

**BUILDING A 21ST CENTURY VA HEALTH CARE
SYSTEM: ASSESSING THE NEXT GENERATION
OF VA'S COMMUNITY CARE NETWORK**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE**

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BUILDING A 21ST CENTURY VA HEALTH CARE SYSTEM: ASSESSING THE NEXT GENERATION OF VA'S COMMUNITY CARE NETWORK

WEDNESDAY, FEBRUARY 11, 2026

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:02 p.m., in Room SR-418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Sullivan, Sheehy, Blumenthal, Hirono, Hassan, and Duckworth.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. Good afternoon everyone. Thank you for your presence. Welcome to this week's hearing. Two weeks ago, we had the opportunity to discuss with Secretary Collins his vision for bringing the organizational and governance structure of the VA's direct care into the 21st century. Today we're here to discuss how to achieve that same goal for the VA's Community Care system.

Healthcare is local, and for many veterans in Kansas and across the country, the ability to see a doctor in their community is not a luxury. It's an essential part of their healthcare and well-being, and the ability to use the VA healthcare benefits they earned through their service.

Congress recognized the reality of this circumstance in 2018 with the enactment of the MISSION Act. The MISSION Act intended to make certain that no veteran would be limited by geography, long wait times, bureaucratic barriers, the need for specific kind of care in seeking care from the VA, and that every veteran would have the opportunity for meaningful choice in where and how they receive the care they require.

This afternoon, we are here to discuss where the VA has made strides in delivering on that promise, and where it's fallen short. We'll also discuss where improvements are needed to make the VA's Community Care program stronger, more sustainable, and more successful, by putting the veteran first, expanding meaningful choice and providing care when and where veterans need it and want it.

To that end, I was encouraged to see the VA release a Request for Proposals (RFP) in December for the Next Generation of Community Care Network contract, followed yesterday by a separate

request for proposals to establish a national dental community care contract.

In many ways, these procurements reflect a welcome focus on innovation, competition, and accountability. They also signal a long overdue progress toward upholding industry standards, embracing value-based care, strengthening program integrity, and addressing persistent challenges, such as timely return of medical documentation that have frustrated veterans' providers and policymakers alike.

Achieving these lofty goals can't be easy. The contracts must do more than look good on paper. The VA must deliver results for veterans, VA staff, and community care providers, and taxpayers by leading to real measurable improvements in access choice outcomes and costs.

I look forward to hearing from the VA witnesses this afternoon about how the Department can meet that mission and how this Committee can support them. With that, I recognize the Ranking Member, Senator Blumenthal.

**OPENING STATEMENT OF HON. RICHARD BLUMENTHAL,
RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you to our witnesses for being here today and for your service to our country and to all the men and women who work with you veterans, among them, and dedicated to the mission of providing gold standard healthcare to all of our veterans.

We're here to discuss the VA's Next Generation of Community Care contracts, which will total about a trillion dollars. To be live, as I understand it in 2027, which gives us time to assess what the needs are for community care on contracts that will be Indefinite Delivery and Indefinite Quantity (IDIQ), which is kind of scary when you think of all the indefinites there and it emphasizes the need for strong oversight on the part of the Congress and the Inspector General of the VA.

And we can't really talk about community care without talking about its impacts on VA's direct care budget. Because for many veterans, care in VA facilities is veterans care and what they are seeing now is losses of staff through caps on workforce, the attrition of many of the skilled and dedicated men and women who have served, and the potential for lower quality if we take our eye off the ball of direct patient care through VA facilities.

My feeling is that the VA has to prioritize resources for expanding access to direct care by adding and expanding existing facilities, increasing staff to reduced wait times, and supporting the VA's Gap services such as telehealth, emergent and urgent care capabilities.

Community care is a critical component and a supplement to VA direct care. It is veterans care. Community care is veterans care, no question. But it cannot supplant VA direct care.

For all the reasons that everybody here knows well, it is the preference that veterans have to seek care directly at VA facilities, at least for many of them through VA providers. It matches or outperforms the quality of community care in many instances, and it is a more efficient use of taxpayer dollars.

So, first and foremost, we need access to information. The Chairman and I submitted a letter to the Secretary after his appearance here with very specific requests for information that he promised to provide. There has been no response so far. We are hoping, or at least I will speak for myself, that that information will be forthcoming. It is essential to judgments that will be made about community care as well as about direct VA care.

I would oppose a blank check for community care without real guardrails and establishing those guardrails depend on getting straight answers from the Department that enable us to do basic oversight, including the requests that we made on the record.

I will just say Committee staff have not received a quarterly briefing as yet from the Office of Integrated Veterans Care, the office overseeing VA's Community Care system. And I am hopeful that we will see responsiveness on that score as well.

In short, information and communication must be a two-way street, and not just with us, but with veterans. They are the most important constituency here, and I know they expect straight answers promptly to questions that are raised in Committee hearings and also in the inquiries that we raise.

So again, my thanks for being here today. And I'm going to put that letter, Mr. Chairman, if there's no objection, the letter that we did, in the record.

Chairman MORAN. Without objection

[The letter referred to appears on pages 35–36 of the Appendix.]

Chairman MORAN. Mr. Topping, in regard to Senator Blumenthal's comments in his opening statement, would you again remind the Secretary of his commitment. This Committee is always looking for information. It's always difficult to attain, at least slow to obtain. And again, I would encourage the Department to respond soon to the letter that Senator Blumenthal and I sent.

It outlined simply what the Secretary committed to providing, the answers he committed to providing, information he committed to providing to us when he appeared before our Committee just recently.

And I agree with the Senator from Connecticut, that lots of unknowns in the future of what we're talking about today and oversight by this Committee, oversight by the Inspector General, or GAO, remain hugely valuable to getting the right result.

And so, I will encourage that cooperation between an IG and GAO, but more importantly, the continued dialogue with this Committee, its members, but particularly its staff. And with that, Mr. Toppings I think we're ready for your testimony.

STATEMENT OF HON. RICHARD F. TOPPING, ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER, OFFICE OF THE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY ALICIA SKOLROOD, EXECUTIVE DIRECTOR, INTEGRATED EXTERNAL NETWORKS, OFFICE OF INTEGRATED VETERAN CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. TOPPING. Thank you, Mr. Chairman, and absolutely, I'll take that commitment to work with Secretary and his team to get you the information that you've requested.

Mr. Chairman, Ranking Member, Members of the Committee, thank you for the opportunity to discuss the Veterans Community Care Program (VCCP) and the Next Gen contract procurement. I'm accompanied today by Alicia Skolrood, Executive Director of Integrated External Networks for VA.

VA has long been recognized for the world class healthcare we provide to veterans across more than 1,500 medical facilities. In addition to the direct care system, VA has also been a purchaser of healthcare since before the World War II era.

As a healthcare payer, VA partners with local hospitals, doctors, and other healthcare providers to ensure that veterans have access to the care they need, where they need it, and when they need it.

Caring for veterans is about more than operating hospitals. It's about supporting veterans physical and mental health and wellness, their families, their caregiver's mental health, mental health requirements, community requirements, and leveraging community services beyond the walls of our facilities.

Recognizing the key role that purchase care plays in VA's ability to provide care for veterans health and wellness, President Trump and Congress passed the bipartisan MISSION Act of 2018, which expanded access and choice for veterans, and reinforced VA's mission as both a healthcare provider and payer.

Today, VA's the country's largest single healthcare provider through our hospitals and clinics, and the fourth largest healthcare payer. In fiscal year 2025, 41.8 percent of all VA healthcare appointments were in the community. Next Gen is VA's first major procurement effort to support that program. It's our opportunity to increase competition, upgrade and modernize the provider network, enhance services that ensure veterans receive the very best care possible, whether at a VA facility, or in their community from a local healthcare provider.

We did not design Next Gen alone. We talked to our veterans who overwhelmingly want the choice to choose between direct care and community care based on best medical interest, availability, and convenience.

We talked to other government agencies. The Departments of Health and Human Services and of War have decades of experience and data providing healthcare quality, reducing costs, and aligning incentives for better health and wellness.

We talked to industry, which is constantly innovating with new delivery models, leveraging data and analytics, striving to be consumer-oriented while addressing costs that remain too high. Com-

binning VA's history, the data, and this external input, VA successfully issued the CCN Next Gen RFP on December 15, 2025.

We are leading the Nation with an innovative 10-year multiple awards IDIQ. It's a contract vehicle, which has several key advantages over traditional Federal healthcare contracts. First, the IDIQ drives competition and flexibility by allowing both national and regional health plans to successfully bid and be awarded a spot on the IDIQ.

This is the best of both. We'll have vendors with national reach and scale, but also regional plans with unique capabilities that are locally adaptable.

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

The IDIQ is the how of this procurement, but the most exciting part of Next Gen is the what. CCN Next Gen is designed on five pillars: Quality, Value, Alternative Payments, Utilization Management, and Program Integrity.

First, VA will implement comprehensive quality programs for community care providers based on nationally recognized measures from the Agency for healthcare research and quality, and the healthcare effectiveness data and information set. Contractors will track patient safety events, identify veterans at risk of avoidable emergency visits and readmissions through predictive analytics, and while respecting their choice, guide veterans toward high performing providers.

Second, CCN Next Gen modernize how VA pays for the care furnished veterans by implementing value-based payment models. We will begin with episode-based payments for lower extremity joint replacements, and as we gain the data and the expertise to manage alternative payments, we will introduce at least three additional models over the performance period. The contract to continually improve care.

These models will shift away from volume and toward outcomes and the total cost of care, which align incentives with veterans' health and system sustainability. We will also introduce utilization management. This includes active management of inpatient admissions, emergency department use, concurrent hospital reviews and high-cost drugs administered in clinical settings.

This will reduce unnecessary hospitalization and inappropriate care while protecting veterans access to medically necessary services. Next Gen will include a program integrity function to ensure that VA services are protected and maximized. We will identify providers at higher risk of improper billing, formalize oversight processes, expand data and technology use for improper payment detection, and use independent audits to ensure that veterans receive what VA is paying for.

Next Gen also changes how VA pays our contractors to incentivize performance and outcomes. Next Gen will incorporate incentives and disincentives based on the total cost of care, quality performance, value-based care adoption, and payment integrity. Ultimately, contractors who achieve VA quality targets while reduc-

ing costs will share in the value they create for VA and for veterans.

And speaking of costs, along with the improved care for veterans, Next Gen provides real savings for taxpayers. Next Gen's actuarial estimates based on independently verifiable data show significant savings of 18 to 14 percent over the life of the contract. These savings range from a low end of \$54 billion to nearly a hundred billion over the life of the contract.

These are gained by fewer unnecessary hospitalizations, improved management of high-cost services and drugs, improved quality, stronger fraud prevention, and payment controls.

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

[The prepared statement of Mr. Topping appears on pages 41–48 of the Appendix.]

Chairman MORAN. Thank you for your testimony. Ms. Searight, welcome.

STATEMENT OF LEIGH ANN SEARIGHT, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. SEARIGHT. Chairman Moran, Ranking Member Blumenthal and Committee members, thank you for the opportunity to discuss the OIGs oversight of VA's Community Care Network contracts.

Our auditors focus on providing findings and recommendations that help VA improve the efficiency and timeliness of both direct and community care. Our healthcare inspectors work to elevate the quality of that healthcare and increase patient safety while our investigators leverage data analytics to prevent and stop healthcare fraud and related crimes.

In our oversight work, we routinely see VA staff committed to providing patients with the care they need, but challenges persist. As VA's reorganization unfolds, the OIG will monitor its implementation to understand the impacts on veterans, VA, and stakeholders.

VA's new Community Care Network contract solicitation provides an opportunity for VA to enhance services to millions of veterans. The OIG has noted positive steps in the request for proposals on the performance work statements, such as requiring community providers to use the central submission system for sharing medical records and to use the electronic visit verification for home health services. These changes could improve care coordination and reduce the risk of fraud. VA must remain vigilant to these new contracts to prevent the recurrence of risks previously addressed through implementation of our recommendations.

The OIG reports have highlighted four general challenges and community care program management. First, barriers to veterans getting timely and coordinated care. Second, inadequate visibility over the resolution of quality care concerns. Third, workforce gaps

and lack of VHA management controls, and lastly, outdated and incomplete financial systems and data impede effective payment management.

Our work has identified risk to the quality and continuity of veteran care through VA's current TPA—Third Party Administrators contracts. For instance, the TPAs are required to ensure the community care providers send patient records back to VA. However, this was not enforced.

Also, the contract performance metrics do not do enough to help VA track where there is a lack of qualified community providers and needed specialties. Further, IT solutions could resolve delays and barriers to getting VA patients additional community care services identified after the initial VA referral.

It is critical that the Next Generation contracts have actionable steps to move beyond faxes and flawed portals for sharing records, and also create measures and reliable tools to address these and other identified problems.

Regarding opioid prescriptions, Congress laid out specific guidelines for community care providers to follow. TPAs must ensure providers adhere to VA's Opioid Safety Guidelines and conduct checks of state prescription monitoring programs.

The OIG has identified previous noncompliance that warrants ongoing monitoring. VHA must intensify oversight of the TPAs regarding the adequacy of community care provider networks, which we have sometimes found do not fully meet veterans' needs or demand.

Our previous work has also identified overpayments to TPAs or non-adherence to fee schedules and inconsistencies between the TPA contracted billing structures. All of these should be addressed in the new contracts proactively.

The OIG has been in discussions with VA officials over the last three years about improvements in the Next Generation contracts that can enhance oversight, prevent fraud, and advance healthcare delivery, including the following:

TPA and care providers should not require a subpoena from the OIG to turn over documents.

Contract provisions should ensure community providers are responsive to VA.

Community provider training and quality standards should align with VA's, and fee schedules should be established that TPAs rigorously follow.

In conclusion, VA will need to strengthen its efforts to work with the healthcare industry and all its stakeholders to develop contracts that help veterans receive care when and where they need it. We'll be monitoring those efforts closely.

The OIG remains committed to providing independent oversight of VA and delivering actionable recommendations to help VA deliver the healthcare veterans have earned. Chairman Moran, Ranking Member Blumenthal and Committee members, thank you, and I'm happy to answer any questions.

[The prepared statement of Ms. Searight appears on pages 49–54 of the Appendix.]

Chairman MORAN. Thank you both for your testimony. Mr. Topping or Ms. Searight, does the potential described efforts by the VA in these new contracts meet the requirements that the Inspector General has recommended be included as parts of those contracts?

