emergency. However, some VA officials acknowledged that they were aware of specific recent cases where veterans delayed or avoided seeking treatment at non-VA providers to go to a VA facility instead. For example,

- one VA official explained that a veteran experiencing chest pains drove over 100 miles to a VA facility rather than going to the nearest emergency department;
- two VA officials said the wife of a veteran who had gunshot wounds drove him to a VA facility about 30 miles away, bypassing a number of non-VA emergency departments; and
- another VA official explained that a veteran experiencing chest pains died during a weekend as he waited to seek care until the local VA community-based outpatient clinic opened on Monday.

Alternatively, we found that without knowledge of specific criteria for VA payment of non-VA medical care, specifically Millennium Act emergency care, veterans may seek treatment in situations where the Department cannot pay. For example, veterans may seek care at a non-VA provider for conditions they believe require immediate attention—such as one for which they have not been able to obtain timely treatment from a VA facility. However, VA staff reviewing the claim may decide that the condition does not meet the prudent layperson standard for emergency care and deny payment. Veterans that are admitted as inpatients to non-VA providers also may not be aware that they should be transferred to VA facilities once their conditions have stabilized and a VA facility has

notified the non-VA provider that a bed is available for their care at the VA facility.

To help VA address concerns about veterans' lack of knowledge of non-VA medical care—specifically, Millennium Act emergency care—we recommended in March 2014 that VA take steps to better understand gaps in veterans' knowledge regarding eligibility for non-VA coverage by surveying them about their health care benefits knowledge and using information from those surveys to tailor the Department's veteran education efforts. While VA concurred with this recommendation, in June 2014 VA officials indicated that the Department has decided not to pursue veteran surveys but instead will promote veteran education by appearing at conferences and town halls with veterans service organizations and updating the information on its public website. We remain concerned that, without surveying veterans directly, VA will not be able to identify specific veteran knowledge gaps regarding coverage of non-VA medical care or determine ways to better target VA's veteran education efforts.

Non-VA Providers Reported Communication Problems with VA

For our March 2014 report, all four non-VA providers we visited cited problems in their non-VA medical care claims processing communication with VA regarding the following issues:

- ***Points-of-contact not designated.*** Two of the four non-VA providers said they did not have a specific point-of-contact at their VA facilities who could answer concerns and issues about claims they had submitted, which led to problems resolving their issues in a timely manner.
- ***Delays in claims processing.*** Billing officials at one non-VA provider described lengthy delays in the processing of their claims, which in some cases went on for years.
- ***Lack of responsiveness when trying to transfer veterans and failure to document discussions about potential transfers.*** Officials at one non-VA provider said they had experienced challenges connecting with the inpatient admissions staff at their local VA facility, making it difficult for them to transfer veterans to the VA facility after the veterans were stabilized. According to this provider, the VA facility did not consistently answer calls during business hours or weekends. Officials from a non-VA provider also described cases where they had attempted to transfer stable veterans to the VA facility, but the VA facility informed them that there were no beds available. Later, the VA facility denied these claims because VA could

find no record of this contact with the non-VA provider or authorizations for continued care.[24]

VA officials said they have attempted to improve communications with non-VA providers. Specifically, they have established a website and electronic newsletter for non-VA providers in order to disseminate information about non-VA medical care requirements. In addition, VA mailed letters to all non-VA providers that had submitted claims during the previous 2 years to inform them of these online resources. However, none of the four non-VA providers included in our March 2014 review recalled receiving the letter that VA mailed. Two non-VA providers were familiar with the website, but one commented that it lacked some necessary information and was not useful. None of these four non-VA providers were aware of VA's electronic newsletter, and VA officials acknowledged that a very small percentage of the non-VA providers who submit claims to VA had signed up for it. While these communications have not always reached their intended audience, VA is continuing its efforts to improve communications with non-VA providers. Specifically, VA has been conducting satisfaction surveys to continue monitoring its communications with non-VA providers and has been holding training sessions for VA staff on improving outreach with non-VA providers.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann, Assistant Director; Emily Beller; Cathleen Hamann; Katherine Nicole Laubacher; Alexis C. MacDonald; and Jennifer Whitworth.

[24]Unless VA authorizes continued care, it cannot pay for non-VA medical care past the point at which the veteran was medically stable for transfer to a VA facility.

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Mr. Matkovsky, you are recognized for five minutes, sir.

STATEMENT OF PHILIP MATKOVSKY

Mr. MATKOVSKY. Thank you, sir.

Good morning, Mr. Chairman, Ranking Member Michaud, and Members of the Committee.

Thank you for the opportunity to discuss VA's non-VA care programs. I would also like to take a moment to thank and acknowledge our partners, TriWest, Health Net and the Cary Medical Center for their collaboration in providing health care to veterans.

We at the VA provide care to veterans directly in our facilities or through contracts which includes individual authorizations or reimbursements for emergency care. Taken together, these are the non-VA care programs and they are designed to ensure veterans receive safe, effective and timely health care. It is our policy to provide veterans necessary care within our system when feasible. When we cannot provide necessary hospital care and medical services in our facilities, we are authorized to provide that care through qualified community partners.

On May 23rd, we deployed the Accelerating Care Initiative, a coordinated systemwide initiative to accelerate care to veterans. This initiative strengthens access to care in the VA system, but also ensures flexibility in use of private sector care when and where it is needed. Where we cannot quickly increase our capacity, which we owe the American taxpayers, we are increasing our use of care through the community. I would like to say that we have identified in excess of $300 million dollars additional funds for non-VA care at this point.

Today, I am focusing on two major initiatives to improve oversight, management and delivery of non-VA care, Patient-Centered Care in the Community, PC3, and the Non-VA Care Coordination Program, NVCC. PC3, as we heard earlier, is a nationwide program of health care contracts to provide veterans access to specialty care. PC3 is really formed by these contracts with Health Net and TriWest that we learned about earlier.

These two firms have developed networks of providers who deliver the covered care including specialty care, mental health, limited emergency, and some newborn. This program first received its authorization in January and in some cases is fully implements.

The Non-VA Care Coordination Program, again, NVCC, is really an internal program to improve and standardize our processes for referrals. NVCC really is about referral management, effective controls, consistency, documentation, tracking, and coordination of patients in community health facilities. Through this activity, our staff are to use standardized processes, templates for the administrative functions associated with non-VA care. This system is now nationwide deployed.

Authority to pay for non-VA emergency treatment, I need to explain, is limited by statute. Generally speaking, we can authorize non-VA emergency treatment for serious medical emergencies experienced by veterans who are receiving medical services in VA facilities when we cannot clinically manage that. When a veteran experiences a medical emergency apart from these situations, we advise

on all of our phone calls—phone systems that the veteran should seek care at the nearest emergency department.

I need to say that, however, by law, such care is not always considered to be authorized or pre-authorized. Whether VA has legal authority to pay for emergency treatment depends on certain eligibility factors for reimbursement or payment of those expenses. Simply put, veterans must meet statutory and regulatory criteria applicable to benefits under the U.S. Code Title 38. Unfortunately, not all veterans meet those criteria.

I acknowledge on Mr. Williamson's comments that we should have improved our communication to our veterans making sure that we provide information about what we are allowed to and not allowed to cover. We have done some of that in our tailored health benefits plan that each veteran receives, but there is more to do. We can and will improve that work.

We are completing Project ARCH or Access Received Closer to Home. That is a three-year pilot program to evaluate how to improve access to quality health care. Authority for Project ARCH does expire August 29th.

The PC3 contracts that we learned about earlier provide coverage for veterans in rural, highly rural areas for inpatient and outpatient medical and surgical specialty care, as well as urban areas; therefore, veterans requiring those services will not be impacted by the expiration of ARCH contracts.

Individual transition plans have been developed for all veterans and we are now extending our use of contract care to include primary care. We developed a solicitation which is now receiving proposals for contract primary care services in Arizona, New Mexico and parts of Texas. We will extend that effort next for primary care nationwide

In conclusion, our mission is to provide timely and quality health care to those who have served our country in an environment that understands and honors their military service. We recognize and acknowledge we cannot always do that timely in our facilities. We are enhancing our use of non-VA care to ensure that we provide veterans with quality and timely care when, where and how they want it.

Mr. Chairman, Mr. Ranking Member, I thank this Committee for its dedication to and care for our nation's veterans. I appreciate the opportunity to appear before you and I am prepared to answer your questions.

Mr. BILIRAKIS. Thank you, gentlemen, for your testimony. Appreciate it.

I will recognize myself for five minutes for questions.

