PROJECT HEALTHCARE EFFECTIVENESS THROUGH RESOURCE OPTIMIZATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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PROJECT HEALTHCARE EFFECTIVENESS THROUGH RESOURCE OPTIMIZATION

WEDNESDAY, MARCH 29, 2006

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to call, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Brown, Michaud, Boozman, Brown-Waite, Bradley, Udall, Herseth, Strickland, Berkley, Moran, Snyder.

Mr. Brown. [Presiding] Good morning. The Committee will now come to order. Welcome, colleagues and distinguished witnesses and all in attendance this morning.

Our colleague and Chairman, Mr. Steve Buyer, is unfortunately unable to be here to start this hearing due to unavoidable conflict. However, I do anticipate the Chairman will be joining us shortly.

Our hearing today provides an opportunity to consider new and innovative ways to enhance health care access of our nation's veterans while at the same time making prudent use of the taxpayers' dollars. Specifically we are here to critically examine the Project Healthcare Effectiveness Through Resource Optimization, a demonstration known as Project HERO.

One of the reasons that I am excited to be here today is that I think it is important to hear what is currently being considered inside the VA, gain a better understanding of how these demonstrations will be rolled out, and to put to rest in a public forum some people's concern over the outsourcing of VA health care.

Project HERO, as I understand, is a series of VISN-wide demonstrations that seek to improve the level of collaboration between private contractor providers and the VA to ensure the most prudent expenditure of VA's resources while enhancing the continuity of services provided in and outside the VA system.

Project HERO is intended to be a purely voluntary program for cur-

rently-enrolled veterans that will not seek to expand eligibility.

The competitive contractor process is currently projected to take place in the summer, with contracts awarded the end of 2006.

The testimony we are about to hear today from Congressman Osborne, the VA, a private-sector contractor, and the Veteran Service Organization, I sense, will help detail a set of VISN-wide demonstration projects that are still in their infancy. That is to say I think it is clear that there is still a considerable amount of work to be done before Project HERO becomes a reality.

I would now like to recognize Mr. Michaud for any opening statements he might have.

MR. MICHAUD. Thank you very much, Mr. Chairman. I want to thank you for holding this hearing and also would ask that my full statement be part of the record.

MR. BROWN. Without objection.

MR. MICHAUD. Because the scope, focus, cost, and duration of this project have not specifically been authorized by this Committee, this hearing, I think, is extremely important. I appreciate that because we are at the beginning stage of this project most of the parameters are undefined.

While VA may not know at this time whether this project is going to cost two million or $2 billion, I believe it is important to clarify the cost of this demonstration and projected savings the VA hopes to achieve by better coordinating fee-based care.

With respect to this demonstration project, we have a balancing act. We want to encourage bold thinking about ways to enhance quality and cost efficiencies, but we must also exercise responsible stewardship to ensure accountability and performance.

Chairman Buyer, as Chair of the Oversight and Investigation Committee, was a leader in examining how poor contract management can ruin good ideas. With CoreFLS, VA attempted an innovative idea to generate synergies through an integrated system that combined logistical, billing, and other management functions, but we know that the results did not come close to meeting that expectation.

At is inception, the VA did not clearly define what it needed from its contractor. VA, in effect, invited the contractor to make government decisions without the necessary independent evaluation to ensure success.

Mr. Chairman, it is my hope that with this hearing and in future action as authorizers, we can help VA flush out a clear focus of the scope, cost, projected cost savings, and quality performance measures for this project to advance quality care for our veterans.

I am also interested in learning how this program will work in conjunction with the implementation of CARES' recommendation, and particularly how can we reduce VA's cost by purchasing care, by moving forward on established, needed CBOCs, and outreach centers.

So, Mr. Chairman, I will submit the rest of my testimony for the record. Thank you.

MR. BROWN. Thank you, Mr. Michaud.

[The statement of Mr. Michaud appears on p. 49]

MR. BROWN. Mr. Boozman.

MR. BOOZMAN. Thank you. Very quickly, I would like to thank the staff on both sides. We had a hearing in Arkansas concerning updating the GI Bill and the Transition Assistance Program. And Mr. Snyder, Ms. Herseth, and Senator Pryor were there. I just want to thank the hard work of the staff. We had an excellent meeting.

The other thing is, and I know we are going to do a lot more on this, but I just want for the record to let everyone known how saddened I am by the retirement of Mr. Evans. Nobody has worked harder for veterans or been more active on this Committee than he has. And so hopefully we will do a lot more along that line. But, again, thank you.

MR. BROWN. Thank you, Mr. Boozman.

Ms. Berkley.

MS. BERKLEY. Thank you, Mr. Chairman.

And, Mr. Boozman, I think those are very lovely words. I was very heartsick to hear about Lane Evans' retirement, although I thought it is a long time coming. And he will be missed by the veterans and by the people that worked with him on this Committee and throughout Congress on both sides of the aisle.

Mr. Chairman, I am going to submit my comments, my opening statement for the record, but there are a couple of comments that I would like to make on the record.

I am a proponent of the VA system. And I read with great interest the Independent Budget letter to Dr. Perlin expressing concerns about the HERO demonstration project, and I share those concerns.

I have a series of questions that I would like answered. Unfortunately, I have three Committees meeting simultaneously and I am not going to be able to stay to hear the responses to my questions, but we are very delighted to welcome our colleague, Mr. Osborne.

And if you would not mind, when -- and I am sure that in your opening remarks you will address yourself to your thoughts on the best way to provide private care for our veterans.

Should they be able to go to any doctor, hospital, or clinic, or will they go to one location? I would like to know your ideas on the best way to run Project HERO.

And I recognize while I represent the very urban part of our country that many of our veterans living in rural areas are in need of care and have difficulty finding a VA hospital or clinic near enough to them to actually help.

When we have our second panel, I would be very appreciative if

certain questions were answered regarding the care provided to veterans by VA contractors. The fact that it is usually disconnected from VA quality standards, electronic medical records, clinical guidelines, a continuum of VA provided care, how will they hold private providers to VA standards and guidelines?

And one of my primary concerns is the fact that the VA budget in my estimation is underfunded as it is. Is this project going to divert limited funding away from the established VA clinics and outreach centers that could replace the need for the VA to collaborate with private contractors? And my concern is that we do not substitute and use this as a foothold to start dismantling the VA health care system.

I do not have in my packet Dr. Perlin's response to the letter written by the Independent Budget, but I would appreciate either seeing his response or having the questions that were asked in this letter answered for the entire Committee. I think they brought up some very interesting points that need addressing. And before I would embrace this project, I would need to have these questions answered to my satisfaction.

And with that, I want to thank you for giving us an opportunity to share your thoughts with us. Appreciate it very much.

MR. BROWN. Thank you, Ms. Berkley.

[The statement of Ms. Berkley appears on p. 59]

MR. BROWN. Mr. Moran, do you have an opening statement?

MR. MORAN. I do, Mr. Chairman. Thank you very much for recognizing me. I applaud the opportunity to be here today with the department.

Appreciate the opportunity to cross-examine Mr. Osborne. I will miss the opportunity for him and I to work together. He and I share districts that are very similar. And this is an important issue for us in trying to make certain that rural veterans have access to health care.

I think there are two components of this project that I think I want to hear more about. I want to lend my support in efforts to make improvements to see that something happens in this regard, at the same time making certain that our hospitals in communities across the country, our VA hospitals, have the adequate resources to provide the specialized care that they so adequately provide.

So I very much want to make sure this is not a net loss to the VA hospital system. But I represent a district in which there is no VA hospital and to me, there are two issues about access, one being access, the other being sharing of information between the VA, its physicians and community physicians, and hospitals.

On the access side, two examples. And I have seen Mr. Osborne's testimony and he will talk about what the situation is in Nebraska.

But in my district just within the last couple of months -- one of my neighbors down the street is a retired FBI agent who has been receiving VA approved dental care for his injuries that he received during his military service in our hometown since 1989.

And recently the VA has determined that no longer will they provide dental services at home, but that Mr. Schwartz, who is in his eighties, must now travel to Wichita, which is about a three-hour drive, to see the dentist.

The other one, about a four-and-a half-hour trip to Wichita or to Denver to the VA hospital in the community of Hocksee. This gentleman needed a new pair of glasses, was not eligible to see his hometown optometrist, as he has for his past history in dealing with the VA, told that he must go to Wichita in order to see the optometrist to have his glasses adjusted. It is at least a four-hour, four-and-a-half-hour trip either to Wichita or to Denver.

In the first instance, we were able to satisfactorily resolve the issue and the second, we have not been able to. But those are just examples of people who are in their eighties who have the difficulty.

Clearly going to the city for many of my constituents is a long drive. It can be a frightening experience and something that they are uncomfortable with and generally takes family members or friends, someone from a VSO to get them there.

And so we want to work with the VA and the VSOs to try to make access to health care much more readily available, particularly in the routine circumstances. We have been successful in a number of instances. And community outpatient clinics, very much a supporter of those, but there is a niche that is still, in my opinion, is unfilled.

And, finally, the second issue is adequate communication between the VA's physicians and the community physicians in regard to medical records.

One of my close friends is a professor of family practice medicine at the University of Kansas at their campus in Wichita, Kansas. He is now the President of the National Association of the American Academy of Family Physicians.

His point and his letter here to me just within the last few weeks, community physicians complain they do not receive consultation notes, lab tests, and X-ray results back from the VA. The community physician does not know the medications that have been charged or tests that have been conducted.

When the patient shows up at a local hospital for an appointment, the local physician is unaware of the changes in the veteran's care. And for dual-care patients, I think this is a dangerous circumstance, and we want to work closely with the VA to see if we can solve the problem of that hometown physician or other health care provider that is providing services to the local veteran, that they know about the continuum of care between the VA and that hometown physi-

cian.

Mr. Chairman, I thank you for having this hearing. I look forward to hearing the witnesses. And, again, appreciate Mr. Osborne in particular highlighting the importance of this issue to many veterans, particularly those who live in rural America.

THE CHAIRMAN. [Presiding] Thank you, Mr. Moran.

Ms. Brown-Waite, you are now recognized.

MS. BROWN-WAITE. Thank you very much, Mr. Chairman.

You know, certainly looking at ways that we can stretch those health care dollars is something that this Committee is very interested in as the number of veterans increase, whether it is from the War on Terror or whether they are from Vietnam, the Korean War or World War II, I still have veterans from, as we all do, thankfully. We need to find new ways to stretch those dollars so that health care is provided and provided in a very cooperative manner.

Last week, I had a veteran come to me and he said I know that the VA does not want to become a pharmacy, but he said it is such a duplication of effort, he said, on my part and also on the part of the health care system that we have in America to go to a Medicare physician first, get a prescription, and then have to have a totally new exam and take up a slot that another veteran who does not have Medicare could use.

So finding ways to stretch those dollars so that the veterans in every single VISN are taken better care of is something that I know this Committee feels very, very strongly about. And I look forward to hearing the testimony on this, Mr. Chairman.

THE CHAIRMAN. Thank you very much.

I apologize to everyone for my late entry. I would like to thank Chairman Brown, the Chairman of the Health Subcommittee, for taking over in my absence.

Shortly we will hear testimony on Project HERO, a VA demonstration project that seeks to better coordinate fee-based care currently purchased outside the VA. The chief purpose of this initiative would, as I understand, be to enhance the access of quality care to America's veterans.

I believe this is a timely topic in the sense that Project HERO is currently being considered by the department, and I thought this hearing would also provide us a good opportunity to discuss very publicly what Project HERO is and what it is not.

Moreover, it will provide everyone here with an opportunity to share with the VA what they think it should look like and what matrix should be adopted to evaluate the effectiveness of the demonstrations as the requirements are drafted over the coming months.

