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MISSION CRITICAL: ASSESSING THE TECHNOLOGY TO SUPPORT COMMUNITY CARE

HEARING

BEFORE THE

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

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MISSION CRITICAL: ASSESSING THE TECHNOLOGY TO SUPPORT COMMUNITY CARE

Tuesday, April 2, 2019

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

The Committee met, pursuant to notice, at 2:03 p.m., in Room 2360, Rayburn House Office Building, Hon. Mark Takano [Chairman of the Committee] presiding.

Present: Representatives Brownley, Rice, Lamb, Levin, Rose, Brindisi, Cisneros, Lee, Underwood, Cunningham, Luria, Pappas, Allred, Peterson, Sablan, Roe, Bilirakis, Radewagen, Bost, Dunn, Bergman, Banks, Barr, Meuser, Watkins, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good afternoon. I call this hearing to order. Today, the House Committee on Veterans Affairs is gathered to assess the implementation status of the community care requirements under the MISSION Act, including the technology that will support the program.

The impetus for this hearing is a report prepared by the U.S. Digital Service at the request of Dr. Melissa Glynn of the Office of Enterprise Integration. Before we discuss the report, I want to establish a few items for the record. First, I had hoped that the U.S. Digital Service would be here today to discuss both, the work that it is doing at VA in general, and, specifically, its work on this report.

I want to be clear that I believe USDS is doing good work at VA and in other Federal agencies. USDS is filled with very talented individuals who have heard the call of public service and are tempting to help fix very challenging technology problems.

Although the administrator of USDS was invited, it appears that the Office of Management and Budget, OMB, had a role in Mr. Cutts, or his staff, not being here today. I have to say that I am disappointed in this result, and I urge OMB to reconsider whether its bureaucratic internal processes are actually serving the government and the taxpayer well. If Congress is prevented from conducting legitimate oversight because of unnecessary bureaucratic hurdles, then it is a real problem. I hope we will have an opportunity to hear from USDS at a future hearing and to learn more about the work the digital services team is doing at VA.

Second, I understand that there are sensitivities involved in USDS's role in advising agencies on technology. We want agency staff to speak freely to USDS and for USDS to be able to provide

unvarnished advice because we want agencies to succeed at their technology projects. We want agencies to have the room to fix known problems before it endangers an entire program.

The Committee understands that this report was not meant for the public, but it is now in the open. And as the Committee responsible for overseeing the implementation of one of the most significant pieces of veterans' legislation, we are compelled to ask questions about it. This is what brings us here today.

Third, I want to be clear that this is a fact- finding hearing. We have invited VA leadership here in order to exchange information and to have a robust discussion about that state of implementation. I want you to understand, Dr. Stone, Dr. Glynn, and Mr. Gfrerer, that I want to have an open and honest conversation, and if there are things that the Committee needs to know about, such as resources, implementation timelines, or the real state of the technology, this is the time to share that information. We want transparency. Veterans expect and deserve transparency.

And this is because when we talk about technology at VA, we are talking about more than technology. Information systems at VA support the very backbone of the mission of VA. These are systems that directly impact veterans' lives, their health, and their ability to access the benefits they have earned.

The MISSION Act is a big mandate and we need to get it right. If the technology experts say that VA should cease development on the Decision Support Tool and for VA to rethink its approach to implementation, we want to understand those recommendations and what VA is doing about them. If a veteran-centric vision is not guiding this implementation, then we need to figure out what needs to change. Our veterans deserve nothing less.

So, I want to thank the witnesses for being here today and I look forward to their testimony. And with that, I now recognize Dr. Roe for his opening statement.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman. I welcome the opportunity to be here this afternoon to discuss the implementation of our new MISSION Act Community Care Program. That program is intended to take place of many disparate Community Care programs that the Department of Veterans Affairs uses today and create a streamlined process for veteran patients to be referred to community providers.

The MISSION Act requires that the Community Care Program to begin on June 6th, just a little more than two short months from now. I know that Secretary Wilkie and his team are working hard to meet that deadline; however, United States Digital Service, USDS, issued a report last month that was highly critical of VA's implementation of the law to date and called into question, VA's ability to ensure timely access to care for veterans using authorities Congress provided under the MISSION Act.

Some of the media reports, especially the headlines about the report, were down right alarming. Unfortunately, alarming reports about the readiness of major VA modernization efforts are nothing new. We have seen VA stumble too many times because of inadequate IT solutions, poor communication, failure to properly train

clinical and sports staff, contract problems, and more. This Committee has done a deep-dive work into all of those areas in the past and I am sure that we will continue this moving forward.

But in the meantime, veterans are counting on us to deliver. You heard me say before, and I will say it again, that I believe in taking the time to get things right, not just get them in a hurry. I said it in December when I chaired the first oversight hearing regarding MISSION Act implementation, and I will say it again now: I would rather postpone—VA postpone implementation of this program than to rush to implementation in name only and have veterans pay the price for it.

I do not want to repeat the mistakes that were made with respect to the G.I. Bill last year. As such, I am taking the additional service findings seriously and I am focused on solutions. The way I see them, they fall into three general areas. First, there are concerns about Decision Support Tool, the eligibility-determination software underdeveloped to support the Community Care Program. Second, there are various critiques of this, strategic decisions VA made with regard to the Community Care network contracts. And, thirdly, there are continued alarms that VA needs to institute better interoperability capabilities with community providers right now.

I think the Digital Service recommendations are right on target with respect to interoperability and the need to use data standards in what are called "application program interfaces" or APIs to jump-start interoperability with community providers' electronic health records. Certainly, it will undoubtedly improve interoperability, but the nationwide rollout is 9 long years away and we are 60 days from getting started. We are working on legislation that would create a competitive interoperability strategy to make sure we resolve this problem as soon as possible. I look forward to discussing that bill in a future hearing.

As for other concerns detailed in the report, there is no doubt that the rollout of the new Community Care Program will bring with it, its own set of complications that VA will have to overcome. The same could be said of any new endeavor. Transformation is never easy, especially for an organization as large and complex as VA.

I want to hear today how VA is preparing clinical and support staff on the front lines for the rollout of this new program, how they are training them on the new processes, procedures, and systems, that they will need to work with and how VA will mitigate any setbacks that may occur to prevent disruptions to veteran care.

As to DST, my understanding is this new system is meant to create an automated system to replace a manual process that is been used for a number of years. If done well, the DST would make processing veterans' eligibility more efficient, but its failure or delay means continuation of the status quo, not the falling off of some sort of cliff. The Digital Service report raised the possibility of a worst-case scenario that the VA's daily appointment capacity nationwide could be reduced by 75,000 if DST usability issues are as severe as the report suggests.

I want to be sure that we leave this hearing today absolutely clear on what would have to happen for the worst- case scenario

to come to pass. My understanding is it would entail rushing DST into use after inadequate testing, that only doctors are permitted to use the DST, rather than nurses or medical-support personnel, and that VA employees try to use DST with web browsers other than Google Chrome, and that a glitch between those other web browsers and VA's EHR cannot be fixed. I wanted you all to know this is not an infomercial for Google, but it sounds like it would be a good idea for everybody at the VA to download Chrome.

Now that we have this report out in the open and we are discussing these issues, my sincere hope is that we can help VA work through them, rather than arguing about them later about what happened.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

Before I recognize—not recognize myself yet—Dr. Stone, you are recognized for 5 minutes.

STATEMENT OF RICHARD STONE

Dr. STONE. Good afternoon, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity to discuss the implementation of information technology systems that will support the new Veterans Community Care Program under the MISSION Act.

I am accompanied today by Dr. Melissa Glynn, assistant secretary for enterprise integration, and Mr. James Gfrerer, assistant secretary for information technology, and our chief information officer.

The MISSION Act is an unprecedented opportunity to increase veterans' empowerment over their own health care and to drive the entire health care industry on behalf of those that we serve. Under the MISSION Act, veterans and their families will be able to choose the balance of VA-coordinated care that is right for them.

Our job in VA is to ensure that the VA health care system is so exceptional that it earns the trust of America's veterans and they, therefore, choose VA. We know that veterans who are given the opportunity to choose their care from VA or from the community will typically choose to stay with the Veterans Health Administration. That is because research has shown that the VA provides care that is as good as or better than what veterans can receive in the community.

While we increase veterans' empowerment and choice with Community Care, we are continuing to invest in our direct care delivery system and will use tools provided under the MISSION Act to ensure that high-quality, direct VA care is readily accessible for veterans who choose it. VA's recent achievements in expanding access to care are supported by new authorities under the MISSION Act that focus on underserved facilities, recruitment, and retention of health care providers. We are, in fact, the only health care system in this industry to make information about quality and access to VA health care fully transparent to our patients and we will continue to increase that transparency.

While our vision is to ensure veterans choose VA for their care, we are committed to successfully implementing the expanded Community Care options under MISSION Act. VHA Community Care

has partnered with information technology staff to design technology improvements that will streamline the process of identifying which veterans are eligible for Community Care.

Because of the importance of the MISSION Act, VA has welcomed broad input on how best to implement these major programmatic changes. That is exactly why we asked U.S. Digital Services to review the development of the Decision Support Tool. Digital Services has offered VA in past initiatives. While I acknowledge the draft report, I reiterate that VA will be ready to offer veterans Community Care under the MISSION Act on June 6th.

Once it goes live, the Decision Support Tool will improve efficiency for VA providers, making referrals by helping to simplify decisions about Community Care eligibility. But the tool is not essential for implementing any of the new provisions of the MISSION Act. VA is planning to develop tests and deploy the Decision Support Tool by June 6th. In the event that any technical challenge occur, VA will be able to make eligibility decisions, using existing and enhanced methods and tools. Veteran care will not be disrupted.

VA's actions to modernize our systems and leverage the opportunities in the MISSION Act will place VA at the leading edge of health care evolution. We are committed to building both, the trust and health of our patients, and will continue to advance options that empower them to receive care when and where they need it.

Your continued support is essential to providing this care for veterans and their families. Mr. Chairman, this concludes my oral testimony. My colleagues and I are prepared to answer your questions.

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

The CHAIRMAN. Thank you, Dr. Stone.

Dr. Stone's full written testimony will be included in the hearing record.

Before I recognize myself for questions, without objection, I will enter the report from the U.S. Digital Services into the record.

The CHAIRMAN. I now recognize myself for 5 minutes. So, I wanted to begin with Dr. Glynn. Dr. Glynn, why did you request that the U.S. Digital Service conduct a discovery sprint of the VA's preparations to implement Section 101 of the MISSION Act?