Mr. Matkovsky, information VA released last week revealed that over 57,000 veterans have been waiting 90 days or more for their first VA medical appointment and 64,000 veterans, who have enrolled in the VA Health Care System over the last decade, never received the appointment they requested. That is 121,000 veterans who have not been provided the care they have earned and deserved.

Why did the Department allow these veterans to wait months and even years in some cases on a VA waiting list instead of refer-

ring them to a non-VA care provider to receive the care that they needed?

Mr. MATKOVSKY. Congressman, I will tell you for the 57,000 on the electronic work list, we are working that process now with accelerating care. For the newly enrolled appointment request, which you reference, which was roughly 64,000, you are correct, that is just not excusable and we should have had our eye on that and we did not.

I will tell you one thing that our staff did as they assessed all veterans who had not received an appointment yet, out of an abundance of caution, here's what we did: If a veteran had an enrollment processed at a VA medical center and we could not definitively identify an appointment in that facility—I don't care if they were seen anywhere else in our system, but if they applied in the Tampa VA for instance, and they did not have an appointment there, we went all the way back to the beginning of the enrollment and added them to our contact list. So as of the 64,000 where we were before, as of this morning, and I think we will be producing an additional update, we had below 30,000 to contact. We are working that list aggressively. We should not have let it slip, but we did, out of an abundance of caution, pull everybody we could imagine.

Mr. BILIRAKIS. Yeah, I just can't—I just don't understand. It is reprehensible, inexcusable that these veterans would have to wait that long, and some months, and years.

Anyway, what interaction exists between the non-VA care and the VA's electronic waiting list?

Mr. MATKOVSKY. Right now, what we have done with accelerating care, we have produced directive out to the field. And what we asked the field to do, and we published their productivity numbers, their capacity numbers, and their efficiency numbers. The first order of business what to determine whether or not they could increase their capacity. If they could not, they could not run an extra clinic, an extra half-day clinic, evening hours or weekend hours, they were directed to identify capacity in the community.

One of the things we did with that, our PC3 program office shared all of our data with the PC3 contractors so that they would have that available. Their instruction was if they could not find it inside the facility, to then refer that to care in the community through non-VA care. We made over $300 million dollars available in supplemental. As of yesterday, close of business, $127 million dollars of that supplemental had already been obligated for non-VA care episodes.

Mr. BILIRAKIS. Next question, sir, for you: I understand from your testimony that claims processing, activities for non-VA care are centralized at the VISN level or decentralized at the facility level. How much variance did you find from location to location on how non-VA claims are processed throughout VA and what effect do you think such variance has to the timeliness and accuracy of non-VA care claims processing?

Mr. MATKOVSKY. That is for me, sir?

Mr. BILIRAKIS. Yes, for you.

Mr. MATKOVSKY. I will be candid. I think that the variability does exist site to site. We began in October and one item that we

focused on in addition to claims payment accuracy, which we focused on throughout all of fiscal year 2013—beginning in fiscal year 2014, our drive was really to make sure, quite simply, that we paid our bills on time, irrespective of the distributive nature. So we had been focusing on each one of our claims payment centers, whether it is a VISN or a facility level, but the distributed system does have variability.

Mr. BILIRAKIS. Mr. Williamson, could you comment on that, please?

Mr. WILLIAMSON. We looked at a number of systems, some of which were centralized at the VISN level and others that were at individual VAMCs, and we didn't really see a variation in the quality of the claims processing. There were a pattern of errors no matter what system used.

Mr. BILIRAKIS. Thank you.

I will recognize the ranking member, Mr. Michaud for five minutes.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Mr. Matkovsky, thanks again for coming here, appreciate it.

Under the PC3 program, what are the reimbursement rates of both TriWest and Health Net?

Mr. MATKOVSKY. Well, I can tell you—I think the technical term—I think I am going to get this wrong—but I think the technical term is privity of contract. As the Government does not have privy of contract to the PC3 network, but the PC3, we reimburse at CMS rates, sir. We also have an administrative fee that we pay out.

Mr. MICHAUD. So they get paid Medicare rates, plus administrative?

Mr. MATKOVSKY. That is correct, sir.

Mr. MICHAUD. What are you reimbursing the ARCH program?

Mr. MATKOVSKY. ARCH, I believe there are different rates, but I believe for Cary is at CMS rates.

Mr. MICHAUD. At CMS rates.

Mr. MATKOVSKY. And there are different rates for different sites.

Mr. MICHAUD. But you are not paying administrative rates above and beyond?

Mr. MATKOVSKY. I do not believe so, sir.

Mr. MICHAUD. Okay. We heard earlier about payments to ARCH is slow in getting there, why is that? Is there anything to speed up the payments?

Mr. MATKOVSKY. I was looking through our VISN 1 where they are currently located and in network one our payments rates had dipped a little bit below 80 percent, but now we are—80 percent of our unpaid claims are 30 days or younger. One thing I would have to do is go in and take a look at them and have a detailed poll run for Cary. It shouldn't be a case where we have got payments that are outstanding very long.

Mr. MICHAUD. Okay. Do you need additional authority to continue the ARCH program?

Mr. MATKOVSKY. Well, actually, very interesting question. Thank you for that.

Technically speaking, we have the authorities to cover that. We would have both the sharing authority under 8153 and frankly we have the fee authorities under 1703.

PC3 is very comparable. I have to say, you know, PC3 is kind of an outgrowth of what we have learned in ARCH and some other previous efforts, so it is an extension of that and we are using our existing authorities of 8153 and some of 1703 to do PC3 nationwide. So, no, I don't think we require that.

Mr. MICHAUD. Oh, so you don't need additional authority to continue the ARCH with looking at all of your other authorities?

Mr. MATKOVSKY. I will say one thing about ARCH, and I am not a contracting officer, but ARCH does expire as a contract. It was a firm-termed contract with a base one year and then two option years which expires, I believe, September 30th. I think there has been some question about when does it expire. The legislative authority identified as August 29th. The contract is September 30th.

And typically, unless the contracting officer can determine a compelling reason to extend that, and I am not a contracting officer, we let the contracts expire.

Mr. MICHAUD. Okay. And what about reimbursements—my big concern is getting back to the reimbursement rates, particularly when you look at, it is my understanding that they are less for the PC3 program, and my big concern is if you are reimbursing TriWest and Health Net at the CMS rate but they are contracting with a provider and their contracts will then give you a little bit less than CMS rate, first of all, can they do that?

Mr. MATKOVSKY. Well, again, I am certainly limited on what I can say called privity. There is only so much and only so much we should. Purely anecdotally or conjecturally on my part, some of my friends and peers were in the private sector health care community, as we discussed the evolution of ACOs, I think what we are seeing in the ACO marketplace is reimbursement rates below CMS rates, as well. So I realize there is some concern that has been voiced here, both officially and then through other channels, my sense is that the market is heading that way anyway.

Mr. MICHAUD. Well, here's my big concern is the fact that, particularly when you look at states like Maine, we have the oldest population in the country, number one in Medicare, number two in Medicaid, second from the bottom on reimbursement rate. And when you have providers that have 65, 70 percent of their patient workload on either Medicare or Medicaid rate, then that is a huge problem as far as them being able to provide the services and we are already hearing providers saying that they are not going to take anywhere Medicare or Medicaid patients because they can't sustain that type of loss.

And that is the huge concern I have, particularly if you do not continue the ARCH program in its form or whatever the reimbursement rate that they are getting in rural areas because it is—we are not in the Boston market area and it is very difficult, particularly for specialty care, and that is the huge concern that I have with that program going away if you don't reauthorize it, what is the, you know, existing rates.

Mr. MATKOVSKY. Well, let me tell you this, you know, as I understand it, that network under the PC3 program is getting built out

even in rural Maine. I just need to address that first of all, not to get into any specifics. But we have individual authorization authority as well.

And in another GAO study which reviewed our overarching program, one of the things that they advised us to do is to look at the beneficiary travel reimbursement rates and use that as a determining factor as well. I think it is good input. We are working on our procedure guidelines to do that. We spend about just shy of $800 million dollars in travel reimbursement a year.

Now, granted, veterans are owed that. It helps with the travel burden, but if a veteran would receive that care closer to home, we would prefer that. It would obviate the need for travel which can be dangerous which is inconvenient, right? Then we should factor that in and use individual authorizations or other means to make sure that that care can be closer to Caribou.

Mr. MICHAUD. Yeah, I appreciate that because I can't see it in my notes, but it is my understanding that they were able to save travel rates, about $600,000.

Mr. MATKOVSKY. Yes, they did.

Mr. MICHAUD. I thought that is what they said the savings would be.

