THE U.S. DEPARTMENT OF VETERANS AFFAIRS' IMPLEMENTATION OF THE ENHANCED CONTRACT CARE PILOT PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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THURSDAY, APRIL 29, 2010

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

The Subcommittee met, pursuant to notice, at 10:16 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Rodriguez, Halvorson, Perriello, Brown of South Carolina, Moran, Boozman, and Buchanan.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to ask the Committee to come to order. And I want to thank everyone for being here today.

I would now ask the first panel and only panel to come forward. We have Pat Vandenberg from the the U.S. Department of Veterans Affairs (VA) who is accompanied by Gita Uppal. I want to thank you both for coming today.

The purpose of today's hearing is to examine the VA's implementation of the Enhanced Contract Care Pilot Program for rural veterans. This pilot program was authorized in the 110th Congress and has an effective date of 120 days after October 10th of 2008. However, the pilot program remains unavailable to eligible veterans.

I want to thank Congressman Moran for introducing this legislation back in the 110th Congress and his continued support to make sure that veterans, regardless of where they live, have access to the health care that they need.

About 40 percent, or nearly 3 million veterans who use the VA health care system live in rural areas, which includes over 100,000 veterans who reside in highly rural areas. This trend is likely to continue since a large number of the men and women serving our country in Iraq and Afghanistan are recruited from our rural communities.

I recognize and appreciate the VA's effort to address the health care needs of our rural veterans who are more likely to be in poorer health than those in urban areas. However, more work remains in this area as our rural veterans face unique challenges that are both extensive and complex.

The Enhanced Contract Care Pilot Program is a potential tool for expanding access to health care for our rural veterans, veterans in areas where VA is unable to provide care.

I would like to learn more about the steps that the VA has taken to implement an Enhanced Contract Care Pilot Program. I also would like to fully understand any potential barriers that are hindering the implementation of this important pilot program. And I look forward to hearing the testimony of our witness today.

I would now like to recognize Mr. Brown for any opening statements that he may have.

[The prepared statement of Chairman Michaud appears on p. 21.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

As always, I appreciate your leadership and thank you for holding this hearing today to review the status of VA's implementation of the Enhanced Contract Care Pilot Program enacted into law in the 110th Congress as section 403 of Public Law 110–387.

I also want to commend my good friend and colleague from Kansas, Jerry Moran, for his work and continued commitment to serving rural veterans.

Jerry was responsible for the Rural Veterans Access to Care Act which led to the establishment of this 3-year demonstration project to allow highly rural veterans to receive covered services through non-VA providers.

Of the almost 8 million veterans enrolled in the VA health care system, approximately 3 million reside in rural areas. Often these veterans face incredible difficulties in accessing VA health care. Many must find transportation and traverse hours across rough terrain to reach the nearest VA hospital. If a round trip is not possible in 1 day because of distance, the rural veteran and their family may be compelled to stay overnight.

These difficulties can make even routine medical appointments an expensive and lengthy chore and discourage rural veterans from using the health benefits to which their service entitled them.

Helping to ease that burden and ensure that even those veterans who chose to make their homes in the most rural areas have access to the high-quality care they deserve is a priority of all of us on this Subcommittee. And this pilot is very important to determine ways to best serve our veterans residing in highly rural areas.

As more and more veterans return to their rural homes from Operation Enduring Freedom and Iraqi Freedom and rural veterans from earlier wars continue to require care, we must continually evaluate our actions and determine what more can be done to provide timely and appropriate access to medical care.

In that vein, I am eager to hear from the VA this morning on what the Department is doing to implement the law and what additional steps will be taken to ensure its success.

I thank you for coming today, and I yield back.

[The prepared statement of Congressman Brown appears on p. 21.]

Mr. MICHAUD. Thank you, Mr. Brown.

Do any other Committee Members have an opening statement?

[No response.]

Mr. MICHAUD. Hearing none, once again, I want to thank Pat Vandenberg for coming.

Pat, as I mentioned earlier, is the Assistant Deputy Under Secretary for Health for Policy and Planning and is also Acting Director of the Office of Rural Health for the Veterans Health Administration (VHA).

I appreciate your willingness to take on dual responsibilities. And it is my understanding that we are closer to having a full-time Director of the Office of Rural Health and look forward for that individual coming onboard so we can have real attention paid to rural health issues.

So without any further ado, Ms. Vandenberg.

STATEMENT OF PATRICIA VANDENBERG, M.H.A., B.S.N., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, AND ACTING DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GITA UPPAL, DIRECTOR, POLICY ANALYSIS, OFFICE OF POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. VANDENBERG. Thank you, Mr. Chairman. I thank you for the invitation to meet with you today and describe the VA's progress in implementing section 403 of Public Law 110–387.

Joining me today is Gita Uppal, the Director of Policy Analysis, who has been the lead on the implementation of this pilot project.

Section 403, as you well know, requires VA to conduct pilot programs to provide non-VA health care services through contractual arrangements to eligible veterans. The statute directs that the pilot programs be conducted in at least five Veterans Integrated Service Networks (VISNs). VA has determined that VISNs 1, 6, 15, 18, and 19 meet the statute's requirements.

The statute defines a veteran to be highly rural on driving distance to the nearest VA health care facility. Veterans are also considered highly rural and eligible to participate in this pilot if they experience hardship or other difficulties in travel. Details of what constitutes hardship are not specified in the law, so VA is formulating regulations to define this term with sufficient clarity to provide practice standards.

Immediately after the law was enacted, VA established a cross-functional, multidisciplinary work group with a wide range of representatives from various VA program offices as well as VISN representatives to identify issues and develop an implementation plan.

VA soon recognized that the pilot program could not be commenced in the 120 days of the law's enactment as required and in March 2009, VA officials briefed Subcommittee staff on these implementation issues.

The first challenge that VA shared with Congress was the statute's definition of highly rural. The statute uses driving distances to define a highly rural veteran whereas VA uses Census Bureau definition and defines a highly rural veteran as a veteran who resides in a county with fewer than seven civilians per square mile.

VA has developed our data systems based on the Census Bureau definition and uses these systems to identify highly rural veterans.

To implement the law, we knew that we would need to reconfigure our data systems to identify travel distances for each enrolled veteran for multiple VA facilities, conduct analysis to identify eligibility according to the statute's definition, and develop enrollment and utilization projections for the pilot program using the definitions in the law. VA completed this reconfiguration and analysis in October 2009.

The second challenge involves the term hardship which VA needs to define through regulations. This process involves many steps, as you well know, including public review and comment and can take up to 24 months to complete.

VA notes that section 308 of S. 1963, which was recently enacted by Congress, would amend that requirement regarding hardship exception and the mileage standard.

We believe these changes will facilitate faster implementation of the program and we are very grateful to the Committee for including these technical amendments in the Caregiver and Veterans Omnibus Health Services Act of 2010.

While progress has been slower than you expected and than we would have liked, VA has made notable strides in implementing this law. And the goal is to have the pilot program operational in the latter part of 2010 or early 2011.

Specifically VA has taken the following actions. We have developed a comprehensive implementation plan, which contains the work group's recommendations on implementing the various implications of the pilot program.

We have analyzed the driving distances for each enrollee to identify eligible veterans using the drive distance criteria and reconfigured our data systems and now we will make whatever accommodation is necessary in light of the technical change.

We have provided eligible enrollee distribution maps to each of the participating VISNs to aid them in their planning for potential sites.

We have developed an internal request for proposal and disseminated that to the five VISNs for proposals on potential pilot sites.

We have developed the application form, which the veterans participating in this program will use.

We have formulated the definition of hardship, but in light of the technical changes, we may not have to use that.

We have also taken extensive action to leverage the insights from Project HERO, the Healthcare Effectiveness through Resource Optimization pilot, and adapted those insights for this pilot project.

VA will assemble an evaluation team of subject matter experts to review the proposals that are submitted by the five VISNs. This team will then recommend specific locations for approval by the Under Secretary for Health. We anticipate this process will be complete this summer. After sites have been selected, VA will begin the acquisition process.

Since this process depends to some degree on the willingness of non-VA providers to participate, we are not able to stipulate exactly when the pilot can commence. However, we are using all of the resources and insights gained through Project HERO and contracting specialists to expedite the process. This would allow us to

begin the pilot, as I said a minute ago, in the latter part of this year or early 2011.

So we thank you today for the opportunity to come before you to discuss progress. We believe that this pilot will give us a further opportunity to explore innovative approaches to providing health care for veterans in remote areas and we are eager to proceed with the implementation.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Vandenberg appears on p. 22.]

Mr. MICHAUD. Thank you very much, Ms. Vandenberg.

