

**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important oversight hearing of the Subcommittee on Health. DAV is an organization of 1.2 million wounded and injured veterans, and is dedicated to empowering veterans to lead high-quality lives with respect and dignity; ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life.

We appreciate the Subcommittee's leadership in overseeing the Department of Veterans Affairs (VA) contract and purchased health care programs, including fee basis medical services, contract hospitalization, and scarce medical specialist services contracting, on which many service-connected disabled veterans must rely for their care. DAV recognizes these programs are essential in providing access to vital health care to veterans, but significant improvements are needed.

The delegates to DAV's most recent National Convention passed Resolution No. 212 regarding VA's purchased care program. Our resolution urges Congress and the Administration to conduct stronger oversight of the non-VA purchased care program to ensure service-connected disabled veterans are not encumbered in receiving non-VA care at the Department's expense.

This resolution also urges VA to integrate and promote care coordination with all non-VA purchased care programs and services. Such coordination should include provider credentialing, case management, ensuring quality of care and patient safety, timely processing of claims, reimbursing at adequate rates, integrating records of care with VA's electronic health record, and scheduling appointments through a centralized process. With the exception of the ongoing Project on Healthcare Effectiveness through Resource Optimization (Project HERO) pilot program,¹ today's VA contract and purchased care programs do not exhibit most of these attributes.

¹ Project on Healthcare Effectiveness through Resource Optimization (See H. Rept. 109-305 for the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (P.L. 109-114). Project HERO's dental contract with Delta Dental of California will end September 30, 2012. Project HERO's medical and surgical contract with Humana Veterans Healthcare Services, Inc. is intended to be extended for six months to March 31, 2013.

Under current law, VA practices three basic approaches in furnishing non-VA care: pre-authorized fee-for-service arrangements (called Non-VA Fee Care); contract care, including obtaining scarce medical specialists; and sharing agreements with the Department of Defense and VA's academic affiliates and their associated professional groups.

Non-VA Fee Care

The statutory authority for fee basis health care is title 38, United States Code, section 1703. This section authorizes VA to contract for inpatient care and limited outpatient care by contract or individual authorizations for certain categories of veterans, when VA facilities are unable to provide needed care, or when VA facilities are geographically inaccessible to those veterans. This contracting authority is not limited to contracts that contain prices negotiated between VA and non-VA providers, but of individual authorizations that serve as price offers to non-VA providers chosen by eligible veterans. Contract hospitalization is generally reserved to emergency situations for which VA reimburses contract hospitals at Medicare rates.

Notably, the purpose of fee-basis health care is addressed in the regulatory authority which implements the statutory authority granted by section 1703. Specifically, title 38, Code of Federal Regulations, section 17.52, allows for individual authorizations when demand is only for "infrequent use." Over the past several fiscal years, however, expenditures for fee basis services have been rising dramatically. In fiscal year (FY) 2005, VHA spent approximately \$1.6 billion serving approximately one-half million veterans. By FY 2011, that amount had increased by 185% to approximately \$3 billion, serving nearly one million veterans. This expenditure now comprises an estimated 9 percent of VHA's total medical services appropriation.

In addition to our organization's concern regarding the lack of care coordination and rising costs in fee care, specific concerns have been raised by others. The program is highly decentralized to the facility level, and lacks a standardized business process across the VA health care system. These concerns and others were raised by the National Academy of Public Administration (NAPA) in its 2011 analysis of VA's organizational model supporting the fee-basis program, and by VA's Office of Inspector General (OIG) regarding the significant number of improper payments and the need for improvement in risk assessment in fee care.

Generally, fee basis and contract hospitalization are unmanaged, are not governed by a program office locally, are not standardized or consistent across the system, do not exhibit "patient-centered care" attributes that characterize VA's internal care programs, and their costs to VA have surged over the past decade without sufficient action being taken to ensure program integrity, efficiency, and integration in the Department's health care system.

In general, VA agreed with the observations and recommendations of OIG. DAV is aware of the Department's efforts to address these concerns. Among such efforts is the Non-VA Care Coordination (NVCC) project, which is a focus of today's hearing.

Non-VA Care Coordination

The Non-VA Care Coordination (NVCC) project is part of a major initiative VA calls Health Claims Efficiency (HCE). The purpose of HCE is to coordinate and accelerate the ongoing cost savings initiatives with new initiatives to allow VA to enhance services to veterans.² Specifically, this initiative includes reducing operational costs and streamline program deployment to enhance program efficiency, achieving cost savings through consolidated purchasing and reducing variability in non-VA care coordination clinical and business practice.