Ms. GLYNN. Thank you for the opportunity to be here today. Well, I joined the VA coming from the private sector and it's a common leading practice when you have a milestone, a priority to enlist all of the expertise that we have at our disposal and certainly believe that our veterans, you know, the best value that we can bring to them is bring forward that level of expertise. Digital Service represented that level of expertise, especially around digital technology and pushing the envelope on technology. So, we sought an independent perspective on our implementation efforts and that was the impetus for the request.

The CHAIRMAN. Did you have any particular concerns about the implementation?

Ms. GLYNN. There were no particular concerns, just making sure that we were doing everything in our power to make sure that the

implementation would go smoothly, that we had thought of every kind of pitfall, and we had thought of how to mitigate the situation from an implementation standpoint.

The CHAIRMAN. Were there any other reviews or assessments conducted about preparations prior to the discovery spread?

Ms. GLYNN. No, there were not, sir.

The CHAIRMAN. This is really just your general standard practice when you come onboard and are trying to—

Ms. GLYNN. Yes, my responsibility is to make sure that we deliver, and this was the path we took.

The CHAIRMAN. Okay. Thank you for that.

We understand that the U.S. Digital Service held a discussion with VA after it prepared its report. Who from the VA was present for that discussion; do you recall that?

Ms. GLYNN. I know I was present. I'm trying to think of—I would have to go back and look at the attendee list. There were members of our working team, but there not broad representation from some leadership. I would have to go back and check our attendance to give you names.

The CHAIRMAN. Okay. If you would, I would appreciate that, if you could provide that to the staff.

As you know, we have been concerned about access standards, as currently contemplated. The criteria needed to develop the tool adds further complexities and exposes the ambiguity in the standards. The United States Digital Service requires a simpler, technical approach to attempt to avoid inconsistent and unfair results from this tool.

Do you agree with the USDS' recommendation?

Ms. GLYNN. I believe I understood the recommendation that in order to make sure that there was consistency that we would have to put policies in place to support the fielding of the tool and I believe that we can deliver that level of consistency with the policies that are drafted currently.

The CHAIRMAN. All right. So, what is VA doing to establish clear standards—I mean, you just mentioned the policies in place—

Ms. GLYNN. Yes.

The CHAIRMAN [continued].—and veteran-centric guidelines to address the discrepancies due to data variation?

Ms. GLYNN. So, we're working internally to make sure, I think as Dr. Roe and yourself had mentioned, it is critical that we are ready for June 6th, so we are working internally on implementation planning and the rollout process, which includes training, policies, all of those tools that will make sure that there is consistency for the veteran working on communications that are directed specifically for the veterans and their family and support teams to make sure that there is understanding of how we can implement these access standards.

The CHAIRMAN. Yeah, you know, as I was reading through the U.S. Digital Service report, I am trying to remember some of the particular—I mean, some of the particulars of just how—some of the examples that they gave for how the tool could be inconsistent. Of course, what we are concerned about is veterans thinking that they should qualify and veterans not qualifying, people comparing notes and finding out that they are not qualified to go into the com-

munity and that this tool was potentially a source of a lot of inconsistency.

But do you feel that you can get these policies in place in time for—

Ms. GLYNN. I personally feel, and my colleagues will certainly join in and provide their perspective from technology and from the leadership from the Health Administration, but overall, I feel that the tool will actually help us drive consistency and certainly drive more consistency. It is the sort of front-facing dashboard, which will help everybody have the same kind of perspective and see the same kinds of information every time they have that opportunity to look at whether they are going to receive care in the community or not.

The CHAIRMAN. That is great. My time is up.

I want to now recognize Dr. Roe for 5 minutes.

Mr. ROE. Thank you. I was sitting down for dinner last night about 8:30 and my phone rings and it is a veteran who had been in the hospital at our local hospital, which is about a quarter mile from the VA medical center. So, he calls me up to get his record transferred from—he can't get the record transferred between his 7 days he had spent in the hospital, so that when he sees his doctor over at the VA. We are having that problem now 2 months from—so, how are we going to make sure that there is a seamless flow of information—anybody can take this—between the outside providers?

Because if this doesn't work, then the whole system won't work. It will defeat what we are trying to do if we can't do that one simple thing, is get that information from me on the outside, back to the VA and vice-versa. That happened last night.

Dr. STONE. So, certainly this is exactly the problem that we have dealt with for decades across medicine and one of the things that we are doing—and one of—there are 11 separate information systems that we are implementing as part of the MISSION Act. Some are out there already. Some are in further development, but the ability to move medical records right now is dependent upon the participation of various community providers in our health information exchange.

One support we could get from the Committee, we would hope, is that good discussion with the community providers about participating in our health information exchanges so we are not forced to either fax or hand-carry records back to the VA from community referrals.

Mr. ROE. And this is for you, Dr. Stone, you said this, but I want to make sure that we get it on record. How confident are you that the VA is on track to enact the MISSION Act Community Care Program on June 6th, as required by law? And the second part of that question is: You mentioned something in your testimony, if it didn't work by the—if the digital system, new system didn't work, that existing and enhanced tools could be used. What does that mean?

Dr. STONE. So, let me answer the second half of that first, sir. We fielded last October, a provider-listing software system. That provider-listing software system included 30- and 60-minute drive time calculations. That is been in use since last October.

Now, since at least 2013, under the PC3 Program and then under the Choice Program in 2014, our providers and our provider care teams have been working hard to adjudicate 40- mile distances for veterans, as well as wait times of 30 days.

What you have asked us to do under the MISSION Act is to take some different access standards in order to adjudicate whether the patient is eligible to go out. That work is going on every day today.

What the Decision Support Tool does is automate it. So, if I am seeing you as a patient and make a decision to send you out for orthopedic care, that when I make that decision in VistA or CPRS, our current electronic system, a pop-up comes up that I need to use the Decision Support Tool. When I click on that, the whole thing pops up and gives me all the information I need on a single screen.

But if that fails or that system is just not at the point that it should be, all of the software systems that are necessary to support the referral of you to a patient—or to an outside provider are in place.

Mr. ROE. Okay. And you feel comfortable that you will be ready to go?

Dr. STONE. I do, sir.

Mr. ROE. And how will the experience of a veteran patient who is seeking Community Care referral and VA employees, who will be authorized Community Care referrals differ on June the 5th before the MISSION Act Community Care Program is implemented and on June 7th after the MISSION Act Community Care Program is—what difference will they notice, if any?

Dr. STONE. The mainstay of VA health care is the patient-aligned care team, and what I mean by that is the physician, the nurse, the assistance, the schedulers that all work with that provider and that veteran in order to provide care. On June 6th, just like on June 5th, the veteran will be interacting with their care team in order to make decisions ongoing forward.

So, although, I would not underestimate the fact that there are multiple criteria that are included in the Act—and this is complex work—for the veteran, it is not going to look terribly different in their approach to getting care.

Mr. ROE. So, that pop-up screen is going to be the same then? They won't notice a difference.

Dr. STONE. I think—with your permission, sir?

The CHAIRMAN. You may.

Dr. STONE. For you and I, as clinicians, we have spent our whole career with people calling us up saying, what do I do? All of us, when we get symptoms, and especially lay personnel, when we have symptoms, you don't want people out just Googling those symptoms and figuring they have got some sort of awful thing and end up in the emergency room.

What you really want is them interacting with their provider and making decisions together. We are not going to abandon the American veteran on June 6th; they are still going to be interacting with their care team, making decisions on what is best for them.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Pappas, you are recognized for 5 minutes.

Mr. PAPPAS. Thank you, Mr. Chairman.

I appreciate your comments. And, you know, my concern is with the end user here and the veteran and their teams. I am just wondering on Page 5 of the report, the quote is, "Little research has been done in the field to understand how veterans' physicians and clinical staff are currently providing and receiving care in the community through the VA before a new process is established."

And I am just wondering if you could talk a little bit more about the field research that was done as part of the IT rollout.

Dr. STONE. Yes, I can, and I appreciate that question. As you are well aware, sir, we have been buying care since 1945. We have been through 6 major transitions in care. I talked earlier about the 2013 change in PC3 and the 2014 Choice Act and now the MISSION Act. But, literally, since 1945, we have been buying care in the community.

On any given day, we decide to buy care about 50,000 times and we will see about 323,000 patients today. About 50,000 additional patients will go out to the community.

The Decision Support Tool was designed by our clinicians in the field, and, literally, a field clinician designed this and said, you know, what do I need today and what would be nice if I had that all in a pop-up screen? And there are 6 major information systems that connect to the Decision Support Tool that provide a single screen.

And I have had an opportunity to see the prototype of it; it is pretty impressive. I sat with other clinicians from the field looking at it, and so the research, although, I would guess I would refer to it as anecdotal because we drew in people, it was all from actively practicing clinicians.

Mr. PAPPAS. And, you know, if there are delays in further development or deployment of the new IT systems, I guess, do you have contingency plans of how to stay on track and do you potentially anticipate any further funds-transfer requests to make sure things hit their mark and they are on schedule?

Dr. STONE. I think that the contingency plan is the fielding of the other 10 software systems with the Decision Support Tool as sort of being the icing on top that brings everything together. Should the Decision Support Tool not be effective or hit a technology glitch, then we will be working just about the same way we are working today as we go through.

We do not anticipate large movement of patients into the system. I don't think the MISSION Act is going to force somebody that trusts their doctor to leave their doctor and come to the VA. By the same token, I don't see patients that trust their doctor in the VA leaving in large numbers to go out someplace else. Now, there may be transactions of care, and we monitor this, as I have said, on a daily basis.

The second question you asked is about funds transfer. As you all are well aware, the MISSION Act was passed without appropriation as we looked at the one-year implementation, as we have moved our way through the requirements, as well as then getting the feedback from the comment period on those requirements for access, and as we then began to design these systems and move forward. That is a lot of work to do in 12 months.

When we found ourselves without appropriation, IT leadership came to me and said, Gee, we need some help. Now, IT has committed funds to this, but we are able, because of the generosity of all of you and how you funded us over the last few years, that we do have the funds in order to support this until appropriate appropriation occurs.

And, Jim, I don't know if you have additional comments?

Mr. GFRERER. I guess from a technical perspective, the only thing I would offer additionally is I think there is a lack of understanding broadly around what the tool does. It is actually pretty simple. It goes out. It looks at the master veteran index. It then establishes some level of eligibility. It looks at the provider database and it makes a determination around drive and wait-time eligibility.

