TRACKING TRANSFORMATION: VA MISSION ACT IMPLEMENTATION

JOINT HEARING

BEFORE THE

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

AND THE

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TRACKING TRANSFORMATION: VA MISSION ACT IMPLEMENTATION

Wednesday, December 19, 2018

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

The Committees met, pursuant to notice, at 2:00 p.m., in Room HVC-210, Capitol Visitor Center, Hon. David P. Roe [Chairman of the House Committee on Veterans' Affairs] presiding.

Present from the House Committee on Veterans' Affairs: Representatives Roe, Bilirakis, Coffman, Radewagen, Dunn, Arrington, Bergman, Banks, Takano, Brownley, Kuster, O'Rourke, Lamb, and Esty.

Present from the Senate Committee on Veterans' Affairs: Senators Isakson, Moran, Boozman, Tillis, Sullivan, Tester, Murray, Sanders, Brown, Blumenthal, Hirono, and Manchin.

Also Present: Representative Sablan.

OPENING STATEMENT OF HONORABLE DAVID P. ROE, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

Before we begin, I'd like to ask unanimous consent that Congressman Sablan be allowed to sit on the dais and participate in today's proceedings.

Hearing no objections, so ordered.

Welcome, and thank you all for joining us today for the joint hearing of the House and Senate Committees on Veterans' Affairs.

This afternoon, we will discuss implementation of the John S. McCain, Daniel K. Akaka, and the Samuel R. Johnson Department of Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, better known as the VA MISSION Act.

The MISSION Act is a truly transformative piece of legislation that will impact virtually every aspect of care that VA provides. Developing it took many months of intense negotiation and close collaboration between our Committees, the Trump administration, the Department, and numerous veterans service organizations, stakeholders, and advocates. We should all be proud of our work on the VA MISSION Act and of the benefits our Nation's veterans will derive from it in the years ahead.

However, in many ways, the real work has just begun. Almost 6 months ago, the MISSION Act was signed into law. Almost 6 months from now, one of the act's most noteworthy requirements,

the creation of a consolidated community care program, will go into effect.

Today, at the midpoint between enactment and execution, we are here on a bicameral and bipartisan basis to evaluate both the progress the VA has made thus far with regard to the implementation of the MISSION Act and the barriers that may exist to full, on-time, and on-budget implementation in the coming months.

Seeing the MISSION Act signed into law took the collective effort of all of us working closely together with one another and with the VA's senior leaders, with the White House, and with our veteran's service organization partners. Seeing the MISSION Act implemented appropriately will require no less than the same amount of teamwork.

In 2014, we passed the Choice Act in response to what can rightfully be categorized as a crisis in access. A recent news article has criticized the execution of that program—namely, the high cost of administrative fees. While I do not dispute that the costs of this community care expansion were higher than typical government insurance coverage, the Choice program represented a transformational first step in how VA provides care where and when it is needed. These contracts were stood up in record time, and changes were made both legislatively and contractually over the past 3 years as the program matured.

And I will say this. As a physician, we asked the VA at that point in time to do something no one could do, which was to stand up a nationwide network in 90 days. No one could have accomplished that on time.

The Choice program is not perfect, but it did allow for an undeniable expansion of access and care, both internal to VA and in the community for veterans. This is why it is so vitally importantly that the MISSION Act, which will guide VA's future coordination of care, be executed efficiently and thoughtfully.

Mr. Secretary, thank you for being here today to provide concrete answers to our many questions about the work that the agency has been doing these last 6 months and the work that lies before you in the next 6 months and beyond. The importance and the enormity of the task ahead cannot be overstated. But I have faith in you and your team, and I know that considerable support from this administration and this Congress is behind you. We want you to succeed.

I implore you to be as up front as possible today and every day about the challenges you are facing and the help that you need from us to ensure success for our veterans. I look forward to working together to overcome any barrier that may be in your way.

I will now yield to Chairman Isakson any opening statement that he may have.

OPENING STATEMENT OF SENATOR JOHNNY ISAKSON, CHAIRMAN

Senator ISAKSON. Well, Chairman Roe, thank you very much for the introduction, and thanks for spearheading the calling of this meeting today to look at the first 6 months under the MISSION Act. I am glad we are doing it.

And before I make my comments on the MISSION Act, I want to say this. Your service when working with you has been a privilege. You have done a phenomenal job as Chairman in the House, have helped us in the Senate immensely. Your goal-setting and what you focused on has been unbelievable. And with the exception of a few minor things, mainly where we might have dropped the ball, we have carried the ball and made significant changes in the Veterans Administration that are going to serve us well for a lasting and long period of time.

So I just wanted to publicly thank you for your cooperative spirit, your desire to work. It is so great to have a physician at the top of the leadership in the House, or the Senate for that matter, because we make better decisions when we have people who actually have done it. Talking about it is easy for somebody like me. I am a professional patient. We need a professional doctor. And you have done a great job. And I appreciate your friendship, what you have done, and the leadership you have provided the Committee.

And John Towers deserves a lot of credit too. He does a great job.

And let me say this. We are prepared in the next 2 years to do everything we can do to continue the cooperative spirit between Republicans and Democrats that we have had on the Senate side and to work on fine-tuning the acts that we have passed and implementing things that need to be done to help you in the VA, those that are here from the VA, get your jobs done.

We understand that what is ahead of us is tough, but we have no choice but to see to it the VA is functioning at the highest possible level so those who have risked their life for our Nation and pledged their service to us as soldiers have the same treatment back to them when we are ensuring their health care and those benefits they are promised under the laws of the United States of America.

So I look forward to serving with you and working with you, and I want to tell you how much I appreciate the great job that you have done. I want to tell my Senate membership and our Committee Members that are here, Democrat and Republican, we have had the greatest cooperative spirit we could have. We had the MISSION Act, passed in Committee with only one negative vote, sail through the floor. You all did a great job on your end.

We realize that we dropped the ball with you on one thing. You all got the Blue Water Navy through on a voice vote on the floor, or a suspension vote, I think, on the floor. We failed in the Senate on two UCs, one today and one last week. And we are going to try one time or another, but I still have a difficulty with one or two objections.

But we are going to come right back and hit the ground running. Secretary Wilkie has done a great job of indicating that he wants to work with us and help us where he can. And I am not going to take that bone out of my mouth. This is one bulldog from Georgia that is going to keep that bone in my mouth until we get it done. Because a lot of people on the House Committee have worked on the Blue Water Navy issue, and we have in the Senate as well, and we want to do the same teamwork where possible.

But I primarily want to just thank you and thank Secretary Wilkie for bringing a breath of fresh air to the leadership of the

VA. He has done a great job. He took over after a problematic and a tumultuous time, but he has a good bedside manner, which most physicians—good physicians have. He is a good leader for the agency. He is doing a great job.

We welcome you and all your VA membership here today.

So thank you very much, Chairman Roe.

Merry Christmas to everyone in the audience today.

The CHAIRMAN. Thank you, Mr. Chairman. And I wish that bulldog for Georgia could have done something to those folks in Alabama. I really wish that could have happened, but—

Senator ISAKSON. I can't talk about what we want to do to the Alabama people in public, but I will do one other thing. I have to slip out in a minute, and I apologize. When you see me slip out, it is not that I am walking out on you, but I have one more thing to do on our side.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes, sir. Thank you, Mr. Chairman. It has been a privilege to work with the Senate this year too—this term, I should say, the last 2 years. And I was going to reserve my remarks until the end for you, but I didn't realize you had to leave. But how incredible you and Senator Tester have been to work with this year. My goodness, we could have never passed 80 bills in the House and had so many heard in the Senate. And our staffs, as you pointed out, worked hand-in-hand behind us to make this possible. It wouldn't have happened otherwise. And I think either 29 or 30 pieces of legislation.

And just very briefly, a small thing like a contract, a cable contract you might have signed, or a contract on an apartment, and then your spouse loses their life in service to the country, and you not being able to get out of that contract for a year; now you are going to hopefully be able to do that. Little things like that that don't seem like big things, but if you are the person on the end of that, they are big things. And I personally have seen it and witnessed it with my friends that have had to deal with this.

So these are ideas that came from both sides of the aisle, and I want to thank all of my colleagues, both in the Senate and the House, for those ideas.

I will now yield to Mr. Takano for any remarks he may have.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Thank you, Chairman Roe.

And, Chairman Isakson, I look forward to working with you in the next Congress to serve our Nation's veterans.

Thank you, Ranking Member Tester, for also being here.

Good afternoon, Mr. Secretary. Thank you for taking the time to testify before us today. We will always welcome the opportunity to speak with you about the progress you have made regarding the implementation of the MISSION Act.

It has been a little over 6 months since the MISSION Act was passed and 7 months since you were confirmed as Secretary of Veterans Affairs. I commend you on your hard work so far and assure you that, as we move into next Congress, you will continue to find a willing partner on this Committee, meaning me, and that, as the most bipartisan Committee in this Congress, I intend to work with

my colleagues on both sides of the aisle, with you, Mr. Secretary, and with our VSO partners to ensure veterans get the benefits that they have earned.

Transparency and open communication between the Department and Congress is key to our oversight efforts and to ensure that our work here is effective.

Now, we have asked for and need information from the Department so that we have an understanding of the steps VA must take to achieve the objectives mandated under the MISSION Act over the next 6 months. We also need to know more about the reported outsized influence a group of advisors may have had on your decisions, as VA should not be subject to outside influence or the whims of individuals or interests who cannot be held accountable and who do not have veterans' best interests in mind.

However, VA should ensure that the voices of veterans expressed through our veterans' service organizations are adequately considered when important decisions, such as the adoption of the designated access standards, are made.

The term "designated access standard" seems a bit wonky, so what I would like to hear from you today is a simple explanation of what those different scenarios look like in practice. And I think, to unpack designated access standards, I think, for the public, we can just simply understand them as the criteria by which the VA refers veterans out to private-sector doctors, outside the VA, non-VA providers.

What are those criteria? And, of course, we only began with an arbitrary criteria of living 40 miles outside of a VA radius, the radius of a VA health center, and somebody who has been waiting for more than 30 days. Without those arbitrary standards initially, we would have spent large sums of money, diverted large sums of money of VA health care dollars. So it is important that we get these standards right.

The truth is we have always, always at the VA—the VA has always embraced outside, non-VA medical providers as part of the solution. And so this is nothing new in terms of how we take care of our veterans. But we can't do that at the expense of maintaining and adequately growing the internal capacity of the VA.

So these access standards will outline when and where and how veterans will be referred to private-sector providers under the MISSION Act and how much of your budget will be needed to pay for this private-sector care, which we know is often more expensive than VA's internal services.

And we know based off of multiple studies by the likes of the RAND Corporation and Dartmouth University, VHA care is often—or is frequently of higher quality than the private sector. So standards that are too liberal for access to private care could easily jeopardize that high-quality VA care that our most vulnerable veterans rely on as the dollars that support this care will be diverted into private-sector care. So we need that right balance.

So we need answers to these questions, and I remain concerned with the Department's lack of transparency. For instance, yesterday we discovered via the media, not the VA, that yet another veteran has taken his life at the Bay Pines VA medical facility. This is the fifth suicide since 2013. We should not be first learning

about this in the press. We should be notified immediately with facts that will help us act so that we can prevent other veterans from taking their lives.

The GAO report requested by Ranking Member Walz demonstrate a lack of leadership and commitment by the Department to prevent veteran suicide. This is the Department's top clinical priority. When veterans between the ages of 18 and 34 are committing suicide at the highest rate, the Department's failure to communicate services and attempt to reach veterans in this age group via social media is shameful. VA offers excellent mental health services, but to quote disabled American veterans, they are useless in actually preventing suicide if veterans and family members don't know they exist or are unable to access them.

Now, it is simply wrong—simply wrong—that only $57,000 in funds Congress prioritized to address preventing veteran suicide has been sent and $6.2 million has been left on the table. Now, I am committed to achieving progress over the next 2 years. And I hope that you will, in fact, make suicide prevention the priority that the department claims it to be so that we, as Congress, can support, not criticize, your efforts.

The same offer applies to the implementation of the MISSION Act. Now, the implementation of the MISSION Act thus far has been rocky, and, all too often, Members, their staff, and veterans feel misled or misinformed.

In the next Congress, let's work towards having a productive relationship and open dialogue so that we can work together on behalf of the veterans we serve. And I look forward to our discussion today and hope that it is the beginning of a strong partnership between the Department and Congress.

I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

I now yield to Ranking Member Tester for any opening comments that he—

OPENING STATEMENT OF SENATOR JOHN TESTER, RANKING MEMBER

Senator TESTER. Yeah, thank you, Chairman Roe, Chairman Isakson. If Tim Walz was here, I would be thanking him too. And, Congress Takano, thank you very, very much.

Before I get into my written statement, I just want to say it has been a pleasure, this last Congress, working with all the other three corners. And I think what has made the relationship work is communication. We have tried not to surprise one another. We have tried to keep one another informed of where we want to go.

And I just want to give you a prime example of it. When I was walking over here to this hearing just now, one of my staff Members said: Dr. Roe wants to say something about confirmations, and he is concerned it might embarrass you. That is damn nice of you. I just want to tell you that.

And, by the way, give them hell on the confirmations, because it is ridiculous that these folks aren't confirmed for ID and the Office of Whistleblower Protection.

The last thing I just want to say before I go to my opening statement is Blue Water. We just did a live UC in the Senate, and it

was objected to. I know that the VSOs in this room have been providing information after information after information on this issue.

I am going to tell you, if we aren't willing to take care of our veterans, we shouldn't be making them. And the bottom line is we have to get this done. The science is clear.

And I would say that I think that maybe the folks in the legislative branch don't realize it, but we are different than the executive branch, and we need to make the call. And if they want to veto the damn bill, then let the executive branch veto it. In the meantime, we need to take care of our veterans.

Secretary Wilkie, thank you for being here.

Implementation of the MISSION Act was going to fundamentally transform the delivery of health system for our Nation's veterans. For more than a year, we all worked carefully with the White House and the VA to negotiate the text of that bill. We were in regular communication with the VA on how it would interpret and implement the bill, passing it back and forth for technical assistance, ensuring that we were all on the same page. Since that time, though, I have grown increasingly concerned with the Department's planned implementation of the new Veterans Community Care Program created in the bill.

Mr. Secretary, the VA is moving away from the direction it was headed just 6 months ago; make no mistake about that. The most dramatic example has to do with the VA designating certain types of care as nearly automatic eligibility for community care. Six months ago, we agreed that if veterans faced excessive wait times or driving times or distance to access certain services at a VA facility, they should be offered referrals in the community. Specifically, we discussed designating access standards for services like routine lab work and x-rays. But we agreed to give the VA the authority to decide exactly which services or categories of care should make veterans automatically eligible to receive care within the community.

Now that we have passed the VA MISSION Act, VA has decided to head in what I believe is a completely different direction. VA now indicates it plans to designate access standards that apply to each and every type of care a veteran might need. This would essentially outsource all segments of VA health care to the community based on arbitrary wait times or geographic standards, which we were supposed to be moving away from by ending the Choice program.

And that is despite the fact that several studies, one as recently as last week, have indicated the quality of care at the VA is good or better than the private sector. Let me say that one more time, because it is not said enough. As recently as last week, we received yet another study that indicated that VA care is as good or better than the private sector.

To make matters worse, VA officials have offered only vague verbal descriptions of the various sets of potential access standards under consideration by you, Mr. Wilkie.

It also concerns me that, each time we have discussed this issue in the last 2 months, VA officials have given us wildly different estimates of budgetary resources needed to implement these sets of

access standards that you are considering. For example, if the Department chooses to go with the same access standard used by TRICARE Prime, we have been told it could cost anywhere from $1 billion for the first year to more than $20 billion over 5 years.

Some of the VA estimates indicate that costs will be less than what we spent on Choice but would make a greater percentage of veterans eligible for community care referrals. That doesn't make sense.

So we need to know what you are doing, Mr. Secretary, and how much it is going to cost. No conflicting or vague answers, no fuzzy math, no games, because the stakes are simply too high.

Mr. Secretary, not even 6 months ago, you came before the Senate Veterans' Affairs Committee, and you said you would oppose attempts to privatize the VA health care system. I believe you. I believed you then; I believe you now. But if you move further down this path, gutting the VA health care system for those veterans who want and need to use it, you will end up bringing down the whole boat. And you are going to spend a whole lot of time and money sending veterans in the community for care that is less timely and not as high in quality.

That is a bad deal for our taxpayers. It is a bad deal for our veterans, who would ultimately bear the brunt of cuts to other services or benefits to cover the increased costs of community care. And that will lead to a bad deal for veterans, because, at some point, you will burn through the funds quicker than expected and come to us because VHA is running out of money again. Veterans will be in limbo when seeking community care as Congress sorts out the VA's fiscal issues.

I am frustrated because this hearing would have been a great opportunity to talk about the great work being done by VA employees across this country every single day—and, indeed, they are—and about how their critical work will be bolstered by additional high-quality health care professionals hired under the new authorities within the MISSION Act and about how streamlining various community care programs in the new Community Care Network will make care more efficient, more timely, and more seamless for veterans.

Instead, we are here left trying to figure out why the VA decided to take things in a different direction than what I believe Congress has intended and certainly what veterans have advocated for. My suspicion is that it is politics. I hope I am wrong, because at the end of the day I really hope that meaningful consultation will take place before final decisions are made. We have gotten this far by working together and by taking our cues from veterans, and it would be a shame to undermine those efforts and relationships because of a political agenda.

I have said it before, and I will say it again: I have tremendous faith in you, Secretary Wilkie, to make sure that the VA is run in a way that our veterans deserve. We need to really step up and do it.

Thank you for being here.

The CHAIRMAN. I thank the gentleman for yielding.

We are joined on our first and only panel today by the Honorable Robert Wilkie, Secretary of the Department of Veterans Affairs.

And welcome, Secretary Wilkie. Thank you for being here this afternoon.

The Secretary is accompanied by Dr. Melissa Glynn, the Assistant Secretary of the Office of Enterprise Integration, and Dr. Steven Lieberman, the Executive in Charge of the Veterans Health Administration.

Thank you all for being here.

Secretary Wilkie, you are now recognized.

STATEMENT OF THE HONORABLE ROBERT WILKIE

Secretary WILKIE. Thank you, Mr. Chairman, and thank you, Chairman Isakson, Chairman-elect Takano, and Senator Tester, and distinguished Members of both Committees. I want to thank you for the opportunity to address the efforts underway to implement the VA MISSION Act as well as share with you the governance and management approach instituted over the last 130 days.

As you have said, we are on cusp of the greatest transformative period in the history of VA, and your leadership led to the passage of that historic legislation.

As I testified in front of the Senate Veterans' Affairs Committee earlier in the year, I am happy to report that the state of the Department of Veterans Affairs is better. And it is better because of the work of these Committees and the attention paid to our department by the President.

As Secretary, I have visited 17 States in 130 days, 23 hospitals from Anchorage to Orlando, 4 claims processing centers, and the Veterans Treatment Court in Maryland, and I, as Senator Tester said, am astounded by the commitment of the VA workforce. It is dedicated, and it is, in my opinion, the finest workforce in the Federal Government.

Today, I am honored to have with me two senior VA leaders: Dr. Steven Lieberman, the current Executive in Charge of the Veterans Health Administration, and Dr. Melissa Glynn, the Assistant Secretary for Enterprise Integration.

We are committed to implementing the MISSION Act by June 2019 and describe how that commitment is being fulfilled. We have established a task force representing key offices across VA and guided by experienced program leaders. We now have a battle rhythm of progress reviews to align resources, identify and mitigate risks, and deliver on the promise to transform VA health care that puts veterans at the center of everything that we do. This effort is emblematic of the new governance and management structure we established throughout the Department.

That is how we were able to identify that the technology supporting the GI Bill implementation was untenable. I made the decision to define a new approach to deliver education and housing benefits to our veterans and their family members. And I want to emphasize that we will execute the law as written and every post-9/11 GI Bill beneficiary will be made whole for their housing benefits based on both Sections 107 and 501 of the Forever GI Bill. I made the decisions not only to stabilize the delivery of services but to improve the current Choice programs.

The expansion and extension of the TriWest contract ensures access to community care for our veterans. The decision allows for

smoother transition to the Community Care Network contracts when awarded. After multiple delays prior to my arrival at VA, the acquisition process and subsequent awards are back on track. Community care regions 1 through 3 will be awarded before the end of February 2019, and region 4 is expected to be awarded in March. Once active, these contracts will support a key pillar of the MISSION Act by giving veterans expanded choice in their health care.

As part of our new community care program, we are addressing the timeliness and accuracy of payments to providers. We are moving away from paper claims and requiring providers to submit electronic claims through our new electronic claim administration and management system that will be deployed next year.

Through the MISSION Act, we have established a Center for Innovation for Care and Payment to develop new approaches to testing payment and service delivery methods. The Senate has developed a charter and is developing criteria for pilot projects to drive health care quality and efficiency.

Another pillar of the MISSION Act is groundbreaking support for caregivers. There are 5.5 million veteran caregivers across the country. I had the privilege several weeks ago to address the third annual national convening of military and veteran caregivers, jointly sponsored by the Elizabeth Dole Foundation and Veterans Affairs. The work of Senator Dole to invest in caregivers and their experiences will strengthen our ability to successfully execute an expanded program of comprehensive assistance for family caregivers under the MISSION Act.

I would be remiss if I did not thank the foundational VSOs for their efforts to making sure that this benefit was incorporated into the legislation.

And I will take the opportunity also to thank in person someone who is familiar to all of you and who was instrumental not only in the development of the MISSION Act and the caregiver program but someone who has been on point for veterans for many years. He is retiring. And that is Garry Augustine of Disabled American Veterans. And I thank him for being here as well.

The other most meaningful aspect of this legislation is the series of related products that ultimately support the work of the Asset Infrastructure Review Commission. These include outputs of national market assessments and our strategic plan and a data-driven asset and infrastructure assessment and recommendations with input from our veterans, employees, VSOs, local communities, and other key stakeholders. The VA is embracing the opportunity to assess our footprint and develop recommendations for modernization and realignment of facilities.

Mr. Chairman, I would like to beg your indulgence for a minute, and I am going to go off script. And it is partially in response to a series of stories that I read this morning, stories that have particular meaning to so many Members of these Committees, and that is on the issue of suicide prevention.

When I was Acting Secretary of the Department for 8 weeks, I declared that suicide prevention is the number-one clinical priority of the Department. In addition to that, I named a permanent head of our Office of Suicide Prevention, Dr. Keita Franklin, who was

the head of our efforts at the Department of Defense when I was the Under Secretary.

In addition to that, we have developed with the Department of Defense a streamlined and comprehensive program to begin addressing the issues that impact our veterans and the issue of suicide beginning from the time that they enlist. Our Transition Assistance Program is done in conjunction with Secretary Mattis. And now, thanks to the work of this Committee, we are including other-than-honorable dischargees in our education and outreach efforts when it comes to suicide.