Do we know that yet? Have you reviewed to see if their contracts are going to meet your requests or your suggestions, and if you reviewed the suggestions to make sure your contracts are going to agree with them?

Ms. SEARIGHT. We've done some preliminary reviews of the contract language or the performance work statement language, and it does have some good indications of that information. However, until these contracts are actually awarded and the negotiations are finalized, and we're going to remain diligent in reviewing that information.

Chairman MORAN. Diligence is fine too. Diligence is all. Mr. Topping, do you agree with the recommendations and intend to pursue them in the contract process?

Mr. TOPPING. Chairman, absolutely. IG has been a great partner in this. The recommendations and they're about 98 percent of them I fully agree with, we are working on implementing and the rest of them will work it out. So absolutely a good partnership. We're working on that together as we move forward.

Chairman MORAN. Mr. Topping, an IG office last April issued a report about the Omaha VA Medical Center and found that the VA staff were limiting veterans access to community care by manipulating clinically indicated dates in violation of the MISSION Act.

Just this week, my office heard a similar allegation at another VA facility, and so I am interested in knowing whether there's been any follow up. But Mr. Topping, will you commit to looking into these allegations and quickly make a course correction as needed?

Mr. TOPPING. Yes, Mr. Chairman. I will.

Chairman MORAN. I mean, I've had this sense for quite some time through numerous administrations that I think we've learned that it's true. That there was a concerted effort to discourage the use of community care. That discouragement came from VA officials and employees, and affected the capability of veterans who qualify for community care to receive that community care.

Do you know of what I speak and do you know if there's a problem that exists, and has it been corrected or is going to be corrected?

Mr. TOPPING. I do Mr. Chairman, and here's what we're doing about that. And so, as I said in my opening statement, VA is a direct care provider. That's our hospital and clinic system, and VA is a payer, and that's the community care program. These are different systems, different purposes, different tasks.

What we have done in the past is combine management of these programs together. And what Secretary Collins has directed, is that as an operational vertical, community care will be its own payer vertical within the VHA system. We will account for and manage the funding of that system independently of the direct care system, and there'll be leadership that is focused directly on community care.

This will go a long way to remedying some of these confusions between what the role of a direct care provider is versus what a

payer is, and ensuring that we can meet the requirements, both the program, the MISSION Act, and anything else that Congress wants us to meet.

Chairman MORAN. Mr. Topping, there are graphs, there are charts, there is allegations that's—I don't like that word. There are indications that the community care costs are rising more rapidly than the direct care costs. I would say that cost is, in my view, a misleading word. It could be more spending is occurring in one category over the other.

But what I know about that is, first of all, the MISSION Act allowed veterans to receive care if it was in their best interest to do so, determined by the veteran and his or her provider, not by the VA. And there were no artificial limitations on the amount of community care that could be provided in the MISSION Act. So, a number of categories by which one could receive care in the community, but one of them is, is it in the best interest of the veteran?

And so, I want to either confirm or indicate that I should be looking at additional ways of describing this, but there ought to be the opportunity to receive care if it's in that veteran's best interest. And the idea that we're spending more money, and again, I don't think spending is the right word, more veterans are choosing or being cared for in community care.

I also want to point out again, and you can correct me if I'm wrong, but what I know from information that I've seen that I believe to be accurate, is the largest increases, in fact, as I understand it there's been \$26.7 billion increase in community care spending fiscal year 2019 to '23. And that the largest components of that, number one is emergency care.

So, it's perhaps not even a decision made by the veteran. It may be where the ambulance service is taking a veteran, what's most proximate to his or her home, or where the injury or need for community care originates. And the second is geriatric and extended care.

It caught my attention that extended care, which is in-home care for veterans' family members caring for them, is considered community care and included in those statistics, about increasing spending on community care. And so, it's really half of the increase in spending on community care has been emergency services and geriatric and extended care in the home for veterans.

And part of that comes with a very bipartisan passage of the Elizabeth Dole Act, that it provides opportunities for that care to be increased. What am I missing here? How can I be corrected? I know that the Veterans Healthcare Administration is also here, maybe this is a question for you Ms. Skolrood, but tell me the facts here that makes sense to when we have this discussion.

Mr. TOPPING. Mr. Chairman, I think everything you said was true and I'd have sort of three points in response that help clarify that. Number one, there has been an increase in spending, but there's also been an increase in utilization. And those numbers that you see and that we show are not risk adjusted. So, it doesn't show the type of care that we are purchasing.

So, we are purchasing more care for veterans in the community, and we are purchasing higher cost, higher value care for veterans in the community. I think that's number one. Number two, it's not

necessarily a negative, it means that we are adjusting where veterans receive care, to ensure that we are meeting their needs, including locally, not just within the VA system.

And I think the last point to that too is those numbers taken in a vacuum sort of belie the overall VA spending. And so, while we talk about this being a 10-year trillion-dollar contract that it is, over that same period, we're going to spend \$2 trillion on direct care. So, this is one piece of the overall continuum of care. These work together to ensure that veterans receive the care that they need, where they need it, when they need it.

And so, making sure that we are accountable for that is a different task than whether or not those numbers are right or wrong. And last point on this too, is the intention of the community care and Next Gen program is to give VA the tools to manage the quality of care so that we know what we are getting and it's the best possible quality of care for our veterans, and for us to be able to manage the cost to be responsible for that.

So, the tools that we need to manage this program are included in Next Gen so that we can be responsive to these concerns and questions.

Chairman MORAN. Thank you for your answer. I'm going to turn to Senator Blumenthal, but I would indicate that I share the concerns about what we've seen in an Inspector General's report about quality, about medical records. There needs to be improvements that I believe your efforts here are designed to achieve in community care.

It's not that it doesn't have its faults and challenges. And we need the VA to be watchful in regard to providing care in the community to veterans. Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. Since 2019, the funding for—disregard this chart for a moment [points to chart]. Since 2019, funding for the VA Community Care program has increased from \$9 billion to more than \$48 billion in the VA fiscal year 2026 request. That's an increase of 530 percent. That's a staggering increase, wouldn't you agree?

[The chart referred to appears on page 37 of the Appendix.]

Mr. TOPPING. Ranking Member, that's a large increase.

Senator BLUMENTHAL. Over that same period, funding for VA direct care has increased by far less, about 200 percent from approximately 50 billion to 97 billion. Why the disparity?

Mr. TOPPING. Ranking Member, I think that goes back to my prior comments to the Chairman that these numbers are not risk adjusted. And so, what they show is we have more veterans receiving more care. It doesn't account for the type of care those veterans are receiving.

I think back to the point the Chairman made too, that they're receiving disproportionately emergency care in-home and geriatric care, which are expensive services to provide. And so, what I would say is the measure of this is not just the gross spending, and what the difference is. What I'd say is what is VA getting for it? And does VA have the tools to ensure that we are getting the highest value of care for those dollars, and that we are maximizing our dollars to get the most that we can?

Under the current community care program, we do not have those tools. We are the only payer program, the only government payer program that does not have the ability to manage quality, to manage cost, to use value based, to use alternative payments, to do UM—utilization management—to have program integrity. We are the only program that does not have these controls.

We are introducing those to Next Gen. And so, I share your concerns about the expenditures and the increase and ensuring that we're maximizing the value. This program gives us the tools to do that and to be accountable to the Congress, to our veterans, to be able to do that.

Senator BLUMENTHAL. So just so I understand, you agree that more needs to be done to maximize oversight, to make sure that we get quality for the dollars that are being spent on veterans care. And your explanation for the disparity is that it's a different type of care, more specialized care, geriatric care that is provided in the community as opposed to VA direct facilities? Is that an accurate summary? I'm trying to put it in—

Mr. TOPPING. Senator, that's possible. But there are two issues here. Number one, we don't risk adjust that for what the care is that is received and what's driving those costs. So that's a dollar amount. What's behind it is not adjusted. So that's number one. And then number two, because we do not measure quality in the community care program right now, I can't tell you that the care is less or more different or better in the community versus direct care. We don't do that today.

Next Gen includes our ability to do this. That's a huge movement forward so that we can then compare, are we getting more or less? Are we getting best value or are we not? I can't answer that for you now because the program isn't built to do that.

Senator BLUMENTHAL. This chart indicates that the rate of increase in the numbers of veterans served has been far less than the rate of increase in the amount of spending. Ms. Searight, do you have an explanation for that fact?

Ms. SEARIGHT. No. We haven't evaluated that in our ongoing audit, so I can't speak to that exactly.

Senator BLUMENTHAL. Mr. Topping, do you?

Mr. TOPPING. Senator, what those charts show me is that we have more veterans receiving more care. That's what they show me. The ability to dive into what that care is, whether that's the right care, whether that's the appropriate care, whether there's good value for that care, that doesn't show me that. And the program today is not built to do that. Next Gen is, which is why this is so exciting for us.

Senator BLUMENTHAL. Well, I would suggest that we need to answer those kinds of questions. You don't have answers right now. You say that the program isn't designed to provide those kinds of answers, but anybody running a healthcare program would say, we really ought to be answering those questions. Wouldn't you agree?

Mr. TOPPING. Senator, I want to answer those questions, which is why we have designed Next Gen to include these tools and capabilities. I want to answer those questions.

Senator BLUMENTHAL. Okay. Talking about Next Generation, Ms. Searight, your report indicates that we need to, and I'm quoting,

“Community care providers should be incentivized to meet the same training and quality standards as VA providers.” Isn’t the word “incentivize” a little bit light on requirements. Shouldn’t we absolutely guarantee that they meet the same training and quality standards as VA providers?

Ms. SEARIGHT. Providers whether they’re in the VA or in the community, have a standard that they are all trained to, right? But within VA, they have additional standards that they train to the culture of the veteran to serve the veterans.

In our position, the VA is asking the community providers to do more, to have a higher level of education or awareness of the community that they’re serving.

Senator BLUMENTHAL. But I guess maybe saying instead of just incentivizing them, shouldn’t they be absolutely required to meet the same standards of quality and training and efficiency and all of the criteria that a veteran going to a VA facility has a right to expect?

Ms. SEARIGHT. If it’s within the contract, yes, they should be required.

Senator BLUMENTHAL. In the contract as a matter of definite provisions and requirements.

Ms. SEARIGHT. Correct.

Senator BLUMENTHAL. And let me just ask you very quickly finally, Ms. Searight. Have you looked into amounts of overpayments or lack of contract enforcement relating to community care since the enactment of the MISSION Act?

Ms. SEARIGHT. Yes. We’ve done quite a bit of work in relation to community care since the enactment of the MISSION Act. Those that work varies from payment oversight to services provided. Our investigative division looks at fraud investigations and things that evolve from hotlines as well. In the payment integrity world, we also do annual reviews of the reports that VA provides on underpayments and overpayments to community care as well.

Senator BLUMENTHAL. Do you have an estimate as to how many taxpayer dollars have been lost to improper payments or lack of enforcement?

Ms. SEARIGHT. Since 2021, VA has reported about \$4 billion in improper payments of overpayments to the TPA, which is about 4 percent of the total amount paid out.

Senator BLUMENTHAL. Four billion dollars.

Ms. SEARIGHT. Yes.

Senator BLUMENTHAL. Okay. Thank you. My time is expired on this round, Mr. Chairman. Thank you.

Chairman MORAN. Yes, sir. Senator Sullivan.

**HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA**

Senator SULLIVAN. Thank you, Mr. Chairman. And I want to thank the witnesses for their service. Mr. Topping, I think you’re doing a good job over there. And I know it’s not an easy job, it’s never an easy job with the VA, but I appreciate your hard work.

I want to talk about the effort to move to a multi-vendor framework. And I want to be a little bit more parochial, focusing on my state. You know, we have more veterans per capita, any state in

the country, Alaska. And we also in the MISSION Act, were able to get a provision, I was able to get a provision for states like mine and actually New Hampshire that don't have full-service VA hospitals to have the ability to go get community care just in the bill, right? People can go get that immediately.

A lot of times the VA hasn't read the bill, right? So, it's not always easy to get those appointments in Alaska. I don't know what the situation in New Hampshire or why those are the other two states. But it is a challenge and I'm always reminding the VA, hey, we're different here because we don't have that. So, keep spreading the word on that. That's important from my perspective.

I have a concern, in some ways I understand the multi-vendor framework approach, but I also have concerns particularly in a place like my state where healthcare is very expensive and it's a very, very big state. You know, our experience when Obamacare initially passed, we lost almost all of our health insurers, right? We went from four in the individual market to one, and we almost lost that one.

So, we have this challenge where a small population, very expensive healthcare, very expansive territory to cover. And I worry that if you move to a multi-vendor framework given the cost, it might create Alaska without bidders, and which would put veterans access to care at real risk.

So, I know you put a lot of thought into the model, but I'm concerned, like I said, high-cost remote areas in my state, you might have nobody who steps up. So, how will the VA ensure that vendors will bid for these areas, these states in particular like mine with a lot of vets, but a lot of ground to cover high costs? And how will contracts or reimbursements be adjusted to reflect the higher costs without discouraging participation? In that issue of discouraging participation like I said, it's a real one. We've seen it before in other settings.

Mr. TOPPING. Senator, thanks for the question. I love the question because it gives us a chance to highlight, I think, one of the best aspects of how we're doing this with the multiple award IDIQ. So, first of all, the program itself, for all of the vendors who participate in this, we will have the five pillars, we will have the tools and that's nationwide.

But what this then allows us to do is invite bidders who are both national and regional and put them on the IDIQ vehicle. And we currently don't have that. What we've got the ability to do is pick a vendor and we've picked two, and the current program has two. And what that means is we don't have any of those tools that we've talked about, those five pillars, but we operate largely the same program in Los Angeles, California, and Phoenix and wherever else as we do in Alaska. And that does not match. Yes, all healthcare is local.

Senator SULLIVAN. One-size-fits-all for my state. Never matches, never works.

Mr. TOPPING. It does not. And all healthcare is local and it's based on local needs, local infrastructure, local differences. Alaska obviously very unique. What this multiple award IDIQ allows us to do is solicit bids from vendors who do have expertise in Alaska and

do have the ability to serve that region, understand the local populations, understand the differences to bid and be on the vehicle.

And then most importantly, it allows us to have a regional model that is different from the way we operate in the rest of the country. And so, very much it is possible, that what we would do in Alaska would be different. And so one example would be, I do not think that we would change our quality requirements in Alaska. We want providers who serve our veterans to provide the very best care wherever it is.