The other, I think, misconception is the tool does have the opportunity to what is called in software "fail elegantly"; in other words, if any one of those steps, if there is an interruption in the data query from the system, it can come back with a null and continue on with the process. So, it is not an all-or-nothing proposition.

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

The CHAIRMAN. I now recognize Mr. Banks for 5 minutes.

Mr. BANKS. Thank you, Mr. Chairman.

Once again, as I have said before, we really may be whistling be past the graveyard with the access standards debate. I understand that there is a lot of pent-up political energy anticipating the release of the standards, but they don't appear to be radically different than the existing standards.

My concern is that the MISSION Act actually fixes Community Care, that the situation actually improves. That we don't just wind up with different programs with different names with the same old problems. Claims processing has been far and away, the worst problem.

Dr. Stone, the Digital Service recommends scrapping the new Community Care network contracts. VA has a new claims system called eCAMS used to pay the network administrators, but it is my understanding that VA is expecting these contractors to provide the new claims system that is actually used to pay the providers' claims.

Is getting rid of the contracts realistic and what would it mean to claims processing?

Dr. STONE. I don't find, sir, that getting rid of contracts is realistic. I think we are going to need a third-party administrator.

Let me talk a little bit about the standup of the Choice system and, certainly, across the Nation we ran into very substantial problems paying our bills, as well as the fact that we needed to change out one of our third-party administrators partway through that. We have done two things. Number one, we have gone to a nationwide safety net under a third-party administrator while we get our additional contracts out for Community Care. Secondly, we have moved from processing from about 140,000 claims a month to 1.7 million claims in the month of March in paid claims. So, we have dramatically increased the amount of claims that we are paying.

We will still need a third-party payor. We have two systems coming online. One is eCAMS, which you talked about, which our non-

network providers will be paid from. The second something called the Community Care Reimbursement System, CCRS, which will literally pay our third-party administrators and monitor their work. Those two systems are—the first, eCAMS is in production in VISN 19 and will expand in the next few weeks over the entire system. It is operating very well. The second, the Community Care Reimbursement System is a new system that will be completed in the month of May.

Mr. BANKS. Okay. Let me move on.

Dr. Stone and Mr. Gfrerer, it is very important to me that the claims-processing system improves. I never want to hear from another veteran being hounded by a bill collector because the VA or its contractors failed to pay a provider. VA is asking the new network contractor to walk in the door with a claims system that meets all of VA's requirements, meaning it can handle all the EDI transactions that VA uses.

First of all, can anyone tell me what claims system the company, I believe it is call Optum, uses? Dr. Stone? Mr. Gfrerer?

Dr. STONE. I certainly cannot tell you, except that I have had—I do a monthly meeting with Optum talking about problems and this is—

Mr. BANKS. If you don't know, maybe you can take that for the record and get back with us?

Dr. STONE. I would be happy to do that for you.

Mr. BANKS. Okay. So, Dr. Stone and Mr. Gfrerer, VA also set out 14 requirements for how the contractor system will adjudicate claims. Does the system already do those things, or would the company need to modify it to meet VA's requirements?

Dr. STONE. We will take that for the record, also.

Mr. BANKS. Okay. Mr. Chairman, Dr. Roe, I think that we should keep an eye on both of these issues—they are very important—I know it is a big lift.

And Dr. Stone, just as a follow-up to that, the VA also has to provide a company with the correct fee schedules for every type of claim. As you know, VA personnel have had a hard time picking the right fee schedules to pay their own claims. Has this problem finally been solved, and if so, how did you solve it?

Dr. STONE. I believe it has been solved because it was part of the contractual bid of the winning bidder that proposed a fee schedule as part of it.

Mr. BANKS. As simple as that?

Dr. STONE. Yes, sir.

Mr. BANKS. Okay. With that, I yield back.

The CHAIRMAN. I now call on Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Thank you all for being here and, you know, we, obviously—this piece of it for implementation of the MISSION Act is critically important and it was certainly concerning to all of us here on the dais to read this USDS report. And just, you know, in the executive summary it says really right up front, it says, "To stop the development on DST as it is currently implemented." And it goes on to talk about the interoperability with the 6 legacy systems and then goes on to say, you know, "adding this eligibility work to the already time-constrained physician in a worst case could increase

each appointment by an estimated 5 to 10 minutes forcing physicians to see approximately 3 fewer veterans each day and ultimately decreasing the VA's nationwide capacity by approximately 75,000 appointments daily."

That is a concern for me. When I read that I think—and, particularly, we have an oversight responsibility to say we should stop right here and now until we can get some assurances and not just trust, but real honest-to-God assurances that we are moving ahead, understanding some of these recommendations that are coming out from this report and moving down a path of success.

And so, I guess my question, Dr. Stone, you had said that this was all designed, but with the input of practicing physicians, but then the report gives some quotes from various physicians and one of them says, These people are out of their minds; they aren't housekeepers, door keepers, or garage men, saying, you know, really, you are going to ask me to do all of this, you know, sort of enforcement, who is eligible, who is not eligible.

So, it raises my concerns. We don't have a great reputation when it comes to IT within the VA, and so I guess my question is, you know, how are you going to give us assurances that you are traveling down the right road and at the same time, able to meet these deadlines? It seems to me that if you have a way of interacting, if you don't meet the June 6th deadline, you have said that you have a way of addressing that, that you will do it the way that you are doing it now and interacting with a physician team and making, you know, good, solid clinical decisions down the road. But if we don't meet that deadline, we can do that, so I understand that there is a backup here, but should we just be doing that now and taking a deep breath, doing it as we are doing it and taking a deep breath and making sure that we are doing this properly to ensure that we are going down a road to success? It is a long-winded question, I understand, but—

Dr. STONE. Congresswoman, it is exactly the question. This is complex work that you have asked us to do and I wouldn't underestimate it in any way. There is a lot of new requirements. There are a lot of new pieces to it, and in essence, every single veteran that we are seeing needs to have adjudicated, are they eligible to go out.

And so, I would say, are we concerned? Yes. Do I think that the Decision Support Tool will make life easier when it comes into fruition? Yes.

That said, the Choice Act expires on the 6th. I have no ability to buy care if we don't go forward. We must go forward with the MISSION Act on June 6th. And that said, I think your expectation of me is to be transparent, especially when I am concerned.

What I have to say to you is that I am very, very pleased that the team has been working closely with IT. That we have gotten a third party to take a look at us, that has given us a really hard look, hence we are sitting here, but—

Ms. BROWNLEY. And I applaud you for doing that, too.

Dr. STONE [continued].—most importantly, it was a chance to take a good hard look at ourselves. And so, are we concerned about the complexity of work? Absolutely, but I am optimistic that we are going to get this done.

Now, that optimism is not a blind optimism. It is an optimism by the fact that we have gotten our provider- automated system out into the field last October and our providers and our care teams that I referred to earlier are using it today and they could call up the 30- and 60-minute drive time today.

Ms. BROWNLEY. Well, I thank you for that, and I appreciate your confidence, and, you know, I hope that we can interact more frequently as we move forward in the next couple of months. I apologize that I am over my time, but I hope that we can, you know, communicate closely over the next few months to keep us informed of the progress.

So, sorry, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Ms. Brownley.

Who is next? Ms. Radewagen, you are recognized for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairman Takano and Ranking Member Dr. Roe for holding this hearing.

I want to thank the panel for being here. I also want to welcome my constituent, Ms. Lisa Tuato'o, who is all the way in from American Samoa on Homeland Security business.

I appreciate everyone's work here to ensure that the MISSION Act implementation is going smoothly. And as I have mentioned in previous hearings, I also appreciate that the VA is really making an effort to meet the unique needs of those in rural areas, as well as the U.S. territories through the Community Care contracts.

So, my question is for anyone on the panel who can answer: What is the status of the Community Care network contracts and what are you doing to ensure that the transition from the PC3 Choice contracts to the CCM contracts will be as seamless as possible for veterans, community providers, and VA staff? And, also, what do you any are the major differences between the current PC3 Choice contract and the CCM contract that members should be aware of?

Dr. STONE. So, the status of the contracts are as follows: Region 1 in the northeast part of the United States is in the process of implementation with Optum, as you heard previously. The major difference in that contract is a stable payment levels tied to Medicare, and so I think that is the major change, as well as probably about 140 other data points that we have locked through with the vendor as we have gone forward in improvements and how we interact with each other, and we would be happy to lay those out for you in separate session.

Region 2 and 3 are under protest. They were awarded and then protested. We anticipate in the month of May, they will come out of protest, and, certainly, I would not suppose what the effect is of the protests, but we are hopeful.

Region 4 will award in the next few months. Those bids are back in. That is the western half of the United States. Those bids are all in and being evaluated, and I probably should say nothing more about that at this point.

Region 5, Alaska, we just finished tribal consultations and will implement the further either RFIs or RFP over the next year.

And then Region 6 will also—we have consultations, an industry day actually tomorrow in Region 6 that we will begin to look at

what the questions of the provider community are in providing care in the Pacific.

Ms. RADEWAGEN. Thank you. USDS alleges that the additional administrative burden of continuing to pursue the new contract arrangements outweigh their benefit. Do you agree? Why or why not?

Dr. STONE. So, I do not agree, and as a matter of fact, they refer in their report to maybe we should use Medicare. Please remember that Medicare uses third-party administrators. Medicare does not deliver care directly.

I spent most of my career in the upper Midwest. I dealt with Blue Cross of Illinois as the Medicare adjudicator of payment of claims. So, I think that criticism reflect a failure to understand Medicare and how it reports. And I am not being pejorative in any way towards U.S. Digital Services, but that concept just didn't bear fruit.

I think the second thing they suggested is maybe we have to use TRICARE. And please remember that I spent 25 years in uniform, so I know a little bit about TRICARE and certainly have been a consumer of TRICARE services over my family's time and service and even today.

The problem with the regional delivery systems with TRICARE is they are centered in areas of the country that just are not broad enough in order for us to take care of the dispersed veterans as we look in the Pacific, as we look in Alaska, and in the rural areas of this country. Forty-five percent of our veterans are out in rural areas, well away from TRICARE delivery networks.

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

The CHAIRMAN. Thank you, Ms. Radewagen.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman.

Dr. Stone, if we could just step back for a second, the MISSION Act and Choice before that were all done before I arrived in Congress, but my understanding of them is that the expansion of Community Care was motivated by what is good for our veterans, right?

Dr. STONE. Absolutely. I think all of the work going back to 1945, has been what is good for veterans.

