

CHOICE CONSOLIDATION: IMPROVING VA COMMUNITY CARE BILLING AND REIMBURSEMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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CHOICE CONSOLIDATION: IMPROVING VA COMMUNITY CARE BILLING AND REIM- BURSEMENT

Thursday, February 11, 2016

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

The Subcommittee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Roe, Huelskamp, Coffman, Wenstrup, Takano, Ruiz, and O'Rourke.

Also Present: Representatives Lamborn, and Posey.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. Before we begin, I would like to ask unanimous consent for Congressman Doug Lamborn from Colorado and Congressman Bill Posey from Florida to sit on the dais and participate in today's hearing. So without objection, so ordered.

Good morning. Thank you all for joining us for today's Subcommittee hearing on Choice Consolidation: Improving the VA Community Care Billing and Reimbursement.

This morning's hearing is the second in the series of hearings the Subcommittee is holding over the next several weeks on several aspects of VA's plan to consolidate community care programs under a new and improved Choice Program.

Last week, we met to discuss eligibility for community care under the consolidation plan. This morning, we are going to discuss billing and reimbursement being considered under the plan.

The importance of VA's effort to consolidate community care programs and the impact that consolidation will have on the future of VA's health care system cannot be overstated. The VA simply cannot offer veteran patients across the country the health care they need without using community providers to supplement the care provided in the VA medical facilities. That is a fact that is becoming increasingly obvious and increasingly expensive.

In fiscal year 2012, the VA spent \$4.5 billion on care in the community. Four years later in fiscal year 2015, care in the community costs more than doubled to just over \$10 billion. That is almost an unprecedented increase over a relatively short time period and there is no sign that upward trend will reverse itself any time soon

with the budget submission that was released Tuesday estimating a need for \$12 billion for community care in fiscal year 2017.

In order for that money to be well spent and for our veterans to be well served by it, the VA must be a willing, fair, and consistent partner with community providers around the country. Unfortunately, the overly bureaucratic, highly manual claims process that VA currently employs to reimburse community providers does meet that standard.

Despite aggressive oversight from this Subcommittee and by individual Members of Congress, community providers both large and small continue to report millions of dollars in past due unpaid claims, and my office continues to hear regularly from providers who would like to serve veterans, but they are hesitant to continue accepting referrals from the VA because it is so difficult for them to get paid for their services.

My office also hears a lot of confusion and frustration from community providers about what they are supposed to be getting paid in the first place. Reimbursement rates vary widely across the VA's multiple care in the community programs.

In some cases, the VA reimbursement rates are lower than Medicare which makes it difficult for community providers to accept veteran patients and keep their doors open. In other cases, VA reimbursement rates are higher than Medicare. This is an inefficient way to run a large hospital, much less the Nation's largest health care system.

So moving forward, the VA must automate and simplify the department's community care claims processing system so that community providers are reimbursed accurately and in a timely, transparent manner.

VA must also honor the important role that community providers play in treating veteran patients by developing standardized reimbursement rates that are fair, competitive, and consistently applied. Multiple bureaucratic steps that only time rather than value must be eliminated. The stakes are simply too high for the VA to do anything less.

Thank you again for being here and I will now yield to Mr. Takano for his opening statement. Thank you.

OPENING STATEMENT OF MARK TAKANO

Mr. TAKANO. Thank you, Mr. Chairman, for calling this hearing on VA's future plan to improve billing and reimbursement practices so that providers in the community can expect prompt, accurate payments for services rendered to veterans in a community setting.

We are all aware of the challenges that face the department in this area. Numerous VA Inspector Generals' Reports, Government Accountability Office reports, and the recently released independent assessment all outline several problems that VA should and needs to address in order to ensure that proper billing and reimbursement practices are put in place and adhered to.

The department is first and foremost a health care provider, not an insurer of care. Congress saw the need to address the wait time crisis that surfaced in 2014. The Veterans Choice Program was authorized as a temporary program to address that issue. Congress has now required VA to consolidate their numerous purchased care

programs under one umbrella in order to become more efficient and less confusing for veterans, employees, and providers.

The new Veterans Choice Program offered by VA in the care consolidation plan is designed to do just that. Now that the wait time crisis has subsided, it is important to ensure the VA continues its mission of providing health care to our Nation's veterans.

It is important we remember that VA was built to provide unique medical services to veterans who suffer from combat-related injuries and illnesses. We know veterans feel that they get the best care at the VA. It is our job to make sure that the VA has the resources it needs to provide medical care services veterans need.

We know the current claims infrastructure and claims processes are complex and inefficient due to highly manual procedures. VA lacks a centralized data repository to support auto adjudication.

According to VA, there are more than 70 centers processing claims across 30 different claims systems. VA's system is a labor intensive, paper-based process that results in late and sometimes incorrect payments.

The Government Accountability Office reports that VA's expenditures for its care in the community programs, veterans for whom VA has purchased care, and the number of claims processed by the Veterans Health Administration have grown considerably in recent years.

In fiscal year 2015, VA obligated about \$10.1 billion for its care in the community programs for about 1.5 million veterans. This is compared to fiscal year 2012 when VA spent about \$4.5 billion on care in the community programs for about 983,000 veterans, about 50 percent less.

The most startling statistic is that the number of processed claims for VA care in the community programs increased by 81 percent. Given this increase and the state of VA's information technology infrastructure, we potentially have a long, expensive road ahead of us. It will be no small task to fix this problem, and we must work together to get this right.

Mr. Chairman, I am interested to hear from the department in more detail on how they plan to implement improvements, how much it will cost, and what they will need from us legislatively or otherwise in order for the plan to succeed.

I agree with The American Legion that a strong, robust veterans' health care system that is designed to treat the unique needs of those men and women who have served our country is what we need. Getting there in a timely manner remains to be seen.

I look forward to hearing from all the witnesses today, and I look forward in the coming days to bring the best quality care to all of our veterans. Thank you and I yield back my time.

Mr. BENISHEK. Thank you.

Joining us today on our first panel is Randall Williamson, the Director of Healthcare for the Government Accountability Office; Gary Abe, the Deputy Assistant Inspector General for Audits and Evaluations for the VA Inspector General's Office, accompanied by Larry Reinkemeyer, the Director of the Kansas City Audit Office; and Dr. Baligh Yehia, the VA Assistant Deputy Under Secretary for Health for Community Care, accompanied by Dr. Gene

Migliaccio, the VA Deputy Chief Business Officer for Purchased Care.

Thank you all for being here today. Mr. Williamson, we will start with you.

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Good morning, Chairman Benishek and Members of the Subcommittee. I am pleased to be here today to discuss our preliminary findings on VHA's efforts to improve the timeliness of its payments to non-VA providers when veterans access care in the community.

The number of processed claims from community providers has almost doubled since 2012 and this sharp increase has overwhelmed the staff at some VHA claims processing centers in terms of their ability to process claims in a timely way.

In fiscal year 2015, VHA paid less than 70 percent of its claims from community providers within 30 days. In contrast, TRICARE and Medicare paid about 99 percent of their claims within 30 days.

To make matters worse, VHA data overstates their timeliness because paper claims which represent about 60 percent of the claims they get are not always promptly scanned into VHA's claims processing system. Until this is done, the 30-day clock VHA uses to measure processing time doesn't start to tick.

At one VHA claims processing center we visited, for example, we observed about a dozen bins of paper claims and medical documentation awaiting scanning, some of which were received a month before our visit.

Community providers who participated in our study were frustrated with VHA for requiring providers to submit claims and medical documentation multiple times, paying medical claims late, and being unresponsive to repeated attempts by providers to contact VHA and resolve payment issues.

If these timeliness and poor customer service issues persist, VHA will risk losing the cooperation and participation of community providers as it attempts to transition to a future care delivery system that would heavily rely on them to deliver care to veterans.

To its credit, VHA has recently taken steps to improve claims processing timeliness such as hiring more claims processing staff to replace those lost through attrition and establishing productivity standards for them. However, VHA acknowledges that its current claims processing system is not sustainable and longer-term solutions are needed including revamping archaic information technology systems.

At the behest of the Congress, VHA is in the process of consolidating its various purchased care programs into a single program called the new Veterans Choice Program. To do so, VA has developed a broad consolidation plan which it presented to the Congress late last year to develop a robust network of community providers and streamline clinical and administrative processes.

According to VA, implementing this plan will allow it to put into place a much improved claims processing system. As well-intentioned as VA might be, bringing this community care consolidation plan to fruition will require a herculean effort on many fronts.

The sweeping changes VA is planning will likely be costly, and will require major organizational and structural changes and modernization of its IT systems. Achieving the objectives laid out in the plan will require strong leadership, careful and thoughtful planning, effective project management, and transparency and involvement with multiple stakeholders including the Congress.

The absence of these elements can have severe consequences. Our prior work has shown that some of VA's past attempts to achieve goals of similar magnitude have been derailed by poor planning, project management weaknesses, and insufficient oversight.

VA's past failures to modernize its systems for outpatient appointment scheduling, financial management, and inventory and asset management are stark reminders of what can happen if mega projects of this scale are mismanaged. These projects were canceled after investments of hundreds of millions of dollars leaving VA with little to show for its efforts.

To date, we have not seen a detailed blueprint and specific strategies for how VHA plans to successfully implement the major components of its consolidation plan, especially as it relates to the claims processing system.

Such a blueprint should include an analysis of available options, estimates costs, staff resources and new systems needed, specific timelines and a critical path for achieving its objectives and key milestones, performance measures to gauge success and hold managers accountable, and a process to ensure transparency among major stakeholders.

That concludes my opening remarks.

[THE PREPARED STATEMENT OF RANDALL B. WILLIAMSON APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much.

Mr. Abe, could you please go ahead, five minutes.

STATEMENT OF GARY K. ABE

Mr. ABE. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's work concerning VA's purchased care programs.

I am accompanied by Mr. Larry Reinkemeyer, the Director of our Kansas City Audit Division.

VA's purchased care programs are critical to VA in carrying out its mission of providing medical care to our veterans. Our audits and other reviews have reported the challenges VA faces in authorizing, scheduling, and ensuring contractors provide medical records in support of services provided.

It has been challenging to conduct effective oversight of VA's purchased care programs because VA continues to make significant changes and additions to the programs. For example, we published four reports on PC3 in fiscal year 2015 that reviewed the effectiveness of PC3 in providing timely access to care.

We had planned to review the timeliness and accuracy of PC3 payments this fiscal year after providing VA sufficient time to process a significant number of claims to make reliable findings and

conclusions. However, PC3 was soon followed by the Veterans Choice Program.

Nevertheless, we have started a quarterly review of paid Choice claims in order to meet the Choice Act requirement to submit a report on the timeliness and accuracy of payment of claims after 75 percent of the almost \$10 billion of program funds are spent or when the program ends in August 2017.

This approach enables us to view the expenditure activity over time and helps assess whether VA's payment process is improving or worsening.

In September 2013, VA awarded Health Net and TriWest PC3 contracts. In October 2014, VA amended the PC3 contracts to include administration of the Veterans Choice Program. This is an important matter when evaluating VA's plan to align all non-VA care programs under the new Veterans Choice Program.

Since Health Net and TriWest have built their Choice provider network upon the backbone of the PC3 network, there are lessons that can be learned from the series of reports we issued in fiscal year 2015 addressing aspects of VA's implementation efforts.

All four PC3 reports identify issues with inadequate processes for submitting timely authorizations, scheduling appointments, returning the medical document for continuity of care, and the provider network that lacks sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them.

Being a retired Army officer, I decided to seek care under the Veterans Choice Program. This was my first experience with VA health care. In July 2015, I visited my VA primary care provider and he ordered medical services that were not available timely from VA. For the first month, I was told I was not eligible for the Choice Program. Then in late August, I was told I was authorized for care and I would be notified of my appointment in three to five days. Months passed without a word.

On December 14th, I received a letter from Health Net saying that they had scheduled an appointment with a local provider. However, the appointment was for December 12th, two days earlier. This is what VA considers blind scheduling. So I was a no show on Health Net's records.

I called the Veterans Choice call center and I asked if I could call the provider to avoid another blind scheduled appointment. They said yes. I called the local provider and scheduled an appointment on December 29th, about 165 days or five and a half months after my visit with my primary care provider in July.

My experience is similar to the issues we identified in our PC3 and recent Veterans Choice reports. The obstacles I experienced are also similar to those that many veterans are calling in to our hotline and most likely your local congressional offices.

The complaints fall into the following general categories: program eligibility enrollment; the authorization process; appointments and scheduling; and veteran provider payments.

In conclusion, our recent work has shown that VA faces challenges in administering its purchased care programs. While purchasing health care services may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA, and

more importantly, a great deal of frustration and risk to our veterans' health when adequate controls are not in place.

Without adequate controls, VA's consolidation plan is at an increased risk of not achieving its goal of delivering timely and efficient health care to our veterans.

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

[THE PREPARED STATEMENT OF GARY K. ABE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Abe. I appreciate you including your personal experience.

Dr. Yehia, you are recognized.

STATEMENT OF BALIGH YEHIA

Dr. YEHIA. Thank you.

Good morning Chairman Benishek and Members of the Subcommittee. Thank you for the opportunity to testify today regarding the department's plan to consolidate community care programs, specifically on our efforts to improve billing and reimbursement.

I am accompanied today by Gene Migliaccio who is our Deputy Chief Business Officer for Purchased Care.

And I would like to take a moment, and look forward to the discussions from some of the other panelists and their experiences, and be able to talk a little bit about some of the improvements we are doing to address those.

To start, community providers are critical to VA's ability to deliver timely and quality care to veterans. As a clinician, I personally understand the importance of these partnerships and often jointly care for veterans with community providers.

To strengthen and grow these important relationships, VA recognizes a need to pay claims accurately and timely. For many providers, late payments have a major impact on the practice, and may cause some not to care for our veterans. We know this is unacceptable, and it is particularly problematic in rural areas where the number of providers is limited. Late payments may also negatively impact our veterans by creating unnecessary financial hardships. That is why in our plan to consolidate community care programs, we are keenly focused on improving how we interact with community providers including payment.

I want to provide the Subcommittee with an update on our progress since the June 3rd hearing related to claims processing and prompt payment.

In the last eight months, we have focused our efforts on improving people, process, and technology. So first, related to people, we filled 220 vacancies in 57 days and that is 33 days faster than our 90-day goal. We also provided and implemented productivity and quality standards.

Second related to process, we have implemented real-time monitoring of claims to ensure that the oldest claims are paid first, and we are actively removing any unnecessary steps that may be barriers to paying timely claims.

Third related to technology, we continue to try to automate steps where we can and, for example, we removed the duplicate claims process and now that is automated.

These efforts have produced results. As of today, 81 percent of authorized claims, meaning our current, meaning they are within 30 days of receipt. This compares to 73 percent in June of last year.

Some sites have improved more than others. So, for example, in Louisiana, claims processing has improved from 69 percent to 96 percent in the last six months. This improvement is even more noteworthy given the fact that we continue to experience tremendous growth in the claims volume.

Last fiscal year, we processed roughly 17 million claims which represents a 21 increase from the prior year. Even though we continue to improve in this area, there is still much work to be done to meet industry expectations.

We also recognize that our Choice contractors have not been paid timely and understand the frustration this has caused. We are actively working to address these issues with an eye towards removing any barriers in the contract that may slow payment.

I believe that open communication is critical for these partnerships to work, and have made it a point to meet weekly with the executives from Health Net and TriWest to talk about issues that we are discussing today. Getting these partnerships right is important for VA, and impacts our relationship with community providers and the veterans that we serve.

We are taking steps to improve community care today, but also looking towards the future incorporating lessons learned from the current program and industry best practice. We aim to move towards a claims solution that is more fully automated. That is why in the recently released draft performance work statement, we include a specific section focused on claims processing and payment.

Lastly, we take the recommendations from GAO and OIG seriously. We are closely monitoring their reports and working to resolve issues that are identified. However, we do need help from Congress to formalize VA's prompt pay standard which will help us align with current industry practice, and then also help from Congress to change the recording of obligations to the time of payment so that we can improve our accuracy in terms of funding.

These two proposals will address many of the deficiencies identified in both GAO and OIG reports. Getting provider payment is critically important. We look forward to continuing to work with veterans, veteran service organizations, yourself, and Congress as well as we move forward.

I appreciate the opportunity to appear before you today, and am prepared to answer any questions you or other Members may have. Thank you.

[THE PREPARED STATEMENT OF BALIGH YEHIA APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. Yehia.

I now yield myself five minutes for my questions. Dr. Yehia, I guess I didn't hear anything from you about some of the things that Mr. Williamson brought up to tell you the truth, and that is that we have a plan to consolidate all these different forms of com-

munity provider relationships. And we haven't heard anything about how is that going to work. How are you thinking about it? What are the options?

To me, it is kind of scary because right now there are seven different ways to do it which is complicated bureaucratically, but at least physicians then have kind of a choice as to what they do and where they fit in. And when you narrow it down to one system, that is pretty important to get that one system right then. You understand what I am getting at here?

Dr. YEHIA. Yes.

Mr. BENISHEK. And developing that system is going to obviously take time, but I would like to be involved in seeing what you are doing so that we can provide input.

As you know, I took care of patients at the VA in multiple different ways throughout my career. Sometimes it was very frustrating. Then we finally settled on a system which was equitable, I think, for the VA and for my practice.

Dr. YEHIA. Yeah.

Mr. BENISHEK. One of the things that we wanted to talk about, too, is how are we going to set fair and competitive reimbursement rates for physicians. That is one of the things that comes to my mind as a provider.

Can you talk about that a little bit?

Dr. YEHIA. Yes. You know, when I talk to providers just as you talk to providers, without a doubt they want to care for veterans. And when I ask them kind of what stands in their way, one of the issues relates to payment and that deals with what you just described. One is reimbursement rates.

Right now under all these different programs, we pay differently. So under the traditional PC3 Program, it is less than Medicare. Under the Choice Program, it is up to Medicare. In some of our emergency room authorities, we pay 70 percent of Medicare.

It is very confusing for community providers to know what they are going to get billed for, what they are going to get paid for. And that actually causes some of the problems that we are experiencing today with prompt payment. A lot of folks are expecting the VA to pay a specific amount, but we don't because they don't understand all the rules that are in place.

So what we hope to do is move towards a standardized fee schedule. That fee schedule will as best possible be based on Medicare which is kind of the common practice in the community. We know that some specialties we might have to pay a little bit more than Medicare and in some locales, specifically rural areas, we might have to pay a little bit more.

But for the most part, we want to try to move the system towards Medicare rates as best as possible. So that is kind of some of the efforts that we are hoping to do.

The other thing that is important to recognize is that not everything has a Medicare rate. So, for example, dental care, there is not actually a Medicare rate. And across our facilities in the VA, we pay different rates when there isn't a Medicare rate.

So some of the work that we are trying to do is for those services that there isn't a fee schedule by Medicare, how can we come up with a regional fee schedule or a VA fee schedule so that folks

know exactly what they will get paid for the services they provide. That is a little bit of some of the work that we are starting.

Mr. BENISHEK. Where are you in this consolidation situation? Do you have a blueprint of what you are going to do like Mr. Williamson talked about? When can you show that to us?

Dr. YEHIA. So let me explain a little bit of where we are. So in the consolidation report that we presented, that provides a little bit of the overview, the blueprint, the direction. There are a number of things that we can do today. So what we are doing is, we are categorizing, one of the things within VA's control that we can try to impact today. A lot of those have to do with, like process improvements, removing unnecessary steps.

But as we kind of talked about as well last hearing, and in the plan, there are a number of things that we need to partner on to be able to do together, so being able to get to one eligibility criteria as we discussed before, we can't do that. We need help from Congress.

So there are a couple of things that are squarely in our field that we are trying to move forward, and then a couple things that we need partnership with you to move forward.

Mr. BENISHEK. Can you tell me anything specifically that you are doing as far as this paperwork requirement from community providers? Apparently, there is different criteria as far as what the provider has to do depending on who they are, where they are, what medical center. It seems to be very variable. Can you just talk about that for a minute?

Dr. YEHIA. Yes, I would love to discuss that because the other thing that I was mentioning is when I talk to community providers, one is payment. The other one is paperwork. And it comes in two forms. Currently our contractors, as many of you know, there is a requirement in there that we have to get the medical record before we can issue payment. That is not an industry standard. That is not how other health insurance companies work.

As Dr. Shulkin mentioned yesterday, we are in the final stages of being able to remove that barrier from the contract. I think that is going to go a long way to ensuring that we provide more timely payment.

The other thing that we are doing is, as you know, we don't need every single piece of the record. I think back of when I was an intern taking care of patients, and I would get volumes from an outside hospital that I would have to comb through to figure out what piece of information do I need to care for this patient.

So what we are doing as well is defining exactly what are the important pieces that we need from providers. So that is the treatment plan, what new meds they started, what procedures and labs they did. We don't need every single nursing note or every single time a medication was administered. And I think that is going to reduce the paperwork burden.

So those are two things that we are working on today to make the lives of community providers a little bit better.