The tragic aspect of this is that, for the 20 American warriors who take their lives on a daily basis, 14 of those warriors are outside of the Department of Veterans Affairs. When I have gone across the country, I have asked Governors, I have asked mayors, I have asked VSOs to help us find those veterans. When I was in Alaska recently, I spoke to the Alaska Federation of Natives. Fifty percent of the veterans in the State of Alaska are outside of the VA system. And I have asked them to help us find those who might be in danger.

Suicide prevention is the number-one priority of this department when it comes to our clinical efforts to keep our veterans healthy and well.

In addition to that, I do want to say that I echo what Senator Tester said. Last week, Dartmouth, in the Annals of Internal Medicine, indicated that the Department of Veterans Affairs' health care, medical care, is as good or better as any in the private sector. That is a story I wish to tell.

The other part of that story is—and it will come as a confounding statement for some in the press that a conservative Republican is here saying this—I am incredibly proud to be part of the workforce that I consider to be the finest in the Federal Government. In my travels, I have seen the dedication of our men and women, 370,000 strong. And it is my pledge to tell the good news stories that they have created on the behalf of our veterans.

In addition to that, another story that I am proud of is that the Partnership for Public Service for the first time in memory has now included the Department of Veterans Affairs in the top third of all Federal departments when it comes to workplace satisfaction and the pride that our workers have in being part of the VA. That is a great step forward. Without that pride, we will not be able to deliver the kind of customer service that our veterans expect.

In addition to that, I am also happy to say that the Department of Veterans Affairs, when Time issued its list of the 50 most influential health care minds and providers in this country, the Department of Veterans Affairs had researchers on that list.

It is a good news story to tell. It is one that I am proud to tell. And I am very happy and humbled to be part of that outstanding workforce that, on a daily basis, helps veterans remind all of us why we sleep soundly at night.

Mr. Chairman, I thank you for the indulgence and look forward to your questions.

[THE PREPARED STATEMENT OF SECRETARY WILKIE APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank you very much.

And just very quickly, since we have a large number of people here, I will be dropping the gavel at 5 minutes, including myself.

I appreciate you being here, but I would like to focus today, in this hearing, on the implementation of the VA MISSION Act, specifically the community care part, because that is coming up in 6 months.

And, really, it is literally—if we can do three things, I think, Mr. Secretary, and if you can lay out and give me some ease about how I feel about this: One, will we have networks in place? Number two, can you schedule an appointment to the doctor in those networks? And number three, will you pay the bills once the veterans have seen them, so they don't get dunned for the bills? I think if we can do those three things.

And my concern—we have the four regions of the country. The various regions have a year, according to the law, to put these networks together. And I know you are signing the contracts for 3, you said, hopefully by February and then region 4 by March. That is less than 90 days from the time this thing goes live, that last contract. Because I remember very well in 2014 the fiasco that occurred there.

So, of those three things, when we go live—or are you going to need more time? And, quite frankly, if you see it isn't happening, I would rather keep doing exactly what we are doing and implement it a month later than I would have this thing fall on its face and we fold up all the community care programs we have into one and it not work.

Secretary WILKIE. Yes, sir. Obviously, the goal is to fulfill those time commitments. I am going to take a step back and answer the third part of your question first, and that is the timely payment to our community caregivers and particularly our small-town doctors across the country. Without that, the entire Choice system contained in the MISSION Act fails.

We have learned valuable lessons from the experience of Choice. I do believe that we have the beginnings of a comprehensive set of standards we will take to the country to bring those community care providers into the networks. Those contracts are ready to go. We do have the lessons learned from, as I said, the problems that we had with Choice right now.

And I will go ahead and address an issue that was raised in the media this morning. TriWest is the bridge to the expansion of our program through the community care networks. And I am confident that, given the governance structure that we have in place, that we will be able to reach those goals.

I will also say that if at any time I don't think we can, I will be up here posthaste to make sure that we inform the Congress of that contingency.

I don't know if Dr. Lieberman wants to say anything about where we are in terms of the contracts.

Dr. LIEBERMAN. So we are really pleased with how our contracting has been going. We have been meeting weekly on this, and, as the Secretary said, we expect it to be completed on schedule, as he told you. And then we are ready to go with all the topics that you have brought up.

You know, we certainly are implementing a number of things to help with timeliness, including the timeliness of the payments. We are going to be requiring, except in rare circumstances, that the payments be electronic, which speeds up the claims process. We also are going to have an off-the-shelf product that will auto-adjudicate the claims and pay them timely.

Secretary WILKIE. And I would note—sorry, Steve—that is key. The Department of Veterans Affairs, as these Committees have noted on more than one occasion, has an IT problem. When it comes to claims processing, hands have to touch each claim.

What we have done is look to the market for off-the-shelf technology that will allow us to automate the claims process so that individuals are not having to touch each claim. And this will put the Department of Veterans Affairs in line with the most modern health care administrations in the country.

The CHAIRMAN. Well, my time has about expired, but this is what I want to have happen. If I am a patient and I come to see the doctor, and I need to go see a neurologist or whomever, well, I am seeing the VA doctor that day. I walk out front. The VA doesn't have that specialist in the hospital. I get my appointment scheduled, I get it made. I go see the doctor. That information is transmitted back, and the doctor gets paid. That is how the system work.

I had surgery 2—well, 18 months ago. Two weeks after surgery, the bills had been paid by the third-party administrator. And that is the kind of—I know it is not going to be that quick, but that is the kind of efficiency we want, and I hope that we have it. I am not expecting it on June 7, but I am expecting it sometime fairly soon.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, over the last few months, Committee staff has heard from various stakeholders, including VA, conflicting information regarding VA's development and/or adoption of what I talked about in my opening statement, designated access standards.

We have also heard from VA staff the President is likely to announce the adoption of a designated access standard model during his State of the Union address. However, Congress has not yet been made aware of which models are being considered and the reasoning behind any imminent decisions.

Would you commit to us today that you are willing to offer each of the four corners—and, I would say, Members of the Committee, but, I mean, it should be made available to all of us—a briefing by Milliman, who is the actuary, prior to the State of the Union, and reasonably before the State of the Union?

Secretary WILKIE. Well, Mr. Takano, what I will promise is that, as soon as the President is briefed—I owe him that courtesy, and certainly he is responsible for the final decision. And once he makes that decision, I will be up here with our team to brief this Committee, these Committees, for any comments and advice you have and any corrective actions that you might have.

It is absolutely vital. I think I mentioned in my confirmation hearing, I grew up in this institution. I know why Article I is the

first article. And I will commit to coming up here when the President does make his decision.

And it is still not clear if he is going to announce anything at the State of the Union, but I hope to have him briefed and have those decisions made before then.

Mr. TAKANO. Well, Mr. Secretary, I am a little concerned that this decision could be made, you know, the night before he delivers his speech and makes a grand speech about how every veteran is going to be able see any doctor they want to see. I mean, that is one model, any veteran they can see any doctor they want to see. Of course, that sounds good, but there are a lot of downsides to that kind of a model.

All the more reason why the VSOs are—many of them are complaining that there is a lack of participation as per what we said in the MISSION Act, that they should be participating in the development of these access standards.

And so I am not really satisfied with the answer. I wish we were able to get better insight as to what models you are considering, what the costs are associated with each of those models. Because that has a lot to do with how much money might be diverted from, you know, regular central VA care.

Secretary WILKIE. Mr. Takano let me answer the second part of the question first, in terms of engagement with the VSOs.

I can say that they are a vital part of what we do at the Department. In my time as Secretary, we have doubled the number of VSO engagements that the Department had prior to my arrival. The majority of our VSO engagements are handled at the Under Secretary level or above. Over the last 9 weeks, our VSOs have experienced briefings from senior leadership in the Department that last well over 4 hours a week.

I will also tell you that in my travels across the country I have made it a point to reach out to veterans' organizations in the rest of the United States. In Alaska, I spoke to the largest VFW post, I think, west of the Mississippi. I was just in your area of California, spent 2 hours with veterans' leadership in southern California. Did the same thing with the Indian Nations, the Native Nations in Oklahoma and also in Senator Hirono's State, in Hawaii, on the Big Island and also in Oahu. So that is important to me. If the veteran is not at the center of the decisions, it won't work.

But I will say, when it comes to access standards, I have in mind not only Senator Tester's State of Montana when it comes to the ability of our veterans to get to services but also have in mind some of the most heavily congested metropolitan areas of this country. We have to make it easier for our veterans to get the care that they need.

But I will also say—and I will repeat what I said when I testified in the Senate in September. My observation, my experience—and Senator Tester said it earlier today—veterans are happy with the service they get at the Department of Veterans Affairs. I have not seen any indication that the majority of our veterans are champing at the bit to find alternative ways to take care of themselves.

The most important of this is the one that is not quantifiable, and that is the communal nature of veterans' care. Veterans want to go places where people speak the language and understand the

culture. That is what I have experienced in my lifetime around the military, and that has certainly been validated in the travels that I have undertaken in the very short time that I have been the Secretary. Veterans will always be at the center of any decision that I make.

The CHAIRMAN. Appreciate the gentleman for yielding.

Senator Tester, you are recognized.

Senator TESTER. Yeah, thank you, Mr. Chairman.

I want to thank, Mr. Secretary, you and Dr. Glynn and Dr. Lieberman for being here.

I am sure, Mr. Secretary, you are aware of an article that was published yesterday outlining the overhead costs of the Choice program. It was reported that $1.9 billion, nearly a quarter of the funds spent on Choice, were for admin fees. I have a huge problem with that. Do you have a problem with that?

Secretary WILKIE. Absolutely.

Senator TESTER. Okay. So, moving forward, what are you going to do, or what are you doing, when it comes to admin costs from the private providers?

Secretary WILKIE. Well, in order to move forward, Senator, may I please take a step back?

Senator TESTER. A quick step.

Secretary WILKIE. This Committee addressed the problems with Choice with the MISSION Act. The article in question addressed the problems with the system before MISSION was passed, before I became the Secretary. I am cognizant of what went on with Choice, and you mentioned it: hastily put together in response to a tragedy in Arizona.

So it is my direction and I believe, because of the negotiations that we have been having with potential community care providers, that those administrative costs you will not see at the level that we experienced during Choice, because the Department, I will admit, was taken advantage of because of the hasty nature—

Senator TESTER. Okay.

Secretary WILKIE [continued].—that took place when the program was put together.

Senator TESTER. I will kind of accept that. But a lot of the folks who are delivering the care now under your thumb are close to one-quarter in admin costs—close to one-quarter. Now, I asked my staff to find out where the VA was before Choice for admin, but, as I recall, it was one of, if not the cheapest delivery care systems in the Nation when it comes to an admin cost. So I would say that.

The other thing I would say is this. And Congressman Takano talked about this. If access standard models are expanded to the point—and I don't think it was congressional intent for this; in fact, I know it wasn't—for unfettered choice, we got a big problem. Because it is going to cost more money. The care isn't going to be good. I talked in my opening statement about Blue Water veterans. You know why we can't get Blue Water folks covered? Money.

So extrapolate this out a little bit. If it costs more to be in the private sector, if admin costs are higher, benefits are going to be cut. And so, while you say it is the President's decision—and it is; he is the boss—there better be some good, good information coming

from you and the people that know better that this access standard needs to have some controls around it.

Would you agree?

Secretary WILKIE. I agree with you.

Dr. LIEBERMAN. I just want to mention that the administrative costs were not as high as was quoted in that article. The number is less, and it has actually been over years, so it is a much lower percentage.

We have learned since Choice was first implemented in a hurry. What we have now moved towards is itemization of the administrative charges, so there is now a range of what the charges are, and to—close to the amount that was in the article for individual. But then with the Community Care Network, we actually have learned more, and we are going to go to a new model which will further decrease the administrative costs.

Senator TESTER. Okay. And so are you planning on putting overhead caps in those contracts?

Dr. LIEBERMAN. We are moving towards a standard similar to what the community does.

Senator TESTER. So that is a no, correct? You are not going to put caps in them?

Dr. LIEBERMAN. We certainly can—

Senator TESTER. No, I am not advocating for it, but what I am saying is somebody has to have the finger on these costs. Because I will tell you, we are talking billions of dollars, and, after the fact, we can't get it back. And those are dollars that should be spent taking care of veterans.

So do we have a plan? Because the truth is the MISSION Act, we passed it with the best of intentions, but it could be a train wreck too. And I hate to tell you this, but it is kind of in your lap. It is in your lap. And so, when we are talking about too-high admission costs, when we are talking access standard models that were basically unfettered choice, we could end up with a problem where we are actually cutting benefits for our veterans moving forward. And my guess is, if you asked any of the VSOs, that that would not be a good thing. So I just want to make sure that is on your radar screen.

I have to have one more because I have to get it—I only have 25 seconds left. You talked about giving information to the VSOs, you talked about briefings. Are you gathering information back from them? That this isn't an information dump on the VSOs, that you are actually listening to them and finding out what their concerns are. Because I am telling you, it is critical. It is critical for us; it is critical for you.

Did you want to answer that, Dr. Glynn?

Secretary WILKIE. I can do it.

Senator TESTER. Go ahead.

Secretary WILKIE. Absolutely. In fact, many of the people in the audience will be with me tomorrow morning in my office discussing what was discussed here, and they will be telling me their input after—

Senator TESTER. So I am not throwing anybody under the bus here, but I am going to tell you that a lot of VSOs have talked to

me about the communication within the VA. It is not where it needs to be.

Secretary WILKIE. Senator let me add one thing to that.

Senator TESTER. Okay.

The CHAIRMAN. If you could add that quickly.

Secretary WILKIE. I will do it real fast.

Something has happened in the makeup of our veteran's population. For the first time since the fall of Saigon, half of our veterans are now under the age of 65, which means they have different cares, they have different interests.

What I have done in my short time is actually opened the aperture to the table at the Department of Veterans Affairs to bring in veterans who are not traditionally part of the system—Purple Heart, blinded veterans, student veterans. In fact, we have more veterans at the table discussing their issues with us than we have ever had, and that mirrors the change in the Active Duty, Reserve, and retiree population that we have seen.

So you have my commitment that every veteran who wants to talk will be heard and input be given.

Senator TESTER. Thank you.

The CHAIRMAN. I thank the gentleman for yielding.

Senator Moran, you are recognized.

Senator MORAN. Chairman, thank you very much.

Mr. Secretary, thank you for you and your team's presence today.

I asked my staff to give me the statutory requirements of your consultation with Congress, and it turned out to be pages. In the MISSION Act, you are directed to consult with us as you develop regulations. And the goal of that language was to make certain that Congress was informed before the regulations were determined, not a consultation that says: This is what the regulations will be.

My understanding is that those consultations that have occurred have progressively gotten better. We still want more specificity, and you seem to be headed in that direction, but I would encourage you and your team, as we get those briefings, to give us the details so that we can encourage, comment, suggest in advance of decisions made at the Department of Veterans Affairs. That was a very intentional aspect of the language included in the bill.

Let me see if I can get a couple of things in the 4 minutes, I now have left that are specific.

First of all, how you define how the Department of Veterans Affairs defines episodic care is a hugely important issue in regard to how the MISSION Act will be implemented and what kind of care our veterans will receive.

Can you, Mr. Secretary, in a specific way tell me how you will define episodic care?

Secretary WILKIE. Well, I will let the doctor describe that.

Senator MORAN. Doctor, thank you.

Dr. LIEBERMAN. So it will depend on what the issue is. Certainly, we have the six different criteria that go into it. If it is something where you require orthopedic surgery, require physical therapy, we will bundle the care for that, whereas, if we can't provide it, we would provide it outside. So—

Senator MORAN. Obviously, in 4 minutes there is not a way to be terribly specific, but it will be something we will continue to ask you.

Dr. LIEBERMAN. Sure.

Senator MORAN. I would tell you that my interest in these topics is generated by our casework, what veterans bring to our office and what problems they have had under Choice. The idea that you have to go back to the VA every time to get the laboratory work, the x-ray, that is not an efficient system and one that is designed to fail and not be beneficial to the veteran.

Would you commit that we will be able to review your definition, Mr. Secretary, of episodic care before the regulatory process—

Secretary WILKIE. Absolutely.

Senator MORAN. Thank you, sir.

Let me then turn to access standards, which has been a topic of conversation by most of my colleagues who have spoken already this morning.

Here is what I would look for in today's setting: I would like to have assurance that access standards will be applied to where a veteran actually lives, not his or her post office box, as has been the case in the past.

Secretary WILKIE. Absolutely. And I have said on many occasions—and most of my focus has been on the western United States. That is absolutely necessary if we are going to make Choice work. It is striking to me that still, in 2018, we don't understand the scale of the American West. And what you have said is absolutely essential if we are going to make access standards work.

Senator MORAN. Another piece of casework that has become a challenge for us is the definition of "in the VA." And that is that, in circumstances in which our veterans are trying to access care, the VA's response is: The care is available within the VA broadly. In my view, the question is, is the care in the VA available at the facility, the hospital where the veteran lives? And our veterans are being asked to travel long distances because the care is available in the VA but not geographically available.

Secretary WILKIE. And that is one of the things that we will fix as a result of the MISSION Act, and we will get a system in place that allows the veteran the opportunity to get that care that is most convenient to him and to his family.

Senator Tester is gone. The example I use is the 700-mile round trip in Montana. In Kansas, the distances are almost as great. So, absolutely.

Senator MORAN. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Secretary WILKIE. Thank you, sir.

The CHAIRMAN. I thank the gentleman for yielding.

Senator Murray, you are recognized.

Senator MURRAY. Yeah, thank you very much, Mr. Chairman.

Mr. Secretary, before I get into the main focus of this hearing and my concerns about the caregiver bill, I do want to mention the current chaos with the GI Bill.

Secretary WILKIE. Yes.

Senator MURRAY. It is unacceptable to leave veterans without a stipend or an incorrect stipend or a delayed stipend, especially

when they rely on that to pay for rent or food. And it is unacceptable to put veterans' enrollment at risk by failing to get tuition payments to the universities, as well, on time. These are basic tasks that the VA cannot get wrong.

You have had more than a year now to implement the changes in the Forever GI Bill. I have written you two letters, one more than a month ago, one 3 weeks ago, looking for answers on how the VA is going to fix these payment problems, how they are going to address the shortcomings with the GI Bill comparison tool, and, especially in light of the recent collapse of the ECA, to explain why the Department of Education has stopped sharing accreditation information with the VA.

I don't want you to take the time to answer right now. I would like a written response back to those—

Secretary WILKIE. Yes.

Senator MURRAY [continued].—and I want you to know we are all very concerned about it.

Senator MURRAY. But I do want to ask about the caregivers program, because, according to briefings from the VA, the Department has ruled out trying to narrow the eligibility criteria for the caregiver program, but I am still very concerned that there is a number of issues the VA is looking at that I am concerned about, including changes to the stipend, restricting veterans based on their type of injury, or requiring a minimum disability rating. This seems to be VA still focused on keeping people out of the program instead of making it work better for our veterans.

And, yesterday, NPR reported on several cases where veterans, including a double and a triple amputee, were downgraded or kicked out of the program completely inappropriately. And these are, by the way, not one-off VA cases; we are hearing that this is a continuing problem in the VA's management of this program.

When the VA previously downgraded and terminated caregivers, the VA assured me that it had resolved the problems that led to these types of actions, but it is very clear that is not true. And I would like you to immediately reinstate a ban on downgrades and terminations until VA can demonstrate to us that the serious management problems have been corrected and these types of outrageous errors will not occur again.

Secretary WILKIE. Senator, I will say that caregivers is especially important to me. I am the son of a gravely wounded Vietnam—

Senator MURRAY. I appreciate that.

Secretary WILKIE [continued].—warrior, and I have seen my mother and family take care of my father prior to his passing last week.

Senator MURRAY. I appreciate that.

Secretary WILKIE. The—

Senator MURRAY. So will you reinstate the—

Secretary WILKIE. Yes?

Senator MURRAY [continued].—ban? Will you reinstate the ban?

Secretary WILKIE. I am not familiar with all the rules, but I will tell you that the National Public Radio story, that problem was corrected within 24 to 48 hours.

Senator MURRAY. Those are not isolated cases. We are hearing many of them.

Secretary WILKIE. And those cases, is my understanding, have been corrected because of directives from this department, that people were not reading the regulations properly.

So my promise to you is that I am going to do everything I can to make sure everybody stays in the program. It is that important to me personally.

Senator MURRAY. Can I have your assurance that no one else will be downgraded or kicked out of the program until you look and make sure that the regulations are being implemented at every level correctly?

Secretary WILKIE. Absolutely. I will make that commitment and will brief these Committees.

Senator MURRAY. Okay. And also—I won't have enough time, but I would like you to get me what your guidance to the program office is and your guidance to the field on how this is being implemented so that we can see what you are telling your staff.

Secretary WILKIE. Yep. Yes.

Senator MURRAY. Okay. And I am also very concerned about the implementation of the changes to the caregiver program that were passed as part of the MISSION Act. Before the expansion can begin, you have to certify that a new IT system is in place. And the law required you to have that system in place by October 1st. That was a month and a half ago.

This was not a new requirement. GAO's initial recommendation to fix the IT system was made in September of 2014. And the VA has repeatedly assured us that it is working on that issue. I want to know when you will have that IT system in place and make the certification as the law requires.

Secretary WILKIE. The goal is October 1st.

Senator MURRAY. That—

Secretary WILKIE. I would not be telling you the truth if I told you that that I was absolutely certain that, given the state of VA's IT system, that that date will be met.

Senator MURRAY. That was a month and a half ago. The date has passed.

Secretary WILKIE. No, I am talking about for—no, it is October of 2019—

Senator MURRAY. No.

Secretary WILKIE [continued].—to certify that the IT works. Are we confusing two dates?

Senator MURRAY. That is your new goal. That is not the goal you were given by Congress.

Secretary WILKIE. Go ahead.

Ms. GLYNN. The timeline to certify the new system is ready is 2019—October 2019.

Senator MURRAY. Okay.

Ms. GLYNN. We did miss the October 2018 date to support the new system.

Senator MURRAY. So you gave yourselves another year?

Ms. GLYNN. Well, there were two dates—there are two dates, Senator, associated with the requirement. The first date, which was October of this year, was for validating and deploying a new system. We have not deployed the new system, but—the certification of that system, which is required prior to expansion—

Senator MURRAY. Okay. Have you fully defined all of the requirements for that system?

Ms. GLYNN. We have worked on—we have fully defined requirements. We are working, as the Secretary mentioned, on user-acceptance testing of the system, and we are working through that. We do not want to deploy a system until it has been thoroughly tested and we feel it is capable of serving caregivers' and veterans' needs.

Secretary WILKIE. And I would say that has been the problem that I identified and talked, discussed, with the Members of this Committee. GI bill was a classic case, Senator, of a program being imposed on a system that was incapable of handling it. That is why I had to make the decision to go back to the old system on the GI bill.