Mr. LAMB. And we have kind of reached a shared understanding at this point that one thing that might be good for them would be to give them more choice in where they could get providers; again, for their own sake, not for anybody else's sake, but so that they could feel like they had some choices for things that were closer to home, for simple conditions, they wouldn't have to go all the way to the VA; that was the idea, right, to do something nice for veterans?

Dr. STONE. Sir, I would not suppose to think or to suppose what Congress thought as they passed it, but as I read it, I think this is law that is good for veterans.

Mr. LAMB. I agree. I guess my point is just we didn't do this to make things easier on the VA or to give Congress something good to talk about. We did it because veterans wanted it and we thought it might be a better way to get them health care; would you agree with that?

Dr. STONE. Yes.

Mr. LAMB. Now, does this Decision Support Tool that we are talking about here, does it allow veterans, themselves, to use it?

Dr. STONE. It does not.

Mr. LAMB. Okay.

Dr. STONE. It is a provider-facing, patient-aligned care team facing tool.

Mr. LAMB. So, it does not provide a tool for the veterans, themselves, before they go in to the VA to determine if they are eligible for Community Care?

Dr. STONE. It does not, although, that is something that Digital Services suggested, and we are respectful of that.

Now, the complexity of delivering care to America's veterans has to reflect how complex their disease processes are. This is not about giving them a Google site to go to and then make decisions. Those decisions are best made in conjunction with their provider care team.

Mr. LAMB. And I appreciate that, and that is a mission that we have given you and that you are trying to execute, so I totally understand that.

But as a result of the way that this Decision Support Tool was developed, the discussion and decision is going to have to take place during the appointments, right?

Dr. STONE. No, not at all. Certainly, the patient can call for their care team as they do today. They can call for an appointment and say, Gee, am I eligible to go out? And all of this can be done with the patient-aligned care team scheduler or the nurse. Usually, we do involve either the nurse or the physician in that discussion just because of the complexity.

I referred earlier to, gee, if I want to refer you to out for an orthopedic visit, well, if you are on a blood thinner, just me referring you out to an orthopedic surgeon will create a disconnect in care and potential risk if you are not talking to your care team.

Mr. LAMB. Right. Absolutely.

So, do you accept the finding or suggestion of this report that this will probably result in fewer appointments a day systemwide because of the additional time that it is going to take from the care teams?

Dr. STONE. I do not.

Mr. LAMB. Okay. And that is a fair disagreement.

I am trying to think of how I want to ask this. Given what we have happening right now is the risks presented in this report, one of which, for example, is that—I guess I want to back up. The report suggested that several primary care providers told the authors of this report that veterans often are not presented directly with a choice for a veteran's care if they don't ask about it from their care team or don't ask about it with the providers. Have you heard that before, as well?

Dr. STONE. Just in the report.

Mr. LAMB. Okay. Do you accept that as a possibility? I mean, that has, obviously, been said to these authors.

Dr. STONE. Certainly, I would expect all of our providers to act in an ethical and honest manner with their patients. I think that is how you earn future trust.

Mr. LAMB. Sure.

Dr. STONE. And I would expect everyone to discuss exactly what is in the best interests of the veteran.

Mr. LAMB. Okay.

Dr. STONE. And that is actually in the law as part of the statute, that if it is in the best interests of the veteran, even if they don't qualify to be referred out because of wait times or drive times, that if it is it in their best interests, they should be referred out.

Mr. LAMB. Sure. And that part I understand. I guess it is just coming back to my point that what we are supposed to be doing here is presenting our veterans with an actual choice that they get to make, obviously, in conjunction with their care team. But we have created a tool that they are not able to use. They have to know to ask about it in some cases from their care team. They may have to call. They may have to do it in an appointment, which slows it down. They may reduce the number of appointments systemwide, and that seems, to me, to not accomplish the mission of giving them more actual choices.

Given all of that I just—and I am out of time—I just urge you to consider slowing down on this and doing a less- complex version of it on June 7th. I understand that you are under the gun timewise, but this seems rushed in a way that does not reinforce the actual choices that our veterans get to make.

And, Mr. Chairman, I yield back. I apologize for going over.

The CHAIRMAN. All right. I thank the gentleman.

I would like to move on to asking Mr. Barr, you are recognized for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman.

Dr. Stone, good afternoon. How are you? That is okay. Dr. Stone, last year my office assisted a veteran from our district who, after receiving two hip replacements from the same Choice-approved doctor through TriWest, was told at the desk of the doctor's office when he showed up for an appointment that he was no longer eligible to see that doctor under the Choice Program. After looking into my constituent's case, it was found that due to a VA system glitch, my constituent's distance eligibility was erroneously terminated under no fault of his own.

How is the VA going to ensure that veterans are not going to be arbitrarily kicked off of the eligibility rolls for the Community Care Program, particularly, with the issues being highlighted by the rollout of the Decision Support Tool?

Dr. STONE. So, I think this is exactly what I was talking about in the Provider Profile Management System that we rolled out 6 months ago, and have begun to look at that getting ready for June 6th. That is a generally used tool across at least 13 states and 20 health care systems in that 30- and 60-minute time.

We have got really good data that we currently have on our wait times on the 20- and 28-day wait time that the secretary has ordered as part of the access standards and the eligibility to go out. What we don't good data yet is the wait time in the community; it is just not as transparent as we are in VA.

Now, in the Decision Support Tool, when we looked at the prototype, it pops up our wait time, as well as any information on the distance from the home address for the veteran in the 30- and 60-

minute software system, as well as any information eventually when we accumulate it on wait times in the community. So, in essence, that provider team scheduler will need to make a phone call with you, the veteran, in front of them, to find out what—how long it is going to be before we can get you in before you leave the office.

Mr. BARR. And this DST is an automated system, and I think my veterans would want to know the role of human beings in checking the system. And so the next question I have is, you know, what role will VA personnel play in reviewing the accuracy of these determinations and then also when there is a change in a veteran's Community Care eligibility?

Dr. STONE. So, I think we are comfortable with the work and transparency that we have been doing for a number of years on wait time—how many days' wait there is inside of our system and the accuracy of that data. It appears that the 30- and 60-minute tool is going to be solid just because it has been used for many years in the commercial space.

But your question really relates to how are we going to manually override that and check it?

Mr. BARR. Well, so, in other words, if the veteran is pretty confident that he or she would meet the criteria and for whatever reason the digital tool, the Decision Support Tool, rather, makes an alternative, a different determination, you know, how can there be an appeal? How quickly can the veteran question that automated determination?

Dr. STONE. So, that automated determination is also going to be overseen by your provider care team, and your provider care team then will decide if it is in your best interests. And if you are convinced that because of some other health problem or transportation problem, you ought to be someplace else for your care, then the beauty of this law is it says, if in the best interests of the veteran, that can all be overridden right at the point of care, at the point of scheduling.

Mr. BARR. As you know, one of the flaws, with respect to the implementation of the Choice Program was a failure to properly communicate with trained VA staff regarding expectations, processes, procedures, et cetera. What is the status of that work for the MISSION Act Community Care Program, and can you ensure that the VA staff on the front lines will be ready, willing, and able to effectively administer care under this new program on June 6th, again, speaking to the issue of, you know, human beings ultimately being accountable, Dr. Stone?

Dr. STONE. So, we have automated all of this training and both, web-based training and e-training. We have got at least two dozen training modules out even for our community providers and Web sites and I would be happy to go through that training with you. But this has all been done through automated training that does not require the provider to go to anyplace.

Mr. BARR. Thank you. I yield back.

The CHAIRMAN. I knew call on Ms. Lee for 5 minutes.

Ms. LEE. And I am down here. Thank you all for coming out. And, clearly, this is an incredibly complicated task with, you know, very far-reaching and potentially grave consequences if we don't get it right.

And, Dr. Stone, I wanted to ask you, you made a comment earlier, you know, this, obviously, is dictated by the MISSION Act. There is a June 6th deadline. And I wanted to ask you, like, waving a magic wand, if we did not have this June 6th deadline, what would you be doing differently?

Dr. STONE. I think the ability to move—first of all, the ability for me to buy care in the community expires on June 6th. What I would be doing differently is trying to figure out how to go back to a system that preceded 2013 that didn't work very effectively.

I think all three pieces of legislation could have been implemented slightly differently, but it is good legislation, and I think it brings us from 6 or 7 different ways of buying care to 1. That is good for the veteran. The veteran will now be able to understand from a single methodology how decisions are made, instead trying to figure out which program they are eligible for.

I wanted to ask, you know, the MISSION—and I am sorry if this was asked earlier, but the MISSION Act emphasizes the need for efficiency, potential consolidation for the provider network. The USDS recommended that the VA discontinue its efforts to create its own payer network and explore—perhaps explore partnering with another existing network. What is the response to this—the VA's response to that recommendation?

Dr. STONE. Congresswoman, we did go over that previously. Let me say to you that the two recommended systems that they suggested were Medicare, one. Medicare does not run its own delivery system. That is done through fiscal intermediaries out in the commercial space. The second is TRICARE. And the problem with TRICARE is it is just not broad enough because of the rural nature of many veterans. Forty-five percent of veterans are in rural space.

Ms. LEE. Are you exploring any other opportunities?

Dr. STONE. Certainly. We are exploring a number of other opportunities. Number one, we have given priority to our third-party administrators to the federally disadvantaged clinic system. We have over 900 providers that are in the federally disadvantaged clinic system that participate with us. In fact, we will buy this year almost three quarters of a billion dollars' worth of care through those Federal clinics.

Secondly, we continue to work in innovative methods with the Department of Defense, as well as Indian Health Service, in order to buy services through them as preferential partners.

Ms. LEE. And finally, the USDS also recommended using resources to have like a concierge approach to managing care, essentially closing the loop with the veteran-centric approach. What is your response to that recommendation?

Dr. STONE. I think that is exactly what we are trying to move to. I think by—if you were seeing me as your provider, you would get me involved in a concierge approach of what is best for you, what are the nuances and difficulties of care.

Because of the extraordinary amount of pain we deal with across the veteran population in chronic pain, degenerative diseases of the spine, hips, and knee, it requires a concierge approach to every one of our veterans. And I think this goes back to Congressman Lamb's question of what you want is a veteran-centric approach to this care.

Ms. LEE. Thank you. I yield.

The CHAIRMAN. Dr. Dunn, I recognize you for five minutes.

Mr. DUNN. Thank you very much, Chairman Takano. Dr. Stone, it is good to see you again. I want to describe my district briefly to you, so you understand my situation. I have 19 largely rural counties, a couple of CBOCs, one VA hospital. The vast majority of my veterans—there are 70,000 veterans living in my district—the vast majority of them per force meet all of the choice requirements. I mean, you just know they aren't within an hour's drive of specialty care. So and it is the specialty care, specifically, I would like to address.