So thank you very much, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

I will recognize Ms. Brown for five minutes.

Ms. BROWN. Thank you, Mr. Chairman.

Florida has close to 1.6 million veterans, so whatever system that you are beginning to develop, I would think that Florida would be foremost on the planning when so many of the veterans, even though we have close to two million, so many of the veterans from the northeast come to Florida particularly during the wintertime, and, of course, Secretary Brown was the person that helped us get reimbursements because at one point they were using the system and we weren't getting the reimbursement for the system.

We have had problems with the system and as we go into this afternoon there is a bill on the floor, House, Senate, then we are going to go to conference. I want to make sure that we develop a program that will keep the quality of care, which is some of the best in the world, but also this timeliness serving the veterans.

And what is some of your recommendations regardless of—you know, I think the Senate bill might be a little bit better than the House, I can't believe that, but I do—but what are some of your recommendations to make sure that—you know, I have been accused of being a VA person, I am a veterans person.

Mr. MATKOVSKY. First and foremost, we have heard some of the comments and Mr. Williamson has alluded it as well, we have to make sure that we do coordination of care, that we monitor that. I have heard some of the comments earlier, I think, from some of the committee members about making sure we have eyes on the referral timeliness, that we can monitor that. So one of the things that I would say we need to make sure that when we do Non-VA Care Coordination we staff it with adequate clinical resources, as well as administrative resources so we can monitor that care, ensure that it is quality care. We have a responsibility to that.

In the VA when we refer to the community, we are not absolved of the responsibility for that care. It is still VA care, and even though we may call it non-VA care, it is still our care that we are delivering to veterans. So I think that is one thing to be mindful of is what oversight responsibility must we have to make sure that that is done right.

Ms. BROWN. Absolutely. In fact, in the hearing the other night, someone came and talked about a death in the system and that person was outsourced to someone and the VA—that person didn't have the follow up, so it is very clear that when VA works with other stakeholders, that you have to have that relationship and that follow up.

Mr. MATKOVSKY. The only other thing that I would mention, as Mr. Williamson alludes for processing of claims, a lot of our claims processing today remains kind of manual. It is getting a little bit more automated with older systems.

Ms. BROWN. And I know that, and I know that the Chair recognized that because we used to do most of that process out of his area in Florida.

St. Petersburg, isn't that your area?

Mr. BILIRAKIS. Right.

Ms. BROWN. Yes, sir.

But go ahead.

Mr. MATKOVSKY. The other thing that I would mention is you consider—and this is just a personal opinion realizing that I am just trying to give some personal input, opining, if I may—that some of the legislation that is being thought about may really alter the structure of the consumption of health benefits in the general marketplace and we have to understand what that might mean to the administrative and other systems within the VA.

What do I mean by that? If we look at the structure that seems to be used for the geographic distance and other, it sort of models TRICARE. It may also model Medicare. But based on reimbursement rates, based on out-of-pocket co-pays more folks may use this other payment system instead, right?

Ms. BROWN. Uh-huh.

Mr. MATKOVSKY. We just have to make sure that we also consider the administrative ramp-up and other factors associated that, as well, that this may be really a game changer in a way that we don't yet understand.

Ms. BROWN. And I think it is very important that we keep a handle on that.

Mr. Williamson, would you like to respond to that?

Mr. WILLIAMSON. I couldn't agree more with Mr. Matkovsky, especially, regarding his comment about oversight. I think that oversight and having sound data to base that oversight on is extremely important, so I would agree with his comments, and I think he recognizes that.

Ms. BROWN. All right. Well, we will work together, and I yield back the balance of my time.

Mr. BILIRAKIS. Thank you so much. Appreciate it.

PREPARED STATEMENT OF PHILIP MATKOVSKY

Good morning, Chairman Miller, Ranking Member Michaud, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) non-VA care programs.

As former Secretary Shinseki and Acting Secretary Gibson have stated, we now know that within some of our Veterans Health Administration (VHA) facilities, VA has learned of some systemic issues that are unacceptable and demonstrate a lack of integrity. That breach of trust—which involved the tracking of patient wait times for appointments—is irresponsible, indefensible, and unacceptable to the Department. Let me apologize to our Veterans, their families and loved ones, Members of Congress, Veterans Service Organizations, and to the American people. You all deserve better from us.

VA provides care to Veterans directly in a VHA facility or indirectly through contracts, including contracts formed when providers accept individual authorizations, or through reimbursements, such as for emergency care. This mix of in-house and external care provides Veterans the full continuum of health care services covered under our medical benefits package. VA's non-VA Care programs are designed to ensure high-quality care is provided to Veterans under its non-VA care authorities. The programs are also designed to ensure Veterans receive effective and efficient non-VA care seamlessly.

It is VHA policy to provide eligible Veterans necessary care within the VA system when feasible and authorized by law. When VA cannot provide the necessary hospital care and medical services at a VA medical facility, it is authorized to provide that care through non-VA providers through non-VA care programs in accordance with 38 United States Code (U.S.C.) 1703, 1725, 1728, 8111, and 8153.

On May 23, 2014, VHA established the Accelerating Care Initiative, a coordinated, system-wide initiative to accelerate care to Veterans. This initiative increases timely access to care for Veteran patients; decreases the number of Veteran patients on the Electronic Work List (EWL); decreases the number of Veterans waiting greater than 30 days for their care; and, standardizes process and tools for ongoing monitoring of access management at VA facilities. This initiative includes activities such as ensuring Primary Care clinic panels are correctly sized and achieving the desired level of productivity; extending or flexing clinic hours on nights and weekends; and, assessing the availability of community providers to meet care needs. The initiative strengthens access to care in the VA system while ensuring flexibility to use private sector care when needed. Where VA cannot quickly increase capacity, VA is increasing the use of care in the community through non-VA care.

VA is focusing on two major initiatives to improve the oversight, management, and delivery of non-VA care: Patient-Centered Community Care (PC3) and the Non-VA Care Coordination (NVCC) program. PC3 is a VHA nationwide program of health care contracts to provide eligible Veterans access to specialty care. Under PC3, VHA contracts with Health Net and TriWest which have de-

veloped networks of providers who deliver the covered care, including specialty care, mental health care, limited emergency care and limited newborn care. The goal is to ensure Veterans receive care from qualified community providers that is timely, accessible, and courteous, that honors Veterans' preferences, enhances medical documentation sharing, and that is coordinated with VA providers when VA services are not available or feasible.

NVCC is VA's internal program to improve and standardize our processes for referrals to non-VA care. The NVCC model centers on effective referral management and consistency in documenting, tracking, and coordinating patients in community health facilities. Through NVCC, non-VA care program staff use standardized processes and templates for the administrative functions associated with non-VA care, including when a Veteran is admitted to a non-VA health care facility for emergency treatment.

VA utilizes additional authorities in furnishing hospital care and medical services to Veterans. When a Veteran experiences an emergency situation, VA recommends that a Veteran seek care at the nearest emergency department. VA is authorized to pay or reimburse for non-VA emergency treatment furnished Veterans in accordance with 38 U.S.C. 1728 and 1725. In general, 38 U.S.C. 1725 requires VA to provide reimbursement for non-VA emergency treatment of certain Veterans with non-service-connected conditions. Veterans must meet all conditions of this statute to be eligible for payment/reimbursement to include that the Veteran be an "active Department health-care participant" who is personally liable for the emergency treatment furnished. A Veteran is an active Department health-care participant if he or she is enrolled in the VA health care system and has received health care services under the authority of 38 U.S.C. Chapter 17 within the previous 24 months. In general, 38 U.S.C. 1728 requires VA to reimburse for emergency treatment related to a Veteran's service connected conditions.

Also, VA is completing Project ARCH (Access Received Closer to Home), which is a 3-year pilot program to evaluate how to improve access to quality health care for rural and highly rural Veterans by providing these services closer to where they live through contractual agreements with non-VA medical providers. Project ARCH authority, section 403 of P.L. 110–387; 38 USC 1703 note, expires on August 29, 2014. The PC3 contracts provide coverage for Veterans in rural and highly rural areas for inpatient and outpatient medical and surgical specialty care, therefore Veterans requiring those services should not be impacted by the expiration of the ARCH contracts. In preparation for the expiration of the Project ARCH authority, individual transition plans for each Veteran participating in Project ARCH are being created. In addition, VHA is leading an integrated project team to review alternatives for providing primary care for rural Veterans.