But because of the distance, because of the geography, because of the rural nature of it, cost may be less of an issue. So, we may pay more in Alaska to get the care that our veterans need under this model. We can do that and we can account for it. We don't have to do the same thing in Alaska that we're doing in LA. That's the opportunity here.

Senator SULLIVAN. Good. That's a good answer. I appreciate that answer. So, you're going to tailor this to make sure it's tailored to meet the needs of each individual state. Let me give you another example. You know, we have a very large native population, almost 20 percent of the population, by the way, they serve at higher rates in the military than any other ethnic group in the country. So that's another reason we have so many veterans and it's a great kind of heritage and culture of our Alaska Native community in my state on all the military service.

In the Tribal Health Organizations are often doing—I met with the Ketchikan Indian community leadership just yesterday. And they just recently inked a compact in an agreement with the VA, which many of our Tribal Health Organizations do. And that extends the ability for the VA to reach into real rural communities, have access to native populations and non-native populations when they do these compacts with you guys.

So, will the VA continue to coordinate with tribal health providers under the new multi-vendor framework? Because I think that's a model that's working and it's very unique and it kind of gets to what you just said in your answer to me earlier.

Mr. TOPPING. Yes sir, we will. And yes sir, we have the ability to do that.

Senator SULLIVAN. Good. Okay, great. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Senator Hassan.

**HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE**

Senator HASSAN. Well, thank you Mr. Chairman. And I want to thank Ranking Member Blumenthal, too, for this hearing and to our witnesses, thank you for being here and for your service to our country's veterans.

Mr. Topping, as the VA looks to draft and commence its next generation of community care contracts, it's really important that veterans remain the focus of this effort. And that's what I think you're hearing from all Members of this Committee today.

One particular area I want to make sure that the VA is planning for is the continuity of care. If a veteran is receiving high quality

care from a community provider and the veteran is satisfied with that care, they should be able to keep seeing that provider.

So, what is the VA doing to ensure that as the next generation of community care contracts come online, veterans can continue to see their preferred current community care doctors without interruption?

Mr. TOPPING. Senator, I think the short answer to your question is we have extended the authorization period, and so that when a veteran is referred out he or she can remain with the provider for the full episode of care. That's number one. Number two, what we've done is we've made it easier through the best medical interest for a veteran and the VA provider to select that veteran would go to community provider and remain with that provider for the treatment. So those are the two controls that are in place now too.

But what we're also able to do under Next Gen, again, our ability to have regional models, and again, what's going to work in Alaska is going to be different than what we're going to do in New Hampshire. Our ability to adapt to the local infrastructure, the local capabilities.

So, for example, without a full-service VA currently in New Hampshire, we do leverage community care, particularly for the hospital systems that sit around, and Manchester sits in the Boston medical market. Unique reach and capabilities. We are able to leverage those in a way that is not going to be one fit. We will be able to adjust to the region to be able to do that. And then as we do work on capacity at the VA in Manchester, we'll be able to do that and respond to that via this vehicle.

Senator HASSAN. Well, I appreciate that and I appreciate the regional and specific approach. I do also just want to point out that for some people the continuity of care is going to be more than an episode of treatment. They're going to have a condition where they've developed a relationship and a treatment plan with a doctor, with a condition that's going to last the rest of their lives.

And the notion that because VA changes its contracting relationships, that all of a sudden that person has to transition to a new provider, which does happen in the private insurance market and is a real problem. It's something I want you all to think about because I really want veterans to be able to have that continuity of care.

And in a place like New Hampshire where there are shortages of physicians it's going to be important that we continue to focus on that issue. Does that make sense?

Mr. TOPPING. Senator, it absolutely does and I'll take that. And again, I think as Secretary Collins implemented best medical interest, this is exactly the type of situation that he sought to address, to ensure that there is continuity of care and veterans have the choice to be able to do that.

Senator HASSAN. Okay. Let me ask you another question because it certainly won't get overlooked in Alaska. But I want to make sure that in all our areas, all our states that have a lot of veterans in rural areas, that we're thinking about access for rural veterans.

Where a veteran life shouldn't determine whether they can get the care and support that they've earned. And because rural veterans aren't always able to easily reach a VA facility, they often

rely on community care, particularly, you know, in a mountainous wintry place like New Hampshire. It may only be 10 miles away, but it might as well be a hundred miles away some days.

So, how is the VA planning to address care for rural veterans in these updated VA contracts? And what mechanisms will you put in place to ensure that the recipients of these contracts are providing a robust network of provider options for rural veterans?

Mr. TOPPING. Senator, thanks for the question. And 10 miles in the White Mountains could feel like 100, that's for sure. And so, part of what we're doing this, and so even for rural veterans, there is a community provider usually local, and then that may not be full service, but certainly there's a community provider near, if not in the veteran's community, next community over to.

One of the pain points on the community care contract, has been that it has been difficult for providers to do business with VA. It's been hard to get referrals, it's been hard to get authorizations, it's been hard to be reimbursed, and we have unique requirements.

What we are doing in this program is trying to make VA, again, with the fourth largest payer, but to make our payer program operate like other government programs, including Medicare. So, one example, we use a Medicare fee schedule and Medicare DRGs, the codes that we use are Medicare.

Every single provider in rural New Hampshire likely provides Medicare, accepts Medicare and provides Medicare treatment. To the extent that we can operate our programs so that it operates like that and for the providers ease of doing business with VA, that means our veterans can go local. And if that veteran then needs a higher level of care or specialized care, we may move to the VA or we may move to a specialty provider further away.

But the idea is any provider that participates in other government programs, Medicare or Medicaid, can participate in VA Community Care and provide those same services to our veterans.

Senator HASSAN. Well, I appreciate that and I appreciate that I'm over time. So, I'm going to submit a question for the record on making sure that community care providers are getting the veterans updated medical records back to the VA before the case is closed out.

I think you've recently done a look at that issue and there's a real problem. Cases are getting closed without the community provider getting the records updated back to the VA. I will also just point out, for my colleagues, that one of the challenges we have in rural New Hampshire right now is because of the Medicaid cuts that came along with the "Big Bill."

Two of my rural health clinics where veterans might be referred for community care have had to close. And so that's a real problem related to the Medicaid cuts that just leaves a dearth of providers in certain regions. Thanks.

Chairman MORAN. Senator Hassan [Inaudible]. And what you talked about is the difficulty that a provider has in providing services to veterans, and it's what we lived with, I mean, CHOICE. In my view, the VA has always been reluctant to promote CHOICE and in some instances has made it difficult to be utilized.

And I understand that nobody wants to lose a patient and veterans, the people who work at a VA hospital care for patients and

they want to continue to do so. But the MISSION Act was a replacement for CHOICE. And the MISSION Act was designed to make it more easily attainable, the providers and the community who would want to provide services to a veteran through, now MISSION.

And it was designed to eliminate the barriers that a private provider would face in dealing with the VA wait, that the referrals, the record keeping, the rates charged. There's just a whole list of things that we attempted to—requiring the payment of Medicare rates. And we still have a long way to go.

I visited every hospital in Kansas numerous times and 50-some of them last year. And I always ask this question, and the answer is, generally it's getting better, but we still have problems in getting authorizations. We need another referral for an X-ray or lab work. And again, I hope that in the process that not only related to these contracts, that in the process we're simplifying the opportunity for community care providers to provide and meet the needs of veterans. Does that make sense and is true?

Mr. TOPPING. Mr. Chairman, it does. And I have yet to meet a provider who has said that they don't want to provide care to veterans. Most providers do. It's incumbent upon the VA as the contracting agency to make this program as easy to participate in and as smooth. There are ways to do that.

We've addressed that during this in this program design, working on how we do the referral, how we do the eligibility, how we do the authorization, and then most importantly, how we make sure payments are made promptly, correctly and accurately?

Chairman MORAN. Senator Hassan also talked about continuation of care. It is an issue. Two years ago, brought to the attention to the VA that a veteran in my hometown was receiving cancer treatments. He was required to receive 17 of them. After the 15th one, the VA decided that they should move the care out of the community.

The first 15 treatments that he'd received in the community, the last two, he was required by the VA to return to the hospital for those treatments. And the explanation was, you don't live 60 miles from the VA, you live 59. The drive, I said that wrong, the drive is 59 minutes, not 60. Therefore, you are ineligible to continue to have the care provided for by the doctor, the provider that you have been using for the first 17 of your treatments.

I assume this is anomaly. I assume it doesn't happen. I assume that people have common sense, but, and I don't know how you legislate this stuff, but this idea that Senator Hassan raised about, once you start with a community care provider, and most recently, I would say time and time again, chiropractic care has been called back to the VA, after a veteran has been receiving chiropractic care in the community for months or years, and the VA wants to change the provider by bringing it back in-house.

I assume we will attempt to avoid those kinds of circumstances, and I mostly wanted to make sure that you know that that circumstance has existed.

Mr. TOPPING. Chairman, I do, and I'm aware of that specific case, and I do think it was an anomaly, but an unacceptable one nonetheless. One of the things that we are doing again in Next Gen is

the use of utilization management in which the treatment matches the diagnosis.

And so, part of what we've had now is the authorization does not necessarily match. These have been separate from each other. So, the idea though is that when we refer a veteran out for cancer treatment, that the care that is then provided to that veteran in the community would match the diagnosis. We'll be able to manage to that and manage to the quality and the cost.

And particularly as we look at how we manage this program internally, again, it's very manual now between the referral, which is a relatively well understood clinical process that treating physician says we're going to refer the veteran out.

But then the eligibility process, the appointment making process, the time and distance process, that's been very manual. That needs to be automated. That entire process should be relatively seamless, and it shouldn't be something that the veteran has to get involved in. It should be something that between VA, as the program manager and the payer, works out directly with the provider. We are working on those in this procurement, yes, sir.

Chairman MORAN. Follow up with you and further questions about it to make sure it will be.

Chairman MORAN. Senator Duckworth.

**HON. TAMMY DUCKWORTH,
U.S. SENATOR FROM ILLINOIS**

Senator DUCKWORTH [Inaudible.] Assistant Secretary Topping, according to VAs own survey of healthcare experiences of patients, on most measures, does VA outpatient care score higher than private sector care experiences?

Mr. TOPPING. Senator, we don't measure quality and community care, so I can't answer that question.

Senator DUCKWORTH. Okay. What I've seen is that veterans report better communication, more trust, and higher satisfaction with VA clinicians compared to private sector clinicians. And that's not in your own survey of healthcare experiences of patients?

Mr. TOPPING. Senator, what I'm saying is currently in the community care program, it does not have quality measures. And so, I cannot benchmark between direct care and community care. I can't answer that question based on data.

Senator DUCKWORTH. Why would you not collect that data on community care experiences?

Mr. TOPPING. The community care program does not manage data at the community care provider level. So, I can't answer the question based on data.

Senator DUCKWORTH. So, we're just going to trust the patients. How do you compare the community care satisfaction to direct care satisfaction? You're not collecting that data. I'm confused. I'm sorry. Perhaps you can better explain it to me why you don't measure patient's experiences in community care.

Mr. TOPPING. So, Senator, I think what you're asking about is survey data. And what I'm referring to is quality data, where we actually measure the quality of the care that a veteran receives in the community.

In the current community care program, we do not have quality measures or requirements. In Next Gen, we do. We use industry standard measures so that we can report like with like, measure and track, so that we will know what the quality of the care a veteran receives from a community provider is, and then we can data-to-data benchmark that against what the veteran receives in the direct care system.

Senator DUCKWORTH. Do you have data that is consistent with VSOs testimony that veterans want VA as a primary care provider?

Mr. TOPPING. Senator, I'm not aware of the specific survey or results, but generally that sounds right. That many veterans do enjoy the ability to use both the direct care system and the community care system as that best meets that veteran's need.

Senator DUCKWORTH. So, I believe, at least in theory, that community care providers can serve a valuable complementary role to fill the gaps that exist for rural veterans, also, skill gaps. I'm one of those veterans; I go to VA as my primary care but I get my prosthetics made by a specialty provider that has a level of expertise that's not available at my local VA.

And I think it's important to increase patient access to wider range of specialty care providers. But however, I haven't yet seen a comprehensive plan to invest in the most efficient, effective veteran preferred healthcare to VA house, which is our VA medical facilities.

You had met with some of my staffers the other day, and you said that there was going to be a plan for \$1 trillion investment into direct care. We have not yet seen it. When can we expect to see a part three of this VHA modernization series on direct care investments? And is that \$1 trillion amount, correct?

Mr. TOPPING. Senator, so first of all, direct care versus community care, and I'll come back to community care in a minute. So, on direct care, what we've done in this Administration is number one, we've reduced backlogs. So, more veterans now have access to VA care.

We've opened 25 about to be 30 new clinics. We've spent \$800 million already. And in this year, in fiscal '26, I'm investing \$5 billion in maintenance, deferred maintenance on VA facilities to get those facilities up to par. That excludes minor construction, major construction and leasing. We are investing in the direct care system.

Senator DUCKWORTH. Can I see a plan? Do you have a plan?

Mr. TOPPING. Yes, honor, we can provide that.

Senator DUCKWORTH. Can you provide that? Okay, thank you. Community care spending nearly doubled from 32 billion in 2018 to 62 billion in 2023 over that same period. Did VA double its contract oversight workforce in that same timeframe? You were sitting at 50 percent staffing in the contracting oversight. And I worry that if you're doubling the amount of community care spending that we're keeping the same number of workforce in the oversight role. Did you double the number of contract oversight workforce in that same time period at VA?

Mr. TOPPING. Senator, what we're doing in Next Gen is focusing on, again, Next Gen is program design, but the next step for VA

is program management. How do we manage this? And what the Secretary has done is, he has moved the community care team into a vertical. There is an office now designed to focus on this. We will do the cost accounting for this program directly and leadership directly for this program. We are going to build the program management capabilities.

In the past, what we have done is we have taken direct care staff and folks and ask them as an extra duty to work on community care. We are focused on the program management so that we can operate this program. We can be accountable for the cost, accountable for the quality and responsive to the Congress—

Senator DUCKWORTH. I agree with you that direct care staff should be providing direct care to veterans and not doing this extra work. But my concern is we went from 32 billion in 2018 to 62 billion in 2023, and we're still not staffed up where we should be. And I worry about you know, oversight in all of those contracts. What percentage of authorized employees is the Office of Integrated External Networks and its contracts management and performance department staffed at today? Do you know?