We saw—we never turned away a veteran in my offices, but I will say that our accounts receivable with the VA habitually were in the 180 day plus range. There are a lot of physicians who will not tolerate, that can't tolerate that really in their offices. And so the reimbursements become the problem. And the choice of provider goes away if there is no reimbursing the other specialty providers there in the district.

And so what I would like to know is what are we going to do to make sure that this problem ends, so that we don't have the problems with the veterans going out, seeking care, and there is no reimbursement?

Dr. STONE. Congressman, first of all, your district is one of the most rapidly growing areas we have in the country when it comes to veterans. Veterans are seeking that area of the country and—

Mr. DUNN. We are nice to our veterans. We like them down there.

Dr. STONE. Thank you, sir. Secondly, the primary corporate structure of the physicians providing care to veterans in your district and many areas of the country is small businesses. They cannot carry 180-day accounts receivable. So for that reason, community care has been working hard to increase the number of claims that they are processing on a monthly basis. And I monitor that on a weekly basis of where they are at.

And I am pleased that we have moved, and I have said earlier from 140,000 claims a month to over 1.7 million. We will approach 2 million claims processing a month and begin to exhaust this backlog.

As this system grows, we will need to continue that growth, and therefore I have authorized the expansion into a third-party claims payer that will move us towards the goal of at least 90 percent of claims paid within 30 days.

Mr. DUNN. We would be very grateful for that. That would certainly be a change that we would experience. And I would like to know that we have some recourse offline. We will talk to your office. Some recourse to talk to when I do get complaints from my district from the care providers on the civilian side. And we can talk about that offline.

Dr. STONE. I know that wasn't presented as a question, but please understand that we recognize the fact that unless we have credibility as a payor, we cannot maintain a delivery network. And our providers in the community deserve better than that.

Mr. DUNN. We understand each other. Let me ask you also if you will nail something down for me. I am a little fuzzy on this. Is it

only the physicians who are using the DST, or is it your mid-levels, nurses, administrative personnel, contracts, who gets to use the DST?

Dr. STONE. You are exactly correct, sir. It is entire patient aligned care team. So it could be the—

Mr. DUNN. Okay, so not the veteran, but anybody else in the VA, basically, who does patient care?

Dr. STONE. Exactly. This is not unique. It could be the telephone scheduler. It is not just the physician. So if I, as a physician, make a decision to refer you out for some sort of episode of care, it may be that the nurse that is working with me that day, the physician extender that is working with me that day will pick that up and finish that work. This is not simply the physician who needs to do that.

Now, we have talked to a number of physicians that enjoy doing all of that work, right up to the point of picking up the phone and calling the referring office for an appointment.

Mr. DUNN. We don't have a lot of those. Thank you very much. I appreciate your reassurances, Dr. Stone. I look forward to working with you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Dunn. I now recognize Mr. Bilirakis for 5 minutes. He is not here. I now recognize Mr. Watkins for 5 minutes.

Mr. WATKINS. Thank you Mr. Chairman. I have the honor of representing eastern Kansas, rural communities. I think communities 3,000 people and less. So the MISSION Act is very important to us. Thousands of rural veterans in eastern Kansas live outside the VA medical facility areas. They need community care options and the MISSION Act is imperative.

So Dr. Stone and Mr. Gfrerer, which IT systems do you consider critical to implementing the MISSION Act by June 6th and which IT systems are not?

Dr. STONE. So all of them help. All of them help, right down to those systems and program integrity for us to detect fraud. So all of them help and together, they make our life a lot easier. In order to do this, none of them can we operate without. Now, it just makes it a more inefficient system.

And this is where we acknowledge digital services concerns. I think you bring it all together, and you lay DST over the top of it, it all works pretty well. But every one of them, we are still going to be delivering care on June 6th if every one of them failed.

Mr. WATKINS. Thank you very much, Mr. Chairman. I yield my time.

The CHAIRMAN. Thank you. Mr. Meuser, you are recognized for 5 minutes.

Mr. MEUSER. Thank you, Mr. Chairman. Thank you all very much for presenting here today and discussing this complicated and difficult initiative. I have had experiences in implementing IT systems in the private sector, as well as for the Commonwealth of Pennsylvania, when I served as Secretary of Revenue. Something we called a tax integration system and modernization act.

The moment I reviewed when I entered as secretary, after the—it went online or began to be implemented a few months earlier and contracted, after about 3 months, I realized that everything

was going to be about 6 or 7 months delayed from the initial—from the get-go.

So I certainly can understand a system like this and running into some shortcomings and some—particularly from contractors, then perhaps overstating what can be done in a perfect scenario. I also recognize very clearly the backgrounds of all of you, just incredibly impressive. Thank you for your service and thank you for what you are doing now, Dr. Stone, Assistant Secretary Gfrerer.

Mr. GFRERER. Gfrerer.

Mr. MEUSER. Gfrerer. All right, and Dr. Melissa Glynn. I won't go through your resumes. You probably did that before, but incredibly impressive and clearly you are the right people to be handling this very challenging task, which is very important to all of us.

I, as well in my district, Pennsylvania Ninth, I have 80,000 plus veterans. We really—we have two Vas: one in Lebanon VA, which does a terrific job for our veterans, as well as the Wilkes-Barre VA. So again, very appreciative and understanding.

Now, the USDS assessment did point out three areas. Number one, it says your IT systems to automate veterans' eligibility determinations for community care. That is clearly important. I will leave it open to whoever would like to respond to that. And maybe you did earlier. My apologies. But where do you think you are versus their assessment or just honest—your honest look at where things are right now? And when do you think you will get to where you would be satisfied?

Mr. GFRERER. Congressman, as I came on in January, the decision had been made that, you know—as you know probably from your experience, you have to manage a program according to a certain set of risk parameters, cost schedule, and performance. This one was clearly falling into the schedule bucket. As you said, too, with the delays that you have seen in IT systems, you know that information technology serves to automate and support a business process.

And so when you look at one year to accomplish everything that is in a very complex statute, and then all of the activities that have to occur from the regulations, to eliciting user requirements, to—from there on forward. That is quite a lengthy flow if you are going to get it right.

And so I would tell you that I am confident we will have the functionality by 6/6 for the decision support tool. I think when you look in the report, you are sometimes left with choosing—making a binary choice. We talked about the ability of the system to fail elegantly across the different criteria that it is going to look at, so it doesn't just blow up and cease.

Alternatively, I would say as well that we certainly looked at and within VA, we are going to an application program interface architecture, right? Applications are the wave of the future. We are going to the cloud, again, managing that program to risk. We just couldn't get there fact enough from January to June 6th.

Now, that said, there is a parallel development team that is taking those requirements around that Legacy architecture and developing it on an API basis. So it is really not an either/or, it is an and. It is just, again, managing the program to a schedule risk.

Mr. MEUSER. All right. Very good. I'm going to jump to the third that they mentioned here regarding health record exchange with the community providers. That certainly sounds like a bit of a challenge. Maybe you could just address that in the remaining seconds.

Mr. GFRERER. I know at the HIMSS Conference in Orlando in January; the entire medical and health care community really looks to the VA to be a leader in this area. So we are, again, via our API approach, we are rapidly, and we are a leading adopter of the fire standard, you know, the fast health care interoperability resource standard. Again, the entire market is looking to the VA to develop that and kind of put its weight behind it, because I think, again, as someone that has served in uniform for 28 years and then migrated to VA with putting my paper records over, and you know, no one thinks that that is a vision of a future that we all want to be a part of.

And so whether it is—those health information exchange opportunities and those standards are things that we are rapidly adopting. And as Dr. Stone sort of alluded to, bringing our community care partners into that. And part of the reason for that, too, is around the proliferation of electronic health record systems.

Someone corrected me a couple of weeks ago. I thought I was on over about 80 systems and I said—they said, "No. It is about 400 different electronic health record systems."

Mr. MEUSER. Well, thank you. You have many veterans counting on you. Let us know how we can help. And I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Bergman, you are recognized for five minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. And thanks to all of you for being here. Now that Mr. Gfrerer, right? Colonel Gfrerer, retired.

Mr. GFRERER. Recovering.

Mr. BERGMAN. Recovering. Well, that is—there is no such thing as a recovering Marine. Maybe retired. We know that one of the challenges that we have in any system, but especially, let's say as related to United States military, the challenge of balancing, maintaining Legacy systems while we overlap and implement Next Gen systems. So now that you are in the VA system, I am hopeful that you will bring that tenacity that you had as a Marine to the urgency to truly seek a balanced blending of the Legacy with the Next Gen, whatever it is we are trying to do, and not look at life just linearly: we are going to do A, then B, then C. We are probably doing all three of them at the same time. We are just running at different speeds.

So let's take, for example, here as to the two community care network contracts that are under protest currently. Why has the secretary not exercised his authority to allow the contractors to proceed with their work while the protests are being resolved? To me, that sounds linear. How can we keep the ball moving forward while we deal with protests?

Dr. STONE. I would need to defer that to counsel. Counsel made the decisions on how to proceed with this, and advised the secretary, and I would ask to take this one for the record.

Mr. BERGMAN. Well, please do, because the—again, the—we all have our roles to play and while we need to make sure we do everything legally, we can't let the battlefield just lay, if you will. In this case, the battlefield is the implementation so that we can move it forward. So I appreciate you taking that for the record. And because if there is a way possible, let's keep the inertia going.

Next question. What abilities will the VA have to improve these IT systems over time, again. Okay. We are going to go from Legacy to Next Gen. But that Next Gen is going to be Legacy at some point. And how do we keep a—because I think in somebody's resume here, I saw Lean Six Sigma certifications. How do we keep that system updated over time, future updates, what is the plan?

Mr. GFRERER. Congressman, I would start by saying that part of the job of the Chief Information Office is to constantly partner with the business and find ways to increase effectiveness, contain cost, but also drive innovation, right? And so sometimes that innovation responsibility of the CIO is really kind of top of mind. I know it is something that I have prioritized. While I have all of the, you know, kind of keeping the lights on activity, I can't just be maintaining, as you would say, the Legacy systems. I have to be looking to the future.

I would point to a few things that specifically—certainly, our migration to an electronic health record. I am spending a lot of cycles on that with our partner, Mr. John Windom in that office, and Dr. Stone. Certainly our movement to the cloud. We have an entire enterprise cloud strategy where we are moving applications and there is a lot of really good use cases around that, about increased functionality.