Conclusion

VA delivers high quality health care to Veterans in an environment that understands and honors their military service. A continuum of health care services is covered under our medical benefits package. VA's policy is to provide timely care to Veterans within its system where feasible, but we recognize we cannot provide the necessary care to every Veteran in our facilities. We are en-

hancing our use of non-VA care to ensure we provide Veterans with quality healthcare when, where, and how they want it. Mr. Chairman and Mr. Ranking Member, I appreciate the opportunity to appear before you today. I am prepared to answer your questions.

Ms. Kuster, you are recognized for five minutes, please. Thank you.

Ms. KUSTER. Thank you very much, Mr. Chairman.

Thank you, both of you, for being here with us today. I have a question for Mr. Matkovsky. In light of these audit findings and the reports that we have been receiving from OIG and GAO, why did the veterans medical centers not use the authority that they had to use non-VA care to send veterans out to the private sector and was it that the VA did not want to spend the money to get the veterans off the electronic wait list? I don't think I yet understand what was the hold up. If this was an option, why wasn't it used more often and why were people languishing on wait lists?

Mr. MATKOVSKY. Sure. This is sort of a very complicated question, so if you don't mind, I will try to break it down and answer it. I think a couple of things, first of all, there is a historical context, right? So some years back we were receiving a good deal of criticism for our use of non-VA care, so historically we have been criticized and so, maybe inappropriately, we overcorrected to use that less. I think that is part of it; it is not all of it.

I think the other thing, as we are going to get better wait-time data, as we improve the integrity of that reporting, we are going to have a better sense of where veterans are waiting for care. We started reporting another set of numbers last week which was this prospective wait measure, right, which showed us veterans who were scheduled and who were scheduled out longer. Historically, we have not looked at that either.

So if we add those two factors, improve the integrity of our data so that we can have a sense of where veterans are waiting, and then look out, if you will, into the upcoming months where veterans are waiting, we can use that to help us determine where should we offer care to veterans. That is what we did with accelerating care. We took those numbers and said this is your situation. These are your veterans that are waiting too long. You have VA resources. If you can get more out of them, great, do that. If you cannot, you have the authority in non-VA care, go, tell us how much you need, right?

We have not done that before. We have not really married up waiting time information with our use of non-VA. Going forward, we are going to.

Ms. KUSTER. Well, I think that was my biggest concern and maybe Mr. Williamson, you can comment on your report, but it appeared to me that you didn't have effective data and you weren't able to use it in a timely or even rational way to determine whether or not it would be more cost effective for taxpayers and frankly, more beneficial to veterans, if you either added history resources, medical providers to the VA system or went to the private sector.

And even when veterans were sent to the private sector, there has not been this cost-benefit analysis. How are we, as Members of Congress, to determine how best to employ—deploy the resources? We don't even know at this point. Should we be hiring

more doctors and nurses and healthcare providers or should we be sending people out to the private sector? We don't have a logical way to make those decisions.

We are talking about significant dollars here and we are talking about a fundamental promise that we have made to our veterans. We want to get this right.

Mr. WILLIAMSON. I think the first priority is to get the wait time scheduling problem resolved and once that is done, there will be a more accurate idea of just how many people need to seek care from non-VA care providers. And I think to do that, a number of fixes have to be made. Then, there needs to be oversight, especially the first line of supervisory level to make sure that new procedures are being carried out the way they are supposed to be.

Ms. KUSTER. So you mentioned about getting to the crux of the scheduling because obviously it is a pretty inefficient system that we have learned about, 50 percent no-shows. Are you familiar with the DoD process that they have? A patient-centered infrastructure where the patients, themselves, can go online. It is a web-based system. They can schedule an appointment. They can refill a medication.

Are you familiar with that, and would you recommend that type of process to the VA and do you think it would impact this scheduling fiasco that we are worried about right now?

Mr. WILLIAMSON. I am not. I heard you mention that earlier and I thought it was very intriguing. We have not done any work on the DoD side in this regard.

Ms. KUSTER. Yeah. I would just say to Mr. Matkovsky I would highly recommend this approach. I just learned about it myself today, but it seems as though it would be particularly with the recent vets who are used to using this system in the DoD, that you could just cut right to the crux of the matter in terms of not only scheduling the appointments in a timely way, in an effective way that they would be likely to show up, but that they could change appointments, that you could get them the notices of the appointment coming.

So my time is expired, I apologize Mr. Chairman, but thank you very much.

Mr. BILIRAKIS. Thank you, Ms. Kuster.

Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke.* Thank you, Mr. Chair.

First, Mr. Williamson, thank you for your report and presenting your findings, one of which was that the VA does not currently track wait times for care that is delivered in the community, if I understood your comments correctly?

Mr. WILLIAMSON. Correct.

Mr. *O'Rourke.* And so would you say that it is fair to conclude that we still don't know what wait times are for veterans, because while there is a distinction between care delivered by the VA and care delivered in the outside community, there is not enough difference in that distinction to ultimately matter. You just want to know how long it took to see the person that you needed to see.

Mr. WILLIAMSON. Right. Up to this point, it is true that wait times have not been tracked, but I think there are going to be some changes under PC3 and under a system called NVCC, which Mr.

Matkovsky references in his statement. The difficulty there is that NVCC, which is a care coordination set of protocols to help the veteran go from the VA system to schedule an appointment with a non-VA provider, is that the wait time portion of NVCC is not yet automated. It is done manually, and the data feeding into it is also self-reported by the provider.

So VA will be able to track a veteran to the point where the veteran gets scheduled for an appointment, but if that appointment is rescheduled, VA's NVCC will relie on the provider to tell them. I don't think VA has good visibility over when an appointment actually occurs.

Mr. *O'Rourke.* I think that is an incredibly important finding and recommendation that you made because, you know, until we have the facts and the best information, we are not going to be able to make the best authorizing and appropriating and oversight decisions as a committee and the VA won't be able to do its best in its job.

And to use El Paso as an example, as I have done in previous hearings, as recently as a month ago we were told there were zero days wait time for new patient mental health care appointments who were told last week on Monday from the VHA's audit that it was actually 60 days. But if there were people who were referred out into the community and that is not being tracked, we may still not have a correct—I think I want to trust that the VHA is giving us the best information post-audit that they can, but it is still not all the information. So I think that is still something for us to continue to follow up on.

And for Mr. Matkovsky, I want to ask some—follow up on some questions relating to how the VHA makes decisions about referring out to community care. We saw that there was a very good intention from VA to see people within 14 days, so see veterans within 14 days, and that that very good intention was then turned in to a goal and then a performance measure and then something that was part of the criteria for which VHA administrators were bonused.

Is something like that happening when it comes to referring veterans out to community care? Is the local VHA director bonused in part by how much money he is able to save by not referring people out into community care?

Mr. MATKOVSKY. I don't believe so, sir. You know, I haven't reviewed every single performance contract. I have to be clear. One of the things that we need to focus on, I think, is the undermined is a veteran—experienced, right? If we have better data about wait times, we can make better decisions about where care should be delivered and how.

The other thing that we owe, quite frankly, is to make sure that we have productive, high-performing clinical resources in our facilities. Scheduling is the mechanism to access those and a way to manage efficiently, the delivery of that care. So as our scheduling data are better, as we look forward in our scheduling calendar, we can find individual veterans who we think are waiting too long and then use that as a basis to refer, at their choice.

Mr. *O'Rourke.* Yeah.

Mr. MATKOVSKY. Now, the other thing we need to do, just very quickly, we also need to make sure that we are monitoring that care and as quickly as we can, get some automation solutions to know that you are seen timely in the community.

Mr. *O'Rourke.* Will you commit to getting back to me and the committee in just answering that question conclusively about whether or not that is part of the criteria used to bonus?

Mr. MATKOVSKY. Yes.

Mr. *O'Rourke.* I think it is important, given what we now know about how people are bonused and how that leads to some unintended consequences.

Mr. MATKOVSKY. I will do that definitively.

Mr. *O'Rourke.* You mentioned $300 million dollars in additional non-VA care resources, where did that money come from?

Mr. MATKOVSKY. It came from a variety of sources, but the vast majority of it, from what we call carryover to offset some of the fiscal year 2015 requirement.

Mr. *O'Rourke.* And at a press release last week, acting VA secretary announces $7.4 million dollars to Fayetteville, North Carolina for additional care.

Mr. MATKOVSKY. Yes, sir.

Mr. *O'Rourke.* Does that come out of the $300 million dollars?

Mr. MATKOVSKY. Yes, sir.

Mr. *O'Rourke.* And the $1.9 million dollars that came out or that is being directed to El Paso, I am told by Dr. Jesse that comes out of the $300 million dollars?

Mr. MATKOVSKY. That is correct, sir.