The same applies here. The system was not capable of addressing it. I give you my commitment: I am doing everything that I can, and so is the Department, to bring the IT system up to modern standards.

The GI bill, we were talking about a 50-year-old IT. system. And it is not acceptable, but you have my commitment that we are working with the best minds we can find to make VA a modern health care administration and benefits—

Senator MURRAY. Mr. Chairman, I know my time is out. I have been on this Committee for more than 20 years, and I always hear we are not going to get an IT system because there is a problem. Every time it changes, every time, there are problems. We have got to get this right. People are counting on it.

The CHAIRMAN. I appreciate the gentlelady yielding back, and all I can say is amen to that IT. I have heard it for 10 years.

I now yield—and please be respectful of everyone's time. There is a lot of people here. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. I could yield back right now. But I won't.

Folks, we will get to the heart of the matter very quickly. You are designing a system that you are going to implement for the benefit of the outcome of the veterans. In my district, the First District of Michigan, if any system will work in that district, it will work anywhere because you have a largely rural district with some small cities. So I am hoping, or at least optimistic, that you have factored that in, that whatever system you are designing to get the veterans, caregivers in this case, into a functional status, that you consider the tyranny of distance, the tyranny of weather, and all of that.

Now, in setting up your network, I am guessing—although I don't see it in the slides—there are certain assumptions that you have made, and certain risk assessment involved with those assumptions. And I would like to ask you to just take this for the record. If you could—we don't need to talk about it here, but if you would give us that list of assumptions and the risks that you have, you know, put together, that would be greatly helpful.

And I noticed in the slides here—great slides—I would guess that these meetings that are, whether they be weekly, daily, bimonthly, when you find there is a course correction as a result of a meeting or an update, that needs to be made, what do you do?

I mean, I don't see that in the slides, okay, we have ID'd it—and I am a pilot. You see a need to change your heading, change your heading. Don't wait.

Ms. GLYNN. Thank you, Congressman. Right now, our team actually is engaged in 180-day reviews back at the VA on all elements and the provisions of the MISSION Act. And we are, as you say, identifying risks and identifying, as Senator Murray highlighted, concerns with things like IT, how do we take different, parallel paths towards getting to that October date. So we are bringing that through our executive Committee, and then issuing guidance to the teams, working through resource requirements, working through changes in project plans, understanding what our needs are, and bringing forward a stakeholder engagement protocol so we can continue to uplift this program and make sure we can hit the—

Mr. BERGMAN. Do you feel that there is—seems like—you know, as a Chairman on the Subcommittee on Oversight and Investigations, one of the questions was always asked in every hearing: Is there a sense of urgency? You know, within your folks that are trying to implement, you got good people trying to do the right things. Is there a sense of—this may sound like an oxymoron—bureaucratic urgency?

Secretary WILKIE. Yes, sir. And that is one of the reasons why a battle rhythm was implemented. I have, as you know, a military background, not as extensive as yours. The Department has never had a governing structure for anything this—and we do now, and we have timelines to meet just as we would on the flight line in my Air Force life. So, yes.

And I will also point back to what I said earlier about the attitude of those in the Department. It has been my experience that we have incredible support from those in the career leadership because they understand that VA can't fail on this one. And I am very happy with that attitude.

Mr. BERGMAN. Okay, well, number one, thank you for your service, and all honorable service is—it should be respected by all. And I could just say personally the biggest, proudest moment I have had is to lead marines and be mentored by lance corporals who have a 20-year-old view of the world, and that is what drives us.

But, with that, in the interest of time, I am going to yield back 50 seconds.

The CHAIRMAN. I thank the gentleman for yielding. And one of the things our Senate colleagues could do to help the Secretary is to confirm his Assistant Secretary for IT That would be helpful.

I now yield to Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you, Mr. Secretary for being with us today. I wanted to follow up with Senator Murray's questioning with regards to the caregiver program. And if I could, I heard you make a commitment, but I want to be abundantly clear that you are committing to us today to not modify any of the current eligibility requirements within the caregiver program as it expands?

Secretary WILKIE. I am committing to review every case involving a caregiver who is in distress. I am also committed to making sure that before any decision is made on the future of the program,

that this Committee is involved in it. And as I told Senator Murray, I will be reporting to her on the path forward.

It is important to me personally because of my own experiences. And we are going to get this right for the 5.5 million family caregivers out there.

Ms. BROWNLEY. You had mentioned earlier in response to some other questions with regards to the importance of the input of VSOs and veterans in general. You responded, I think, by saying, you have even expanded that audience of veterans from younger veterans and trying to get a broader representation, which I think is good.

On the other hand, the leadership of the VSOs really lead by consensus within their organization, and representing that broad census. And I, too, have heard from many of the VSOs that they don't feel, and particularly in the caregiver expansion, that they are—or have not been involved to the degree that I believe, and I think we all believe that they should be, in terms of properly making right decisions as you move through this process.

Secretary WILKIE. Well, you have my commitment, and so do they, that they will be involved, they are involved, in making sure that we make the right decisions. But I will fall back on what I said earlier. It is important for us, as you pointed out, to make sure that we hear from the entire cross section of the Nation's veterans.

I said in my statement that, on the caregiver effort, that would not have been able to come to the finish line without the work of what I call the foundational VSOs, and that is my recognition that they are central to the entire issue of caregivers because the majority of veterans who are in that category and who need that family care at home come from Vietnam, the Vietnam era. Some less in the Korean era. And the foundational VSOs are the ones who represent the community most impacted by the caregiver.

Ms. BROWNLEY. And can you commit to providing our Committee progress reports in terms of the IT system for the caregiver?

Secretary WILKIE. Yes.

Ms. BROWNLEY. So that we can feel as confident as you do in terms of meeting the October 2019 deadline.

Secretary WILKIE. Absolutely.

Ms. BROWNLEY. That would be great.

Just in terms of broadly, you know, the governance structure that you have set up for assistance in the implementation of the MISSION program, I think, you know, one of my frustrations on the Committee—I have served on the Committee now for 6 years—is that we have VA representatives come to testify that are updating—in this case, we are going to want, obviously, frequent updates on the progress with the implementation of the MISSION program. But many times they come, they avoid answering the tough questions. The response is usually: We will take it for the record; we will get back to you.

I have found that I don't get—I don't get responses. If I do, it is months and months later. So I just, you know, would like, again, to get your commitment that if it is you or others representing you, that you will provide us with the best information possible to be informed and prepared for our questions, and at the end of the day, given you have set up a governance structure that—I want to hear

from you that, at the end of the day, the buck stops with you and that you alone are accountable for the successful, hopefully, completion of the MISSION Act.

Secretary WILKIE. Congresswoman, that is right. I mean, I am accountable to you. I am accountable to the VSOs. And I am accountable to veterans. I will say—and I mentioned having grown up in this institution—that I will note that in the time that I have been the Secretary and the Acting Secretary, we have seen a 20-percent increase in terms of the number of roundtable briefings that we have given to Committees—the Committee and staff.

And we have seen a 50-percent increase in terms of the number of actual individual congressional engagements with offices across the Congress. That is part of the commitment I made to Senator Isakson and Senator Tester in my confirmation hearing. I will make that better. Again, having grown up in the institution, I am aware of Article I.

Ms. BROWNLEY. Thank you, Mr. Secretary, and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Banks, you are recognized.

Mr. BANKS. Thank you, Mr. Chairman.

Mr. Secretary, in my mind, the MISSION Act is about making sure the community care dollars that Congress appropriates actually makes it and reaches the veteran. Our Committees have a spirited debate every year about the funding levels, but the reality is—and you can pick your analogy here—it seems like we have been pouring money into a leaky bucket, or through a clogged-up pipe.

When authorizations get delayed or lost, the veteran does not receive the necessary care in a timely fashion. When the providers do not get paid, they eventually drop out of the network, and the veteran far too often winds up in collections. So, by consolidating all of the different, legal authorities and programs for community care, the MISSION Act actually gives the VA the first chance in years to actually make the system work.

My question to you, though, is this: Do you agree that the MISSION Act merely makes it possible, and the law's implementation is only the beginning of a lot of hard work to establish better payment procedures, stronger audits, connected IT systems, improved customer service, clear communication to veterans, and in so many other areas?

Secretary WILKIE. Absolutely. Absolutely, it is the greatest first step, but it can't stop.

Mr. BANKS. I appreciate that sentiment. But I do want to explore one aspect of that hard work. Achieving interoperability with the community providers and their EHRs is one of my top priorities. And I know, from speaking with you personally, it is one of your top priorities as well.

The VA implementing Cerner is going to advance interoperability with community providers that already run Cerner, but what about the other medical practices that have other EHRs? What is the linkage between the Office of Community Care and the Office of Electronic Health Record Modernization to start specifically attacking that problem?

Secretary WILKIE. Right now—I will confess I am not an IT expert, but right now, we are testing those standards, those operations in the Pacific Northwest and in Alaska so that these systems talk to each other. Our first goal was to make sure that DoD and VA talk to each other. I think we are pretty far along the road on that.

The next is to make sure that we communicate with doctors in the private sector, community-care hospitals, as well as private pharmacies, and to talk to those systems that are not part of the Cerner network. It is done in other areas of the country. I am confident that it will be done here.

I will say quickly, you are absolutely right about the interoperability, and I will also say to the issue of privatization, I have argued that the success of the electronic health record system ensures that VA will stay at the center of a veteran's health care, that VA will be the central node, no matter what that veteran decides to do, and that that is one of the answers when it comes to the issue of privatization. I see that as a veteran myself, I see that when I look at the experiences of people in my family as well.

Mr. BANKS. I appreciate that. One of the other key areas is claims processing. We have talked about this a little bit already, but the VA is essentially asking the consolidated community care network contractors, whoever wins the contracts, to bring to the table a new and improved claims processing system. VA is still going to have to pay the company somehow, though. But the idea here seems to be to outsource the IT system along most of the claim—along most of the claims-paying function. Can you please comment on the thinking here and how that will improve the situation?

Ms. GLYNN. Thank you, Congressman. Overall, we are making—as you have mentioned specifically, there are many changes. It is not just the consolidation of the regulations that govern the Choice Program now. We are implementing an electronic claims payment system so we can auto adjudicate claims.

We also are changing the way we will pay the third-party administrators as well so that they have the funding available to pay the providers. So all of that has to happen in tandem and as part of the implementation to get to June 6. So, as you mentioned, there are many aspects of this, and it is certainly not just the consolidation of programs and new regulations; it is building up the technical infrastructure associated with the community care program.

And there will be changes in how the TPAs are paid as well. And we have committed significantly to looking at the potential for fraud, waste, and abuse in that system.

Mr. BANKS. Thank you. My time has expired.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Mr. Secretary, thank you for joining us today. Are you aware the Congressional Budget Office estimated that the MISSION Act would cost around $46.5 billion over the 4 years from 2019 to 2023?

Secretary WILKIE. Yes, sir.

Mr. LAMB. That number is familiar to you?

Secretary WILKIE. Yes.

Mr. LAMB. Now, as far as I am aware, there is no pay-for that is specifically for that $46.5 billion, right?

Secretary WILKIE. Correct.

Mr. LAMB. Okay. And those would be discretionary funds?

Secretary WILKIE. Yes.

Mr. LAMB. So they would count against the budget cap on VA under the current arrangement?

Secretary WILKIE. Yes, sir.

Mr. LAMB. And if we went over that budget cap because of this $46.5 billion or any other spending, that would trigger sequestration, right?

Secretary WILKIE. Correct.

Mr. LAMB. So, in other words, for that $46.5 billion, in order to avoid the sequestration, we will have to find the money within VA's current budget, right?

Secretary WILKIE. Correct.

Mr. LAMB. Okay. Now, are you aware that the President has asked that each of his agencies cut their total budget by 5 percent?

Secretary WILKIE. Yes, I am.

Mr. LAMB. Did you receive that request yourself from the President?

Secretary WILKIE. I did. I did.

Mr. LAMB. Okay, now do you have a plan to do that?

Secretary WILKIE. I have discussed the plan with OMB.

Mr. LAMB. What is the plan?

Secretary WILKIE. I have discussed the plan with OMB. The President hasn't approved it, so I will wait for his decision.

Mr. LAMB. Will the money for community care be cut by 5 percent?

Secretary WILKIE. I am—well, first of all, for the—I will just say for the Choice Program, we are fully funded. We are funded into next year. I have no—and I will say that in the submission that I made, there were no cuts in community care.

Mr. LAMB. There were no cuts in community care. So the 5 percent would come from the rest of the VA's budget that does not involve community care, correct?

Secretary WILKIE. Absolutely. And as a steward of the taxpayers' money, I am going to do my best to make sure that we are as efficient and lean as possible.

Mr. LAMB. So actually the non-community care part of the VA's budget is going to be cut twice, right? It is going to be cut by this 5-percent requirement, and it is going to be cut by whatever needs to be spent on community care?

Secretary WILKIE. Well, we don't know where it is going to be cut. I have made—I have made proposals—

Mr. LAMB. You have made a proposal?

Secretary WILKIE. I have made a proposal.

Mr. LAMB. And you are not sharing with us any of the details of that proposal?

Secretary WILKIE. Because I have not had that conversation with the President.

Mr. LAMB. Does it involve cuts to personnel?

Secretary WILKIE. It makes efficiencies in the system, I will say that.

Mr. LAMB. Does it involve fewer personnel 2 or 3 years from now than there are today?

Secretary WILKIE. No, I can't say that. I can say that in the last fiscal year, we have hired 11,000 more employees at VA. So we have been hiring at a very steady rate.

Mr. LAMB. Will you commit to providing us, before the end of this year, an itemization of the things that you propose to be cut with that 5-percent requirement?

Secretary WILKIE. I commit to discussing with the Committee, at the earliest possible date, the decisions that are made by the people who are responsible for those decisions. Again, I owe the President the courtesy of having him make the decision and then come to the Congress. And you are the ultimate arbiter of what that budget will be.

I can tell you from my experience what usually happens in Democrat and Republican administrations when a budget comes to Congress. I can't think of the last time one was passed as it came over from the White House. That is just the practical nature of the business.

Mr. LAMB. Do you know when you will find out from OMB or from the President?

Secretary WILKIE. Oh, I certainly hope in the next few weeks.

Mr. LAMB. Okay. And we do have your commitment, once you receive word from them, to brief us on your proposed cuts to—

Secretary WILKIE. Once the President has given the all-clear—and you know the dance that goes on with the budget process, usually coming in to the finish line sometime in February. I will be as transparent as I can be within the strictures of the system as it has existed all the way back to 1974.

Mr. LAMB. Well, we would like to see an itemized proposal that you have given to the White House as to what should be cut, and we would like to see that at the earliest possible date.

Secretary WILKIE. Absolutely.

Mr. LAMB. Thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Just to clarify a little of this, it does get wonky, but the fact that you would cut 5 percent doesn't necessarily mean it would come out of the VA's budget. And I would refer to this graph right here. You can take a look at—these are the number of employees right here, Mr. Lamb, that have been hired. And I have been here 10 years and looked at this, and the VA has had an average of employees who left, from 2013 to 2017, of about 25,000 per year, and they have averaged hiring 31,000 during that time.

And on the budget caps, if we go back to the sequester levels—that was the way for 2 years—we have gone from $97 billion when I showed up here in 2009 to this—I think this last budget was $206 billion, so it is over doubled in the last 10 years, and we found that money elsewhere in the caps. It didn't necessarily come from the VA. The VA actually benefitted under the caps.

Secretary WILKIE. Mr. Chairman, may I make one more comment—

The CHAIRMAN. Yes.

Secretary WILKIE [continued].—to Mr. Lamb's line of questioning? And I may be out ahead of my skis—I have come from the Department of Defense. I am now at the other Department in the Federal Government whose needs, its mission, is unique. I mean, you have served in one of the two—one of the two Departments. As the Chairman has said, our budget has been going up. It is at record levels.

I do expect the President to continue his robust support for this Department, as he has for the Department of Defense. We are different, and as the Chairman has said, that has been reflected in the increase of our budget and the priority which this administration has placed on both Department of Veterans Affairs and the Department of Defense.

The CHAIRMAN. I thank the gentleman for yielding.

Thank you.

Mrs. Radewagen, you are recognized.

Mrs. RADEWAGEN. Talofa. I want to thank Chairman Isakson, Chairman Roe, and Ranking Members Tester and Walz, who is not here, for holding this joint hearing, and greetings, Chairman-elect Takano.

I want to thank Secretary Wilkie and the panel for their testimony.

I also want to thank the VA for working directly with my staff in keeping me informed on the status of the community care network contracts in the U.S. territories.

The Pacific territories, including my home of American Samoa, face unique challenges due to their relative isolation both physically and economically from the rest of the United States. So one-size-fits-all measures simply do not work for the territories, and special care must be taken to ensure that the unique health care needs of Pacific veterans are considered.

To that end, I am glad that VA is considering the uniqueness of the territories in handling their CCN contracts separately.

Secretary Wilkie, VA staff briefed my office on CCN contracts just last month, and I would like to take this opportunity to touch on the topic once again. Could you go over how the unique challenges faced by the Pacific territories will affect both the timeline for the CCN contracts and your ability to comply with MISSION Act requirements?

And could I also get your commitment to work with Congress so that implementation of the MISSION Act, the contracts, and any future related legislation is in line with the needs of the territories? To put it another way, will you help us help you provide for our Pacific veterans? Timeliness is always a factor, but we also want to make sure we get this right.

Secretary WILKIE. Thank you. I just returned from Hawaii, and I made a commitment to one of your counterparts, the Governor of the Northern Marianas, that I will be visiting American Samoa, Guam, and the Northern Marianas. It is important to me.

I have made a commitment in the continental United States to reach out to the Native peoples of this country. The same applies to the American citizens in the Pacific. No group serves in the military at a greater rate than the men and women of the Pacific Islands or the Native peoples of the continental United States.

The unique nature of the challenge is 4.5 million square miles that we have to take care of in the Pacific. My commitment is that that special categorization of the community care network for the Islands in the Pacific will address the unique needs.

We will make sure, particularly through the implementation of additional telehealth services, more robust visits from our major medical center in Hawaii, to the Pacific Islands, that we always take care that the Islands are recognized for the special needs that they have.

Dr. LIEBERMAN. And I just wanted to add—and you probably are also briefed on this—that we want to look at how TRICARE has succeeded in these areas, lessons learned from them also. And, yes, we have to get this right, and so we will continue to work until we get this right.

Mrs. RADEWAGEN. Thank you, Mr. Chairman.

I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Ms. Esty, you are recognized for 5 minutes.

Ms. ESTY. Thank you, Mr. Chairman.

I want to thank Chairman Roe and Chairman Isakson and Ranking Members Tester and Walz, in particular for their efforts on the Blue Water Navy veterans. This is an incredibly important issue. These are folks who served decades ago, and we owe it to them, and it is relevant to today's hearing. Because if we are not managing these budgets appropriately, they will not be able to get the care they deserved.

They say: If you bought it, you broke it.

When we break people, when we ask them to serve this country, we owe it to them to find the means, not just the will, but the means to do right by them, and I, again, thank our colleagues in the Senate for their enduring efforts to get this passed.

I wanted to quickly say something on the CARE for All caregivers, as Senator Murray did. Several of us have worked on these issues. And, again, this is an area where we have made commitments; we know it is the preference of our veterans; and we need to find a way to honor those commitments.

And that brings me to today's hearing, the utter importance of managing these budgets appropriately. We have made promises to people that we are going to get them care where they want it, how they want it. And in order to do that, we have to manage those budgets. So first—and I see I have not lost all my time here, but we will continue on. They have me at negative 12 seconds already.

Will you have sufficient funds in the 802 account given what we know right now? Do you have sufficient funds for the community care networks in the 802 accounts, given closeout costs, given authorizations and contested claims, that you still need to finish? So this wanting to make sure that we make that transition to MISSION, but we can't let go of what we currently have.

Ms. GLYNN. Let me assure you that overall we are monitoring, on a very close basis, the expenditures related to 802 and the current Choice and PC3 Programs, and we do believe and forecast that we will have funding available through the end of this fiscal year and have taken account all closeout costs and what we believe from a claims perspective in those projections.

Ms. ESTY. Thank you, Dr. Glynn. And if it turns out not to be correct, please do let us know because obviously it is very important. We should not leave anything in that transition.

Secretary WILKIE. And I would add to that: You are correct. This is the wave of the future for medicine, for VA care, particularly for—even though the majority are from the Vietnam era—for the new veteran. They demand service at home. They expect service at home, and the trends in medical care in this country, as you have rightly pointed to, are that people get better when they are at home.

And you have my commitment to do everything I can to make sure that this is fully funded, and it reaches every veteran that we can touch.

Ms. ESTY. Thank you. Thank you again, Secretary, for being with us here today. I wanted to just review again, from the very beginning, what timeline we are to expect right now with the awarding of the contracts for Regions 1, 2, 3, and 4, because they are a little bit different than what we had in briefing, and I want to make sure we are all on the same page, please.

Dr. LIEBERMAN. For 1 to 3 is by the end of February, and 4 is by the end of March.

Ms. ESTY. All right. Well, we will want to be, you know, looking at that timeframe again.

And I would like to return for a moment to the discussion we had on the number one clinical priority, and that is on military suicide prevention. And it is, Secretary Wilkie, in part that connection between the handoff from DoD to the VA that is something we need to do a much better job of. I would suggest those of us working on this, on the Committee, really do believe a checkback in 6 months after returning would be a very helpful time, to make sure people are in the system; that is number one.

But, number two, I do have to push back, as my colleagues have, if we know for younger veterans that they are using social media and they are not already involved in the system with VA, why in the world have we barely touched the money that this Congress has allocated for you to do that outreach? It is just astounding to me, knowing that this is a group who is not in the system, they need different ways of being connected. We are baffled as to—with this epidemic of military suicide, how we have done so little to use those funds that we have allocated.

Dr. LIEBERMAN. So we actually used $1.5 million of that, not as—as the year went on, we used $1.5 million, but overall, we actually have used—$12.2 million we spent last year in outreach, and we have done a number of different efforts.

We were in the Nielsen top 10 for the public service announcements. We did 22,000 outreach events. Last week—last year our suicide coordinators reached 2.2 million individuals. We also had the Be There campaign. I don't know if you saw the advertisement with Tom Hanks. And we actually set up a Web site with information and actually had over 100,000 hits to that site. So we have actually been very active.

And this year, I am making sure that we are spending the funding 100 percent, and so I am reviewing the budget monthly and making sure that this moves forward. We certainly have obligated

all the dollars, and we have plans to reach out, including social media this year. We have to get it right.

Secretary WILKIE. And I would also say that I was responsible, as the Under Secretary of Defense for Personnel and Readiness, for instituting the training and the awareness on the part of Pentagon commands on the challenges and the threats to our servicemen and women, regarding suicide. We instituted the Transition Assistance Program to include those markers indicating that there is a potential for a very tragic event. Secretary Mattis has committed to that. I am committed to being part of that.