I have several questions. However, I will recognize Ranking Member Brown first to begin with his questions.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you. Madam Secretary, have you identified providers to participate in the pilot and if not, why not? And are you expecting challenges regarding the willingness of non-VA providers to participate in the pilot program?

Ms. VANDENBERG. Mr. Brown, we have not identified providers at this point. We are focused at this stage on identifying the sites that the VISNs believe will be the appropriate sites. And then the next step in the process would be to announce the opportunity to serve these veterans at which point, the provider community will be engaged.

We do not have any specific understanding at this point that we will not have a welcome reception in the provider community. However, we do know in other instances in rural health service delivery that not every community has an adequate number of providers who are interested in working with VA.

So we do not see any absolute impediments at this point in time.

Mr. BROWN OF SOUTH CAROLINA. In the structure of locating providers, how would you classify their reimbursement? Would it be based on Medicare or Medicaid reimbursement? How would you determine that?

Ms. VANDENBERG. Sir, I will have to take that question for the record. And I would just observe that there are a number of discussions underway right now regarding reimbursement and various contracting activities that we pursue for various components of VA health care.

And so this is an area of interest and concern to some stakeholders. So we will provide the technical response to your question for the record, but I am sensitive to the fact that the provider community does have concerns about the level of reimbursement that they are able to achieve in VA contracting in some communities.

[The VA subsequently provided the following:]

> In general, the Department of Veterans Affairs (VA) utilizes Medicare reimbursement rates as a standard in determining appropriate pricing when purchasing health care services. While final agreements may be either higher or lower than Medicare, it is VA's desire to maintain this Federal health care pricing standard whenever possible.

Mr. BROWN OF SOUTH CAROLINA. That is the reason I asked because I think in order to attract the proper providers, you are going to have to have some initiative to encourage them to participate.

I know in South Carolina, we have a lot of rural health care centers already established. And I do not know whether part of your

plan was to try to interact with some of those rural health care centers.

Ms. VANDENBERG. Our goal is to secure the services of qualified providers that will optimize the performance of this pilot. And so at this point, we do not have any parameters set that would preclude any willing provider from participating in the contracting process.

Mr. BROWN OF SOUTH CAROLINA. All right. Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Perriello. I should say, Mr. Rodriguez, do you have any questions?

Mr. RODRIGUEZ. Let me ask you. I know I represent probably one of the largest districts in the country. It stretches 650 miles straight and then about 800 miles through the border. And in the middle of there, it is cut into two districts.

I have people from my area in Texas that have to go all the way to Albuquerque, New Mexico, for services. I know that there are some expansions that are looking at El Paso, which is a lot closer, however this is still 200 to 300 miles away.

In that area, I think there was a little contract in one of the communities and it did not go well in terms of the payment problems, that were taking 2, 3 months to pay, this kind of problem.

Have we looked at this in terms of what we have done in the past and how we can improve on this because I know that we are waiting, providers are waiting 3 months before they got reimbursed?

Ms. VANDENBERG. Yes, sir, I have. And I would also observe that there is a representative on the Veterans Rural Health Advisory Committee that the Secretary has established from Texas. And she has made us very aware of some of the practical implications of contracting and timely payment of contractors.

In the instance that you are citing, I think we have attempted to rectify that situation in terms of timely payment. We had a change in the provider group and needed to establish that new relationship and smooth out the payment mechanisms.

But I am familiar with at least one circumstance and I would be happy to entertain the particulars of the circumstance that you are referencing and follow up on that.

[The VA subsequently provided the following:]

> VA contacted the Chief Executive Officer of Community Health Development, Inc. in Uvalde, TX and a member of the Veterans Rural Health Advisory Committee to discuss issues regarding VA contract Community-Based Outpatient Clinics (CBOC) operations. VA acknowledges that there have been VA issues with timely payments of the contractor, and is taking steps to resolve the matter.

Mr. RODRIGUEZ. As we look in terms of providing those kind of services to our veterans, have we looked in terms of how comprehensive or what would be the type, for example, the first four or five types of services that we would provide for veterans?

Ms. VANDENBERG. Our initial emphasis in our conversations with the VISNs has been around primary care services since that is the cornerstone of the VA's model of care.

And we are also going to be looking out beyond primary services to what are the characteristic patterns of need among that popu-

lation for specialty, subspecialty services. So we will look at the range of service that the veteran needs.

Mr. RODRIGUEZ. And if I could follow up with a question. I know that, ironically enough, we wanted access, but there are some that are willing to travel all the way to, to San Antonio, for example, 150 miles or 200 miles.

And they are indicating in that particular situation that they are required to go to that local clinic when they have had a relationship, even though it is 150 miles away, that they would prefer to do that.

Are we requiring them to go to that local facility?

Ms. VANDENBERG. I would have to take that question for the record in terms of the specifics of what the practice has been in that VISN and in that community. But let me just make an observation that I think is germane to this discussion.

[The VA subsequently provided the following:]

> Veterans may choose to receive VA health care services at any VA medical center. However, there are advantages to veterans using the site of care closest to their homes:
>
> - Continuity of care is enhanced by using a local site for all health care instead of just urgent or emergent care;
> - Timeliness of access to care is improved by reducing the distance to be travelled;
> - Costs of travel are reduced; and
> - VA's beneficiary travel regulations limit reimbursement to the veteran to the nearest site that is able to provide the service.
>
> While all services, particularly specialties, are not provided at each site of care within the El Paso and Big Spring catchment areas, both facilities have a system of referrals to other VA facilities or to community care through fee basis arrangement, depending upon what is most clinically appropriate. El Paso also utilizes arrangements with William Beaumont Army Medical Center (WBAMC) to provide care for veterans.

Ms. VANDENBERG. The major thrust in the Department of Veterans Affairs' Veterans Health Administration strategy at this time is for us to become more veteran-centric. And in our health care delivery, we have launched a major initiative referred to as the patient-centered medical home.

In that model, we are committed to asking the veteran their preference and attempting to honor that preference more systematically.

So in an instance where there are options, rather than instructing the veteran that they absolutely have to go one place or another place, working with that veteran to understand what best suits their health care needs and their preferences to the best of our ability.

So there may be two veterans, one preferring to receive care in that civic community and a second veteran for whatever reason preferring to travel to a VA facility, a VA provider, a community-based outpatient clinic (CBOC), or a VA medical center.

So I think our overall effort at this point in time is to in every way possible attempt to be more veteran-centric and hopefully when it comes to our rural and highly rural veterans, this new approach to our basic model of care will go a long way to better meeting their needs because we will be more attuned to what works for them.

Mr. RODRIGUEZ. I do want to thank you also because it has been really good, at least the last two, and the beauty of it is, I have not heard any more complaints except that more veterans are actually participating and showing up.

Ms. VANDENBERG. Well, I am aware of one instance where I know that my office intervened and basically pointed out to the VISN that we would have to do a better job.

Mr. RODRIGUEZ. Thank you. Thank you very much.

Mr. MICHAUD. Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you. Thank you for holding this hearing.

And, Ms. Vandenberg, thank you for being here.

I generally have a sense that the VA has worked hard and pursued this issue, so I am very appreciative of that. You have kept me and my staff informed, and so I am grateful for that.

Your testimony raises a significant concern for me, however. This started out as legislation that would affect the entire country. And if you lived a certain number of miles from a provider, you would then be eligible for VA care provided by a local provider.

It was narrowed to be a certain number of VISNs as a pilot or demonstration project. But your testimony suggests to me that we are now narrowing it even further and that you are going to do only a particular community within that VISN. And that is troublesome to me because we have went from a broad scope, taking care of a large number of veterans.

But we analyzed this and as the VA talked about its cost to me, it was never suggested that we were not going to provide the same opportunity for community-based service for every veteran who lived that number of miles—now that number of minutes—from a provider, from a VA provider.

Am I understanding the testimony correctly that now we are just going to select certain communities within the VISN and make that the pilot program?

Ms. VANDENBERG. We have asked the VISNs to identify multiple sites as focal points within their VISN for potentially standing up this pilot project. At this point in time, that is the direction that we are moving in.

We understood the wording in the law when it said the Secretary will select areas, sites, that that was permissible, that that was feasible in the pilot structure. So we are here obviously today to gain further insight from the Committee as to your expectations.

Mr. MORAN. That certainly would be different than my expectations, and Mr. Michaud and others may have an opinion, but I would be very critical of the concept that we are going to narrow the opportunities for veterans even further.

So, if you are a veteran that lives the number of minutes from a provider, you may or may not qualify depending upon whether the VISN Director decided that your community is one that now qualifies.

What I envisioned and what I hoped that the VA would pursue is that if you meet the definition of highly rural and you are in that pilot demonstration VISN, you qualify, and in effect, the VA has the obligation, finding a provider for you to meet your health care needs.