Mr. *O'Rourke.* How do you all decide that Fayetteville gets 7.4, El Paso, 1.9, some other community, another amount? When I look at the metrics from the VHA audit, I see that El Paso performs at the worst of all VHAs in the entire country for some categories like existing patient access to mental health, second to worst for specialty care, fourth to worst for specialty care, fourth to worst for new patient, and Fayetteville was nowhere near those. So what was the criteria that was used?

Mr. MATKOVSKY. Fair question. Part of it, just to be candid was just working with the local facility. Now, if I can offer you just some comparable examples.

El Paso, unlike Fayetteville, has roughly a third of its health care budget in non-VA care. That is largely because it offers really no inpatient services, right? So already a large share of its care is delivered through non-VA resources. So as a proportionate level, it is considerably higher using non-VA than is Fayetteville, proportionately.

And then I think if you looked at their already existing spend pattern, they identified an additional 1.4, so I don't know the proportional difference between Fayetteville's overall budget and El Paso, but some of that went into it.

Mr. *O'Rourke.* And I will return to the Chair, but before that I just wanted to ask, would you provide the Committee—because I am not the only member who is interested in this, we all want to make sure that the veterans that we serve are getting the care that they need—would you provide to the Committee a written response to the question how does the VA—what criteria does the VA

use to determine which local VHAs are going to get these additional resources?

Mr. MATKOVSKY. I will produce it in writing, yes.

Mr. *O'Rourke.* Thank you.

Mr. BILIRAKIS. Thank you. They just called votes.

I have one additional question and I am going to allow my ranking member to ask one question and then we will go ahead and adjourn.

But the question for VA, the non-VA care program is overseen by the chief business office, yet CBO does not exercise direct line authority over non-VA care operations; that is my understanding. Who is responsible for accountability within the non-VA care program?

Mr. MATKOVSKY. Well, I think there are two sets of responsibilities. The program has responsibility for policy, for establishing training, making sure that training is distributed and performing oversight functions. We are responsible in the program office for that.

For claims payment, accuracy of those claims being paid, timely paid, coordinated care, and making sure that care gets delivered to veterans is through medical centers. I feel I have a direct personal accountability to this. I have been involved with this program now since 2012, focusing on the accuracy of the payment. It is something that we haven't seen a lot of, but, you know, beginning in 2012 until today we have seen an over 25 percent improvement in the payment accuracy. That was led by the CBO, but it was also led by the field. So it is a shared accountability, but none of us are shirking from it.

Mr. BILIRAKIS. How many FTEs, total FTEs currently support the non-VA purchase care?

Mr. MATKOVSKY. It is roughly one thousand, but there are—that is one thousand out of the CBO and then the facilities have other resources as well, sir.

One thing that I would point out about the program, the VA runs almost a fee-for-service insurance program called CHAMPVA which is a little bit over a billion dollars where we provide for beneficiaries for veterans, basically a fee-for-service that mimics, quite frankly, TRICARE for them. So that is also wrapped in there, and we pay those claims directly out of our chief business office. We run the call center for that, et cetera.

Mr. BILIRAKIS. Thank you.

I will recognize Ms. Brown for one question.

Ms. BROWN. Thank you.

Mr. Williamson, my question is when a veteran gets emergency service, who is responsible for the reimbursement, is it the veteran or the facility?

Mr. WILLIAMSON. The way it works is that the veteran gets the emergency care and the provider of that care, let's say it is a hospital, sends a bill to VA. The VA claims processing staff at the applicable VA medical facility process the claim and pay the provider. The veteran doesn't get involved with paying the provider unless VA denies the claims.

Ms. BROWN. Mr. Matkovsky, my last question: As we move forward with the VA and the VA bill in the conference, I am still in-

terested in making sure that, you know, some people would push us further than I would ever go to privatize the system. I want to make sure that we have quality in the system and we make sure that the veterans get the care that they need.

But wait time is an issue, so what is it that we can do with our stakeholders and partners to make sure that we keep the VA system intact because I am very interested in it. Someone mentioned DoD; DoD have their own problems and I understand that. The regular hospitals, you know, have their—they have problems. So there is no system that is perfect and I understand that.

And if I don't go to a certain appointment I am fined, you know, so how many of the veterans that we are talking about that didn't show up, they said well they need to call or they could have had an emergency—so it is all of us working together. So what would you close—what word could you give me?

Mr. MATKOVSKY. I would say to you, Congresswoman, that working together with this Committee, I think that we will work together in a much more transparent way to make VA a better system. We will use non-VA care where it is required based on when a veteran needs care, when, where and how, but one thing that we need to be clear about, I think the VA, it completes America's promise, right? And if we do this right, if we work together, oversee this correctly, the Committee, the Agency, we can work for veterans. We can make this a transparent excellent organization. We have 300,000 dedicate staff out there who will make this work.

I think if we open this, we deal openly with where we have challenges, balance the communication. Yes, we have some problems. Yes, we do some things great. Always the pair, hand in hand, we can help complete the promise. I just urge us to keep that in mind.

Ms. BROWN. Thank you so very much and thank both of you for your service.

Mr. BILIRAKIS. Thank you so much. Thank you for your testimony.

And if there are no further questions, you are excused—oh, there is a question.

Mr. *O'Rourke.* May I, Mr. Chairman?

Mr. BILIRAKIS. Sure. You are recognized, Mr. O'Rourke.

Mr. *O'Rourke.* All right. It will be a quick question.

Mr. BILIRAKIS. Quickly.

Mr. *O'Rourke.* You mentioned 64,000 who have not been able to get an appointment at all, we found in El Paso 36 percent of veterans seeking to make a mental health appointment were unable to obtain one at all. I hear anecdotally from veterans they call the VA, the VA says we can't schedule you right now, call back in a year.

So you can find the people who are in the system who tried to make an appointment and never received one, how are you going to reach those veterans who attempted to make an appointment and were never in the system at all? Will you publicize a 1–800 number? Can we have it and advertise it? How do we reach these folks who haven't been able to get an appointment?

Mr. MATKOVSKY. Any veteran who is trying to get ahold of our system today, 1–877–222–VETS; that is our contact center in the Topeka, Kansas and Waco, Texas. I urge them to call us. We will

find it. We will figure out where you are and we will get you your appointment.

Mr. *O'Rourke.* Great. Thank you.

Mr. BILIRAKIS. Thank you.

Okay. You are excused. I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I would like to once again thank the witnesses and the audience, of course for joining us here this morning—it is afternoon now—and this hearing is now adjourned.

[Whereupon, at 1:10 p.m. the committee was adjourned.]

APPENDIX

STATEMENTS FOR THE RECORD

Statement Of Raymond C. Kelley, Director
National Legislative Service Veterans Of Foreign Wars Of The United States
For The Record
Committee On Veterans' Affairs United States House Of Representatives
With Respect To Non-VA Care: An Integrated Solution for Veteran Access
June 18, 2014

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to submit for the record regarding non-VA health care.

The recent events at the Phoenix VA Medical Center and the subsequent national audit of all VA facilities have shed light on the fact that many facilities lack the capacity to meet demand for care. This means that access is insufficient, leading to a diminished level of care, which in some cases could be life threatening for veterans in need of essential services and procedures. The VFW finds this absolutely unacceptable and appreciates the urgency with which Congress is acting to address this problem.

VA must use all available tools to provide timely access to care, including non-VA care when necessary. Ideally, VA would have the capacity to provide timely, quality direct care to all those who need it. We know, however, that they currently do not. Although the VFW supports expanding VA infrastructure and hiring enough health care professionals to meet demand at Department facilities, we recognize that these improvements will not happen overnight. Veterans cannot be allowed to suffer in the meantime, and non-VA care must be used as a bridge between full access to direct care and where we are now.

It is vitally important that VA remains the guarantor of care, wherever that care is provided. This means that VA facilities must refer veterans to community providers using a system that requires full coordination and guarantees access and quality. Under the old fee basis system, VA would issue veterans in need of non-VA care authorization letters. It would then be up to the veteran to shop this letter around, searching for a community provider who was willing to accept the authorization and could schedule an appointment in a timely manner. Following the appointment, the veteran would be responsible for returning any records to VA, in order to have them included in the veteran's VA medical record. This system was entirely uncoordinated, failed to guarantee access or quality, and was highly susceptible to improper billing.

The dangers of uncoordinated care are well documented. An April 2013 OIG report revealed the mismanagement of non-VA care at the Atlanta VAMC in which approximately 4,000 veterans were referred to non-VA mental health providers without an adequate tracking system. OIG found that this led to an average wait time of 92 days, with 21 percent of veterans receiving no care at all, and never receiving any follow up from the VAMC. Even VA staff admitted to OIG that, due to the large number of referrals, many veterans had "fallen through the cracks." The lesson from Atlanta is clear: VA must not be allowed to push large numbers of veterans to outside providers without proper coordination simply to create the appearance that access is being provided.