We also, thanks to these Committees, are treating those who have other than honorable discharges and making sure that they have that transition assistance and that we join with the Department to try to catch this before it becomes tragic.

Ms. ESTY. Thank you, and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Senator Boozman, you are recognized.

Senator BOOZMAN. Thank you, Mr. Chairman.

Secretary Wilkie, thank you for being with us, and we really do appreciate your service very, very much. I have had the opportunity to serve on the House or Senate VA Committee since I came to Congress, and over the years, I have seen the VA go, repeatedly, through pains of implementing many new programs.

This Congress may pass significant legislation that will bring, quote, fundamental transformation to the VA. As you know, when the VA fails to properly implement programs, these Committees become the backstop to ensure resources are surged to mitigate the impact to the greatest degree possible.

During a staff briefing about how the VA is going to fix its implementation of the Forever GI Bill monthly housing stipend payments, the VA was unprepared to answer basic oversight questions about how much funding had been spent on failed attempts, how much funding had been spent on efforts to react to the problem, and what lessons the VA had learned from the situation that it can take forward to other implementation efforts in the future and under way at the current time.

These aren't hard-hitting questions. These are just the basics. More to the topic of this hearing, MilCon-VA staff had a meeting with your staff to get an update on where the Department is with determining access standards, a key factor that will have an impact on our VA funding levels.

When I hear that one set of information is provided to authorizing staff, another set of information is provided to appropriating staff, and a different set of information is provided in briefing to all Committee staffers, that is a problem.

And I agree with you, totally, the VA is filled with truly wonderful people, but when your staff comes over without their act together, with no semblance of transparency, that reflects on VA leadership, which you have direct control over. We know that it just works better when we can trust each other and work together. We simply don't have any other choice.

For fiscal year 2019, the Congress appropriated $5.2 billion for the Veterans Choice fund and $9.4 billion for community care. Can

you tell us what the current burn rate is of community care in the Choice programs?

Dr. LIEBERMAN. It is—I don't remember the exact number, and we can get it for you, but it is somewhere—

Senator BOOZMAN. We have gotten two different ones, 460 or 340.

Dr. LIEBERMAN. Yeah. My understanding is, it is around the 460 one.

Senator BOOZMAN. Okay.

Dr. LIEBERMAN. But we will get back to you with the exact number.

Senator BOOZMAN. And you are saying under current estimates, funding is sufficient. I guess the next question would be: If it is not—and times have come up in the past when it wasn't—how does VA intend to address any possible shortfall?

Secretary WILKIE. Well, I would certainly come to the Congress with that, but let me talk about the burn rate for a second. One of the things that we saw with the Choice Act is that many fewer veterans decided to take advantage of it than was originally projected after what happened in Phoenix. Of those veterans eligible for 100 percent care outside of the VA, less than 1 percent took advantage of that. That number of veterans is in the three- or four-thousands.

So every trend that I have seen indicates that we are well positioned to take care of Choice funding for the rest of this year.

Senator BOOZMAN. As the VA develops regulations that will govern things like rates and access standards for the MISSION Act implementation, many decisions will have significant budget implications. Certainly those do.

We understand VA continues to explore multiple options, ranging from TRICARE standards to variations of Choice and Medicare Advantage. What is the estimated budgetary impact of the range of options? When will you be prepared to let the Committee know how much you expect MISSION Act-compliant, community care to cost annually?

Secretary WILKIE. Senator, I expect to be up here as soon as the President approves the recommendations that I give him.

In terms of the access standards, I perceive them to be a hybrid of several of those programs that you just discussed—CMS, TRICARE—and that we will come to a conclusion based on the combination of those standards and what is best for veterans. But I will be up here as soon as the President approves the access standards.

Senator BOOZMAN. Good. Thank you, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you for yielding back.

Senator Sanders, you are recognized for 5 minutes.

Senator SANDERS. Thank you, Mr. Chairman. Let me get unanimous consent to place into the record a recent article that appeared in ProPublica and PolitiFact.

The CHAIRMAN. Without objection.

Senator SANDERS. Thank you. And it talks about the fact that several private companies have been paid nearly $2 billion for over-

head, including profit, to provide health care to veterans, and that is about 24 percent of the company's total program expenses.

So we have enormous administrative costs in private care for veterans at a time when I hope we could agree that the function of the VA is to provide the highest quality care to all veterans in a cost-effective way.

And, Mr. Chairman, my ongoing concern—and this article kind of demonstrates that—is that we are in the process of dismembering the VA, taking resources away from the VA, putting it into the private sector, and the results will be that many of our veterans will not get the quality care that they deserve.

Mr. Secretary, it is no secret—and by the way, thank you very much for being here—it is no secret that I opposed the MISSION Act. There are parts of the law that I obviously support, like expanding the caregivers support program and increasing loan repayment through the education debt reduction program.

However, I remain very concerned that, as written, and without needed funding, this law puts us into a situation where we are forcing the VA to pay for private-sector care at the expense of investing in its own facility budget, staff, and infrastructure. And I remain very concerned about the level of understaffing at the VA that continues to exist.

I fear this is nothing short of a steady march toward the privatization of the VA. And I think sometimes when people talk about the privatization of the VA, they think that one day the Secretary is going to come forward, and he is going to announce the VA is now privatized. That is not the way it is going to happen.

It is going to happen piece by piece by piece until, over a period of time, there is not much in the VA to provide the quality care that our veterans deserve.

No one disagrees—we have been through this discussion a million times—that veterans should be able to seek private care in cases where the VA cannot provide the specialized care they require or when wait times for appointments are too long or when veterans might have to travel long distances for that care. There is no disagreement. The VA has done that for decades.

But to my mind, the way to reduce wait times is not to direct resources outside the VA as the MISSION Act does, but to strengthen the VA. VA should be focused on recruiting and retaining the best health care professionals in our country to care for those who have put their lives on the line to defend us. VA should be focused on investing in its aging infrastructure so veterans can benefit from the best health care facilities, and VA should be focused on figuring out the budget it needs to provide the demands of our veterans—our veteran patients.

Mr. Secretary, let me start off by asking you a simple question, and that is: The veterans' organizations, to my mind, do a very good job in understanding where the veterans are at, the problems that the veterans of our country see when they interface with the VA. To my mind, what the law says is that you are to consult with the VSOs. That is what we have in law, but that does not simply mean a one-way discussion. It does not mean simply you telling them what is going on. It means you are listening to them.

So let me just ask you this, Mr. Secretary, can you tell me exactly, in as precise a way as you can, how you have solicited feedback from the VSOs, and how that feedback has been incorporated into the regulations currently being written on quality and access standards, Mr. Secretary?

Secretary WILKIE. Well, thank you, Senator. In the little less than 4 months that I have been the Secretary, I have doubled the number of VSO engagements. I have also opened the aperture on VSO engagements by including groups that represent the new breed of veterans, even some that represent veterans going back to Vietnam that have not been included, like the blinded veterans, the Purple Heart veterans.

I am meeting tomorrow with many of the people who are in the audience today. It is absolutely essential. I have served; I have a long line of family service. Without talking to the veterans—and when I say, "talking to the veterans," when I am out in the country, in the great Nations of the plains, when I was out in Oahu—

Senator SANDERS. I am sorry to interrupt.

Secretary WILKIE. I do meet with them. It is not a one-way—

Senator SANDERS. Here is the point, here is the point. And I appreciate that, and I know you are trying to do that. But meeting with them and talking to them is different than listening to them. Can I have your commitment that you will incorporate their ideas and their concerns into the work that you do?

Secretary WILKIE. Absolutely.

Senator SANDERS. I think my time has expired.

Secretary WILKIE. Mr. Chairman, may I add, sir, a comment—

The CHAIRMAN. Go ahead.

Secretary WILKIE [continued].—make a comment about what Senator Sanders said. I agree with him about privatization, and I agree with him about understaffing the VA. But I do need to make it clear that we do not exist in a vacuum.

The United States, as you have pointed out in many floor debates that I heard when I worked in this institution, is suffering from a shortage of mental health professionals. It is suffering from a shortage of women's health professionals. It is suffering from a shortage of primary care and internists. We are competing for those.

What has happened with the MISSION Act, and one of the benefits that I have now, is that I have the opportunity to offer more impressive packages to bring those health care providers into the VA. We are doing our level best because you are absolutely right: we are short on those.

And I will also say that when it comes to privatization, you and I discussed this in your office several months ago prior to my confirmation. I believe this strongly. I have said it all across the country. I don't believe that veterans will allow VA to be privatized, and I will tell you why. It is not anecdotal, but it is emotional. Veterans want to be where people understand their culture and speak their language.

Senator SANDERS. Good.

Secretary WILKIE. I am from that world; I understand it. And I agree with you that my job right now is to ensure that those vet-

erans who need that care outside of the VA—and we don't have it—get it. So—

Senator SANDERS. Thank you. Let's continue the discussion.

Secretary WILKIE. Yes, sir. Thank you.

The CHAIRMAN. I think, gentlemen, I would also encourage support from the VA and from the Senate and House on a bill that I have on an immigration bill to help allow doctors who are trained here in this country to stay here. We are sending them out of the country, and it is ridiculous that we are doing that when we have such a need here.

Mr. Arrington, I recognize you for 5 minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman, and Mr. Secretary, thank you for your service.

If a veteran doesn't get good care at the VHA, do the doctors still get paid over there?

Secretary WILKIE. Well, they get paid because they are on a Federal scale. However—

Mr. ARRINGTON. So the Federal Government will pay them whether they serve the veterans or not. Will the administrators get a paycheck whether or not the veterans are receiving good quality care and service?

Secretary WILKIE. Well, I can give you an example of how I acted on that.

Mr. ARRINGTON. Just historically, just historically, is the answer that they get paid regardless of the outcome for the patient?

Secretary WILKIE. Historically, before the Accountability Act was passed, historically, before the MISSION Act was passed, the Secretary of the Department of Veterans Affairs was under the same strictures that every Cabinet leader was under, that there was a laborious process involved in removing Federal workers who did not perform. That does not exist anymore.

In the 1 year that—well, the 1 year that I had been in and out of VA, we have removed 5,000 employees, including the director of one of our largest VA medical centers. I did that because the work was not getting done, veterans were not getting treated, and I felt that the powers that the Congress had given us needed to be exercised.

And I intend to exercise those powers whenever I see a problem because veterans are first; the institution is not first. And—

Mr. ARRINGTON. And I hope you continue to do that. That is the only way you are going to stay relevant. It is the only way you will prevent the veterans from voting with their feet about where they want to go and what this all is going to look like.

Let's not be so arrogant that we think we can build a mouse trap from the Federal Government from Washington that is going to satisfy the customer.

Either you deliver good service and either they are satisfied, or they are not. And if they aren't, they will make the decision on whether this is privatized or not privatized, or some hybrid. Good for you, I hope you continue to do it. Because in the private sector, if they don't delight the customer, the private providers, they don't have a business; they can't pay the bills; they can't feed their families. That is the incentive you are competing with, and that is why I am for choice.

That is why I am for giving the veterans freedom to choose, to opt out of a system that may not be working for them. Maybe a union-controlled monopolistic bureaucracy isn't the best way to provide service to our heroes. I don't know. Where it is working, good, great. Continue to do good. Where it is not, I get why it is not because it is a very different animal altogether. So, okay.

It was good to meet you the other night, by the way.

Secretary WILKIE. Good to meet you too, sir.

Mr. ARRINGTON. And your wife. I am really not an angry guy. I just get fired up when I talk about this, and I know you're passionate about it, too.

Let me ask you this. Are people choosing to go to community care at a greater rate today than they did a year ago?

Secretary WILKIE. They are not choosing to go to community care at a greater rate than they did when Omar Bradley ran the VA in 1945 to 1947. It has been about the same level, which is 30 to 35 percent, historically. I think we are even seeing, Dr. Lieberman, a slight dip in the use of community care.

Mr. ARRINGTON. So fewer veterans are choosing to go outside of the VA today than they did a year ago, 2 years ago, 5 years ago?

Secretary WILKIE. A little bit. A little bit. It is a small, small number.

Mr. ARRINGTON. Let me ask you—I will take your word for it—I assume you guys measure the quality and the overall service that veterans get at the VHA. Do you all measure the quality of care and overall service at your various facilities in the VHA? Yes or no, Doctor?

Dr. LIEBERMAN. Within VHA?

Mr. ARRINGTON. Yes, sir.

Dr. LIEBERMAN. Yes, sir.

Mr. ARRINGTON. And do you all compare the quality metrics and the service metrics in community care with the quality care and service at the VHA?

Secretary WILKIE. Absolutely. But we also compare it to—

Mr. ARRINGTON. How do they compare, Mr. Secretary? Are they comparable? Are they better at the VA?

Secretary WILKIE. I will tell you, The Dartmouth released its most recent study a week or so ago in the Annals of Internal Medicine, and their conclusion was that care at the Department of Veterans Affairs is as good or better than any care in the rest of the country. Of course, that includes community care. So we are being judged by comparison to—

Mr. ARRINGTON. Well, that is good—that is good to hear.

Secretary WILKIE [continued].—the biggest health networks in the country.

Mr. ARRINGTON. Last question. I represent a big swath of rural west Texas. How are the access standards going to affect their access to VA care?

Secretary WILKIE. I have talked a lot—

Mr. ARRINGTON. And I yield back.

Secretary WILKIE [continued].—Congressman, about the scale of the American West. I have sometimes joked that the loneliest sign in America is on Interstate 10 in Houston that says, "El Paso, 910 miles." What we see access doing is, is offering our veterans, par-

ticularly in rural America, the opportunity to alleviate a burden on themselves and their families by giving them the option to seek care that is closer to home, if they have to embark on a 300-, 400-, 500-mile round trip journey to get to a VA center.

As I have said many times, it is incredible that in 2018—and I saw this in Hawaii last week—we do not understand the scale of the West, and we certainly don't understand the scale of the Pacific.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. ARRINGTON, I was in Greg Walden's district in Oregon a year ago. And his congressional district has more square miles than the State of Tennessee does. So our challenge in this Committee was to devise a MISSION Act, a program that was good for rural America and for urban America, and that is hard to do when you are trying to do both.

So, if you are on the 405 in Los Angeles, you may be quicker to somewhere else, if you are stuck on there to get an appointment, if you don't live 10 miles from somewhere. So it is a real challenge to do this, and to get it right where you provide the care at the point of service for those veterans.

And I think the VA's moving in the right direction with their CBOC model, taking the care of the veterans, I absolutely believe that.

Mr. O'Rourke, you are recognized.

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

Mr. Secretary, in answer to Senator Tester's question about administrative costs totaling around 24 percent, and then that number was disputed, but in response, you said: We were taken advantage of.

Could you clarify by whom the VA was taken advantage of?

Secretary WILKIE. I meant in a generic way, that the Choice Act—and I think there is agreement from the leadership of both Committees—that the Choice Act was rushed, and we were given such unreal, unnatural timelines to implement a program in a 370,000-person Department.

Mr. O'ROURKE. So there was no actor or third-party administrator or outside contractor who took—

Secretary WILKIE. We were forced to take what we could get to implement a law based on the timeline that was created by that act which has now been rectified by the MISSION Act. So, when I said, "taken advantage of," we—and I wasn't there; I was happily in the Department of Defense.

Mr. O'ROURKE. But—

Secretary WILKIE. My understanding was VA had to move as rapidly as possible, and there was not that time for reflection that you would usually have in an issue like this.

Mr. O'ROURKE. The articles about the recently released GAO report about unspent suicide prevention outreach dollars, $6.2 million allocated, as of September, 57,000 spent, and then, Doctor, you suggested there was, perhaps, another 1-, 1.5 million spent on top of that out of the 6.2. You say you will exhaust that before the end of the year. You say that you got 100,000 hits on the Web site. Another thing the GAO says that is perhaps more alarming than the

unspent money is that you have not established targets for the efficacy of this outreach effort.

So hits to the Web site, don't know what it means and don't know if it matters. How do you know how you are doing on what you have established as your number one clinical priority, suicide reduction, which I am grateful for, that that is a priority? How do you know how you are doing against that priority? What are your goals?

Secretary WILKIE. Well, let me talk about the national situation that we face. First of all, I was responsible for the Department of Defense end of this.

Mr. O'ROURKE. I have got limited time. I don't want to hear an anecdote. I want to hear the goals—

Secretary WILKIE. I am not going to give you an anecdote. Fourteen of the 20 veterans who die by their own hands every day are outside of VA.

Mr. O'ROURKE. Correct. We have known that for years.

Secretary WILKIE. We spent $12.2 million on that outreach just in the time I believe that I have been in charge, which is just a few months. But I have to go beyond what that GAO report says, talk with Governor Brown, talk with Governor Inslee, talk with Governor Ige. I am busy.

Mr. O'ROURKE. If it is your priority, what is your goal, and how are you doing against your goal? I am not blaming you for where we are.

Secretary WILKIE. No.

Mr. O'ROURKE. And I don't know what to know what you have done in the short tenure. I want to know what your goal is and how we are doing against it.

Secretary WILKIE. The goal is to do our best to make sure that we have done everything possible.

Mr. O'ROURKE. And we will never be able to judge you on that.

Secretary WILKIE. And that's right. We can't.

Mr. O'ROURKE. Do our best, what does that mean.

Secretary WILKIE. The majority of those warriors who take their own lives come from my father's warrior generation. That means these are problems that are 50 years in the making. I am not going to tell you that I can wave a magic wand and correct problems that began when Lyndon Johnson was President. I am doing my best through the outreach that we have, and the resources that start with the Department of Defense. We never had a transition program or and awareness program on suicide until the last year or so at the Department of Defense. That is where it has to start so that we make sure that the mistakes that began back in 1968 and 1969 and 1970 are not replicated now. That is not anecdote. That is just historic.

Mr. O'ROURKE. I hear you, but if you don't measure it, you will never be able to improve it. So do you or do you not agree with the GAO's finding that you have not established targets for the majority of metrics you use to gauge the effectiveness of your suicide prevention outreach campaign. If you agree with that, what are you doing to correct the finding?

Dr. LIEBERMAN. So we concur that we did not have robust enough metrics at the time of the GAO evaluation. We have re-

sponded to the report. We are in the process of developing more robust ones.

Mr. O'ROURKE. When will you have them?

Dr. LIEBERMAN. Later this year.

Mr. O'ROURKE. This year. This year, or—

Dr. LIEBERMAN. I'm sorry. 2019.

Mr. O'ROURKE. Okay. Thank you.

Secretary WILKIE. As I said, Congressman, I put in place, that is as the number one clinical priority, and I can promise you that we will expend everything that we can to try to correct this and address this great national tragedy.

The CHAIRMAN. I thank the gentleman for yielding. I think Mr. O'Rourke's question was if you don't know where you are going, you might end up someplace else. If you don't have your goals set, you don't meet those goals. I think that is what you were asking. Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. Mr. Secretary, I think the VA has always had the authority to reach out to community providers. Prior to the Choice Act, I think in specific relationships—I am trying to remember the name of the program. Is it the P3 program? P3 program. One of the complaints I have heard about that program that still exists today is that every separate agreement is negotiated independently, and what I think—in Colorado, we have had some potential providers under the P3 program drop out because of the length of the negotiations and the complexity of the negotiations where I think one question they always raise to me was why don't we simply use Medicare rates as reimbursement on the P3 program so we are not renegotiating every new agreement from scratch?

Dr. LIEBERMAN. Well, we actually are moving away right now with the TriWest and in the future with the agreements, the community care agreements with the MISSION Act, and right now, we have—TriWest has stood up, actually, in Colorado, in Denver, and in the first week—and they are getting Medicare rates. And in the first week, they actually have entered 2,700 consults, and already scheduled 500 patients, and so they have been able to create the network that the facilities have been struggling to do on their own, and so they are creating it. And that is what is going to be part of the community care networks as we roll them out.

Mr. COFFMAN. Okay. And how are we doing in terms of efficiency on telemedicine? I think it was raised about rural America, certainly rural Colorado. It is a struggle. We have got people in Grand Junction, Colorado. There is a CBOC there, but for—oftentimes for care, they have to go to the VA medical center, regional medical center which is now in Aurora. That is a 4-hour drive. I know they are reimbursed for the mileage for that, but are we doing better in terms of telemedicine?

Dr. LIEBERMAN. Through support of the Congress, we are investing in increasing bandwidth at many of our CBOC locations which is really important. We also are doing the anywhere-to-anywhere, so when someone has internet access in their own home, we can provide telehealth into the home.

We also are joining in partnerships with different private entities to—they are going to give us a private room in a more rural area,

and the veteran can go there and have their appointment in that location that is closer to their home. So we are really working a lot in this area.

Mr. COFFMAN. Okay. There was legislation passed that I authored, I think it was included in a larger bill, that requires an independent study as to those veterans who died, who committed suicide who were under VA care, and I think one of the objectives of it is to go look into what prescriptions that they had at the time of their death, because I do have a concern that we are overprescribing some of our veterans in mental health.

Secretary WILKIE. Yeah. Let me talk about the opioid issue, which is part of that continuum, and also to Congressman O'Rourke's well-founded observations about the suicide program. I do want to say that we are not divorced from national problems. We are one part of that, which is why, in the answer to your question, I will say in this case, VA has taken the lead in creating alternative therapies, alternative prescriptions for those with great pain. The one factor about VA care that is not shared in the private sector is that we help people who come from a dangerous profession, people like my father after 30 years of jumping out of airplanes, needed two knees, two new hips, and had lead in his body from Vietnam. So what we have done is we have been able to reduce the amount of opioid prescriptions by 41 percent, just in the last 2 years.

In addition, we are on the cutting edge of alternative therapies, occupational therapies, Tai Chi, acupuncture, things that would have been unimaginable 10, 15, 20 years ago. And that is part of the answer to those veterans who are suffering from pain and subsequent issues like mental health.

Mr. COFFMAN. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you. Thank you very much. And just to pick up right there, I very much appreciate the progress that is being made by the VA on the opioid epidemic, and I hope that we can spread new alternative pain management strategies not only within the VA, but frankly, within the private sector as well.

I just want to revisit briefly this issue because I think certainly my constituents, but I think constituents across this country were so shocked and concerned to read today about this issue that your Department had only spent 1 percent of the $6 million for suicide prevention. We have had a little bit more testimony on that today. You say that you are doing your best, but what I am concerned about is that that can't be true when we have so many leadership vacancies at key posts in the VA related to these programs. What are you going to do about getting the right people in the right place? And I just want to give you one chance to revisit Mr. O'Rourke's question because we can't really respond here in our oversight function to the concept of doing your best if we don't know what your goals are. And you talk about the majority of the suicides are committed by people outside the system. That is true. That is our frustration. How do we bring them into the system?

Secretary WILKIE. As Dr. Lieberman said, we began to move when I became Acting. The vacancy that you talked about at the

head of the Suicide Prevention Office was immediately filled by me by making permanent the position.