So I welcome additional dialogue. Maybe other Members of the Committee have an opinion in regard to the intention. But as I recall, the Congressional Budget Office (CBO) budget estimation did not narrow it one more step that you suggest may occur. So my red flag is up.

Ms. VANDENBERG. Thank you for the clarification, sir.

Mr. MORAN. You are very welcome.

The legislation that the President is now expected to sign, which redefines miles to minutes and the definition of, help me, the definition of——

Ms. VANDENBERG. Hardship.

Mr. MORAN. Thank you. Hardship. Will it speed up the implementation date? Do you have a sense that now we are moving ahead 6 months more quickly or——

Ms. VANDENBERG. It certainly will facilitate us not being impeded by the regulatory process. And so we believe that we are on a path at this point having issued the guidance to the field and asking them to identify sites. We may have to amend that per the conversation we are having.

But we do not see any firm impediment except for the fact that I referenced earlier, we have no way of knowing when this goes out to the provider community what the level of receptivity would be. So I would say that the rate of progress going forward will be a function of the contracting mechanism and the receptivity in the provider community to work with us.

Mr. MORAN. I think that receptivity will in part depend upon the reimbursement rate that you concluded is appropriate. And my understanding is that the VA's current fee base is fee based and you cover the entire cost of care. You provide health care for veterans with local providers today.

Ms. VANDENBERG. Yes, sir.

Mr. MORAN. And I think you cover the entire cost of doing so. That, I assume, would be the most desirable role model for the veteran and for the health care provider in getting this implemented and widespread use. So I am hoping that you take and you follow the same practice that you have been following in the past of how you reimburse hometown providers today.

Mr. Chairman, my time has expired, but I would welcome your input or the staff input on this issue of a pilot within a pilot. I am fearful that we are narrowing the scope and the number of veterans that we wanted to take care of across the country that was already narrowed to a certain number of VISNs, and we need to make sure, in my opinion, that it is not narrowed further so that you have to live in a particular community within that VISN in order to access this health care.

And I thank the Chairman.

Mr. MICHAUD. Thank you very much, Mr. Moran.

And you are absolutely correct. The intent was for this program to include the VISN, the whole VISN, and not a pilot within that VISN. I believe we actually received a CBO score predicated on the full VISN, not on pilots within that VISN. And you are 100 percent correct that the intent of the legislation was for the program to be conducted through the full VISN.

And that is a concern because this is not the first time we have seen the same thing happen. We actually saw it back in legislation that was passed in 2006 relating to State veterans nursing homes, which required the VA to provide the full cost of health care for veterans. Through the rule-making process, the VA narrowed that down to what full cost meant for the VA. And we are trying to correct that issue currently.

So you are 100 percent correct, Mr. Moran. The program was intended to include the full VISN.

Mr. MORAN. Mr. Chairman, excuse me, and I would point that to my knowledge, at least this is the first time I have heard, as we have had briefings from the VA on this topic, this is the first time I have seen the narrowing of the narrowing. And so I appreciate the Chairman's comments.

Ms. VANDENBERG. Mr. Chairman, may I make a further comment?

Mr. MICHAUD. Yes.

Ms. VANDENBERG. We obviously will respond to the feedback that we are receiving today. But just to go back to the question of what further challenge or impediment might we experience, I would just like to observe that when attempting to put a provider in place for highly rural veterans who will no doubt be dispersed in a VISN, we will likely experience a situation of multiple contracting relationships. And so that could potentially extend the timely implementation for coverage in an entire VISN.

So I am just wanting to acknowledge that I hear you. I further appreciate the intent. And just practically speaking, obviously we are going to honor the intent and just realize that we may be dealing—in a number of instances, it would be ideal if there were a provider network established that had outlets, if you will, in those multiple venues. Having had some experience in my prior life in Idaho where the organization I was associated with attempted to set up those multiple venues in rural communities, it made it very easy if someone wanted to serve those communities. They just came to my organization and we helped them get that done.

In our experience thus far in rural contracting, that has not always been the case. So I hear what the Committee is telling us today. We will proceed to respond to this and just work with due diligence to work through the contracting as timely as possible.

Mr. MORAN. Mr. Chairman, I think what Ms. Vandenberg is telling me is that my two desires of having broad scope and quick implementation may be mutually exclusive and putting the reminder back to us that this may slow the process down if they have to contract in a multiple number of ways.

But at least from my perspective, I would put the priority on doing it right which is to take care of every veteran regardless of where they live, not within a particular community as compared to the speed of its accomplishment. We want both.

But, again, I think we would make a terrible mistake if we go through this pilot program and we only in a sense take the easy areas within a rural VISN and which it is easier to find a provider or there is a multiple number of providers or there is a larger number of veterans. We are still isolating that veteran who lives a long distance from a VA hospital. And so my priority would again be

back to making sure that we implement this in a way that we can demonstrate it can be done VISN-wide.

Thank you.

Mr. MICHAUD. Thank you.

Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman.

And while we have been discussing all this, there are probably many veterans who have not been able to find a way to get taken care of. So while we are trying to figure out how to do this, our veterans still need help.

Ms. VANDENBERG. Uh-huh.

Mrs. HALVORSON. So instead of reinventing the wheel or trying to figure out what is rural, what is hardship, why aren't we just taking care of our veterans and letting them go wherever it is that they need to be taken care of?

Now, I may be naive and I am new. This is my first term. But while we are trying to figure out the intent of a law or how to do it the right way no matter if it takes long, what are we doing right now for our rural veterans? Where are they going and how are they getting taken care of?

Ms. VANDENBERG. Thank you for the question. I am glad you asked it because I can speak very directly to it.

We are already providing a significant amount of fee care to rural and highly rural veterans. And under the aegis of the Office of Rural Health in fiscal year 2010, we have just put out $200 million to the VISNs to afford them the extra resource to provide fee care to rural and highly rural veterans.

So I think it is important to note that that is a mechanism that is already in place. And what I understood the intent of this to do was to give VA additional incentive and capacity to further contract out care to extend that access even more.

But to answer your question, we are already meeting the needs of rural and highly rural veterans through the fee-care mechanism.

Mrs. HALVORSON. So then, and not to interrupt, so then what is the estimate of how many extra veterans are we going to take care of and the cost? So we are already spending money. We are already taking care of people. So this program, what are we assessing the pilot program's cost, the quality, and how many veterans are going to be eligible for the pilot program?

Ms. VANDENBERG. Let me take the assessment of cost first.

Mrs. HALVORSON. Okay.

Ms. VANDENBERG. In our initial analysis of the implementation of the pilot as we previously understood it, we estimated up to $100 million. However, we knew that that was putting significant emphasis on primary care service delivery and as you add in the multi-specialty dimensions of a patient's care that that cost could rise.

So our current working assumption is that the pilot project as we previously conceived it would cost at least $100 million.

And your second question about quality, that is part of the analysis and the process of contracting and we are using all of the resources of VHA that we currently employ in the contracting process, pulling those in to look at the specifics of assessing the quality of the care and the patient's satisfaction with the care.

Mrs. HALVORSON. So for $100 million, we are going to help more people?

Ms. VANDENBERG. Yes, ma'am.

Mrs. HALVORSON. And better?

Ms. VANDENBERG. I think I would just observe that we believe that the standard of care, the quality of care that is evident in our current fee relationships is of a high quality nature. So when we say better, that could connote that there is something lacking in our current approach, but——

Mrs. HALVORSON. Correct. That is not a good word. Better is not a good word.

Ms. VANDENBERG. But I just want to be precise. We definitely are trying to enhance access and by spreading the network of contract relationships further into highly rural communities and attempting to structure those relationships where in some instances, they do not exist today, that will definitely enhance the quality of veterans' care because of the elimination——

Mrs. HALVORSON. Okay. I just hope we are not reinventing the wheel. It looks like you have taken all this time to discuss hardship and rural when we should be taking this time to help our veterans with their health care. And now with 1963, I believe, we take hardship out altogether. We should have no problem now implementing this bill.

So, you know, I know my time is about up, but I am concerned about the care of my veterans, not debating whether they are rural or if they have a hardship. We are talking about people that we just want to take care of.

Ms. VANDENBERG. I understand that.

Mrs. HALVORSON. So thank you.

Ms. VANDENBERG. And I am committed to that same mission.

Mrs. HALVORSON. Thank you.

Mr. MICHAUD. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

And we appreciate Ms. Vandenberg being here. And I really have enjoyed the discussion. It has been very helpful.

What I would like to do is go ahead and yield my time to Mr. Moran in the sense that he is so knowledgeable about the issue. And, again, we are getting some good testimony.

Mr. MORAN. Mr. Chairman, thank you.

I have actually exceeded my time previously, but I appreciate Mr. Boozman yielding.