You know, one of our team told me about recently was right before Hurricane Harvey, the decision was made to move some benefits applications into the cloud, along with that associated data. And as soon as Harvey rolled in and the on-premise data centers were shut down, because it had been migrated to a cloud, the rating officials were able to continue their business.

Mr. BERGMAN. Okay. Well, and I know my time is running short and I appreciate that because there are sometimes you cannot predict, stuff happens. Life happens around you. But it would, I think it would be helpful for all concerned, especially as Congress, as we continue to give money to the VA for projects, that if there is a way on some kind of a scale for all of you to say, "Well, we think at this point, 2 years from now, or based on whatever it is, it could be a guess, but let's see how close we get." Because without any kind of predictive nature, we are going to have surprises. Let's face it. That is just the nature of the world. If we could predict and see how close we get to some of these surprises, then it would help us long term to have better planning, and I yield back, Mr. Chairman.

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

Mr. CISNEROS. Good evening. Thank you all for being here. Or I should say good afternoon. Thank you all for being here today. You know, in my—I'm from California, 39th Congressional District, and unfortunately, we don't have a VA health center. My veteran constituents need to travel at least 30, 40 plus miles in about two

hours of traffic to get to the VA care, which depending on the time of day, like I said, could be anywhere from an hour to two hours.

This is something I am very mindful of when thinking of VA services for the veterans in my district, as traffic congestion is a way of life for many constituents in Los Angeles and Orange County area. And although the MISSION Act has expanded the community care access standards to include drive time, there are major concerns that neither the law nor the draft regulations specify to an adequate level of detail how the VA should calculate drive time and wait times to make eligibility determinations leading to unreliable and inconsistent calculations.

Additionally, the USDS report finds that much of the data necessary to determine eligibility is currently housed across several VA systems that don't interoperate. However, the VA only gave itself 12 weeks to develop the decision support tools meant to address this. It is a big concern of mine.

So where is the VA in the development of tools veterans makes access on the development Web site to determine the drive time associated with their local facility? And is the VA open to adopting a people-centered approach in this field, providing that most liberal interpretations possible for eligibility criteria as recommended by the USDS report?

Dr. STONE. Congressman, we appreciate the nature of the drive times in that area of the country. There are many areas of the country that we have struggled with drive times and various different drive times at different times of the day or different times of the year.

We struggled mightily with the 40-mile limit, just because of geography that 40 miles in an area like the Pacific Northwest may be just completely untenable. Whereas, in Montana, it may be fairly acceptable in an area that is— that you are able to get through.

So as we adjudicate this, and as we work these, the actual 30- and 60-minute drive time is a commercially available system that has been linked to one of our programs and is in current use today. So we are comfortable at its accuracy because it has been used for many, many years, including in the State of California to assess the adequacy of the Medicaid system. And so the California Medicaid system uses the same software system.

So we are comfortable with its accuracy, but remain respectful of the fact that different times of the day are pretty tough to get around the area that you represent.

Mr. GFRERER. Congressman, I just wanted to address your technical concerns and I think this was before you stepped in, potentially. There are certainly three systems that are at the core of what the decision support tool has to reference in order to help the clinician and the veteran reach this best medical interest decision. One is the master veteran index; one is the enrollment system; and the other is the provider database. So there is just kind of no getting around. Those are three very discreet and differential databases.

And I know in the report, one of the things it talked about was the brittleness of the architecture, really referring to could the data calls on these three systems handle the additional load that would potentially occur, even with say a 50,000 to 75,000 patient a day

referral. And I can tell you that we have done the sufficient stress test to show that it is orders of magnitude more capable of handling that increased load.

Mr. CISNEROS. On another—just kind of changing the subject a little bit. The overachieving findings of the report also said the need for a veteran-centric vision for implementation. For technology implementation, this translates to user-based approach. In this case, the user is both the care team that has to manage the eligibility determination and the veteran whose care is at issue. Do you agree or disagree with the assertion that the VA leadership has to define what community care should be from a veteran's perspective?

Dr. STONE. Congressman, I think that is exactly what we have done. The VA's foundational service is to be veteran-centric and to recognize the nuances of service and the injuries that it causes, even injuries that can't be seen. And the reason this system was designed in this manner is because of that belief in the integration of care between the provider team and the veteran.

This is not simply a system that you can go out and say to a veteran, "Well, get on the Web site and decide if you are eligible to go out or not." That doesn't at all recognize how many of our patients suffer from mental health diseases, as well as the amount of even—I could just focus on military sexual trauma. The real importance of this as a health care system is about our ability to integrate care and not just simply send people out to a Web site in order to make a decision on care.

Now, that is the same as people have in the commercial space, and the frustration of trying to figure out what doctor to go to. What we do is partner with the veteran and make this a veteran-centric system.

Mr. CISNEROS. I yield back my time.

The CHAIRMAN. We have an option for a second round of questions. I will recognize myself for the first 5 minutes. Dr. Stone, you mentioned the participation of community care providers in the VA's health system as a concern of yours. Can you tell me what —

Dr. STONE. Sir, I—

The CHAIRMAN [continued].—that they may or may not participate. Is that the—

Dr. STONE. There are areas of the country where Medicare participation is very low: Alaska. As we begin to work our way through and effectively recover from a period of years in which we were slow to pay bills, as you heard from your colleagues, we need to regain the trust of the providers in America. And so I do worry about the willingness to participate in our system as we regain that trust.

The CHAIRMAN. Okay. So that wasn't about the Health Information Systems? The—

Dr. STONE. That was not.

The CHAIRMAN [continued].—ELH, so that was, okay.

Dr. STONE. No, that strictly related to the fact of are we paying the right rates to earn your trust, and are we paying in a timely manner, and are we giving you a bundle of care that is—

The CHAIRMAN. I understand now the issue. Okay. I want to ask you about the Patient Aligned Care Team initiative within the VA and the workflow that that entails. And there was—on page five, there was some pull quotes from actual VA physicians. One said—one of the pull quotes says, "There was a misconception that the primary care provider," i.e., the provider within the VA, "will co-manage community care."

And there is a sense of, like, resentment about that. And it says, "I will instruct every one of my primary care providers not to do this." And I believe that is coming from a place of the concern within VA among the primary care providers that the way MISSION is going to be implemented is not really taking into consideration about the workflow and the potential disruption of the workflow. Can you respond to that?

Dr. STONE. I can. And it certainly is a concern. And what it reflects the fact is we need to do more training. We need to do more communication. And as we have come out of the period of comment on the regulations on access standards, we have begun communicating more effectively, I think, with our providers.

Our providers are nervous. Our providers are concerned about the change. And our providers are concerned about privatization. They read about privatization all the time and they are concerned of, "Are we going to do that?" I would hope that from my comments today, and my previous testimony, and the secretary's testimony, you would recognize that the fact that we are not privatizing, the future of the VA's health care system is in the hands of the American veteran. And just like you and I get to choose sort of where we are going for our health care, the American veteran will choose, and they will determine our future.

The CHAIRMAN. Well, I will remind you that it is a pretty limited choice. I mean, depending on which health care plan we belong to. We stay in network, or out of network, and we pay our price if we go out—I mean, this idea that choice is being extended willy-nilly to all veterans, I think no American seems to have that unless you are super wealthy and can—it is no—price is no consideration, right?

Dr. STONE. Yes, sir.

The CHAIRMAN. So it is—I mean, I want to be careful about the language we are using because I think people in the leadership of the administration often throws it out there and I think it is misleading, because we are not looking at unfettered choice here. And to create a sense of—like the charter school movement. I mean, that is also—I also have problems the way we talk about choice in that context as well.

So I hope that we are retaining the coordinating role of the VA and it is not sort of being outsourced to some sort of technological formula that we are looking all—I mean, I am concerned about how much—we don't even know how much all of this is going to cost in terms of what these access standards will do to the cost of care.

And that is, I think, the concern is that will it raise cost so much in private sector care that it is going to hollow out existing internal capacity?

Dr. STONE. Sir, I appreciate your comments and that is exactly right. I think all of our intention is to have the VA remain as the

centerpiece of the decision process for America's veteran. And as America's veterans go through these decisions, it is our intention to remain the integrator of that care.

The CHAIRMAN. Thank you. I recognize Dr. Roe for five minutes.

Mr. ROE. Thank you, Mr. Chairman. Obviously, and briefly, so look, I am a veteran and I have been a patient. And like any other veteran or patient, civilian or not, I am going to seek out the best care that I feel for me and my family. That is what I am going to do, and I think that is what veterans will do. And you started out, Dr. Stone, VA care in most places is as good or better than the community. And I think that sale itself will keep people in the VA.

Where I live, the veterans are very happy with it. We are very fortunate where we live. But that is not the case in other places. And so we tried to create a MISSION Act that was good from east coast to west coast. And I think we have succeeded if it is implemented properly and doing just that to meet most—you can't meet every need, but most veteran needs.

And we know that VA can't be everything to everybody, just like the private sector sometimes has to—we have a very sophisticated center at home, but we have to occasionally send some out for a super specialist somewhere that we can't handle at home. So having said that, just a couple three real quick questions.

One is still making sure that our doctors out there in network can access VA data. That is extremely important for me when I see a patient to have all necessary information, and will that be live come June 6th? Can we get to it? Number two, it is amazing you processed 1.7 million claims, but did the payment go out on time? Did we process those claims that were clean claims and got the check out the door for those folks?

Because I talk to people all the time. They have hundreds of thousands of dollars of back claims to VA.

Dr. STONE. First of all, the community care referral and authorization system allows us to move data to the community providers.

Mr. ROE. Okay.

Dr. STONE. So to your first question, yes. I think one of those software systems of the 11 I talked about moves data out in an effective manner to—

Mr. ROE. That's great.

Dr. STONE [continued].—you as a provider if I am sending somebody to you.

Secondly, it is my understanding that the 1.7 million last month was not only authorization but also payment of claims.

Mr. ROE. And thirdly, we need to know the status of the clinical networks because—and we asked VA in 2014 to do something no organization can do, which is to put up a nationwide network together in 90 days. We also asked MISSION in 365 days to put this network out. And the contracts are just now going out. Are your partners that have gotten these contracts now, and I know there are two that are being held up right now, is that network going to be ready to go? Because once again, if that network is not ready to go, it won't work.

Dr. STONE. So this is exactly why when I came last summer to this position, we stood up the Triwest nationwide system as a safety net, to begin building across the Nation a delivery system as our

other vender went away. And then to hopefully use that provider network as our next generation of community care comes on board to actually facilitate a rapid and smooth transition.