We all know that the quality of health care provided by the Department of Veterans' Affairs is excellent. The challenge often lies in the access to VA facilities, especially for veterans living in the rural

areas.

Public law authorizes VA to use contracted, fee-based, private health care providers for service-connected injuries and conditions when its own facilities simply cannot provide suitable care for reasons such as emergency, inaccessibility, or certain other factors.

Our first panelist, Mr. Tom Osborne, a member of Congress from the State of Nebraska, knows only too well the challenges faced by veterans in his part of this country. Some of his constituents must travel for days to get VA health care.

And so, Tom, I want to thank you for your appearance before the Veterans' Affairs Committee, for your being here this morning, and for your testimony.

I would also like to thank our panelists, Dr. Mike Kussman, representing the Department of Veterans' Affairs, Ms. Cathleen Wiblemo on behalf of the American Legion, and Dave Gorman representing the Disabled American Veterans. We also have Humana Military Healthcare Services President and CEO, David Baker, himself a veteran.

And, Mr. Baker, I want to thank you for your willingness to step up to the plate and testify here today, especially in light of sort of traditional hesitancy among contractors due to potential procurement sensitivities. And so your willingness to step forward and be helpful to us is welcomed.

These panelists will present a good deal of information this morning and we appreciate the opportunity to learn about this care coordination, its demonstration, its potential, and its potential limitations early in the process.

Health care is undergoing a revolution. Earlier this month, this Committee held a hearing on collaborative approaches to the provision of health care through enhanced partnerships with teaching universities and other entities such as the Department of Defense.

These innovative partnerships have already proven their value in delivering America's veterans efficient health care of the highest quality. But these affiliations are only part of the solution to ensuring wide and timely access to quality care.

Project HERO, which stands for Healthcare Effectiveness Through Resource Optimization, is an outgrowth of the conference report of the VA's 2006 appropriation. Its stated objectives are to increase the efficiency of VHA process associated with purchasing care from outside sources, to reduce the growth of costs associated with the purchased care, to implement management systems and processes that further quality and patient safety, and make contracted providers virtual, high-quality extensions of VHA, control administrative costs and limit administrative growth, increase net collections of medical care revenues where applicable, and increase enrollee satisfaction with VHA's service.

In other words, Project HERO should help us learn how to improve some of the contracted care we now provide and the way we provide it. My understanding is that HERO is not intended to undermine our affiliations or to lead to expanded outsourcing or replacement of existing VA facilities.

With that in mind, open to the possibilities, but cognizant of the importance of preserving the quality associated with VA health care, I look forward to hearing more about this demonstration project.

I would yield to Mr. Osborne of Nebraska. I know you have a written statement. It will be submitted for the record, and you are now recognized for an opening statement.

STATEMENT OF HON. TOM OSBORNE, MEMBER OF CONGRESS, STATE OF NEBRASKA

MR. OSBORNE. Thank you, Mr. Chairman, members of the Committee, and staff. Particularly appreciate some of the staff work that has gone into this. I want to thank you for holding this hearing and really appreciate the Chairman's leadership on this issue.

Access to health care is one of the greatest obstacles facing veterans in Nebraska, as well as many veterans across the nation. What we found is that the older you are, the sicker you are, and the further away you are from a facility, the less likely you are to get care. At some point, the veteran simply does not go. And so I think people throughout the VA system recognize this shortcoming.

And so currently in the district I represent, there are 64,000 square miles. And if you look at VISN 23, which is what we are talking about here, this would be 390,000 square miles. It would encompass Iowa, Minnesota, Nebraska, North Dakota, South Dakota, parts of Illinois, Kansas, Missouri, Wisconsin, Wyoming.

So these are all relatively sparsely populated areas and the veterans in VISN 23 are traveling thousands of miles for their medical care. There is no question that there is a huge amount of travel involved.

At each stop that I make in Nebraska, veterans continue to express to me their concern about traveling hours for medical care. Many travel one to two hours to receive primary medical care, while some veterans who live in the western part of Nebraska must travel four days in order to have testing done in Omaha at the veterans hospital.

Let me explain how that works. They often will drive, sometimes have to get a family member to take off from work to drive them down to Grand Island or some place where they get on a bus and then they will go down to Omaha. They will spend usually a day or two days there and another full day coming back. And at some point, a veteran simply will not make that trip. They can no longer do that physically.

So it is certainly a problem.

Many veterans in Nebraska who are elderly encounter difficulty or find it impossible to travel long distances to receive their health care. If a veteran has to cancel an appointment, it may take months to reschedule.

We had a massive snowstorm, which we were very pleased to get. It covered the whole State of Nebraska a week ago. And the depth of the snowfall was anywhere from a foot to two feet, so almost every appointment had to be cancelled. And as you know, this may mean a three-month, six-month wait to get that rescheduled and as a result, this certainly creates a hardship.

I recently received a letter from the widow of a World War II veteran who resides in my district. Her husband had served 44 months in the military including 39 months overseas during World War II. In recent years, this veteran suffered from poor circulation and lung problems as a result of years spent serving his country.

Because of this man's poor health condition and physical limitations and the distance he lived from a VA medical facility, he was not able to travel the great distance necessary to access the care that he needed on a regular basis. He passed away in a local community hospital in 2005. and this is unacceptable.

The thing I would like to point out here, Mr. Chairman, is that because of the distance factor, sometimes these people simply do not get preventative care. Sometimes their care is undertaken only when things become critical. And as a result, the life expectancy of many of these veterans is shortened considerably simply because they do not get their blood pressure checked on a regular basis. They do not get their medications adjusted and all the things that people living closer to a facility can get done on a regular basis.

So we are trying to rectify that situation as much as we can. After looking at various options to address these problems, I introduced House Resolution 1741, the Rural Veterans Access to Care Act, and this would establish a pilot program to assist highly-rural or geographically-remote veterans who enrolled in the VA in obtaining primary health care at a medical facility closer to home.

The legislation requires the Secretary of the VA to use authority to contract with nondepartment facilities in order to furnish routine medical services to enrolled veterans who were classified as highly rural or geographically remote.

I believe VISN-wide care coordination demonstration will address many of the issues that my legislation is intended to address with regard to access to care.

And I might mention, let us say that you are in Chicago and you live on one side of the city and the VA facility is on the other side. It may not be a huge distance in miles, but it may take you an hour, hour and a half to get there.

So this is not strictly an isolated rural problem. It also affects people in relatively densely-populated areas. So we think this would serve all veterans.

Although I believe the demonstrations can be an effective way to provide reliable quality care to veterans in these areas, I understand that the contracts have not yet been written and all the demonstration requirements have not been completely defined.

So we are dealing with something that is a little bit amorphus here. However, I hope today's hearing will provide a valuable opportunity for everyone to get a better sense of what can be accomplished through the demonstration and give the department a better sense of what veterans' needs can and should be addressed through the demos.

While I believe it is critically important to provide additional access points through the Veterans Integrated Services Networks that have been selected for the demonstration, I think we should also demand that quality standards be effectively maintained. After all, my interest like yours, Mr. Chairman, is to provide timely, quality care to those who have served and are eligible for VA care.

Once again, I would like to thank the Chairman and the Committee and the staff for developing this demonstration project, and we hope that it will be looked upon favorably.

And at this point, I would be glad to entertain any questions that people might have.

THE CHAIRMAN. Thank you, Mr. Osborne.

[The statement of Tom Osborne appears on p. 60]

THE CHAIRMAN. The issue that you are touching on and exercising leadership on has also been an issue that has been addressed in the Independent Budget. It has been an issue that was touched in the Presidential Task Force. And so there are individuals who are advocates on how to provide this care in the rural areas.

But it is one where we say, oh, I know there is a problem, gosh, I hope somebody takes care of it. We really do not want it to affect our facilities. We want to preserve those facilities and the access and personnel. And there is such a tendency in this town not to ever make a change if it is going to affect the FTE. And it is a bizarre nature of the town, I think.

But I want to thank you for your willingness to step in to define this because it deals with the access to quality care. And it is interesting, some people will take that really simple word and say, well, it is defined only through the gateway toward a VA-based facility.

And what you are saying is that it is getting health care on a timely basis to a veteran in need. And so you have given some pretty good examples for us on how difficult it is in rural areas. And if the VA cannot provide that form of specialized care, whatever the need is, it ought to be done on a contracted basis.

That is sort of your recommendation to us, correct?

MR. OSBORNE. Absolutely. The main thing we want to make sure is that there is fairly equal access across the country and that there is reasonably equal quality of care. Nobody is going to be able to construct an entirely level playing field. Obviously if you live out, you know, 50 miles from the nearest town, there is going to be some difficulties.

But most of these veterans at least live within ten or fifteen miles of a health care facility where they can get their blood pressure checked, where they can get their medication adjusted, where they can at least get primary care. And in many cases, this is what keeps us going a lot longer because if your blood pressure is out of control and you do not even know it, you obviously are going to go downhill a lot faster than somebody who can get that primary care.

So we think that access is critical and we are certainly not trying to undermine the VA system. We are just saying, you know, as these folks get older and as they get sicker, they just do not go. And really I think everyone would like to see people treated somewhat equally in the system. And that is what we are after.

THE CHAIRMAN. Thank you.

Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman.

I want to thank you, Mr. Osborne, for your testimony. Like you, I am very concerned with improving access to health care for our veterans in rural areas.

And when you related a situation where it took a veterans four days to receive care, travel time, I can relate to that being from the State of Maine. I have heard where veterans have taken four days to receive their care. I look forward to working with you as we deal with the issue of rural health care and access. Thank you very much for your testimony.

Thank you, Mr. Chairman.

THE CHAIRMAN. Mr. Moran.

MR. MORAN. I have already complimented Mr. Osborne during my opening remarks, so it would only be repetitive, although he is very deserving of those compliments. I appreciate his efforts to once again highlight how difficult it is for many veterans in our country to access health care.

And I think he particularly did a fine job in reminding us that it is about extending life. It is about quality of life. It is not just numbers and statistics and number of miles. There is actual consequences to our failure to develop adequate policies to meet our countries veterans' needs wherever they live.

And so I commend Mr. Osborne and I look forward to working with him throughout the remainder of this term to see if we cannot get something done.

I thank you, Mr. Chairman, for this hearing.

THE CHAIRMAN. Thank you, Mr. Moran.

Mr. Strickland.

MR. STRICKLAND. Mr. Chairman, I also would just like to say to our colleague thank you for his obvious concern for a very real problem and thank you for your efforts to address that problem.

Thank you, Mr. Chairman.

THE CHAIRMAN. Ms. Brown-Waite.

MS. BROWN-WAITE. I do not have any comments.

THE CHAIRMAN. Dr. Boozman.

MR. BOOZMAN. Nothing, sir.

THE CHAIRMAN. Mr. Osborne, if you have recommendations as the VA proceeds with the drafting of this demonstration program, please let them know and let us also know what they are. I will not put you on the spot today. But what is wonderful about your testimony is is that we are going to be helpful.

Usually what happens is with demos, right, we send them down to the Executive Branch of government and we wait to see what it is. Right now we want to know what it is as they are proceeding. We do not do this very often.

But we know about your legislation. There are members that sit on this Committee who also represent rural areas. And we have all experienced a very similar fact scenario as you have described.

And sometimes we can be cold and we can draw a catchment area, a circle around a VA hospital and say, okay, if you are within the catchment area, then these types of rules apply. If you are outside it, other types of rules apply. And we really do not have that sort of managed care on a personal basis that perhaps we really should.

It is kind of interesting. We are challenged on this Committee because we are managing a social health system. It is. So as we are managing a government-based social health system, we then try to incorporate best business practices of the private sector into a government system to try to perfect a government system. And then as you try to perfect a government system, the system itself develops a culture and the culture then adopts defensive measures to protect itself.