Just a couple more thoughts. One, we have always had contention, it seems to me, in regard to pharmaceuticals, the ability for a local pharmacist to prescribe medication to a veteran. And we have pursued this issue before. There have been a number of bills introduced that would allow or require the VA to allow for a local physician to have a prescription honored by the VA.

Is there any discussion, any policy work in place in regard to how we are going to handle the prescription drug issue and the local pharmacy?

Ms. VANDENBERG. I will ask Ms. Uppal to respond to that in terms of the work that the implementation team has done thus far.

Mr. MORAN. Thank you.

Ms. UPPAL. Thank you, sir, for the question.

That is something that the implementation plan working group really did spend a lot of time on. In fact, we have engaged very closely with our pharmacy colleagues on this issue. So we have come up with a number of recommendations on how we would address this ranging from potential retail pharmacy network access and a number of other things.

So if it is okay, we would certainly welcome the opportunity to keep the Committee apprised of this issue, but that is certainly a major issue that we are very cognizant of and intend to work very closely on.

Mr. MORAN. Very good. It will be somewhat self-defeating if we are able to go to our local doctor and get a prescription, but then cannot go——

Ms. UPPAL. Right.

Mr. MORAN [continuing]. To our hometown pharmacist and have it filled.

Ms. UPPAL. Yes.

Mr. MORAN. And then on the Project HERO, it is implemented VISN-wide. Are there some analogies there that we can draw as to how this implementation may or should work?

Ms. VANDENBERG. I think there are and we have spent an extensive amount of time with the lead staff. And we actually have an agreement with the business office staff that are the support to Project HERO. We have struck a service level agreement to make it very clear that we want to leverage their experience and their expertise so that we do not reinvent the wheel.

Mr. MORAN. Mr. Chairman, thank you.

Again, I would reiterate that I have a strong sense that the VA is serious about implementing this program in a way that is advantageous to veterans, and I very much appreciate the working relationship that we have had on this legislation. And the concerns I have raised today are not critical of the VA, but just an attempt to make certain that our intentions are fulfilled in the VA's efforts to implement this bill.

So I thank you for the dialogue, and I look forward to our continued working relationship.

I thank the Chairman.

Ms. VANDENBERG. Thank you, sir.

Mr. MICHAUD. Mr. Perriello.

Mr. PERRIELLO. Thank you very much, Mr. Chairman. Thank you for your leadership, Mr. Moran's and others on this.

Rural care is of tremendous interest to the veterans in central and southern Virginia. We have great primary care providers, to Mr. Brown's point, who are ready and eager to participate in the program, many of whom are veterans themselves. So there is a lot of interest through various clinics and primary care centers there.

And I really want to thank you for your work on moving forward with implementation on this and coming up with the criteria. And I do want to reiterate Mr. Moran's concerns and Mr. Michaud's concerns about the VISN-wide issue.

But to disagree a little bit with Mrs. Halvorson, I think obviously the goal here is to get care as quickly as possible, but I think there is a genuine disagreement here where many of us on the Committee feel like this is going to provide better care at a cheaper

price. There are those who disagree with that and believe that getting people through the existing VA facilities is going to be better care at a quality price.

So I think that as we pick the data points here, the important thing is that we are picking enough and a varied enough set to be able to answer that question which is how are we going with this, are we getting higher quality or equivalent quality care at a cheaper price.

So as we choose these facilities, I know there are a lot of concerns and you have put a lot of work into the criteria, but, you know, part of the point of a pilot project is to be able to say at the end with some degree of certainty, yes, this system is working and, therefore, not only do we want to go VISN-wide but really nationwide with it if it is, as I think many of us believe, going to be a better product.

And, again, that is a place where good people can disagree in advance, but hopefully we will produce the evidence through this and look at that.

With that in mind, just very quickly, what is the timeline for making some of the decisions moving forward of where you see these pilots going forward?

Ms. VANDENBERG. As I indicated earlier, we envisioned being able to move to the contracting phase and after the selection and potentially have the pilots up by the end of this calendar year or early 2011.

In light of the conversation that we have had here today, we are obviously going to go back and apprise the Under Secretary for Health of the need for us to think more broadly and make whatever adjustments are necessary then in the next steps of the process.

But I would not envision us lagging dramatically. We are eager. We are on a marathon at this stage of the game and we see that, you know, line where we are going to cross over from implementation planning to actually doing. So we are going to press on with all due diligence to keep this moving as fast as we can.

Mr. PERRIELLO. And, again, we have throughout VISN 6 a lot of interest, Virginia, North Carolina, West Virginia. I happen to know central and southern Virginia the best and there are doctors and veterans organizations that are very interested in this.

Would it be possible to facilitate a meeting between folks in your office and them just to keep them apprised and letting them know about this as it develops?

Ms. VANDENBERG. Absolutely, yes. And I am familiar with some of that interest by virtue of the roundtable——

Mr. PERRIELLO. Right.

Ms. VANDENBERG [continuing]. Conversation. So I fully appreciate that there are members of the provider community who are eager to move on this.

Mr. PERRIELLO. Well, thanks. And, again, I just want to thank the Members of this Subcommittee and yourself for moving this forward. I really do believe in this project in a big way and if we implement it well, I think we are going to see good results. So thank you very much.

I yield back.

Mr. MICHAUD. Thank you, Mr. Perriello.

I have a few questions and then if others have additional questions, we will go around again.

And I know, Ms. Vandenberg, this issue began before you were in this position, but my concern is I think all too often sometimes when Congress passes legislation that is very well intended, we tend to not be so prescriptive in order to give the agencies the flexibility to make adjustments as they see fit. But the concern is that sometimes if we are not prescriptive, then they tend to implement the law the way that they want to implement it.

And that has been a concern, especially since I have been on this Committee since 2003. We have heard a lot from colleagues all around the country about issues affecting veterans that live in rural areas. We have constantly had bills before our Committee that would encourage the VA or mandate the VA to contract out.

I know that the VA has always looked at this issue, as they do provide good service and do contract out in some areas, but you do not want to have VA become more or less like the insurance agency where they contract everything out, and I can understand that. But in order to prevent that from happening, those of us who live in rural areas want to see results.

And the concern that I have is—and I know it is from before your time—this legislation passed in October of 2008. We did not hear back from the VA until March of 2009 on why they cannot implement it. When we went through the hearing process and the markup process, that was the time that the VA should have been before us saying, well, we need these changes.

They were not. And we did not hear about their concerns until after the fact, which is a concern that I have; making sure that we are cognizant of the problems that VA has with legislation. But we cannot do it unless you are at the table. And the time to have been at the table was during the hearing process and during the markup process, not after the fact.

So I can assure you that for Members of this Committee—whether it is this Congress or the next Congress or 10 Congresses down the road—rural health care issues for veterans will continue to be a problem and a concern.

Another issue that I want to discuss is, you mentioned that you have asked the different VISNs to report back on the areas within their VISN that they would like to use as sites for this pilot program. And as you heard, the intention was for this program to be implemented VISN-wide.

I do not believe that that is a problem since we have dealt with the Project HERO Pilot Program. I think there are a lot of similarities between Project HERO and what Mr. Moran was suggesting when he originally put forward this legislation.

So, when this program is implemented VISN-wide, one of the concerns I would have is if the Central Office does not intend to give VISNs additional resources to implement it. I have heard at Mini Mac meetings in Maine that when you VA facilities offer fee for service care, with the increase in mileage reimbursement, that actually puts a lot more stress on the medical facility within that VISN. The Central Office is requiring medical facilities to meet their budget requirement and, hence, they might have to actually

stop providing fee-for-service care. They might have to not fill a position that needs to be filled, to meet the budgetary constraints.

Do you envision that once this program is fully operating, or during that process, that you would need to give the different VISNs additional resources to meet the pilot program? And if so, how much or how much flexibility do you intend to give the different VISNs?

Ms. VANDENBERG. I can answer that. I am responsible as the Acting Director of the Office of Rural Health for the $250 million appropriation. And so in looking out to fiscal 2011, we expected, as I mentioned earlier, to spend at least $100 million on this pilot. So now that we are going to go back and reset our parameters, we may need to amend that estimate.

My understanding with the Under Secretary of Health is that this will be in essence the top line in the Office of Rural Health. And so looking at a $250 million appropriation, if this is the top, then we are committed to providing those resources through the conduit of the Office of Rural Health for the duration of the pilot project. And then the implications of that are that other efforts that we might have considered pursuing through the Office of Rural Health might need to be reevaluated in light of that.

So it is my current understanding, given the policy discussion that we have had within VHA, that this is our top line.

Mr. MICHAUD. And how are you going to go about implementing this?