Currently VA lacks industry standard automated tool sets to identify and take action on improper payments, including fraud, waste and abuse. Further, while fee care's information technology systems and infrastructure have been improving, they have not been updated for cost effectiveness due to local variations in how they are established. DAV believes VA should continue to pursue private sector IT solutions to modernize the processing of non-VA health care claims.

With care coordination included in its name, a fully implemented NVCC as envisioned by the Chief Business Office will include improvements to patient-facing aspects of fee care. These include timely patient notification of Fee Care approval, appointment scheduling assistance, tracking appointments for completion, health care information sharing and timely notification of results to the patient as well as the VA provider responsible for the fee care referral.

DAV applauds VA for taking steps in the right direction to meet the goals of DAV Resolution No. 212 to provide proper care coordination in fee care and to make care coordination a standard business practice. To ensure these new processes are being achieved in each VA facility, we have requested from VA results for key metrics for this and other focus areas. Until DAV has had the opportunity to review these results, we are unable to provide further comment on NVCC and whether this initiative will address concerns outlined in this testimony.

The 2011 NAPA report observes that the organizational, administrative, and technological systems used to operate and manage fee care have not kept pace with the unprecedented growth of fee care. Unlike OIG reports, VA comments were not part of the report and DAV is unaware of any public response from the agency regarding the NAPA report.

Madam Chairwoman, it should be noted that VA is authorized to attempt to recover any improper payments. VA also has the authority to bill third-party health insurers for non-VA care. DAV believes that internal controls should be improved to help prevent improper payments for non-VA fee care, and recovery auditing and third party billing should be included as a part of this Subcommittee's oversight and the Department's overall strategy to improve VA's purchased care programs.

² Department of Veterans Affairs Strategic Plan Refresh, FY 2011-2015.

Project HERO and Patient Centered Community Care

Under section 8153, the VA exercises discretionary authority to use contracts and sharing agreements with non-VA providers as a means to provide hospital care and medical services (defined in title 38, United States Code, section 1701) to all enrolled veterans. The stated purpose of VA's contracting authority under section 8153 is "[t]o strengthen the medical programs at Department facilities and improve the quality of health care provided veterans under this title by authorizing the Secretary to enter into agreements...while ensuring no diminution of services to veterans." Since the law does not address quality of care and care coordination, it only partially meets the goals of DAV Resolution No. 212.

VA has informed DAV of its plan to rely on the authority of section 8153 to create a new approach to centrally supported health care contracting, to be provided throughout the VA health care system. The program is to be entitled "Patient Centered Community Care" (PCCC). This effort is described by VA as a "soft approach" to contracting, but that it will apply lessons learned from Project HERO, now in its fifth and final year.

According to VA, the goal of PCCC is to create centrally supported health care contracts available throughout the VHA to provide veterans coordinated, timely access to high quality care from a comprehensive network of VA and non-VA providers. VA has completed a draft specification for PCCC, and we understand PCCC may include contracts covering five regional subdivisions with standards for access to care, quality of care, and medical documentation to facilitate the provision of care. Further, use of contract services under the PCCC umbrella will receive priority over other non-VA care options.

VA has repeatedly assured DAV that the care coordination that patients experienced under Project HERO will be made part of PCCC, but as of this date we are uncertain of these particulars. Information in more concrete terms will become available in VA's official Request for Proposals (RFP), which VA currently projects will be released in November 2012, with contract awards in March 2013. Given the national scope and complexity of this change by VA, the challenging history of contract care, and the current leadership vacuum in VA's Chief Business Office, we believe these plans may be overly optimistic. While building on the successes in Project HERO, this is an untested concept for the VA health care system, and one that is not intended for pilot-testing for effectiveness.

DAV considers Project HERO to have been a moderate success story. The Chief Business Office in VA Central Office and the contractors, Humana Veterans Healthcare Services, Inc., and Delta Dental, responded effectively to veterans service organizations' early expressions of concern about the potential for Project HERO to be corrosive or even destructive to Congress's intention that VA's contracting authorities be used to strengthen medical programs at VA facilities and improve the quality of health care while ensuring no diminution of services to veterans. While Project HERO is meeting those goals now, VA field facilities have been slow to utilize Project HERO principally because Project HERO lies low on a multi-tier algorithm used by VA fee-basis clerks, after their considering existing sharing agreements and availability of accessible services at other nearby VA facilities, but before authorizing unmanaged fee-basis services as described above. As a result, the volume of referrals to Project HERO has been low.