Ms. KUSTER. And does that person have the staff they need on board.

Secretary WILKIE. Yes. Also the expertise as having been the leader at the Department of Defense in the Suicide Prevention Office.

Dr. LIEBERMAN. We are in the process of hiring staff just for the record.

Ms. KUSTER. I am sorry. There are other vacancies, and you are in the process of hiring for that.

Dr. LIEBERMAN. We are building a larger office underneath this individual, so we are hiring more people to support her.

Ms. KUSTER. And does that program have functional capacity at all the VSNs around the country as well.

Dr. LIEBERMAN. They certainly work with all the VSNs. The VSNs have their own responsibility to roll out and work with her what ideas are coming out. I also just want to let you know that we really are focusing in a new way on the high-risk veteran populations, both within VHA and the ones outside. And so number one, there is an executive order to work on transitioning veterans, and so we have been working with DoD on that. The Other Than Honorable, we have been working on that since 2017, but this month—this week, I am sorry, and the rest of the month, we are actually mailing out letters to the over 500,000 Other Than Honorable encouraging them to come to us to seek whether they are eligible for care here in mental health.

And we are also looking at the Reserve and the Guard that have never served. They have been identified recently. As our data gets mature, we can identify more at-risk populations, and they are at risk, and so we do mobile vet center outreaches to them on the weekends when they are doing their drills, and we are reaching out to leadership in those areas. And then, finally, another risk that we identified recently was that if a veteran came to the emergency room in the prior 3 months, and had just a little bit of suicidal ideation, not enough to have to admit them or—if we did research, and we found that if we made a suicide safety plan with them where if they are having suicidal thoughts, what are they going to do? Are they going to call a loved one? Are they going to call their therapist? Are they going to listen to music? What are they going to do? And it has been shown to reduce the suicide rate by 50 percent. And so, what we have done is we have actually implemented this rapidly at all our VAs across the country. So we are trying new novel things as they come along.

Ms. KUSTER. Well, and I think the research is important. My time is running short. I had another question about the whole issue under the VA MISSION Act and the designated access standards, but I guess I will just leave it at this. New Hampshire is one of the rare States without a full service VA Hospital, and I think we are all trying to find this balance of care at the VA, and if that is not possible, then care within the community, but I would just use New Hampshire as a cautionary tale and the problems that we had recently at Manchester when the level of care drops below what is necessary for a robust VA going forward. And I think that was the

point that Senator Sanders was making, and I think it is instructive as we move forward. But at that, I yield back.

Secretary WILKIE. And I would just add. I agree with you completely about suicide. I mentioned that I was in and out of the VA as Acting, and then had to go back to DoD and wait confirmation. In my first week, I laid down the first path on the suicide issue. I will tell you, there is nothing more important, and there is nothing more tragic, and you have my commitment that as long as I am privileged to be part of the VA team, that will continue to be the case.

Ms. KUSTER. If I could, one quick second. I have been in Congress for 6 years. You are our fifth VA Secretary in those 6 years, so I appreciate your personal commitment. I have literally heard that five times, and veterans are dying every single day, so we will hold you to the commitment. We will want to know the metrics. I appreciate the innovative solutions, and we will look forward to continued discussion. Thank you.

The CHAIRMAN. I thank the gentlelady for yielding. Senator Hirono, you are recognized for 5 minutes.

Senator HIRONO. Mr. Secretary, I am glad to know that you are in Hawaii and you obviously—not to mention I have a cold. Let me slide over to this mic. Okay. This one is working. Can you add to my time? Are you listening?

The CHAIRMAN. We froze the clock.

Senator HIRONO. Thank you very much. I am glad you were in Hawaii, and obviously you spoke with Governor Ige, but did you let the congressional delegation know that you were going to be in Hawaii?

Secretary WILKIE. Yes. In fact, I think I mentioned it to you the last time we spoke, that I would be in Hawaii in December.

Senator HIRONO. I don't think we got the date, but not to beat you over the head with it, but I think that it would be good for your team to alert the congressional delegation—

Secretary WILKIE. And we do. We do.

Senator HIRONO [continued].—when you are in our State so we can to maximize our ability to support and work with you.

Secretary WILKIE. We did, and I will go back on what you and I discussed last time. I made two commitments: one to go to Hawaii, and one, to go—if you are not there, I have got to go back because I am going to go to Samoa and Guam.

Senator HIRONO. Oh. There you go.

Secretary WILKIE. Go there when you are there.

Senator HIRONO. Thank you very much. The VA, over the years, of course, not only have we had so many Secretaries over the last 5 years, as mentioned, though, their ongoing challenges whether it be IT, homelessness, suicides, construction delays, of course, access to care. So you have been asked whether there is a sense of urgency at the VA, but I ask you whether you have a sense of urgency?

Secretary WILKIE. Absolutely.

Senator HIRONO. So if you have a sense of urgency, what are your top priorities for the VA?

Secretary WILKIE. Well, my top priorities for the VA, and I mentioned the first clinical priority, which is suicide prevention.

Senator HIRONO. Right. That is one.

Secretary WILKIE. My top priority is to create, with the assistance of these Committees, a modern 21st century health care administration that keeps veterans at the center of their health care. This Committee has already laid down the template for that, and it is my duty to carry that out.

Senator HIRONO. So I think I am looking for something a lot more measurable. So, for example, you were asked how can we verify whether you are reaching your goal regarding suicide prevention. So a former VA Secretary said that his goal would be to end homelessness. So those are the specific kinds of priorities that I am asking you to articulate if you have them.

Secretary WILKIE. Well, I will tell you. I am not going to come to this Committee and tell you that I will end homelessness, and I am not going to come to this Committee and tell you that I can eliminate suicide amongst veterans.

Senator HIRONO. Well, that is not what I am asking you. What I am asking is, out of a sense of urgency, what are your top priorities for the VA? So whether it be decreasing suicides, increasing—decreasing homelessness, do you have those kinds of priorities?

Secretary WILKIE. Well, I just mentioned them. Modern 21st century health care administration for the VA, which means modern IT meaning the best medical care possible.

Senator HIRONO. When you say something like best medical care possible, you know, how do you come up with a verifiable matrix?

Secretary WILKIE. Well, I can tell you that our health care—we have the standards. We have the metrics which we share with this Committee. We compare what we provide with health care across the country. I have referenced the latest comparison that Dartmouth Ivy League has done that was in the Annals of Internal Medicine last week, that says—

Senator HIRONO. I am running out of time.

Secretary WILKIE [continued].—that our care is as good or better than any in the country. I want to make sure that—

Senator HIRONO. If you have those priorities for you because, you know, I think it would be good for us to hold people accountable, and that there be transparency and accountability, and I would certainly want to apply that to you. So if you have those priorities, and they are listed and how you are going to—whether you have verifiable metrics to enable us to realize whether you have attained those priorities, that would be great.

I have a question about the family caregiver, comprehensive assistance for family caregivers. That is a very important program for a lot of veterans, and I am glad that we expanded it. So I have received, though, for example, a note from a caregiver in Hawaii just this week, and she wrote, quote, "I just received the devastating news that we were no longer eligible for the caregiver program. I did not even receive a phone call, follow up from my coordinator," or even an explanation other than the fact that her husband is simply no longer eligible. So how are you communicating with the 5,500 family caregivers as to what it happening with this program and what the requirements are, et cetera?

Dr. LIEBERMAN. So first of all, if your office could share with us that individual so we can follow up on it.

Senator HIRONO. Certainly.

Dr. LIEBERMAN. So the MISSION Act is giving us the tools to do this right moving forward and making sure that we have objective ways so that we make sure that we are implementing the same, no matter what State you are in across the country, and part of it is we want—what we are proposing is to move away from these reassessments and more towards wellness checks to make sure that the caregiver has what they need to succeed, and the veteran is receiving the services that they need.

We have regular ways that we communicate with the caregivers. We have phone calls with them around the country. We have a phone line where they can call in, but we have not yet made our decision on how we are rolling it. We are still getting input. Right now it is in the Federal Register, some of the ideas of how to improve upon the services available in the program.

Senator HIRONO. Thank you.

Secretary WILKIE. And you are absolutely right. It is 5.5 million family caregivers—

Senator HIRONO. Oh. Did I say 5,500?

Secretary WILKIE [continued].—that we have to support. Yes, ma'am.

Senator HIRONO. Yes. That is a lot of people to stay in touch with. Thank you for the information—

Secretary WILKIE. Absolutely. But it is the wave of the future.

Senator HIRONO [continued].—regarding this particular inquiry I got. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Senator Blumenthal, you are recognized.

Senator BLUMENTHAL. Thanks, Mr. Chairman. Thank you for having this hearing. Thank you to the Secretary and your colleagues for being here today. I want to thank my House colleagues for passing the Blue Water Navy bill unanimously. I want to say how disappointed, in fact, ashamed I am that the Senate failed to do the same, even though as recently as a couple of hours ago, I was on the floor of the Senate asking for unanimous consent from my colleagues to move ahead so that that bill would become law. If the VA were doing its job and supporting this bill, it would have overcome the opposition of a small number, a handful of my colleagues, who are blocking it now.

I am going to ask you to commit, as I have before in hearings, that you will help us pass that Blue Water Navy bill.

Secretary WILKIE. I committed to the Chairman and to Senator Tester, that I would do everything I could to help your Committee.

Senator BLUMENTHAL. Well, you have done that before, but unfortunately, that support has not been translated into active advocacy with my colleagues, and I hope you will do better during the next session.

I want to follow up on a number of questions asked by Congressman O'Rourke about metrics. You can't do better unless you measure what you are doing, and so far, as I can see, one of the chief criticisms of the GAO report has been the lack of metrics and measurement. And I would suggest to you, respectfully, the two good ones would be whether the rate of suicide is coming down,

which it is not, and whether the GAO is using all the resources at its disposal to bring it down, which it is not. Would you agree?

Secretary WILKIE. Well, I agree with the state of affairs at VA that the GAO laid out.

Senator BLUMENTHAL. You agree with the GAO report?

Secretary WILKIE. Which is why—

Senator BLUMENTHAL. And so you would agree that the reason that you failed at the VA to spend more than a fraction of the money given to you by the United States Congress is, I am quoting, "The reason they did not spend the remaining funds on suicide prevention paid media in fiscal year 2018 was that the approval of this paid media plan was delayed due to changes in leadership and organizational realignment of the suicide prevention program," and they go on more specifically to say on pages 15 and 17 that it was a "lack of leadership available to make decisions about the suicide prevention campaign." And then on page 17, "By not assigning key leadership responsibilities and clear lines of reporting, the VHA's ability to oversee the suicide prevention media outreach activities was hindered, and these outreach activities decreased." That is a failure of leadership.

Secretary WILKIE. Senator, I am going to agree with you, and you and I, I think, discussed in your office when I was the Acting Secretary, that the first thing I did when I became Acting, which is sort of being in limbo, but I did it anyway, was to start moving on the suicide prevention issue. I identified leadership, and I made this the number one clinical priority. I agree that the Department had not done what this Congress and what veterans demand of it, and that is—

Senator BLUMENTHAL. Well, let me ask you because my time is limited. I apologize for interrupting. Can you commit that the VA will spend every dime devoted by the Congress, allocated by us, to suicide prevention during the coming fiscal year?

Secretary WILKIE. Absolutely, and I will probably ask for more or allocate more because of this national tragedy.

Senator BLUMENTHAL. How much more do you think is necessary?

Secretary WILKIE. I don't know. I don't know. That is why I mentioned it, and you weren't here. In the last few weeks, I have been on the phone, or in person with Jerry Brown, with Governor Ige, with Governor Inslee, discussing the way ahead. We have not had a comprehensive nationwide response to veterans' suicide. I need the cooperation of our governors, and that is why I put in train the development of the metrics that Senator Hirono talks about that you talked about so that we have, in place, a program to go and attack this problem. That is the best answer I can give you, that I moved on it as soon as I moved into VA.

Senator BLUMENTHAL. Well, I know that you have moved on it, but you have to forgive me, and maybe us, that we have seen this movie before. As one of my colleagues remarked, we have seen a slew of Secretaries who have made commitments and promises, and I think we are, at least speaking for myself, expressing the frustration and impatience that is well-founded, in fact, because of the turnover in leadership from the top through the middle ranks, and with all due respect, Dr. Lieberman is an example. He follows

others who have been in that position for small lengths of time. We can't demand accountability if there is this constant churn and turnover in leadership, which then becomes a failure to spend the money that is allocated to suicide prevention and maybe other programs.

Secretary WILKIE. And I agree with your observation about suicide. The program, at best, it was inchoate in 2017, and that is why I permanently appointed the DoD leader in suicide prevention, the person with the most expertise in this matter available to the government, and that we are increasing the size of that operation. I agree with your criticisms.

Senator BLUMENTHAL. My time has expired. I apologize, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Blumenthal.

First of all, thank you all for being here, and I would like to yield to my colleague, Mr. Takano, next year's Chairman, if he has any closing comments.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, I do look forward to hearing as soon as possible more about the designated access standards. I know you told me in your response to me that you still need to await the President's choices, but I hope that you will consider speaking to us before that time because I see no reason why the VSOs and Congress cannot participate with you, I think, as the spirit of the MISSION Act does stipulate that these access standards were not to be developed alone between you, Mr. Secretary, and the President. And I certainly don't want to see expectations unnecessarily raised at the State of the Union speech, and Congress being in the position to have to try and pull those expectations back.

So I would like to, in the time between now and the third week of January, like to see your Department work more closely with the VSOs and Congress in developing these access standards, because so much is at stake, and we need to do some trust building among the stakeholders, Congress, and your department.

I want to reiterate what Senator Blumenthal has said, the frustration of Congress being able to hold, you know, the VA accountable when we have seen such changeover or Acting Secretaries, and some of it is on, I hate to say, the Senate, for not confirming people in a timely manner. But nevertheless, it has been very disappointing to see, in the last 2 years, an administration that has not been able to put in place stable leadership at the VA. And I see the IT failure with regard to the BAH payments, the issue with the social media, and adequate marketing being done to inform veterans about suicide prevention hotlines, all leading back to the same fundamental problem which is the unstable leadership at the very top. And this has got to change.

And, so, Mr. Secretary, I would like nothing more than to see you succeed and for you to serve out a tenure which allows you to implement changes. I certainly do appreciate the sentiment you expressed when you quote the Dartmouth study recently, and further back, the RAND Study, and that you have an understanding about how well our VA does deliver health care, and you recall that the RAND Corporation Study indicated that the main problem is access. And we have still 41,000 vacancies. I want to work with you,

Mr. Secretary, on not slow-walking those vacancies, but doing all that we can to improve the personnel function of the VA, so that applications are acknowledged, people are quickly made offers, and that we also take a look at what we need to do to develop the health care workforce of this country, because I think that is part of the problem. It is not just doctors, it is the technicians. It is the allied health professions that we need to pay attention to.

So not everything needs to be resolved with medical degrees and 4-year degrees. Some of this could actually be putting a lot of Americans to work in the service of our country. So Mr. Secretary, in the spirit of that, I hope we—I intend to work with you, and I intend that we change and turn around the situation.

Secretary WILKIE. I thank you, sir, and I intend to work closely with both Committees. I mentioned earlier this is where I was trained. My respect for this institution knows no bounds, and the beauty, as you said at the beginning, is that this is a bipartisan effort. I like to think of the Department as being nonpartisan, like the Department of Defense, and you have my commitment to do everything that we can to make sure that the lives of our veterans are better.

The CHAIRMAN. I thank the gentleman for yielding, and I will, first of all, thank you, Mr. Secretary, and your team for being here today. I want to thank our staffs. We passed a major piece of legislation in the VA MISSION Act that would not have happened without the staffs, and John and Ray, thank you for your leadership in the Senate. We worked very closely with our Senate colleagues on both sides of the aisle, so thank you for the work that you all did. You were very, very helpful in this.

And I personally, just as a point of personal privilege, one of the great honors of my life is serving as the Chairman of this Committee, and I will continue to serve as Ranking Member just as passionately as I did before. I also want to thank—I look around this room, and I see a lot of our veteran service folks out there, our veterans' organizations, and they were very instrumental. I remember sitting around that table in my office for hours on end hammering out the details of this, so you had tremendous input, and it would not be the bill it is today without your input, so thank you for that.

The VA MISSION Act, the idea was to take a bill, a piece of legislation, and as I said before, make it applicable to rural America, and make it applicable to urban America and make sure that the number one thing that happened was that the veteran got the absolute very best care this Nation has to offer, whether it was at the VA, whether it was outside the VA. I was one of those physicians who provided care outside the VA. I have also worked in a VA with some of my medical training. I have also been a doctor in the Army, so I think I understand the system fairly well. And I want to get three things out before we leave.

Number one, on June 6, we are ready to go, and if we are not, would you be willing to come back, Mr. Secretary, let's say, at the end of March, and give us one more—it could be a combined meeting or however we want to do it?

Secretary WILKIE. Absolutely.

The CHAIRMAN. It would be informal to let the Members know we are ready to go live on the June 6 or thereabouts. Number two, that we can make appointments at the VA for our veterans in a timely fashion. Number three, can we pay our providers so they will stay in the network, because I have lots of friends personally who want to serve veterans right now who won't because they can't get paid. And these are good doctors that want to serve, so I would like to see those three things happen. And certainly there will be other hearings on the caregiver bill and on the asset review. We will certainly do that.

And I would really encourage my Senate colleagues. We have a couple of people, your IT position and the accountability and whistleblower protections. The young woman who is a staff member on our Committee right now, Tammy Bonzanto, an incredible young woman, an immigrant to this country who came here without any education, served in the U.S. Navy, has gotten an RN degree, now a doctorate degree, and has done investigations of VAs all over this country. And she could be in that position right now doing her job, and I don't go to a speech that the President gives if he doesn't talk about the Accountability and Whistleblower Protection bill. We need to get that done, and she needs to be confirmed sooner rather than later. That is a point of frustration for me to hold her up.

On the mental health side, and we started with Mr. Takano's help and Mr. O'Rourke and others. Certainly, Mr. Coffman needs to be shouted out for the work he has done. We held a hearing, and I looked at this 20 number. That is veterans and Active duty military, that number is. I said if we are spending $8, $9 billion a year, and we haven't moved the needle at all, why don't we thoroughly evaluate that and change what we are doing?

And there are plans out there, one in my State, Guard Your Buddy. The commander of the Guard, he took over in 2011, had four suicides the first 40 days he was the commander of the Tennessee State guard. He instituted a plan called Guard Your Buddy. I won't go into the details of it, but he has lowered the suicide rate among our Guardsmen in continues by 70 percent. That is scalable, and it is inexpensive. We should do that across the country, evaluate what works and what absolutely we are doing. And. Mr. O'Rourke made a great point. I was at Canandaigua. We had this great call center there. There is one in Atlanta another standing up, but I said are we changing anything? We are spending all this money and talking to people, but is the number still the same? We need to do something different. That is where the metrics are so important.

So, I think working with Mr. Takano, we will continue to work on that. It is a tragedy beyond calculable, the suicide rates are, because I have said it many times. I have spent hours in the operating room operating on a cancer, and then treated the patient afterwards and saved one life. Dr. Lieberman, what you mentioned, if you have lowered the rate by as much as 55 percent by doing a simple thing in the emergency room, why are we doing that in every emergency in the United States whether you are a veteran or not? That should be done. And to Senator Hirono, your question about—it is fairly simple in medicine now. If you are looking at quality metrics, they are fairly standard, and if you just look at it,

you look at what Medicare uses. Basically, the VA does the same. And if you come in, you are a certain age, you know, you get screened for hemoglobin, A1C, have you had your mammogram if you are female, your blood pressure checked, do you exercise.

Always irritates me when my doctor asks me can I stand up. I always get a little offended by that, but they ask you those questions, and those are scalable. And vision screen, hearing screening, all of those things are measurable, and I think the VA does an outstanding job. And I want to finish by saying this: If what I hear about my VA at home, and this is Mountain Home VA in Johnson City, Tennessee, and I have traveled from Long Island to Los Angeles and Puerto Rico in the last 2 years, is that all, not 100 percent, but a vast majority of people like the care they get at the VA. I almost never hear anything negative. I do occasionally, as you would in a big organization like that. And it is very customer-friendly. The veterans believe, and I believe they are getting great care. I want to see every veteran get that kind of care, and I am committed to that, and other people, the men and women in this room, and Mr. Secretary, I absolutely know in your heart that you are committed for that.

I thank you all for being here today, and I thank you for the point of personal privilege, and if there are no further questions, I ask unanimous consent that all Members—Mr. Takano.

Mr. TAKANO. I just want to mention. I don't know if I mentioned this, but Mr. Sablan could not be with us for the questions, but I will be submitting questions on his behalf.

The CHAIRMAN. Okay. That will be fine. I think you are going to visit the Northern Marianas also.

If there are no further questions, I ask unanimous consent for all Members to have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

The hearing is adjourned.

[Whereupon, at 4:40 p.m., the Committees were adjourned.]

A P P E N D I X

Prepared Statement of Honorable Robert Wilkie

Chairman Isakson, Ranking Member Tester, Chairman Roe, and Ranking Member Walz, distinguished members of the Committee: Thank you for this opportunity to discuss the current state of the Department of Veterans Affairs (VA) and my vision for the future of America's Veterans.

After serving two months as Acting Secretary, and now four months as Secretary, I am happy to say that the VA is better. It's better because of the work of this Committee; better because of the attention paid to Veterans Affairs by the President; better because the turmoil of early 2018 is in the rearview mirror; and better because we have a workforce dedicated to the care of America's warriors.

While all Executive Branch departments and agencies must carry out their missions without consideration or influence of partisan politics, I have said in my visits across the department - visits that in the last five weeks cover ten VA hospitals from Boston to Las Vegas—that there are two departments of the Federal Government that must be especially careful to rise above partisan politics: the Department of Defense (DoD) and the Department of Veterans Affairs-this Committee is proof of that postulate.

Now more than ever we are seeing the need for DoD and VA to work together to provide quality care for the Nation's Service members and Veterans. And now more than ever we also are seeing the benefit of strong bipartisan support for our DoD/VA partnership in the many major acts of Congress passed in the recent years. Congress has infused VA with a $200 billion budget. You have passed the Accountability Act to shake up complacency, and you have passed the MISSION Act to strengthen VA's ability to ensure Veterans have access to the best care available when and where they need it. The future now is up to the department. I look forward to working with the Committee and Congress to carry forward that work of transformation, and I pledge to make our efforts as transparent as possible to you, to Veterans, and to the American people.

I would like to acknowledge the recent Veterans Day observance. For the second year in a row, President Trump declared November as National Veterans and Military Families Month. On November 11, the 100th anniversary of the ending of World War I, I gathered at Arlington National Cemetery with my colleagues from VA, DoD, Veterans Service Organizations, and others to pay tribute to those who have served and sacrificed on our behalf. It was a privilege to attend this ceremony and I am honored to serve as Secretary of Veterans Affairs and work daily to remember, honor and thank the men and women who embody the values and ideals of this great Nation.