The other thing that digital services did in their report is they actually questioned continuity of care. Please understand that we have been through this a number of times, including as Health Net stepped away. And we will not disrupt the care if we have authorized a bundle of care for somebody that has got ongoing chemotherapy or ongoing dialysis. We are not going to disrupt that care.

Mr. ROE. Because really all the patient—all the veteran patient cares about June 7, I come down to the VA and I need an appointment, can I get an appointment? That is all they really care about.

Dr. STONE. That is right. And the goal, sir, in community care and in all of VA is to take on the administrative burden of this ourselves and to make sure it is invisible to the veteran and we are just meeting the veteran's needs.

Mr. ROE. I appreciate it. I will yield back.

The CHAIRMAN. Thank you. Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chair. I wanted to ask, again on the USDS report, do you agree with what they suggest that if the criteria model for the MISSION Act fully implemented, you know, the regulations of 30 minutes for primary care, 60 minutes for specialty care, that the—that they expect a significant increase from 685,000 veterans under the Veterans' Choice Program to 3.7 million veterans under the MISSION Act. Do you believe in that premise or—

Dr. STONE. It is my belief that they got that from our actuaries. I am not really sure the source of the 3.7 million, Congresswoman. But I would bet it is from our actuaries. Now, there is something else—

Ms. BROWNLEY. Does that mean that is good data or—

Dr. STONE. I think it is good data. I think it is good data. I think that already today, every single veteran we are seeing, we are looking at these criteria based on 40 miles and 30 days. We are just changing this to 20, 28 days; and 30- and 60-minute drive times.

I don't believe that if you came to me as a doctor, and I incurred trust from you in the way I handled myself and my professionalism, that if I looked at you and said, "Well, you know, I can find you another doctor 10 minutes closer, or 30 minutes closer, or even an hour closer, you are going to leave me." I think very few people will leave a provider based on that kind of convenience.

And we have actually surveyed five million veterans that don't use us. And that is exactly what they have told us. It is not just about convenience. So I don't see that somebody that is seeing us, and trusts us, and our trust scores are approaching 90 percent, about 87 percent, are going to leave us based on the fact that we have told them that we have got something that might be more convenient.

Now, if they have never interacted with us, I think that is different. And I think that is a different discussion. By the same token, I don't see people that are out in the community already looking at the MISSION Act and saying in great numbers that they are going to come in to see us because of something that is in the

MISSION Act. I don't think people leave your doctor for that reason.

Now that I have said that, let me say to you that it appears in the first 6 months of this year that we have grown by a million visits. Not only that, 100,000 veterans have joined us that weren't with us 6 months ago. So I think we have got to watch it, we have got to communicate with you. I think we owe you, as part of oversight, really predicting what the future looks like. But I don't think there is—that 3.7 million number we should be concerned that droves of patients are going to leave us.

Ms. BROWNLEY. Thank you. Thank you for that. And just one last question in terms of the PPMS, these acronyms always just drive me absolutely crazy. Reading all this stuff, I have to go back and figure out, you know, what that acronym means again. But with regards to that, so the wait time in the community can vary day to day, week to week. So the question is how will the VA ensure that the PPMS data is current so that eligible veterans are able to make informed decisions about where they obtain their health care and how frequently will the system be updated to ensure it is providing the most accurate and up to date data?

Mr. GFRERER. Congresswoman, I am not—I would have to take that one for the record. I am not in a position to tell you exactly how those updates occur around that database and that data element. But I can take that for the record.

Ms. BROWNLEY. Very good. Thank you. I yield back.

The CHAIRMAN. Thank you, Ms. Brownley. All—well, I want to thank all of the witnesses today and we look forward to working with you, your staff, and the USDS in the future. All Members will have five legislative days to revise and extend their remarks and include extraneous material.

Again, I thank you all for appearing before us today and this hearing is now adjourned.

[Whereupon, at 3:43 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Richard A. Stone, M.D.

Introduction

Good afternoon Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity to discuss the Information and Technology (IT) systems that will support the new Veterans Community Care Program required by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (the MISSION Act). I am accompanied today by Dr. Melissa Glynn, Assistant Secretary for Enterprise Integration, and James P. Gfrerer, Assistant Secretary for Information and Technology and Chief Information Officer.

The MISSION Act, in combination with the transformative modernization efforts underway in VA, represent a unique opportunity for VA to lead the evolution of health care. VA is a leader in patient empowerment: we were among the first in the industry to make health care information and documents fully transparent to our customers; we are building technology and programs that are inclusive of the most important people in Veterans' lives, their families, and caregivers; we are driving innovation and research that informs better care and services; and we are emphasizing the whole health of Veterans well beyond the institution. For example, the MISSION Act has strengthened VA's ability to furnish telehealth across State lines and into Veteran's homes, allowing VA to enhance the accessibility, capacity, and quality of VA health care. VA has integrated telehealth technology with the Whole Health initiative, which is an approach to health care that empowers and equips Veterans to take charge of their health and well-being by focusing not only on treatment but also on self-empowerment, self-healing, and self-care. To accomplish that, VA is combining innovative complementary treatments like yoga and tai chi with the latest technology to allow Veterans to receive world class treatments in their homes or local VA clinics. VA will also launch a Whole Health app this year that will guide Veterans through the Personal Health Inventory and resources available at VA.

Alongside the MISSION Act, VA is expanding access to care in our direct care delivery system. VA is implementing the Improving Capacity, Efficiency, and Productivity initiative, a collaboration among VA offices focused on creating efficient practice solutions, including offering extended hours (evenings and Saturdays), using telehealth and video appointments, providing facilities with appropriate guidance for overbooking, and adopting point-of-care scheduling.

These are only a few examples of the way VA is using its authority, including the MISSION Act, to strengthen both the in-house and community aspects of our integrated system, giving VA the ability to build on its innovative legacy and drive the industry forward. Veterans, their families, and their caregivers will now be more able to choose the balance of VA-coordinated care-whether direct care or community care-that is right for them, with an optimized network of excellent choices.

MISSION Act Community Care IT Collaboration

The Veterans Health Administration (VHA) Office of Community Care (OCC) has been developing and deploying improvements to the community care program to improve the experiences of Veterans, community providers, and VA staff. Work began in 2016 to develop a standardized operating model for the community care staff working in VA medical centers (VAMC) and in recent years tools and technologies have been developed to support the upcoming implementation of the Community Care Network contracts. The operating model provides a standardized way to manage consults, referrals and authorizations, and perform care coordination to ensure good customer service.

Even before the MISSION Act passed, OCC was working closely with VA's Office of Information and Technology (OIT) to discuss expected IT requirements and systems that would either be impacted by the new law or created entirely as a result

of the law. Since passage of the MISSION Act, OCC has worked closely with OIT to develop new tools, such as a Decision Support Tool, to aid in community care eligibility determinations, as well to support enhancements to existing tools that will ensure that the capabilities necessary to implement the MISSION Act will be in place.

Deployment of many tools that will support implementation of the MISSION Act already started and, for example, a tool known as the Provider Profile Management System (PPMS) was deployed nationally in Fiscal Year 2018 that provides VA staff and Veterans with a directory of VA providers, Department of Defense (DoD) providers, and community providers who are part of VA's network. In the coming months, VA will be deploying a new referral and authorization system that will streamline information sharing between VA and community providers and expand its deployment of Electronic Claims Adjudication Management System (eCAMS), which is a tool that will modernize our claims processing systems and improve both timeliness and accuracy of payments to community providers.

Enhanced community care eligibility determination capability:

- **Decision Support Tool (DST):** This tool will help VA identify Veterans eligible for community care, as well as the basis for their eligibility, and will document the Veteran and provider decision. The tool interfaces with the PPMS, enrollment system, scheduling, and the access standard table on the use of community care. This will be available June 6, 2019.

Enhanced referral and authorization/care coordination capabilities:

- **Provider Profile Management System (PPMS):** This is a directory of providers, including those in the DoD military treatment facilities, VAMCs, and in VA's community provider network. This is active with 1,500 VA users accessing the system 10,000 times in the past month since it went live in October 2018. PPMS will allow Veterans to find community providers via the VA.gov site. It also supports VA staff in identifying community providers when scheduling appointments for Veterans.
- **Health Share Referral Manager (HSRM):** This is a referral and authorization tool that includes a portal and will standardize how VAMC staff create and share referrals with VA's network contractors, other community providers, and with the claims payment systems (for validation that a claim was authorized by VA). It allows for electronic exchange of information between community providers and VA. Deployment is scheduled to begin in April and complete in June 2019.
- **REFDOC:** This is a Web-based tool that allows VA users to quickly extract a Veteran's health information and compile it into a PDF to send to community providers. This was deployed in May 2017.
- **Community Viewer:** This allows community providers to securely view Veteran health information via a Web browser. This was deployed in May 2017.
- **Virtru Pro:** This is a secure method for VA to exchange health information with community providers using encrypted e-mail. This was deployed in May 2017.

Enhanced timeliness of payment of claims:

- **Electronic Claims Adjudication Management System (eCAMS):** This is a modern, efficient, and automated commercial-off-the-shelf product to process health care claims submitted by community providers. eCAMS will replace the legacy system and increase our capabilities to improve the accuracy and timeliness of payments.

VA OIT IT Development Process is Modernizing

VA recognizes that we have faced technology challenges at times. Thus, we have made a strategic pivot in our approach to technology implementing the MISSION Act requirements. The business and technical elements of the organization have formed a tight partnership and focused on improving the Veteran experience. For example, OIT and VHA worked together on Community Care projects such as the PPMS release in September 2018. Prior to the deployment of this system, VA staff were required to locate provider information on spreadsheets and SharePoint sites. This system gives VA staff the ability to do location searches to identify nearby providers while scheduling care for Veterans outside of the VA. The Community Care teams also released the Veterans Choice Locator on VA.gov on December 26, 2018. This release allows Veterans and Staff to search for approved VA providers within a search radius by provider specialty. Prior to this functionality being available on VA.gov, Veterans had to call their local facility to identify providers. Our aim is for

technology to be an enabler of streamlined business functions-all of which become invisible to our customers as they enjoy a smooth, coordinated, personalized experience of care.

U.S. Digital Services Report

VA recognizes that we needed all available talent at the table for this shift in approach. U.S. Digital Service has been helpful in driving differential approaches to some VA business processes. Therefore, we recently invited them to review the development of key systems, including the Decision Support Tool (DST). Under the MISSION Act, DST will streamline the eligibility determination process to improve Veterans' experiences and support our local clinicians and field staff by improving the efficiency and effectiveness of eligibility determinations for Veterans seeking community care.