And what you have done is you stepped forward here with an idea that coincides very closely with the initiative from the Appropriations Committee on this demo. And so we are going to try to figure out how we can provide that timely, accessibiliy to good-quality health care that you are seeking.

So I would just ask for your continued leadership on the subject. And I will yield to you if you have any closing comments you would like to make.

MR. OSBORNE. No, Mr. Chairman. I just appreciate the openness of the Committee and the fact that I have not been grilled extensively

by Mr. Moran. I was expecting much harsher treatment than I got. And so he must be having a good day.

But I do apologize for the fact that, you know, we are at the start of this whole process. We do not have all the answers. And so I think as we move forward, what we can expect is there will undoubtedly be -- some difficult decisions have to made. There may be some additional expense on the front end.

But hopefully as this thing proceeds, there will be some long-term savings and certainly people will be much better served because if you think about the cost of providing a van to go from Ainsworth, Nebraska down to Grand Island and doing this every day, which is essentially what is happening -- that is a trip of 400 miles -- when most of the people in that van could probably go four or five blocks away and get whatever treatment they need, that is tremendously expensive.

So long term, long haul, we think there will be some savings plus access will certainly be much better and health care will be much better of some of these remote veterans.

So appreciate your initiative and thank the Committee and the staff very much.

THE CHAIRMAN. To be very up front here with you, Mr. Osborne, is we have two distinct paths in front of us. We have a defined present system and it is facilities based. And we are sort of in this pause at the moment because we are coping with a system that is taking in so many of our returning veterans from the war.

So not only for those who have been recently injured and wounded, but not for those who have the right of access to care that we have given them because we are caring for present population, we have this pause with regard to building outpatient facilities and these clinics.

So what we have in front of us is an advocacy of, well, Mr. Osborne, the best way we can do that is to continue a build-out, maybe even CARES plus, and build these clinics on almost every corner of America. And that is how we can deliver the care.

That is a huge advocacy, a build-out of the national system. It is also very, very expensive. And we are learning this as we have five hospitals in front of us that we are to build for billions of dollars in cost. Or, do we hold on to a present system like we are and then turn to an initiative that you have done?

So we have really two very distinct paths in front of us. And so I want to thank you for your leadership. You are right. We need to examine this and the challenges that are in front of us.

Thank you, Mr. Osborne, for your testimony.

MR. OSBORNE. Thank you.

THE CHAIRMAN. The first panel is now excused.

For our second panel, if you will please come forward, is Dr. Michael

Kussman, who is the Principal Deputy Under Secretary of Health for the Department of Veterans' Affairs.

Dr. Kussman began his military career in 1970, serving with the 7th Infantry Division in Korea. He left active duty in 1972 to resume medical training and complete his residency at the Joslyn Clinic in Boston.

In 1979, Dr. Kussman returned to active duty at Tripler Army Medical Center in Honolulu serving as the Chief of Internal Medical and was later serving as a division surgeon in the Department of Medicine of Brook Army Medical Center in San Antonio; he became the Army Surgeon General's chief consultant in internal medicine, and the governor for the Army region for the American College of Physicians in 1988.

He commanded the Martin Army Community Hospital at Ft. Benning, Georgia from March 1993 to August 1995 and later commanded Walter Reed in Washington, D.C. where he was promoted to Brigadier General.

Following Walter Reed, Dr. Kussman served as the commander for Europe Regional Medical Command, the command surgeon for the United States Army in Europe, and the TRICARE lead agent for Europe.

Dr. Kussman, I appreciate you being here.

Mr. Loper, good to see you.

Gentlemen, if you have a written statement -- you do?

DR. KUSSMAN. Yes, sir. I think that has been submitted and we would appreciate it being submitted for the record.

THE CHAIRMAN. It shall be. So ordered.

And, Dr. Kussman, you are recognized.

STATEMENT OF MICHAEL KUSSMAN, M.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY C. MARK LOPER, CHIEF BUSINESS OFFICER, VETERANS HEALTH ADMINISTRATION

STATEMENT OF MICHAEL KUSSMAN

DR. KUSSMAN. Yes, sir. Good morning, Mr. Chairman and members of the Committee.

I am here today with Mr. Mark Loper, the Veterans Health Administration's Chief Business Officer to talk to you about Project HERO. As mentioned, we will submit our written testimony for the record.

And let me just up front apologize for my voice. If I lose it, I apologize, and my sidekick will act as my ventriloquist here.

My oral testimony will be brief. My testimony today will focus on the goals of the program, our plans to work with Veterans Service Or-

ganizations, and business partners in academia in implementing the pilot, our criteria for selection of the Veterans' Integrated Services Networks, or VISNs, for participation in the pilot, and finally our preliminary plans to evaluate the pilot.

Mr. Chairman, Project HERO is a pilot program developed in November 2005 in response to requirements in the Appropriations conference report of November 17th, 2005. The report called for expeditious action by VA to implement care management strategies that have proven valuable in the public and private sectors.

The report counsels VA to implement this pilot in a manner that ensures purchased care will be secured in a cost-effective manner that complements the VHA's system of care, preserves the agency's interest, and sustains our affiliate partnerships.

HERO stands for Healthcare Effectiveness Through Resource Optimization. Project HERO is intended to help VA better manage contracted health care by reducing the associated overall expenditures and improving quality. Done right, the pilot has the potential to reduce our contract costs while improving access, accountability, care coordination, patient satisfaction, and clinical quality.

Project HERO's demonstration objectives have been defined and communicated to a number of key stakeholders including the VA's National Leadership Board, VSOs, industry, and academia.

Some of these objectives include reducing the rate of cost growth associated with purchased care, implementing managed systems and processes for contracted care that foster quality, patient satisfaction and patient safety, and that will make contracted providers virtually high-quality extenders of the VHA, sustaining partnerships with university affiliates, controlling administrative costs and limiting administrative cost growth, increasing the efficiency of VHA processes associated with purchasing care from commercial and other external sources, increasing net collections of medical care revenues, and moving toward the integration of the use of the VA's electronic health record with the episode of care in contracted settings. This last step is really essential to our ability to succeed.

During this pilot, VA will work with business partners, including medical schools, to explore potential management strategies that might help VA meet the goals of the HERO Project. Participating networks will develop proposals for pilot consideration incorporating the best available strategies and tactics.

Proposals for each network will be reviewed by the network director, VA headquarters, and the Veteran Service Organizations to ensure that they align with our VA health care model and to ensure that the best interests of the veterans are addressed at every point in the process.

Each proposal will be assessed in terms of its potential impact on the clinical training program of each facility.

VA has selected four Veterans Integrated Service Networks to pilot Project HERO demonstrations. They are VISN 8, which includes all of Florida and southern Georgia; VISN 16, which includes Oklahoma, Arkansas, Louisiana, Mississippi, and portions of the States of Texas, Missouri, Alabama, and Florida; VISN 20, which includes Washington State, Oregon, most of the State of Idaho, and one county each in Montana and California; and, last, VISN 23, which includes Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and portions of northern Kansas, Missouri, western Illinois, Wisconsin, and eastern Wyoming.

The VISNs selected were among those who have the highest expenditures for community-based care relative to the number of veterans enrolled for care. In addition, these VISNs include some of our largest VA networks representing 25 percent of our total enrollment and 30 percent of our annual out-of-network expenditures.

We use these selection criteria to ensure that our demonstration will be representative of the larger VA population and to facilitate our ability to measure whether the pilot is successful.

We will assess the pilot's success by evaluating each program using a methodology that is still under development by the Project HERO team. This methodology will measure both clinical and business performance and patient satisfaction and will incorporate rigorous scientific means of measuring results relative to VA's performance matrix. Strategies with demonstrated success will be considered for adoption by other networks.

Mr. Chairman, Project HERO is an opportunity for our business partners to work with us to improve VA health care, especially health care we contract for the VA. We plan to implement the Project HERO demonstration and we welcome your continued thoughts and ideas about this process.

Thank you for your continuing interest in this most important initiative. This concludes my statement, Mr. Chairman. I will be happy to answer any question that you or other Committee members have.

THE CHAIRMAN. Thank you.

[The statement of Mr. Kussman appears on p. 63]

THE CHAIRMAN. This is a very challenging project that you have in front of you because we have not even made the present system sophisticated on how we are delivering the care to category sevens and eights.

The reason I say that, meaning with collections, is this movement to the electronic medical record, if we want there to be extenders into the system--you know, are we saying then that these providers out there have to also be up to date with electronic medical records and we get into some legal issues?

I do not know where this is going to take us. I just know this is -- I

do not mind stepping into something that is difficult and dark and try to define it. It is how we press the bounds. I just recognize there are some really challenging issues here in front of us.

You know, we also struggle with management tools with regard to utilization rate. So whether it is in our Medicaid and our Medicare and TRICARE, thinking about reimbursement systems out there, it is a real challenge and struggle that we have.

You know, the highest utilization rate--it is not now, but it was a few years back--for health care in the country was in Kokomo, Indiana, and it was in my congressional district. And UAW has a very strong presence there and it was first dollar, no deductible. And the utilization rate was very, very high. And they had to come in because it just got out of whack. It really did.

And so if you have an individual that has a right to care and it is in the community and just around the corner, being able to put together a system with regard to effective management tools and utilization is going to be extremely important in the management of the health system.

I just want to throw that out to you as some of my thoughts as we begin to work through this.

The other is Coach Osborne was referring to his legislation with regard to enrolled veterans who are classified as highly rural or geographically remote.

How would you define that?

DR. KUSSMAN. Mr. Chairman, I appreciate all the comments that you made and I agree with you that these are challenges. We will work through these to maximize what we can do.

I have not seen the legislation specifically that Representative Osborne has put forward, so I do not know exactly what is defined as extremely rural or not having access to care. But obviously it will be someone that had to travel a long distance, but I am not sure what that would be defined specifically as.

THE CHAIRMAN. In your demonstration program, are they going to take these types of veterans into account, individuals that are highly rural or in a geographically-remote area?

DR. KUSSMAN. Sir, as you know, that care for rural veterans and care for people who live in rural areas of the country is a very important issue.

The Project HERO was not geared or specifically directed in any way to the rural health issue. Not to say that it is not important, but it was not geared to do that. It was geared to look at what we are doing now when we contract fee-based care, but it was not directed at development of a program specifically for rural health.

THE CHAIRMAN. I know we have some overlapping things happening. That is why I sort of asked the question to you.

In your written testimony, you mentioned that the VA will develop

specific regional action plans to focus on purchasing care in a cost-effective, high-quality manner that is complementary to larger VA systems.

Do you anticipate the action plans to greatly differ between the four VISNs selected as demonstration sites?

DR. KUSSMAN. Obviously, sir, using the four VISNs with the characteristics that I described in my oral testimony, there may be some nuances from VISN to VISN because of the specifics related to the VISNs. But there will be certain basic tenants that would be with all the VISNs, setting certain standards.

Right now, as you know, we fee base and contract a large amount of care. But the ability to monitor that care and assure the quality is a challenge for all the reasons that you already articulated.

One of the efforts here would be to have a better ability to put in the contracts specifically what we expect to do to meet the standards that we have in our system, hopefully be able to integrate.

I certainly appreciate your comments about the electronic health record. We hope to be able to improve what we are doing with the contract.

THE CHAIRMAN. I am going back to Coach Osborne again. How will geographic regions dictate your action plan?

MR. OSBORNE. As I said, I do not think that they will dictate the action plan. I think that the action plan will be generally the same for all four VISNs.

I am just leaving it open that it could be that there are some nuances from one VISN to anther that they would have to look at. But generally the plan would be fairly standardized.

THE CHAIRMAN. Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman.

Will Project HERO mean that CBOCs and other access points will be delayed in opening?

DR. KUSSMAN. Are you suggesting that if we implement this plan, there would be something different about our implementation plan for CBOCs?