Initial Assessment

From what I have seen and from what I have been told by Veterans' advocates, it is clear to me that the Veteran population is changing faster than we realize. For the first time since the fall of Saigon in 1975, more than half of our Veterans are under the age of 65. They are computer savvy, they expect quick service, and they expect that service to be delivered closer to home. They expect an integrated VA that is agile and adaptive and will do what they need, when they need it. My goal is to provide them with that service.

In many cases, I have seen wonderful examples of VA accomplishments that deserve more attention than they normally get.

- Not enough Veterans and Americans know that the VA health care system continues to outperform the private sector in the quality of care and patient safety for our Veterans.
- We are on the cutting edge of medical care and rehabilitative services, prosthetics, traumatic brain injury, spinal cord treatment, opioid management, mental health care, and telehealth.

- The Department has added its 136th National Cemetery in Colorado Springs at Pikes Peak. The first burial took place last month.
- Fifty-two state Veterans homes received construction and renovation funds this year.

For the first time in many years, overall VA customer satisfaction rate is on a steady rise. Thanks to an unprecedented series of legislative actions aimed at reforming the Department and improving care and benefits for our Veterans, we are now tackling issues that have vexed VA for decades, including:

- Giving Veterans more choice in health care decisions with the historic MISSION Act.
- Increasing accountability and protecting whistleblowers with the Whistleblower Protection Act.
- Improving transparency - VA is the first hospital system in the Nation to post wait times, opioid prescription rates, accountability, settlements, and chief executive travel.
- Adopting the same electronic health record as DoD so there can be a seamless transfer of medical information for Veterans leaving the service.
- Overhauling the claims and appeals processes to create a simplified system for filing to provide Veterans with clear choices and timely decisions.

We are on the cusp of the greatest transformative period in the history of VA. With the support of the President, the Congress, and our many partners, we are now tackling head-on issues that have lingered for years. This is not business as usual. This is fundamental transformation, not seen at VA since just after World War II, when General Omar Bradley headed the VA.

My Vision for VA

Many of the issues I encountered as Acting Secretary and more recently as Secretary were not with the quality of medical care but with getting our Veterans through the door to reach that care. Those problems are both administrative and bureaucratic. Alexander Hamilton said that the true test of a good government is its aptitude and tendency to produce a good administration. That is where VA must go.

Our first challenge is to improve the culture to focus our attention and efforts on offering world-class customer service through all our operations. Our second challenge is increasing access to care and benefits through VA MISSION Act implementation and business transformation, which includes adopting a new electronic health records system, implementing a new appeals process for disagreement on VA claims, and modernizing our human resources, financial management, construction program, and supply systems.

For the purposes of this hearing, I will focus my testimony on our efforts to deliver world-class customer service while implementing the historic VA MISSION Act.

Customer Service

My prime objective is customer service. When an eligible Veteran comes to VA, they shouldn't have to hire a team of lawyers to get VA to say yes. It is up to VA to get the Veteran to yes, and that is customer service.

VA receives 140 million phone calls a year. Ten million people contact VA online each month. We have 348 contact centers, hundreds of websites, and dozens of databases. Veterans think of VA as a single entity, but we deliver services in silos, forcing the Veteran to figure out which VA phone number to call, website to search, or office to visit. For many, finding the right office to access the right benefit or service is a fractured, frustrating experience.

Driven by customer feedback, we are integrating VA's digital portals, contact centers, and databases so that Veterans easily find what they need no matter which channel they choose. On Veterans Day, we re-launched our www.VA.gov Website and we are unifying Veteran data, adding customer preferences for electronic correspondence to our new Vet360 database, and integrating the Vet360 profile service with mobile apps. VA has been identified as the "co-lead" of the White House cross-agency priority goal on improving customer service.

These efforts were recently recognized by the nonprofit Partnership for Public Service which honored VA employee Marcella Jacobs and the Digital Service Team during the 17th annual Samuel J. Heyman Service to America Medals (Sammies) awards gala in Washington D.C. We are demonstrating that it is possible for Federal agencies to give the American people the online experience they expect and deserve.

Our goal is to make accessing VA services seamless, effective, efficient, and emotionally resonant. The delivery of world-class customer service is my responsibility and the responsibility of all VA employees. When the interactions between VA employees and our Veteran customers in these areas are positive, our Veterans will trust and Choose VA, for their care, benefits, and memorial services across their lifetime.

Customer service must start with VA employees not talking at each other but with each other across all office barriers and across all compartments. If we don't listen to each other, we won't be able to listen to our Veterans and their families and we won't be able to provide the world-class customer service they deserve. We must be a bottom-up organization, with energy flowing upward from those who are closest to those we are sworn to serve. It is from our dedicated employees that the ideas we carry to Congress, to Veterans Service Organizations, and to America's Veterans will come. Our highest imperative to deliver customer service to our Veterans is to execute the legislation passed by this Congress and signed by President Trump giving Veterans the choice they deserve.

Implementing the VA MISSION Act

The VA MISSION Act is landmark legislation that will fundamentally transform VA health care and improve Veterans benefits and services. To successfully implement this historic legislation, we must engage stakeholders at all levels and be transparent throughout the process. We have established an enterprise program management office reporting to Acting Deputy Secretary Jim Byrne with integrated project teams to implement specific MISSION Act provisions. We are providing recurring updates to Congress, VSO's and others to hear feedback, address concerns and course correct when necessary. Mr. Chairman, it is critical that we deliver a transformed VA health care system that puts Veterans at the center of everything we do.

Community Care

A key provision of the VA MISSION Act is the consolidation of our community care programs into a new Veterans Community Care Program that will be much easier to navigate for Veterans, families, VA employees and community providers. My vision is to keep VA at the center of any Veteran's care to ensure we deliver world-class customer service as Veterans navigate the continuum of care between internal and external providers. This will ensure our Veterans receive the best health care possible, whether delivered in VA facilities or in the community.

Since October 2017, VA has completed approximately 24 million appointments in the community and 58.1 million in our facilities. Veterans may now request an appointment without a referral in numerous clinics including: audiology, optometry, orthotist (braces and splints), prosthetist (prostheses, artificial limbs), women's health, podiatry, nutrition, and wheelchair and amputee services. The average time it took to complete an urgent referral to a VA specialist has decreased from 19.3 days in FY 2014 to 3.2 days in FY 2017 and less than 2 days in FY 2018. This figure continues to improve and is now down to 1.4 days in October of 2018. In FY 2018, VA completed more than 619,000 appointments when compared to the previous fiscal year. The average new patient wait times for an appointment at a VA health care facility were 21.2 days for Primary Care, 22.1 for Specialty Care, and 11.2 for Mental Health services.

VA has also made notable progress in ensuring Veterans receive time-sensitive follow up appointments. Currently 95 percent of all time-sensitive appointments are completed within the provider recommended date. Additionally, all VA Medical Centers and Community Based Outpatient Clinics now provide same-day services in primary care and mental health for Veterans who need them. I have found many Veterans prefer to receive their care at VA facilities and we are increasing access to meet this need.

Upon enactment of the VA MISSION Act, we began developing regulations required to implement the new community care authorities. To ensure continuity of operations, VA extended and expanded its contract with TriWest Healthcare Alliance to ensure access to community care while the next generation of community care network contracts are awarded and implemented.

As part of our new community care program, we are addressing the timeliness and accuracy of payments to providers. We must ensure community providers are paid in a timely manner so they are willing and able to deliver services to our Veterans. To this end, VA is moving away from paper claims and requiring providers to submit electronic claims in most cases through a new claims processing system. This automated electronic Claims Administration and Management System (eCAMS) uses technology with workflow-based analytics to provide feedback on poten-

tial bottlenecks and business performance issues in our claims process. Additionally, providers will have 180 days to submit claims for reimbursement rather than waiting years to submit them. This will align VA with industry standards and ensure providers are receiving timely payments.

Through the VA MISSION Act, we are establishing a Center for Innovation for Care and Payment to develop new approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of VA health care. The center will explore models for incentivizing performance internally and when VA purchases care in the community. With the support of this Committee we hope to improve the lives of those we serve by accelerating and scaling VA innovation.

Eligibility for Community Care

Veterans deserve access to the best health care providers, state-of-art facilities and cutting-edge technology. The VA MISSION Act of 2018 will strengthen VA's ability to deliver the quality care and timely service Veterans have earned. Eligibility for community care will be Veteran-centric and enable VA to deliver care more efficiently. With only specific exceptions, VA will stop paying providers above Medicare rates and will minimize the use of local contractual agreements to further reduce variability in payment rates. Under the new walk-in/urgent care authority, we will ensure that if eligible Veterans have an urgent health care need, they will be able to see a provider quickly. In developing access standards, VA has specifically:

- Discussed access standards with DoD and the Centers for Medicare & Medicaid Services.
- Performed research on industry standards including state insurance and state Medicaid programs.
- Solicited feedback with a notice in the Federal Register published June 29, 2018, and hosted public comments on July 13, 2018.

As a guiding principle, I have reviewed DoD's TRICARE standards and continue to promote interoperability of our health care systems. My objective is to ensure Veterans receive care where and when they need it and to ensure VA remains on the leading edge for access and quality of health care.

STANDARDS FOR QUALITY

A study released this year by the RAND Corporation found VA health care generally outperforms the private sector in quality and patient safety, but recommended VA address variations in quality among VA health facilities. The VA MISSION Act will do this and more by requiring VA to establish standards for quality for hospital care, medical services and extended care services delivered by VA and community providers and establish a remediation process for service lines that do not meet those standards.

We are committed to using industry-standard quality measures to compare our performance to that of the community, with consultation from key stakeholders, and to use those comparisons to ensure the best possible outcomes for Veterans. Our commitment to transparency will allow Veterans to compare data across VA and community care and make informed decisions when selecting a provider. In developing quality standards, VA has:

- Assessed existing industry quality standards including those used by DoD, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services.
- Solicited feedback with a notice in the Federal Register published August 24, 2018, and hosted public comments on September 24, 2018.
- Hosted several Veteran Insight Panels, which are online focus groups, to hear directly from Veterans about their experiences and how we can bridge the gap between VA and community care specific to quality.

We recognize the high level of interest from Veterans, community providers, and others in VA about the access standards and standards for quality and I am deeply committed to ensuring an open, transparent process for implementing the VA MISSION Act. We have developed communications products and tools, including a public-facing Website, talking points or key messages, frequently asked questions, fact sheets, and handouts covering various provisions of the law.

In May 2018, we began hosting monthly webinars for community providers to provide updates and keep them informed of changes to the community care program. In September, we participated in a collaborative webcast with the Association of American Medical Colleges and presented an update on the VA MISSION Act community care requirements. In November, we began hosting listening sessions in

VA's four community care regions to hear directly from Veterans, employees and other stakeholders. Our goal is to host 20 listening sessions with stakeholders by the end of the calendar year. It is critical that we continue to engage stakeholders as we implement this historic legislation.

Caregivers Expansion

As VA expands the Program of Comprehensive Assistance for Family Caregivers, we recognize the incredible sacrifice of families who have cared for a loved one injured in the line of duty. We expect tremendous interest in the program's expansion and anticipate a significant increase in applicants. We are also addressing issues identified in the August 2018 Office of Inspector General's report on the program.

VA has engaged with key stakeholders including VSOs, members of the public, and House Veterans Affairs' Committee round tables. Several consistent themes emerged during these engagements. In expanding the program, VA must ensure:

- Eligibility determinations are Veteran and caregiver-centric, easy to understand and transparent.
- Participation is targeted to those Veterans who will benefit the most.
- Program requirements are less burdensome for caregivers and Veterans (e.g., a different track for the catastrophically inured).

While the timeline for expanding the program to all eligible Veterans is still under development, VA must develop and implement a new information technology system to support administrative and record-keeping needs. We are working with a developer on a new IT system known as the Caregiver Tool, or CareT, to manage the new requirements. Once we have fully fielded the new system, we will develop and implement the functionality required by the MISSION Act. We need to ensure high system reliability before enrolling a new Caregivers cohort.

VA supports and recognizes the sacrifice and value of Veterans' family caregivers not only through this program but through its first Federal Advisory Committee for Veterans Families, Caregiver and Survivors and its new Center of Excellence for Veteran Caregiver Research. Caregivers and Veterans can learn about the full range of available support and programs by visiting www.caregiver.va.gov or by contacting the Caregiver Support Line toll-free at 1–855–260–3274.

Hiring and Vacancies

The VA MISSION Act gives us greater ability to recruit and retain the best medical providers through improvements to the education debt-reduction program and improved flexibility for bonuses for recruitment, relocation and retention. VA will also pilot a scholarship program for Veterans to get medical training in return for serving in a VA hospital or clinic for four years. VA is keeping pace with both normal retirements and job changes and has added nearly 14,000 more employees onboard since January 1, 2017 (3.8 percent growth), which is keeping pace with VA's patient base (enrollees) growth of 1.4 percent during the same period.

As required under the law, we are posting quarterly vacancy data online. Our recent data shows as of September 30, 2018, VA had 46,522 overall vacancies and a total of 377,210 employees onboard for an 11 percent vacancy rate. Indeed, most large organizations will have what appears to be many vacancies due to normal retirements and job changes. VA's vacancy rate of 11 percent is a normal part of doing business and reflects the historical annual 9 percent turnover rate and a 2 to 3 percent growth rate.

VA vacancy rates mirror those of the health care industry. There is a national shortage of healthcare professionals, especially for physicians and nurses. VA remains fully engaged in a fiercely competitive clinical recruitment market and has increased its number of clinical providers including hard-to-recruit-and-retain physicians such as psychiatrists. Additional steps to attract qualified candidates include:

- Mental Health and other targeted hiring initiatives.
- Leveraging flexible pay ranges resulting in competitive physician salaries.
- Utilization of recruitment/relocation and retention incentives.
- Utilization of the Education Debt Reduction Program for recruitment and retention of hard-to-recruit/retain healthcare providers, including the new higher award amounts authorized by the MISSION Act up to $200,000 over a five-year period.
- Targeted nationwide recruitment advertising and marketing.
- The "Take A Closer Look at VA" trainee outreach recruitment program.
- Expanding opportunities for telemedicine providers.
- DoD/VA effort to recruit transitioning servicemembers.

Asset and Infrastructure Review (AIR) Commission

The VA MISSION Act provides an opportunity for VA to assess our health care infrastructure footprints and develop recommendations for modernization and realignment of facilities to meet the demand for VA's services both today and for years to come. Our Asset and Infrastructure Review assessment and recommendations will be data-driven with input and feedback from our Veterans, employees, VSO's, local communities, and other key stakeholders throughout the process to ensure VA's recommendations are robust and fair.

The AIR process will be informed by the assessment of 96 local market areas to identify availability and gaps in furnishing health care services to veterans. Each local assessment will consider short and long-term demand; VA staffing capacity; VA infrastructure capacity; VA's facilities conditions and future costs to maintain or modernize them, and non-VA health care capacity. We will provide robust recommendations for modernizing and realigning the Veterans Health Administration facility footprints to ensure the finest integrated care delivery to our Veterans.

Given the oversight and approval process outlined under the MISSION Act for the Asset and Infrastructure Review, VA is confident that the AIR Commission, the President, and ultimately, Congress will concur and approve our recommendations.

Conclusion

I would like to again thank Congress for passing VA's FY 2019 funding bill. Starting the fiscal year with our full year's appropriations in place is extremely important as we implement the laws Congress has passed.

As I mentioned, we have instituted strong governance and management processes that will facilitate successful implementation of the VA MISSION Act. This will be a long journey that will not be accomplished overnight. I am committed to providing you with regular updates on our progress and the challenges that arise.

As we look to the next few years and full implementation of the new Veterans Community Care Program and an expanded Caregivers Program, VA will need to address the necessary funding requirements to meet the requirements of the law. We are embarking on the most comprehensive improvements to Veterans care and benefits since World War II. Our transformation will require fiscally responsible use of additional resources and for us to streamline and improve our internal operations to become as efficient as possible.

I look forward to working with you and this Committee and appreciate your many courtesies to me. I am also eager to continue building on our reform agenda. The mission of this Committee is clear-you help remind all Americans why they sleep soundly at night because of those who sacrificed in uniform. There is no more noble mission in all of government.

Thank you.

Statement For The Record

Veterans Of Foreign Wars Of The United States (VFW)

KAYDA KELEHER, ASSOCIATE DIRECTOR

NATIONAL LEGISLATIVE SERVICE

After four years of tireless work and development, the VA MISSION Act of 2018 was signed into law on June 6, 2018. The main prerogative of the VA MISSION Act of 2018 is perfectly stated as Title I—Caring for Our Veterans. The Veterans of Foreign Wars of the United States (VFW) believes that to successfully implement this multifaceted portion of the law, the Department of Veterans Affairs (VA), Congress, and veterans service organizations (VSOs) must collaboratively work together, while maintaining its implementation as the top priority of the 116th Congress. The VFW thanks the Committees for the continued oversight of this important law and leadership in ensuring VA has the resources to properly implement it.

If the law is effectively implemented, veterans' health care will enter a new era of timely access to high-quality care. However, if implementation strays from the overwhelming consensus reached by stakeholders involved in development of the law, VA health care could decline, resulting in negative consequences for the millions of veterans who rely on VA for their health care, and threaten the viability of VA's teaching, world-class research, and emergency response missions. While there are groups that believe VA facilities should be downsized and that veterans should receive more care through private sector doctors, the VFW's numerous sur-

veys show veterans want VA to hire more doctors and increase internal capacity. In fact, our latest VA health care survey indicates nearly 60 percent of veterans who were offered community care elected to stay with VA. The main reason veterans prefer VA is they like the quality of care they receive, which a recently published peer-reviewed study entitled Veterans Health Administration Hospitals Outperform Non-Veterans Health Administration Hospitals in Most Health Care Markets found is better than the private sector.

The law requires VA to develop regulations for new access and quality standards to replace the current arbitrary rule of a 30-day wait and 40-mile distance standards, by March 6, 2019. This will be done by consolidating seven current community care programs, including the Veterans Choice Program, into one. This program will be the Veterans Community Care Program (VCCP), and will use local health care networks and academic affiliates to provide care to all eligible veterans. The VFW has serious concerns about the lack of collaboration and working communication from VA with VSOs to establish these new regulations. While VA has held consistent meetings between VSOs and the Office of Community Care, the majority of such meetings have been one-sided conversations. Without proper stakeholder input, VA will fail. For example, VA is considering up to 20 different access standard models, none of which have been shared with VSOs. The VFW understands Congress intended for VSOs to receive specific data and to work in cooperation with VA to develop these future regulations that will affect the lives of millions of veterans. The VFW also has concerns with the lack of participation at Office of Community Care meetings from VA's Executive Steering Committee, which will ultimately assist the Secretary in choosing access standard models and how the law is implemented. The VFW is encouraged by this past week's decision to include VSOs in VA MISSION Act workgroup meetings with VA leadership. We hope such meetings will be more productive, and look forward to working with VA to ensure this important bill is implemented in the best interest of the veterans VA was created to serve.

The VFW has made clear time and time again that VA must back away from setting arbitrary standards for when patients using VA are given the option to use community care. VFW members have made clear the many negative unintended consequences of not upholding the decision to use community care as a clinical decision made between a patient and their provider. It is optimistic to hear VA working toward solutions in overcoming this range of arbitrary barriers, such as when a patient lives within close proximity to a VA facility based on miles, but must overcome geographical difficulties such as mountains. VA must adapt lessons learned from the Veterans Choice Program and study recommendations from industry experts, such as the Transforming Health Care Scheduling and Access: Getting to Now independent review conducted by the National Academy of Medicine, formerly known as the Institute of Medicine, to establish access standards that are appropriate for the users of the VA health care system. The VFW warns VA against adopting arbitrary standards which would fail to address the uniqueness of the VA health care system and the needs of our nation's veterans.

It is important for VA to establish access standards that define objective criteria for access to VA community care networks. Unless these standards are pragmatic and clinically appropriate, both veterans and VA will suffer negative consequences. VA must establish standards that are sensible for VA's capacity, and comparable to measures of local health care systems outside VA. As with access standards, quality standards must balance the need to maintain the unique features of VA that effectually serve veterans, but are different than those in the private sector.

The VFW also has concerns with feedback from facilities that veterans are being automatically placed into community care based on arbitrary guidelines without discussion or input from their providers. The VFW continues to oppose patients being involuntarily placed into community care simply because their appointments may not be scheduled within 30 days. First and foremost, veterans and their providers must remain part of this process to ensure patient understanding and continuity of care. Second, many of these patients would prefer to stay with VA. Finally, not every appointment must be fulfilled within the 30 days. If the appointment is not medically necessary in that timeframe, veterans must be able to choose whether to wait for VA or seek care through the community care networks.

The VFW also urges VA to account for how the implementation of a new electronic health care record impacts productivity. In partnership with the Defense Health Agency (DHA), the VFW has kept a keen eye on the implementation of the Military Health System GENESIS electronic health care record, which is the same system VA has elected to adopt for the VA health care system. While the VFW hopes VA adopts lessons learned from DHA to ensure a more seamless implementation, we are certain VA medical facilities will experience a temporary reduction in productivity that comes with change management. However, military treatment fa-

cilities report an eventual increase in productivity after full implementation. The VFW suspects VA medical facilities will experience a similar trend in productivity, which will lead to a temporary increase in demand for community care.

This and other temporary spikes in demand for community care, such as snowbirds, will require VA to adjust its community care networks and VA medical facility capacities to ensure veterans can receive the care they need where they need it. VA must make certain that temporary increase in demand for community care does not jeopardize the long-term viability of capacity at VA medical facilities. That is why the VFW urges VA and Congress to consistently evaluate whether VA should be expanding its community care networks or increasing internal capacity. This must be done by hiring more doctors or having VA deploy a quick reaction force of VA doctors to areas facing temporary spikes in demand for care.

VA facilities with service lines that fail to meet established quality standards will undergo remediation. Patients who rely on the 36 service lines that fall under the quality standards will have the opportunity to choose if they would rather stay with a VA doctor or use private sector doctors in their community. It is important that VA take into account what options veterans use and where they would prefer to go when developing remediation plans. VA must also take into account the ability for VA medical facilities to provide severely disabled veterans, such as those in spinal cord injury centers or polytrauma network sites, a full continuum of care. Simply closing such service lines in favor of community care would fail veterans who prefer to see a VA doctor and those who are unable to use community care.