Here is another concern that I have had when receiving information from veterans service organizations (VSOs) at the Mini Mac meeting in Maine, for instance, and also I have heard it elsewhere around the country; I will use Maine as an example. In northern Maine, if the veteran has to go to Boston to access health care, they travel to Togus, stay overnight at Togus, go to Boston, do their operation in Boston, come back, stay overnight in Togus, then go back home. It is a 4-day affair, which is unfortunate.

There has been a situation in which a huge medical facility in the city of Augusta, not too far from the Togus VAMC, was willing to build a whole wing just for veterans if VA would be willing to utilize that wing, knowing that VA is not going to build a brand new facility at Togus.

What I have been told by some of the VSOs is the medical facility was amenable to looking at that. However, the VISN office said no.

So I can envision, as you move forward in this pilot program, you might have a medical facility in a rural area with a different idea of how to move forward. However, there are constraints at the VISN office preventing the facility from doing it that way.

So how is the Office of Rural Health or the Under Secretary going to make sure that this pilot program is a good pilot program and that there are not constraints put on the different medical facilities who might have a different idea from what the VISN office, in my case Boston, might consider doable?

Ms. VANDENBERG. I think your question illustrates a very fundamental dynamic in the Veterans Health Administration today between the VISNs and the authority that they have to implement a plan using the resources that are provided to them for the popu-

lation within the VISN and the role that my Office of Policy and Planning plays and in this instance the Office of Rural Health in particular.

So as we from my office look out across the system and look at some of the gaps in service delivery, we are in a dialogue with the VISNs about how are they addressing those gaps and deploying resources. And that balance of influence then between the VISNs' authority to proceed along the lines that they lay out and the Office of Policy and Planning observing certain patterns and potential emerging needs is a constant dynamic back and forth.

And so I can just speak from the vantage point of the Office of Rural Health and this pilot in particular that my sense is that when you have a pilot and you are gathering this data during the course of the pilot, you come to various milestones where you can say that it is clear that there is higher veteran satisfaction, comparable, at a minimum, comparable quality, and this is what the cost looks like.

And in instances where veterans are having to travel those long distances and there might be an alternative provider mechanism available, it would be the Office of Rural Health talking to that VISN and saying let us talk about this make by, let us look at this more carefully because here's a population that has this need and we have demonstrated a way to address that need.

So that is from my vantage point the conversation that I have had already with some of our VISN Directors and will continue to have in terms of striking a balance between the authority that they have and the responsibility that I have in my office to observe and question.

Mr. MICHAUD. Mr. Moran, do you have any further questions?

Mr. MORAN. Chairman, thank you for your indulgence.

Just one additional inquiry about CBOCs. Has the Department taken into account in its CBOC planning the consequences or effects of this legislation, or did that follow after we get the pilot in place? Would we expect a different alignment of CBOCs, less necessity?

Ms. VANDENBERG. If I could explain what our current process is with regard to CBOCs, several years ago, in light of some of the dynamics that the Chairman just illustrated, my office was empowered to be responsible for the analysis of the gaps. And so what we do each year now prospectively is work with the VISNs to point out areas that appear to be underserved and then they have to come in with a submission that responds to that.

So to answer your question specifically, the further placement of CBOCs was not something that we were juxtapositioning with vis-à-vis this pilot. However, that process of looking for gaps, underserved areas, and the population at risk is very integral to the work that is going on in the Office of Policy and Planning routinely.

And so we have the capacity to take this pilot and the implications of this pilot into consideration.

I would also observe that a decision was recently made to help to underwrite the cost of 51 CBOCs that had been previously approved that will serve rural veterans through the Office of Rural Health.

And so by virtue of us funding those CBOCs, I have a new window into the VISNs and how those CBOCs will perform. And so that gives the Office of Rural Health a new opportunity for dialogue with my VISN colleagues regarding how we are meeting the needs of rural and highly rural veterans.

Does that respond to your question, sir?

Mr. MORAN. Yes, ma'am, it does. Thank you very much.

And thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Rodriguez.

Mr. RODRIGUEZ. Yes. Let me follow up on this because I know as we reach out, at least in my community, I know it was done with private providers. Do we have any contracts right now, I know in the past we had, with community health centers?

Ms. VANDENBERG. Sir, I would have to take that question for the record. I do not have that data at hand.

Mr. RODRIGUEZ. Okay. Because I would think that based, and although I have received indications that the reimbursements were not appropriate when they did have it with the VA, but I am wondering as to why because I know they get the reimbursements on Medicare, Medicaid, and all the others and I gather we collect right? Is that correct? Does the VA get reimbursed also from or just from the private sector?

Ms. VANDENBERG. I am not sure I understand your question. Does the VA get reimbursed by——

Mr. RODRIGUEZ. From Medicare, Medicaid on the veterans.

Ms. VANDENBERG. No, sir.

Mr. RODRIGUEZ. No? Okay.

Ms. VANDENBERG. We take——

Mr. RODRIGUEZ. You just get private sector?

Ms. VANDENBERG [continuing]. Private insurance coverage——

Mr. RODRIGUEZ. Private insurance.

Ms. VANDENBERG [continuing]. But not Medicare and Medicaid coverage.

Mr. RODRIGUEZ. Can you look to see if you have any contracts now with community health centers——

Ms. VANDENBERG. Yes, sir. We——

Mr. RODRIGUEZ [continuing]. Since they are reimbursed also from the Federal side and especially from the community mental health centers that might be out there—because I know they do have a good number of providers, that in some cases, there is a great need for them.

And as you look at continuing to move in that direction, we are optimistic that at some point, we will have 94 to 97 percent of the people insured in the future. Right now I know in my community, one out of three is not insured in terms of cost, as this is another factor.

Ms. VANDENBERG. We have begun the analysis within the Department to understand the implications of health care reform and broader health insurance accessibility to the entire population including veterans who are not currently enrolled with VA.

And so that analysis is underway and we are eagerly awaiting some further clarification as to the language in the law pertaining to the tax credits that an individual would be able to access for coverage vis-à-vis a veteran's eligibility or current enrollment with VA.

Mr. RODRIGUEZ. Okay. And if you can get back with me or my staff in reference to possible contracts with community health centers——

Ms. VANDENBERG. Yes, sir, we will.

Mr. RODRIGUEZ [continuing]. Through our community and seeing what kind of arrangements we might be able to make since they also get Federal resources.

Ms. VANDENBERG. Yes, sir.

[The VA subsequently provided the following information:]

> Neither the El Paso nor Big Spring facility has contracts for care in the community at this time. Big Spring maintained the Ft. Stockton Community-Based Outpatient Clinic through a contract with a private provider for primary care for most of fiscal year 2010, but this was converted to a VA-staffed clinic in August 2010 to improve the quality of care provided to veterans in this area.

Mr. RODRIGUEZ. Thank you very much.

Mr. MICHAUD. The last question I have is, what steps will be taken to foster an efficient but secure flow of patient medical information between VA and participating providers? And I assume there may be some analogies that could be drawn with Project HERO in that regard.

Ms. VANDENBERG. Yes, sir. Basically our answer at this point is that we are working within the parameters that VA IT has given us regarding the transfer of information. There are mechanisms available for read-only interface at this point.

There is not a clear signal that we will be able to transmit information and receive information very easily, but we are certainly going to take full advantage of the mechanisms that have been put in place vis-à-vis Project HERO in this pilot.

Mr. MICHAUD. And do you have any concerns with the IT? I have heard some concerns that when we originally separated IT from the medical facility account, that the medical facilities and IT might not be on the same page.

So you said you have to live within the parameters of what they have set. Are those parameters too restrictive or should they be changed in any way?

Ms. VANDENBERG. Well, what I meant to say by that is that there are rules that govern interoperability and those rules are determined not only by VA policy but also by broader considerations of requirements for privacy, for example. And so we are operating within those parameters.

The large IT question, I will defer to the Under Secretary for Health. There is an ongoing dialogue within the Department about the balance of the multiple strategic issues facing the Department and the IT support that is required to achieve the Secretary's vision of a transformed VA.

Mr. MICHAUD. Are there any other questions?

[No response.]

Mr. MICHAUD. Well, I want to thank you, Ms. Vandenberg, for coming today. This has been really helpful and I look forward to working with you as we move forward to implement this program in the way that it was intended to be implemented.

And if there are any problems as we move forward for full implementation, I would appreciate if you could let the Committee know what those concerns are. I look forward to working with you.

Ms. VANDENBERG. Absolutely.

Mr. MICHAUD. So, once again, thank you very much——

Ms. VANDENBERG. Thank you.

Mr. MICHAUD [continuing]. For all your hard work——

Ms. VANDENBERG. Thank you.

Mr. MICHAUD [continuing]. And dedication——

Ms. VANDENBERG. Thank you.