Mr. BENISHEK. All right. I am out of time.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you very much.

Mr. Abe, you mentioned your comments about the risks posed by inadequate controls. Can you elaborate a little bit more what you meant, that part of your comments? What controls were you referring to?

Mr. ABE. Well, there are a number of them. I think one of the things that VA has to do is effectively identify the veterans who are eligible for Choice. The other thing is that they also need to stabilize all these programs, because as has been discussed, there are so many non-VA care programs, different eligibility requirements, and different payment methodologies.

And they have continued over the years to produce a pilot, another pilot, and another pilot. And so it is very, very confusing out in the field to know how to pay claims and which veterans are eligible. I also think that if VA uses contractors, they need to hold these contractors accountable to the contract terms.

I think the biggest thing from the veterans' standpoint is that VA needs to minimize the veterans' requirements, that veterans have to jump through all these hoops to get this care. I think those are probably the major lessons and major obstacles that we currently face.

Mr. TAKANO. Okay. I don't know who can answer this question, but where do third-party administrators fit into the new Veterans Choice Program? Are you going to create your own high-performing network in-house or how will the VA communicate with veterans using care in the community for their health care?

Mr. MIGLIACCIO. Sir, I will take that question. The work we have been doing over the past since we were here in June of last year talking about prompt pay and the hard work that we put together in terms of the plan that we delivered to Congress at the end of October, we have also stood up as a part of the plan, something we call an integrated project team to focus on the future state.

Looking at our patient-centered community care contract that we call PC3, we are looking for a follow-on contract. So what we are looking at in that contract is to look at high-performing networks, a claims solution, and other areas that we can support purchasing care in the community for our veterans.

And I just want to give you a couple of examples, and we have been working at really a brisk, fast pace. We stood up this group a number of months back. In December, we had met with industry for an industry day. We presented our preliminary request for information, met with over 80 individuals representing 30 major health care entities in the country.

From our meeting with industry, we developed, as Dr. Yehia had mentioned, a draft performance work statement that was released just a few weeks ago that will form and shape a draft request for proposal. We will come back to industry very very soon after, and then put a formalized request for proposal out in the next two months.

Mr. TAKANO. So you are looking for a third-party administrator?

Mr. MIGLIACCIO. That is contained in the draft performance work statement, yes, sir.

Mr. TAKANO. All right. I want to get to another question. I know you had a second example, but I want to get this question out there. The Administration is proposing a creation, the creation of

a fourth medical care account, medical community care. This account estimated at \$7.3 billion will be funded out of medical services for fiscal year 2017, but is included as a separate request for fiscal year 2018 at \$9.4 billion.

What will the creation of an additional health care appropriation account mean in terms of the budget flexibility the secretary has continued to call for, and how will this additional account better enable VA to meet demand and provide quality and timely care to veterans?

Dr. YEHIA. I will take that one. I think that account was required to be created as part of the Choice law that was passed. So I think it was something that Congress had asked us to do. I do think there is value, though, to make sure that there is a very specific pot of money that is designated for community care.

I think your point about flexibility is important, though. We should make sure that there is adequate flexibility. So if we need to use a little bit more community care dollars in one year, we can move from the medical services account to the community care account.

Mr. TAKANO. So, Dr. Migliaccio, I mean, so you are not going to build this billing system in-house? It is going to be a third-party administrator that you are looking to work with?

Dr. YEHIA. What we are doing is in our draft performance work statement, our intention is to put out requirements, and so we say this is what we want. We want to be able to have a system that pays on time, that is mostly automated, and we put that out in our draft performance work statement.

What we are doing now is receiving feedback from industry to say can they meet this requirement. So we are in that first phase to figure out is there partners in there, is there partners in the private sector that can do this. I think there probably are. We have just got to wait on their responses to see if they can actually meet those requirements.

Mr. TAKANO. All right. Thank you.

Mr. BENISHEK. Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

First of all, I applaud VA for consolidating these six programs that are different. That makes it very, very hard to administer. There is no question. We have got different rules.

Let me sort of lay out where I think falling short has hurt the VA like Mr. Abe in trying to get care. I have said this a hundred times if I have said it once in this hearing. I have made hundreds or thousands of appointments for people. It ain't that hard to do. And Mr. Abe could pick the phone up and call his primary care doctor and make an appointment in five minutes. I can do that right now while we are waiting. It is not hard.

We made it incredibly complicated and he had to wait almost six months to get an appointment with a doctor that he needed to see that his primary care doctor decided.

The other thing that the VA has done that has really hurt—in a group like my size, if we don't get paid promptly, we have enough cash reserves to survive that. If you are in a small one or two or three person practice, you cannot.

And when the payments have been cut with Medicare down to really very low levels, when you have an ACA out there that has created an out-of-pocket expense that most people can't afford, three or four thousand dollars out of pocket, they can't pay the doctor.

And then the VA decides not to pay the doctor. You are out of business. And that is why they don't want to see, and even the reimbursement levels. Most of us, many of us are veterans, some are not, you almost never talk to a provider who doesn't want to take care of a veteran. I mean, they just want to do it for a lot of noble reasons.

So my question, I want to start out is why didn't the VA just use a system like the Medicare is doing? They paid us promptly, quickly. I filed a lot of claims last year during my wife's illness. Blue Cross and Blue Shield, they figured it out. They paid the hospital and the doctors very very promptly. What is the big deal? Why can't you just do that?

Dr. YEHIA. I have been nodding my head when you were talking because I agree with what you are saying. We actually, our team took a trip to one of the Medicare processing sites that processes claims to look at industry best practice because I asked the same question, why can't we do that.

And the more that I thought about it, there are a couple barriers that stand in our way. One is the technology piece. But as we had talked about, being able to partner with folks in the community that has access to those technology pieces like some of the Medicare subcontractors would address that.

The other thing that is very convoluted is the fact that we have all these multiple programs with different eligibility. For Medicare, it is pretty crystal clear if you are eligible or not eligible. For us, and let me use the example of like ER care. We pay differently depending if it is service-connected or not service-connected. So it requires someone to look at the medical record to see did they go to the ER and was it for a service-connected related injury. If it is, we pay a different way. If it isn't, we do something different.

So I realized as I was going through this, is that we have to get the eligibility piece right which is what we talked about last week because if we continue to have a complex eligibility system, even if we partner with the best performers in the private sector, they are still going to have problems paying on time because it is so complex.

So I think it is kind of a two-prong thing where we have got to find those partners or the technology that works, but we also have to do our part in partnership to simplify eligibility so it is not too complicated.

Mr. ROE. Let me ask this question. These claims are paid out of what, 90 something different sites around the country?

Dr. YEHIA. Yes, sir.

Mr. ROE. And would you foresee a situation where one site would not pay one hospital to catch up the payments in another facility?

Dr. YEHIA. Say that—

Mr. ROE. In other words, here is one medical center over here and here is another medical center and someone has directed the payment. This one is behind three or four or five months.

Dr. YEHIA. Yes, yes, yes.

Mr. ROE. This one is caught up.

Dr. YEHIA. Yes.

Mr. ROE. Would you just direct all the assets over here?

Dr. YEHIA. Yes. So that is exactly, yes. And so we are working on that right now. This is one of those things that I was describing about, things that we can do that are within VA's control. Those 90 different sites, and part of the reason is claims processing used to be at local medical centers, and now a lot of it is under the shop of community care. So that is why there are so many different locations.

Because they are in different locations, there is different IT security clearances that have to occur. They can't tap into one system. They actually have to get privileges to access the other system. I don't know why it is that way, but that is what it is.

So what we are working now is with our IT partnership and LaVerne Council who is the new Assistant Secretary for IT. Her team is really helping us to give security access to the sites that are performing really well, so they can process the claims for the sites that are performing not so well. We hope to—

Mr. ROE. My time is about up. Let me—

Dr. YEHIA. Yeah.

Mr. ROE [continued]. —just tell you the real-world implications of that. Okay? I have a friend of mine who retired from his dental practice because there is always not enough dentists at a VA. He sees just VA patients. That very thing has happened where he works, so he doesn't get paid.

So he is going to have to close his dental practice because of what you guys are doing to pay claims somewhere else. And that means that veterans in a facility close to where I live are not going to get dental care.

I yield back my time.

Mr. BENISHEK. Mr. O'Rourke, you are up.

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

Dr. Yehia, thank you for helping us better understand the plan and the proposal.

And I want to begin by saying, when Dr. Shulkin, you, and the team first announced this in October, it was very encouraging and I was very excited by the vision that you all outlined for the VA. It was comprehensive. It made sense of leveraging community capacity. And what I read into it was having the VA better focus on what I think its core priorities should be.

But given the skepticism well earned by the VA that I hear from Mr. Williamson and Mr. Abe, and in Mr. Abe's case from his personal experience included, given the fact that you have ten and a half months left, given the scope of these changes, and then again to bring up what I think is the most critical urgent priority, reducing veterans' suicide, and the crisis that we have there, that really will take concentrated focus for us to make a meaningful impact, what of this lift could you offload to someone else either in the public or private sector?

So to follow-up on Dr. Roe's question, if CMS has a 99 percent under 30-day pay rate, I know there are obstacles, and I know these are different animals, but is there a way to bust through that

and contract this with CMS who seems to have figured this out, and has a lot of experience doing it right, or at least better than the VA? Is there some other part of the billing reimbursement validation process that could be outsourced to a private provider who does this really, really well and we could set these benchmarks and standards?

So that will be my first question. The second one, a shorter one, can we get a copy of the draft performance work statement that you keep referring to? So my two questions for you.

Dr. YEHIA. Sure. So yes to the second one. And I think we sent it to the Committee staff last week.

Mr. O'ROURKE. Great.

Dr. YEHIA. It is publicly available. And not only can you get a copy, but if you want me or others to come and walk you through it, we are happy to do that.

And to your first point, that is exactly what is in the performance work statement. So there is a section in the performance work statement which is the first part of like an acquisition cycle. So as Gene was describing, it is kind of the first step and later on is the RFP and etcetera.

So that is exactly what we are looking for. We are looking for who are those high-performing claims processing sites that potentially could in the future be able to bid on a proposal that we hope to do in the coming months to be able to see if they can meet those needs. And so we are looking exactly at that option.

Mr. O'ROURKE. This is for Mr. Williamson and if time permits Mr. Abe. Within the ten and a half months, given the fact that we have VA's past performance as a potential predictor of future performance, but also given the fact that we have people like Dr. Yehia, Dr. Shulkin, Secretary McDonald, who really do seem intent on turning this around and have some success to show for that, is this realistic? Should we temper our expectations? What are your thoughts?

Mr. WILLIAMSON. Well, I have been working with GAO a long time, and I have become somewhat skeptical in that time. And I have heard a lot of well-intentioned stories from agencies. I really doubt whether it can be done in ten and a half months. I think the IT challenges alone, are daunting. On past IT modernization projects, VA's track record hasn't been real good.

But I really appreciate VA's enthusiasm and their progressive attitude toward solving this problem. I really think that is good, but realistically, it is going to be a tough pull.

Mr. O'ROURKE. Dr. Yehia, how much is the IT part of this cost? And then if time allows, I would like Mr. Abe to comment.

Dr. YEHIA. I guess the point of this RFP or, I am sorry, the draft performance work statement is to look for private sector commercial folks that could do the work. So that is out of all the different options, we are not talking about an off-the-shelf IT product.

Mr. O'ROURKE. How much will we have to invest in addition to what we are spending on IT today to make this work?

Dr. YEHIA. I would have to get back to you on that number.

Mr. O'ROURKE. Okay. Mr. Abe, any thoughts? I know I don't have a lot of time. Maybe an additional 15 seconds.

Mr. ABE. Just to summarize, I think I agree with Mr. Williamson in the sense that, you know, the IT solution is a real big obstacle, especially considering their past performance.

The other issue is that it really does take a lot of project management to do this. And, again, I think based on past experience, that has probably been inadequate.

Mr. O'ROURKE. Thank you. Appreciate it.

Thank you, Mr. Chairman.

Mr. BENISHEK. Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman.

Well, whoever would like to answer this. I have heard time and time again from ambulance companies that VA misapplies a prudent layperson standard for emergency transportation.

For example, VA has been requiring ambulance providers to wait for underlying emergency care claims to be processed, and to provide medical documentation from the veterans' emergency room visit prior to processing the transportation claims. Although VA insists this isn't required, clearly the practice continues throughout the country, and veterans are often left with the bill.

What is needed to correct the prudent layperson standard in the case of emergency ambulatory care? Who can answer that question? Yes.

Dr. YEHIA. I will take it. You are spot on. The emergency system and the emergency ambulance part of the care system is challenging. That is why we wanted to tackle it, and we did tackle it in our consolidation plan.

The problem with ER care, which is what we spoke about a little bit more last week is, there is multiple authorities that we have for providing ER care. If it is service-connected, we are the primary payer. If it is not service-connected, we are the payer of last resort. So they first go to other health insurance, then us.

On top of that being the difference in payers, we have different requirements, if you were seen at the VA in the last 24 months, did you bypass a VA on your way to the ER, and the list goes on and on and on.

I actually don't think it is the application of the prudent layperson is the biggest barrier here. That is a common practice in most health plans. It is all the other things that we have in place based on statute and regulation that we hope to consolidate and fix that. And that is what we present here.

As you know, that comes with a little bit of a cost. We wanted to be able to streamline and get to being the primary payer and remove all those barriers, but that is exactly what we want to do. And we have drafted some legislative proposals that get at that. So we are happy to share those with you if you are interested.

Mr. COFFMAN. Okay. Last Saturday, I spoke at a convention for ophthalmologists. There were about 400 in Colorado. Well, last Sunday. And there were some VA personnel in there as well, docs as well. And everybody seemed to uniformly complain about Health Net—

Dr. YEHIA. Yeah.

Mr. COFFMAN [continued]. —and just how impossible it was to get paid. Is that the case throughout the country, or is this something endemic to Colorado?

Dr. YEHIA. No. That is the case unfortunately across the country. And that is why we are taking actions to remove those barriers. The biggest barrier in that area is the fact that we require medical documentation before we pay the bill. I don't know why that was in the contract. It was in the contract when I first started this role a couple months ago. I looked at it. I was like, this doesn't make sense. No one else in the industry does this.

We are in the final stages of finalizing that, and removing that barrier. I think Dr. Shulkin mentioned it will be done in two to three weeks. That is the timeframe that we are working on. As soon as we get that done, we will make sure that everyone is aware of that.

The challenge is, when you get paid by Medicare or by a health plan, they don't ask you to give the record. And this addresses a lot of the various issues that the IG and the GAO found in the report, too, of we are getting all these paper claims and all these medical records that we have to scan and do that. That is, part of the reason is because we have been tying payment to getting medical documentation back, which is not a standard of care in the community.

Mr. COFFMAN. Who devised this contract? Who is responsible?

Dr. YEHIA. This contract came about in September 2013, I think, or in the end of 2013, started implementing in 2014. I don't exactly know. I don't know exactly who designed that contract. I will say one thing—

Mr. COFFMAN. But it was designed for the PC3 Program?

Dr. YEHIA. Exactly.

Mr. COFFMAN. And now it is being used on the Choice Program?

Dr. YEHIA. Yeah. And that is like a very important point as you raise, Congressman. That initial vehicle, that contract was not meant to run the Choice Program. It was not designed to run a program like Choice where we are sending hundreds of thousands of veterans into the community expanding community care.

That vehicle was not meant to do that. That is why we are moving out on this new draft performance work statement, getting a machine, a car that can actually run the race we want it to run. So part of it is, it just wasn't designed to do what we want it to do.

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

Mr. BENISHEK. Thanks.

Dr. Ruiz.

Mr. RUIZ. Thank you, Mr. Chairman.

The damage veterans suffer due to the VA's current billing and reimbursement system is irreparable and unacceptable. A decorated Vietnam combat veteran from my district attempted to pursue care in the community for orthopedic issues and pain management. After navigating the complex and burdensome process of receiving care within his community, he was diagnosed with soft palate complications that would require surgery before other issues could be addressed.

As he learned to treat and manage his neck and back injuries, he also learned that the VA refused to pay his medical bills in a timely manner. This delayed payment meant that the patient couldn't just concentrate on improving his health, he had to spend

time worrying about his credit as the clinic, and later collections agencies hounded him for payment of his medical bills.

Now this veteran has damaged health and damaged credit due to the VA. The VA is meant to serve veterans, but it is clear in this instance that they did the exact opposite. They added a bad credit to a veteran who is barely making ends meet. This was a grave disservice to him, one of our Nation's heroes.

So we talked about how the complicated system affects physicians and physicians' ability to provide that care, but how does your team plan, and this is to Dr. Yehia, how do you and your team plan to prevent this from happening in the future?

Dr. YEHIA. Thank you for that question.

And, you know, I have been getting kind of similar letters, too, and it is not the VA that is sending them to the collection agency. There are two things here.

Mr. RUIZ. It is the providers.

Dr. YEHIA. It is the providers.

Mr. RUIZ. But the providers—

Dr. YEHIA. Because they are not—

Mr. RUIZ [continued]. —as Dr. Roe said are hurting.

Dr. YEHIA. Yes.

Mr. RUIZ. And they are not getting payment, so they start to charge the patient.

Dr. YEHIA. Yes.

Mr. RUIZ. But the providers are under the expectations that they are going to get paid, and if they don't get paid or if they don't get paid in a timely manner, then they charge the patient.

So how are we going to prevent the providers from getting late payments and, two, what are we going to do to correct—

Dr. YEHIA. Yes.

Mr. RUIZ [continued]. —the bad credit for the veterans who already suffered the ill consequences?

Dr. YEHIA. You are describing it right. There are two things that we are doing. Number one, we have got to get the root cause, and the root cause of what we just described. The biggest barrier to prompt payment by our contracting partners is this requirement to submit the records. So we are getting to that basis. Once, I think we uncouple or unlink those, it is going to be a lot better to be able to pay more timely and accurately.

When I started hearing reports that veterans were getting adverse credit reporting, you know, I got very frustrated because there should be no administrative burden that stands in the way of them getting care.

So let me tell you what our team did. We actually stood up folks in our call center, and so if a veteran has any problems with adverse credit reporting, we have a 1-800 number they can call. It is a VA folk. They can chat with them. We will be able to connect with the community provider, and our contractor, as well as a debt agency to try to correct those.

So I am happy to give you that phone number if you want to share it with your constituents or put it on your Web site.

Mr. RUIZ. Go ahead and put it on C-SPAN right now. What is it?

Dr. YEHIA. I will tell you, though. It is 1-800-877-881-7618. And I am happy to provide it to the community because it is unacceptable. And so we are trying to do what we can on our part to help veterans that have an adverse credit reporting.

Mr. RUIZ. And what has been those results of our veterans? Have they eliminated that bad credit? Have they corrected the problem?

Dr. YEHIA. We just rolled this out a couple weeks ago, so I would have to get back to you on the kind of the results that we are getting.

Mr. MIGLIACCIO. Prior to the rollout, we have written letters to credit bureaus on behalf of our veterans. It is a travesty.

Mr. RUIZ. And what has been the results?

Mr. MIGLIACCIO. We have seen some good results because they have corrected credit reports. And I can get you some data on that also. I don't have specifics, but I am told that we have seen good, positive outcomes. But we will intervene.

Mr. RUIZ. I would like to talk more about that because there are plenty of veterans throughout our country that don't even know what their resources are to remedy this problem.

Many of our veterans just accept it because they don't like to complain and that means that sometimes they can't apply for that loan to make home improvements. They have bad credit so they can't pay rent in their apartment or other financial burdens. And so we need to outreach to make sure that that gets remedied. So thank you very much.

Mr. BENISHEK. Mr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

If I can just add to that, I would hope that we don't have to keep adding layers upon layers because layer one isn't being done. Now you have layer two of writing letters saying, hey, it is not this guy's fault. I mean, thank you for doing that, but that is not the answer obviously.

My next question is, what does the individual, the patient, the veteran do, and what does the physician do when these claims aren't getting paid? Is there a customer service branch that they can reach and have the same person to talk to when they call about the claim either from the doctor's office or on behalf of the veteran or are they just—because I have been getting reports that every time they call, it is somebody different and they have to start all over and wondering where this is taking place?

Dr. YEHIA. I think that is an area for improvement for us. To speak frankly, a lot of our claims processors also provide some of the customer service. What we are hoping to do is to kind of build a more robust customer service function for community providers.

I don't know how the focus of those relationships has been in the past, but if you look at our consolidation plan and where we want to go in the future, we think about three stakeholders—veterans, community providers, and our employees. And maybe it is a little bit because I am a clinician. I am very focused on making sure that we have robust provider relations and customer service for community providers.

I think once we roll more of our plan out, this is going to be more localized so that at the regional level, there will be someone that they can talk to if they have issues and then also kind of nationally

if they have just general information questions that they need, they can reach out. So I think we have more work to do in that area.

Mr. WENSTRUP. And I appreciate you acknowledging that, and I hope that it can be more fluent, if you will, but also hopefully less of a need for that. Again, another layer that could be reduced if we are doing things right.