Mr. TOPPING. Senator, No. I don't know the exact answer.

Senator DUCKWORTH. But can you get it to me?

Mr. TOPPING. I can get you the answer.

Senator DUCKWORTH. Okay, great. Will you commit to hiring staff at a hundred percent authorization to supervise these extremely lucrative contracts that currently seems to lack guardrails for all veterans?

Mr. TOPPING. I will commit to building the program management office and design we need to manage this contract accountably and responsibly to be accountable for the quality of care that veterans receive and the cost to taxpayers. I will commit to building that program management function so that we can do that, and staffing it as needed so that we can be successful.

Senator DUCKWORTH. And in what timeframe is that happening as you are increasing spending on community care? Because I don't want to be out here spending all this money and you're still building the plane, right?

Mr. TOPPING. Senator, we are building that as we speak. We are in the procurement cycle. There'll be awards next year for this. There'll be a 1-year implementation period, but we are building the program management capability.

The Secretary has already directed the internal design. We're already beginning in terms of financial management to be accountable for these costs, and so that we can manage this as we go forward, we award these contracts.

Senator DUCKWORTH. When do you think that whatever program you come up with will be in place and operational that will provide oversight for all of these contracts that we're letting in this procurement cycle right now?

Mr. TOPPING. We are working on this real time, and these contracts are expected to be awarded in January 2027. And so, we will be live and ready when we do that.

Senator DUCKWORTH. Okay. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Thank you. Senator Hirono.

**HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you, Mr. Chairman. So, I am attempting to better understand what it is that you're here to explain to us. So, you already have these private contracts and you're about to go into renewals of these contracts. So, what, what are you here to explain to us regarding this renewal of contracts that you already have?

Mr. TOPPING. Senator yes. We're here and we're excited to talk about the design of the Next Gen RFP and what we are doing to improve the care that veterans receive through community care program.

Senator HIRONO. Well, that is not a particularly specific kind of response because of course, what we're supposed to be focused on, what you are supposed to be focused on is care for veterans. I mean, are we basically moving toward a more of a privatized model for VA care through these contracts?

Mr. TOPPING. We're not.

Senator HIRONO. Okay. Because that's kind of what is looking like, we're creating an opportunity for that to happen. And the veterans we know would much rather receive care in the VA setting. So that is what you would refer to as direct care.

And so, I understand the need for community care because the VA doesn't always have all of the providers onsite and especially in rural areas. So, there's that. But I think there is always this concern that we're moving toward a privatized model.

And when you come and tell us that you're about to renegotiate these contracts, I'm not sure, I don't even know what Next Gen is. How is that different from what you are already doing through these contractual agreements with providers?

Mr. TOPPING. Senator, two major differences between the current program and the RFP, which we are calling Next Gen, which is currently out for procurement. Number one, we're introducing five pillars into the program. We're going to have quality requirements. We're going to have program integrity, we're going to have value-based care, we're going to do utilization management, and we're going to have all alternative payment capabilities.

Those are the five tools that every other payer program has had, many for decades. We are introducing those controls, those tools to the VA program so that we can be accountable for the cost of care and the quality of care that veterans receive. That's number one.

Number two, we are issuing this as a multiple word IDIQ, which allows VA to have competition among the vendors who serve veterans. And so currently we've got a two-award system. We've got two vendors, east and west. What this allows us to do is have multiple vendors, some national, some regional, and allows us to operate regional models that are adaptive to the needs of veterans where they live, the local infrastructure and communities, and allows us to do that.

Senator HIRONO. Well, explain to me about competition among providers. When I think of providers, I'm thinking of what is the definition of providers that you want to have more competition among?

Mr. TOPPING. Senator, there'll be two types of contractors in this, as there are now. There will be a vendor to VA who manages the payer program. VA operates it, we're the funder, we're the contracting agency, but we'll have a vendor who will operate this program for us and be responsible for claims, payment, measuring data, et cetera.

And then we'll have the community providers themselves who will contract with these payers who contract with VA that will actually deliver the care to the veteran at the community level.

Senator HIRONO. So, when you talk about competition, are you mainly focused on how much these levels of whatever the services that will be provided, is it the competition by the cost of providing these kinds of services through the contract center?

Mr. TOPPING. I want everybody to compete for my veterans. I want everybody to compete on the quality they can provide. I want everybody to compete and the cost they can provide. And so, what I want, I want payment vendors, payer vendors, our TPAs on this, our plan partners. I want them to be focused on serving VA and veterans and the community providers who provide that care. I want them focused on delivering the highest possible quality care they can.

Senator HIRONO. Well, the thing is that there's certain areas of commerce that's not particularly activities that lend itself to competition. I mean, competition is usually on things like price, where you look at product A, product B, and you know what the price is. But in the medical field and the care and all of that, it is not that easy to discern.

So, I like the idea of competition that's supposed to probably give us the best bang for the buck, but I don't know how easy it's going to be to determine whether we're getting the best services for the buck.

So I have a question about that, but you explain everything in a way that sounds reasonable, but the question would be, how would these things be implemented at a time when VA is cutting its people? And who's supposed to oversee all of these contracts and make sure that A, B, C, D, whatever your five points, or whatever. Who's supposed to be providing that oversight when you are cutting back on VA employees, and there's a hold on the vacancies, the filling of the vacancies?

See, when you put a hold on it, it's like these vacancies go away and it's like, oh, well, there's not a problem. But there's always been a problem with finding people to work for VA. I certainly know that in the Hawaii situation where it's really hard for us to keep, especially primary care people in Hawaii, and there's a lot of movement.

And when you get rid of the positions, I don't know what that says. I mean, does it make the bottom line look better? I don't know. Why would you do that? Why would you freeze the hiring of people that the system needs and where these vacancies have existed for a long time, obviously needing to be filled. Why would you put a freeze on hiring?

Mr. TOPPING. Senator, Next Gen is about the program design of community care, and what VA is now working on while this procurement is out, is the program management, ensuring that we

have the structure, that we have the people, that we have the expertise and capabilities, including tools and technology to be able to manage this program effectively so that we can achieve the outcomes that we are all looking for in this.

And we are competing on this. We are competing on quality. We want the very best care that can be provided to our veterans, and we are competing on cost. We ultimately want to lower the cost of this program.

Senator HIRONO. It's nice that you have those goals, it's implementing and getting all of that that I have some serious questions about. Thank you, Mr. Chairman.

Chairman MORAN. You're welcome. Senator Sheehy.

**HON. TIM SHEEHY,
U.S. SENATOR FROM MONTANA**

Senator SHEEHY. Thanks for coming today. Great to see you. Before we get to community care health record transfer from active duty, where are we on taking active duty service members who have a very finitely documented healthcare records when they are separating. There's no reason that once they separate those health records should be thrown in the trash bin, and then they have to get a whole new physical examination done, not just for their disability claims, but then also for the VA to have their healthcare records on file.

I think it's about time, instead of having them show up with a car and then taking that car apart and spending six months building them a new car. They're getting out of the DoD with clean healthcare records, they should be able to take that departure physical exam conducted by the DoD and have it seamlessly transferred to the VA as their induction physical with the VA to eliminate that leap of faith in that gap, that so many veterans fall into as they're getting off active duty and being awaited to be ingested by the VA healthcare system for both disabilities as well as healthcare.

So, would like your comments on what the path forward for that could be?

Mr. TOPPING. Senator, I think so. Number one, this is called the zero-day record issue. This is something that Secretary Collins and Secretary Hegseth are personally engaged on and have met. Deputy Secretary Lawrence is leading this for VA. I know that there was a meeting between Department of Veterans Affairs and Department of War on this issue yesterday.

We are looking at how we do that and how those records automatically come over, and that this would be seamless to the service member who then becomes the veteran. But these records come on day one or zero day. Yes.

Senator SHEEHY. Good. And as the CFO, you'll know, that'll save you a lot of money, that you can spend on other things instead of having to pay for another health exam to happen that's already happened before. You can direct your focus on providing the care needed.

Community care, as has been referred to, has been the law for a long time. And the general assumption, in fact, I just left a meeting of Montana Rural Hospitals, is that in the opinion of a state

like ours that has not just rural healthcare, but frontier healthcare, that the VA has intentionally made itself a very hard customer to do business with as a payer.

And for these hospitals, a number of hurdles they have to go through both to qualify potential veteran patients to come in, in a state where it could be the difference between a 30-minute drive and a 5-hour drive, having to wait weeks or months to get the care they need because they're waiting for authorizations, is unacceptable.

So how are you going to knock down those barriers that are blocking veterans from accessing community care, specifically in the very rural environments, in places like Montana?

Mr. TOPPING. Senator, access to care should be seamless for the veteran. And particularly in a place like Montana where you've got very rural areas, where you've got rural care, where you've got the community providers who want to participate in the program, they want to be part of this.

VA has made it difficult. We've made it difficult via the referral process, the eligibility process authorizations, and then payment. The goal of this program is to make this program operate like the other payer programs. And virtually every single rural provider that maybe you've talked to and has been in your office is a Medicare provider. They treat Medicare patients. VA uses the Medicare fee schedule in this program.

So, it already looks like and pays like Medicare, but it doesn't operate like that. So, to the extent that our processes and that our requirements match those, it makes it very easy for a provider to do business with us.

And that allows the veteran to go down the street, whether it be rural, community, town, over, whatever it may be, and access care. The goal of this program and our ability in this and how we manage this is to make this seamless. And even things like measuring quality, we spent a lot of time talking about that too.

How VA is going to measure quality in this; are industry standards, everybody already does this who's providing care. It makes it easy and it makes it seamless to provide care for our veterans in this program.

Senator SHEEHY. And you know, a follow-up tip to any of you who care to jump in, but I think, you know, when you look at that, that ease of access and pay, you know, TRICARE and the DoD, no one's perfect, but they have a system that if you talk to most active duty or reserve members who have TRICARE or healthcare systems, they're like, listen, TRICARE is easy. I mean, it's seamless.

And those members will tell you, yes, this is pretty seamless. I was an active-duty guy who was married, my wife was active duty. You know, we dealt with that for years. And it's frustrating that why is the VA also a Federal agency that's obviously closely affiliated with the military as far as personnel?

How come one can be so easy and the other doesn't? So I would just encourage you, let's not reinvent the wheel if we don't have to. There are systems that are in place that work that the Federal Government has been using for decades. If we don't have to build something from scratch, like we've been doing with the electronic health records for like 30 years, let's just use something that works

already and put it to work. The veterans are tired of waiting for community care to work for them. So, thank you.

Chairman MORAN. Senator Sheehy, thank you. I now recognize the Ranking Member.

Senator BLUMENTHAL. Thank you, Mr. Chairman. Just a couple of quick questions. Mr. Topping, I think you told the Committee staff that the VA used the \$6 billion in supplemental funding last year to cover payouts and expenditures related to the deferred resignation program and early retirement requests. I think the VA now says that none of these funds were spent on the deferred resignation program or terminal leave payouts. Can you tell me how the \$6 billion was used?

Mr. TOPPING. Ranking Member, I did not say that to staff. What I said to staff is that we used \$581.1 million on these deferred resignation payouts. And of the 6 billion supplemental appropriation, 5.8 billion of that was used to purchase community care services, and 200 million of that was to purchase medical equipment.

Senator BLUMENTHAL. So, the vast bulk of it was spent on community care?

Mr. TOPPING. Yes, Senator.

Senator BLUMENTHAL. And Ms. Searight, does your office have the access it needs to all the information that you need to make proper evaluation of community care?

Ms. SEARIGHT. For the Office of Audits, we have had no issues with obtaining the necessary information to support our audits. However, our Office of Investigations has had challenges getting necessary information from the providers directly, which is why we've asked for that language to be included in the contract. With regard to eliminating a requirement for a subpoena.

Senator BLUMENTHAL. You need more information from the providers?

Ms. SEARIGHT. Correct.

Senator BLUMENTHAL. Thank you. Thanks, Mr. Chairman.

Chairman MORAN. Mr. Topping, do you intend to include a provision, as it was just described, to make sure that the providers fulfill a responsibility to provide information to the IG?

Mr. TOPPING. We do, Mr. Chairman.

Chairman MORAN. Thank you. And you've talked a lot about measures of quality, actually the absence of measures of quality. Is there a standard way of, it's maybe an IG issue as well. What's the criteria for determining quality of care? How do you measure it?

Ms. SKOLROOD. Thank you. So, in the community care, in a managed care setting, quality of care is measured differently than in a direct care setting. It's just as important. It's equally as important, but it is measured slightly differently. In our setting we are not handing over lives to the responsibility of the TPA, we maintain the responsibility of the veterans. We are not capitulating, per lives or anything like that.

So, the veteran's outcome measurements, their quality metrics, that measures both internal quality and external care quality. So, focusing on the outcomes of our veterans, whether that's cancer treatment or cardiovascular or diabetes, whatever those disease pathways may be, the outcomes are what we want to make sure

that we're measuring. And that will be indicative of both direct and external care.

Chairman MORAN. That's the outcomes or whether a person got better, whether they recovered, whether their lives were extended, or?

Ms. SKOLROOD. Exactly. Their direct outcomes from their disease pathway. And also in external care, there are national quality metrics, core measures, CMS measures, inpatient hospitalizations, your length of stay, your hospital acquired infections. There are indications that are national metrics that we can pull systematically that the TPAs and our Next Gen contracts, we are going to require them to pull that.

When you get down to direct providers like primary care providers, it does get more difficult. And that's where you need to rely on the outcome of the veteran's disease process. I mean, that's ultimately the measure of quality of care. Did the patient get better? Did the care work?

So, all of that is what's really exciting about what we're building, is that that will be wrapped into the Next Gen, and we don't have that now. We just don't have capabilities to visualize these outcomes.

Chairman MORAN. And when you say we don't have that now, what you're really saying is we've never had that. I mean, it's never been, since the MISSION Act, maybe since CHOICE, the ability to compare hasn't existed. But even within the VA direct care that quality measure has or has not been present?

Ms. SKOLROOD. In the VA, indirect care has a very robust quality metric system. I can't speak to it personally, but there are people who can, and it is very robust for veteran outcomes. I'm saying that that's indicative of both direct and community care because veterans are getting both.

So, if their outcomes are good, then you know that's measuring both. What is new in our current legacy contracts, we do not require the TPAs to—we do not put into those contracts to measure quality. We have put that into our Next Generation contracts, so that is something that we then will be able to hold the TPAs accountable for, and we'll be able to get that information.