In order to address the problems of non-VA care, VA developed a new contract care model, Patient-Centered Community Care (PC3). Under this program, networks of specialty care providers were created across the country to provide care at pre-negotiated rates in a well-coordinated manner. According to VA, veterans will be referred to PC3 providers if direct care cannot be readily provided due to lack of available specialists, long wait times, or geographic inaccessibility.

In theory, this program should help solve the access problems that have been plaguing many VA facilities. The program cannot succeed, however, if individual facilities are not open and honest about access to care issues and appointment wait time data continue to be unreliable. We believe that VA must develop and implement wait time standards that would trigger PC3 referrals, and enforce those standards at each facility. Rather than an arbitrary number of days, these wait time standards should be developed based on the type of care being provided and the immediacy of the individual veteran's need for that care, based on a physician's medical opinion.

Although the VFW supports PC3, we will be watching its progress closely, and ask Congress to conduct robust oversight to ensure it is being utilized to its full po-

tential. Specifically, we will want to know which facilities are using PC3 properly to reduce actual wait times, and which are not. If it appears that certain facilities are not making proper referrals due to improper training, lack of standards, or institutional resistance, VA must move swiftly to correct those problems. If PC3 is not being used effectively due to insufficient funding at the local level, we will call on VA and Congress to work together to get them the resources they need.

The PC3 program is new, and we recognize that the capacity of its networks may not immediately be sufficient to provide timely access for all specialties. In addition, PC3 is not currently set up to provide primary care. Consequently, it may be necessary for some facilities to enter into local contracts for specific services. Under no circumstances should veterans be expected to coordinate their own care or be held responsible for record sharing when receiving care outside of VA. The VFW believes that all contracts should include provisions that ensure the same level of coordination, access, and quality as the PC3 contracts. Anything less would not only fail to address the access problems many VA facilities are facing, but would also represent a huge step backwards in the evolution of non-VA care.

Mr. Chairman, this concludes my testimony and if you or the Committee has any questions, I would be happy to respond to them for the record.

June 18, 2014

GAO Highlights

VA HEALTH CARE

Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care

Highlights of GAO-14-696T, a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Due to serious and longstanding problems with the timely scheduling of veterans' appointments in VA facilities, VA recently announced that it will allow additional veterans to be treated through its Non-VA Medical Care Program.

This testimony is based on two GAO reports and addresses the extent to which (1) VA collects reliable information on wait times and cost-effectiveness of the Non-VA Medical Care Program; (2) VA facilities comply with Millennium Act claims processing requirements and VA oversees claims processing activities; and (3) VA educates veterans about eligibility for Millennium Act emergency care and communicates with non-VA providers. For both reports, GAO reviewed relevant requirements and visited 10 VA facilities. For its report on the oversight and management of the Non-VA Medical Care Program, GAO reviewed non-VA medical care spending and utilization data from fiscal year 2008 through fiscal year 2012. For its report on the Millennium Act emergency care benefit, GAO reviewed 128 denied Millennium Act claims to determine the accuracy of processing decisions.

GAO made numerous recommendations to VA in the two prior reports related to improving (1) data on wait times and cost-effectiveness for non-VA medical care; (2) compliance with claims processing requirements; and (3) veterans' knowledge of non-VA medical care eligibility. VA agreed with these recommendations but has yet to fully implement them.

View GAO-14-696T. For more information, contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

GAO's May 2013 report on the oversight and management of the Non-VA Medical Care Program found that the Department of Veterans Affairs (VA) does not collect data on wait times veterans face in obtaining care from non-VA providers. The lack of data on wait times limits VA's efforts to effectively oversee the Non-VA Medical Care Program because it is not possible for VA to determine if veterans who receive care from non-VA providers are receiving that care sooner than they would in VA facilities. In addition, GAO found that VA cannot assess the cost-effectiveness of non-VA medical care because it cannot analyze data on all services and charges for an episode of care, which is a combined total of all care provided to a veteran during a single office visit or inpatient stay. As a result, VA cannot determine whether delivering care through non-VA providers is more cost-effective than augmenting its own capacity in areas with high utilization of non-VA medical care.

GAO's March 2014 report found patterns of noncompliance with applicable requirements for processing emergency care claims covered under the Veterans Millennium Health Care and Benefits Act (Millennium Act) at each of the four VA facilities visited. This led to the inappropriate denial of some claims and the failure to notify veterans that their claims had been denied at these facilities. The Millennium Act authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other specified criteria. Specifically, GAO determined that about 20 percent of the 128 claims it reviewed had been denied inappropriately, and almost 65 percent of the reviewed claims lacked documentation showing that the veterans were informed their claims were denied and explained their appeal rights. As a result of GAO's review, the VA facilities reconsidered and paid 25 claims that they initially had inappropriately denied. GAO also found that there is significant risk that these patterns of noncompliance will continue because VA's existing oversight mechanisms do not focus on whether VA facilities appropriately approve or deny non-VA medical care claims or fail to notify veterans that their claims have been denied.

GAO also reported in March 2014 that gaps exist in veterans' knowledge about eligibility criteria for Millennium Act emergency care, and communication weaknesses exist between VA and non-VA providers. Specifically, GAO found that veterans' lack of understanding about their emergency care benefits under the Millennium Act presents risks for potentially negative effects on veterans' health because they may forgo treatment at non-VA providers, and on veterans' finances because they may assume VA will pay for care in situations that do not meet VA criteria. Despite VA's efforts to improve communications, some non-VA providers reported instances in which VA facilities' claims processing staff were unresponsive to their questions about submitted claims.

LETTER FROM DAVID J. MCINTYRE, JR., CEO OF TRIWEST HEALTHCARE ALLIANCE

The Honorable Jeff Miller, Chairman, Committee on Veterans' Affairs
U.S. House of Representatives , Washington, DC 20515
The Honorable Michael Michaud
Ranking Minority Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington DC 20515
Dear Chairman Miller and Ranking Member Michaud:

I want to express my sincere appreciation for the opportunity to testify before your Committee on June 18, 2014. It was an honor to represent TriWest Healthcare Alliance before your distinguished panel.

During the hearing, I was asked to answer "yes" or "no" in response to a question concerning whether VA pays Medicare rates to TriWest under the VA Patient-Centered Community Care (PC3) program. I answered "yes." However, as the hearing progressed, it became clear that the question was whether we are provided reimbursement by VA at 100% of the Medicare rate. We are not.

As such, I want to clarify my answer by making it clear that TriWest is not reimbursed by VA at 100% of the Medicare rate for health care services. While it is true that the reimbursements under PC3 are Medicare-based, which is why I responded in the affirmative, in general, VA reimburses TriWest at a discount off of the Medicare rate. The discount varies by type of service and the PC3 region to which it applies. However, with the exception of Region 6 (Alaska), reimbursements for health care services are at rates below Medicare. As such TriWest is incentivized – and indeed at risk – to obtain care from network providers at a discount off of 100% Medicare reimbursement.

I hope this provides some clarification to my answer as well as some additional information that will be helpful to the Committee. Should you deem it appropriate, I would appreciate it if this clarification could be made a part of the hearing record.

Respectfully,
David J. McIntyre, Jr., President and CEO
Chairman Miller and Ranking Member Michaud
June 19, 2014

QUESTIONS FOR THE RECORD

The Honorable Sloan Gibson
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW., Washington, DC 20420
June 27, 2014
Dear Mr. Secretary:

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. In reference to our Full Committee hearing entitled, "Non-VA Care: An Integrated Solution for Veteran Access" that took place on June 18, 2014, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 8, 2014.

In preparing your responses to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a Word document, to Carol Murray at Carol.Murray@mail.house.gov by the close of business on August 8, 2014. If you have any questions please contact her at 202–225–9756.

Sincerely,
MICHAEL H. MICHAUD
Ranking Member
MHM:cm

Question by Mike Michaud, Ranking Member

1. From my conversations with the veterans in Maine, Project ARCH has been quite successful. Unfortunately the VA appears to be moving to close down this popular program.

a. It is my understanding VA has authority to provide an extension of the program beyond August. Does the VA believe existing authority allows for an extension of the program? If so, will VA exercise that authority and continue the program?

b. In March this year, Under Secretary Petzel told me VA would ensure the continuation of services for those veterans participating in ARCH. You mentioned development of individual transition plans, please provide more detail on what these entail? What actions is VA taking to follow up on this promise?

c. I understand the participating ARCH providers will receive lower reimbursement if they choose to enter the PC3 network. Is VA taking any action to facilitate the transition of ARCH providers into PC3?