You know, you talked about the complexity of all the various eligibilities and that is true. And I would throw out there, you know, sitting here, and you are involved with it, if there are ways that we can reduce that complicated process from this side of things, let us know what those are, you know. We would love to hear from you on that. And I imagine you will gather some ideas as you get more and more familiar with it. And I hope that you give us some feedback in that regard.

Dr. YEHIA. I welcome that opportunity. We definitely do have some ideas, and I am looking forward to working with you.

Mr. WENSTRUP. But I do think at the same time there will always be some variables as far as eligibility. But it seems to me that an algorithm can be built. You are in this classification, you are in that classification, push the button and let the claim roll. Because hopefully, it is not that complicated, but if it is giving us the opportunity on this end to change things, if we need to that, is fair to the veterans and gets the job done. And I do not know if you want to comment? If anyone else would like to comment on that any further? But anyway.

When it comes to where you are headed, and there is a claim, there is usually a review of the claim when it comes from the provider. Do you anticipate, especially if you go outside the VA to process claims, do you anticipate the review to come within the VA? Or at that other claims processor?

Dr. YEHIA. I would, as best as possible it would probably be outside. And this is how it would work. We want to create—the simpler that we can get the better which is, you know, more aligned with industry and Medicare. We would be able to, the way that I envision it working is with a partner. We would give them the business rules. So we would have you to check the name, make sure the provider's address is right, make sure the bill charge was right, make sure they have the right eligibility criteria. So we would give them the business rules, they would put it into their system, and the way that it works now for Medicare and a lot of the other sites is, for the most part, it is green lights all the way through. A check is sent electronically and deposited in someone's bank account. That is where we want to go to. The more complexity that we add, whether it is, we have to double check this because there is this eligibility in there, it makes it harder to automate every single step. So that is why I really welcome your comment to work together. Because we definitely need to be able to get to a simple, streamlined eligibility criteria that makes sense. Because those will form the business rules that we give to our partners in the community to process claims.

Mr. WENSTRUP. Thank you. And I yield back.

Mr. BENISHEK. Thanks. Mr. Huelskamp? You are recognized.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I will try to arrive at that time again in the future. This is pretty quick. And I apolo-

gize for being late. There was another Subcommittee hearing. And if I repeat some questions, hopefully it still provides some insight.

But yesterday, I visited with, I do not remember whatever deputy under secretary it was, said that we were going to see some changes, and paying before a paper claim would be required, and some changes there. Doctor, can you describe that a little bit more? It was a short part of the discussion in my questions yesterday.

Dr. YEHA. Sure, and we have been chatting a little bit about that. What we were describing is the fact that in our current contract there is a requirement that we have to get the medical information, the medical record before we can issue a payment. And I was stating that it is different than the private sector. This is not a common practice in the private sector. This does not mean that we do not want records back, but we should not penalize community providers in that way. And so, what we are working on in the very near future to be able to kind of uncouple those, delink them so that we pay the claim when the work has been done, and then we still ask for the records, but not tie it to payment.

Mr. HUELSKAMP. I appreciate that, and it was in less than two weeks? Is that the frame that—

Dr. YEHA. Yes, that is the timeframe we are working on. Yes, sir.

Mr. HUELSKAMP. Okay. Okay. And if Choice was made permanent rather than a pilot program—which some in the VA still approach it that way. The Secretary has said he would like to see it made permanent and hopefully we can do that this year. Does that change that? Is that part of the reason that you want to have those records back? Describe that a little more if you would, doctor, from that perspective.

Dr. YEHA. Sure. I think that was a requirement that was embedded in the contract. It was a kind of a contractual agreement that we had to hold that, that folks had to be accounted to. I do not think there needs to be a specific, I do not think we have to get into that level of detail when we hopefully craft a new Choice program by law. So I think it was more of a barrier that was in the contract than a barrier in the law.

Mr. HUELSKAMP. So again, you think it is a barrier in the law and the contract?

Dr. YEHA. No, the tying the payment to the record was more a contractual barrier than a legal barrier.

Mr. HUELSKAMP. And who made that request, though? The VA would make that request? I mean, I doubt the providers made that request. That was a VA request, is that correct?

Dr. YEHA. We heard from our providers that they were not getting timely, so we looked at why were they not getting timely. And the biggest reason was they have to submit all these paper records to us. And so, we looked at our contract and that was a requirement, and we are working on uncoupling it.

Mr. HUELSKAMP. Describe though why the VA wanted those records back?

Dr. YEHA. Oh, well we want the records for care coordination. So if someone goes out into the community and gets seen by a community provider, and I am their doctor, and I come back and see them, I want to know what happened. So we want to get records

back to coordinate care. We do not need every single piece of the record.

Mr. HUELSKAMP. Yes.

Dr. YEHA. The ones that are most important for the treatment plan. But it is important to get records for care coordination. But it should not be linked to payment.

Mr. HUELSKAMP. Yes, absolutely. And I appreciate that. And fixing that, you know, I have 70 community hospitals in my congressional district. I think as of two weeks ago, we were up to all those hospitals, plus another 1,300 providers. And they would like to continue, and add on. But their goodwill is not going to run forever. And so we have got to fix that, and this looks like the worst payer in the whole system is the VA. And I will be meeting with some of them next week and would be happy to say, hey, we are going to fix that. In two weeks we will have some changes.

One thing though I want to point out that I thought was astounding was page 21 of written testimony. It said that processing centers still require providers to use fax machines to place inquiries about the status of their claims. When are you going to get past the fax machine?

Dr. YEHA. That was the whole idea of customer service, where I said we still have a long way to go. I actually had a conversation with the head of our customer service for community care. And I would love to be able to discuss that a little bit more. Like I said, we have a long way to go to make sure that we are providing good customer service to our community providers. But we are focused on that. That is what we want to do. You should not send a question by fax.

Mr. HUELSKAMP. Yes. You might actually send their bonuses by fax, and see how that would work, doctor. But so when will the fax machine be obsolete at the VA? I mean, when is this going to happen? I understand.

Dr. YEHA. Yes. Yes.

Mr. HUELSKAMP. I mean, all joking aside, I mean, this looks silly. And if we cannot move past that, we have got some deeper problems, IT problems. Doctor, so when are we going to have customer service that reflects the 21st Century then?

Dr. YEHA. I think it is something that is going to be incremental. So I do not have a specific timeframe in my mind. But we are taking steps today to make it better.

Mr. MIGLIACCIO. Yes, if I can give you a case in point?

Mr. HUELSKAMP. Absolutely.

Mr. MIGLIACCIO. Where eight months ago we were here, physicians could call in and check on their claims. And we put an arbitrary number on it, we said you can only ask about three claims and then you have got to call back. And so—

Mr. HUELSKAMP. Oh my.

Mr. MIGLIACCIO [continued]. —innovative physicians, you know, kept a number of lines going so they could continue their questions about their claims status. Well after our hearing in June, we went back and we stopped that practice because it did not make any sense.

Mr. HUELSKAMP. Okay.

Mr. MIGLIACCIO. I mean, we will take it step by step. As Dr. Yehia had mentioned, it is really evolutionary. But we want to get to a state where we can join that 21st Century.

Mr. HUELSKAMP. Yes. And thank you, Mr. Chairman. I will say it is not evolutionary. This is a revolutionary change to the VA. And that is what I hope Choice does. And for my district it is, and everyone varies but—

Mr. BENISHEK. You mean getting rid of the fax machine?

Mr. HUELSKAMP. That could be considered revolutionary in some parts. So thank you, Mr. Chairman. I yield back.

Mr. BENISHEK. Mr. Lamborn?

Mr. LAMBORN. Thank you, Mr. Chairman, and thanks for having this hearing. I am sure you were probably watching the discussion we had with Secretary McDonald yesterday. And one thing that I was, and continue to be very upset and concerned about, is the recent Inspector General's report on the problems in Colorado Springs. And whether we call it falsifying or just bad training and poor recordkeeping, there were people on the wait list who went way beyond 30 days. And yet the records did not reflect that. And it was not an honest recordkeeping. It was not a proper recordkeeping. And part of the problem is also veterans who are eligible for the Choice program, which we are here today to talk about, were not put on that list of eligible veterans. And that was a big problem and continues to be.

Now the claim is that these have all been fixed in Colorado Springs. I think the jury is still out on that because we are still hearing reports of people falling through the cracks. And that simply should not be happening. In particular, and I know that you already discussed this today. And I apologize. I was at other meetings up until now, so I do not want to, sorry if I am covering old ground, but we have people, providers in the community, who are not being reimbursed on a timely basis. And I know this is anecdotal. But we have one provider in particular who has had to stop seeing veterans because he has not been paid for six months. Now how in this day and age, even if we are using fax machines, how can this be happening?

Dr. YEHIA. Yes, I appreciate those comments. And if you give me the name of the provider we will have our team, we have actually created a rapid response team to work with providers that are having issues. So please give me that name, and we will be able to work on it.

We are doing this like two-pronged approach where we are driving towards the future, but at the same time, we know there are problems in the current state. And so we are standing up and taking actions to address those.

You know I will say about Eastern Colorado, because I did watch the hearing yesterday and I did a little bit of digging, they are in the top five in the country for utilizing Choice. And so I think, yes, I think we need to do better in making sure that everyone understands how the program works. But when I looked at it I was like, wow, they are actually sending a lot of the people out in the community. And I think people want, when I spoke with the medical center director and the VISN director, I think they want to see

Choice succeed in Colorado. And that for me was very telling, the fact that they are sending so many folks in the community.

The one other thing that I think want to mention is, you know, I looked at all these different reports that came out from the IG and GAO, and I think there are nuggets in there, there are themes in there that it is important to put into practice. But as both of the co-witnesses here presented, this program has been evolving so rapidly. PC3 rolled out in the beginning of 2014. Choice, end of 2014, got changed again in 2015. Those are only some of the law stuff. Continuously we are making improvements in the program. So just imagine the level of training and really retraining that has to occur over and over again to learn new processes.

We have not reached steady state yet, and in my mind that is good. Because I do not want to be at this state. I want to be at a much higher state of excellence. But when I looked at the reports there, a lot of them had to do with, you know, training and system issues. And I think hopefully as we continue to evolve and get to a better place, we are going to be able to deliver the care that we need to deliver.

Mr. LAMBORN. Doctor, I hope there is not still a need, although I suspect there is, of a culture change, an attitude change. That there are those in the VA who simply are not comfortable or resist having the private sector be more involved with providing veterans care. And I know you all know this, but I want to say it for the record.

Dr. YEHIA. Sure.

Mr. LAMBORN. It is true that there are a lot of veterans providing health care within the VA system. That is wonderful. But there are a lot of veterans, at least in my community, in the private sector who are providing health care. And they also have the similar motivation to want to do a good job for their former colleagues in arms.

Dr. YEHIA. No, I am with you. I am, you know, I am a clinician, and I practiced at a VA, and then I have also practiced at academic hospitals and community locations in taking care of veterans. And I jointly, I have a number of patients on my panel that I jointly care for with community providers. The fact is last fiscal year, we had 1.5 million veterans, unique veterans, that received community care. I think this trend is going to continue. I think as we get a little bit better at level setting, what is going to be offered in the VA, what we leverage the private sector to help us with, when I talk to the doctors at the VA, a lot of them, it is their colleagues down the street that they are sending their patients to. So I do not think they are, I do not know if it is a systemic culture thing. I think a lot of people welcome a community of practice.

Mr. LAMBORN. Well I hope it is not. Mr. Chairman, I am going to yield back. But we will get you the name of that provider. Thank you.

Mr. BENISHEK. Mr. Posey, you are recognized.

Mr. POSEY. Thank you very much, Mr. Chairman. And thank you so much for letting me participate in your Committee today. Doctor Yehia, I hate to be redundant, but my concerns are very similar to those expressed by virtually every other Member of the Subcommittee. In my congressional district, we are already losing doc-

tors because they have had such a bureaucratic nightmare trying to get paid. The physician's billing department is being told that it is something they did wrong, even when they make the required changes. It is as much as five months time. And from what I have heard, my guys are lucky it is only taking them five months to get paid.

Can you tell me what is being done to shorten the time between billing and payment? And what I mean by that is, besides just saying this is what we are doing, can you tell me where it has been enacted? Or have you got rules that have changed that?

Dr. YEHIA. I do not want to sound like a broken record, but the biggest thing that we are talking about is coming in these next couple of weeks where we unlink the record from the payment. That, I think is going to really speed up payment. And your district is in Florida, right?

Mr. POSEY. East Central Florida, yes.

Dr. YEHIA. Yes, and Florida is dear to my heart because I grew up in Florida, I went to the University of Florida. And so I have read a lot of news articles about the hospital association and various challenges that Florida hospitals have been facing. Gene can describe a little bit about some of the work that we are doing with, specifically with some of the Florida providers to improve it.

Mr. MIGLIACCIO. Sir, some of the things that we are doing as part of this, as Dr. Yehia had mentioned the rapid response team. We have gone out and met with congressional staff members in local districts. We also work with the hospital association, state hospital associations. And we have been out to Florida, not in your district, but if you would like us to come out and talk to some of the hospitals, we would be more than happy to do that. We provide a lot of provider education. We will take cases back with us and start to work on claims. A lot of it centers in some of the accounts receivable. But, you know, a case in point, we spent a lot of time in VISN 16, in Louisiana and Arkansas. And we have seen some phenomenal changes, not only in terms of paying our providers, but also working with our staff members. We pay, in we call it VISN 16, Arkansas and Louisiana, about 96 percent of the time within 30 days of our claims. And we are just having phenomenal cooperation. By working with providers and their business staffs, it does make a difference. And we would do that for you, too, sir.

Mr. POSEY. Well I would appreciate it if you would come to our district and do that. Veterans who use the Veterans Choice Program, they are usually those in pain who cannot wait for long periods of time, obviously, to get treatment. For instance, spinal surgery, knee, hip replacements, and things like that. Why are they getting paperwork authorizing the procedures and care that expire before the paperwork is even generated?

Mr. MIGLIACCIO. On the authorization side, we have also made a change on that recently too. And that was, we gave an authorization out, it expired, it had a very short life span. That authorization was only good up to 60 days. And that just did not make a lot of sense to us. And with Dr. Yehia, we talked about this when we created and drafted the plan that we presented to Congress in October. And we have extended that now in many, many cases up to a year.

Mr. POSEY. Good, I am glad to hear that. What percentage of employees that handle veterans health care have a military service background?

Mr. MIGLIACCIO. The number is about 30 percent, a little over 30 percent of employees in the Veterans Health Administration that are vets. In our claims department it is over 50 percent.

Mr. POSEY. You know, I mean, when we hear from you, all it, you know, sounds like everything is going to be quickly headed toward roses, and of course you all have been hearing that probably as long as you have been serving on this Committee. And, but when we get back in the districts and we seem to encounter claims people, for example, that do not seem quite frankly, and simply to have much respect for our veterans. And I wonder if you have ever considered making prior military service a condition of employment, at least in those departments, where it is, you know, point of service?

Dr. YEHIA. Let me take that. So I want to clarify one thing. We do not think this is a sprint. This is, there are certain things that we have to get right today because they are such pain points. But, you know, we know this is going to be a journey to be able to get us to the ideal state where we want to be.

I think what you are getting at is like military cultural competency training. And I think back to my medical training, and I never received anything specifically related to veteran or military cultural competency when I was training to be a doctor. My only experiences were when I was a medical student working at the VA taking care of veterans that I actually gained that appreciation and that respect. I think we could do a lot better at making sure that our community providers have access to that sort of training and we are actually taking steps to do that. We have four courses that are available online. People can get CME, continuing medical education credit, to learn more about the uniquenesses and the nuances of military and veteran health care. And so I think we can, I would love to be able to share those links with folks on the Committee so you guys can push them out to community providers in your community.

Mr. POSEY. No, my thought, it's just respect for the customer, you know, so they do not get the fast foot shuffle and the razzle dazzle. And I mean somebody is giving them authorizations that expired before they got the paperwork. Now nobody who respects the veteran that they are there to serve would do something that stupid. And so my thought is, maybe the claims people that process the claims actually ought to not get some kind of sensitivity training, maybe there ought to be a requirement that they have had military service, that they have some respect for the job.

Dr. YEHIA. Well I think as Gene said, half of them have served. I would love to talk to you a little bit more about that.

Mr. POSEY. I am sorry, Mr. Chairman. I went over. I apologize.

Mr. BENISHEK. Well does anyone have any questions? You know, one of the things that came up here, Dr. Yehia, and I just wanted to kind of reemphasize it, is the number of stupid rules that the VA seems to have which hinder the accomplishment of its mission. And that, simply removing one of the rules is not going to solve all

of these problems. A comprehensive review of all your practices has to be done. Go ahead.

Mr. TAKANO. You know, I just am struck by, I just want to remind everyone on the Committee that the VA was never set up to be an insurer and a payer. And so it is a revolution of sorts that we are undergoing. I mean, increased only, accelerated in the last two or three years. But you were set up mainly to be a provider organization. And the mind set has been that you are a provider organization. It is not that you have a bias against care in the community, it is that you know the integrated health care that you provide was, you know, the idea that you are getting the records back was all about making sure that we manage the patient's care.

But now that we are looking at other approaches, and it looks like we are moving in the direction of maybe a permanent program of care in the community that is going to maybe expand over time, you know, you are setting up the systems to do that and taking on more of the characteristics of provider organization as well as an insurer and a payer. So it was never really set up to be like Medicare, which is a payer organization. So let us make that distinction. And a lot of the beating up, the beating up on the department, you know, it can be put into context. And so that is what I want to make sure we clarify. That you are undergoing this attempt to become, take on more of the role of a payer, somewhat of an insurer, and working with other partners.

Mr. BENISHEK. The panel is now excused. Thank you very much.

Joining us on our second panel is Roscoe G. Butler, the Deputy Director of the National Veterans Affairs and Rehabilitation Division of the American Legion; and Carlos Fuentes, the Senior Legislative Associate for the Veterans of Foreign Wars. I appreciate you coming today, gentlemen. And Mr. Butler, you can begin when you are ready. Thank you.

STATEMENT OF ROSCOE G. BUTLER

Mr. BUTLER. Thank you. The American Legion is committed to a strong, robust veterans health care system designed to treat the unique needs of those who have worn the uniform. However, even in the best of circumstances, there are situations where the system cannot meet the needs of the veteran and the veteran must seek care in the community.

Chairman Benishek and Members of the Subcommittee on Health, I am privileged to be here today and to speak on behalf of The American Legion, our National Commander Dale Barnett, and more than two million members in over 14,000 posts across the country that make up the backbone of the Nation's largest wartime veterans service organization.

The VA purchased care program dates back to 1945 when VA's Hometown Program was created. Since then, VA has implemented a number of programs in order to manage veterans health care when such care is not available in a VA health care facility, could not be provided in a timely manner, or is more cost effective, programs such as Fee Basis, Project Arch, PC3.

Most recently in 2014, the Veterans Choice Program was enacted so that more veterans could be referred outside the VA for needed health care services. However it quickly became apparent that

layering yet another program on top of the numerous existing non-VA care programs each with their own unique set of requirements resulted in a complex and confusing landscape for veterans and community providers as well as the VA employees that serve and support them. Therefore Congress passed legislation in July of 2015 that required VA to develop a plan to consolidate existing community care programs, which VA delivered on October 30th, 2015.

Generally, the American Legion supports the plan to consolidate VA's multiple purchased care programs into one new Veterans Community Program. We believe it has the potential to improve and expand veterans' access to health care. Most depend on how VA will work with its employees, Congress, VSOs, private providers, academic affiliates, and other stakeholders as they move forward in developing and implementing the plan.

As noted in the plan, the current system is a decentralized and highly manual process. The new VCP plan proposes integrating most of VA's Community Care Program into one single program that would be seamless, transparent, and beneficial to enrolled veterans. VA states its new VCP will focus on operational efficiencies to include standardized billing and reimbursement as well as geographically adjusted fee schedules that are tied to Medicare and deemed appropriate.

These efforts would make it easier and more appealing for community health care providers to partner with VA. The American Legion strongly believes VA must standardize its reimbursement rates, but not set the rates too low where providers would be discouraged from signing up as participating providers in the new VCP, such as providers in Alaska and other rural areas.

In November 2015, we received an inquiry from a veteran requesting assistance with payment of a medical bill that was authorized under the current Veterans Community Care Program. The veteran explained that he was approved to be treated by a non-VA health care provider for a hernia surgery to be performed outside the VA. After the care was provided, VA payment was delayed for months which resulted in the claim being referred to an attorney's office for collection. As a result, the veteran expressed disbelief and has lost faith in the VA system. This should never happen, but occurs more often than it should.

The American Legion supports VA developing a 21st Century claims and reimbursement process that is rules-based, and to the extent, possible eliminates as much human intervention as possible. Therefore, we are pleased to see that VA proposes to implement a claims solution which is able to auto-adjudicate a high percentage of claims, enabling VA to pay community health care providers promptly and correctly, and to move to a standardized reasonable fee schedule to the extent practicable for consistency in reimbursement.