Chairman MORAN. The current existing contracts, they have an expiration date. And is there a plan that then what you want to replace those contracts with will be available to replace it at the correct time?

Ms. SKOLROOD. Yes, sir. As we approach, there's a rolling termination of the contracts. They don't all end at one time. So, the first contract will end at the end of this year, and we will have to work with OGC and SAC to make sure that we bridge those and or have plans in place so that by the time the next generation of contracts are in place, there's seamless coverage.

Chairman MORAN. And no one's raised the topic of dental care. And I believe that's becoming a new opportunity within the contract. Would you explain that to the Committee?

Ms. SKOLROOD. Yes, sir. So, in current state are our two TPAs, dental is within the medical contracts. And Next Generation we've pulled dental out. It is a specialty niche kind of service. And we feel that a one national contract for dental will allow us to build

a more robust network and be able to—we've had some IG investigations with regard to dental payments. It will allow us to fix those situations, make sure that our rates are consistent, so there will be a national dental contract.

Chairman MORAN. Does dental care for veterans cover the wide gamut of dental care?

Ms. SKOLROOD. It does. There are and I'll have to phone a friend on that. I can't speak to all of the dental coverages, but it is a robust service. There are robust services.

Chairman MORAN. Mr. Topping, one of my legislative priorities, a significant one on this Committee, remains adoption of the ACCESS Act. It would build on the MISSION Act and in my view, help the VA deliver better access, convenience, quality care in the community, particularly for veterans with mental health and addiction issues.

I want to express my appreciation for the feedback and technical assistance that you have provided in the ACCESS Act. The ACCESS Act passed this Committee last year with bipartisan support. The Ranking Member and I are working together to reach an agreement on how to get it passed in the Senate.

Does the VA continue to support the ACCESS Act? And if it isn't enacted this year, like I hope it will be, would the ACCESS Act help or hinder the goals laid out in the RFP?

Mr. TOPPING. Mr. Chairman, so ACCESS Act was the first fire-fight I was dropped into after being confirmed and had a chance to work with your staff. Everybody supports the goals of increased access to mental health treatment for veterans. But when we came in, there were issues with how would we do this? How do we pay for this? How do we operationalize this? And the team spent a lot of time working on how we would do this.

Number one, the goal on expanded access is absolutely the type of thing that VA can and should be working on. And one of the things that VA does, perhaps better than even in the community is VA's mental health treatment. So that's number one.

But then paying for it requires on how we're going to operationalize that. And so, one of the things that the staff that we all worked on were, what are the tools that VA needs to operationalize this type of program? And so, where we've landed on are the types of things, regional opportunities, the ability to pivot pilots that may be different in different areas based on different requirements, different capabilities, infrastructure. Those are the tools and capabilities that are built into Next Gen.

So, the things that VA would need to do to operationalize in a fiscally responsible way on ACCESS Act, are built into Next Gen. We have that capability in that contract. And so, if and when ACCESS Act is passed, VA stands ready to implement that.

Chairman MORAN. They are compatible.

Mr. TOPPING. Yes, sir, they are.

Chairman MORAN. Thank you, Senator Blumenthal.

Senator BLUMENTHAL. Just say a question. I should know the answer to it. Is there a lot of variation among the contracts that you have with individual providers at present?

Mr. TOPPING. Ranking Member, there's great variation. And so, VA holds the contracts with the TPAs who are payment vendors.

Our payment vendors hold the contracts with the individual healthcare providers. And there are great variations in that.

Some of those variations are good things. They're regional variations. How we're going to provide care in Connecticut, it's going to be very different than rural Montana, for example. But some of those are because we've got different systems, different requirements, that makes it very difficult to administer.

And that's why in this contract with the multiple award IDIQ, the ability to have national vendors and regional vendors who serve with VA, it allows us to use vendors that have specialty, have networks in an area that may not have it in another, but that may be able to improve the quality of care and the cost of care that veterans receive. So that's the intent of this. That's the point behind the multiple award IDIQ.

Senator BLUMENTHAL. So, the Next Generation of contracts will have some variation as well?

Mr. TOPPING. Variation is not a bad thing. Variation adopted to the needs of the community, to the infrastructure, to the needs of the veterans, including VA infrastructure, where we have clinics, where we don't. Variation is not necessarily a bad thing.

Having a program that can be flexible, that can do different things managed in a different way in a rural area versus an urban area. That's the ability we have in this contract that we currently don't have an existing community care contract.

Senator BLUMENTHAL. But the variation may be to accommodate specific needs in different communities, but the standards should be uncompromising. Correct?

Mr. TOPPING. Senator, the standards should be the same, and the goal should be the same. And the goal is the highest quality of care for veterans at the lowest cost to the taxpayer.

Senator BLUMENTHAL. And the oversight should be as rigorous in contracts in Connecticut, Montana, all around the country?

Mr. TOPPING. Senator, VA is committed to building the program management capabilities to ensure that we can operate a contract of this size and complexity and be accountable for it.

Senator BLUMENTHAL. Thank you. Thank you.

Chairman MORAN. And that conversation ended up where I liked it ended. But the standard of care would be the same, whether it's direct care within the VA or it's community care. True?

Ms. SKOLROOD. Yes, sir.

Chairman MORAN. Okay. Is there anything that any of you would like to say that you haven't had the opportunity to say and with greater brevity than any Senator?

Mr. TOPPING. Mr. Chairman, we're delighted to have the opportunity to come in and talk to you about this program. Thank you.

Chairman MORAN. I'm pleased that you're here. We're pleased that you're here. And again, I think this is another in a series of hearings that have been very beneficial to the Committee.

Senators who would like to submit questions for the today's witnesses, or additional statements to the record have one week to do so. And we would request our witnesses to respond to any questions for the record received following today's hearing in a timely manner.

Chairman MORAN. Speaking of timely manner, please remind the Department that we are still awaiting responses to previously asked questions.

With that, the hearing is adjourned.

[Whereupon, at 4:28 p.m., the hearing was adjourned.]

A P P E N D I X

Submissions for the Record

JERRY MORAN, KANSAS
CHAIRMAN
JOHN BOOZMAN, ARKANSAS
BILL CASSIDY, LOUISIANA
THOM TILLIS, NORTH CAROLINA
DAN SULLIVAN, ALASKA
MARSHA BLACKBURN, TENNESSEE
KEVIN Cramer, NORTH DAKOTA
TOMMY TUBERVILLE, ALABAMA
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February 4, 2026

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

Dear Secretary Collins,

Thank you for your testimony at our hearing last week. We appreciate you and your team engaging with this Committee on the future of the Veterans Health Administration (VHA) and your efforts to improve the care it provides to veterans. That hearing will be one of several public engagements on this topic and we look forward to continuing a productive dialogue with you and your team as we fulfil our congressional oversight duties.

We are writing to document in one place the requests for information and briefings our Committee has made related to the hearing and several briefings on the Restructure for Impact and Sustainability Effort, or RISE, and the state of VA operations. As stated during the hearing, transparency is essential - especially as it relates to your proposed reorganization of VHA - to ensure veterans can access the care and benefits they have earned. You have already completed or begun to address several requests made during the hearing, and our staff is standing by to receive the additional information and briefings detailed below.

The list of information requests is as follows:

1. A full accounting of spending for the \$6 billion Congress gave VA in Fiscal Year 2025 to meet higher than expected cost and demand for VA health care. Specifically, proof this funding was not used to subsidize the deferred resignation program and/or voluntary early retirement authority.
2. A detailed compilation of current workforce data, including the number of staff who have left VA and those who have come onboard since January 2025, broken down by facility and position.
3. A detailed breakdown of the baseline staffing caps being established and any positions, including vacant positions, being cut based on those caps, broken down by facility and position.
4. The release of the annual veteran suicide prevention report.
5. A copy of the dashboard information referenced by Under Secretary Bartrum and others showing national wait time averages for primary care, mental health care, and specialty care for January of 2026. Please also provide a breakdown by medical center of the same information. We request to receive this information on a monthly basis moving forward.

6. A one-time briefing for Committee staff on how the information in the dashboard is compiled and validated and how wait times are calculated.
7. An action plan for a full-service medical center in New Hampshire.
8. A briefing by Deputy Secretary Lawrence for the Michigan delegation on the Electronic Health Record Modernization (EHRM) program before April 11, 2026.
9. An accurate and updated list of cancelled contracts, including the breakdown of how much each contract cost and a description of what each contract did. When you stated you would work to alleviate our concerns with this matter, a list detailing this information would be extremely helpful for us to have a better picture of the services VA still offers.
10. The white paper and updates on development of the VHA reorganization plan as they occur, with corresponding analysis.
11. Once available, share the risk assessment list for veterans' timely access to care under the VHA reorganization plan and provide a briefing on VA's plan to mitigate those risks.
12. List of key performance indicators (KPIs) and data collection methods implemented in developing the VHA reorganization plan.
13. List of the 18 KPIs every VA Medical Center now uses per VHA's instructions, and each facility's data on these KPIs.
14. An explanation of the roles and responsibilities of the VISNs and of the HSAs once RISE is implemented.
15. A list of benchmarks and specific outcomes VA and this Committee can use to evaluate the success of RISE after it is implemented.
16. As you mentioned during the hearing, VA has reduced the overall inventory of disability and pension claims pending decision. Please provide actions VA has taken or plans to take to reduce the inventory of claims.

We look forward to receiving the information above so the Committee can adequately conduct oversight and allow us to better ensure veterans can receive the highest quality care and benefits possible. Sharing this information in a transparent and timely manner will enable more constructive dialogues moving forward about the state of the Department. We also appreciate your commitment during the hearing that VA will meet with the Committee when invited to do so on a bipartisan basis. We are confident that working together on major reforms to VA will help produce the best outcomes for veterans and the dedicated VA staff that serve them.

Sincerely,

Jerry Moran
Chairman

Richard Blumenthal
Ranking Member

Pace of Community Care Spending has Far Outpaced Growth in Veterans Served



Prepared Statements

**STATEMENT OF
RICHARD TOPPING
ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
BUILDING A 21st CENTURY VA HEALTH CARE SYSTEM: ASSESSING THE
NEXT GENERATION OF VA's COMMUNITY CARE NETWORK
FEBRUARY 11, 2026**

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

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

of our facilities.

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

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

We talked to other Government agencies. The Department of Health and

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

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

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

First, this approach allows VA to make multiple awards to offerors that meet

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

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

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

performance improvement between VA and our contractors.

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

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

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

contractor incentives with Veteran health and system sustainability.

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

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

The last exciting innovation in CCN Next Gen is how VA will manage its contractual relationship with contractors. VCCP's goal is to provide the highest quality care for Veterans at the lowest cost to taxpayers. Achieving this outcome depends equally on the agency and industry. CCN Next Gen will be a contractual relationship with contractors, leveraging all VA and industry brings, in the service of our Veterans. Historically, VA's approach, like most Government Agencies, has

been to try to predict the next several years, compete it, award it, and then manage it. CCN Next Gen will allow VA to gain the information needed during the contractors' performance on capacity, capabilities, regional adaptations, innovation, and pricing and to do so continuously through the task order formation and issuance process.

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

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

Our actuarial analysis of the CCN Next Gen program design changes, along with these payment changes, estimate significant savings of 8-14% over the life of the contracts. Under conservative assumptions, the cost-containment framework is

expected to reduce community care spending by approximately \$54 billion over the next decade. Under stronger performance scenarios, the cost-containment framework's estimated reduction could approach \$100 billion. These savings will be driven by fewer unnecessary hospitalizations, improved management of high-cost services and drugs, improved quality, and stronger fraud and payment controls.

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



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEPUTY ASSISTANT INSPECTOR GENERAL LEIGH ANN SEARIGHT
FOR THE OFFICE OF AUDITS AND EVALUATIONS
OFFICE OF INSPECTOR GENERAL FOR THE
US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
US SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
*"BUILDING A 21ST CENTURY VA HEALTH CARE SYSTEM: ASSESSING THE NEXT
GENERATION OF VA'S COMMUNITY CARE NETWORK"*
FEBRUARY 11, 2026

Chairman Moran, Ranking Member Blumenthal, and committee members, thank you for the opportunity to discuss the oversight conducted by the Office of Inspector General (OIG) related to the contracts governing the community care network. Meeting veterans' healthcare needs requires VA to support and coordinate highly skilled multidisciplinary clinical teams that prioritize the quality and timely delivery of direct care. That mandate to provide prompt and exemplary services becomes more complex when VA refers veterans to community care. In keeping with our mission, the OIG's Office of Healthcare Inspections and our Office of Audits and Evaluations provide comprehensive oversight of Veterans Health Administration (VHA) programs and services. Our Office of Investigations works with data analytics and other teams to identify and address healthcare fraud and other related crimes.

It is important to acknowledge that OIG personnel regularly observe dedicated VA staff providing veterans with needed direct care and services, as well as acting in veterans' best interests when referring them to care in the community. As VHA executes its plans for reorganization, which may reshape aspects of the community care program, the OIG will continue to monitor actions that affect patient safety; the provision of timely, high-quality care; compliance with laws and governing standards; and the efficient and effective use of taxpayer dollars.

The OIG has reported on challenges with the current community care program contracts. The recent announcement of the Community Care Network Next Generation solicitation presents an opportunity for VA to learn from prior oversight and to develop a contract grounded in best practices. VA is already taking some steps in that direction. The OIG's initial review of the contract solicitation found positive developments in medical documentation return requirements, which can help prevent and detect fraud and improve continuity of care. While 50 of the 63 community-care-program-focused recommendations contained in the OIG reports discussed in this statement are now closed, they represent areas of

vulnerability for VA in contract management. Specifically, the issues that those recommendations addressed could reemerge, particularly in new or amended contracts.

Prior OIG reports on VA's management of the contracting and business aspects of the community care program have consistently found that (1) VHA struggles to ensure veterans experience timely, seamless coordinated care when they are referred to the community; (2) VHA cannot be certain of the quality of care that community providers deliver; (3) workforce challenges and insufficient VHA controls for managing community care exacerbate coordination problems; and (4) outdated or inadequate information technology systems, as along with inaccurate and incomplete data, significantly restrict VA's ability to manage community care payments.¹

The information that follows spotlights OIG findings and recommendations related to the management and oversight of the current contract. In addition, it outlines provisions the OIG proposes should be considered for inclusion in the next generation of contracts to maximize the use of taxpayer funds and ensure veterans receive high quality, timely care from community providers.