2. Please explain how the Non-VA Care Coordination program and PC3 interact or complement each other in the coordination of care for a veteran receiving non-VA care.

3. I understand that PC3 requires a seven-step process. Can you detail the steps in this process and discuss any efforts VA has made to streamline the process going forward?

4. In looking at data from FY 2013, FY 2012, and FY 2011, please provide the amount of monies, by VISN, available for obligation but not expended at the end of each fiscal year. In addition, if any VISN or facility within a VISN has not expended funds at the end of these fiscal years, has that fact been a consideration in terms of any evaluation of VHA personnel in regards to performance awards or bonuses.

5. What is the process for VA to timely pay non-VA providers? What are the current challenges to prompt payment?

6. What do you believe are the top three challenges the Department faces to ensure effective and efficient standards and processes are in place so that veterans receive timely, quality, health care whether it is in a VA facility or non-VA care?

Rep. O'Rourke

1. Are VA Directors' bonuses based on staying under budget? Are there disincentives in place that keep them from sending veterans into the community for care?

2. What criteria did VA consider when determining how to allocate the $300 million in carryover funds that went to specific medical centers?

3. Precisely what data was measured in the document we were given on May 9th, versus the wait times measured and reported in the audit on June 9th? What consequences will there be for reporting false data?

Questions Submitted by Ranking Member Michaud

Question 1. From my conversations with the veterans in Maine, Project ARCH has been quite successful. Unfortunately the VA appears to be moving to close down this popular program.

a. It is my understanding VA has authority to provide an extension of the program beyond August. Does the VA believe existing authority allows for an extension of the program? If so, will VA exercise that authority and continue the program?

VA Response: Section 403 of Public Law 110–387 required that VA conduct a pilot program, called Project ARCH, under which the Secretary provides covered health services to covered Veterans through qualifying health care providers for a three-year period, pursuant to contracts with qualifying non-Department health care providers for the provision of such services.

Section 104 of Public Law 113–146 requires VA to extend the pilot program to August 7, 2016. At this time, VA is determining how to quickly implement section 104 in order to continue to provide covered health services to eligible Veterans in the program.

b. In March this year, Under Secretary Petzel told me VA would ensure the continuation of services for those veterans participating in ARCH. You mentioned development of individual transition plans, please provide more detail on what these entail? What actions is VA taking to follow up on this promise?

VA Response: Section 104 of Public Law 113–146 requires VA to extend the pilot program to August 7, 2016. At this time, VA is determining how to quickly implement section 104 in order to continue to provide covered health services to eligible Veterans in the program.

c. I understand the participating ARCH providers will receive lower reimbursement if they choose to enter the PC3 network. Is VA taking any action to facilitate the transition of ARCH providers into PC3?

VA Response: The VA contractual relationship for PC3 is between VA and the two PC3 contractors, Health Net and TriWest. Each contractor is responsible for developing their own PC3 provider networks, and VA has no involvement in the development of prime to subcontractor relationships.

Question 2. Please explain how the Non-VA Care Coordination program and PC3 interact or complement each other in the coordination of care for a veteran receiving non-VA care.

VA Response: All non-VA medical care is to be authorized via the defined Non-VA Care Coordination (NVCC) process. PC3 is one type of purchasing that can be done as part of non-VA medical care. The PC3 Authorization Process Guide (attached below) identifies the PC3 touch points with the NVCC Process Guides.

Question 3. I understand that PC3 requires a seven-step process. Can you detail the steps in this process and discuss any efforts VA has made to streamline the process going forward?

VA Response: Please see flow chart and corresponding narrative in the PC3 Authorization Process Guide attached above. We currently are establishing governance groups that will be gathering feedback from all elements of the PC3 process and looking for opportunities for improvements.

Question 4. In looking at data from FY 2013, FY 2012, and FY 2011, please provide the amount of monies, by VISN, available for obligation but not expended at the end of each fiscal year. In addition, if any VISN or facility within a VISN has not expended funds at the end of these fiscal years, has that fact been a consideration in terms of any evaluation of VHA personnel in regards to performance awards or bonuses.

VA Response: Please see spreadsheet below for monies not obligated at the end of each fiscal year. The attached spreadsheet displays by appropriation (Medical Services, Medical Support & compliance and Medical Facilities) the amount that Veterans Integrated Service Networks (VISNs) carried over from one fiscal year into the next fiscal year for FY 2011, FY 2012, and FY 2013. VA carryover amounts by account are never more than the carryover amount authorized by the Congress.

A superior performance award is a one-time cash award that may be granted to an employee each year based on his/her rating of record provided that the rating of record is at the fully successful level (or equivalent) or above. VA's performance appraisal program for employees appointed under Title 5 of the United States Code is approved by the Office of Personnel Management (OPM). For employees appointed under Title 38 of the United States Code (e.g., doctors, nurses), VA has a proficiency rating system governed by VA Handbook 5013. Under statute and regulation, VA may use an employee's performance as a basis for pay, awards, development, retention, removal, and other personnel decisions. Cash awards, time off awards, suggestion awards and other honorary or non-monetary awards are also given to employees for other contributions, acts, service, or achievement that benefits the VA or the Federal government. They are not issued based on a performance rating but rather the overall value of the contribution. These would include on-the-spot awards.

Question 5. What is the process for VA to timely pay non-VA providers? What are the current challenges to prompt payment?

VA Response: VA's priority goal is to process a minimum of 90 percent of claims within 30 days of receipt and maintain an aged inventory of 80 percent less than 30 days old. This data is reviewed on a weekly basis and action is taken as appropriate to resolve any issues that might be impacting claims processing. There have been a number of challenges in maintaining our goals to include an increase in the number of claims received, staffing shortages, and technology issues. In addition, claims are currently processed throughout VA in a decentralized model, which results in a great deal of variability. Steps have been taken to address these challenges while plans are underway to move to a centralized model, including improved technology to ensure continued sustainment. Ongoing success is driven by data analysis and trending to ensure we have early warning of potential problems. VA has established two remote claims processing teams that are able to provide claims processing assistance to decentralized locations that are experiencing difficulties.

VA has seen a large improvement over the past several months in reaching our goals. Claims paid within 30 days have improved from 75 percent in December 2013 to

83 percent in June 2014. For inventory aged less than 30 days there has been an improvement from 63 percent in December 2013 to 79 percent as of July 14, 2014.

Question 6. What do you believe are the top three challenges the Department faces to ensure effective and efficient standards and processes are in place so that veterans receive timely, quality, health care whether it is in a VA facility or non-VA care?

VA Response: VA is committed to addressing our top three challenges:

* First, our process initiatives—using available resources to get Veterans off wait lists and into clinics, while also fixing our scheduling system.

* Second, but simultaneously, our changes of leadership—addressing VA's cultural issues, holding people accountable for willful misconduct or management negligence, and creating an environment of openness and transparency.

* Third, the resource challenge—making a compelling case for the resources needed to consistently deliver timely, high-quality healthcare.

Questions Submitted by Congressman O'Rourke

Question 1. Are VA Directors' bonuses based on staying under budget? Are there disincentives in place that keep them from sending veterans into the community for care?

VA Response: VA medical center directors' performance awards are paid based on annual performance ratings. Ratings are based on each senior executive's performance agreement. Every medical center director's performance agreement includes a critical element of "business acumen," which is a government-wide standard set by OPM. A station's total yearly budget is comprised of General Purpose and Specific Purpose funds, augmented by alternative revenue from first- and third-party collections and sharing agreement partners. Once a facility's budgetary total is determined using the above process, it must also be appropriately be divided among the three Medical Care budget accounts. Within these limitations, facility leaders are expected to develop and execute a resource management plan that integrates budget, human resources, and capital expenditures, including the proper execution of specific purpose funds. The VA and VISN budget processes are dynamic, requiring frequent budgetary adjustments throughout the year as care needs change or other operational issues arise. Part of effective management is carrying out the facility mission within the allocated resources. However, if resources need to be augmented or realigned between appropriations or facilities, this is accomplished by using a 1.0–1.5 percent VISN reserve for contingencies.

Senior Executives are expected to implement business processes in non-VA Care programs to ensure appropriate and timely non-VA care service provision as well as compliant claims processing. In addition, they are responsible for ensuring non-VA care payment accuracy through robust internal controls and independent compliance and business integrity reviews. VA has taken steps to ensure all VA health care leaders and managers clearly understand the following: (1) there are no financial disincentives to referring Veterans for non-VA health care; and (2) VA has robust funds to apply for such referrals. VA's goal is to always provide timely, quality, and appropriate health care whether it is provided directly within VA facilities or through

non-VA care in the community.