U.S. Digital Service agreed to review the IT system and related policies over a 2-week period. They reviewed whether VA's technical solutions would meet the legal requirements for implementing the MISSION Act. While we fully anticipate that the DST will be operational on June 6, VA will still have the ability to perform the necessary functions to support MISSION Act implementation if it is not operational on-time. We look forward to continued engagement with U.S. Digital Service.

Funding Transfer Request

To ensure the technology to support the MISSION Act is successful, VHA recently responded to a request from our OIT partners for additional funding. Despite proposing to use funding from the Medical Community Care and Medical Services accounts, the repurposing will not adversely affect Veterans' health care. Medical Services funds are available for repurposing as a result of efficiencies in the hiring process and improved ability to fill critical positions with the correct staff, reducing the need to over-hire to meet retention targets. VHA maintains staffing levels sufficient to provide exceptional care to Veterans, as evidenced by improving access and outcome measures. Medical Community Care funds are available for transfer as a result of higher than expected medical care collections from other health insurance for care provided in the community.

On top of the $33.56 million committed from OIT, VA intends to transfer $95.94 million of Fiscal Year 2019 funds ($68.78 million from the Medical Community Care account and $27.16 million from the Medical Services account) to the IT Systems account to fund IT projects for various MISSION Act programs, including the projects listed above. VHA and OIT are collectively tracking the planned use and allocation of that funding through to fruition. Currently, VA OIT is tracking all MISSION Act investments at the program and project level where they are being executed. All MISSION Act spend plans are tagged with a unique identifier to allow transparency and accurate reporting of expenditures linked to existing program performance and goals. Additionally, VA's OIT Chief Financial Officer currently hosts weekly meetings with program officials to discuss planned acquisitions to meet the mandate and any foreseen risks that need to be mitigated.

Conclusion

VA's transformation under the MISSION Act, is one of the largest such efforts the Department has ever seen. Veterans' care is our mission. We are committed to rebuilding the trust of Veterans and will continue the improvements we have made to Veterans' access to timely, high-quality care from VA facilities, while providing Veterans with more choice to receive community care where and when they want it. Your continued support is essential to providing this care for Veterans and their families. This concludes my testimony. My colleagues and I are prepared to answer any question.

Questions For The Record

House Committee Members to: Department of Veterans Affairs (VA)

Questions for the Record from Congressman Mike Levin

Question 1: The USDS report quotes a Marine veteran from my district saying, "I don't know how they hand off records for a consult. I'd like them to have my history, so they could understand my condition." I understand the VA plans to use its new HealthShare Referral Manager to exchange records. However, the USDS found it unlikely that community providers

will adopt a VA-specific platform, instead opting for manual, one-off methods such as fax or secure mail. Dr. Stone, have you considered this concern, and how do you plan to address it?

VA Response: HealthShare Referral Manager (HSRM) allows VA and community providers to easily upload and download medical documents such as medical records and images. Prior to providing care to a Veteran, community providers can download and review documents that VA shares regarding the Veteran/patient. Following care, community providers upload relevant patient care documentation for VA's review. The use of HSRM eliminates faxing and emailing documentation and greatly enhances the accuracy of patient documentation. In the instances where a community provider does not utilize HSRM, a packet of information that contains referral details, additional referral information, billing and precertification information, patient details to include relevant medical history, and standardized episode of care (SEOC) information will be sent by the provider's preferred method to include secure email or electronic fax. VA medical center staff will document that medical packet was sent to a community care provider within the VA Consult Toolbox. The use of HSRM is highly encouraged in the Community Care Network by our contracting partners.

Question 2: Dr. Stone, in your written testimony, you state, "While we fully anticipate that the DST will be operational on June 6, VA will still have the ability to perform the necessary functions to support MISSION Act implementation if it is not operational on-time." While I hope that the Decisional Support Tool is rolled out on time and smoothly, I also want to be sure we're prepared if that doesn't happen, as the USDS report anticipates. Can you explain in more detail how VA would conduct the new eligibility determinations without a functional DST?

VA Response: The Decisional Support Tool (DST) went live and has been operational since June 6, 2019; however, VA has developed and tested a community care eligibility contingency plan which requires VA staff to access the Veteran's static community care eligibility (e.g., No Full-Service VA Medical Center in the State, Service Unavailable, Grandfathered Choice, certain categories of best medical interest, specifically Hardship) through both the Enrollment System and Computerized Patient Record System (CPRS). These static eligibility determinations generally will not change, as opposed to dynamic eligibility criteria (e.g., designated access standards, remaining categories of best medical interest, and VA medical service line), which could result in different eligibility determinations based on the care that is needed. VA staff will access the Veteran's dynamic Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) eligibility through Veterans Information Systems and Technology Architecture (VistA) clinic data and the Provider Profile Management System (PPMS).

Question 2a: Who would be responsible for making those determinations, and how would that affect the existing workflow?

VA Response: DST went live and has been operational since June 6, 2019. In the unlikely event that DST is not available, VA's system will allow VA clinic staff, including the provider and clinic scheduler, to access the Veteran's static community care eligibility through both the Enrollment System and CPRS. Clinic staff can review the Health Benefits Plans section in the CPRS Patient Inquiry screen to determine the Veteran's static eligibility for community care. These will be actions that will need to be taken by the clinic staff within the appointment workflow or when speaking to the Veteran over the phone.

The codes in CPRS will appear as follows:

CPRS Eligibility Health Benefit Plans

Veteran Plan - CCP Grandfather	Grandfathered.
Veteran Plan - CCP State with No Full-Service Medical Facility	No Full-Service VA Medical Facility in Veteran's State of Residence.
Veteran Plan - CCP Hardship Determination	Hardship.

VA has also separately established a code, "Veteran Plan - Urgent Care," to reflect a Veteran's eligibility for the walk-in care benefit under 38 United States Code § 1725A.

For dynamic eligibility criteria, VA clinic and administrative staff can access wait time for the specific clinic in which the Veteran is to be scheduled by reviewing the appointment availability through the approved VA appointment software, which links to VistA clinic data. The average drive time eligibility determination can be made by using PPMS to calculate the average driving time from the Veteran's residence to the VA facility that can provide the requested care within the wait time standard.

The VA provider will determine clinical need for community care purposes by reviewing if the care is nationally available at any VA facility; if VA does not offer this care at any location, the provider will enter a community care consult following normal consult entry processes as outlined in Veterans Health Administration Directive 1232(1), Consult Processes and Procedures, and the Office of Community Care Field Guidebook. The VA provider will also need to determine if it is appropriate to request community care for the specific episode of care based on such a referral being in the best medical interest of the Veteran. If the referring clinician and the Veteran agree it is in the best medical interest of the Veteran to receive care in the community, the provider will either utilize DST to document the best medical interest eligibility or add the justification to the appropriate community care consult.

Question 3: I appreciate VA launching the Veterans Choice Locator so that veterans can identify approved community providers. I believe, as the USDS recommends, that user-driven transparency should extend to eligibility determinations. Dr. Stone, has VA considered developing a veteran-facing eligibility tool?

VA Response: VA is developing several tools to help Veterans understand and directly query their eligibility to receive community care. The VA Online Scheduling (VAOS) tool will incorporate the new MISSION eligibility criteria that are static, such as residing in a state without a full-service VA medical facility; VAOS has been available since June 6, 2019. The display of dynamic eligibility criteria such as average drive time will be available in VAOS by September. VA is also analyzing self-service capabilities that can be incorporated in MyHeatheVet to provide Veterans more information about their eligibility; there is currently no timeline for when this will be completed. Additionally, VA has established an Interactive Voice Response option to allow Veterans the ability to directly obtain eligibility information about the walk-in care benefit under 38 U.S.C. § 1725A by working with the third-party administrator.

Question 3a: If such a tool isn't provided, how will VA ensure every veteran knows and understands their eligibility status?

VA Response: Veteran empowerment is at the core of VA's approach to the VA MISSION Act of 2018, and VA personnel are being trained to provide the best information available to each Veteran. As outlined above, eligibility under the VA MISSION Act of 2018 can be determined with or without a tool. VA is also working to educate Veterans and train Veterans Service Organization representatives on the eligibility process.

Questions for the Record from Congressman Chip Roy

Question 1: During the hearing, the VA witnesses mentioned some new systems, RefDoc, VirtuPro, and Community Viewer, that VA is using to share health records with community care providers. Are these one-way transfers of records from VA to the provider? Or is there a capability for VA to transfer data from its electronic health record to the provider, that provider treat the veteran, and then that provider transfer the information back into VA's electronic health record? If not, what is the plan to achieve that capability?

VA Response: RefDOC generates an electronically consolidated .pdf file that contains administrative and clinical information needed to facilitate a referral in a standardized format. Community Viewer is a "read only" secure Web-based application that allows community providers to view a Veteran's entire Electronic Health Record once permission is granted by facility community care staff. In addition, the new portal, HSRM, has bidirectional communication functionality that can be used by VA and the community provider to upload medical records. Currently VA also utilizes Health Information Exchanges, which are secure networks of trusted partners that allow VA and participating community providers to electronically request and receive medical information about a specific Veteran for whom they are providing care. Direct messaging is also available, which allows the exchange of med-

ical information via secure email-like messaging under a trusted network. With the implementation of Cerner, interoperability will continue to mature with the improved seamless flow of health data between VA and community providers.

Questions for the Record from Congressman Jim Banks

Question 1: What is the claims processing system used by Optum and any other new CCN contractors? Please provide as much information about these systems' capabilities as possible.

VA Response: First, Community Care Network contracts do not dictate utilization of any specific claims processing system. Second, to the extent that Optum has identified the claims processing system(s) that it has elected to use to meet contract requirements, such details would be confidential commercial information which is not typically disclosed without going through the predisclosure notification process (Executive Order 12600, 38 Code of Federal Regulations (CFR) 1.558).

Question 2: In the CCN contracts, VA also set out 14 requirements for how the contractor's system will adjudicate claims. Does the system already do those things, or will the contractor need to modify the system to meet VA's requirements?

VA Response: The 14 requirements for how the contractor's system will adjudicate claims include VA-specific requirements such as incorporating VA's fee schedule and adjudicating claims for emergency services under 38 CFR 17.4020(c). Therefore, the contractor is modifying its systems to meet VA's claims adjudication requirements. VA has been working closely with Optum to ensure Optum's claims systems are configured to meet VA's requirements for claims adjudication.