VA'S MANAGEMENT OF THE THIRD-PARTY ADMINISTRATORS' PERFORMANCE IN ADMINISTERING THE COMMUNITY CARE NETWORKS

The OIG has regularly reported on the clinical and administrative challenges VA, VHA's Office of Integrated Veterans Care (IVC), and individual VA medical facilities face in managing the community care program. VA has third-party administrators (TPAs) to oversee community care provider adherence to the contracts, and the OIG previously found both TPA oversight and provider adherence to the contracts lacking. In addition, VA has not consistently followed its own processes when administering the program and coordinating clinical care for veterans.

Obtaining and Importing Community Care Documents into the Patient's VA Electronic Health Record Facilitates Care and Fraud Prevention Efforts

VHA clinicians have emphasized that prompt receipt of community care medical records is crucial for care coordination and quality of care oversight.² Delays in sending medical records can also compromise efforts to combat fraud. Many VA leaders reported problems receiving records from community providers and long lag times from the facility's receipt of those records to when VA facility staff scanned them into the patient's record. VHA policy requires that all internal and external documents be imported into the electronic health record within five business days of receipt from the provider. VHA staff have identified technological limitations as contributing causes to providers' lapses in sending records, such as the reliance on electronic faxes and complexity in using the web-based portals. At the same time, VHA staff attributed limited time and personnel to scanning backlogged

¹ All OIG reports filtered to highlight VA's community care program can be found on the [website](#).

² VA OIG, *Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records*, August 7, 2025.

records. The lack of coordination also burdens VHA clinicians and staff who must divert attention from patient care to chasing down records.

**VA's Oversight of Opioid Prescriptions and Special-Authorization Prescriptions
Written by Community Care Providers**

Veterans are at an elevated risk of opioid overdose, often due to higher rates of chronic pain and co-occurring mental health conditions, such as those associated with posttraumatic stress disorder and military sexual trauma.³ When veterans receive care in the community, opioid prescriptions must be tracked and coordinated with VA. The MISSION Act of 2018 requires VA to ensure that community providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.⁴ By contract, VA also requires providers to query state prescription drug monitoring programs to determine if a veteran has existing opioid prescriptions before issuing a new one. In two reports, the OIG found nonadherence with these requirements at facility and national levels.⁵ Based on VA's corrective actions, the recommendations from these reports are now closed; however, community opioid prescribing practices pose a risk to veterans that the OIG continues to monitor.

Additionally, in 2024, the OIG found that VA and the TPAs were not ensuring that community care providers submitted contract-required justifications for initial prescriptions of special-authorization drugs, partly because the IT system lacked the needed capabilities, requiring provider work-arounds.⁶ VHA reported workforce issues because of the increasing number of community care prescriptions processed in VHA-operated pharmacies that required work-arounds. The OIG found the processing often exceeded VHA's four-day standard, averaging about 11 days. VHA also did not hold TPAs accountable for ensuring community providers followed procedures. Less than 2 percent of community providers completed the TPA-developed training. The OIG questioned about \$200 million in prescription costs that lacked justification from community providers. The report had seven recommendations, now closed, to improve community providers' prescribing compliance, system capabilities, training adherence, VA pharmacies' documentation of justifications, and the clarity of requirements for VA pharmacies to report noncompliant community providers.

³ John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020); VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022.

⁴ [P.L. 115-182](#). The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.

⁵ VA OIG, [Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth](#), September 26, 2023; VA OIG, [Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans](#), September 26, 2023.

⁶ VA OIG, [Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times](#), August 15, 2024.

Community Care Provider Requests for Additional Services

When community care providers evaluate VA patients, they may identify additional care needs that were not in VA's referral. The provider can send a request for additional services back to VA for approval. However, OIG teams have found VA community care staff do not consistently process the requests within the required three business days of receiving the referral.⁷ These delays, along with failures to properly document or notify providers of denials, can hinder follow-up care for veterans.

VA's Oversight of TPA Performance and Provider Network Adequacy

VHA must oversee the TPAs' administration of the community care provider program, including ensuring the TPA's healthcare provider networks are robust enough to provide timely services to veterans. The OIG found that IVC did not hold the TPAs accountable for contract requirements designed to ensure facilities have enough community providers to administer care within timeliness and drive-time standards. As a result, facility staff struggled to convince the TPAs to build up the network. IVC also did not analyze facilities' network adequacy to help inform the TPAs of the need to expand provider networks and did not ensure the TPAs maintained provider networks that accepted VA patients. The OIG recommended that IVC hold future TPAs accountable for operational readiness and provider network adequacy, and that IVC develop processes to update and maintain community care network data, challenges, and needs. The improvements VHA made in performance measurement that enabled these recommendations to be closed should be considered for inclusion in the next generation contract.⁸

In a 2025 audit, the OIG examined whether VHA made accurate and timely community care payments for outpatient healthcare and dental services.⁹ The OIG estimated that although error rates were small, the combined estimated errors resulted in overpayments of about \$178.5 million because VHA did not charge the correct Medicare rate or applicable VA fee rate in cases for which VHA lacked an established contractual rate, resulting in payments at invoiced amounts.

Additionally, the OIG estimated that VHA paid over \$900 million more to both TPAs combined than the TPAs paid community providers for dental services. About \$650 million resulted from a VA contracting error caused by an incorrect pricing spreadsheet being incorporated into contracts that went undetected during VA oversight reviews. This contracting error has been corrected, and the corresponding VA OIG recommendation is closed. Other recommendations called on VHA to prevent and recover overpayments in timely manner and to work with the Office of Acquisition, Logistics, and Construction so healthcare invoices are monitored by the appropriate staff. Additionally, four of the five community care regions

⁷ VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*, July 29, 2025.

⁸ VA OIG, *Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance*, April 9, 2024.

⁹ VA OIG, *Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*, February 20, 2025.

did not cap VHA's dental reimbursements to TPAs at provider invoice amounts; the recommendation to address this issue remains open.

NEW CONTRACT PROVISIONS COULD ENHANCE THE COMMUNITY CARE PROGRAM

In addition to providing VA with actionable recommendations to improve the community care program, the OIG has engaged with VA about provisions that can be inserted in the next generation contract to improve oversight, fraud detection, contract compliance, program efficiency, and healthcare delivery.

- **To support statutory independent oversight, the OIG should be able to obtain requested documentation of care from the TPAs without a subpoena.** Under the IG Act and other authorities, the OIG may subpoena testimony and documents from entities and individuals, regardless of their contractual relationship with VA or the TPAs. The next generation contract should require contracted entities to provide documents to the OIG without a subpoena and notify all entities of that mandate. This will more efficiently enable the OIG to examine concerns about the quality of community care and potential fraud.
- **To help deter fraud, the TPA should be required to include in all healthcare provider agreements a standardized notice of providers' obligation to comply with federal laws and the consequences for nonadherence.** Healthcare providers are already subject to a similar standard contract provision when applying for reimbursement from the Centers for Medicare & Medicaid Services. Tailoring it to VA contracts, it could include language such as:

In submitting any claim for payment to a TPA for reimbursement from VA, the healthcare provider certifies that the services were medically indicated and necessary to the health of the patient and were personally furnished by the provider or their employee under their direction. Provider understands that its claim will be reimbursed from Federal funds and any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal laws.

- **Enforcement provisions should be included for provider noncompliance with record-sharing requirements, and inpatient facility incentives considered to periodically update VA on treatment.** Given VA's difficulties in receiving records from community care providers, it should consider an enforcement mechanism for community care facilities and providers that fail to provide records as required. Ideally, inpatient facilities could also be incentivized to provide ongoing treatment updates and plans to VA during a veteran's treatment.
- **Community care providers should be incentivized to meet the same training and quality standards as VA providers.** The OIG has found that the TPAs could not account for whether community providers completed training on specific medication ordering and opioid-prescribing checks. VA and TPAs should be encouraged to identify ways to maintain an accurate database of provider training (accounting for frequent changes to network participants). Additionally, the OIG would welcome a requirement for provider training on their obligation to cooperate with the OIG.

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- **The TPAs should be incentivized to follow fee schedules.** To consistently control costs and avoid TPA overpayments, a contract provision could address the need to follow any VA-established fee schedules for specified medical services. As an example of this need, the OIG's recent management advisory memo on community substance use disorder treatment facilities noted that VHA completed a contract modification with only one of the two TPAs to implement a fee schedule for this care, which resulted in significant overpayments.¹⁰
 - **Improved oversight of referral processes and quality reviews can strengthen veteran care.** To increase assurances that veterans referred to the community are receiving health care that meets VHA's quality standards, VHA should consider contract provisions that provide additional checks on provider credentialing and ongoing competence as well as quality reviews of patient safety reporting and follow-up. Delegating contractor performance oversight to another contractor weakens the government's ability to know it is receiving the services it purchased. In addition to raising the quality of care, including these provisions may further facilitate anti-fraud efforts and reduce duplicative and unnecessary care, leading to higher patient satisfaction and lower costs.

CONCLUSION

The OIG is focused on its mission to conduct independent oversight of VA to provide findings and recommendations that help VA use its resources to efficiently provide veterans with benefits and services. The next generation community care contract provides VA an opportunity to make improvements that draw from lessons learned from implementing prior OIG recommendations and addressing risks identified in oversight reports. VA contracting and program officials should engage industry and other stakeholders to help create a robust community care network that increases access for veterans. Failures in monitoring, quality reviews, compliance enforcement, program management, and other issues raised in OIG reports risk cascading problems that can affect patient safety and care and undermine efforts to protect VA against fraud, waste, and misuse of resources meant to improve healthcare services to veterans and support the providers who serve them.

Chairman Moran, Ranking Member Blumenthal, and members of the committee, this concludes my statement. The OIG looks forward to working with Congress to advance VHA's provision of care to veterans, regardless of where it is delivered. I would be happy to answer any questions you may have.

¹⁰ VA OIG, *Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans*, September 17, 2025.

Questions for the Record

**Department of Veterans Affairs (VA)
Questions for the Record submitted to
Mr. Richard Topping
Assistant Secretary for Management and Chief Financial Officer;
Ms. Alicia Skolrood
Executive Director, Integrated External Networks, Office of Integrated Veteran
Care, Veterans Health Administration
From the Committee on Veterans' Affairs
United States Senate
"Building a 21st Century VA Health Care System: Assessing the Next Generation
of VA's Community Care Network"**

February 11, 2026

Questions for the Record from Senator Kevin Cramer:

Question 1: Mr. Topping, I commend the Department's goal to modernize management of the VA Community Care Program. For too long, veterans have faced barriers accessing care as intended under the VA MISSION Act of 2018. Many of the objectives outlined in the Community Care Network (CCN) Next Generation (Next Gen) Medical Indefinite Delivery Indefinite Quality (IDIQ), including a regional approach, will make the experience smoother and more predictable for veterans and community providers. However, proposals related to utilization management must be carefully structured to ensure veterans' access to care is not compromised. Regarding plans for utilization management as part of CCN Next Gen. How is VA incorporating the realities of rural healthcare delivery: limited provider availability, longer travel distances, and thin hospital margins into any utilization management standard?

VA Response: VA is building rural considerations directly into utilization management (UM) standards by accounting for limited provider supply, longer travel times, and rural hospital capacity. Utilization management standards will allow greater flexibility in referral decisions and emphasize timely access.

Question 2: The Biden Administration leveraged the VA bureaucracy to limit and deter veterans from using their community care benefits provided under the MISSION Act. How will you ensure utilization management tools aren't positioned to be next lever for preventing community care access for veterans? How will the VA be proactive in informing veterans of their community care options?

VA Response: Eligibility decisions are distinct from utilization and will occur prior to any utilization management decisions. VA will ensure UM management tools cannot be

used to deter or delay community care by maintaining clear oversight and requiring transparent, Veteran-facing communication. VA will proactively inform Veterans of their community care options through standardized notifications, clearer referral explanations, and improved digital tools.

Question 3: Will VA retain ultimate authority over any utilization management standards? What guardrails will ensure these tools do not become final arbiter in deciding what medically necessary care is, in place of the veteran and their doctor.

VA Response: Yes—VA will retain full authority over UM standards. UM applies evidence-based clinical criteria, standardized coding, and decision-support tools to guide appropriate referrals, admission, and post-acute care decisions. UM tools will support, not override, clinical judgment. Guardrails include VA-defined criteria, clinician-to-clinician review requirements, and explicit protections ensuring that decisions about medically necessary care remain between the Veteran and VA

Question 4: How do you view the various facets of CCN Next Gen, including the utilization management tools, as improving the veteran and provider experience? Specifically, how will VA evaluate whether utilization management tools are improving, rather than delaying, access to care?

VA Response: NextGen's UM tools are designed to reduce administrative burden, speed up the authorization process, and give providers clearer, more consistent processes. VA will evaluate performance through measurable outcomes—authorization timeliness, reduced delays, and Veteran satisfaction.

Questions for the Record from Senator Maggie Hassan:

Question 1: As the VA looks toward the future of community care, what changes is the Department going to make – both within the VA and within the community care contracts – to ensure that veterans' community care records are promptly received by the VA and integrated into veterans' overall health records?

VA Response: VA is taking several targeted steps to ensure community care records are received quickly and fully integrated into Veterans' health records. Internally, VA is strengthening its health information exchange infrastructure, standardizing workflows, and expanding automation so records are routed and incorporated faster. Externally, the Community Care Network Next Generation (CCN Next Gen) contracts will include clearer, enforceable timelines for record submission, require submission through defined systems, and hold contractors accountable for timely and accurate documentation delivery.

Questions for the Record from Senator Dan Sullivan:

Question 2: While some Veterans Affairs medical Centers offer innovative services, veterans' access through Community Care can vary when contractors are involved. As the Department transitions to NextGen, how is VA approaching the standardization of benefits across regions? Will access be consistent nationwide, or shaped by vendor contract structures? And more broadly, how does VA plan to support access to medically appropriate, innovative treatment options within the new framework?

VA Response: VA is designing the CCN NextGen community care contracts to deliver far more consistent access nationwide. VA is standardizing key benefits, referral processes, and performance expectations across all regions so that Veterans' access is not determined by which contractors serve their area. While contractors will operate the networks, VA—not the contractors—will define the benefit structure and the clinical needs. VA recognizes that not all services are available in the community, so Veterans will continue to have the choice to receive services through the VA. At the same time, VA is building flexibility into the framework to ensure Veterans receive medically appropriate, innovative treatments when clinically appropriate. This includes clearer pathways for referring to specialized services, stronger clinical oversight, and contract requirements that ensure networks can support emerging therapies and evidence-based innovations.