MR. MICHAUD. Yes, in those pilot areas.

DR. KUSSMAN. I do not believe that there is any direct relationship with the implementation of the CBOC plan with Project HERO.

MR. MICHAUD. Okay. Given that the VA has already submitted its fiscal year 2007 budget, will you need to request additional funding for the development and implementation of Project HERO and, if not, where in the budget will you be getting the money to do this project?

DR. KUSSMAN. Thank you for that question.

We believe that we have the resources available to implement this plan and that long-term, when the plan gets implemented, hopefully, it will pay for itself with the savings that we are going to achieve by better managing our contracting and outsourcing.

MR. MICHAUD. Now, the resources that you said you have available for the plan, is that coming out of the different VISNs' operating budgets or will it be out of the central office?

DR. KUSSMAN. At present, the money will be coming out of the business office and the central office to work on the standards for the plan. We do not believe we will have to tap into the VISNs early on to develop the plan and develop the contracts.

MR. MICHAUD. The Independent Budget testimony has raised concerns that Project HERO has strayed far off the course from the Independent Budget recommendation.

Is Project HERO broader in scope than the Independent Budget recommendation and is there anything that you can do to put to rest the concerns raised by the VSOs?

DR. KUSSMAN. Yes, sir. I have read the Independent Budget. There were obviously questions raised by the VSOs and concerns about that.

We have had the opportunity to meet with the VSO leadership. I was not there. Mr. Bill Feeley and Mr. Loper were there last week talking to the VSO leadership about the issues that they raised.

It is my understanding that they have a better understanding of where we are going. Some of the concerns that were raised, they are appreciative of the fact that will not be the case.

MR. MICHAUD. Thank you very much.

Mr. Chairman, I know we will be taking some votes pretty soon, so I would request permission to submit the remainder of my questions in writing.

THE CHAIRMAN. No objection.

MR. MICHAUD. Mr. Chairman, Ms. Brown, she has requested her statement be included in the record.

THE CHAIRMAN. No objection. So ordered.

MR. MICHAUD. Thank you, Mr. Chairman.

[The statement of Corrine Brown appears on p. 51]

THE CHAIRMAN. Mr. Bradley.

MR. BRADLEY. Thank you very much, Mr. Chairman.

I realize this question, General, may not be a hundred percent germane to this hearing today, but I raise it because of a concern that information that I found out in the last few days regarding emergency rooms at VA medical centers are under review with a possible definition change from emergency room to urgent care center that is being considered by the Veterans' Administration.

When I first got involved on this issue in my home State of New Hampshire in the Manchester VA, myself, the veterans' leaders that I work with believed that this was a local issue in VISN 1, that it was not part of a nationwide policy debate that the VA was conducting.

I, therefore, asked the Medical Director of the Manchester VA as

well as VISN 1 Administrator, Dr. Post, to come to a meeting in my office earlier this week with veterans' leaders. And I was somewhat surprised to find out that this is not just a VISN 1 issue, but, as I said, a change in the definitions from emergency rooms to urgent care center.

And just wondering if you might be able to illuminate a little bit where this policy change is, you know, what kind of oversight this Committee potentially has, where you are in your decision making. And if it is totally outside your purview, then just let me know that too.

Thank you.

DR. KUSSMAN. Yes, sir. Thank you for the question.

You are right. It is not necessarily directly related to HERO, but I appreciate your concerns and I am aware of your concerns and the issue that you bring up.

I think there are two issues related. The Manchester issue, just like all other things that really are a local phenomenon, that each place has to determine what they are going to do and make recommendations.

But as far as the larger thing, we have had an ongoing review of the quality of care and the level of care that we provide in different emergency departments, emergency rooms, urgent care centers. There are a lot of definitions and terms that get kicked around. No policy has been established, no national plan has been articulated.

We are in the process of looking at that not for any reason other than to be sure that the veterans who are getting care there can expect to get the level of quality care and safety at the institution.

If people believe that they are having an acute problem and they really believe there is an emergency room at the place they go, and it is clearly not the standard of being able to provide that level of care, we probably should not call it an emergency room because we are doing a disservice to the veteran. And they need to be informed that they would be better off potentially going some place else.

This whole issue is purely to look at what is in the best interest of the veterans and maintain the quality of care and safety for them.

I hope I answered your question.

MR. BRADLEY. Yeah. If I could, Mr. Chairman, just illuminate on that a little bit. I certainly share the thought expressed that the idea here is to make sure that whether it is an urgent care center or an emergency room is giving the greatest level of care possible, especially in those dire circumstances.

And one thing that was brought out to me in this meeting that I had the other day was that oftentimes in my state, because of the payment issue, a veteran will get in their car or their family member will get them in their car and drive, could be, you know, as much as an hour to get to the Manchester VA when there are other hospitals

much closer.

And, quite frankly, when you talk about whether it is stroke or heart attack or other emergencies like that, that golden hour is critically important for the ability to save somebody's life. And so there is certainly legitimate issues there.

But what was brought out -- and this is more of a comment than a question -- by the VSO leaders at the time was that if there is an unintended consequence, if you will, of an unknown, if you are not Medicare eligible, if you are not Millennium eligible, of who is going to be responsible for payment in those emergency situations -- and let's face it, that is an expensive situation -- that there is an unintended consequence of an incentive to get in your car and to drive to the VA center because you believe the payment will be taken care of.

So I really hope that in any debate on this, and I am pleased to see that, you know, you have not established a plan, and I hope that this Committee will conduct oversight hearings and work with the administrators, but I hope and trust that before any plan is established, if there is going to be a diminution of hours of operation of these emergency rooms, that the payment issue is also addressed so that the unintended consequence of in a dire emergency somebody thinking, well, I need to go to the VA center because that is where the payment issue will be resolved, that we do not impinge upon the safety of the veteran because that payment is not resolved.

And I really feel that the one goes with the other. Has to be part of any plan for change of emergency rooms nationwide. And look forward to working with you and the Committee and the Chairman on this.

THE CHAIRMAN. Thank you.

Ms. Herseth.

MS. HERSETH. Thank you, Mr. Chairman. And if I might just continue along the line of questioning of Mr. Bradley and I understand some of the other questions that were posed before I was able to get here by Mr. Michaud about just the payment, the budgeting for all of this.

I am glad to hear that it is not going to affect community-based outreach clinics. And I understand that in terms of the budgeting for Project HERO that it is not going to initially come out of any VISN's budget; is that correct?

DR. KUSSMAN. Yes.

MS. HERSETH. So does that leave open the possibility that while it may not initially come out of the VISN's budget that at some point in time, the budget for a particular VISN may actually be impacted?

DR. KUSSMAN. Well, thank you for that question.

The issue here is that ultimately as the pilots go out, hopefully as I mentioned, that any cost to the VISNs would be more than adequately covered by the savings that they get for not having the ability to

manage their care, contracted care and fee-based care, better than we are doing now.

So hopefully at the end of this, there will be actually a profit for the VISNs, not a loss.

MS. HERSETH. And is there a plan in place to track that in terms of projected cost savings and actual cost savings and how it impacts the VISN budgets?

DR. KUSSMAN. Yes. The whole idea, that is what a pilot is about, is to make sure that we can benefit by doing this. If it turns out that we are not maintaining the quality or doing the things that we intended to do including saving money and be able to get a bigger bang for our buck, then we would have to reevaluate that.

MS. HERSETH. With all due respect, I understand that is what pilots are about, but our experience suggests those pilots become expanded and systems change, that sometimes those tracking devices for each pilot tend to not work quite as well once those programs are expanded and then we find ourselves in a budget crunch. That has been the case in a number of programs.

And in just my short time here in Congress coming up on two years, I know that that is the case. So I appreciate the assurance and I appreciate the affirmation about what pilots are intended to do.

I just want to make sure that beyond the initial pilot stage, that as the projects are expanded to the degree that we find that Project HERO is indeed achieving the goals that we hope it achieves, that your responsibility, our responsibility on the Committee is to continue to share that information to ensure that the VISNs' budgets are not unduly affected or to ensure that cost savings that are projected are actually being realized at the level that we hope that they will achieve.

DR. KUSSMAN. Yes, ma'am.

MS. HERSETH. And the last question would be, as Project HERO moves forward, do you feel that cost savings is the most important consideration when making decisions regarding patient care, for example?

And I ask this because many of the veterans in South Dakota are in geographically-isolated areas. But will a patient who can receive more cost-effective care through a contract provider be forced to receive care with the contract provider instead of a VA facility?

DR. KUSSMAN. Thank you for the question, yes. I do not mean yes to the answer, but yes to the question.

Obviously if a contracted mechanism, fee basing with a contractor is going to be successful, the majority of patients would have to use it; otherwise, you will not get your maximum benefit.

We understand the reality of people having formed relationships with particular providers that are clinically important to maintain. We will look at that on a case-by-case basis because, although to make

it work as I said, we would presume that most people would use the provider network; otherwise, we will not get our maximum benefit of assuring the quality and tracking and as well as cost-effectiveness.

But we certainly do not want to do anything inappropriate clinically.

MS. HERSETH. Thank you for your responses.

I yield back, Mr. Chairman.

THE CHAIRMAN. Ms. Herseth, I thank you for your questions.

She is correct. Sometimes these pilot projects and demonstrations and commissions, three entities that we in Congress love to create, become more organic than mechanical and they take a life of their own. And so the oversight of these things is pretty important.

We have one vote. And so I intend to recess the Committee and return because I have some questions for you, Mr. Loper.

So the Committee will stand in recess for 15 minutes.

[Recess.]

THE CHAIRMAN. The Committee will come back to order.

I have some questions for the second panel. With regard to Project HERO, as I understand, you are simply trying to better coordinate the care that is already purchased outside the VA, right?

DR. KUSSMAN. Yes, sir.

THE CHAIRMAN. Now, as you do that, my sense is that as you begin to work with private providers, we are going to learn things in the process and it could provide for additional venues.

Now, I recognize the comment I made before we broke with regard to how demos and pilots and commissions all become organic, and there is a reason they become organic. It is because sometimes we get into these things and we learn things that we did not know and we are seeking latitude.

And sometimes just things grow, you know. Kind of like PFSS, right, Mr. Loper, they kind of grow, right?

MR. LOPER. I will take your word for it.

THE CHAIRMAN. Pardon? You are going to take my word for it?

But at some point, my sense is that when you do this VISN-wide, we have to be able to anticipate that points of access will increase. Would you agree with that?

MR. LOPER. Yes, sir. I think there is potential for that to occur in the demonstration framework.

THE CHAIRMAN. So if there is potential for that to occur within the framework, would that potential come from the strength that private contractors also bring to the demo?

DR. KUSSMAN. Sir, I think that that is what we are looking at now is some input from contractors who have done this, other public venues that have done it, academia, thought leaders on all of this, as well as bringing into account, as I mentioned earlier, our affiliates to be

sure that as we develop the pilots, we try to incorporate the lessons learned from other people who have gone down this road in the past.

THE CHAIRMAN. Now, Mr. Loper, as you put this thing together, what performance measures do you intend to use to assess the use, cost, and consistency and continuity of care for the veterans enrolled in the demonstrations?

MR. LOPER. Sir, we have a team working on the specifics of that, but the basic framework that I would offer is that we have a very sophisticated system of performance measurement in the VA and we intend to use that.

The principal reporting unit for the demonstration operations is at the network or VISN level. And we would seek whatever interventions are made within the network to lead to favorable performance in those existing measures.

THE CHAIRMAN. Let be me circle back to an opening comment that I had made referencing the electronic health record.

So what measures do you intend to put into place to make sure that the complete medical records associated with the purchased network care will be part of his or her electronic health record?