However, we do not believe Congress should continue to provide VA an open checkbook without any assurance from VA that the plan will work. Much as further funding for the joint electronic record is contingent on providing benchmarks are met, Congress can and should require progress benchmarks here.

In conclusion, VA plans for the new Veterans Choice Program need Congress' approval. The American Legion believes the VA plan is a reasonable one given that desired result. VA has identified a number of necessary legislative items that require action by Congress in the short legislative window available this year in order to best serve veterans going forward in 2016. The American Legion supports many of those, such as measures budget flexibility, the Purchased Healthcare Streamlining and Modernization Act, flexibility for the Federal work period requirement, and special pay authority to help VA recruit and retain the best talent possible to lead their hospitals and health care networks.

The American Legion believes that together, we can accomplish these legislative changes before the end of this session of Congress. We cannot let another year slip away. Our veterans deserve the same sense of urgency now that Congress has shown numerous times since the VA scandal first erupted in 2014.

The American Legion thanks this Committee for their diligence and commitment to our veterans, and as they struggle to access health care across the country. And I am happy to answer any questions.

[THE PREPARED STATEMENT OF ROSCOE G. BUTLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Butler. Mr. Fuentes, five minutes.

STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Mr. Chairman, Members of the Subcommittee, on behalf of the VFW and our Auxiliary, I would like to thank you for the opportunity to present our views on VA's plan to consolidate community care programs.

The brave men and women who have worn our Nation's uniform have earned and deserve timely access to high quality, comprehensive, and veteran-centric health care. That is why the VFW has made a concerted effort to evaluate the VA health care system and has worked with VA, Congress, and other stakeholders to implement reasonable solutions to issues we have identified.

In the past year, we have collected and evaluated direct feedback from more than 12,000 veterans. Through this work, we have identified several concerns with the Choice program. Given the focus of today's hearing, I would limit my remarks to billing issues we have identified.

The most common billing complaint we hear from veterans who use the Choice program is that they have been improperly billed for their community care appointments. This typically occurs when a veteran is authorized to use the Choice program, but requires follow-up care that is outside of the scope of the original authorization. This is where the program often fails veterans. At times, a veteran arrives to a follow-up appointment before the care is authorized, so the veteran is either required to reschedule the appointment or assume the responsibility for the cost of that care. Most veterans reschedule that appointment and are forced to wait longer for the care they need.

In some instances, a veteran arrives at the appointment and is unaware the care is not authorized. If the veteran's provider is also unaware of the authorization status, or fails to inform the veteran, the veteran may be billed for the cost of that care. For example, a veteran in Saginaw, Michigan was authorized to use the Choice program for a vision exam. The provider prescribed him a specific treatment to save his vision. Since the provider was unable to administer that treatment, he was referred to a clinic nearby, where he received four courses of that treatment before being told that VA refused to pay his bill, and that he would need to pay his outstanding balance before he could continue to be seen. The VFW worked with Health Net to ensure that that veteran could continue his treatment while we figured out a way to pay for his bill. Since his treatment at the clinic was beyond the scope of the original authorization, Health Net did not have the ability to retroactively authorize the veteran's care. Luckily, we were able to work with VA to have his bill paid, but it should not require our involvement to resolve this issue. That is why the VFW urges Congress and VA to empower local VA community care staff and the program's contractors to make common sense exemptions to the Choice program requirements to prevent veterans from being needlessly billed for care VA is required to furnish.

The VFW also believes that it is time to fully integrate community care providers into the veterans health care delivery model to ensure veterans have timely access to high quality comprehensive veteran-centric health care without having to cut through bureaucratic red tape.

The VFW has also learned that providers at times are responsible for improper payments or billing. The Choice program requires that payment be contingent on providers providing the medical documentation. Private sector providers are not accustomed to reporting medical documentation before receiving payment. As a result, some of them will bill the veteran before sending VA or the program's contractors the requisite medical records. To address this issue, VA has proposed decoupling medical documentation and payments. We are concerned that decoupling medical records and payments would remove the incentive of community care providers to share medical records with VA which could impact VA's ability to verify the quality of care veterans receive. Ultimately, we will hold VA accountable for providing high quality care to veterans, regardless if it is at a VA medical facility or through community care providers. In order to ensure that quality, VA needs that medical documentation.

The VFW believes that this issue can be addressed without decoupling medical documentation. For example, VA could develop IT solutions to facilitate a seamless integration of the health care records between medical facilities and their community care partners. This would prevent community providers from having to PDF or fax medical records to VA, and ensure that VA can verify the quality of care veterans receive.

As this Committee continues to evaluate VA's plan to consolidate community care programs, the VFW will continue to ensure veterans' preferences and health care needs are prioritized. Mr. Chair-

man, this concludes my remarks and I am ready to answer any questions you may have.

[THE PREPARED STATEMENT OF CARLOS FUENTES APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Fuentes. I yield myself five minutes for questions. And let me just comment about this medical record thing, and I noticed in your written testimony that you had that position.

But you know, as a provider myself, you cannot be responsible for, like the hospital medical record may not be your medical record. And the physicians get delayed. Now there is certainly a reasonable requirement that if the physician has a habit of not returning any of the records, he should be reviewed as a provider and then maybe eliminated as a provider if he does not do medical records. Private practice physicians are responsible to get the referring doctor the pertinent records all the time. And they do it, and if they do not do it, then the people do not refer to them anymore. That is just a better way, in my opinion as a provider, to make sure that continues as we go by.

Now you heard Dr. Yehia talk about improving the process. And I do not know if each of your organizations have any position on, would you be supportive of the VA moving to a Medicare model, or a TriCare model for payment? And using contractors to do that sort of thing? Would your organizations support that? Mr. Butler?

Mr. BUTLER. I can speak for the Legion. We do not have a position on that. We have not been asked to consider that as an option at this time. But we can take that up and look at that at a future date and bring that back to the Committee.

Mr. BENISHEK. Mr. Fuentes, do you have any position there?

Mr. FUENTES. Mr. Chairman, to us, it does not really matter which vehicle is used. Really what we want to prevent is what happened in Phoenix at the urology clinic, when hundreds of veterans were sent to community care providers and VA had no way of seeing if those veterans received care, or if they received the proper care. So like I said in my statement, we are going to hold VA accountable for veterans receiving that high quality care. And VA needs that medical documentation. The vehicle they use, you know, it does not matter to us as long as they are able to—

Mr. BENISHEK. Right.

Mr. FUENTES [continued]. —guarantee that care.

Mr. BENISHEK. Right. Are there any particular issues that you have not talked about that your membership is sort of interested in? To me it is a real worry about how this is actually going to work out. Consolidating all the aspects of care into one thing and having it work. So that is a real concern of mine. Is there any other thing that you did not bring in your testimony that you all are concerned about?

Mr. BUTLER. I think similar, like the comment expressed by the GAO, we have similar concerns. This is a huge and tremendous undertaking. And VA's track record has not been good when you look at trying to take a system and then develop the IT changes necessary. VA talked a lot about bringing in contractors to see how they are going to deliver a product. Oftentimes when that happens,

when we look back at the scheduling redesign, when we look back at CoreFLS, VA spent millions of dollars in those type of initiatives, which was a huge IT network undertaking, without any deliverables.

Mr. BENISHEK. Yes.

Mr. BUTLER. And so we do not want the same thing to occur. And that is why in our testimony, Congress needs to assure, get some assurance from VA that they are going to be able to deliver, whatever the changes that they are saying they are going to be able to implement, they need to provide proof that they can deliver those changes first.

Mr. BENISHEK. No I—

Mr. BUTLER. Before you commit millions of dollars.

Mr. BENISHEK. I agree, your benchmark idea makes a lot of sense. One of the concerns I have with the third party provider, the outside provider, is that what are they going to, are they going to cut any of their staff now if they have these outside providers doing a lot of the work? Does that mean that they are going to need less people in the VA? And is that going to actually happen? Or are we going to have two? That is my concern, are we going to be paying for two bureaucracies instead of one? So I have a lot of concerns about how this is done as well. And it is such a big project, it has a lot of scariness to me. I will yield back. Mr. Takano?

Mr. TAKANO. Gentlemen, so you know the VA as a provider, historically has had, I think an interest in managing patient care in house. Over, from what I can tell, over the last several years it has initiated a number of contract programs to be able to refer patients out when they did not have certain services in house, whether it was OB/GYN or certain specialties. But now we seem to be at a point where we have authorized a temporary program that the Secretary is now saying that he would like to see permanent, which is this, the Choice Act, which was initially conditioned on how far you lived away. But that seems to all be, but now we are looking at consolidating all of these care in the community programs, all of these different contract programs now.

And Chairman Benishek, you know, asked you your comfort level with this idea of becoming more like Medicare. Medicare, as you know, is not like the VA in the sense that it does not have, you know, its own hospitals, its own doctors. You know, it is a payment agency, right? Is that what your two organizations are comfortable with moving toward? When he says Medicare model, that VA maybe is less and less an institution that has its own doctors and is going to contract everything out? And it is kind of like we are more a payer agency?

Mr. BUTLER. I can tell you that The American Legion position has not changed, that we believe the VA is a system worth saving. We advocate that. We supported the Choice Act as a temporary measure to allow VA time to get the resources, the doctors, and the necessary staff to care for our veterans. So our original position has not changed from our initial position, that we support the Choice Act as a temporary measure until such time as VA can be able to provide the care and service to veterans.

We know that community care, there will always be a need to refer veterans out in the community. But there also will be a need for the VA system.

Mr. TAKANO. Mr. Fuentes?

Mr. FUENTES. The VFW opposes, you know, making VA simply a payer of health care. We feel that VA delivers high quality health care and, unfortunately, it cannot deliver timely access to that high quality health care all times and everywhere. So you need to integrate the community, or community providers, into the veterans health care system. However, you need to eliminate that barrier that currently exists between the community and VA, where VA providers or VA facilities see the community as a safety valve, right, to alleviate the pressure on its demand. Instead, it needs to assess the demand and evaluate the capacity, similar to what Congressman O'Rourke has done in El Paso, assess, you know, the capabilities of the community and VA to really determine where those services need to be provided, and what the true demand is, so that VA can focus on the areas the community lacks.

Mr. TAKANO. So we are not talking here about this question about reducing personnel in the VA because it is now being taken up outside the VA. That is, your organizations are not interested in that, is that correct?

Mr. FUENTES. That is correct.

Mr. BUTLER. That is correct.

Mr. TAKANO. So you know the Secretary has used language and has said, you know, that he wants to, he is interested in making Choice permanent. I mean, that is what I have heard, you know, being said. So you still envision the Choice program as something that should be temporary? Because this question about how much money we are going to spend on IT systems to make VA more efficient at billing, more efficient at paying, I mean we can justify that based on what kind of VA prospectively we are looking at. I do believe we should be paying people more efficiently and taking away the bureaucratic problems in terms of whether we require them to get the records back before they are paid. But you know, the question of how much we invest in this, I mean, I think has some relationship to what kind of VA we are looking prospectively at—

Mr. FUENTES. So, I think the problem here is that you consider community care, and I think everyone is considering community care, and the Choice program as something completely separate from VA. When moving forward, community care and community providers need to be an aspect of the system. They need to be incorporated into it. And honestly, VA needs to treat providers who participate in their high performing network like they would any other clinic within a VA medical facility.

Mr. TAKANO. Okay, thank you. My time is up and—

Mr. BUTLER. And let me just add, community care is never going to go away. You know, it has taken the form of many names, Hometown Program, fee basis. There is always going to be a need for community care. But there is also going to be a need for the VA health care system. And so there needs to be a balance between the two. One cannot replace the other. They have its place in meeting the needs of our veterans.

Mr. TAKANO. Thank you for clarifying your position. Thank you.

Mr. BENISHEK. Dr. Roe?

Mr. ROE. Thank you, Mr. Chairman. And I thank you, Mr. Butler and Mr. Fuentes, for your service to our country. A couple of things, I totally agree with Mr. Fuentes. What I have said for a long time is as a veteran physician, who served in the Second Infantry Division, I understand the needs I think of VA, of veterans. And why could I not be a veteran certified physician out here, but my bricks and mortar are off campus? You are absolutely right. And I could not agree more with that.

There is a difference between the VA and private practice. In VA, every year we appropriate hundreds, well billions of dollars and they have got a big pot of money. On January 1 every year in my practice, I have no money. So I have got to generate that income to keep my bills paid. And the last person to get paid is the doctor. Everybody else gets paid before that. So when the VA is holding up their payment, every other system in the world pays differently than the VA does for outsourced care. Medicare does, private payers do, they all do. We can assure and just to show you how the payment models have changed, I was very deeply involved, as Dr. Benishek was, on the SGR reform. Medicare now requires us on the private side to pay for performance and outcomes. And so the private sector is already ahead of VA in paying for that quality of care.

So I agree with you, Mr. Butler. I think there are going to be two systems. I think that the VA should embrace the private sector and identify quality physicians and provide quality care, and they are out there, and they want to provide the care. And then find a timely way to pay them. And then as Mr. Fuentes is saying, is to make sure that that quality of that care is as it should be. I agree with everything that has been said. And I think what we have to do is make this easier, so Mr. Abe, when he needs to get an appointment does not wait six months. I mean he gets an appointment in three weeks or a month or whatever his time, whatever his schedule shows. So I think that is what we need to get to. And I think we are all aligning up going in the same direction. I agree with you. And at home where I am, we have a very robust private sector. Many veterans out there, physicians, who want to see patients. I am in a group that had five, in an OB/GYN group that had five veterans in it. And so we were willing and able and more than happy to see those patients. And as I said previously, in the previous testimony in a large group you probably have the revenue to keep you going when VA did not pay you for six months. If you are a small surgical group with two surgeons, as Dr. Benishek may have been, or you are in a small internal medicine group, two or three doctors, or a family practice, and you do not get paid along with those other payers that are paying less than they used to, you shut the door. You lock the door and go somewhere else.

So anyway, I just wanted to make those statements. I agree with most of the things you said, except I think Mr. Fuentes, I think there is a way VA and I think the VA is moving to a different payment system which will be better for veterans and for the doctors and the providers out in the community. So with that, I yield back.

Mr. BENISHEK. Thank you. I had one more question, Mr. Fuentes, and that was about your statement about somebody going

to outside the VA to get care, like the ophthalmologist or the eye doctor, then that patient was then transferred for appropriate care elsewhere, but then the VA would not cover that other physician. How should they fix that? Do you have any suggestions for that?

Mr. FUENTES. Yes. So like I said before, VA needs to treat all the providers within its high performing network like it would a provider within a VA clinic. So essentially, if I need to go to an ophthalmologist and receive specialized treatment, and then have to go to another clinic, I should not have to wait a month for VA to authorize that care, right? It should not be authorization based. Essentially, just like when I go to an ophthalmology clinic at VA, they are authorized to treat me and provide whatever care I need without having to go back to my primary care doctor and request authorization.

Mr. BENISHEK. Right. All right, thank you. Any other questions? Well, thank you for your participation. I truly appreciate your input. Feel free to get hold of us as time goes by, to provide more input. Because we certainly want to hear what you all have to say. So you are all excused. I will ask unanimous consent that all Members have five legislative days to revise and extend their remarks and to include extraneous material. So without objection, that is ordered. This hearing is now adjourned.

[Whereupon, at 11:54 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Randall B. Williamson

VETERANS' HEALTH CARE

PRELIMINARY OBSERVATIONS ON VHA'S CLAIMS PROCESSING DELAYS AND EFFORTS TO IMPROVE THE TIMELINESS OF PAYMENTS TO COMMUNITY PROVIDERS

UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

I am pleased to be here today to discuss our ongoing work related to the plans of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) to consolidate its care in the community programs and improve the efficiency, accuracy, and timeliness of its payments to non-VA community providers. The majority of veterans utilizing VHA health care services receive care in VHA-operated medical facilities, such as VA medical centers or community-based outpatient clinics. However, to help ensure that veterans are provided timely and accessible care, the agency has purchased health care services from community providers through its care in the community programs since as early as 1945.¹ While the eligibility requirements and types of care purchased through the programs currently vary, in general VA purchases community care when (1) wait times for appointments at VA medical facilities exceed VA standards; (2) a VA medical facility is unable to provide certain specialty care services, such as cardiology or orthopedics; or (3) a veteran would have to travel long distances to obtain care at a VA medical facility. Under certain circumstances, VA is also authorized to purchase emergency care from community providers.² When veterans obtain care from community providers, these providers submit claims to VA for reimbursement on a fee-for-service basis. VHA staff at 95 claims processing locations throughout the country are responsible for processing and paying these claims.³

VA's expenditures for its care in the community programs, the number of veterans for whom VA has purchased care, and the number of claims processed by VHA have grown considerably in recent years. In fiscal year 2015, VA obligated about \$10.1 billion for its care in the community programs for about 1.5 million veterans.⁴ Just

¹For the purposes of this statement, the terms "VA care in the community" and "community providers" refer, respectively, to the services the department purchases outside VA medical facilities and the community providers who deliver the services under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153. Before 2015, VHA referred to "community providers" as "non-VA providers" or "fee basis providers" and to "VA care in the community" as "non-VA medical care" or "fee basis care." The agency began using the terms "community providers" and "VA care in the community" in the spring of 2015.

²All emergency care purchased from community providers must meet the prudent layperson standard of an emergency, which means that the veteran's condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would 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). There are additional criteria that must be met for VA to purchase emergency care from community providers, and these criteria vary depending on whether the care is related to the veteran's service-connected disability.

³As of November 2015, there were 141 VA medical facilities responsible for authorizing VA care in the community services and 95 VHA claims processing locations responsible for processing claims from community providers.

⁴Final figures for expenditures on VA care in the community in fiscal year 2015 will not be available until VHA's claims processing locations finish processing all fiscal year 2015 claims. As of November 9, 2015, VA had paid about \$6.65 billion for VA care in the community that was delivered in fiscal year 2015, but VHA's claims processing locations also had a backlog of

three years earlier, in fiscal year 2012, VA spent about \$4.5 billion on care in the community programs for about 983,000 veterans—about 50 percent fewer veterans than were served in fiscal year 2015. From fiscal year 2012 through fiscal year 2015, the number of processed claims for VA care in the community programs increased by about 81 percent.

The substantial increase in utilization of VA care in the community programs poses challenges for VHA, which has had ongoing difficulty processing claims from community providers in a timely manner. A 2010 report by the VA Office of the Inspector General found that VHA needed to take action to address the timeliness of its claims processing.⁵ In 2011, the National Academy for Public Administration described numerous weaknesses in VHA's claims processing system, which delayed payments to community providers.⁶ In 2014 and 2015, we reported that some providers delivering services through VA care in the community experienced lengthy delays (i.e., in some cases, months or years) receiving payment on their claims. During a June 3, 2015, hearing of this Subcommittee, several witnesses testified about VHA's continued lack of timeliness in paying claims for VA care in the community services.⁷ The VA Budget and Choice Improvement Act required VHA to develop a plan for consolidating its VA care in the community programs (of which there are currently about 10), and VHA submitted this plan to Congress on October 30, 2015.⁸ As part of this plan, VHA said it would examine potential strategies for improving the timeliness and accuracy of its payments to community providers.

My statement today will draw from our ongoing work examining the timeliness of VHA's payments to community providers and its plans for addressing challenges that have impeded the timeliness of claims processing and payment.⁹ We began this work in March 2015 and plan to issue a final report this spring. In particular, this statement reflects our preliminary observations about:

1. VHA's claims processing timeliness in fiscal year 2015, and how this timeliness compares to Medicare's and TRICARE's;
2. the factors that have impeded the timeliness of VHA's claims processing and payment;
3. providers' experiences with VHA's claims processing; and
4. VHA's recent actions and plans to improve the timeliness of claims processing and payments for VA care in the community programs.

To provide preliminary observations from our ongoing work examining these questions, we reviewed applicable policies; interviewed officials from VHA, the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services agency that administers Medicare; and the Defense Health Agency (DHA), the Department of Defense agency that administers TRICARE; and obtained fiscal year 2015 data on claims processing timeliness from VHA, CMS, and DHA.

To assess the reliability of VHA's, CMS's, and DHA's data on claims processing timeliness in fiscal year 2015, we interviewed knowledgeable agency officials about their respective data sources and methods for collecting data.¹⁰ We found CMS's

about 453,000 claims awaiting processing as of October 29, 2015. Total fiscal year 2015 expenditures for VA care in the community are expected to be closer to \$10.1 billion.

⁵Department of Veterans Affairs Office of Inspector General, Veterans Health Administration: Audit of Non-VA Inpatient Fee Care Program, 09-03408-227 (Washington, D.C.: August 18, 2010).

⁶National Academy of Public Administration, Veterans Health Administration Fee Care Program (Washington, D.C.: September 2011).

⁷See GAO, VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit, GAO 14 175 (Washington, D.C.: March 6, 2014) and GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, D.C.: October 28, 2015).