Questions for the Record from Senator Tammy Duckworth:

Question 1: How many full-time equivalent (FTE) employees who support Community Care Network (CCN) contract oversight (in any capacity) is the Office of Integrated Veteran Care (IVC) authorized to employ?

VA Response:

As part of RISE, The Office of Integrated Veteran Care (IVC) has transitioned into a new organization, Veterans Community Care (VCC). For purposes of this response, "contract oversight in any capacity" includes VCC functions that directly or indirectly support CCN administration, clinical oversight, operations, payment and claims, network and contract management, analytics, and enterprise support. As of September 2026, VCC is authorized approximately 1,920 FTE that support CCN contract oversight in some capacity under this definition.

Question 2: How many FTE employees who support CCN oversight (in any capacity) did IVC employ on January 1, 2025? On September 1, 2025?

VA Response: In legacy IVC, 339 employees supported CCN oversight in some capacity as of January 1, 2025, and 310 employees as of September 1, 2025.

Question 3: How many FTE employees who support CCN oversight (in any capacity) are currently employed at IVC?

VA Response:

IVC has transitioned into VCC, and as of September 2026, VCC currently employs approximately 1,298 FTE that support CCN contract oversight in some capacity. VCC is actively working with workforce management to recruit and fill vacant positions.

Question 4: During the 2025 calendar year, how many employees who support CCN oversight (in any capacity) departed IVC because of reductions in force (RIFs), voluntary early retirement authority (VERA), deferred resignation programs (DRPs) or non-conversion of term-appointments to permanent employment?

VA Response: In legacy IVC, 13 employees supporting CCN oversight departed through VERA or DRP during calendar year 2025.

Question 5: How many FTE employees who support CCN oversight (in any capacity) is IVC's IEN authorized to employ?

VA Response: In legacy IVC, approximately 511 positions were authorized in IEN to support CCN contract oversight in some capacity.

Question 6: How many FTE employees who support CCN oversight (in any capacity) did IEN employ on January 1, 2025? On September 1, 2025?

VA Response: In legacy IVC IEN, 339 employees were employed to support CCN oversight in some capacity as of January 1, 2025, and 310 employees as of September 1, 2025.

Question 7: How many FTE employees who support CCN oversight (in any capacity) are currently employed at IEN?

VA Response: The legacy IEN organization has transitioned into VCC, primarily under Networks and Contracts Management, which as of September 2026 has approximately 117 authorized FTE that support CCN contract oversight in some capacity.

Question 8: During the 2025 calendar year, how many FTE employees who support CCN oversight (in any capacity) departed IEN because of RIFs, VERA, DRPs or non-conversion of term-appointments to permanent employment?

VA Response: In legacy IVC IEN, 13 employees supporting CCN oversight in some capacity departed through VERA or DRP during calendar year 2025.

Question 9: How many FTE employees who support CCN oversight (in any capacity) is IEN's Contracts Management and Performance department authorized to employ?

VA Response: The legacy IEN Contracts Management and Performance department transitioned under VCC Network and Contracts Management, Contract Administration which has 30 authorized positions supporting CCN contract oversight.

Question 10: How many FTE employees who support CCN oversight (in any capacity) did IEN's Contracts Management and Performance department employ on January 1, 2025? On September 1, 2025?

VA Response: In legacy IVC, the Contracts Management function employed 19 employees supporting CCN oversight as of January 1, 2025, and 17 employees as of September 1, 2025.

Question 11: How many FTE employees who support CCN oversight (in any capacity) are currently employed at IEN's Contracts Management and Performance department?

VA Response: The legacy IEN Contracts Management and Performance department transitioned under VCC Network and Contracts Management, Contract Administration which currently has 19 authorized positions employed supporting CCN contract oversight.

Question 12: During the 2025 calendar year, how many FTE employees who support CCN oversight (in any capacity) departed IEN's Contracts Management and Performance department because of RIFs, VERA, DRPs or non-conversion of term-appointments to permanent employment?

VA Response: In legacy IVC, two employees from the Contracts Management function who supported CCN oversight departed through VERA or DRP during calendar year 2025.

Question 13: What specific planning conferences, meetings and decision briefings did the VHA conduct in developing the CCN Next Generation (Next Gen) program? Please share an overview of the timeline, meeting attendees, and all stakeholders/offices who participated in this process.

VA Response:

- 2021: Initial Market Research
 - Held Industry Days
 - Completed Environmental Scans
- 2022: Internal Research
 - Identified current pain points through lessons learned working sessions
 - Worked with key stakeholders to find solutions to pain points
 - Brainstorming activities for now and innovative requirements
- 2023: Expand Market Research
 - Issued six (6) Industry Requests for Information (RFIs)
 - Researched major initiatives (Value Based Care/Alternative Payment Models, technology, med docs, etc.)
- 2024: Requirements Finalization
 - Finalized procurement structure (Medical East/West and National Dental)
 - Closed out final decisions and actions from each workstream
 - Final refinements made to performance work statements
 - Integrated content into manuals
- 2025: Final Request for Proposal (RFP) Release
 - Shifted the procurement strategy and contract type selection based on new innovation requirements.
 - Posted final RFP, including Indefinite Delivery Indefinite Quality (IDIQ) and Task order proposal Requests, on 12/15/25
 - Hosting weekly CCN NextGen Integrated Project Team (IPT) meetings which include stakeholders from Office of Integrated External Networks, Integrated Veteran Care Chief Medical Office, Strategic Acquisition Center (SAC), Office of General Council (OGC), and the CCN NextGen Program Management Office (PMO)

Question 14: What alternative courses of action did VHA consider before selecting this plan? Please share all documentation, risk assessments and comparative analysis related to these courses of action.

VA Response: Before selecting the CCN Next Gen acquisition strategy, VHA evaluated the existing CCN structure and considered whether to continue or modify elements of the legacy model. After assessing performance limitations and market conditions, VHA determined that maintaining the prior structure would not sufficiently modernize community care purchasing or address known challenges.

Specifically, VHA considered the following alternatives:

1. Continuing the Legacy Two-Third Party Administrators (operating 5 distinct regions) Single-Award Contract Model

Under the legacy CCN construct, VA operated through five large regional, single-award contracts covering medical, pharmacy, and dental services.

Consideration:

Maintain the existing regional single-award structure.

Assessment:

VHA determined this model was difficult to modify and limited VA's ability to:

- Address network adequacy gaps.
- Improve interoperability and credentialing processes.
- Strengthen claims processing and quality reporting.
- Adapt to telehealth growth and emerging care models.
- Replace underperforming contractors.

The static nature of these long-term regional contracts constrained competition and flexibility.

2. Maintaining Bundled Medical and Dental Regional Contracts

The legacy model bundled medical and dental services within the same regional contracts.

Consideration:

Continue integrating dental services within regional medical contracts.

Assessment:

VHA determined that bundling dental services limited the ability to:

- Standardize benefits and oversight nationally.
- Establish consistent performance metrics.
- Streamline accountability for dental-specific outcomes.

As a result, VHA selected a separate national Dental IDIQ to provide greater coordination and focused oversight.

3. Retaining Static Long-Term Contracts Without Ongoing Competition

Under the legacy construct, VA had limited mechanisms to adjust performance requirements or introduce new service models during the life of the contract.

Consideration:

Continue with long-term contracts without ongoing competitive task orders.

Assessment:

VHA concluded this approach did not provide sufficient flexibility to:

- Introduce targeted improvements over time.
- Address emerging access gaps.
- Align payment structures with outcomes.
- Off-ramp underperforming vendors.

This led to adoption of a multiple-award IDIQ model that enables competitive task orders and performance-based accountability.

4. Limiting Market Participation to Large Incumbent Regional Contractors

The legacy structure inherently favored a small number of large regional contractors.

Consideration:

Maintain a limited competitive field focused primarily on large incumbents.

Assessment:

VHA determined this approach constrained:

- Market participation.
- Specialized vendor capabilities.
- Competitive pressure to drive innovation and cost containment.

The selected multiple-award IDIQ structure broadens bidder participation and strengthens competition.

After evaluating these alternatives, VHA determined that continuing the legacy regional, single-award structure, whether bundled or unbundled, would not adequately support modernization, competition, accountability, or flexibility. The CCN Next Gen strategy was selected to expand market participation, enable competitive task orders, strengthen performance oversight, and improve outcomes for Veterans.

Question 15: What specific selection criteria were used in choosing these indefinite delivery, indefinite quantity (IDIQ) contracts over other courses of action? Please share all documentation explaining these criteria.

VA Response: For CCN NG Medical, it has been determined that a multiple award, IDIQ contract will be awarded for the CCN Next Gen - Medical. This requirement is being solicited and awarded under the authority of 38 U.S.C. § 8153, Sharing of Healthcare resources and FAR Part 12-Acquisition of Commercial Products and

Services, in conjunction with the policies and procedures for solicitation, evaluation and award prescribed in FAR Part 15 Contracting by Negotiation and FAR Part 16.5 Indefinite-Delivery Contracts.

In accordance with FAR 16.504(c)(1)(i) the CO has determined that multiple awards would be more favorable than a single award IDIQ. Given this information, the CO has identified the following benefits of a multiple award structure:

- Increased Competition at the Task-Order Level. Multiple award IDIQs create ongoing competition for each TO, which:
 - Drives better pricing
 - Improves technical quality
 - Encourages contractors to continuously innovate to win work
 - Aligns strongly with FAR 16.505(b)(1) policies favoring fair opportunity
- Reduced Performance and Supply-Chain Risk. Relying on one contractor can be risky if that contractor underperforms or experiences capacity issues. Multiple awards:
 - Provide redundancy
 - Allow fallback options if one contractor has performance issues
 - Ensure continuity of operations
- Greater Access to Specialized Expertise. A single awardee rarely excels in every niche task. Multiple award IDIQs allow the Government to:
 - Pull from diverse skillsets
 - Match Tos with the contractor best suited for each requirement
 - Accommodate evolving or emerging technical needs
- Better Price Reasonableness and Market Responsiveness Over Time. Because contractors must compete repeatedly:
 - Pricing stays aligned with market conditions
 - The Government benefits from discounts and efficiencies
 - Contractors are incentivized to offer more favorable rates and solutions over the contract's life
 - VA benefits in a rapidly changing market during long-term IDIQs

For CCN NG Dental, it has been determined that a single award, IDIQ contract will be awarded for the CCN Next Gen Dental Network region. This requirement is being solicited and awarded under the authority of 38 U.S.C. § 8153, Sharing of Healthcare Resources, and FAR Part 12 Acquisition of Commercial Items, in conjunction with the policies and procedures for solicitation, evaluation and award prescribed in FAR Part 15 Contracting by Negotiation.

The use of a single award IDIQ allows for flexibility and responsiveness to ensure outstanding delivery of care to Veterans. The single award IDIQ is necessary as managing multiple awardees would heighten the risk of inconsistencies in service delivery and cause delays in patient care due to the need to coordinate efforts across several contractors. The use of multiple vendors would also create significant risks to the national Dental Network strategy to include significant management and network scaling issues, variances and changes in quality and scope of provided services across the country, and significant administrative and overhead burden to the Government.

Question 16: You testified to this Committee that CCN does not collect data on patient experiences. You also testified that CCN Next Gen will collect quality metrics data for its patients. Will VHA also collect customer/patient satisfaction data as it pertains to Veterans' experiences with Community Care providers?

VA Response: Yes. Veteran feedback is collected through structured customer service mechanisms embedded in the contract. The CCN Next Generation framework requires the contractor to maintain contact center operations and includes after-call survey capabilities and customer service quality assurance processes under the Customer Service task area. In addition, VA maintains independent oversight authority through the Quality Assurance Surveillance Plan and can audit performance data at any time. Veteran experience is therefore not left to anecdotal reporting; it is captured through formal survey tools, monitored through required reporting, and subject to VA review and validation.

It is also important to distinguish between direct survey data and proxy operational measures. Direct experience data includes after-call surveys, documented complaints, customer service performance monitoring, and structured reporting on service interactions. These mechanisms capture Veterans' expressed satisfaction, concerns, and service issues. Proxy measures, by contrast, are operational indicators that strongly correlate with experience, such as appointment timeliness, drive-time compliance, referral processing efficiency, and patient safety reporting. For example, appointment timeliness is contractually measured from referral approval to the initial date of service, and network adequacy standards require defined travel thresholds. While these are operational metrics, they directly affect how Veterans perceive access and reliability. Together, direct feedback and objective performance indicators create a layered and more reliable picture of Veteran experience.

Question 17: Why do the CCN Next Gen Performance Work Statements not require CCN providers to complete lethal means safety training, Science

Technology and Mathematics Skills Training for Evaluation and Management of Suicide (STEMS), the VA's SAVE Program or the High-Risk Flag program?

VA Response: VA needs to balance requirements but align with industry. Creating specialized requirements may deter providers or contractors from wanting to work with VA. Providers still have to do their State level training to be eligible to practice in the State.

Question 18: Why do the CCN Next Gen Performance Work Statements not require CCN providers to complete Veteran cultural competency training, beyond what Section 133 of the MISSION Act dictates, such as the VA's Patient Education: TEACH for Success or Motivational Interviewing (MI) programs?

VA Response: VA needs to balance requirements but align with industry. Creating specialized requirements may deter providers or contractors from wanting to work with VA.

Question 19: What impact assessments has VA conducted to understand the risks posed by the lack of these stringent requirements in questions (16) and (17)? Please share all pertinent planning documentation and risk assessments with me.

VA Response: VA has assessed the risks of not requiring additional lethal means safety training through a broader access, quality, and market impact lens. With respect to patient satisfaction, VA determined that the risk of insight gaps is mitigated by embedding structured customer service and feedback mechanisms directly into the CCN Next Generation contract. Veteran feedback is captured through after-call surveys, complaint documentation, customer service quality monitoring, and required reporting, all subject to independent oversight under the Quality Assurance Surveillance Plan. In addition, VA collects operational performance data—such as appointment timeliness, drive-time compliance, referral processing efficiency, and patient safety reporting—that serve as validated proxy indicators of Veteran experience. This layered approach reduces the risk that experience issues would go undetected, even in the absence of standalone survey instruments.