DR. KUSSMAN. Yes, sir. Obviously one of the weaknesses that we have now with people who use different delivery systems, whether we fee based it or whether they are using a Medicare benefit or some other insurance plan, even TRICARE, and then they come to us, the problem is the coordination of that care.

What we expect to do is write into the contracts the intent to have the providers use our CPRS Vista Electronic Health System that is proprietary, and it would not be all that costly for that to be used to be able to electronically continue to track the patients. That is one of the linchpins of our potential program.

THE CHAIRMAN. Let me go back to the issue on costs with regard to the demo. If there are costs associated with the demo, do you know what accounts you might be looking to take from?

MR. LOPER. I think I would like to take that sort of officially for the record with Mr. Norris as the CFO.

But having said that, we have invested small amounts of money from the business office to organize the program and acquire the services of someone to help us with the acquisition which should get us to the point of award for a very modest amount of money.

Dr. Kussman suggested that we believe the demonstration will essentially pay for itself. What specific account it comes out of for this medical care or what have you, we will sort out.

DR. KUSSMAN. I appreciate the question and we will get back to you on that. I am not sure exactly which --

THE CHAIRMAN. So you are anticipating that for most of the fee-based care for the service-connected conditions or injuries, you are going to have collections sufficient to pay for all of this?

DR. KUSSMAN. Sir, as mentioned, we are already paying a huge amount of money for contracted and fee-based care. We believe the pilots will show that when we can coordinate this care, we will be able to save money on it, whatever that turns out to be, and that will pay for any overhead that we had for the contractors and potentially generate some dollars for us above and beyond that.

THE CHAIRMAN. Mr. Loper, I understand the VA is reprogramming $5.5 million for the Patient Financial Service System Project in Cleveland. Could you please describe why the additional $5.5 million is needed?

MR. LOPER. Yes, sir, Mr. Chairman. We look forward to the scheduled briefing on Friday to a deeper level of review on this.

Our program had a scope in 2006 to deploy PFSS to Cleveland and to Dayton and be prepared to go further. In the light of the recent IT appropriation adjustments to the current program, PFSS was funded at about $5 million.

And what we explored was what it would take to actually deliver PFSS to the Cleveland operating location and for a marginal amount, we would seek restoration by reprogramming within our program to 10.5. They are marginal 5.5 to get us to 10.5 and we will deliver a functional PFSS product at Cleveland later this year.

THE CHAIRMAN. So these dollars will keep the demonstration project on track for deployment this fall? Is that what --

MR. LOPER. Yes, it will, Mr. Chairman.

THE CHAIRMAN. All right. How is the second competitive demonstration project going?

MR. LOPER. Yes, sir. You mean the Revenue Enhancement Project has been awarded to a veteran disabled business with a subcontractor, and they are beginning work in Asheville at the CPAC. And we look forward to that. It has been awarded basically in a three-phase effort.

The first phase is an assessment. Our competitive bidders each were asked to provide an assessment phase and a performance phase. In the down select, we were real pleased with the nature of the work offered by the successful bidder.

THE CHAIRMAN. And why did you choose Asheville, North Carolina?

MR. LOPER. Mr. Chairman, we chose Asheville in the sense that we know the sense of the Committee was that there was an interest in two low-performing medical centers. And as you know and I believe with the Committee's knowledge and consent, we thought CPAC by addressing at least six medical centers provided better leverage.

And, frankly, one of the aspects of all the business proposals anticipated a business model for following success, a site-by-site rollout which was pretty labor intensive. So what we are intending is to demonstrate a CPAC, at the same time demonstrate CPAC in a

streamlined deployment to a broader application if that is indicated.

THE CHAIRMAN. I would ask unanimous consent that minority counsel be given the opportunity to offer two questions. Hearing no objection, so ordered.

Minority counsel is recognized.

MS. BENNETT. Thank you, Chairman Buyer.

In the past, the VA has based its budget on claims of management efficiencies that the GAO found could not be fully substantiated.

What assurances could you give us that this demonstration will indeed be cost neutral or will save money?

DR. KUSSMAN. Thank you for the question. I understand the issue that you raised. We are very aware of that.

The intent here is to put in very clear performance standards, both clinical and economic, to be sure that we do not after the pilots reinforce something that is not economically viable.

MS. BENNETT. Thank you.

During Industry Day on February 2nd, you discussed a number of objectives for Project HERO. One of the objectives was enhancing VA internal capacities and processes to minimize the need for purchased care.

Can you elaborate on the role you see for contractors in achieving this objective and the likely cost savings for this component of Project HERO?

DR. KUSSMAN. Are you asking whether we are going to use contractors to look at our efficiencies in-house?

MS. BENNETT. I was asking you to elaborate on the role you see for contractors in that process.

DR. KUSSMAN. I think that we are doing that internally. I do not believe that there is any contracting mechanism, but we are looking at -- I mean, just like any other enterprise, we have got to continually look critically at how we do our business. I think that we are looking at our processes to try to be more efficient and approximate our great clinical performances.

THE CHAIRMAN. I have a question. Are you at any time going to seek independent evaluations? Have you thought about this, for the end?

MR. LOPER. Mr. Chairman, at Industry Day and hence forth, we have expressed a specific interest in external evaluation, validation, or whatever program reviews take place.

THE CHAIRMAN. All right. I may have additional questions for the record. And I know Mr. Michaud also does. Minority counsel indicates they will have additional questions.

I want to thank you for your leadership and, Mr. Loper, appreciate your service.

MR. LOPER. Thanks, Mr. Chairman.

THE CHAIRMAN. This panel is now excused.

DR. KUSSMAN. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you.

The third panel may proceed and come forward.

The panel consists of Ms. Cathleen Wiblemo who is here representing the American Legion as their Deputy Director for Health Care in the Veterans' Affairs and Rehabilitation Division. She is a graduate of Black Hill State University in South Dakota where she received her degree in history.

Upon graduation December 1984, she was commissioned as a Second Lieutenant in the United States Army. During her ten years in the military, she served in various positions both in country and overseas and is currently a major in the reserves.

How often have we all been introduced as we were commissioned as a Second Lieutenant? I have never heard anybody say, yeah, okay, we were commissioned as a Brigadier, you know, commissioned as a Major, commissioned as a Lieutenant Colonel, right?

MS. WIBLEMO. Right.

THE CHAIRMAN. It is like that of course, isn't it? I know we get some direct appointments and commissions, but it is always Second Lieutenant, in the most humbling years of our lives, that always seems to come back as if that was our greatest achievement, when we were commissioned as a Second Lieutenant.

MS. WIBLEMO. I have never actually been introduced, so that is very -- that is the first time anybody has ever said that.

THE CHAIRMAN. What, that you were a Second Lieutenant?

MS. WIBLEMO. Commissioned as a Second Lieutenant.

THE CHAIRMAN. Okay. Well, I will call you Major, Major.

Our next witness is Dave Gorman representing Disabled American Veterans. Mr. Gorman entered the United States Army in 1969, serving with 103rd Airborne Brigade, the famed Sky Soldiers of the Vietnam War.

During a campaign to secure an area in central Vietnam where the United States forces had suffered extremely high casualties, Mr. Gorman stepped on a land mine, leaving him with wounds that required amputation of both legs.

Discharged in 1970, Mr. Gorman immediately joined the DAV and is currently a life member of DAV's National Amputation Chapter in Chapter 12, Rockville, Maryland. Mr. Gorman was appointed as Executive Director of the DAV in 1995.

Our final witness is Mr. David Baker, President and CEO of Humana Military Healthcare Services. Following a distinguished active-duty career of 27 years in the United States Air Force Medical Service Corps., Mr. Baker joined Humana Military Healthcare Services, Region 3, Executive Director in 1996. In 1999, he became Humana's chief military operating officer and in January 2000, he assumed his current position.

Mr. Baker holds and MBA in Health and Hospital Administration

from the University of Florida and a BS Degree in Business Administration from the University of Maryland. He is a graduate of the Executive Program in Health Care Management from Ohio State.

And were you commissioned as a Second Lieutenant? Proudly, Mr. Baker was commissioned as a Second Lieutenant in the United States Air Force.

I would like to thank all of you for coming and your patience today.

And with the American Legion, we will begin with you.

STATEMENTS OF CATHLEEN WIBLEMO, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; ACCOMPANIED BY DAVE GORMAN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS, REPRESENTATIVE FROM THE INDEPENDENT BUDGET; DAVID J. BAKER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HUMANA MILITARY HEALTHCARE SERVICES

STATEMENT OF CATHLEEN WIBLEMO

MS. WIBLEMO. Thank you. Thank you for the opportunity to present the American Legion's views on the comprehensive care coordination demonstration projects. My remarks will be brief, but I ask that my full statement be submitted for the record.

THE CHAIRMAN. So ordered.

MS. WIBLEMO. We all know VA has made giant strides in improving the quality of care provided to America's veterans. The improvement has not gone unrecognized by the industry and VA is now considered by many to be the best care anywhere.

For the sixth consecutive year, they have set the public and private sector benchmark for health care satisfaction, quite an accomplishment by any standard.

This achievement could not have been realized without the dedication and commitment of the VA employees. They have a special mission that they take very seriously and that is to take care of the nation's heros.

Public Law 109-114 tasked VA without proper funding to implement care management strategies that are proven valuable in the broader public and private sectors. These programs are to satisfy a set of health system objectives related to arranging and managing care by the end of calendar year 2006. VA is to collaborate with academia and private industry to assist in reaching this goal. This obviously is no small task.

As we understand it, these demonstration projects are to be designed as a complement to VA health care and not as a surrogate.

We also understand that the devil is always in the details and the implementation of these demonstration projects will require strict oversight of the contracting process to ensure that veterans who are being treated by non-VA providers receive the same level of quality and professionalism inherent to the VA health care system.

There should not be any semblance of the concurrent system and the process should be transparent to the veteran patient.

The American Legion recognizes the need for contracted care and, indeed, the VA has had the authority to contract care for quite some time. However, the VA has not always been the most efficient at contracting and the American Legion has some real concerns.

VA must routinely monitor all contracted health care services being provided to veterans and they must obtain patient satisfaction feedback on the timeliness and quality of care received from contracted providers.

While some treatments may be handled effectively by outside contractors, the delivery of more specialized care is very difficult to access outside of the VA health care system. Mental health care, blind rehabilitation, amputee treatment, and long-term care services are a but a few that come to mind.

Further, many of VA's patients are older, poorer, and sicker than the general population. The American Legion is deeply concerned that VA patients would be treated differently than other non-veteran patients. Within the VA health care system, patients are our priority, not just a customer, and they receive holistic care.

While the American Legion supports veterans' timely access to quality health care, it is important that we do not create initiatives that will lead to the dissolution of the very health care system created to care for these heros. Accessibility delays must be solved by enabling VA to meet its obligation through adequate funding levels.

There is much left to be done with regard to these demonstration projects and the American Legion looks forward to being involved in the process.

Pass through the doors of any VA medical center and you witness firsthand the price of freedom. It hammers home the very reason the VA health care system exists and it also reminds us that the price tag of freedom does not end on the battlefield.

Thank you very much. I look forward to your questions.

THE CHAIRMAN. Thank you very much.

[The statement of Cathleen Wiblemo appears on p. 70]

THE CHAIRMAN. Mr. Gorman.

STATEMENT OF DAVE GORMAN

MR. GORMAN. Thank you, Mr. Chairman. I know you did not ask, but just for the record, I was never commissioned as a PFC.

THE CHAIRMAN. If you note, I did not ask you and you would have been insulted.

MR. GORMAN. I would not have been.

Mr. Chairman, appearing here as an employee of the DAV, I want to just make it clear that I am making a unified statement on behalf of the Independent Budget, the AMVETS, Paralyzed Veterans of American, and Veterans of Foreign Wars.