To ensure access and quality standards are fully vetted and understood, the VFW urges VA to issue notice of proposed rulemaking in the Federal Register to allow sufficient time for public comments. It would be unacceptable for VA to issue an interim final rule, which does not allow for public input, specifically if stakeholders were not incorporated in developing it. Aside from stakeholders who must be consulted in the development of these rules, veterans and individuals who will be impacted by them must have their voices heard and considered through public comment. Doing so may mean that VA will not meet the deadlines established in the law. To the VFW, it is more important that VA produce high-quality and accurate regulations than it is for VA to rush the decision-making process and repeat previous mistakes in order to meet such deadlines. Also, there must be an organized outreach campaign for veterans who use VA once these regulations are finalized. Since the VA MISSION Act became law, VA has worked with VSOs to design pamphlets and other educational materials to share with patients when the law is ready to be implemented. This must be done so thoroughly and on multiple platforms, while also promising that all VA employees who will be involved in this transition completely understand the program and are able to explain it to patients.

As the regulations for the VA MISSION Act continue to be planned and implemented, the VFW looks forward to continuing to prioritize the remaining sections of the law. This includes working with VA and Congress to perfect billing, market assessments, expansion of the caregiver program, provider education and training programs, and the asset and infrastructure review.

American Veterans (AMVETS)

Chairman Isakson, Chairman Roe, Ranking Member Tester, Ranking Member Walz, and members of the Joint Veterans Affairs Committee, on behalf of the men and women of American Veterans (AMVETS), as well as the 21 million American veterans in our country who we represent, thank you for allowing us this platform to contribute to this very important discussion on the implementation of the Maintaining Internal Systems and Strengthening Integrated Outside Networks, or MISSION, Act of 2018.

When President Donald Trump signed the highly anticipated VA MISSION Act into law on June 6, 2018, it was an inflection moment in our country's effort to devise a system of healthcare that our veterans have needed and deserved for quite some time. The new law's predecessor, the Veterans Access, Choice and Accountability (Choice) Act of 2014, had created a new paradigm for delivering care, albeit imperfect and challenged by its previously untested standards involving coordinating care outside of the Department of Veterans Affairs (VA). The VA Mission Act is intended to build on the lessons learned as veterans' healthcare continues to evolve.

For the new law to be effective, it requires all involved to account for those lessons learned as we approach the end of one community care program and the beginning of another. Along with this notion is a requirement that next-generation vision

will inspire into existence a new system of care that will look as good in three-dimension as it does on paper through timely and effective implementation. Without good implementation in this effort, vision will be just another word for hallucination.

With that in mind, every vision must be driven by a leader. Since the law's passage, we have seen changes in leadership in the VA Secretary and VHA Under Secretary for Health Offices with the unceremonious removal of Drs. David Shulkin and Carolyn Clancy, respectively. The Office of Information and Technology, which will be critical to the success of the VA Mission Act, also faced a leadership shuffle after Scott Blackburn resigned as the chief information officer in April 2018. His successor, Camilo Sandoval, has filled the role in the interim amid negative reports and skepticism. It is our hope that he will be the right person for the job, for the sake of progress above politics. VA has not had a permanent CIO in more than 18 months, which explains, at least in part, the fits and starts that have hindered progress in the plan to fix the VA's IT infrastructure.

AMVETS calls on our political leaders, from the White House to Capitol Hill, to take every necessary step to ensure these important offices are staffed and stabilized by permanent decision makers who have the freedom to do their jobs without fear of politically motivated reprisal. The American taxpayers do not get a refund on wasted time, but that is exactly what has happened when key leaders were removed and progress stalled by uncertainty.

One project that has seen much uncertainty is the establishment of a Veterans Electronic Health Record system. The VA Mission Act provides $1.1 billion for the ongoing integration of VA and Department of Defense records to improve the efficiency and quality of veterans' health care.

Creating the largest EHR in the country is an extraordinary undertaking, and we anticipate issues along the way, as with any endeavor of this scale. However, when asked why the Interagency Program Office was not being used as a single point of governance for the project, officials reported to the Congress that they did not have the authority, staff and funding for the undertaking, an all-too-familiar refrain whenever the agency falls short of expectations. These self-inflicted wounds cannot continue.

The planned rollout of the EHR for year 2020 in Veterans Integrated Service Network 20 in the Pacific Northwest means that veterans will have to endure a two-year wait before seeing progress on the initial operating capability pilot site to test the Cerner project. Whether this two-year wait will be worth the time and expense remains to be seen. But veterans and other stakeholders can no longer accept a "moving of the goal posts" like we are already seeing with the Program of Comprehensive Assistance for Family Caregivers (PCAFC).

One of the key provisions of the VA Mission Act is the long-awaited expansion of the PCAFC. The law mandates the development and implementation of a new information technology system to support administrative oversight and record-keeping needs. Section 162 of the VA Mission Act directs, "Not later than October 1, 2018, the Secretary of Veterans Affairs shall implement an information technology system that fully supports the Program and allows for data assessment and comprehensive monitoring of the Program."

The implementation deadline, which has since passed, was critical because the caregivers who attend to the needs of severely disabled veterans who served before September 11, 2001 will not receive benefits until the VA Secretary certifies to Congress a viable IT system. However, questions persist regarding this mandate to implement a new technology because the VA already has the "Caregiver Application Tracking System," which is used to manage nearly 20,000 caregiver cases. The glitches that need to be addressed, oversight and medical records management chief among them, apparently call for the complete overhaul of the existing system, to the chagrin of veterans and caregivers whose livelihoods are now inextricably linked to the agency's ability to correct longstanding IT problems, an ability that remains challenged.

Moreover, given how forcefully some VA leaders had opposed the expansion of the program to Pre-9/11 caregivers in the past, many of our constituents fear that the VA has found a way to indefinitely stall expansion by conditioning progress on a new system in the distant future instead of fixing the existing one so that expansion can happen much sooner - this while the VA already faces problems with the system that manages Post-9/11 GI Bill housing stipends that affect 360,000 veterans and family members. AMVETS will remain vigilant for evidence that either proves or disproves these suspicions as the situation unfolds. We encourage VA leaders to remain transparent about all milestones and goals, to include timelines, so that progress is measurable and expectations more manageable.

To that point, AMVETS commends TriWest for the corporation leadership's transparency and diligence in managing expectations as its services expand to all 50 states.

When Health Net's Veterans Choice Program contract expired on September 30th, there was little basis for optimism among veteran advocates. VA leadership recruited TriWest to expand services to bridge the gap and deliver health care until all community care contracts are implemented, which offers lukewarm comfort, at best, given the lack of a clear timeline for complete implementation.

However, TriWest has reportedly been actively engaging VA Central Office, Veteran Integrated Service Networks, and VA Medical Centers in order to prepare for staggered transition of support in all states previously covered by Health Net, while handling an average of 120,000 requests for care per month. We were pleased to hear from VA leadership that the 60,000 consults that were returned to the VA from Health Net did not create an immediate backlog or affect future consults. We hope this trend will continue and will be monitoring to ensure that it does.

Chairman Roe, Ranking Member Walz, and members of the Committee, on behalf of the men and women of AMVETS and the nearly 21 million veterans in the United States whose interests are served by our mission, we thank you for the opportunity to contribute to this important discussion. AMVETS looks forward to working with this Committee and the Department of Veterans Affairs to take every step necessary to ensure the successful implementation of the VA Mission Act.

Jacob Gillison (Sanders)

The VA's Private Care Program Gave Companies Billions and Vets Longer Waits
Trump wants to supersize a program that spent almost a quarter of its funds on overhead.

by Isaac Arnsdorf, ProPublica, and Jon Greenberg, PolitiFact
Dec. 18 1:30 pm EST

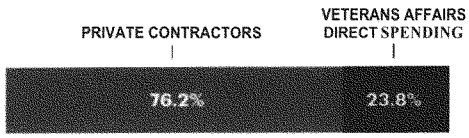
For years, conservatives have assailed the U.S. Department of Veterans Affairs as a dysfunctional bureaucracy. They said private enterprise would mean better, easier- to-access health care for veterans. President Donald Trump embraced that position, enthusiastically moving to expand the private sector's role.

Here ' s what has actually happened in the four years since the government began sending more veterans to private care: longer waits for appointments and, a new analysis of VA claims data by ProPublica and PolitiFact shows, higher costs for taxpayers.

Since 2014, 1.9 million former service members have received private medical care through a program called Veterans Choice. It was supposed to give veterans a way around long wait times in the VA. But their average waits using the Choice Program were still longer than allowed by law, according to examinations by the VA inspector general and the Government Accountability Office. The watchdogs also found widespread blunders, such as booking a veteran in Idaho with a doctor in New York and telling a Florida veteran to see a specialist in California. Once, the VA referred a veteran to the Choice Program to see a urologist, but instead he got an appointment with a neurologist.

The winners have been two private companies hired to run the program, which began under the Obama administration and is poised to grow significantly under Trump. ProPublica and PolitiFact obtained VA data showing how much the agency has paid in medical claims and administrative fees for the Choice program. Since 2014, the two con1panies have been paid nearly $2 billion for overhead, including profit. That's about 24 percent of the companies' total program expenses -a rate that would exceed the federal cap that governs how much most insurance plans can spend on administration in the private sector.

Since 2014, the VA's Veterans Choice Program has spent $10.3 billion. Most of that money went to private contractors.

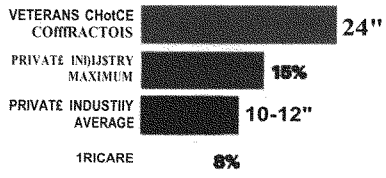


Lucas Waldron/ProPublica

Contractors spent $1.9 billion - or 24 percent - of that money on overhead.

Lucas Waldron/ProPublica

That's about double the private-industry standard rate and three times as much as the military's health insurance program.



Lucas Waldron/ProPublica

According to the agency's inspector general, the VA was paying the contractors at least $295 every time it authorized private care for a veteran. The fee was so high because the VA hurriedly launched the Choice Program as a short-term response to a crisis. Four years later, the fee never subsided- it went up to as much as $318 per referral.

"This is what happens when people try and privatize the VA," Sen. Jon Tester of Montana, the Ranking Democrat on the Senate veterans conunittee, said in a statement responding to these findings. "The VA has an obligation to taxpayers to spend its limited resources on caring for veterans, not paying excessive fees to a government contractor. When VA does need the help of a middleman, it needs to do a better job of holding contractors accountable for missing the mark."

The Affordable Care Act prohibits large group insurance plans fron1 spending more than 15 percent of their revenue on administration, including marketing and profit. The private sector standard is IO percent to 12 percent, according to Andrew Naugle, who advises health insurers on ad1ninistrative operations as a consultant at Milliman, one of the world's largest actnarial firms. Overhead is even lower in the Defense Department's Tricare health benefits program: only 8 percent last year.

Even excluding the costs of setting up the new program, the Choice contractors' overhead still amounts to 21 percent of revenue.

"That's just unacceptable," Rick Weidman, the policy director of Vietnam Veterans of America, said in response to the figures. "There are people constantly banging on the VA, bnt this was the private sector that made a total muck of it."

Trump's promises to veterans were a central message of his campaign. But his plans to shift their health care to the private sector put him on a collision course

with veterans groups, whose members generally support the VA' s medical system and don't want to see it privatized. The controversy around privatization, and the outsize influence of three Trump associates at Mar-a-Lago, has sown turmoil at the VA, endangering critical services from paying student stipends to pi-eventing suicides and upgrading electronic medical records.

A spokesman for the VA, Curt Cashour, declined to provide an interview with key officials and declined to answer a detailed list of written questions.

One of the contractors, Health Net, stopped working on the program in September. Health Net didn't respond to requests for comment.

The other contractor, TriWest Healthcare Alliance, said it has worked closely with the VA to improve the program and has made major investments of its own. "We believe supporting VA in ensuring the delivery of quality care to our nation's veterans is a moral responsibility, even while others have avoided making these investments or have withdrawn from the market," the company said in a statement. TriWest did not dispute ProPublica and PolitiFact's estimated overhead rate, which used total costs, but suggested an alternate calculation, using an average cost, that yielded a rate of 13 percent to 15 percent. The company defended the $295-plus fee by saying it covers "highly 1nanual" services such as scheduling appointJnents and coordinating 1nedical files. Such functions are not typically part of the contracts for other programs, such as the military's Tricare. But Tricare's contractors perform other duties, such as adjudicating claims and monitoring quality, that Health Net and TriWest do not. In a recent study comparing the programs, researchers from the Rand Corporation concluded that the role of the Choice Program's contractors is "much narrower than in the private sector or in Tricare."

Before the Choice Program, TriWest and Health Net performed essentially the same functions for about a sixth of the price, according to the VA inspector general.

TriWest declined to break down how much of the fee goes to each service it provides.

Because of what the GAO called the contractors' "inadequate" performance, the VA increasingly took over doing the Choice Program's referrals and claims itself.

In many cases, the contractors' $295-plus processing fee for every referral was bigger than the doctor's bill for services rendered, the analysis of agency data showed. In the three months ending Jan. 31, 2018, the Choice Program made 49,144 referrals for primary care totaling $9.9 million in medical costs, for an average cost per referral of $201.16. A few other types of care also cost less on average than the handling fee: chiropractic care ($286.32 per reterral) and optometry ($189.25). There were certainly other instances where the 1nedical services cost much more than the handling fee: TriWest said its average cost per referral was about $2, I00 in the past six months.

Beyond what the contractors were entitled to, audits by the VA inspector general found that they overcharged the government by $140 million from November 2014 to March 2017. Both companies are now under federal investigation arising from these overpayments. Health Net's parent con1pany, Centene, disclosed a Justice Department civil investigation into "excessive, duplicative or otherwise in1proper claims." A federal grand jury in Arizona is investigating TriWest for "wire fraud and misused government funds," according to a court decision on a subpoena connected to the case. Both companies said they are cooperating with the inquiries.

Despite the criminal investigation into TriWest's management of the Choice Program, the Trump administration recently expanded the company's contract without competitive bidding. Now, TriWest stands to collect even more fees as the administration prepares to fulfill Trump's campaign promise to send more veterans to private doctors.

Senate veterans Committee Chairman Johnny Isakson, R–Ga., said he expects VA Secretary Robert Wilkie to discuss the agency's plans for the future of private care,when he testifies at a hearing on Wednesday. A spokeswoman for the outgoing Chairman of the House veterans Committee, Phil Roe, R–Tenn., didn't respond to requests for comment.

"The last thing we need is to have funding for VA's core mission get wasted," Rep. Mark Takano, a California Democrat who ,viii become the House panel's Chairman in January, said in a statement. "I will make sure Congress conducts comprehensive oversight to ensure that our veterans receive the care they deserve while being good stewards of taxpayer dollars."

Many of the Choice Program's defects trace back to its hasty launch.

In 2014, the Republican Chairman of the House veterans Committee alleged that 40 veterans died waiting for care at the VA hospital in Phoenix. The inspector general eventually concluded that no deaths were attributable to the delays. But it was true that officials at the Phoenix VA were covering up long wait times, and critics seized on this scandal to demand that veterans get access to private medical care.

One of the loudest voices demanding changes was John McCain's. "Make no mistake: This is an emergency," the Arizona senator, who died in August, said at the time. McCain stiuck a compromise with Democrats to open up private care for veterans who lived at least 40 miles from a VA facility or would have to wait at least 30 days to get an appointment.

In the heat of the scandal, Congress gave the VA only 90 days to launch Choice. The VA reached out to 57 companies about administering the new program, but the companies said they couldn't get the program off the ground in just three months, according to contracting records. So the VA tacked the Choice Program onto existing contracts with Health Net and TriWest to run a much s1naller program for buying private care. "There is simply insufficient time to solicit, evaluate, negotiate and award competitive contracts and then allow for some form of ramp-up time for a new contractor," the VA said in a formal justification for bypassing competitive bidding.

But that was a shaky foundation on which to build a much larger program, since those earlier contracts were themselves flawed. In a 2016 report, the VA inspector general said officials hadn't followed the rules "to ensure services acquired are based on need and at fair and reasonable prices." The report criticized the VA for awarding higher rates than one of the vendors proposed.

The new contract with the VA was a lifeline for TriWest. Its president and CEO, David J. McIntyre Jr., was a senior aide to McCain in the mid-1990s before starting the company, based in Phoenix, to handle health benefits for the 1nilitary's Tricare program. In 2013, TriWest lost its Tricare contract and was on the verge of shutting down. Thanks to the VA contract, TriWest went from laying off more than a thousand employees to hiring hundreds.

McIntyre's annual compensation, according to federal contracting disclosures, is $2.36 million. He declined to be interviewed. In a statement, TriWest noted that the original contract, for the much smaller private care program, had been competitively awarded.

The VA paid TriWest and Health Net $300 million upfront to set up the new Choice program, according to the inspector general's audit. But that was dwarfed by the fees that the contractors would collect. Previously, the VA paid the companies between $45 and $123 for eve1y referral, according to the inspector general. But for the Choice Program, TriWest and Health Net raised their fee to between $295 and $300 to do essentially the same work on a larger scale, the inspector general said.

The price hike was a direct result of the time pressure, according to Greg Giddens, a former VA contracting executive who dealt with the Choice Program. "Ifwe had two years to stand up the program, we would have been at a different price structure," he said.

Even though the whole point of the Choice Program was to avoid 30-day waits in the VA, a convoluted process made it hard for veterans to see private doctors any faster. Getting care through the Choice Program took longer than 30 days 41 percent of the time, according to the inspector general's estimate. The

GAO found that in 2016 using the Choice Progran1 could take as long as 70 days, with an average of 50 days.

Sometimes the contractors failed to make appointments at all. Over a three-month period in 2018, Health Net sent back between 9 percent and 13 percent of its referrals, according to agency data. TriWest failed to make appointments on 5 percent to 8 percent of referrals, the data shuws.

Many veterans had frustrating experiences with the contractors.

Richard Camacho in Los Angeles said he got a call from TriWest to make an appointment for a sleep test, but he then received a letter from TriWest with different dates. He had to call the doctor to confinn when he was supposed to show up. When he got there, the doctor had received no information about what the appointment was for, Cainacho said.

John Moen, a Vietnam veteran in Plano, Texas, tried to use the Choice Program for physical therapy this year rather than travel to Dallas, where the VA had a six-v,eek wait. But it took 10 weeks for him to get an appointment with a private provider.

"The Choice Program for me has completely failed to meet my needs," Moen said.

Curtis Thompson, of Kirkland, Washington, said he's been told the Choice Program had a 30-day wait just to process referrals, never mind to book an appointment. "Bottom line: Wait for the nearly 60 days to see the rheumatologist at the VA rather than opt for an unknown delay through Veterans Choice," he said.

After Thompson used the Choice Program in 2018 for a sinus surgery that the VA couldn't perform within 30 days, the private provider came after him to collect payment, according to documentation he provided.

Thousands of veterans have had to contend with bill collectors and credit bureaus because the contractors failed to pay providers on tin1e, according to the inspector general. Doctors have been frustrated with the Choice Program, too. The inspector general found that 15 providers in Nmih Carolina stopped accepting patients from the VA because Health Net wasn't paying them on time.

The VA shares the blame, since it fell behind in paying the contractors, the inspector general said. TriWest claimed the VA at one point owed the company $200 million. According to the inspector general, the VA's pile of unpaid claims peaked at almost 180,000 in 2016 and was virtually eliminated by the end of the year.

The VA tried to tackle the backlog of unpaid doctors, but it had a problem: The agency didn't know who was performing the services arranged by the contractors. That's because Health Net and TriWest controlled the provider networks, and the medical claims they submit to the VA do not include any provider information.

The contractors' role as middlemen created the opportunity for payment errors, according to the inspector general's audit. The inspector general found 77,700 cases where the contractors billed the VA for more than they paid providers and pocketed the difference, totaling about $2 million. The inspector general also identified $69.9 million in duplicate payn1ents and $68.5 n1illion in other errors.

TriWest said it has worked with the VA to correct the payment errors and set aside money to pay back. The company said it's waiting for the VA to provide a way to refund the confirmed overpayments. "We remain ready to complete the necessary reconciliations as soon as that process is formally approved," TriWest said.

The grand jury proceedings involving TriWest are secret, but the investigation became public because prosecutors sought to obtain the identities of anonymous commenters on the jobs website Glassdoor.com who accused TriWest of"mak[ing] money unethically off ofveteransNA." Glassdoor fought the subpoena but lost, in November 2017. The court's opinion doesn't name TriWest, but it describes the subject of the investigation as "a government contractor that administers veterans' healthcare programs" and quotes the Glassdoor reviews about TriWest. The federal prosecutor's office in Arizona declined to comment.

"TriWest has cooperated with many government inquiries regarding VA's com1nunity care programs and will continue to do so," the company said in its statement. "TriWest 1nust respect the government's right to keep those inquiries confidential until such time as the government decides to conclude the inquiry or take any actions or adjust VA programs as deemed appropriate."

The VA tried to make the Choice Progrmn run more smoothly and efficiently. Because the contractors were failing to find participating doctors to treat veterans, the VA in mid-2015 launched a full-court press to sign up private providers directly, according to the inspector general. In some states, the VA also took over scheduling from the contractors.

"We were making adjustments on the fly trying to get it to work," said David Shulkin, who led the VA's health division starting in 2015. "There needed to be a more holistic solution."

Officials decided in 20I6 to design new contracts that would change the fee structure and reabsorb some of the services that the VA had outsourced to Health Net and TriWest. The department secretary at the time, Bob McDonald, concluded the VA needed to handle its own customer service, since the agency's reputation was suffering from TriWest's and Health Net's tnistakes. Reclaiming those functions would have the side effect of reducing overhead.

"Tell me a great customer service company in the vvorld that outsources its customer service," McDonald, who previously ran Procter & Gamble, said in an interview. "I wanted to have the administrative functions within our medical centers so we took control of the care of the veterans. That would have brought that fee down or eliminated it entirely."

The new contracts, called the Community Care Network, also aimed to reduce overhead by paying the contractors based on the number of veterans they served per month, rather than a flat fee for every referral. To prevent payment errors like the ones the inspector general found, the new contracts sought to increase information- sharing between the VA and the contractors. The VA opened bidding for the new Community Care Network contracts in December 2016.

But until those new contracts were in place, the VA was still stuck paying Health Net and TriWest at least $295 for every referral. So VA officials came up with a workaround: they could cut out the 1niddleman and refer veterans to private providers directly. Claims going through the contractors declined by 47 percent from May to Deceinber in 2017.

TriWest's CEO, McIntyre, objected to this workaround and blamed the VA for hurting his bottom line.

In a Feb. 26, 2018, email with the subject line "Heads Up... Likely Massive and Regrettable Train Wreck Coming!" McIntyre warned Shulkin, then the department secretary, that "long unresolved matters with VA and cutTent behavior patterns will result in a projected $65 million loss next year. This is on top of the losses that we have amassed over the last couple years."

Officials were puzzled that, despite all the VA was paying TriWest, McIntyre was claiining he couldn't make ends meet, according to agency emails provided to ProPublica and PolitiFact. McIntyre explained that he wanted the VA to waive penalties for clai1ns that lacked adequate documentation and to pay TriWest an administrative fee on canceled referrals and no-show appointments, even though the VA read the contract to require a fee only on completed claims. In a March letter to key lawmakers, McIntyre said the VA's practice of bypassing the contractors and refen-ing patients directly to providers "has resulted in a significant drop in the volume of work and is causing the company in-eparable financial harm."