⁸Pub. L. No. 114-41, Title IV, § 4002, 129 Stat. 443, 461 (2015).

⁹The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) included a provision for us to report to Congress about the timeliness of VA's payments for claims submitted by community providers when veterans access care outside the VA health care system, and compare the timeliness of VA's payments to community providers to the timeliness of payments providers receive from Medicare and TRICARE, the Department of Defense's (DOD) health care system. Pub. L. No. 113-146, § 105(c), 128 Stat. 1754, 1767 (2014). TRICARE is a regionally structured health care program for military service members, retirees, and their families. Under TRICARE, beneficiaries obtain health care either through DOD's direct care system of military hospitals and clinics (referred to as military treatment facilities), or they receive care through DOD's purchased care system of civilian providers and civilian facilities. In this statement, we focus on the purchased care component of TRICARE.

¹⁰From VHA, we interviewed officials from the Chief Business Office for Purchased Care; from CMS, we interviewed officials from the Medicare Contractor Management Group; and from DHA, we interviewed the Chief of TRICARE Contract Resource Management.

and DHA's data to be sufficiently reliable for reporting Medicare's and TRICARE's claims processing timeliness in fiscal year 2015. However, as we discuss in this statement, we determined that VHA's data had limitations. As there were no other data available from VHA, we used these data for making comparisons to Medicare's and TRICARE's claims processing timeliness, but note the limitations of VHA's data in making the comparisons.

We also used VHA data on the timeliness of payments for claims that were processed between February 2014 and February 2015—the most recent data available when we began our study—to select a non-random sample of 4 VHA claims processing locations, where we conducted site visits in May and June 2015.¹¹ At each of these four sites, we interviewed managers and staff responsible for claims processing and reviewed documentation associated with a non-random sample of approximately 20 inpatient claims and 20 outpatient claims that were paid between February 2014 and February 2015.¹² We reviewed documentation for 156 claims in all and interviewed managers or staff at the 4 VHA claims processing locations to identify factors affecting the timeliness of payments for these claims.¹³ We also (1) interviewed officials from a non-random sample of 12 community providers that had submitted claims to the 4 VHA claims processing locations we visited and (2) collected written statements from 12 state hospital associations, which collectively represent the views of at least 117 different hospitals or health care systems.¹⁴ We selected the non-random sample of community providers we interviewed from among the providers that had submitted the most claims between February 2014 and February 2015 to the 4 VHA claims processing locations we visited.

To assess the reliability of VHA's data on claims that were paid between February 2014 and February 2015, we interviewed knowledgeable agency officials, manually reviewed the content of the claims data, and electronically tested the data for missing values, outliers, and obvious errors. We concluded that the data were sufficiently reliable for selecting the samples of VHA claims we reviewed. Because the claims processing locations and samples of claims we reviewed at each location were not selected to be representative, we cannot generalize our findings to all VHA claims processing locations or to all claims for VA care in the community programs. Similarly, because the community providers and state hospital associations that participated in our review were not selected to be representative, we cannot generalize our findings to all providers participating in VA care in the community programs.

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

We shared our preliminary observations with VA, CMS, and DHA. All three agencies provided us with technical comments, which we have incorporated as appropriate.

Background

Oversight of VA Care in the Community

In response to a provision of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), on October 1, 2014, VA transferred funds and the responsibility for managing and overseeing the processing of claims for VA care in the community from its Veterans' Integrated Service Networks and VA medical centers to

¹¹The claims processing locations in our sample represented different regions in the United States, a range in timeliness performance, and a range in claims processing workload (i.e., the number of VA medical facilities for which the claims processing location processed claims). The four claims processing locations we visited are located in St. Louis, MO; Helena, MT; Columbia, SC; and Pearl, MS.

¹²We selected our claims sample on the basis of variation in the number of days elapsed between the date of service and the date of payment for each claim.

¹³We initially selected and received documentation for 40 claims—20 inpatient and 20 outpatient claims—from each of the four VHA claims processing locations we visited, for a total of 160 claims. However, we excluded 4 claims from our sample, resulting in a sample of 156 claims. We excluded one claim because the documentation we received was not for the claim we had originally selected as part of our sample, and we excluded 3 other claims that were for home health services, which are processed using a different system than the one that is used to process other claims for VA care in the community.

¹⁴To collect statements from the state hospital associations about their experiences with VHA's claims processing, we obtained the assistance of the American Hospital Association, which solicited written responses to our questions from its member hospitals and health care systems.

VHA's Chief Business Office for Purchased Care.¹⁵ Previously, VHA's networks and medical facilities were responsible for managing their own budgets for VA care in the community and the staff who processed these claims. After this transition, VHA's Chief Business Office for Purchased Care became responsible for overseeing VA's budget for care in the community programs and more than 2,000 staff working at 95 claims processing locations nationwide.

Types of VA Care in the Community Services

VA has several different programs through which it purchases VA care in the community services.¹⁶

- **Individually authorized care.** The primary means by which VA has traditionally purchased care from community providers is through individual authorizations.¹⁷ When a veteran cannot access a particular specialty care service from a VA medical facility—either because the service is not offered or the veteran would have to travel a long distance to obtain it from a VA medical facility—the veteran's VA clinician may request an individual authorization for the veteran to obtain the service from a community provider. If this request is approved and the veteran is able to find a community provider who is willing to accept VA payment, VA will reimburse the provider on a fee-for-service basis.
- **Emergency Care.** When care in the community is not preauthorized, VA may purchase two different types of emergency care from community providers: 1) emergency care for a condition that was related to a veteran's service-connected disability or associated with or aggravating a veteran's service-connected disability and 2) emergency care for conditions not related to veterans' service-connected disabilities. The latter care is commonly referred to as Millennium Act emergency care.¹⁸
- **Patient-Centered Community Care (PC3) and the Veterans Choice Program.** Established in 2013 and 2014, respectively, these programs are administered by two third-party administrators (TPA), with whom VA has contracted to create and maintain networks of primary and specialty care providers willing to treat veterans when they cannot feasibly access services from VA medical facilities.¹⁹ The TPAs are responsible for making appointments with their network providers on behalf of veterans once VA medical facilities notify the TPAs that the veterans are authorized to receive care from community providers.

The rates at which community providers are reimbursed by VA vary depending on whether the care is preauthorized or emergency care, and whether the providers are enrolled in the PC3 or Veterans Choice Program networks. For all types of VA care in the community services except individually authorized outpatient care, community providers must include medical documentation with the claims they submit to VHA or the TPAs.

VHA's System for Processing Claims from Community Providers

Community providers who are not part of the PC3 or Veterans Choice Program networks submit claims for preauthorized and emergency care to one of VHA's 95 claims processing locations.²⁰ For PC3 and Veterans Choice Program care, commu-

¹⁵ Pub. L. No. 113–146, § 106, 128 Stat. 1754, 1768–69 (2014). VHA's health care system is divided into areas called Veterans Integrated Service Networks, each responsible for managing and overseeing medical facilities within a defined geographic area. Networks oversee the day-to-day functions of VA medical facilities that are within their boundaries. Each VA medical facility is assigned to a single network. At the start of fiscal year 2016, there were 21 Veterans Integrated Service Networks, but VA is in the process of consolidating some networks so that by the end of fiscal year 2018, there will be 18 networks.

¹⁶ In addition to the programs described here, VA is also authorized to purchase care from Department of Defense and Indian Health Service facilities, community nursing homes, and community-based home health providers. 38 U.S.C. §§ 1710, 1720, 8111, and 8153.

¹⁷ 38 U.S.C. § 1703.

¹⁸ See Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106–117, 113 Stat. 1545 (1999) (codified, as amended at 38 U.S.C. § 1725) for emergency care not related to a service-connected disability. See 38 U.S.C. § 1728(a)(1)–(3) for emergency care related to a service-connected disability.

¹⁹ The two TPAs that currently hold these contracts are TriWest Healthcare Alliance and Health Net Federal Services.

²⁰ If the claim is for individually authorized care, the community provider submits it to the VHA claims processing location that processes claims for the VA medical facility that authorized the veteran's care. If the claim is for emergency care, the community provider submits it to the

nity providers submit their claims to the TPAs, and the TPAs process the claims and pay the community providers. Subsequently, the TPAs submit claims to one of VHA's claims processing locations-either the one that authorized the care, in the case of PC3 claims, or the one that VHA has designated to receive Veterans Choice Program claims. VHA staff at these locations process these claims using the same systems used to process other claims for VA care in the community programs, and VA reimburses the TPAs for the care.

To process claims for VA care in the community programs, staff at VHA's claims processing locations use the Fee Basis Claims System (FBCS). FBCS does not automatically apply relevant criteria and determine whether claims are eligible for payment. Rather, staff at VHA's claims processing locations must make determinations about which payment authority applies to each claim and which claims meet applicable administrative and clinical criteria for payment. (See table 1 for a description of these steps.) In addition to processing claims for VA care in the community programs, staff at VHA's claims processing locations are also responsible for responding to telephone inquiries from community providers who call to check the status of their claims or inquire about claims that have been rejected.

Table 1: Veterans Health Administration's (VHA) Steps for Processing Claims for Care in the Community

Processing step	Description
Receipt and scanning of claims and medical documentation	VHA policy requires that paper claims be manually date-stamped and scanned into the Fee Basis Claims System (FBCS) upon receipt. Electronic claims are imported into FBCS. If the community provider is required to submit medical documentation for the claim to be processed-which is the case for most types of VA care in the community services-VA can only accept it in paper form, and the medical documentation must also be scanned into FBCS.
Verification	Once paper claims are scanned, staff at VHA's claims processing locations visually compare the scanned image of the claim to the text in FBCS to verify that the system accurately captured information from the claim and manually enter any information that is missing or not accurately captured. They also determine whether claims should be rejected as duplicates of other claims that have already been processed.
Distribution	After electronic and paper claims are entered into FBCS, staff at the VHA claims processing location electronically route the claims to staff with the appropriate processing expertise.
Processing	Staff at VHA's claims processing locations use FBCS to review claims for VA care in the community and determine whether the claims meet administrative and clinical criteria for payment.
Approval or rejection	In FBCS, VHA's claims processing staff manually check off each line item that is approved for payment on a claim and enter into FBCS rejection reasons for any items not approved for payment. After determining which line items should be paid, the staff use FBCS to calculate payment amounts for each approved line item.
Payment	After approving claims for payment, staff at VHA's claims processing locations route the claims to VA's "program integrity tool," which electronically checks claims for potential improper payments before any funds are released. Claims are then released for payment; VA's financial services center issues an electronic payment to the community provider or the TPA, and claims processing staff mark the claims as paid in FBCS.

VHA claims processing location that processes claims for the VA medical facility that is located nearest to where the community provider rendered the emergency services.

Table 1: Veterans Health Administration's (VHA) Steps for Processing Claims for Care in the Community—Continued

Processing step	Description
Notification to community provider	After claims have been paid or rejected, FBCS generates preliminary fee remittance advice reports, which staff at VHA's claims processing locations must print and mail to the community providers and TPAs. These documents include a listing of claim dates and services, the reasons why payments for any services were rejected, and the payment amounts for approved services..

Source: GAO analysis of VHA documents. / GAO 16 380T

VHA, Medicare, and TRICARE Claims Processing Timeliness Requirements

VHA, CMS, and DHA all have requirements for claims processing timeliness. See table 2.

Table 2: Claims Processing Timeliness Requirements

Agency	Requirement
Veterans Health Administration (VHA)	A VHA directive states that 90 percent of all claims for VA care in the community must be processed (either paid or rejected) within 30 days of receipt. ^a
Centers for Medicare & Medicaid Services (CMS)	For Medicare claims, the standards were set by law and require that 95 percent of clean claims—those claims with sufficient information to be processed (either paid or denied)—must be processed within 30 days of receipt. ^b CMS's manual for processing Medicare claims states that the remaining claims must be processed within 45 days of receipt..
Defense Health Agency (DHA)	TRICARE Managed Care Support Contractors are subject to claims processing timeliness requirements outlined in law and in DHA's TRICARE Operations Manual. The requirements in the Operations Manual are more stringent than in the law. It states that 98 percent of claims with sufficient information to be processed must be paid or denied within 30 days of receipt and that all claims must be processed to completion within 90 days of receipt. ^c

Source: GAO analysis of VHA, CMS, and DHA policies. / GAO 16 380T

^a VHA Directive 2010-005, Timeliness Standards for Processing Non-VA Provider Claims (January 27, 2010).

^b A "clean claim" has no defect or impropriety (including a lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. 42 U.S.C. § 1395h(c)(2)(B). Other claims require additional investigation or development before they can be paid. CMS, Medicare Claims Processing Manual, Publication 100-04 (Baltimore, MD: May 15, 2015).

^c By law, 95 percent of clean TRICARE claims must be processed within 30 days of submission to the claims processor, and all clean claims must be processed within 100 days of submission to the claims processor. 10 U.S.C. § 1095c(a).

Preliminary Analyses Suggest VHA's Claims Processing Was Significantly Less Timely Than Medicare's and TRICARE's in Fiscal Year 2015, and VHA's Data Likely Overstate its Performance

Our preliminary work shows that in fiscal year 2015, VHA's processing of claims for VA care in the community services was significantly less timely than Medicare's and TRICARE's claims processing. VHA officials told us that the agency's fiscal year 2015 data show that VHA processed about 66 percent of claims within the agency's required timeframe of 30 days or less.²¹ In contrast, CMS and DHA data show that in fiscal year 2015, Medicare's and TRICARE's claims processing contractors processed about 99 percent of claims within 30 or fewer days of receipt.²² According to

²¹ VHA's claims processing timeliness data do not account for the time it takes the TPAs to pay the community providers' PC3 or Veterans' Choice Program claims; however, VHA's data do account for the time it takes VHA's claims processing locations to process and reimburse the TPAs for these claims.

²² The percentages reported here are for VHA, Medicare, and TRICARE claims that were processed within 30 days of receipt when they had sufficient information to be processed. Both Medicare and TRICARE have separate measures of claims processing timeliness for claims that require additional information to be processed. VHA has only one measure of claims processing timeliness, but if additional information is needed to process claims after they are initially received, VHA excludes from its calculation of timeliness any calendar days that elapse while it is awaiting this information.

CMS and DHA officials, the vast majority of Medicare and TRICARE claims are submitted electronically.²³

However, the difference between VHA's claims processing timeliness and that of Medicare and TRICARE is likely greater than what VHA's available data indicate. Specifically, VHA's data likely overstate the agency's claims processing timeliness because they do not account for delays in scanning paper claims, which VHA officials told us account for approximately 60 percent of claims for VA care in the community services. VHA's policy states that determinations of claims processing timeliness should be based upon the date the claim is received, but its systems can only calculate timeliness on the basis of the date the claim is entered into FBCS.²⁴ When community providers submit paper claims, VHA policy requires claims processing staff to manually date-stamp them and scan the paper claims into FBCS on the date of receipt.²⁵ However, FBCS cannot electronically read the dates that are manually stamped on paper claims, so the scan date becomes the date used to calculate claims processing timeliness.

Our preliminary review raises questions about whether staff at VHA's claims processing locations are following the agency's policy for promptly scanning paper claims. We do not know the extent of delays in scanning paper claims at all of VHA's claims processing locations. However, our preliminary analysis of the non-generalizable sample of 156 claims for VA care in the community services from the four VHA claims processing locations we visited suggests that it may have taken about 2 weeks, on average, for staff to scan the paper claims in our sample into FBCS. This estimate is based on the number of days that elapsed between the creation dates for 86 of the 94 paper claims in our sample and the dates the claims were scanned into FBCS.²⁶ Based on this analysis, we found that the number of days between the creation date and the scanned date for the paper claims in our sample ranged from 2 days to 90 days.

Our observations at one claims processing location we visited were consistent with this analysis. For example, we observed about a dozen bins of paper claims and medical documentation waiting to be scanned, and some of these bins were labeled with dates indicating they were received by the claims processing location about a month before our visit. Additionally, this claims processing location was the only one of the four claims processing locations we visited that manually date-stamped all of its paper claims upon receipt. Staff at another claims processing location told us that they only date-stamp paper claims for emergency care upon receipt because these claims are only eligible for payment if they have been received within a certain amount of time after the date of service.²⁷ However, the staff said they do not date-stamp non-emergency care claims because to do so would be too time-con-

²³ Officials from CMS and DHA told us that their data on claims processing timeliness are reliable because the majority of Medicare and TRICARE claims are submitted electronically, their contractors' claims processing systems are highly automated, and agency officials can independently validate the contractors' performance data.

²⁴ VHA officials told us that they intend to revise their current policy for claims processing timeliness because it does not account for the fact that it takes more time, on average, for VHA to process emergency care claims than it does to process claims for preauthorized VA care in the community services. According to VHA officials, in fiscal year 2015, staff at their claims processing locations took an average of 32 days to process claims for emergency care, compared to an average of 16 days for claims for care that was preauthorized. VHA officials said their future policy would require claims for preauthorized care to be processed in 30 days or less and claims for emergency care be processed in 45 days or less and that these new metrics would be more closely aligned with Medicare's and TRICARE's standards, which permit more time for claims processing when additional information must be requested from providers. However, VHA's systems will still measure claims processing timeliness on the basis of the dates claims are entered into FBCS, which may not be the actual date of receipt for paper claims, so it is unlikely that VHA's new metrics will result in more reliable estimates of the agency's claims processing timeliness.

²⁵ In contrast, electronic claims automatically receive an electronic date-stamp when they are imported into FBCS.

²⁶ Our estimate of the 2-week delay in scanning paper claims factored in 2 days for the paper claims to be mailed to VHA by the community providers. It also excluded 8 paper claims that appeared to be duplicates of claims that the community providers had previously submitted, based on the number of calendar days that had elapsed between the creation dates and the scan dates. At least one community provider told us that they do not change the creation date when they reprint and resubmit claims that VA has previously rejected.

²⁷ Claims for Millennium Act emergency care must be received by VHA within 90 days of the latest of the following: the date of discharge; the date of the patient's death, provided death occurred during transport to or stay in an emergency treatment facility; or the date that the veteran exhausted, without success, actions to obtain payment or reimbursement from a third party. VHA can deny these emergency care claims if they are submitted by community providers after 90 days. Claims for emergency care related to a veteran's service-connected disability or a condition that aggravated a service-connected disability must be received within 2 years.

suming. Staff at the other two claims processing locations told us that they did not date-stamp any claims.

These preliminary findings from the four claims processing locations we visited for this review are consistent with the claims processing deficiencies we identified in our 2014 report on the implementation of the Millennium Act emergency care benefit.²⁸ Specifically, we found that the VHA claims processing locations we reviewed for the 2014 report were rarely date-stamping incoming paper claims and were not promptly scanning a significant percentage of the paper claims we reviewed into FBCS. In our report, we recommended that VHA implement measures to ensure that all incoming claims are date-stamped and scanned into FBCS on the date of receipt, and VA agreed with our recommendations. Soon after we issued our 2014 report, VHA reiterated its date-stamping and scanning policies on national calls with managers responsible for claims processing, posted articles in its biweekly bulletin for managers and staff, and conducted online training for staff that communicated the importance of date-stamping and promptly scanning claims. However, the observations from our most recent review of a new sample of claims at four other claims processing locations suggest that VHA had not monitored the operational effectiveness of their corrective actions to address our recommendation. VHA officials said that when they became aware of these more recent findings, they began requiring managers at their claims processing locations to periodically certify in writing that all incoming paper claims have been date-stamped and scanned on the day of receipt.

Preliminary Analyses Indicate that Technology Limitations and Related Staffing Shortages Have Delayed VHA's Claims Processing

During the course of our preliminary work, VHA officials and staff at three of the four claims processing locations we visited told us that limitations of the existing information technology systems VHA uses for claims processing and related workload challenges delay processing and payment of claims for VA care in the community services. These identified limitations are described in more detail below.

VHA cannot accept medical documentation electronically

While VHA has the capacity to accept claims from community providers and the TPAs electronically, it does not have the capacity to accept medical documentation electronically from the providers and TPAs.²⁹ As a result, this documentation must be scanned into FBCS, which delays claims processing, according to VHA staff. Although VHA policy requires VHA staff to promptly scan paper claims into FBCS when received, delays can occur because staff do not have time to scan the high volume of claims and medical documentation received each day, and the capacity of scanning equipment is limited. For example, VHA staff at one claims processing location we visited told us that on Mondays (their heaviest day for mail since they do not receive mail on weekends), they do not scan any incoming claims with accompanying medical documentation. Instead, they generally scan only claims that do not have accompanying medical documentation on Mondays and scan claims with accompanying medical documentation into FBCS on Tuesdays and Wednesdays. In some cases, the medical documentation community providers must submit can be extensive, which may further delay its entry into FBCS. Officials from one community health care system told us that the medical documentation they submit with claims can be between 25 to 75 pages for each patient. With most types of claims requiring medical documentation, staff at VHA's claims processing locations may need to scan a significant number of pages of incoming medical documentation each day.