Mr. Chairman, historically Congress has granted service-connected disabled veterans an opportunity to receive private health care, but has very much limited VA's power to contract for care.

And it has been stated already, but bears repeating, generally VA only contracts for care when VA facilities are incapable of providing care necessary for a veteran, the VA facilities are geographically inaccessible to the veteran, a medical emergency prevents a veteran from reaching a VA facility in time, VA determines it appropriate preparation for or completion of an episode of VA Care, or VA needs certain specialty examinations in adjudicating a veteran's disability claim.

VA also has the authority to contract for care for services of scarce medical specialists in VA facilities. The Independent Budget acknowledges that VA contract care has been used judiciously and only in specific circumstances so as to not endanger the integrity of VA facilities and the health care system in general.

We believe, Mr. Chairman, that VA must maintain a critical mass of capital, financial, human, and technical resources to provide direct, high-quality care to veterans, especially those disabled in military services and those with highly sophisticated health problems such as blindness, amputations, spinal cord and brain injury, or chronic mental health problems.

Mr. Chairman, in recent months, much has been reported in medical literature and the general media on the stature VA health care has achieved in providing health care of the highest quality. At a time of public cynicism over the ability of the federal government to respond effectively to public needs, VA as the provider of health care for veterans has been touted as being, and I quote, 'the best health care system in the United States'.

VA has achieved this position because they control to whom care is provided and knows who provides and receives that care and, more importantly, measures how that care is given on a daily basis.

The potential direction and scope of Project HERO, at least as we understand it today, could well evolve into an open environment of mixed VA and private providers. The contract element of that en-

vironment, if it focuses on acute and primary care, could well grow. That growth, like the enormous growth we have seen in the TRICARE Program over the last 15 years, may place at risk VA's unique quality as a renowned and comprehensive health care provider for veterans.

We have some fear that the HERO project, if it expands outsourcing of health care services, is only a beginning. Once contractors are in place, we would expect proposals from them for VA to contract out even more services.

We believe that such a mixed program would only become more expensive, threaten VA's restorative and rehabilitation programs, and damage VA's health professions, affiliations, and its biomedical research, which we all know is the bedrock of VA quality.

Mr. Chairman, here is our nightmare scenario. Increasing contract care evolves VA into a mere payor for health care services provided to veterans by others. VA writes the checks to obtain health care to a growing patient population outside the system, but must pay for those services from funds it receives to carry out its health care mission for patients inside that system.

In a struggle to manage its growing insurance function, VA's control over the quality and the quantity of inside services diminishes. As a result, veterans and the American taxpayer will lose out on that process.

We could not object more strongly to this kind of a change, Mr. Chairman. VA is first and foremost a direct provider of health care to sick and disabled veterans. That single fact is why the VA system is a great asset to America's veterans and to America's taxpayers.

We believe the best course for VA is to care for veterans in facilities under the direct jurisdiction of the Secretary when at all possible.

For the past 25 years or more, veterans' organizations have opposed proposals to contract out, voucher, or privatize VA health care.

We believe proposals that claim to expand access to VA to broader areas serving additional veteran populations at less cost or provide health care vouchers enabling veterans to choose private providers in lieu of traditional, well-established VA programs in the end will only dilute the quality of VA care.

Given the dire financial straits VA has experienced over several recent fiscal years, privatization, whether called Project HERO or something else, is a vitally important policy to sick and disabled veterans and those who represent their interest.

Given that background, Mr. Chairman, I know you are not surprised that we have recommended to VA that VA take a series of actions to improve contract health care. VA contract workloads have grown and now cost over $2 billion annually.

VA has not been able to monitor this care very well, consider its relative costs, analyze outcomes, or establish patient satisfaction

measures. VA lacks a viable process to verify that contract care is safe and provided by licensed, credentialed providers, to monitor for care, to direct patients back to the VA health care system, to ensure records of that care are accurate and complete, and to validate the care received is consistent with VA's clinical policies.

Twice in the Independent Budget, we have recommended that VA implement a program of community care coordination that integrates clinical and claims information for veterans currently cared for by contract providers.

VA has achieved significant savings through its current Preferred Pricing Program, which I explain more fully in my written statement. VA has saved more than $53 million since its inception and estimates they will save some $80 million this year.

But much more could be done, Mr. Chairman. By partnering with an experienced contractor in this field, the VA could define a care management model with a high probability of achieving our objectives in the Independent Budget.

The Independent Budget suggests the program features would include established provider networks complementing the capabilities and capacities of each VA medical center, to meet VA access standards, comply with VA performance standards, and address appropriateness and continuity of care, case management to assist every veteran and each VA medical center when the veteran must receive non-VA care in lieu of VA care, standardize billing, record keeping, and reporting, and specific methods to gauge and report veteran satisfaction.

Mr. Chairman, the overall results of our recommendation if implemented by VA, we believe, will offer veterans a truly integrated and seamless health care delivery system. The fact is that currently many service-connected veterans are disengaged from the VA health care system when they receive medical services from private physicians at VA expense.

Based on our current knowledge of VA's pending demonstration project, HERO, today we could not verify that VA is preparing our model of community care coordination for that demonstration.

Both at the Industry forum hosted by VA in February to announce its plans for Project HERO and in more recent meetings with VA's central office officials, we have expressed our concern about the lack of specifics to describe the coming demonstration.

Only within the last week have we learned of the proposed geographic sites for this demonstration. The VISNs were described to us as the best targets because they spend most of the contract care funds.

VA officials have informed us they plan to reduce contract costs on the networks by using some of the ideas we have presented in the Independent Budget. However, we have not yet been briefed on

industry proposals that will shape the VA's bid package and we have not consulted with the four network directors to assess their plans as of yet.

We remain concerned, Mr. Chairman, that in developing Project HERO model, the department has still strayed off course from the intent of the IB's recommendations. Until our concerns are allayed about the true nature and goals of Project HERO, that demonstration project should not be attributed to or justified by our recommendations.

Based on what we know and considering what we do not know at this point, Project HERO is not entirely consistent with our goals for VA contract care.

In summary, Mr. Chairman, we are united that whatever emerges from our managed care industry or from these VISNs. As representatives of millions of enrolled, sick, and disabled veterans, we should be involved in any proposed VA decision making on this initiative.

It is our hope that department will shift the focus of Project HERO to achieve the goal of the Independent Budget. And we hope to work with them and this Committee to secure that objective.

I would also add, Mr. Chairman, that just last Friday, we met with VA, Mr. Feeley, and I am speaking now only for DAV. I think that we are a little bit more optimistic about where the VA is driving this project and their intent of it.

And we are still anxious to see the bids from the contractors and what VA hopes to achieve by this. And we look forward to working closely with them.

THE CHAIRMAN. Thank you.

[The statement of Dave Gorman appears on p. 76]

THE CHAIRMAN. Mr. Baker.

STATEMENT OF DAVID J. BAKER

MR. BAKER. Mr. Chairman, I appreciate the opportunity to provide input today on VA efforts to improve the delivery of and access to cost-effective health care services through Project HERO.

I am Dave Baker, President and CEO of Humana Military Healthcare Services and a veteran of this great country. I have provided a written statement that I would ask be included in the record.

THE CHAIRMAN. So ordered.

MR. BAKER. Thank you, sir.

I want to begin by extending my appreciation to the Veterans' Health Administration for its recent achievements including its advancements in developing state-of-the-art medical records, CARES programs that have realigned VA costs and assets, its increased efficiency and its control of administrative costs, and I also extend

thanks for serving as members of current TRICARE networks when capacity has existed. And, finally, I appreciate VHA's successes in so magnificently improving the quality of VA health care services.

As I heard Dr. Perlin state on more than one occasion, it is not your father's VA, and I agree. It truly has achieved world-class status.

Mr. Chairman, since I have not testified before this Committee before, some background information may be helpful.

Humana Military Healthcare Services is a wholly-owned subsidiary of Humana, one of the nation's largest health benefit companies. Our subsidiary was formed in 1993 to work with the Department of Defense in controlling costs, improving access, and enhancing the quality of purchased care services for the military community under a program called TRICARE. We have delivered TRICARE services since 1996 and today we serve approximately 2.8 million eligible TRICARE beneficiaries.

Our contracts with DoD are founded on achieving five major objectives. First and foremost, optimizing the delivery of health care services inside military hospitals and clinics; second, maximizing the beneficiary satisfaction; third, delivering best value in the purchased care arena; fourth, ensuring smooth contract implementation; and finally providing DoD access to our data.

Though the terminology is a bit different, I have seen the objectives for Project HERO and I believe that they are very consistent and similar.

Now, we operationalize these objectives by providing a number of contractually-required services. Some or all may be applicable to Project HERO, so let me explain.

We provide a stable network of high-quality, credentialed health care providers to augment those in military facilities. We furnish complementary medical management services and clinical support. We provide comprehensive customer information and support.

We perform various eligibility verification, billing, and enrollment services. We process all claims for services rendered by civilian providers. And, finally, we provide DoD access to our health care data.

I have included specific recommendations on each of these functions in my written testimony. And I also included a series of recommendations related to possible contractual elements of Project HERO.

Among the topics the VA should consider are development of measurable standards of performance, inclusion of fair and objective incentives to reward performance excellence, provisions related to the sharing of financial risk, and developing a culture of collaboration and trust with industry partners.

I hope these inputs will be helpful to the VA as it develops Project HERO's specifications and to the Committee as you collaborate in this important undertaking.

Mr. Chairman, thank you again for the chance to be here today. I

look forward to answering any questions you may have.

THE CHAIRMAN. Thank you very much.

[The statement David J. Baker appears on p. 82]

THE CHAIRMAN. Mr. Gorman, I think what I enjoyed most about your testimony was your last statement on behalf of the DAV because I think what we have here is a statement drafted by the Independent Budget and then you met with the VA and that put you in better comfort.

So you gave testimony on behalf of the Independent Budget that is sort of locked in place and you did not have some of the understanding, but you then gave it as testimony on behalf of DAV. That was my sense as I was sitting here listening to it.

And that is why what I enjoyed most was your final statement, not the original statement, because part of the original statement I bifurcated almost. It was very much an alarmist type statement. And then without having the knowledge base, it is hard to be briefed on something that has not even been written.

And so I am concerned about whoever drafted that and gave it to you. And you did your job. You came here to testify on behalf of the Independent Budget, but your last comment was probably the most important comment that I took from your statement. I just wanted you to know that.

MR. GORMAN. Mr. Chairman, I appreciate that, but I would also say that I am not so sure it is an alarmist view that the oral remarks, the majority of them up front, tried to convey, but one that we were just very much unsure of how the VA was proceeding. And in many respects, we still are.

But I think that the leadership of VHA has come forward and tried to allay those fears. And I think generally there is some optimism now that they are going to be moving forward with the bulk of the recommendations the Independent Budget has made, plus what we have heard today for testimony, and not necessarily a free for all as far as contracting out.

THE CHAIRMAN. Mr. Gorman, please understand who you are talking with. You are talking to the guy who helped create TRICARE for life. So as I created TRICARE for life, at no time was that diminished as somehow being is private care and, therefore, bad.

And so we have soldiers being treated in a military medical treatment facility and we have dependents then being treated in TRICARE, receiving private care. So, therefore, we have two different standards and it is a bad program? No.

So even in the VA itself, we have fixed-based facilities and there are certain times with regard to specialized care, what do we do? We contract for it. When we contract for it, that does not mean, when you go out to the private sector, that it is bad. So privatization is not

a bad word.

So the reason I used the word alarmist is because I picked it up not only from the American Legion testimony but also yours on this concern that somehow this is going to erode the present system--the fear of a surrogate for care as if all this can be a bad thing. We do not want to deny access to care. If a veteran cannot get access to care, we want to be able to get them the care.