Question 2. What criteria did VA consider when determining how to allocate the $300 million in carryover funds that went to specific medical centers?

VA Response: VA leadership took a deliberate approach to the analysis and ultimate allocation of funding resources to provide timely and accurate support to maintain Veteran care. VHA directed facility-level reporting requirements that included current facility capacity constraints, productivity challenges, and resource needs. These reports were provided and subsequently analyzed. VHA then clarified and confirmed the resource needs derived in part from the facility analysis with VISN level financial representatives, to include Chief Financial Officers. This input ensured appropriate allocation of funding requests. Those requests were broken down into three categories: Medical Services – Personal; Medical Support and Compliance Services; Personnel and Medical Service – Non-VA Medical Care. Allocation of funds began on June 11, 2014, with VISN leadership allocating funds to their specific facilities based upon their individual funding needs.

Question 3. Precisely what data was measured in the document we were given on May 9th, versus the wait times measured and reported in the audit on June 9th? What consequences will there be for reporting false data?

VA Response: The May 9th report was a PowerPoint related to mental health only.

It showed completed appointment wait time trending from March 2013 to March 2014 for mental health. Below we provide clarification of the Accelerating Care Initiative Data Release of June 9, 2014.

On June 9, 2014, in addition to posting information on the nationwide Access Audit, VA also released additional data from each facility regarding patient waiting times.

The Pending Waiting Time Data (released on June 9) demonstrates the wait times for future appointments; Completed Waiting Time Data demonstrates the wait times for completed appointments – which is the data local facilities probably provided. The two datasets complement each other, and both datasets demonstrate that Veterans are waiting too long for the care they need. VA is taking action to accelerate care for the Veterans we serve and improve the way wait times are reported and monitored.

The facility average waiting times for patients that VA distributed on June 9, 2014, predicts the availability of scheduled appointments in the future for Veterans on a given date. We call this the "Pending Waiting Time Data."

This has the advantage of providing a big-picture view of appointment availability and the capacity of the system to address the needs of Veterans who have not yet been seen in our clinics.

The waiting times datasets that local VA facilities have typically used in the past are "Completed Waiting Time Data" based upon when appointments actually occurred (completed) and take into account appointments moved up, cancelled, rebooked and missed.

In the weeks following the audit, VA has concentrated its efforts on the Accelerating Care Initiative in order to get Veterans off wait lists. As of August 15, 2014, we have reached out to over 266,000 Veterans to get them off wait lists and into clinics sooner. From May 16, 2014, through August 24, 2014, we have made over 975,000 total referrals to non-VA care providers. We have also confirmed that 14-day access measures have been removed from all individual employee performance plans to eliminate any motive for inappropriate scheduling practices and behaviors. Regarding allegations of false reporting from VA employees, VA is already taking corrective action to address issues resulting from the audit. Appropriate personnel action will be taken on a case-by-case basis.

Questions to Currato From Michaud

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
FULL COMMITTEE HEARING
"Non-VA Care: An Integrated Solution for Veteran Access."
JUNE 18, 2014
334 CANNON HOUSE OFFICE BUILDING
Hon. Mike Michaud

1. Regarding the Patient-Centered Community Care (PC3) program of the Department of Veterans Affairs:

a. Have you experienced any difficulty in attracting providers?

b. Have providers expressed any concerns regarding the VA's reimbursement rates or promptness of payment?

c. Do you have any concerns regarding the open-ended structure of the contracts and the ability of providers to address surges in demand?

d. In your experience so far, what difficulties do you face in building networks of providers in rural areas?

Responses From Currato to Michaud

Hon. Michael H. Michaud, Ranking Member
U.S. House of Representatives, Committee on Veterans' Affairs
334 Cannon House Office Building
Washington, DC 20515
August 8, 2014

Dear Ranking Member Michaud,

Please find attached the answers to your additional questions submitted in reference to my testimony before the Full Committee hearing entitled "Non-VA Care: An Integrated Solution for Veteran Access" which occurred on June 18, 2014.

Thank you for the opportunity to testify before the committee and to answer your additional questions. Health Net remains committed to helping increase acces to care for our nation's veterans through the Department of Veterans Affairs.

Sincerely,
Thomas Carrato
President, Health Net Federal Services

1. Regarding the Patient-Centered Community Care (PC3) program of the Department of Veterans Affairs:

a) Have you experienced any difficulty in attracting providers?

Currently, Health Net's PC3 network contains over 39,000 providers across our three PC3 regions. In developing our network, we have had community providers, including providers that participate in our other government programs (e.g., TRICARE), express reluctance to work directly with VA based on previous experiences and/or perceptions of working directly with VA. The four most commonly cited concerns have been: 1) low levels of reimbursement; 2) extensive medical documentation required in time frames shorter than the provider's office practice; 3) inaccurate, slow payment; and 4) the amount of care provided for which payment is

denied by VA. Health Net has worked with providers to address many of these perceived issues and has achieved success building the PC3 network in our regions.

Since Health Net is the prime PC3 contractor in Regions 1, 2 and 4, we serve as a liaison between community providers and VA; it is our responsibility to provide clarity to providers regarding the expected performance of services and to pay network providers promptly and accurately. Health Net clearly defines the services to be delivered and the medical documentation to be returned for network care provided to Veterans. Health Net is able to leverage existing relationships we have with community providers to navigate the complex VA system in which each VA Medical Center has unique processes and requirements. When a provider has a concern or question about what is expected by the VAMC's request, Health Net stands ready to obtain and provide clarifying guidance for the care to be given.

1. Regarding the Patient-Centered Community Care (PC3) program of the Department of Veterans Affairs:

(b): Have providers expressed any concerns regarding the VA's reimbursement rates or promptness of payment?

As discussed above, many providers have expressed concern with low levels of reimbursement tied to Medicare, the amount of administrative effort required to meet VA requirements, and the length of time it takes for VA to pay claims. Health Net, as the payor of PC3 network claims, is committed to paying providers within 30 days. Part of our solution for PC3 is to simplify the administrative tasks required of network community providers, such as timely return of medical documentation to VA prior to VA reimbursing health care claims. Through these efforts, the Health Net network for PC3 continues to grow and expand in all areas.

1. Regarding the Patient-Centered Community Care (PC3) program of the Department of Veterans Affairs:

(c): Do you have any concerns regarding the open-ended structure of the contracts and the ability of providers to address surges in demand?

The true value of PC3 is that it was designed to augment VA's capacity to provide timely access to care for veterans, not duplicate or replace it. As a long-standing TRICARE contractor, we have extensive experience with tailoring and enhancing our networks to augment the specific needs of our customer, and with the leadership and assistance of the VA PC3 Program Management Office (PMO), our focus has been on doing exactly that for VA also.

Since contract implementation in January 2014, Health Net has been collaborating with the VA PC3 Program Management Office and the Veterans Integrated Service Networks (VISNs) and VAMCs within our regions to build an efficient and effective PC3 network to meet the needs of each VAMC. The clear commitment of the VA PC3 PMO and the engagement of VAMC leadership have been key to our ability to identify, and then recruit, the types of specialty providers in greatest demand, as well as to identify projected gaps in VAMC capacity that will require specific services to be available through the PC3 network.

In some cases, however, the current situation within the Veterans Health Administration, including the Accelerated Access to Care Initiative, is placing a strain on network capacity in specific specialties and in certain areas, particularly underserved and rural communities. This is further complicated by the fact that PC3 is a new program and network community providers are still adjusting to the specific requirements of PC3 and establishing the level of PC3 authorizations for which they are comfortable accepting. We view this as a short-term challenge and believe that, in the long term, the PC3 community networks will effectively adjust to meet local VA needs.

1. Regarding the Patient-Centered Community Care (PC3) program of the Department of Veterans Affairs:

(d) In your experience so far, what difficulties do you face in building networks of providers in rural areas?

PC3 utilizes the same healthcare resources available in the broader community, whether urban, rural, or highly rural. Rural access is a national concern. Provider shortages exist in certain geographical areas of the country, as well as national availability in certain specialties to serve the U.S. population overall.

An important component to ensuring adequate coverage in rural and underserved areas is to minimize administrative requirements that go above and beyond the community standards in those areas. PC3 does contain requirements that exceed these community standards. To encourage providers in these more challenging areas to participate in PC3, we are working hard to simplify the administrative tasks associated with meeting the requirements of PC3.