Authorizations for VA care in the community services are not always readily available in FBCS

Staff at three of the four VHA claims processing locations we visited told us that processing and payment can also be delayed when authorizations for VA care in the community services are unavailable in FBCS. Before veterans obtain services from

²⁸ See GAO 14 175.

²⁹ For all types of VA care in the community services except individually authorized outpatient care, community providers must include medical documentation with the claims they submit to VHA or the TPAs. According to VHA officials, VHA cannot accept any medical documentation electronically because of (1) a lack of interoperability between VHA's systems and the providers' and TPAs' systems and (2) concerns about safeguarding the security of veterans' health information, among other things. However, according to VHA officials, selected claims processing locations have made arrangements with certain community providers that enable VHA's claims processing staff to remotely access the community providers' medical records electronically.

community providers, staff at VA medical facilities must indicate in the veteran's VA electronic health record (a system separate from FBCS) that the service or services have been authorized, and then they must manually create an authorization in FBCS. However, VHA officials and staff told us that these authorizations are sometimes unavailable in FBCS at the time claims are processed, which delays processing and payment. The authorizations are unavailable because either (1) they have been electronically suspended in FBCS, and as a result staff at the VA medical facility that authorized the care must release them before any associated claims can be paid, or (2) the estimated date of service on the authorization does not match the date that services were actually rendered, and new authorizations must be entered by staff at the authorizing VA medical facility before the claims can be paid.³⁰

In our sample of 156 claims, 25 claims were delayed in being processed because an authorization was not initially available in FBCS, resulting in an average delay of approximately 42 days in claims processing. Additionally, 8 of the 12 community providers we interviewed said they were aware that some of their payments had been delayed because authorizations were not available in FBCS when their claims arrived at the VHA claims processing location.

FBCS cannot automatically adjudicate claims

FBCS cannot automatically adjudicate claims, and as a result, VHA staff must do so manually, which VHA staff told us can slow claims processing, make errors more likely, and delay claims payment. After information from claims and supporting medical documentation has been scanned and entered into FBCS, the system cannot fully adjudicate the claims without manual intervention. For example, FBCS lacks the capability to electronically apply relevant administrative and clinical criteria for Millennium Act emergency care claims, such as automatically determining whether a veteran is enrolled in the VHA health care system and whether they had received services from a VA clinician in the 24 months prior to accessing the emergency care. Instead, staff processing these claims perform searches within FBCS and manually select rejection reasons for any claims that do not meet VHA's administrative or clinical criteria for payment.

Among the 156 claims we reviewed at four claims processing locations, it took an average of 47 days for claims processing staff to determine that the claims met the administrative and clinical criteria for payment. In addition, even after claims are approved for payment, they require additional manual intervention before the community providers can be paid. For example, in cases where FBCS cannot automatically determine correct payment rates for VA care in the community services, VHA staff manually calculate VHA's payment rates and enter this information into FBCS. Staff we interviewed also told us that it usually takes about 2 days for claims to return from VA's program integrity tool, which is a system outside FBCS where claims are routed for prepayment review of potential improper payments. If corrections must be made after the claims return from this prepayment review, payments can be delayed further.

Weaknesses in FBCS and VHA's financial management systems have also delayed claims payments

According to staff at three of the four claims processing locations we visited, payments on some VA care in the community claims are delayed when VHA does not have funds available to pay them, a problem that occurs in part because FBCS and VHA's financial management systems do not permit officials to efficiently monitor the availability of funds for VA care in the community services. To improve its oversight of VA care in the community, the Choice Act directed VA to transfer the authority for processing payments for VA care in the community from its Veterans Integrated Service Networks and VA medical centers to VHA's Chief Business Office for Purchased Care, a change VA implemented in October 2014. However, according to VHA officials from that office, monitoring the use of funds-at a national level-

³⁰ A VA official provided additional detail on why the authorizations may be electronically suspended in FBCS and why the dates of service on the authorization and claim may not match. According to this official, when authorizations for inpatient care in the community services are entered into FBCS, they must include a discharge date. Because this date is generally not known until after the claim is received, staff at VA medical facilities may electronically suspend the authorization until they are alerted by staff from the VHA claims processing location that the claim has been received. No claims can be paid against an authorization while it is suspended, causing it to seem as though it is not available in FBCS. In cases where authorizations are not suspended, estimated discharge dates are entered. If VHA receives any claims with dates of service occurring after the date that was originally estimated for that inpatient episode of care, staff at the VA medical facility must create new authorizations in FBCS before staff at the VHA claims processing location can pay the claims.

has remained largely a manual process due to limitations of FBCS and the use of separate systems to track obligations and expenditures. VHA uses historical data from FBCS to estimate obligations on a monthly basis. According to VHA officials, these estimates have been unreasonably low for some services, given the unexpected increase in utilization of VA care in the community services over the course of fiscal year 2015. In addition, FBCS does not fully interface with systems used to track the availability of funds, which results in staff having to manually record the obligations for outpatient VA care in the community services in these systems on a monthly basis. Together, these two issues have impeded the ability of VHA to ensure that funds are available to pay claims for VA care in the community as they are approved, according to VHA officials responsible for monitoring the use of funds. Our initial work shows that payments for 5 of the 156 claims we reviewed from four claims processing locations were delayed because funds were unavailable, resulting in payment delays that ranged from 1 to 215 days.

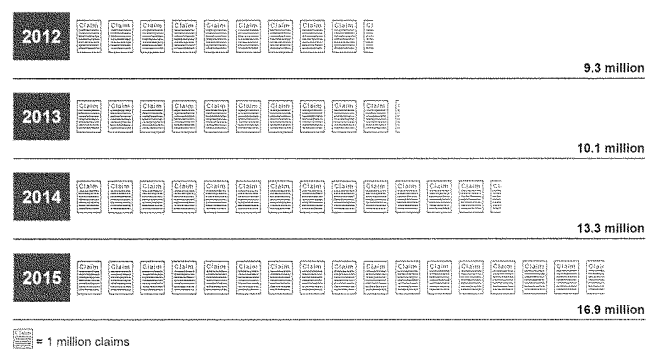
Inadequate equipment delays scanning of paper claims and medical documentation

VHA officials also told us that inadequate scanning equipment delayed claims processing and adversely affected VHA's claims payment timeliness. At the time of our review, staff responsible for scanning paper claims and medical documentation at one of the four claims processing locations we visited told us that they did not have adequate scanning equipment. At this location, the scanners that staff showed us were small enough to be placed on desktops, while the trays for feeding documents into the scanners could only handle a limited number of pages at one time. With an estimated 60 percent of claims and 100 percent of medical documentation requiring scanning, these staff said that they struggled to keep up with the volume of paper coming in to their claims processing location.

Staffing shortages adversely affect claims processing timeliness

In addition to the technological issues described above, VHA officials and staff also told us that staffing shortages have adversely affected VHA's claims processing timeliness. According to VHA officials, the overall number of authorized positions for claims processing staff did not change after the October 2014 organizational realignment that transferred claims processing management and oversight responsibilities to the Chief Business Office for Purchased Care. However, VHA officials said that VHA's claims processing workload increased considerably over the course of fiscal years 2014 and 2015. (See figure 1 for an illustration of the increase in VHA's claims processing workload between fiscal year 2012 and fiscal year 2015.)

Figure 1: Number of Claims for VA Care in the Community Processed by the Veterans Health Administration (VHA), Fiscal Year 2012 – 2015



Source: VHA (data); GAO (illustration). | GAO-16-380T

According to VHA officials and staff, the increase in workload contributed to poor staff morale, attrition, and staff shortages—all of which contributed to delays in processing and impeded VHA's claims processing timeliness. VHA officials told us that in early fiscal year 2015, there were about 300 vacancies among the estimated 2,000 authorized positions for claims processing staff.

VA Care in the Community Providers Cite Administrative Burden, Lack of Notification, and Problems with Poor Customer Service

The 12 community providers and 12 state hospital association respondents who participated in our ongoing review told us about various issues they had experienced with VHA's claims processing system. These issues are described in more detail below.

Administrative burden of submitting claims and medical documentation to VHA

Almost all of the community providers we interviewed (11 out of 12) and all of the state hospital association respondents that participated in our ongoing review described the administrative burden of submitting claims and medical documentation to their respective VHA claims processing locations. For example, one community provider told us that VHA claims only accounted for about five percent of their business, but the provider told us it employed one full-time staff member who was dedicated to submitting claims to VHA and following up on unpaid ones. This same provider employed a second full-time staff member to handle Medicaid claims, but these accounted for about 85 percent of their business.

According to many of the community providers that participated in our review, obtaining payment from VHA often requires repeated submission of claims and medical documentation. Officials from one community provider we interviewed said that, at one point, they had been hand delivering paper medical documentation with paper copies of the related claims to their VHA claims processing location, but VHA staff at this location still routinely rejected their claims for a lack of medical documentation. Similarly, six state hospital association respondents also reported that their members' claims were often rejected, even though they always sent medical documentation to their VHA claims processing location by certified mail. Some of the community health care system and hospital officials who participated in our review explained that they often must submit medical documentation to their VHA claims processing location twice-once for the claim related to hospital services and again for claims related to physician services.

Lack of notification about claims decisions

Community providers who participated in our review also explained that they rarely received written notifications from VHA about claims decisions. To inform community providers and the TPAs about whether their claims have been approved or rejected, staff at VHA's claims processing locations print notices called preliminary fee remittance advice reports and mail them to the providers and TPAs.³¹ However, community providers who participated in our study stated that they rarely received these paper reports in the mail, and even though they received VA payments electronically, it was not clear without the remittance advice reports which claims the payments applied to or whether VHA denied payment for certain line items on some claims. Unlike Medicare and TRICARE, VHA has no online portal where community providers can electronically check the status of their claims to find out if the claims are awaiting processing or if VHA needs additional information to process them. Several of the community providers who participated in our study told us that they would appreciate VHA establishing such a portal.

Issues with telephone-based provider customer service

Almost all of the community providers and state hospital associations that participated in our review (9 out of 12 providers and 11 out of 12 associations) experienced issues with the telephone-based provider customer service at VHA's claims processing locations. For example,

- officials from three of the community providers we interviewed reported that they routinely wait on hold for an hour or more while trying to follow up on unpaid claims.
- Officials from a community health care system that operates 46 hospitals and submits claims to 5 different VHA claims processing locations said that 3 of these locations will not accept any phone calls and instead require providers to fax any questions about claim status.
- According to officials from another community health care system, their VHA claims processing location has limited them to inquiring about only three claims per VHA staff member, per day. The officials explained that if they call twice on the same day and reach the same individual who has already checked the status of three claims, that person will refuse to check the status of additional

³¹The preliminary fee remittance advice reports include a listing of claim dates and services, the reasons why payments for any services were disapproved, and payment amounts for services that were approved.

claims; however, if they connect with a different VHA staff member, they may be able to inquire about additional claims.³²

While VHA Has Implemented Interim Measures, the Agency Does Not Expect to Address All Claims Processing Challenges until Fiscal Year 2018 or Later

VHA Has Recently Filled Staff Vacancies, Introduced Productivity Standards, Invested in Scanning Equipment, and Taken Other Steps to Improve Claims Processing Timeliness

In the course of our ongoing work, VHA officials reported that they implemented several measures in fiscal year 2015 and early fiscal year 2016 that were intended to improve the timeliness of VHA's payments to community providers and the TPAs. The following are the key steps that VHA officials have reported taking.

- *Staffing increases.* VHA officials said that they have recently filled the approximately 300 staff vacancies that resulted from attrition shortly after the October 2014 realignment of claims processing under VHA's Chief Business Office for Purchased Care. The officials also told us that they have supplemented the existing workforce at VHA's claims processing locations by hiring temporary staff and contractors to help address VHA's backlog of claims awaiting processing. In addition, for 2 months in fiscal year 2015, VHA required its claims processing staff to work mandatory overtime, and according to VHA officials, staff are still working overtime on a voluntary basis. At some locations, VHA added second shifts for claims processing staff. As a result, VHA officials told us that VHA was able to decrease its backlog of unprocessed claims for VA care in the community from an all-time high of 736,000 claims in August 2015 to about 453,000 claims as of October 29, 2015.³³
- *Deployment of nationwide productivity standards.* On October 1, 2015, VHA introduced new performance plans with nationwide productivity standards for its claims processing staff, and officials estimated that these standards would lead staff to process more claims each day, resulting in a 6.53 percent increase in claims processing productivity over the course of fiscal year 2016.
- *Improved access to data needed to monitor claims processing performance.* VHA has implemented a new, real-time data tracking system to monitor claims processing productivity and other aspects of performance at its claims processing locations. This tool, which VHA officials refer to as the "command center," permits VHA officials and managers at VHA's claims processing locations to view claims data related to the timeliness of payments and other metrics at the national, claims processing location, and the individual staff level. Previously, many data were self-reported by the claims processing locations. The VHA officials we interviewed said that they monitor these data daily.
- *New scanning equipment.* VHA recently purchased new scanning equipment for 73 of its 95 claims processing locations, including the claims processing location we visited with the small, desktop scanners. The agency awarded a contract in November 2015, and officials said that VHA had installed this new equipment at almost all sites as of January 15, 2016. They expected that installation would be completed at the few remaining sites by the end of January 2016.
- *Improvement of cost estimation tools.* In January 2016, VHA deployed an FBCS enhancement that is intended to improve VHA's ability to estimate obligations for VA care in the community within FBCS. VHA officials said this will help them ensure that adequate funds are available to pay claims for VA care in the community services at the time the claims are processed. However, staff at VA medical facilities still must manually enter estimated obligations into VHA's systems for tracking the availability of funds on a monthly basis, because this information cannot be automatically transferred from FBCS.

VHA Is Examining Options for Modernizing Its Claims Processing System and Estimates Implementing New Technology and Other Solutions Will Take at Least 2 Years

³² VHA officials said that once they became aware of this practice in the summer of 2015, they contacted managers at their claims processing locations to advise them that they should not be limiting the number of claims each community provider could call and inquire about each day.

³³ VHA defines "backlogged" claims to be those that were received more than 30 days ago. However, VHA's data do not account for paper claims that have been received by VHA claims processing locations but not yet scanned into FBCS. Therefore, VHA's data likely underestimate the number of claims that have been awaiting processing for more than 30 days.

VHA officials that we interviewed in the course of our ongoing work acknowledged that the recent steps they have taken to improve claims processing timeliness—such as hiring temporary staff and contractors and mandating that claims processing staff work overtime—are not sustainable in the long term. These officials said that if the agency is to dramatically improve its claims processing timeliness, comprehensive and technologically advanced solutions must be developed and implemented, such as modernizing and upgrading VHA’s existing claims processing system or contracting out the claims processing function. On October 30, 2015, VHA reported to Congress that it has plans to address these issues, but the agency estimates that it will take at least 2 years to implement solutions that will fully address all of the challenges now faced by its claims processing staff and by providers of VA care in the community services.³⁴ According to VHA officials, the success of this long-term modernization plan will also hinge on significant investments in the development and deployment of new technology.

In its October 2015 strategic plan for consolidating VA care in the community programs and improving related business processes, VHA stated that it expects it will significantly increase its reliance on community providers to deliver care to veterans in the coming years. In addition, VHA plans to adopt many features or capabilities for its claims processing system that are similar to Medicare’s and TRICARE’s claims processing systems, including (1) greater automatic adjudication of claims, (2) automating the entry of authorizations, (3) establishing a mechanism by which community providers can electronically submit medical records, (4) creating a Web-based portal for community providers to check the status of their claims, and (5) establishing a nationwide provider customer service system with dedicated staff so that other staff can focus on claims processing. According to this strategic plan, VHA will examine potential strategies for developing these capabilities in fiscal year 2016—including the possibilities of contracting for (1) the development of the claims processing system only or (2) all claims processing services, so that contractors, rather than VHA staff, would be responsible for processing claims (similar to Medicare and TRICARE). The strategic plan states that VHA will finalize more detailed implementation plans before the end of this fiscal year. The agency expects that deployment of its selected solutions will begin in fiscal year 2018 or later.

According to VHA, the efforts underway to address deficiencies in its claims processing system will present major challenges, such as revamping VHA’s information technology systems and securing funding to do so. Our past work on planning best practices calls for an implementation strategy to help ensure that needed changes are made in a timely manner and that ramifications for key decisions (such as ones that relate to an agency’s current and future workforce profile) are considered. To date, VHA has not developed a detailed plan for achieving these goals.

That VHA has not yet communicated a detailed plan is cause for concern, given VA’s past failed attempts to modernize key information technology systems. Our prior work has shown that VHA’s past attempts to achieve goals of a similar magnitude—such as modernizing its systems for (1) scheduling outpatient appointments in VA medical facilities, (2) financial management, and (3) inventory and asset management—have been derailed by weaknesses in project management, a lack of effective oversight, and the failure of pilot systems to support agency operations.³⁵ For example, we found:

- VA undertook an initiative in 2000 to replace the outpatient scheduling system but terminated the project after spending \$127 million over 9 years.
- VA has been trying for many years to modernize or replace its financial management and inventory and asset management systems but has faced hurdles in carrying out these plans. In 2010, VA canceled a broad information technology improvement effort that would have improved both of these systems and

³⁴ Department of Veterans Affairs, Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care, (Washington, D.C.: Oct. 30, 2015). The VA Budget and Choice Improvement Act required VA to develop a plan for consolidating its existing VA care in the community programs. The plan was due to Congress no later than November 1, 2015. Pub. L. No. 114–41, § 4002, 129 Stat. 443, 461 (2015).

³⁵ See GAO, Information Technology: Management Improvements Are Essential to VA’s Second Effort to Replace its Outpatient Scheduling System, GAO 10 579 (Washington, D.C.: May 27, 2010); GAO, Information Technology: Actions Needed to Fully Establish Program Management Capability for VA’s Financial and Logistics Initiative, GAO 10 40 (Washington, D.C.: Oct. 26, 2009); and Veterans Health Care: VHA Has Taken Steps to Address Deficiencies in its Logistics Program, but Significant Concerns Remain, GAO 13 336 (Washington, D.C.: Apr. 17, 2013).

at the time was estimated to cost between \$300 million and \$400 million.³⁶ By September 2, 2009 (just before the project's cancellation) VA had already spent almost \$91 million of the \$300 million to \$400 million that was originally estimated. A previous initiative to revamp these systems was underway between 1998 and 2004, but after reportedly having spent more than \$249 million on development of the replacement system, VA discontinued the project because the pilot system failed to support VHA's operations.

According to VHA officials, instead of investing in administrative systems such as the claims processing system, outpatient scheduling system, financial management systems, or the inventory and asset management system, in recent years VA has prioritized investments in information technology enhancements that more directly relate to patient care. As such, VHA officials said they have had little success in gaining approval and funding for information technology improvements for these administrative systems.

In summary, our preliminary analyses show that VHA's average claims processing timeliness in fiscal year 2015 was significantly lower than Medicare's and TRICARE's timeliness and far below its own standard of paying 90 percent of claims within 30 days. To its credit, VHA has recently implemented measures (including hiring more staff and purchasing new scanning equipment), which are intended to address some challenges that have impeded its claims processing timeliness. VHA plans to address the remaining challenges through its longer term effort to implement a consolidated VA care in the community program in fiscal year 2018 or later. These sweeping changes do not come without risk and cost, and VHA has struggled to make changes of a similar magnitude in the past. However-based on statements made by some of the community providers that participated in our review-without significantly improving the timeliness of its payments and addressing community providers' concerns about the administrative burden of obtaining VHA payments and the agency's lack of responsiveness when they inquire about unpaid claims, VHA will risk losing the cooperation of these providers as it attempts to transition to a future care delivery model that would heavily rely on them to deliver care to veterans.

Because this work is ongoing, we are not making recommendations on VHA's processing and payment of claims from community providers at this time.

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

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

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³⁶The portion of the broad information technology improvement effort that VA canceled in 2010 pertaining to the update of VHA's inventory and asset management system was not officially terminated until 2011.

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Prepared Statement of Gary K. Abe

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General’s (OIG) work concerning VA’s purchase care programs. Our work covers issues discussed in VA’s Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (consolidation plan), submitted to Congress as required by Public Law 114–41, Surface Transportation and Veteran Health Care Choice Improvement Act. I am accompanied by Mr. Larry Reinkemeyer, Director, OIG’s Kansas City Audit Division.

BACKGROUND

VA’s purchased care programs include the Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA’s purchased care programs are critical to VA in carrying out its mission of providing medical care, including outpatient services, inpatient care, mental health, dental services, and nursing home care to veterans. Our audits and reviews have reported the challenges VA faces in administering these programs, such as authorizing, scheduling, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran’s VA medical record, and timely and accurate payment for care purchased outside the VA health care system. Specifically, we reported in January 2015, and October 2015, that the Phoenix VA Health Care System (PVAHCS) was experiencing problems coordinating administrative actions with contracted providers including timely insertion of contracted providers’ medical documentation into VA medical records.¹ We determined that non-VA providers’ clinical documents were not available for PVAHCS providers to review timely and that referring providers may not have addressed potentially important recommendations

¹ Interim Report - Review of Phoenix VA Health Care System’s Urology Department, Phoenix, AZ, January 28, 2015; and Healthcare Inspection - Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ, October 15, 2015

and follow-up because they did not have access to non-VA clinical records. We also concluded that PVAHCS Urology Service and Non-VA Care Coordination staff did not provide timely care or ensure timely urological services were provided to patients needing care.