I cannot believe that the Independent Budget or the American Legion would be saying, okay, it has got to be through a VA fixed-base facility and if it is not, well, I guess tough luck. That is denying access to care and I do not believe that is what you are embracing.

MR. GORMAN. No. That is not what we have said. What we have said, and if you listened, and I am sure you did, we think VA has judiciously used their contract ability so far.

The only fear that we have here is that they are going to or somebody is going to take this legislation and this authority and now the creation of this project to completely try to in certain areas and certain programs, completely contract out care. And I do not think that is a good thing.

THE CHAIRMAN. Let's go down that road for just a second. Why is gaining access for health care for a veteran, a disabled veteran such as yourself -- you live in Nebraska and you cannot gain access to care -- why is that bad? If I were to say, okay, we are going to adopt the position of the Independent Budget, then we are denying your access to care. That is exactly the testimony of Coach Osborne. So please explain to me why that is a bad thing.

MR. GORMAN. Well, it is a bad thing only if you are going to take -- and, for example, I asked a question at the meeting with VA last week, will your contractors, as far as you know, or can you speculate, are they going to require a critical mass, a number of veterans if they want to enter into this contract. And they do not know that.

It is not a question of denying care. It is a question of taking veteran patients who are already in the VA system and saying now we have got a contract out here to provide care in the private sector for them. That is not denying care.

THE CHAIRMAN. It is. It is denying care. If I have a veteran -- Mr. Gorman, let's see if we can get on the same page here. We have a present VA system. We have enrolled veterans in that system. And how do we then access them into the system. If, in fact, they are enrolled and in distant rural areas, how do we access them into that system?

And I just cannot believe that it would be the position of the Independent Budget to say that they should be denied their access to care because they live so far out.

MR. GORMAN. We are talking apples and oranges, I believe, Mr. Chairman. That is not our concern. That is almost a separate is-

sue.

THE CHAIRMAN. Thank you very much. Thank you. That is why I used the word alarmist, because it is a separate issue.

MR. GORMAN. The rural health care issue.

THE CHAIRMAN. Absolutely. So you have testified at a hearing based on HERO and were alarmist based on something that has not even been created. So I want to thank you for -- no, you did.

MR. GORMAN. You have to explain that one to me.

THE CHAIRMAN. Okay. We want to say, okay, of the present dollars that are contracted from the VA, we want them to be able to show to us how they can institute private sector initiatives and managed care, and better utilize those dollars. That is what the Independent Budget says. That is a good thing. That is what Dr. Kussman wants to do.

The testimony goes so much farther--we hear what Coach Osborne is saying in his testimony, but there is this alarmism that I get out of your testimony for the Independent Budget that somehow if you then contract in a remote geographic area with somebody private, that is a bad thing, it is such a bad thing. It is okay to let that veteran die because we are going to protect the VA-based facility system.

MR. GORMAN. You will have to show me in our testimony where we said contracting out for rural health care was a bad thing.

THE CHAIRMAN. Well, then, you know what? I accept it as your testimony that contracting for rural health care is a good thing.

MR. GORMAN. It can be.

THE CHAIRMAN. Thank you very much.

MR. GORMAN. You are missing the point of our concern. It has nothing to do with bringing new veterans into the system. It has more to do with taking existing veteran patients, existing programs that VA provides, taking those away from the control of the VA and putting them out into contract care. That is taking veterans away from the VA and putting them into the private sector.

THE CHAIRMAN. The American Legion gives their testimony. This is the American Legion's testimony. While the American Legion supports the selective use of contracted care in extreme cases where veterans have few or no other options, but we object to the broad blanket approach to outsourcing of care.

These are really clever words, you know, words that have negative connotation or negative meaning, and they are used to generalize. It is always fascinating to me.

Extreme cases, I ask the American Legion, how do you define that? How do you define the word "extreme cases"?

MS. WIBLEMO. If the VA cannot provide the services in the areas that they are needed.

THE CHAIRMAN. What is an extreme case?

MS. WIBLEMO. Well, there would be extreme cases in highly-rural

areas. There would be an extreme case if they did not have the expertise in their facility. That would be an extreme case.

THE CHAIRMAN. They could not gain access to an MRI? They could not gain access to a mammogram? What is an extreme case?

MS. WIBLEMO. Well, the extreme cases would be those that they could not provide. I mean, that to me would be an extreme case.

THE CHAIRMAN. At some point, we cannot build a VA facility that can be all things to all people.

So, Mr. Gorman, you used the words, and I have heard you over the years use them, about critical mass. And you are right. So we build a system with regard to a critical mass and with regard to the services that can be offered.

And because we cannot be all things to all people with regard to disease management, we recognize in our affiliations with our medical universities that there is subject area expertise that we can gain access to. And we contract for that. And that is what Dr. Kussman does. In many different affiliations, every one of those medical-based facilities do that.

So with regard to then these individuals that find themselves in a rural or geographically-remote area, why shouldn't they be able to gain some access?

MS. WIBLEMO. Well, we have never said that they should not have access.

THE CHAIRMAN. Thank you.

Mr. Gorman, in your written testimony, you state that the VA has no systematic process for contract care services. So it seems to me that the stated objectives of Project HERO are nearly identical to those that you called for in your testimony, as I was also listening to that. Do you disagree?

MR. GORMAN. No.

THE CHAIRMAN. Okay. Your meeting that you had with the VA, did you do that in the capacity as Independent Budget or were you there as Executive Director of the DAV?

MR. GORMAN. DAV.

THE CHAIRMAN. Okay. And what is your level of satisfaction with regard to the outcomes of those meetings?

MR. GORMAN. The first one, I believe, was horrible as far as an outcome because there was no good plan laid out. There was no good descriptive nature of the scope of Project HERO. Once that was conveyed, a second meeting was held without the principal of the first meeting, and that was Mr. Feeley, at the second meeting.

I think at that point, the scope, although still largely unknown because the contracts have not been written and all those other kind of variables, the intent of what the VA wants to move forward with was more satisfactorily relayed and described to us outside of -- I think we have always agreed with the principles that the VA has taken as

were relayed in the Independent Budget. It is the generalized contracting of care that has always concerned us. That was more fully described as not their intent.

THE CHAIRMAN. Was the American Legion present at this meeting?

MS. WIBLEMO. I am sorry. What did you say?

THE CHAIRMAN. Were you present at this meeting?

MS. WIBLEMO. Yes, we were.

THE CHAIRMAN. What is your assessment?

MS. WIBLEMO. Well, the meeting with Mr. Feeley went really well. It was very productive. We had good feelings about it. And like I wrote in the testimony, there is a lot left to be done on these projects. I mean, these are demonstration projects. They are pilot programs.

Just like you said earlier, you know, we do not know what we do not know. We do not know and we are going to learn from this. And our major concern is that it grows into something that was unintended.

And, you know, we recognize that VA needs to change with the changing veteran population and the changing patient population, and certainly the demographics of where people live. But the pilot projects are just that, they are pilot projects.

VA has a great leadership in VHA and we know that they are very sincere in putting their program forward and doing the best that they can for the veteran. So the second meeting went, I thought, much better and we look forward to working with everybody as far as getting these projects going and steering them in the right direction.

THE CHAIRMAN. Did you ever have any of your Legionnaires or members of the DAV ever come up to you and say, you know, all I should have to do is I should have a card and I should be able to gain access to health care with any doctor like anybody else and off they go?

MS. WIBLEMO. We have certainly had that. We have that within our membership.

THE CHAIRMAN. I get it a lot.

MS. WIBLEMO. Certainly we do.

THE CHAIRMAN. That is why I am saying that.

MS. WIBLEMO. Yeah. We do. And we get that all the time.

THE CHAIRMAN. Mr. Gorman, I want you to know that my service here in Congress is extensive with regard to the entire medical systems, whether it is the military health delivery system, VA, Medicare, Medicaid, and the private-pay systems. And I enter into many forms of pilots and demos and examinations. And I do so without any form of fear. I never fear. I never fear because I hold on to some pretty strong principles.

I respect the doctor-patient relationship, and whatever we can to do press the bounds of science to enhance the quality of life of our citizens is a good thing. And how do we gain access to this health care for people at prices that they can afford for who earns what. I mean, I deal with all these issues.

But I just do not react hardly at all to things that, oh, if you do this, it triggers that, X, Y, Z, and all kinds of other things. I mean, I think about consequences that are beyond the unintended consequences that you talk about.

But when those veterans come up to me and say, Steve, I should just have a card, if I want to go to the VA, I should be able to go to the VA, if I want to go to my own private-pay doctor, I ought to be able to do that and you ought to pay for it, and away they go, right?

And I also tell them about the importance of VA-based facilities, making sure that we as a country fulfill an obligation to a veteran to provide medical care to them. But I also am conflicted because there are individuals that find themselves, as Coach Osborne had testified, in geographically remote areas and how come they cannot get their care. And if they cannot gain access to it, then you really are being denied care.

You testified to us about that. You use that in all your propaganda and stuff that you put out there, that, oh, my gosh, eights, if they cannot get in, they cannot get the access, therefore, you are denying them care.

So I know what the mantra is and that is why earlier I had mentioned to you that these individuals, if they are in geographically-remote areas, they really are being denied their care.

So I am trying to figure out how we can gain access to them. That is what I am trying to do, an explanation for you, Mr. Gorman.

MR. GORMAN. Well, again, from my perspective, Mr. Chairman, you are still talking apples and oranges. We would holler louder than anyone if a rural veteran cannot get access to care. And we have. That is not the issue here. That is not the issue that we are trying to -- maybe we are just not explaining it very well.

We are talking about a new program that is all of a sudden going to potentially have the impact of taking patients who are already getting their treatment within the confines of the VA health care system under the auspices of VA by VA physicians with all the safeguards that go with that being potentially removed from that system and put out to the private sector. That is not the same as denying veteran access to care. You already have --

THE CHAIRMAN. But this is going to be defined narrowly.

MR. GORMAN. If that is the case, then we are entirely supportive of it based on the IB recommendation.

THE CHAIRMAN. This is going to be defined narrowly. That is why I used the word alarmist. I know you do not like that word. But the reason I used the word alarmist is that we are trying to say, okay, we are working on Project HERO and then, my gosh, if we do Project HERO, then, oh my gosh, this could happen.

MR. GORMAN. Only because Project HERO was not like this. It is like this, right. It is wide open.

THE CHAIRMAN. It is sort of wide open at the moment. They are going to let us know. They are going to work with you. They are going to work with us.

MR. GORMAN. And all we want to say is as long as it is wide open and when you are going to start narrowing the focus down, keep these concerns in mind. That is basically our message.

THE CHAIRMAN. Right. Well, my concern is to make sure that the disabled veteran out there gets his access to care.

MR. GORMAN. As is ours.

THE CHAIRMAN. That is my concern. My concern is not, as you had set the alarms, that somehow this project, if it expands, begins the erosion or dissolution of a health system. That is a huge generalization.

MR. GORMAN. Well, we are speaking in generalization to a generalized situation, Mr. Chairman.

MS. WIBLEMO. Right. It is undefined.

THE CHAIRMAN. Well, that is true because it is not really defined.

MS. WIBLEMO. It is undefined.

THE CHAIRMAN. It's not really defined.

MS. WIBLEMO. It is an undefined situation, so, you know, you encompass everything.

THE CHAIRMAN. All right. Well, I am having this conversation with you here because we are trying to work through this. We believe in the same thing. Okay? It is how we are going to get this delivered. And so do Dr. Kussman and Mr. Loper.

So this letter that you had sent to the VA -- where is this? No, neither of you were signatories to this letter. Oh, no. Joe Violante signed this letter.

This January 5th letter that you sent to Chairs Walsh and Hutchinson, are you familiar with this letter?

MR. GORMAN. Not by date.