McIntyre claimed the VA owed TriWest $95 million and warned of a "negative impact on VA and veterans that will follow" if the agency didn't pay. Any disruptions at TriWest, he said, would rebound onto the VA, "given how much we are relied on by VA at the moment and the very public nature of this work."

But when the VA asked to see TriWest's financial records to substantiate McIntyre's claims, the numbers didn't add up, according to agency emails.

McIntyre's distress escalated in March, as the Choice Program was running out of money and lawmakers were locked in tense negotiations over its future. McIntyre began sending daily emails to the VA officials in charge of the Choice Program seeking updates and warning of impending disaster. "I don't think the storm could get more difficult or challenging," he ,vrote in one of the 1nessages. "However, I know that I am not alone nor that the impact will be confined to us."

McIntyre lobbied for a bill to permanently replace Choice with a new program consolidating all of the VA's 1nethods of buying private care. TriWest even offered to pay veterans organizations to run ads supportiI1g the legislation, according to e1nails discussing the proposal. Congress overwhelmingly passed the law (named after McCain) in May.

"In the campaign, I also promised that we would fight for Veterans Choice," Trump said at the signing ceremony in June. "And before I knew that much about it, it just seemed to be common sense. It seemed like if they're waiting on line for nine days and they can't see a doctor, why aren't they going outside to see a doctor and take care of themselves, and we pay the bill? It's less expensive for us, it works out much better, and it's immediate care."

The new permanent program for buying private care will take effect in June 2019. The VA's new and improved Community Care Network contracts were supposed to be in place by then. But the agency repeatedly missed deadlines for these new contracts and has yet to award them.

The VA has said it's aiming to pick the contractors for the new program in January and February. Yet even if the VA meets this latest deadline, the contracts include a one-year ramp-up period, so they won't be ready to start in June.

That means TriWest will by default become the sole contractor for the new program. The VA declined to renew Health Net's contract when it expired in September. The VA was planning to deal directly with private providers in the regions that Health Net had covered. But the VA changed course and announced that TriWest would take over Health Net's half of the country. The agency said TriWest would be the sole contractor for the entire Choice Program until it awards the Community Care Network contracts.

"There's still not a clear tin1eline moving forward," said Giddens, the former VA contracting executive. "They need to move forward with the next program. The longer they stay with the current one, and now that it's down to TriWest, that's not the best model."

Meanwhile, TriWest will continue receiving a fee for every referral. And the number of referrals is poised to grow as the administration plans to shift more veterans to the private sector.

American Health Care Association (AHCA)

Chairman Phil Roe, M.D.
United States House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Chairman Johnny Isakson

United States Senate Committee on Veterans' Affairs
Russell Senate Building - Room 412
Washington, D.C. 20510

Chairmen Roe and Isakson:

I serve as the Senior Vice President of Government Relations at the American Health Care Association (AHCA), the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 13,700 not for profit and for profit member facilities.

AHCA, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies which balance economic and regulatory principles to support quality of care and quality of life.

Therefore, I appreciate the opportunity today to submit a statement on behalf of AHCA around the joint Senate Veterans Affairs Committee and House Veterans Affairs Committee hearing entitled, "Tracking Transformation: VA MISSION Act Implementation."

Prior to the VA MISSION Act, if extended care providers, including nursing care centers, accepted a veteran patient, they were considered to be a federal contractor and subjected to additional red tape - simply because the patient was a veteran. Our centers already meet very strict compliance guidelines under the Medicare and Medicaid programs. Adding additional regulations on top of this is simply inefficient, redundant, adds cost and takes staff time away from these veterans at the bedside. This disparity of contracting and reporting requirements has deterred many long term care providers around the country from accepting veteran patients. As our veteran population ages, we must be able to provide them with a continuum of care for their dedicated service. Furthermore, we must be able to provide this care closer to their home communities or in close proximity to their families and support system.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 13,700 non- profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

It is long-standing policy that Medicare (Parts A and B) or Medicaid providers are not considered to be federal contractors. However, if a provider currently has VA patients, they are considered to be a federal contractor and under the Service Contract Act. The Office of Federal Contracting Compliance Programs (OFCCP) has administered onerous reporting requirements and regulations even beyond those required by Medicare and Medicaid rules, which have dissuaded nursing care centers from admitting VA patients. This limits the care available to veterans needing long term care in their local communities. Our veterans should not have to choose between obtaining the long term care services they need and remaining near loved ones in their community. Conversely, the same centers contracting with the Centers for Medicare and Medicaid Services (CMS) are not subject to the OFCCP regulations.

AHCA has long been advocating for policies that would make the VA requirements for providers the same as they are for CMS and waives the OFCCP federal contracting requirements. Provisions in the VA Mission Act will help remove some of the existing red tape that may prevent providers from being able to provide care to veterans. More specifically, the VA Mission Act will ensure that extended care providers, including nursing center care, can legally enter into Veteran Care Agreements (VCAs). As the VA is working on implementation of these agreements we must ensure that they are subject to the same rules and regulations as any other Medicare or Medicaid provider as the law intended. We also must ensure that the law is implemented in a timely manner and our providers have access to VA staff with any implementation concerns or questions.

The use of VCAs for extended care services would facilitate services from providers who are closer to veterans' homes and community support structures. Once providers can enter into VCAs the number of providers serving veterans will increase in most markets, expanding the options among veterans for nursing center care and home and community-based services. AHCA appreciates the fact that your Committees have worked to make these VCAs a reality. AHCA asks for your assistance in ensuring proper and timely implementation of these agreements so those

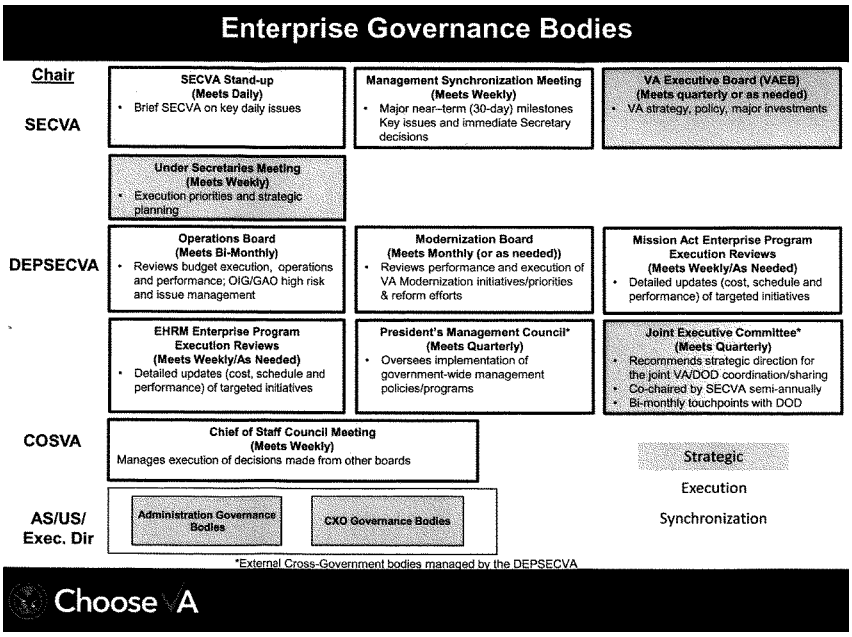
veterans who have served our nation so bravely have appropriate access to quality health care.

Thank you again for the opportunity to comment on this important matter. If you have any questions, please do not hesitate to contact me at cporter@ahca.org or AHCA's Senior Director of Not for Profit & Constituent Services, Dana Halvorson, at dhalvorson@ahca.org.

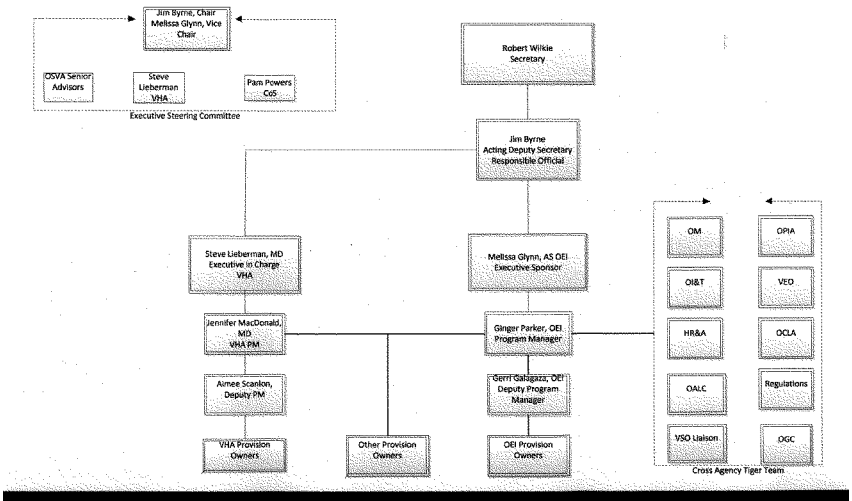
Sincerely,

Clifton J. Porter II
Senior Vice President of Government Relations

GOVERANCE SLIDES



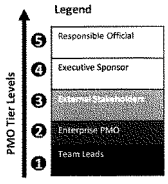
Updated Program Governance and Delivery Structure



Choose VA

MISSION Act Meetings Battle Rhythm

Meeting	Purpose (Attendees)	Cadence
SECVA Brief	Progress/policy briefing on MISSION Act to the Secretary with Executive Steering Committee Members, MISSION Act Program Manager and VHA Project Executive	Bi-Monthly (as needed to support policy decisions)
DEPSECVA Executive Steering Committee Meeting	Status/risk mitigation meeting with Executive Steering Committee Members, MISSION Act Program Manager and VHA Project Executive	Weekly
DEPSECVA and Executive Sponsor Program Management Review (PMR)	Detailed status update briefings on current tasks, deliverables, risks, issues, and dependencies from provisions owners	Bi-Monthly
Executive Sponsor and Program Manager Daily Update	Daily update meeting between Dr. Melissa Glynn and Enterprise PMO Executive Director Ginger Parker	Daily
Enterprise Program Management Office (EPMO) Meeting	EPMO team briefing to Dr. Melissa Glynn on progress, issues, and approvals	Weekly
OMB/DPC Policy and Regulations Council	Collaborative meeting with OMB/DPC on status of regulatory actions/policy	Weekly
Congressional Briefings	OCLA, EPMO and SME status updates briefing to Congressional staff	Monthly/ Quarterly
Cross Agency Tiger Team Meeting	EPMO, VHA Project Executive Team and Cross Agency Team Members meet to discuss – progress reporting, issue tracking, action item tracking, task prioritization; includes required enabling offices (HRA, OI&T, OM, OPIA, OALC, VEO, OCLA, OGC, 02REG)	Daily
Concurrence Review Meeting	Simultaneous review of deliverables for concurrence (OCLA, OGC, OEI)	As needed
Integrated Project Team (IPT) Meetings	On-going progress meetings of the provision owners' IPTs	Weekly



*External Cross-Government bodies managed by the DEPSECVA

Choose VA

1National Committee for Quality Assurance (NCQA)

Key Points

The National Committee for Quality Assurance is a non-profit that works to improve health care quality and value through measurement, transparency and accountability.

NCQA programs and extensive expertise align with MISSION Act requirements and can help the VA expedite the law's implementation.

NCQA is the nation's largest health plan accreditor, stewards HEDIS®[1] - the most widely used set of clinical performance measures, and has the nation's largest Patient-Centered Medical Home (PCMH) program.

NCQA also has the nation's only Patient-Centered Specialty Practice (PCSP) program, which closely aligns with VA Mission Act requirements for provisions for ensuring quality and access for non-Department clinicians.

The PCSP program requires agreements for information exchange between specialty practices and primary care clinicians who refer to them.

The program also includes optional criteria practices can meet to earn additional points needed for recognition, such as electronic and same-day access, patient experience surveys, and measuring and reporting their performance.

We would be happy to work with the VA and its stakeholders to tailor the PCSP program to meet specific MISSION Act provisions.

- For example, we have a PCMH standard on query of prescription drug monitoring program we could add to PCSP to align with the MISSION Act provision on monitoring opioids.
- We also could make optional criteria like same-day access and measuring patient experience must-pass to fully align PCSP with other MISSION Act provisions.

PCSP Recognition there could be a basis for certification of eligible providers, as required by the statue, without requiring the VA to "reinvent the wheel" that we developed through extensive literature review, stakeholder engagement and public comment.

The Honorable Johnny Isakson, Chairman
U.S. Senate Committee on Veterans' Affairs

The Honorable John Tester, Ranking Member
U.S. Senate Committee on Veterans' Affairs

The Honorable Phil Roe, MD, Chairman
U.S. House Committee on Veterans' Affairs

The Honorable Tim Walz, Ranking Member
U.S. House Committee on Veterans' Affairs

Dear Chairmen Isakson and Roe & Ranking Members Tester and Walz:

Thank you for the opportunity to submit a statement for the record on VA MISSION Act Implementation. The National Committee for Quality Assurance (NCQA) is a non-profit organization established in 1990 to improve health care quality through measurement, transparency and accountability. We work to build consensus among stakeholders from government, private industry, consumers and academia on ways to improve quality. As a result, our programs are nationwide market leaders that enjoy broad public and private sector support.

Our programs also closely align with critical Mission Act requirements, allowing the VA to adopt them without "reinventing the wheel" that we already developed through our extensive experience and consensus-building approach. We stand ready and eager to help in any way we can and hope the Department of Veterans' Administration will consider NCQA a valued partner to support its quality improvement efforts.

NCQA's Evidence- & Consensus-Based Process: We develop NCQA programs and measures through a systematic, evidence- and consensus-based process. We start with literature reviews to identify evidence and guidelines on the most appropriate or best practices. We then establish expert Committees representing patients and families, clinicians and other health professionals, employers, insurers and industry, academics and state and federal government to build consensus on the best way to measure adherence to the evidence. We put the resulting consensus out for public comment from all stakeholders and incorporate those comments into final decisions. Once implemented, we monitor the scientific literature and seek ongoing

[1] The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of NCQA.

stakeholder feedback on challenges, potential improvements or updated evidence and incorporate as needed. And we post results in report cards on the ncqa.org website.

Accreditation: NCQA has the nation's largest health plan accreditation program, with over 181 million Americans in NCQA-accredited plans. We accredit plans by rating their actual performance and make the results publicly available to help the VA and many others set benchmarks. The federal government requires such performance-based accreditation for all plans participating in the Affordable Care Act Marketplaces. As a result, more than 85 percent of Marketplace plans are NCQA Accredited. In addition, 26 state Medicaid programs specifically require NCQA Accreditation for managed care plans and another 4 accept NCQA Accreditation. In addition, NCQA has the only long-term services and supports (LTSS) accreditation program, which four states require for managed care plans providing LTSS.

We also have accreditation programs for managed behavioral health care, case management, disease management, utilization management, credentialing, provider networks, wellness and health promotion, and a multicultural health care distinction program to help address culturally and linguistically appropriate services and reduce disparities. We are happy to share the Standards and Guidelines materials for any of these programs and explore how they, or parts of them, might help meet MISSION Act requirements.

Quality Measures: NCQA stewards the Healthcare Effectiveness Data and Information Set, or HEDISr quality measures. HEDIS is the most widely used clinical quality performance measures and includes more than 90 measures that track prevention, management of chronic conditions, misuse and patients' experience of care. Medicare, most states and many private purchasers require HEDIS, and insurers covering 57% of all Americans now report HEDIS.

We continuously update HEDIS for new scientific evidence, to remove "topped out" measures with little further opportunity for improvement, and to raise the bar in areas that need improvement.

We are fortunate to have a liaison from the VA, along with other private and public entities, on our HEDIS Committee for Performance Measurement (CPM) Committee, which guides this work.

We have specific HEDIS sets tailored to the populations of different product lines, such as Medicare, Medicaid and CHIP, Marketplace and Commercial plans. We would be happy to work with the VA to similarly tailor a set of HEDIS and other measures that meet the specific needs of the veterans you serve.

Comparable Results for Public Reporting: It is critical to have all clinicians within each specialty report the same measures to ensure comparable information for MISSION Act public reporting. Programs that let clinicians choose measures from a menu get the false impression that quality is higher than it actually is because people will report measures that make them look best.

It also is important to ensure that clinicians have sufficient numbers of patients to obtain statistically valid measurement results. Results for clinicians with small numbers of specific types of patients are unreliable and will not provide useful comparative information to VA stakeholders. Medicare's "virtual group" option addresses this small numbers problem by letting clinicians voluntarily join together for measurement as a group to achieve numbers large enough for valid measurement results. The VA therefore may also want to explore virtual groups as a way to obtain more valid comparable information for the MISSION Act.

Reporting Burden & Meaningful Measures: We are well aware of the amount of time clinicians now spend to report on quality, which takes time away from patient care. We are diligently working to reduce reporting burden by moving to a system in which we automatically derive measurement data from electronic health systems, registries and other electronic sources. This will allow us to access more robust clinical data that are in these systems compared to health care claims that are primary sources for most measures today. It also will let clinicians report measures by merely entering data electronically as they do in the normal course of patient care without additional data entry as required today.

Additionally, we are working toward the same goals as the Centers for Medicare & Medicaid (CMS) Meaningful Measures Initiative that seeks to minimize reporting burden, streamline measures and focus on outcomes. This includes automated reporting, systematic review of measures to retire and developing outcome measures, especially patient-reported outcome measures (PROMs).

Patient-Centered Medical Homes & Neighborhoods: NCQA has the nation's largest Patient-Centered Medical Home (PCMH) program which includes nearly 20 percent of all primary care physicians, plus additional primary care clinicians, at over 14,000 sites.

PCMHs transform primary care into what patients want by building better relationships between patients and the teams who care for them and directly addressing fragmentation [2] that plagues health care.

PCMHs do this by:

- Helping patients get care when they need it, including electronically and after hours.
- Coordinating personalized, comprehensive, integrated care.
- Preventing costly, avoidable hospitalizations and emergency department visits - particularly for complex chronic conditions.
- Improving staff satisfaction by ensuring practices have systems and structures to work efficiently.
- Leveraging health information technology (HIT) to enhance access and coordinate care.
- Reducing health care disparities and clinician burnout.

A growing body of evidence documents that PCMHs improve cost, quality and patients' experience of care while reducing both disparities and clinician burn-out. [3] In Medicare, for example, PCMHs reduce per capita spending by 4.9%. [4]

We also have related "medical neighborhood" programs for specialists, retail and other clinics. Over 100 public and private payers support our patient-centered care programs. Congress recognized the value of PCMHs and Patient-Centered Specialty Practices (PCSP) by legislating automatic credit for them under Medicare's Merit-Based Incentive Payment System. The Department of Defense has worked with NCQA to help XXXX of its primary care practices transform to PCMHs. Similarly, the Health Resources Services Administration has worked with NCQA to transform XXXX federally qualified health centers as PCMHs.

Patient-Centered Specialty Practices: Our PCSP program, in particular, aligns with MISSION Act provisions for quality and access of non-Department clinicians. We launched the program in 2013 and updated it in 2016. It builds off of a PCMH foundation to establish "medical [5]neighborhoods. [6]

NCQA Patient-Centered Specialty Practice Standards

1. Track & Coordinate Referrals A. *Referral Process & Agreements B. Referral Content C. *Referral Response	**2. Plan & Manage Care** A. Care Planning & Support Self-Care B. *Medication Management C. Use Electronic Prescribing
2. Provide Access & Communication A. Access B. Electronic Access C. Specialty Practice Responsibilities D. Culturally & Linguistically Appropriate Services E. *The Practice Team	**5. Track & Coordinate Care** A. Test Tracking & Follow-Up B. Referral Tracking & Follow-Up C. Coordinate Care Transitions
3. Identify & Coordinate Patient Populations A. Patient Information B. Clinical Data C. Coordinate Patient Populations	**6. Measure & Improve Performance** A. Measure Performance B. Measure Patient/Family Experience C. *Implement & Demonstrate Continuous Quality Improvement D. Report Performance E. Use Certified EHR Technology

*Must Pass Elements

The program requires agreements for two-way information exchange between specialty practices and primary care clinicians who refer to them. The program also includes optional criteria practices can meet to earn additional points needed for recognition, such as electronic and same-day access, patient experience surveys, and measuring and reporting their performance.

PCSP Recognition therefore could be a basis for certification of eligible providers, as required by the statue, without requiring the VA to "reinvent the wheel" that we developed through extensive literature review, stakeholder engagement and public comment.

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[2] Frandsen et al, Care Fragmentation, Quality, and Costs Among Chronically Ill Patients, 2015.

[3] NCQA, Benefits of NCQA Patient-Centered Medical Home Recognition, 2017.

[4] Health Services Research, Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient- Centered Medical Homes, 2015.

[5] American College of Physicians, The Patient-Centered Medical Home Neighbor, 2010.

[6] Agency for Healthcare Research & Quality, Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanism, 2011.

The chart below shows how our PCSP standards align with key VA MISSION Act provisions for access - including same-day appointments, measuring and reporting on quality, coordination and patient surveys.

VA MISSION Act & NCQA PCSP Alignment	
VA MISSION ACT	NCQA PCSPs
Measure Quality	6 A: Measure Performance
Continuity & Coordination	1 A-C: Track & Coordinate Referrals
Standards & Systems for Monitoring Quality	6 A-E: Measure & Improve Performance
Standards for Access	2 A-E: Access & Communication
Offer Comparative Information	6 D: Report Performance
Survey veteran satisfaction	6 B: Measure Patient/Family Experience
Access To & Continuity for Walk-In Care	2 A – Access: Reserves time for same-day appts
Inclusion of Medical History & Current Medications	4 B: Medication Management
Potential for Tiered Network & Certifying Eligible Providers	

We would be happy to work with the VA and its stakeholders to tailor the PCSP program to meet specific MISSION Act provisions. For example, we have a PCMH standard on query of prescription drug monitoring program we could add to PCSP to align with the MISSION Act provision on monitoring opioids. We also could make optional criteria like same-day access and measuring patient experience must-pass to fully align PCSP with other MISSION Act provisions.

Conclusion: NCQA for nearly three decades has worked toward our mission to improve quality, access and patients' experience of care in ways that closely align with the VA MISSION Act. We believe our extensive experience, consensus-building approach and market leading products that track MISSION Act requirements can add real value to your efforts. We stand ready and eager to help any way we can, including tailoring our work to best meet the VA's unique needs and challenges in implementing the MISSION Act.

Thank you again for the opportunity to submit this statement for the record. We welcome the opportunity to discuss these ideas in greater depth. Please contact Paul Cotton, Director of Federal Affairs, at 202- 955–5162 or cotton@ncqa.org if you have any questions.

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