It has been challenging to conduct effective oversight of VA's purchase care programs because VA continues to fast track changes to the program. For example, we had planned to review the timeliness and accuracy of PC3 payments this fiscal year after providing VA sufficient time to process a significant number of PC3 medical claims to make reliable findings and conclusions. However, PC3 was soon followed by the VCP, which has only paid about \$53 million of medical claims as of February 1, 2016. Nevertheless, we plan on reviewing a statistically reliable number of paid Choice medical claims every quarter in order to meet the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 (Public Law 113-146) requirement to submit a report on timeliness and accuracy after 75 percent of the almost \$10 billion dollars appropriated to the VCP is spent or when the program ends in August 2017, whichever occurs first. This approach enables us to view the expenditure activity over time and helps assess whether the program services provided to veterans are improving or worsening. The planned approach also provides more time and opportunity for VA to strengthen its program controls specifically before the majority of funds are spent.

PATIENT-CENTERED COMMUNITY CARE

The PC3 program is a Veterans Health Administration (VHA) nationwide program that provides eligible veterans access through health care contracts to certain medical services. The PC3 program is used after the VA medical facility has exhausted other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. In September 2013, VA awarded Health Net Federal Services, Limited Liability Corporation (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) PC3 contracts totaling approximately \$5 billion and \$4.4 billion, respectively. Then on October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the VCP. Administration includes responsibilities such as, sending out Choice cards to eligible veterans, providing call center service, scheduling appointments, and providing care through their provider networks. This is an important matter when evaluating VA's plan to align all non-VA care programs under the new VCP. Since Health Net and TriWest have built their Choice provider network upon the backbone of their PC3 network, there are lessons that can be learned from the series of reports we issued in FY 2015 addressing aspects of PC3 implementation efforts. A theme that was clear to us was that VA clinical and support staff were dissatisfied with PC3 in such areas as authorizing care, scheduling appointments, and veterans waiting for care.

In our July 2015, Review of Allegations of Delays in Care Caused by Patient-Centered Community Care (PC3) Issues, we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling.² We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and Health Net and TriWest schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. The then Interim Under Secretary for Health agreed with our recommendations to ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements.

In our September 2015, Review of VHA's PC3 Provider Network Adequacy, we reported that inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA spent 0.14 percent, or \$3.8 million of its \$2.8 billion FY 2014 non-VA care budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its non-VA care expenditures. VHA staff attributed the limited use of PC3 to inadequate

²Blind scheduling refers to scheduled appointments for veterans without discussing the tentative appointment with the veteran.

provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because:

- The PC3 network lacked needed specialty care providers, such as urologists and cardiologists.
- Returned PC3 authorizations had to be re-authorized through non-VA care and increased veterans' wait times for care.
- Non-VA care provided veterans more timely care than PC3.

For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care. Further, VHA had not ensured the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3; the CBO lacked an effective implementation strategy for the roll-out of PC3; and neither VHA nor Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health agreed with our recommendations to strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex healthcare initiatives.

In another September 2015 report, Review of Patient-Centered Community Care (PC3) Health Record Coordination, we found that VA lacked an effective program for monitoring the performance of their two contractors. We estimated that about 32 percent of the PC3 episodes of care had complete clinical documentation provided within the time frame required under the PC3 contracts. This was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation. Contracting Officer's Representatives (CORs) did not have an independent source of VA data to verify contractor compliance with the contracts. Instead, CORs monitored contract compliance by reviewing monthly performance reports submitted by the contractors. As a result, VA lacked adequate visibility and assurance that veterans were provided adequate continuity of care, and VA was at an increased risk of improperly awarding incentive fees or not applying penalty fees. We estimated 20 percent of the documentation was incomplete, and an additional 48 percent was not provided to VA within the timeframe required in the contracts. From January 1 through September 30, 2014, we estimated that VA made about \$870,000 of improper payments.

Additionally, we reviewed just over 400 episodes of care and identified 3 critical findings that did not have contract-required elements annotated in the clinical documentation returned by TriWest's providers, such as the name of the VA medical facility staff member contacted and date and time notified. Without this information and the timely receipt of critical findings, VHA lacked assurance that critical findings were being reported in accordance with the contract's performance standards. Further, we examined each critical finding and found that PC3 patients experienced delays in treatment by VA, as well as by TriWest. We made recommendations to the VA Undersecretary for Health including to implement a mechanism to verify PC3 contractors' performance, ensure PC3 contractors properly annotate and report critical findings in a timely manner, and impose financial or other remedies when contractors fail to meet requirements.

The Under Secretary for Health provided a responsive action plan and expected to address our recommendations by August 2016. We are continuing to monitor VA's progress and will do so until all proposed actions are completed.

VETERANS CHOICE PROGRAM

The VACAA created the VCP in November 2014. Following enactment of VACAA, VA turned to Health Net and TriWest, the administrators of the PC3 program, who had provider networks in place nation-wide. The VCP allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates and veterans who live more than 40 miles from a VA facility. Under this program, VA facilities began providing non-VA care to eligible veterans enrolled in VA health care as of August 1, 2014, and to recently discharged combat veterans who are within 5 years of their post-combat separation date. From August 2014 through February 1, 2016, VA has spent \$224.4 million on the VCP. VA has reimbursed Health Net and Tri West \$171.4 million of the \$224.4 million (76 percent) for administering the program and \$53.0 million of the \$224.4 million (24 percent) for medical services provided to veterans.

Our OIG Hotline has received numerous complaints about the VCP during the 4th quarter of fiscal year 2015. These complaints fall into the following general categories:

- Appointments and scheduling
- Program eligibility and enrollment
- Veteran and provider payments
- Authorization process.

In our February 2016, Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, Colorado, we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner.

- For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days.
- For 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all.
- In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests.

As a result, VA staff did not fully use VCP funds to afford Colorado Springs CBOC veterans the opportunity to receive timely care. The Eastern Colorado Health Care System Acting Director agreed with recommendations to ensure scheduling staff use the clinically indicated or preferred appointment dates for primary care appointments, use the earliest appropriate date for scheduling new patient consult appointments, place veterans with appointments over 30 days on the Veterans Choice List within 1 day of scheduling the appointment, and provide sufficient resources to act on consults within 7 days and appointment request for newly enrolled veterans within 1 day. Based on actions already implemented, we closed the recommendation to ensure that scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments.

In our February 2016 report, Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida, we substantiated that when veterans received appointments in the community through the VCP, the facility did not cancel their existing VA appointments. For example,

- We found that for 12 veterans, staff did not cancel the veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt notification from the contractor when a veteran scheduled a VCP appointment and no longer needed the VA appointment.
- We also substantiated that the facility did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List.

This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List, when they were actually removing the veteran from the Veterans Choice List. The Director agreed with our recommendations to ensure the facility receives prompt notification of scheduled VCP appointments, determine if the contractor complies with the notification requirements, ensure appropriate staff receive scheduling audit results and staff verify correction of errors, and ensure staff receive training regarding management of the Veterans Choice List. Based on actions already implemented, we closed 4 of the 5 recommendations, and will follow up to ensure the facility receives prompt notification of scheduled VCP appointments.

In addition to the audit required under VACAA, we have also initiated another national audit. We are reviewing the implementation of VCP to determine if there are barriers preventing veterans' access to the program and whether VA has effectively communicated with veterans and providers about the program.

NON-VA MEDICAL CARE OBLIGATIONS

Sound financial stewardship of funds for purchased care is important to ensure the availability to pay providers. VA uses miscellaneous obligations to estimate the funding requirements needed to ensure that it does not overspend for a variety of

goods and services, including non-VA Care. Beginning in FY 2015, the VACAA required the CBO to use special use funds to pay for non-VA Care services. If CBO de-obligates those funds after the fiscal year ends, those resources can no longer be used to create new non-VA Care authorizations for veterans waiting for services. VA is required to ensure that funds are available to cover the non-VA Care obligation and expenditure prior to entering into an agreement to purchase medical services. Once non-VA Care services are approved, the respective budget and/or finance office is responsible for verifying that funds are available and authorized, and the obligation is recorded in the financial system.

In our January 2016 report, *Audit of Non-VA Medical Care Obligations*, we determined that VHA had overestimated, and thus over obligated, \$543 million out of \$1.9 billion (29 percent) of non-VA Care funds obligated as of the end of FY 2013. The \$1.9 billion represented open obligations for which VA had not yet made payments at the end of FY 2013. The \$543 million represented an over obligation of those funds as they were not needed to make such payments. The \$543 million consisted of about \$265 million of single-year funds, and \$278 million of no-year funds. As a result, over obligated single-year funds were at risk of being unused and returned to the U.S. Department of Treasury due to expiration of the appropriation, and although no-year funds do not expire, they remain unavailable for current needs until deobligated. The overestimates occurred for several reasons, including the lack of adequate tools for medical center staff to reasonably estimate the costs of purchased care and weaknesses in the financial reconciliation processes. VHA also did not ensure that unused funds were deobligated after payments were complete.

If VHA does not improve non-VA Care obligation management, VA medical facilities are likely to continue to over obligate funds, thus reducing the amount of funds facilities have available to spend on non-VA Care. In addition, beginning in FY 2015 the VACAA effectively prohibits VA from using no-year funds for non-VA Care, which puts all over obligated non-VA Care funds at risk of being unavailable for any purpose. VACAA also limited the VA's ability to transfer funds between non-VA Care and other Medical Services obligations, such as medical salaries. These restrictions increase the importance of accurately estimating non-VA Care obligations to maximize the amount funds used to provide care for veterans while minimizing the amount of unused funds that expire and are ultimately returned to the Treasury Department.

We contract with CliftonLarsonAllen LLP (CLA) to audit VA's consolidated financial statements. For the year ending September 30, 2015, they reported processing and reconciliation issues related to purchased care as a material weakness.¹ CLA increased its focus on purchased care given increased funding and implementation of the VACAA. CLA reported problems with the cost estimation process and additionally noted the lack of reconciliation between the Fee Basis Claims System used to authorize, process, and pay for non-VA Care and VA's Financial Management System where obligations are recorded.

All of these issues-lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and weaknesses in reconciling non-VA Care authorizations to obligations in the Financial Management System-makes the accurate and timely management of purchased care funds challenging. To address the challenges in estimating costs, VA has requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. VA cites the Department of Defense's Tricare program as an example of a large program with similar authority.

We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone-i.e., obligating funds at the time of payment-would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and management information processes to ensure they do not spend more than appropriated by Congress.

CONCLUSION

Our audits and reviews have shown that VA faces challenges in administering its purchased care programs. Veterans' access to care, proper expenditure of funds, and timely payment of providers are at risk to the extent that VA lacked adequate processes to manage these funds and oversee program execution. While purchasing health care services from non-VA providers may afford VA flexibility in terms of ex-

¹ Audit of VA's Financial Statements for Fiscal Years 2015 and 2014, November 16, 2015.

panded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. With non-VA health care costs of about \$6 billion in FY 2015 and future costs expected to increase, VA needs to improve program controls. Without adequate controls, VA's consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient health care to veterans.

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

Prepared Statement of Dr. Baligh Yehia

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to further discuss the proposed improvements to the billing and reimbursement processes included in the Department of Veterans Affairs' (VA) plan to consolidate community care programs. To increase access to health care, VA plans to streamline the billing and reimbursement processes and implement system changes that will reduce frustration among community providers. I am accompanied today by Dr. Gene Migliaccio, Deputy Chief Business Officer for Purchased Care.

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in demand for care, it is essential for VA to partner with providers in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans and community providers, as well as VA employees.

Acknowledging these issues, VA is taking action as part of an enterprise-wide transformation called MyVA. MyVA will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. Included in this transformation is a plan for the consolidation of community care programs and business processes, consistent with Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, the VA Budget and Choice Improvement Act, and recommendations set forth in the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (Independent Assessment Report) that was required by section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).

On October 30, 2015, VA provided Congress with a possible plan for a New Veterans Choice Program (New VCP) that would include the consolidation of all purchased care programs. The New VCP will include some aspects of the current Veterans Choice Program established by section 101 of the Choice Act and incorporate additional elements designed to improve the delivery of community care.

Consistent with the principles outlined in New VCP report, VA plans to streamline clinical and administrative processes, including the billing and reimbursement process. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve community providers' experience with VA while also increasing Veterans' access to health care. Currently, many community providers face inaccuracies or delays in payments due to VA's decentralized and highly manual billing and reimbursement process. VA plans to streamline business processes and implement new solutions that allow for auto adjudication of claims processing.

Background

Efficient adjudication of claims processing is the key to effective billing and reimbursement processes. High performing networks invest in centralized, scalable auto adjudication technology platforms and use simplified product and reimbursement rules to facilitate high levels of auto adjudication. This enables automation of most claims and only requires review of claims in question, reducing delays and errors in payments. While this type of technology investment will have significant up-front costs, efficiency gains, savings, and additional key analytic capabilities will be generated once the solution is complete.

Auto adjudication of claims is made possible by establishing standard rules and processes, and integrating with complete patient and provider data. Systems interoperability allows for flexibility, enabling organizations to quickly respond to regulatory and best practice changes. Modern claims platforms can model care outcomes,

and identify fraud, waste and abuse through data analytics. Industry standards do not require the receipt of medical records for payment. VA does have this requirement, which often causes delays in payment. Within the health plan industry, private health providers submit claims using a standard format which typically includes patient information, services provided, and authorization if an authorization was required and obtained. Medical information is provided directly to the referring provider either through a patient summary or electronically. As VA improves claims processing, VA will no longer require medical records for reimbursement. VA will strive to improve the automation of systems to process medical records and conduct retrospective audits to confirm their receipt and develop lessons learned to support continuous improvement.

Current State

The current VA claims infrastructure and claims process are complex and inefficient due to highly manual procedures. VA also lacks a centralized data repository to support auto adjudication. There are more than 70 centers processing claims across 30 different claims systems, resulting in inconsistent processes. Limited automation and manual matching of claims to authorizations prevents efficient adjudication. Low electronic data interchange (EDI) claims submission rates, decentralized and inconsistent intake processes, and limited staff productivity standards (i.e., workload metrics) result in labor-intensive, paper-based processes that generate late, and sometimes incorrect payments. In FY 15, errors were determined in six improper payment categories: duplicate payment, goods or services not received, incorrect amount, ineligible good or service, ineligible recipient and lack of documentation. The overall improper payment rate for Fiscal Year 15 was 54.77% (the error rate excluding acquisition findings would be 12.42%). The majority of error findings were identified following the evaluation of payment compliance with the VAAR and the FAR which was an expansion of the audit scope from FY 14, but does not correspond to an increase in instances where the wrong provider was paid, the wrong amount was paid, a duplicate payment was made or services were not received.

Claims Processing Actions/Strategies Implemented for Improvement

VA has already taken many steps to improve timeliness of payment to community providers. To increase transparency in the claims inventory, VA implemented a claims inventory dashboard allowing VA to monitor claims in near real time, including:

- Backlog details -inventory by age, type of claim, and where claims are in the processing cycle
- Monitor processing strategy - aged claims and “cliff” or claims about to age
- Monitor staff and contractor productivity
- Monitor incoming and processed trends

VA established deep dive calls with Veterans Integrated Service Networks (VISNs) facing the largest backlogs. These calls occur several times per week and involve support staff in the review of data/dashboard, production, barriers, and staffing issues. The calls focus on site action plans for addressing the backlog, eliminating barriers and monitoring productivity, processes and trends. Furthermore, VA established weekly workload calls to specifically align support teams, work through local payment center issues and VISN issues, and address barriers to maximize improvement and contract support.

To reduce aged claims, VA implemented of backlog strategy based on claim type and priorities, such as processing backlog claims and claims that are about to age and contribute to the backlog first. These claims are monitored on a daily basis so that corrections can be made when needed. Additionally, VA implemented claims processing performance standards which have been communicated in performance plans.

Currently, VA is deploying a strategy to realign resources within each VISN and then nationally to ensure that resource allocation is consistent with need. VHA has ongoing communications with VAMC facility leadership to reduce and eliminate facility barriers to prompt payment such as ensuring timely entry of authorizations.

As stated during the HVAC hearing in June 2015, VA would fill over 200 vacancies within 90 days of the hearing. VA exceeded that goal by hiring over 200 staff within eight weeks.

VA has also improved outreach efforts with stakeholders. VA is identifying better and more frequent ways to communicate the status of claims processing timeliness with community providers, Members of Congress, and Veterans. Ongoing training is being provided to community providers on the resources available to address issues identified by the provider accounts receivables reports, to include monthly

calls held with providers to address account claim concerns. VA is meeting with State Hospital Associations across the country to educate them on claims processing, Veteran authorities for payment of claims, and local claims status.

These recent actions have had a significant impact on processing volume. In fiscal year (FY) 2015, VHA processed 16,793,057 claims representing a 21 percent increase over the same period the year before, when VHA processed 13,256,119 claims. As of January 15, 2016, Community Care claims inventory is 72.08 percent current, with a total claims volume at 1.8 million claims.

VA continues to experience tremendous growth in the volume of claims for care provided by community providers. VHA has received 22 percent more claims from October 2014 through September 2015 compared to the same period in the prior year. VHA staff makes every effort to ensure claims are processed timely. Our current standard is to have at least 85 percent of our claims inventory current, which means under 30 days old for “clean” claims and under 45 days old for “other than clean” claims. A “clean claim” is a claim that has no defect or impropriety, such as a coding error.

Future State

VA will pursue a claims solution and simplify processes as it evolves to achieve parity with best practices. Consistent with the principles in the New VCP plan, VA will focus on:

- Standardizing business rules and logic to support claims processing;
- Improving reimbursement processes by removing the requirement for providers to submit medical records as a condition of payment;
- Improving interfaces and coordination with dependent systems; and
- Implementing reimbursement models to recognize and promote Connected Health activities, such as outreach to Veterans for self-help, health promotion and secondary prevention, telehealth, team-based care, and Veteran education.

In the long term, VA will use a scalable, flexible claims platform that supports emerging value-based care models and streamlines data maintenance, storage, and retrieval. This new claims solution will support VA's efforts to reduce waste, fraud, and abuse. In addition, the VA claims solution will integrate with Veteran Eligibility Systems, Authorization Systems, and standardized fee schedules to support auto adjudication. Integration with fee schedules will support new payment models and enable better tracking and billing integration with other health insurance (OHI). VA will also integrate the claims processing system with patient information, increasing VA's ability to efficiently bill OHI. Taken together, the new claims solution will allow VA to pay on time and correctly while meeting Prompt Payment Act compliance. VA protects Veteran identifiable information in its IT systems via secure networks. VA will coordinate referral management with tracking financial obligations to provide the basis for resource and process adjustments based on forecasted versus actual use of funds.

VA will determine whether to improve the system through the adoption of a new one or by purchasing the required capabilities externally. VA will oversee adherence to business rules, standardize internal controls, and have proper access to systems holding information to be reviewed. Keeping in line with best practices, VA will conduct claims audits for accuracy. VA also will provide compliance oversight for the new Prompt Payment compliance process owner in accordance with VA Directives, Handbooks, and other applicable policies. To monitor and improve performance of billing and reimbursement, VA will use industry standards as metrics for continuous process improvement.

Conclusion

VA is continuing to examine how the existing Veterans Choice Program interacts with other VA health programs. In addition, VA is evaluating how it will adapt to a rapidly changing health care environment and how it will interact with other health providers and insurers in the future. As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in this plan into an executable, fiscally-sustainable future state. In addition, VA plans to review feedback and potentially incorporate recommendations from the Commission on Care and other stakeholders.

In the meantime, VA will implement improvements to the delivery of community care through an incremental approach as outlined in the plan, building on certain provisions of the existing Veterans Choice Program. The implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing health care costs. VA will work with Congress and the Administration to refine the approach described in this plan, with the goal of

improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs. These improvements, like many of the enhancements VA has already made, are only possible with Congressional support, including legislation and necessary funding.

VA strongly values its relationship with our community providers. We realize the vital role they play in assisting us in providing timely and high-quality care to Veterans. We are working hard to expedite payments and streamline our claims services in order to make this an effective and efficient process for all.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other Members of the Committee may have.

Prepared Statement of Roscoe G. Butler

The American Legion believes in a strong, robust veterans' healthcare system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances there are situations where the system cannot meet the health care needs of the veteran, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion believes the Department of Veterans Affairs (VA) must "develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account."¹

Chairman Benishek, Ranking Member Brownley and distinguished members of the Subcommittee on Health, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify regarding The American Legion's position on "Billing and Reimbursement for care in the community under VA's plan to consolidate non-VA care programs".