Mr. MICHAUD [continuing]. To take care of our veterans.

Ms. VANDENBERG. I am a nurse. I am sure you have all heard the adage once a nurse, always a nurse.

Mr. MICHAUD. Yes.

Ms. VANDENBERG. And I am very far removed from the bedside, but not far removed from the commitment to reaching out every day in some way to assure that our veterans receive the appropriate care that they have earned and that they deserve.

So thank you.

Mr. MICHAUD. Thank you very much.

If there are no other questions, this hearing is adjourned.

[Whereupon, at 11:18 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I thank everyone for attending this hearing.

The purpose of today's hearing is to examine the VA's implementation of the Enhanced Contract Care Pilot Program for rural veterans. This pilot program was authorized in the 110th Congress, and had an effective date of 120 days after October 10, 2008. However, the pilot program remains unavailable to eligible veterans.

We know that about 40 percent or nearly 3 million veterans who use the VA health care system live in rural areas, which includes over 100,000 veterans who reside in highly rural areas. This trend is likely to continue since a large number of our men and women serving our country in Iraq and Afghanistan are recruited from our rural communities.

I recognize and appreciate the VA's efforts in addressing the health care needs of our rural veterans who are more likely to be in poorer health than their urban counterparts. However, more work remains in this area as our rural veterans face unique challenges that are both extensive and complex. The Enhanced Contract Care Pilot Program is a potential tool for expanding access to health care for our rural veterans in areas where the VA is unable to provide care.

I would like to learn more about the steps that the VA has taken to implement the Enhanced Contract Care Pilot Program. I also would like to fully understand any potential barriers that are hindering the implementation of this important pilot program.

I look forward to hearing the testimonies of our invited witnesses today.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

As always, I appreciate your leadership and I thank you for holding this hearing today to review the status of VA's implementation of the Enhanced Contract Care Pilot Program enacted into law in the 110th Congress as section 403 of Public Law 110–387.

I also want to commend my good friend and colleague from Kansas, Jerry Moran, for his work and continued commitment to serving rural veterans. Jerry was the sponsor of the Rural Veterans Access to Care Act which led to the establishment of this 3-year demonstration project to allow highly rural veterans to receive covered services through non-VA providers.

Of the almost 8 million veterans enrolled in the VA health care system, approximately 3 million reside in rural areas. Often, these veterans face incredible difficulties in accessing VA health care. Many must find transportation and traverse hours across rough terrain to reach the nearest VA hospital. If a round trip is not possible in 1 day because of distance, the rural veteran and their family may be compelled to stay overnight. These difficulties can make even routine medical appointments an expensive and lengthy chore and discourage rural veterans from using the health benefits to which their service entitled them.

Helping to ease that burden and ensure that even those veterans who choose to make their homes in the most rural of areas have access to the high-quality care they deserve is a priority of all of us on this Subcommittee. And, this pilot is very important to determine ways to best serve our veterans residing in highly rural areas.

As more and more veterans return to their rural homes from Operations Enduring Freedom and Iraqi Freedom and rural veterans from earlier wars continue to re-

quire care, we must continually evaluate our actions and determine what more can be done to provide timely and appropriate access to medical care.

In that vein, I am eager to hear from the VA this morning on what the Department is doing to implement the law and what additional steps should be taken to ensure its success.

I thank our witness for being here, look forward to our discussion, and yield back the balance of my time.

Prepared Statement of Patricia Vandenberg, M.H.A., B.S.N., Assistant Deputy Under Secretary for Health for Policy and Planning, and Acting Director, Office of Rural Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Good Morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here today to discuss the progress the Department of Veterans Affairs (VA) has made in implementing section 403 of Public Law (PL) 110–387. Joining me today is a member of my staff, Ms. Gita Uppal, Director of Policy Analysis for the Veterans Health Administration (VHA).

Section 403 requires VA to conduct a pilot program to provide non-VA health care services through contractual arrangements to eligible veterans. This is an issue of significance to both Congress and the Department, and we look forward to continuing to work together to ensure veterans in geographically remote areas receive the care they have earned through service to our country. My testimony will provide background information on the provision, discuss VA's efforts to implement this provision and the challenges it has encountered, document the Department's accomplishments to date, and report on its continuing plan for full implementation of the program.

Background

Public Law 110–387, the Veterans' Mental Health and Other Care Improvements Act of 2008, was signed by President Bush on October 10, 2008. Section 403 of this law requires VA to conduct pilot programs during a 3-year period to provide non-VA health care services through contractual arrangements to eligible veterans. The pilot program must be conducted in at least five Veterans Integrated Service Networks (VISN), which were to be selected using specific criteria defined in the law. In determining which VISNs would meet Congress' requirements, VA reviewed the number of highly rural counties (using the VA definition of highly rural, which is fewer than seven civilians per square mile) in every VISN. Additionally, VA analyzed the number of States within each VISN and excluded those participating in the Project Healthcare Effectiveness through Resource Optimization (Project HERO) pilot program. VA determined the following VISNs met the statute's requirements: VISN 1: VA New England Healthcare System; VISN 6: VA Mid-Atlantic Health Care Network; VISN 15: VA Heartland Network; VISN 18: VA Southwest Health Care Network; and VISN 19: Rocky Mountain Network.

Veterans who are enrolled in VA as of the commencement of the pilot or are eligible under section 1710(e)(3)(C) of title 38, United States Code, reside in any of the five VISNs meeting the statute's criteria (VISNs 1, 6, 15, 18, 19), and meeting the statute's definition of "highly rural" are eligible to participate in the pilot program. Veterans eligible to enroll under section 1710(e)(3)(C) of title 38, United States Code, essentially includes Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans and veterans who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after November 11, 1998. Veterans who meet the driving distance and hardship criteria for eligibility but are not enrolled in VA as of the commencement of the pilot or eligible to enroll under 1710(e)(3)(C) of title 38 are not eligible to participate in the pilot program.

The statute defines a veteran to be highly rural based on driving distances to the nearest VA health care facility. Under the statute, a veteran is considered highly rural if the veteran resides in a location that is:

1. More than 60 miles driving distance from the nearest VA health care facility providing primary care services, if the veteran is seeking such services; or
2. More than 120 miles driving distance from the nearest VA health care facility providing acute hospital care, if the veteran is seeking such care; or
3. More than 240 miles driving distance from the nearest VA health care facility providing tertiary care, if the veteran is seeking such care.

Veterans also are considered highly rural and thus eligible if they experience "hardship or other difficulties in travel to the nearest appropriate [VA] health care facility that such travel is not in the best interest of the veteran." Details of what constitutes "hardship" are not specified in the law. VA is formulating regulations to define this term with sufficient clarity to provide practical standards, while still maintaining a proper breadth to accommodate veterans with special circumstances. As noted below, however, the requirement for this regulation may be eliminated, and the criteria for highly rural may be changed slightly, by legislation passed recently by the House of Representatives and the Senate.

VA's Efforts and Challenges

Immediately after Public Law 110–387 was enacted, VA focused its efforts on plans to implement this pilot program at several sites. Since it is an ambitious and complex undertaking, VA established a cross-functional workgroup (the Workgroup) with a wide variety of representatives from various offices, as well as VISN representatives. The Workgroup began identifying issues and developing an implementation plan. VA soon realized that the pilot program could not be responsibly commenced within 120 days of the law's enactment, as called for in the law. In March 2009, VA officials briefed Subcommittee staff on these implementation issues.

The first challenge VA shared with Congress was that the statute's definition of "highly rural" was one not being used by VA: the statute uses driving distances to define a highly rural veteran, whereas VA defines a highly rural veteran as a veteran who resides in a county with fewer than seven civilians per square mile. VA has well-developed data systems based on its definition and uses these systems to identify highly rural veterans. To implement the law, VA needed to re-configure its data systems to determine which veterans would be eligible to participate in the pilot program. These changes required VA to identify travel distances for each enrollee for multiple VA facilities, conduct analyses to identify eligibility according to the statute's definition, and develop enrollment and utilization projections for the pilot program using the definitions in the law. VA completed this reconfiguration in October 2009.

The second challenge involved the term "hardship," which would need to be defined through regulations. The Federal regulations process involves many steps, including public review and comment. That may be a lengthy process, depending on the number and complexity of regulations. VA is now drafting the regulation defining "hardship," which represents the lengthiest task necessary prior to implementing the pilot.

Our staff had subsequent discussions with the Health Subcommittee staff, continuing to report on the status of the project and also identifying possible changes that could speed implementation. Section 308 of S. 1963, which recently passed the House of Representatives and the Senate, would remove the requirement regarding the hardship exception as well as slightly modify the definition of "highly rural." We believe those changes could speed implementation of the pilot program.