We believe the current approach in Project HERO is a good model for VA to pursue as it moves to the next phase in reforming non-VA purchased care. We have concerns nevertheless that VA will struggle to establish in-house the kinds of services, supports and provider networks that are available within the large managed care systems such as Humana and Delta Dental in fashioning the PCCC effort. In addition, we are concerned PCCC contractors will have too short an implementation period between the time contracts are awarded and when they become operational to establish robust networks of providers.

We applaud VA for announcing its intent to extend Project HERO for six months beyond the final option year that ends on September 30, 2012. Nevertheless, DAV urges VA to extend Project HERO for such additional time until VA has built its own capacity or determines to rely on a contract managed care firm (or firms if the program is regionally dispersed) to handle the workload of VA purchased care. Ending the Project HERO pilot program premature to VA's completing its new initiative would leave ill and disabled veterans, including many of our members, in jeopardy, and could lead to higher costs for non-VA care through the legacy fee-basis program. When VA reaches a confidence level that PCCC is an adequate replacement for Project HERO or any other non-VA health care contract, then and only then should it be ended.

Need for Reorganization of All Fee and Contract Services

VA has a long and distinguished record of providing social support services (including health care services) to veterans, but VA continually struggles to provide adequate business-related services as a part of its responsibility. We see those problems reflected brightly here. We have witnessed this struggle year-in and year-out within the activities of the Chief Business Office, both in terms of its managing VA first- and third-party collections from veterans and health insurers, as well as its lack of management controls over these contract health care programs. With this backdrop we are doubtful that VA will be able to properly construct, staff, and manage a program overseeing VA contract health care that will perform as well as the Project HERO contractor is performing now. We urge the Subcommittee to closely examine VA's plans and make its own determination, but we hope the Subcommittee and VA will take our concerns into account. At minimum, we believe PCCC should be judiciously deployed and carefully expanded to ensure veterans are unencumbered when accessing contracted health care.

Madame Chairwoman, given the cost of this program and its importance to DAV and our service-disabled members, we believe bolder action is required than is currently envisioned by VA in NVCC and PCCC. In our view, the VA Chief Business Office is not the correct organization to build this new system. That office should concentrate on its original and basic mission to improve VA revenue performance for first- and third-party payments.³ VA instead should establish in Central Office a new contract care services management office, charged with the responsibility to use managed care industry best practices in establishing new approaches to VA purchased health care for veterans, taking fully into its jurisdiction all non-VA purchased

³ In May 2002, VA established the Chief Business Office in its Veterans Health Administration (VHA) to underscore the importance of revenue, patient eligibility, and enrollment functions; and to give strategic focus to improving these functions by directing VHA's Revenue Office and to develop a new approach for VA's first- and third-party collections activity.

care under current law. All of these programs have been criticized at one time or another by external reviewers and this may be VA's best opportunity in years to respond effectively to improve them. We believe a new office of this type—if staffed by professionals experienced in private health insurance and the managed care enterprise—could concentrate these similar programs (in which VA pays a non-VA party for the care of a veteran, dependent or survivor) under one management structure, integrated with the VA health care system; clarify accountability for policy and practice effectiveness across the system; and set standards for compliance and reporting.

This new office should coordinate with the TRICARE Management Agency (TMA) in the Department of Defense in developing its plans and policies, and as well with the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services. The TMA office has more than two decades of experience in dealing with managed contract care policy and practice for a very large constituency of military service members, their families and the military retired community. The CMS is the federal government's expert on both health care and pricing policies.

The end goal of this new office would be to allow veterans and other eligible family members to live a higher quality of life with respect and dignity, through receipt of better services, including care coordination, continuity and quality of care, at a defensible and lower cost to VA and taxpayers. Absent this kind of bold action and change, DAV fears that VA's poor record in the management of contract and purchased care will not be corrected or improved.

Madame Chairwoman, thank you for this opportunity for DAV to testify on an important topic to our members. I would be pleased to address your questions, or those of other Members of the Subcommittee.