Background

The VA purchased care program dates back to 1945, when General Paul R. Hawley, Chief Medical Director, Veterans Administration, implemented VA's hometown program. General Hawley recognized that many hospital admissions of World War II veterans could be avoided by treating them before they needed hospitalization. As a result, General Hawley instituted a plan for "hometown" medical and dental care at government expense for veterans with service-connected ailments. Under the Hometown Program, eligible veterans could be treated in their community by a doctor or dentist of their choice.

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

Congress created the VCP after learning in 2014 that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

Therefore, Congress passed the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015 after VA sought the opportunity to consolidate its multiple care in the community authorities and programs. This legislation required VA to develop a plan to consolidate existing community care programs.

On October 30, 2015, VA delivered to Congress the department's Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan seeks to consolidate and streamline existing community care programs into an integrated care delivery sys-

¹ Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs

tem and enhance the way VA partners with other federal health care providers, academic affiliates and community providers. It promises to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care.

Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New VCP. We believe it has the potential to improve and expand veterans' access to health care. Much depends, however, on the department's success in working with its employees, Congress, VSOs, private providers, academic affiliates, and other stakeholders as the agency moves forward in developing and implementing the plan.

The American Legion commends VA Secretary Bob McDonald for his MyVA vision and leadership as he leads the largest and most complex integrated health system in America in a new direction, seeking to transform the department into a veteran-centric organization by transforming VA's culture, processes, and capabilities in order to meet the needs, expectations, and interests of veterans and their families.

Billing and Reimbursement Rates under the New Veterans Choice Program

VA's current community care programs still utilize labor-intensive business processes that are too reliant upon manual data input, prone to errors and processing delays. VA's New VCP billing and reimbursement process is outlined under sections 4.4 and 4.5 of VA's consolidation plan. As noted in the plan, the current system is a decentralized and highly manual process.² The New VCP plan proposes integrating most of VA's community care programs into one single program that would be seamless, transparent, and beneficial to enrolled veterans. The New VCP envisions a three-phased approach to implement these changes to support improved health care delivery for enrolled veterans.

The first phase will focus on the development of minimum viable systems and processes that can meet critical veteran needs without major changes to supporting technology or organizations. Phase II will consist of implementing interfaced systems and community care process changes. Finally, Phase III will include the deployment of integrated systems, maintenance and enhancement of the high-performing network, data-driven processes, and quality improvements.

To improve the accuracy of claims and reimbursement processing, the 2015 Independent Assessment Report recommended that VA employ industry standard automated solutions to bill claims for VA medical care (revenue) and pay claims for Non-VA Health Care (payment).³ VA states its New VCP will focus on operational efficiencies, to include standardized billing and reimbursement, as well as geographically adjusted fee schedules that are tied to Medicare, as deemed appropriate. These foci will make it easier and more appealing for community health care providers to partner with VA. The American Legion strongly believes VA must standardize its reimbursement rates, but not set the rates too low where providers in Alaska and Rural America would be discouraged from signing up as a participating provider in the new VCP.

Too often we receive telephone calls and emails from veterans requesting assistance with their non-VA care claim due to VA's slow payment process. For example, in November 2015 we received an inquiry from a veteran requesting assistance with payment of a medical bill that was authorized under the VCP. The veteran explained he was approved through the VCP to be treated by a non-VA health care provider for a hernia surgery to be performed outside the VA. After months of delays by the VA, the claim was referred to an attorney's office for collection. As a result, the veteran expressed disbelief and has lost faith in the VA system. This is just one example of the many veterans who have contacted our office in the past several months requesting assistance with VA's current inefficient Non-VA claims processing system.

The American Legion supports VA developing a 21st Century claims and reimbursement processing system that is rules-based, and to the extent possible, eliminates as much human intervention as possible. The system must eliminate the guess work out of the claims and reimbursement process and establish an error-free claims process that is responsive to veteran's needs.

Therefore, we are pleased to see that VA proposes to implement a claims solution which is able to auto-adjudicate a high percentage of claims, enabling VA to pay community health care providers promptly and correctly and to move to a standard-

²Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care - Oct 2015

³VA Independent Assessment - Sept.2015

ized regional fee schedule, to the extent practicable for consistency in reimbursement.

Additionally VA proposes to simplify eligibility criteria so veterans can easily determine their options for community care, streamline the referral and authorization process to enable more timely access to community care, and standardize business processes to minimize administrative burden for community providers and VA staff. Improvements in how VA processes claims will enable VA to reimburse community providers in a timely and efficient fashion.

The American Legion understands VA's New VCP is a huge undertaking and agrees the plan will take time to fully implement, particularly the IT component required to auto-adjudicate a high percentage of claims. However, we do not believe Congress should continue to provide VA an open check book without any assurance from VA that their IT plan will work. Congress must require VA to not only provide an IT plan, but provide some proof that the claim and reimbursement system will work. Too often Congress has authorized funding in support of process improvement initiatives like CoreFLS, and VA's scheduling system, to name a few, without any deliverables, resulting in wasted tax payer dollars that can never be recovered. In these situations, the ones who are impacted are our nation's veterans who are calling out to Congress to fix the system.

Prompt Payment Act

The Prompt Payment Act (PPA) enacted in 2000, was to ensure the federal government makes timely payments. Under the PPA, all bills are to be paid within 30 days after receipt and acceptance of material and/or services - or - after receipt of a proper invoice whichever is later. When payments are not timely, interest should be automatically paid. Due to a technicality explained below, which can be easily corrected, the VCP has continually failed to meet the requirements of the PPA.

During The American Legion's System Worth Saving (SWS) visits to VA medical centers, we often hear that when an invoice is submitted for payment, VA's third party administrators (TPA's) have been told to hold payment until the medical documentation to support the invoice is received. We also hear that when the medical documentation is received it is reviewed by the TPA and again by VA before payment is made.

An immediate remedy would be for VA to authorize payment for any Non-VA claim immediately upon receipt of a valid bill for health care services that a veteran receives. So, we are glad to hear from the VA Choice Community Care team that in the very near future VA will authorize the TPA's to begin paying any Non-VA health care claim under the VCP without first obtaining the veterans medical record from the Non-VA health care provider.

The American Legion applauds VA for initiating this action. This will prevent stories like the November 2015 Miami Herald article about Florida hospitals trying to get the Department of Veterans Affairs to pay about \$134.4 million in outstanding claims for medical services they provided to veterans.⁴ If it is determined VA overpaid for the care and services, cost recovery should occur after VA has verified the care and services provided to veterans receiving that health care. Of course, ensuring that records are ultimately returned to VA is very important and we look forward to hearing more about how VA plans to achieve this.

Conclusion

The VA's plans for the New Veterans Choice Program need approval from Congress. The American Legion believes that VA's plan is a reasonable one given the desired results. VA needs to overhaul its outside care reimbursement programs, consolidating them into a more efficient bureaucracy able to systemically and dynamically interact with the network of private providers that are to supplement VA direct provided care.

To do so, VA has identified a number of necessary legislative items that require action by Congress in the short legislative window available this year in order to best serve veterans going forward in 2016. Among these, for example, is the Purchased Health Care Streamlining and Modernization Act, which would allow VA to contract with providers on an individual basis in the community outside of Federal Acquisition Regulations, without forcing providers to meet excessive compliance burdens and while maintaining essential worker protections.

We recognize that the Federal Acquisition Regulations (FAR) are cumbersome, and it discourages a lot of smaller businesses from wanting to sell to the govern-

⁴ Florida Hospitals: VA owes \$134 million in unpaid claims: Miami Herald; November 17, 2015

ment, but we also recognize the protections FAR provides to the taxpayer. Therefore, The American Legion recommends passage of this legislation as a three year pilot program with an Inspector General evaluation mandate after the first year using the tenets of the FAR that are reasonable for the situation to ensure that the taxpayer's interests are protected.

We also support VA's efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the federal work period requirement, which is not consistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead their hospitals and health care networks.

In conclusion, The American Legion believes that together we can accomplish legislative changes to streamline Care in the Community programs before the end of this session of Congress. We can't let another year slip away. Our veterans deserve the same sense of urgency now that Congress has shown numerous times since the VA scandal first erupted in 2014.

The American Legion thanks this committee for their diligence and commitment to our nation's veterans as they struggle to access health care across the country. We look forward to working with Congress, the Commission on Care, the MyVA Advisory Committee, and the VA as we seek to reform America's health care for its veterans into a world-class system that puts veterans and their families at the center of their health care.

Questions concerning this testimony can be directed to Warren J. Goldstein, Assistant Director in The American Legion Legislative Division (202) 861-2700.

Prepared Statement of Carlos Fuentes

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, thank you for the opportunity to offer our thoughts on the Department of Veterans Affairs' (VA) plan to consolidate its community care programs.

The VFW strongly believes that veterans have earned and deserve timely access to high quality, comprehensive, and veteran-centered health care. That is why we have made a concerted effort to evaluate the state of the VA health care system through proactive outreach to veterans and have worked closely with VA, Congress, and other stakeholders to implement reasonable solutions to issues we have identified.

In an effort to evaluate the Choice Program, the VFW has collected direct feedback from more than 12,000 veterans through surveys and direct requests for assistance through our national helpline (1-800-VFW-1899) and our general inquires email (vfw@vfw.org). Through this work we have identified several concerns with the Choice Program, including participation, eligibility, availability, scheduling, information technology (IT) system, and improper billing issues. For more information on our work and to read our latest reports on the Choice Program and the VA health care system, please visit the VFW's VA Health Care Watch website at: www.vfw.org/VAWatch/. Given the focus of today's hearing, I will limit my remarks to IT and improper billing issues.

The VFW has heard from too many veterans that the community care provider they choose to use through the Choice Program has billed them for the cost of their care. While the VFW understands that some veterans are required to pay cost shares, it is unacceptable that any veteran is billed for care that VA is required to furnish. The most common billing complaint we have heard is when a veteran is authorized to use the Choice Program for a specific medical issue or treatment, but requires follow up care that is outside of the scope of the original authorization.

In these cases, the veteran's doctor is required to submit a request for additional services and the program's contractors (Health Net or TriWest) must work with VA to get the additional services authorized before the care can be delivered. This is where the program often fails veterans. At times the care is not authorized before a veteran arrives at his or her follow up appointment, so the veteran is required to either reschedule or assume liability for the care. In most cases, veterans reschedule the appointment and are forced to wait for the care they need because VA is unable to authorize it fast enough.

In some instances the veteran arrives at his or her follow up appointment and is unaware the care has not been authorized by VA. Given that private sector providers are not completely certain how the Choice Program works, many times they are also unaware that VA may not cover the cost of the appointment. This perfect

storm typically results in a veteran being held liable for the cost of the appointment despite being eligible for care through the Choice Program.

For example, a veteran in Saginaw, Michigan, was authorized to use the Choice Program as a 40-miler. He contacted the Choice call center and was referred to an ophthalmologist for a vision exam. His ophthalmologist prescribed him a treatment to save the vision in one of his eyes. Since the ophthalmologist was unable to administer the treatment, he referred the veteran to a nearby clinic where he received four courses of treatment before the clinic informed him that VA refused to pay his bill and that he would need to pay his outstanding balance before he could continue his treatment. After evaluating his case, we were able to determine that his ophthalmologist failed to submit a request for additional services. Since his treatment at the clinic was beyond the scope of the original authorization, Health Net was unable to retroactively authorize the veteran's care. The VFW is working to resolve this veteran's case, but we were able to have his treatments reinstated while we find a way to have his \$1,500 bill paid.

It is unacceptable that veterans are forced to wait for their care because VA is unable to authorize their care in a timely manner. It is also unconscionable that a veteran can be held liable for the cost of his or her appointment because of a process error the veteran has no ability to control. That is why the VFW urges Congress to authorize VA to make common sense exemptions to Choice payment requirements, which includes being able to retroactively authorize care when a process error occurs. VA must also empower its employees and the program's contractors to make such exemptions when it is in the best interest of a veteran's health.

The VFW also believes that it is time to move away from authorization based community care. In the Independent Budget's "A Framework for Veterans Health Care Reform," the VFW and our Independent Budget partners call for an integration of community care and VA care that would do away with the need for pre-authorizing every episode of care a veteran receives from community care providers. Currently, VA uses community care as a safety valve to alleviate the pressure on its health care facilities when VA care is not readily available. Instead, VA should leverage the capabilities of the providers in the local community, including private and public sector providers, to ensure veterans have timely access to high quality, comprehensive and veteran-centric health care options without the authorization barrier the currently exists. The VFW agrees with VA's plan to create high performing networks tailored to each health care market.

However, the VFW believes that network providers should be considered an extension of VA health care, regardless if it is a private or public sector provider. In doing so, VA would treat community providers as it does different clinics within a VA medical center. When a veteran is sent to an ophthalmology clinic for an eye exam, that ophthalmology clinic is authorized to carry out any needed treatment without having to seek authorization from the veteran's primary care provider. Similarly, a network provider must have the ability to provide the care a veteran needs without having to cut through bureaucratic red tape. It is also important that veterans have the ability to receive follow up care at a VA medical facility when clinically appropriate and convenient. Currently, a community care provider is unable to refer patients to a VA clinic for follow up care.

In speaking to private sector providers and Choice Program contractors, the VFW has learned that providers are sometimes responsible for delayed payments. The "Veterans Access, Accountability and Choice Act of 2014" made payment to Choice providers contingent on the return of medical documentation. This means that a provider will not get paid for the cost of an appointment if that provider does not transmit the accompanying medical documentation with the bill to the program's contractor. Private sector providers are not accustomed to having to report medical documentation before receiving payment. As a result, some of them will bill a veteran before sending VA or the program's contractors the requisite medical records. To address this issue, VA has proposed decoupling medical documentation from payment. This would enable VA to pay the cost of an appointment without receiving the requisite medical documentation for the appointment.

While the VFW understands the need to enable VA to quickly pay community care providers, we believe this can be achieved without decoupling medical documentation and payment. VA must do what is necessary to ensure the care veterans receive through community providers is equal to or higher quality than the care veterans receive at VA medical facilities. To do so, VA must integrate medical records from community care appointments into a veteran's VA electronic health record (EHR). However, VA must first receive the medical record from community providers. The VFW is concerned that decoupling medical records and payment would remove the incentive for community care providers to send medical records to VA. When medical records are not returned, VA is unable to evaluate the care veterans

received from community providers or verify whether the veteran received care at all.

For example, in an Office of Inspector General (OIG) inspection of access issues in the Urology Service at the Phoenix VA Health Care System, the OIG found that 759 urology consults sent to community care providers were “lost to follow-up” because the OIG was unable to locate any evidence in affected veterans’ EHRs to validate whether they had been seen by a community care provider. Missing information precluded the OIG from properly assessing the quality of care these patients received from community providers.

In speaking to Choice providers and the program’s contractors, the VFW has learned that the delay in reporting medical documentation is often due to the arduous reporting requirements VA places on Choice providers. Furthermore, the VFW has heard from providers that information VA requires them to report with medical records is not required by other programs, such as Medicare, and is not necessary to ensure quality of care. VA must ensure that the requirements it places on private sector providers are needed to ensure quality, not needless bureaucratic reporting requirements. That is why the VFW recommends that VA evaluate the reporting requirements placed on network and VA providers to identify and eliminate excess reporting requirements that are not necessary to ensure quality, including statutory reporting requirements that must be sunset.

The VFW also learned that many Choice providers receive and send medical information through fax. While the VFW understands the need to protect medical information, there is no reason why, in the 21st century, VA is relying on fax to transmit medical records. VA must develop IT solutions to facilitate a seamless integration of health records between its medical facilities and their private and public sector partners. Congress must ensure VA has the resources necessary to develop IT solutions for its community care programs.

When private sector providers do not have an EHR to integrate with the Veterans Information Systems and Technology Architecture (VistA), VA must authorize and train Choice providers to use VistA. This would serve to incentivize providers without an EHR to join VA’s Choice networks and would also ensure veterans receive fully integrated and coordinated health care within community care networks. Congress must also authorize VA to share its IT programs with network providers.

In evaluating the Choice Program, the VFW found that private sector providers are often reluctant to participate in the Choice network because of misconceptions about the Choice Program. The VFW believes this is due to a lack of outreach and training from VA and the program’s contractors. While VA and the Choice contractors have made a concerted effort to properly train their employees, they have not made the same effort to ensure community care providers are aware of program requirements and changes. For example, the VFW has heard from several private sector providers that they cannot participate in the Choice Program because VA pays below Medicare. This is not true - Choice providers are paid at the Medicare rate. In some instances VA is even authorized to pay above the Medicare rate. Moving forward, VA must conduct outreach to private sector providers to eliminate misconceptions and ensure private sector providers are made aware of how they can partner with VA.

As this Subcommittee continues to evaluate VA’s plan to consolidate its community care programs, the VFW will continue to ensure the voice, preference, and health care needs of veterans are prioritized and ensure VA health care reforms serve the best interest of our nation’s veterans.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Subcommittee members may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in Fiscal Year 2016, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.



Statements For The Record

The American Medical Association

The American Medical Association (AMA) appreciates the opportunity to submit this statement for the record in regards to the Committee on Veterans' Affairs Subcommittee on Health's hearing today on Choice Consolidation: Improving VA Community Care Billing and Reimbursement. The AMA is strongly committed to helping Congress and the Department of Veterans Affairs (VA) ensure the comprehensive delivery of, and timely access to, primary and specialty health care for our nation's veterans. The AMA was an early supporter of the Veterans Choice Program (VCP) and we support the VA's ongoing efforts to reform and improve the care delivery experience from the perspective of both the veteran patient and the physician.

We commend the VA for recognizing that the VCP has not been working as intended, and we support the VA's proposal to consolidate the VCP and all existing community care programs into one streamlined program. Consolidating the programs should create efficiencies and eliminate duplication and costs in administering the new VCP. We think that the poor response to the existing VCP has in part been due to confusion by veterans and physicians between the VCP and the other community care programs, such as the Patient-Centered Community Care (PC3) Program. In order to be effective, the VA's partnerships with private physicians in the community need to be streamlined and easy to navigate for veterans, physicians, and VA staff.

Specifically, we support the VA's proposal to streamline and automate billing and reimbursement processes. According to the VA, "The current VA claims infrastructure and claims process are complex and inefficient due to highly manual procedures, and VA lacks a centralized data repository to support auto adjudication" (U.S. Department of Veterans Affairs, Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care," October 30, 2015, at page 49). The VA has more than 70 centers processing claims across 30 different claims systems, and limited automation with paper-based processes that result in late and incorrect payments. Improving the VA's reimbursement processes would alleviate some of the complaints that physicians and other providers have had tied to the VCP, e.g., administrative hassles and delays in payment. Moving toward auto-adjudication and away from requiring medical records for reimbursement—a current VA requirement—should help to improve claims processing accuracy and predictability and allow claims to be paid promptly, thereby providing an incentive for physicians to join and remain in the provider network.

Under the VA's proposal, the VA intends to standardize provider reimbursement rates to align with regional Medicare rates under a single program and will remain the primary payer. While we appreciate that the VA is moving in the right direction in terms of basing payment to providers on Medicare rates, the AMA supports the Medicare rate as a floor, not a ceiling, especially in areas where there are significant needs for service and limited available specialists. We also appreciate that the VA acknowledges the importance of increasing the transparency of payment rates to providers and allowing regional variation, where needed, recognizing the expense of clinical practice outside of the VA facilities.

We are concerned, however, about the proposal for tiered networks in the New VCP. The VA indicates that they intend to provide veterans access to a tiered, "high-performing network," which will reward providers for delivering "high-quality care" while promoting veteran choice and access. The VA indicates that it will apply industry-leading health plan practices for the tiered network design and that providers in the Preferred tier, versus the Standard tier, must "demonstrate high-value care" in order to be considered in the Preferred tier and to receive higher payment. It is unclear, however, how "high-value care" will be determined or demonstrated. Given the numerous issues with access to care, especially specialty care, that have arisen with the narrow networks offered in the exchanges under the Affordable Care Act, we believe that the VA needs to proceed carefully in moving towards tiered networks. We are concerned that by tiering or narrowing the network, the New VCP will further exacerbate or create access problems. This is already occurring in certain states, tied to exchange plans and Medicare Advantage plans and their narrowed and tiered networks, with patients unable to find physicians in the top tiers in their areas or able to receive necessary specialized services because the tiering is specialty and not service or subspecialty specific. With many veterans requiring specialized services, such as mental and behavioral health care and orthopedics, which are already very limited in many places throughout the country, further tiering seems incompatible and actually in conflict with the direction of the New VCP program to provide greater and faster access to specialty care services in the

community. Narrowing or tiering will do little to demonstrate confidence in the program and could deter participation by physicians in the community. If the goal is to encourage participation and get more “high-value” or “high-quality” physicians to participate in the program, this tiering will likely have the opposite effect.

The AMA, on behalf of its physician and medical student members, is committed to helping ensure that our nation’s veterans receive comprehensive, timely, high-quality care. We look forward to working with the Subcommittee to advance proposals to improve the Veterans Care Program and the care delivery experience for our veterans.