Regarding lethal means safety training, VA evaluated the balance between enhancing safety expectations and avoiding requirements that could create unnecessary market barriers. Community providers must already meet State licensure standards and applicable professional training requirements to practice. Imposing additional, VA-specific mandatory training requirements could deter provider participation or reduce

network adequacy without clear evidence of incremental safety benefit. VA's approach, therefore, prioritizes patient safety monitoring, quality oversight, and compliance with existing state licensure standards while avoiding duplicative requirements that may negatively affect access.

In both areas, VA's assessment concluded that risks are mitigated through structured oversight, performance monitoring, and alignment with established state licensure standards, while preserving provider participation and Veteran access to care.

Question 20: What risk mitigation strategies, beyond the ability to “off-ramp” vendors, does CCN Next Gen implement to prevent contractors from using tools like capitated payment models and risk-adjustment, which incentivize contractors to over diagnose Veterans and ration their care? Please share all pertinent planning documentation.

VA Response: In addition, CCN Next Generation establishes a multi-layered, VA-controlled quality and program integrity framework designed to ensure that financial incentives align with Veteran health outcomes — not volume or diagnostic intensity. VA retains authority over referrals through the VA-approved Request for Service (RFS) process. Contractors operate under a Quality Assurance Surveillance Plan, mandatory clinical governance committees, VA-approved predictive analytics, and structured peer review and utilization management processes. Performance is continuously monitored, audited, and in certain areas tied to incentives and disincentives, with VA retaining authority to validate data and override contractor findings. Quality steerage is based on clinical performance, documentation compliance, and value-based metrics — not risk-score maximization. Together, these safeguards create a payer-grade oversight model that protects Veterans from inappropriate utilization, over-diagnosis, or financial gaming.

Question 21: You have modeled much of this program after Medicare Advantage, which is rife with fraudulent overpayments and inefficiencies. What risk mitigation strategies, beyond the ability to “off-ramp” vendors, are you implementing to prevent issues like overpayments?

VA Response: In an effort to establish best practices in community care risk mitigation, CCN NG utilizes lessons learned from several programs (including Medicare Advantage) to incorporate robust program integrity requirements designed to prevent improper payments and detect fraud, waste, and abuse (FWA). Contractors must implement internal controls, conduct pre- and post-payment reviews, support audits, and report findings to VA while cooperating with investigative authorities. These safeguards strengthen accountability and transparency while reinforcing VA oversight of

taxpayer resources. Each contractor must maintain a Compliance Committee and Compliance Officer and report error rates, remediation plans, and integrity efforts to VA. Anti-FWA controls must identify fraudulent billing patterns on both a pre-payment and post-payment basis, and payments must be suspended within one business day when VA determines there is a credible allegation of fraud.

Question 22: What risk mitigation strategies and detailed planning have you conducted to move beyond large, vertically integrated vendors in your initial task orders to smaller TPAs? Please share all pertinent planning documentation with me.

VA Response: Vertical integration does not reduce VA's authority — it can strengthen it. By aligning network management with clinical and financial accountability, VA gains clearer visibility into performance, stronger tools to manage utilization, and greater leverage to hold contractors accountable. Importantly, CCN Next Generation preserves competition and gives VA the ability to audit performance and off-ramp underperforming contractors, ensuring integration serves Veterans. For Veterans, this is about speed, coordination, and reliability. When clinical, network, and payment functions are aligned, Veterans are less likely to face delays, administrative handoffs, and inconsistent care pathways. At the same time, stronger cost control helps ensure the long-term sustainability of community care — so VA can continue delivering timely access without compromising quality. Veterans should not have to navigate a fragmented system to receive care. Integration helps create a more coordinated experience — faster appointments, clearer accountability, and better continuity.

Question 23: What risk mitigation and detailed planning have you conducted to prevent your TPA vendors from building networks that prioritize providers they own? Please share all pertinent planning documentation with me.

VA Response: VA structured CCN Next Generation with layered oversight, transparency, and enforcement controls specifically to prevent contractors from building networks that prioritize affiliated or owned providers. VA—not the contractor—sets and enforces network adequacy standards, requires formal Network Adequacy Plans, and mandates ongoing network build reporting to ensure visibility into provider recruitment patterns. Contractors cannot justify network gaps based solely on an “inability to contract,” and any waiver from adequacy standards requires documented, evidence-based justification and formal VA approval. Accreditation and credentialing safeguards, including exclusion list checks and Continuous Query monitoring through the National Practitioner Data Bank, apply uniformly to all providers. VA also maintains direct claims transparency through required submission of original claim files and use of VA-directed

clearinghouses, enabling independent monitoring of utilization and referral patterns. Program integrity requirements explicitly address illegal referral arrangements and self-referrals, supported by mandatory FWA risk assessments and audit mechanisms. Together, these controls ensure VA retains visibility, authority, and enforcement leverage.

Question 24: Will VHA know exactly which providers in your TPA networks are owned by the TPA? What data will VHA collect to prevent these relationships from becoming a conflict of interest? Please share all pertinent planning documentation with me.

VA Response: VHA will have visibility into providers participating in the contractor's network, credentialing documentation, and related compliance records upon request. This gives VA transparency into network composition and provider relationships. VHA also collects referral- and appointment-level data through its referral and authorization system, including provider name and scheduling status, along with required reporting when scheduling assistance is exercised. These data allow VA to monitor referral patterns and utilization trends. Finally, credentialing requirements and Federal exclusion list screening, combined with program integrity standards prohibiting improper referral arrangements, provide safeguards to detect and address potential conflicts of interest within contractor networks.

Question 25: Why did you include scheduling assistance as an optional task included in your requests for proposal (RFPs)? How will you prevent TPAs performing this optional task from prioritizing referrals to the providers they own? Please share all pertinent planning documentation with me.

VA Response: Scheduling assistance was included as an optional task to give VA flexibility to improve Veteran access to care when additional support is needed, without making the contractor the default controller of referrals. VA retains authority over referrals through the VA-approved Request for Service (RFS), and any scheduling performed by the contractor must be documented in VA's referral and authorization system with detailed, auditable data and daily reporting when the task is exercised. To prevent inappropriate steering to owned providers, the contract reinforces that network participation does not guarantee referrals, requires transparent tracking of scheduling outcomes, and subject's referral practices to program integrity standards that prohibit improper financial arrangements. Because the task is optional and exercised at VA's discretion, VA can scale, modify, or remove scheduling authority if performance data indicates concerns. In developing a tiered provider network of eligible providers under paragraph (1), the Secretary shall not prioritize providers in a tier over providers in any

other tier in a manner that limits the choice of a covered Veteran in selecting a health care provider specified in subsection (c) for receipt of hospital care, medical services, or extended care services under this section.

Question 26: At what date and time will the IVC's program management office overseeing CCN Next Gen contracts be at initial operating capability (IOC)? Full operating capability (FOC)? Please share all pertinent planning documentation and timelines with me.

VA Response: VA is still in the planning phase, but this will be fully operational before CCN NG award.

Question 27: You have shared that you plan to spend \$2 trillion on modernizing and improving direct care operations and facilities with VHA. What is your strategic plan for this component of VA's VHA modernization? As you affirmed during this hearing, please share all pertinent planning documentation with me, including timelines, impact assessments, meeting attendees and all stakeholders/offices who participated in this process. Please also provide me with your detailed expenditure breakdown that provides a full accounting of this \$2 trillion.

VA Response: Based upon the Enrollee Healthcare Projection Model (EHCPM) used to formulate the Fiscal Year 2027 President's Budget Request (Scenario BAD4), the 10-year analysis shows the VA estimates spending ~\$1.6 trillion on Direct health care (see below table). The EHCPM analysis utilized workload through FY 2024 to reflect emerging information on the enrollee population and their use of VA health care. These analyses are tied to the most recent fiscal years of data and establish assumptions that are based on this recent information, which then persist throughout the full EHCPM projection period or are adjusted to reflect expected changes.

VHA Finance analysis		
	MCC payments ^{1/}	Direct Care ^{2/}
2027	\$47,318,274,364	\$112,694,229,643
2028	\$51,191,693,426	\$121,819,814,114
2029	\$54,778,813,447	\$132,510,439,680
2030	\$58,435,767,547	\$143,561,456,729
2031	\$62,306,087,172	\$155,063,682,502
2032	\$66,490,593,862	\$167,306,622,806
2033	\$70,319,247,224	\$178,871,530,626
2034	\$74,135,284,878	\$190,784,250,855
2035	\$77,729,421,256	\$202,305,328,518
2036	\$81,301,086,948	\$214,239,316,879
Totals	\$644,006,270,123	\$1,619,156,672,352

1/ Excludes CHAMPVA, FMP, TPA Costs, State Homes

2/ Excludes Non-Recurring Maintenance, Caregiver

Question 28: Of the 25 new healthcare clinics VA opened in 2025, how many of them were planned, sourced, and initiated entirely under Secretary Collins' leadership?

VA Response: Planning for many of these facilities have been years in the making, including dating back to President Trump's first term.

Question 29: You testified that VA is spending \$5 billion in fiscal year 2026 on maintenance and deferred maintenance projects for VA medical facilities. What, if any, of these projects are for facilities in Illinois or in the St. Louis metropolitan area? Please provide me with your detailed breakdown that provides a full accounting of this \$5 billion.

VA Response: VA has provided two attachments that detail the list of awards for both Illinois and St. Louis, MO, as of March 9, 2026. VA is unable to share the full list of remaining projects, as the information is acquisition sensitive. However, VA can confirm that as of March 9, 2026, fiscal year 2026 non-recurring maintenance had produced 68 awards in the past 14 days, totaling \$897 million in total obligations.

**U.S. Department of Veterans Affairs
September 2026**

FY2026 Obligated Non-Recurring Maintenance (NRM) Projects



Project Title	VISN	Facility Name	City	State	FY Quarter	Number of Obligations Last 14 Days
Construct SCI Recreational Activities Area	12	Hines VAMC	Hines	IL	Q1	68
Abatement Monitoring Task Order E	12	Hines VAMC	Hines	IL	Q2	
Arc Flash	12	Chicago VAMC	Chicago	IL	Q1	
B7 Roof Drain Improvements (NAVFA)	12	North Chicago Federal Health Care Center	North Chicago	IL	Q2	
Bldg. 1 Soffit, Fascia and Flashing Replacement (NAVFA)	12	North Chicago Federal Health Care Center	North Chicago	IL	Q2	Click to View New Obligations Click to View All Obligations
Bldg1 Renovation Demolition and Abatement	12	North Chicago Federal Health Care Center	North Chicago	IL	Q2	
Bldg37 Envelope (NAVFA)	12	North Chicago Federal Health Care Center	North Chicago	IL	Q1	
Cast Iron Fitting Survey (Action 28194)	12	North Chicago Federal Health Care Center	North Chicago	IL	Q2	
Chiller and Air Handler Replacement	12	Illiana HCS	Danville	IL	Q1	
Correct Mental Health Safety Deficiencies	12	Chicago VAMC	Chicago	IL	Q1	
EHRM Infrastructure Upgrades – Chicago, IL	12	Chicago VAMC	Chicago	IL	Q2	
EHRM Infrastructure Upgrades – Danville, IL	12	Illiana HCS	Danville	IL	Q1	
EHRM Infrastructure Upgrades – East Campus - North Chicago, IL	12	North Chicago Federal Health Care Center	North Chicago	IL	Q1	Total of All Obligations \$897.58M
EHRM Infrastructure Upgrades – Hines CMOP, IL	12	HINES CON MAIL OUTP PHAR CMOP	Hines	IL	Q2	
EHRM Infrastructure Upgrades – West Campus - North Chicago, IL	12	North Chicago Federal Health Care Center	North Chicago	IL	Q1	
Emergent Repairs North Water Tower 71	12	Illiana HCS	Danville	IL	Q2	
FCA - Replace West Side of Building 38 Roof	15	Marion VAMC	Marion	IL	Q1	

This list shows Non-Recurring Maintenance (NRM) projects obligated through the date shown above. These projects focus on essential infrastructure improvements at health care facilities to ensure safe, effective patient care.

Data Current as of 3/9/2026 @ 11:00 A.M

FY2026 Obligated Non-Recurring Maintenance (NRM) Projects



U.S. Department of Veterans Affairs
Department of Health and Human Services
Healthcare Environment and Facilities Programs

Project Title	VISN	Facility Name	City	State	FY	Quarter	Number of Obligations Last 14 Days
Abate Environmental Issues, Building 3, JC	15	St. Louis HCS	St. Louis	MO	Q1		68
Conduct Hazardous Material Abatement 2025, JC, JB	15	St. Louis HCS	St. Louis	MO	Q1		
Correct Electrical Deficiencies from 2016 Electrical Assessment	15	St. Louis HCS	St. Louis	MO	Q1		
Correct Fall Protection Hazards, JB	15	St. Louis HCS	St. Louis	MO	Q2		
Correct Heating, Ventilation, and Air Conditioning Systems for VHA Directive 1116(2)	15	St. Louis HCS	St. Louis	MO	Q1		Click to View New Obligations Click to View All Obligations
Correct Mail Room QCR Issues, JB	15	St. Louis HCS	St. Louis	MO	Q2		
FCA - Create Code Compliant Research Laboratory Space in Building 1	15	St. Louis HCS	St. Louis	MO	Q2		
FCA - Replace Hot Water Generators in Buildings 53, 51 & 24	15	St. Louis HCS	St. Louis	MO	Q2		
FCA - Upgrade Electrical Distribution, Building 3	15	St. Louis HCS	St. Louis	MO	Q2		
Prepare Site for New Accuracy Tomotherapy Unit, A008, JC	15	St. Louis HCS	St. Louis	MO	Q2		
Renovate Ambassador Suite Building 1	15	St. Louis HCS	St. Louis	MO	Q1		
Repair Parking Lots and Roadways, JC	15	St. Louis HCS	St. Louis	MO	Q1		
Repair Site Features, Including Lots and Roadways, JB	15	St. Louis HCS	St. Louis	MO	Q2		
Repair Water Main Break, Near Bldg. 4	15	St. Louis HCS	St. Louis	MO	Q2		

Total of All Obligations

\$897.58M

This list shows Non-Recurring Maintenance (NRM) projects obligated through the date shown above. These projects focus on essential infrastructure improvements at health care facilities to ensure safe, effective patient care.

Data Current as of 3/9/2026 @ 11:00 A.M