Accomplishments

VA has made notable strides in implementing section 403 of PL 110–387, with the goal of having the pilot program operating late in 2010 or early in 2011. Specifically, VA has:

- Developed an Implementation Plan, which contains the Workgroup's recommendations on implementing the pilot program;
- Analyzed driving distances for each enrollee to identify eligible veterans (using the drive distance criteria) and re-configured its data systems;
- Provided eligible enrollee distribution maps to each participating VISN to aid in planning for potential pilot sites;
- Developed an internal Request for Proposals that was disseminated to the five VISNs asking for proposals on potential pilot sites;
- Developed an application form that will be used for veterans participating in the pilot program;
- Formulated a definition for "hardship," and began drafting regulations; and
- Taken action to leverage lessons learned from Project HERO and adapt it for purposes of this pilot program.

Next Steps

VA continues to address the ongoing issues associated with implementing this pilot program. VA will assemble an evaluation team of subject matter experts to review the proposals from the five VISNs regarding potential pilot sites. This team will then recommend specific locations for approval by the Under Secretary for Health. We anticipate this process will be complete in summer 2010. After sites

have been selected, VA will begin the acquisitions process. Because this process depends to some degree on the willingness of non-VA providers to participate, VA is unable to provide a definitive timeline for completion, but it is making every effort to have these contracts in place by fall 2010. This would allow VA to begin the pilot program in winter 2010 or early 2011. These estimates are also dependent upon the approval process for VA's regulations. Delays in final publication of the regulations could further postpone the start date for the program.

VA is developing information materials for veterans participating in the pilot program, for non-VA providers, for VA employees, and for other affected populations so that, when the pilot is implemented, all parties will have the information they need to fully utilize these services. VA is committed to implementing in full, the program directed by Congress and to maintaining the quality of care veterans receive. Other issues, such as securing the exchange of medical information, verifying veterans' eligibility for this pilot program, coordinating care, and evaluating the success of the pilot program, are also important priorities.

Conclusion

Thank you again for the opportunity to discuss the status of the pilot program required by section 403 of PL 110–387. This program will explore opportunities for collaboration with non-VA providers to examine innovative ways to provide health care for veterans in remote areas. VA continues to work diligently to implement the program and will continue to keep Congress apprised on the status of these efforts. VA is prepared to do whatever it takes to serve the needs of all veterans, including those in rural and highly rural areas. My staff and I look forward to answering your questions.

POST–HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
May 4, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning and Acting Director of the Office of Rural Health, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "VA's Implementation of the Enhanced Contract Care Pilot Program" that took place on April 29, 2010.

Please provide answers to the following questions by June 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. VA's testimony noted that the pilot program would be fully implemented by the winter of 2010 or early 2011. As you know, section 308 of S. 1963, which recently passed the House and the Senate, would remove the requirement regarding the hardship exception. Without the need to issue regulations defining hardship, how will the implementation date be impacted?
2. During this hearing, VA heard statements from Representative Moran, myself, and others, clarifying that the intent of the law is for this program to be implemented VISN-wide, rather than at selected sites within the VISN.
   a. What will the new implementation date be for a pilot program meeting this scale?
   b. What key milestones does VA need to meet to make VISN-wide implementation a reality?
3. Given delays in the implementation of this program, does VA require legislation extending the duration of the program?
4. What are VA's plans for accessing the pilot program's cost, volume, quality, patient satisfaction, and benefits to veterans? Has VA developed a way to measure this for the annual report to Congress?
5. Based on VA's best estimate, how many veterans will be eligible for the pilot program and how many are expected to receive health care through the pilot project?
6. Please describe how VA will calculate drive times in determining eligibility for the program. For example, how will VA account for temporary external factors that may cause drive times to fluctuate significantly, such as the presence of heavy construction or areas that frequently experience heavy inclement weather that may drastically alter drive times?
7. What top five health care services does VA expect to contract out the most using the enhanced contract care authority?
8. How will the Enhanced Contract Care Pilot Program differ from and be similar to Project HERO and the fee-basis program?
9. To implement the Enhanced Contract Care Pilot Program, will VA develop new networks with non-VA providers or will VA utilize the existing networks that you use for the fee-basis program?
10. VA has previously indicated to the Subcommittee the importance of leveraging lessons learned from Project HERO and applying them to this pilot program, and your testimony cites that VA has "taken action to leverage lessons from Project HERO." At the ground level, how will VA ensure that the lessons personnel have learned in implementing and executing Project HERO will flow to the personnel responsible for carrying out this pilot program?
11. On March 17, 2009, the Department briefed the Committee on the status of implementation of section 403 of Public Law 110–387. Five challenges were identified as follows: (1) establishing criteria and identifying providers to par-

ticipate in the pilot; (2) establishing contracts for providers participating in the pilot; (3) determining method for providing pharmaceuticals; (4) developing requirements for the exchange of medical information with providers participating in the pilot and determining how to handle ensuring privacy and accuracy; and (5) defining and designing an evaluation component to include performance measures. Please provide specific details regarding actions VA has taken to date to address these challenges and a projected timeline to completely address each issue.

12. Has VA developed communication, training, and education materials for veterans who may wish to participate in the pilot program as well as non-VA providers and other interested parties? If so, please provide specific details, including when materials will be given out. If not, please explain the reason for not doing so.
13. Please provide details as to the type and level of communication provided to VISN directors who will be responsible for implementing the pilot in their respective areas. When can veterans and non-VA providers expect to first hear from the VA?
14. Under this pilot will the non-VA provider cost reimbursement method function in a similar manner to the current VA fee-basis program?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by June 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

HENRY E. BROWN, JR.
Ranking Member

Questions for the Record

HVAC Subcommittee on Health

Oversight Hearing on
"VA's Implementation of the Enhanced Contract Care Pilot Program"

Chairman Michael H. Michaud

April 29, 2010

Question 1: VA's testimony noted that the pilot program would be fully implemented by the winter of 2010 or early 2011. As you know, section 308 of S. 1963, which recently passed the House and the Senate, would remove the requirement regarding the hardship exception. Without the need to issue regulations defining hardship, how will the implementation date be impacted?

Response: Section 308 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law, or PL, 111–163) amends section 403 of PL 110–387, the Enhanced Contract Care Pilot Program, by deleting the hardship provision that expanded eligibility for participation in the pilot program. Section 403 of PL 110–387 also required that the Secretary prescribe regulations to determine veteran's eligibility based on "hardship or other difficulties." The Department of Veterans Affairs (VA) believes this change will facilitate faster implementation of the program as the Department will not need to issue regulations to define hardship, though VA does plan to publish an interpretive rule through a Federal Register Notice announcing the pilot program and explaining how VA will implement the pilot program under the statutory criteria.

VA has been working diligently to implement these pilot programs. Our focus is on ensuring that veterans receive the best possible care through the pilot programs. Once the pilot sites are selected, VA will begin the acquisitions process. Since this process depends to some degree on the willingness of non-VA providers to participate, we are unable to provide a definitive timeline for completion, but are making every effort to have the pilot programs implemented by winter of 2010 or early 2011.

Question 2: During this hearing, VA heard statements from Representative Moran, myself, and others, clarifying that the intent of the law is for this program to be implemented VISN-wide, rather than at selected sites within the VISN.

Question 2(a): What will the new implementation date be for a pilot program meeting this scale?

Response: As VA noted in the hearing, we appreciated the statements made by the Chairman and others regarding the scope of the program and are carefully considering their comments.

The legislation provides that the pilot program "be carried out *within areas selected by the Secretary* for purposes of the pilot program in at least five Veterans Integrated Service Networks (VISNs)." VA is moving forward to implement the pilot programs in selected sites within the VISNs designated under the statute's criteria. VA has been working with Committee staff to meet with them in July concerning the scope and timetable for the pilot.

Question 2(b): What key milestones does VA need to meet to make VISN-wide implementation a reality?

Response: There would be significant operational implications to make VISN-wide implementation a reality. There are numerous and complex issues involved in operationalizing these pilot programs, including first and foremost, quality and coordination of care, as well as the exchange of medical information. Those key considerations may limit the sites that are appropriate.

Question 3: Given delays in the implementation of this program, does VA require legislation extending the duration of the program?

Response: VA's understanding of the statute is that the pilot program will occur for a 3-year period once the pilot program commences. However, VA would not object to legislation amending paragraphs (2) and (3) of section 403(a) of PL 110–387, removing the due date (120 days after the date of enactment).

Question 4: What are VA's plans for assessing the pilot program's cost, volume, quality, patient satisfaction, and benefits to veterans? Has VA developed a way to measure this for the annual report to Congress?

Response: VA has been focused on developing recommendations to assess the pilot program's cost, volume, quality, patient satisfaction and benefits to veterans. For example, VA intends to conduct a survey that will be used to evaluate patient satisfaction of the pilot program. VA staff will continue to work with program offices and participating VISNs to develop program evaluation and clinical quality measures required for the annual report to Congress.

Question 5: Based on VA's best estimate, how many veterans will be eligible for the pilot program and how many are expected to receive health care through the pilot project?

Response: We are unable to provide an estimated number of veterans who would receive health care services through this pilot program at this time because the number will depend on the level of veteran interest, veteran eligibility, pilot sites, types of services provided, and the capacity of contracted non-VA providers.

Question 6: Please describe how VA will calculate drive times in determining eligibility for the program. For example, how will VA account for temporary external factors that may cause drive times to fluctuate significantly, such as the presence of heavy construction or areas that frequently experience heavy inclement weather that may drastically alter drive times?

Response: VA uses the best available commercial geographic information system software and national road network data to calculate drive times to VA facilities to assess enrollees' geographic access to health care services. Each address is assigned a latitude and longitude through a process called geocoding. VA facilities are similarly geocoded. Next, drive time and distance to nearest VA facility is estimated using commercial proprietary algorithms. The algorithms take into account the most current characteristics available for each road traversed such as highway size, number of intersections, etc. The outputs of this rigorous analysis are the enrollee's drive times (in minutes) and distance (in miles) to VA primary, secondary, and tertiary care facilities. The drive time estimates are used to determine enrollee's eligibility to participate in the pilot program, under the amendments made by section 308 of PL 111–138 (replacing the "miles driving distance" measure with the "minutes driving distance" measure).

VA does not plan to take into account temporary external factors that may alter drive times because there are no feasible means to account for these factors. To our knowledge, there are no known standards or guidelines for scoring the impact of temporary incidents and barriers, and no taxonomy for classifying them.

Question 7: What top five health care services does VA expect to contract out the most using the enhanced contract care authority?

Response: Types of services offered through the pilot programs will depend on a number of factors such as veterans' health care needs in the pilot sites, types of services and non-VA providers' availability and willingness to participate in the pilot programs. VA will have a better understanding of the types of services that will be provided to eligible veterans through this pilot program once the pilot sites are selected.

Question 8: How will the Enhanced Contract Care Pilot Program differ from and be similar to Project HERO and the fee-basis program?

Response: The Enhanced Contract Care Pilot Program authorized under section 403 of PL 110–387, Project Healthcare Effectiveness through Resource Optimization (HERO), and the fee-basis program all share at least one common purpose—to purchase care from non-VA providers in areas where VA has limited capacity to provide necessary care to our veterans. As a result of these programs, veterans have increased access to the quality care they need and deserve.

There are many similarities between the Enhanced Contract Care Pilot Program and Project HERO. Both programs involve developing contractual arrangements to improve veteran access for required medical care when the veteran is residing in a remote area. There are also similar challenges between the two programs, such as ensuring the highest level of clinical and quality of care, guaranteeing the exchange of medical information and using contracts to improve access.

The fee-basis program authorities are set forth in 38 U.S.C. 1703 and 38 C.F.R. 17.52–17.56. Section 17.52 describes VA's authority, under 38 U.S.C. 1703, to contract with non-VA facilities for care, and also provides that when demand is only for infrequent use, individual authorizations for care may be used. In contrast to care that will be provided under the pilot program, fee basis care authorized under 38 U.S.C. 1703 and 38 C.F.R. 17.52 is available only when VA facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility, or are not capable of furnishing the care or services requires. Further, VA is authorized to provide this care only to the veterans described in section 1703. Veterans eligible to participate in the pilot program will not be subject to the limitations set forth in section 1703.

Some of the differences among these programs include differences in the eligibility criteria for participation, the types of purchased services and the type and structure of the contractual agreements. Also, the Enhanced Contract Care Pilot Program will be carried out in different locations than the Project HERO locations, as required by section 403(a)(4)(D) of PL 110–387. Unlike Project HERO or the Enhanced Contract Care Pilot Program, the traditional fee-basis program has limited contracts and arrangements with non-VA providers.

The contracted care pilot program staff and Project HERO staff are closely collaborating to leverage lessons learned from Project HERO and to apply them appropriately to successfully implement the Enhanced Contract Care Pilot Program.

Question 9: To implement the Enhanced Contract Care Pilot Program, will VA develop new networks with non-VA providers or will VA utilize the existing networks that you use for the fee-basis program?

Response: To date, we have not disseminated the solicitation package to non-VA providers in the pilot site locations or made the contract awards. We are unable to provide additional information on the types of provider networks that will be selected. However, it is VA's intent to disseminate the solicitation opportunity widely to non-VA providers in the pilot site locations.

Question 10: VA has previously indicated to the Subcommittee the importance of leveraging lessons learned from Project HERO and applying them to this pilot program, and your testimony cites that VA has "taken action to leverage lessons from Project HERO." At the ground level, how will VA ensure that the lessons personnel have learned in implementing and executing Project HERO will flow to the personnel responsible for carrying out this pilot program?

Response: The Project HERO staff plays an active role in serving on the working group to implement the Enhanced Contract Care Pilot Program. As such, knowledge transfer on the lessons learned from Project HERO occurs on an ongoing basis to the individuals involved with implementing the Enhanced Contract Care Pilot Program.

Question 11: On March 17, 2009, the Department briefed the Committee on the status of implementation of section 403 of Public Law 110–387. Five challenges were identified as follows: (1) establishing criteria and identifying providers to participate in the pilot; (2) establishing contracts for providers participating in the pilot; (3) determining method for providing pharmaceuticals; (4) developing requirements for the exchange of medical information with providers participating in the pilot and determining how to handle ensuring privacy and accuracy; and (5) defining and designing an evaluation component to include performance measures. Please provide specific details regarding actions VA has taken to date to address these challenges and a projected timeline to completely address each issue.

1. VA will follow standard procedures in establishing criteria and determining the qualifications of non-VA providers. Identification of potential non-VA providers should be completed once pilot sites are selected.
2. After pilot sites have been selected, VA will begin the acquisition process. We are unable to provide a definitive timeline for contract finalization, since this process depends to some degree on the availability and willingness of non-VA providers.
3. The Office of Policy and Planning in the Veterans Health Administration (VHA) continues to work closely with VHA's Pharmacy Benefits Management service to determine methods for providing pharmaceuticals for participating veterans. We will provide a timeline for completion once the pilot sites are selected and contracts are awarded.
4. The transfer of medical information between VA and non-VA providers remains a challenge. Key learning from the Project HERO effort indicate that timelines for return of medical documentation to the VA from a contracted community provider are very effective in achieving a high percentage of medical documentation being returned for the veterans VA medical record. Project HERO has also established a method for receiving all medical documentation in a secure, electronic format reducing risks of misrouting mail or those associated with using paper fax. However, these solutions are specific to how the Project HERO contracts were defined and implemented. Until the pilot sites for the contracted care effort are selected and contracts are awarded, we are unable to provide a definitive timeline for finalizing a solution.
5. We are unable to provide a definitive timeline for defining and designing an evaluation component, but continue to work with other program offices and participating VISNs to develop program evaluation and clinical quality measures. This remains an ongoing area of focus.

Question 12: Has VA developed communication, training, and education materials for veterans who may wish to participate in the pilot program as well as non-VA providers and other interested parties? If so, please provide specific details, including when materials will be given out. If not, please explain the reason for not doing so.

Response: VA is currently in the process of developing a communications plan for the pilot program. VA already has identified key stakeholders for the pilot and is exploring various communications methods for each stakeholder. For example, one of the key stakeholders for the pilot program is the non-VA providers with whom VA will contract. We will develop training materials for non-VA providers and their administrative staff. The communications plan will include tailored communications channels for various stakeholders and identified training needs and materials.

Question 13: Please provide details as to the type and level of communication provided to VISN directors who will be responsible for implementing the pilot in their respective areas. When can veterans and non-VA providers expect to first hear from the VA?

Response: Since section 403 of PL 110–387 was enacted, VA has been engaging with the VISNs to begin developing an implementation plan for this pilot program. This communication has been ongoing as the VISNs serve on the implementation working group. As we continue to move forward in addressing operational issues, the VISNs continue to play an active role.

Once the sites are selected, VA will start the acquisition process. We expect to communicate with non-VA providers and veterans about the pilot program once we develop the acquisition packages.

Question 14: Under this pilot will the non-VA provider cost reimbursement method function in a similar manner to the current VA fee-basis program?

Response: The enhanced contracted care pilot has not yet been awarded, but the expectation is that the reimbursement methodology will be driven by the contract terms, conditions and standards that will differ from the current VA fee-basis program.