THE CHAIRMAN. It is a letter that expressed the concerns about the HERO Project. Are you familiar with it? Take that letter, Mr. Gorman.

I show you a letter dated January 5th of 2006, with signatures of four of the VSOs of the Independent Budget. Do you recognize this letter?

MR. GORMAN. I do now.

THE CHAIRMAN. First of all, I was trying to reconcile the position of the Independent Budget with positions that were taken in the letter. Do you believe that there are any discrepancies?

MR. GORMAN. I am sorry. Between the --

THE CHAIRMAN. Do you believe there are any discrepancies between the recommendations of the Independent Budget and that letter that you have in front of you?

MR. GORMAN. I do not believe so, Mr. Chairman, on a quick read.

THE CHAIRMAN. Okay. And so then I should today embrace your testimony that the recommendations of the Independent Budget are now closely mirroring that of Dr. Kussman?

MR. GORMAN. In part.

THE CHAIRMAN. Okay. So I should accept the testimony of today, not that letter, right? In other words, some of the concerns raised in that letter have already been addressed? I want to be able to have a credible conversation with Chairman Walsh.

MR. GORMAN. I think so. I think we are still talking the same thing, although we are still talking here that we are supporting as an Independent Budget the better management of the care that VA is contracting out and still in opposition to, as it says here, to ratcheting up the level of contract care or to increase and exponentially expand the level of contract care.

THE CHAIRMAN. Well, that is an issue for another day. Okay? If we are able to learn things, and now we are going back to the issue about being organic versus mechanical, if we get to learn things and somehow we can improve quality of care and access, that is an issue for another day.

Mr. Baker, I would like to ask for your insight that you could offer based on your experience with TRICARE in the development phase. What are some insights that you could give to the VA right now as they formulate this demonstration project? I embrace your testimony, but if you could articulate them a little bit further.

MR. BAKER. Well, thank you very much, Mr. Chairman.

If I could offer any advice to the VA and indeed to the service organizations, it is in the wisdom of incrementally moving down the path that you are moving. The demonstration projects embedded in Project HERO make perfect sense to me.

I am reminded of the way TRICARE has evolved. And as you pointed out in your introduction, I am a TRICARE beneficiary as well. I am reminded of the fact that TRICARE started with a series of demonstration projects in the early 1990s. In fact, the services started some of those back in the 1980s.

And with each iteration, we learned more and more. And, in fact, that was true with the service initiatives. It was true with the demonstration projects that DoD started to run. And it was true with each and every iteration of the TRICARE contracts as they migrated from the west coast to the east over a series of years. They got better all the time. And they were refined to the point that they better met the department's objectives over time.

And I would just encourage everyone to bear in mind that the VA is trying to become more efficient. They are not trying to solve a ten-year problem with one demonstration. It is my belief that the demonstration projects will provide lessons that will serve as springboards and enable the VA to become even better.

THE CHAIRMAN. I am trying to understand your fears a little bit better, Mr. Gorman. The reason I want to have this conversation with you is because you are sitting here with a TRICARE provider, so let's have this conversation.

And, The American Legion, can pipe in any time you would like.

We have actually in the 1990s and prior, soldiers being treated at military medical treatment facilities and retirees gaining their access to facilities-based care at these medical treatment facilities on a space available. But really they would do everything they could to care for them.

And then as we go through the draw-down and base closures, these individuals are going to be triggered then into Medicare. Okay? So we went through that in the 1990s with how we were going to resolve this as TRICARE was evolving.

The one thing that I learned through the development of TRICARE for life and having done the pharmacy redesign was that beneficiaries love convenience. They do. And convenience also has an impact upon utilization. Okay?

So it is interesting. When I look back on the development of TRICARE for life, I probably did not do as good a job on utilization management tools as I should have because the soldiers and dependents are utilizing that program a lot, and it is costing DoD a lot.

And they also then tried to go in and even though we put in management tools that we do not have on sevens and eights, and you have heard me talk about that before, they have an explosion of costs. And they are trying to cope with that within DoD.

Now, my concern, Mr. Gorman, is more on escalation on costs as opposed to yours about the erosion, if you have a surrogate, that begins to erode a critical mass and then you begin to have dissolution. I am kind of commingling two of your testimonies.

I am trying to figure out how we can best serve a veterans' population and I just want to let you know, I do not fear private-pay systems. I do not. So we are managing a social system that really does pretty well cost-wise because of the pressures that Mr. Loper here puts on contractors and suppliers, and you get care at the best rate, better than anybody else out there in the private sector.

So people like to talk about how much better health care is or cheaper -- I should not say the word cheaper -- less expensive in the VA, but we have some challenges.

Well, I should not beat this one continuously. Your fear is any form of erosion of a critical mass of enrolled veterans? Is that sort of a close --

MR. GORMAN. Close. My fear is an erosion of the critical mass of veterans over a period of time to a significant degree where you have veterans who otherwise could or should have been treated within the VA facilities as has been the case up until now with their specialized

programs and expertise all of a sudden being told as new enrollees, we are going to have to put you out on a contract basis.

Once that starts to happen, in our view, the very real potential for critics of the VA would be to scale down the size of the VA or VA medical centers to the point where they become inefficient.

THE CHAIRMAN. But the reason I want to have this conversation with you, to explore this is that I think the real pressure does not come from whereever the critics are. The pressure comes from your membership, the IB, and the beneficiaries or the enrolled veterans, because once you extend it out there -- now I am jumping into the what if -- we extend it out there, and for the American Legion, your cite of the word extremes.

Let's say that we are able to define the types of care that are out there. The pressure of your membership to redefine the access to private based care which is closest or convenient for them will be great. That is why I am just saying what I have learned out there from the management of all these systems, it will. I just sense that could very well happen.

As a matter of fact, I do not even know who the ghost is that you just cited as the critics of the VA. I do not know who those ghosts are. Do you know who they are?

MR. GORMAN. Well, we would typically say it is OMB and has been for years.

THE CHAIRMAN. Well, I do not know. OMB has delivered some pretty good budgets that have built this health system for which you are singing praise. So it cannot be OMB as the ghost.

I just want to let you know, I am trying to get into your vein to define fear and I think it could very well be that when you have an enriched benefit and convenience to access to care as an enriched benefit, that is where individuals begin to erode. That is where it begins to erode.

And without sufficient utilization tools -- matter of fact, the utilization tool that The American Legion is using right now is this one, that it should be defined as extreme cases. That is a utilization management tool. You are setting a definition with regard to who can gain access to private care. That might be permissible.

I would ask unanimous consent to permit minority counsel to ask any questions she may have. Hearing no objection, so ordered.

MS. BENNETT. Thank you, Mr. Chairman.

This is, to the two Veterans Service Organization representatives and, I guess, Mr. Gorman, you are representing both DAV as well as the Independent Budget VSOs.

The written testimony from Dr. Kussman, states clearly that the overall goal is to maximize the care VA provides directly. And he states that VA's care is high in quality and less costly when VA delivers it directly. Only when we cannot provide care directly should we

purchase care.

That seems to state very clearly this is not about outsourcing or trying to reduce that critical mass that you talk about that is important to maintain the VA system's quality to veterans and capacity to provide care in specialized services.

I sense some of the uneasiness about Project HERO has been because many of the basic parameters are undefined. Are there any particular parameters with regard to scope in terms of time or cost or number of veterans to which this would apply or duration so that we can then come back and step back and see what lessons we have learned that would increase your comfort that this is not going to morph into something other than what they are saying their ultimate goal is?

Ms. Wiblemo. I do not have anything to comment about the scope yet. The whole thing with the Project HERO and the parameters and this is what we want to do and the VA saying this is what we want to do, historically -- and I do not know that our testimony was alarming. I would not characterize it as alarming.

Better put, we want to make sure that we are heard and so we repeat ourselves and we say we want the VA health care system to stick around. We think they are the best. Certainly there are reasons why they have to contract out and that is all recognized. It has been recognized for years.

But, again, you do not know. Everything is so undefined. And I know the VA will get there and we want to be there to help them get there and define that kind of stuff.

But when you went to Industry Day, which was back in January, I mean, there was mass confusion as to what was going to happen which led to the meetings, which led to a much better understanding just recently. So I think, again, as we go through this process, like Mr. Chairman Buyer was saying, absolutely we are going to learn from this.

But, you know, we want the VA to stick around and I know everybody in this room does too. We want the veteran to be treated the best way that VA knows how and that they are the priority patient in all of this. And to convey that to the contracted providers is important.

So, you know, there is a lot of discussion that has to go on. But, you know, I would not presume to sit here and try and figure out what the scope is just sitting here right now. We would have to look into that.

Mr. Gorman. I do not want to be duplicative of what Cathy said and I agree with everything she said. I think we wanted to put out front and up front the concerns that we had and also the support that we had with VA for this project to go forward.

We think it has a long way to go. It is going to do great things, I

think, for the VA internally and also ultimately for patient care. But we also want to see it not go too far too fast. And I think that is the concern that we brought to VA and hopefully that ultimately was going to come out of the discussion here is that there are concerns and there is a lot of support out there from everybody for this project.

THE CHAIRMAN. Well, I want to thank all of you for your testimony, more importantly, all three of you for your service to our country.

Mr. Gorman, next time I will make sure I recognize you, the date of your enlistment as a Private E-1.

MR. GORMAN. E-3.

THE CHAIRMAN. You went in as an E-3?

MR. GORMAN. No. No, I did not. I came out as an E-3.

THE CHAIRMAN. Right. You went in as a Private E-1.

MR. GORMAN. E-1.

THE CHAIRMAN. I want to recognize that status. It is an important status in your life. Thank you very much for your testimony.

MR. GORMAN. Thank you.

THE CHAIRMAN. The hearing is now concluded.

[The statement of Thomas Zampieri appears on p. 94]

[Whereupon, at 1:20 p.m., the Committee was adjourned.]

APPENDIX

Committee on Veterans' Affairs
U.S. House of Representatives
Full Committee Hearing
On
Enhanced Access to the Department of Veterans Affairs Health Care
10:30 a.m.
Wednesday, March 29, 2006
334 Cannon House Office Building
Opening Statement of Chairman Buyer

Good morning ladies and gentlemen. Shortly, we will hear testimony on Project HERO, a VA demonstration project that seeks to better coordinate fee-based care currently purchased outside VA. A chief purpose of this initiative would, I understand, be to enhance access to quality care for America's veterans.

I believe that this is a timely topic in the sense that Project HERO is currently being considered by the department and I thought this hearing would provide us a good opportunity to discuss, very publicly, what Project HERO is and what it is not. Moreover, it will provide everyone here an opportunity to share with VA what they think it should look like and what metrics should be adopted to evaluate the effectiveness of the demonstrations as the requirements are drafted over coming months.

We all know that the quality of health care provided by the Department of Veterans Affairs is superlative. The challenge often lies in access to VA facilities, especially for veterans living in rural areas. Public law authorizes VA to use contracted, fee-based private health care providers for service connected injuries and conditions when its own facilities simply cannot provide suitable care, for reasons such as emergency, inaccessibility, or certain other factors.

Our first panelist, Mr. Tom Osborne, Member of Congress from the State of Nebraska, knows only too well the challenges faced by veterans in his part of the nation. Some of his constituents must travel for days to get VA care. Tom, thank you for being here this morning; we look forward to your testimony.

I also thank our other panelists, Dr. Mike Kussman, representing The Department of Veterans Affairs, Cathleen Wiblemo (WIBLIMO) on behalf of the American Legion, and Dave Gorman representing Disabled American Veterans.

We also welcome Humana Military Healthcare Services President and CEO, David J. Baker, himself a veteran. Mr. Baker, thank you for your willingness to step up to the plate and testify here today, especially in light of the traditional hesitancy amongst contractors due to potential procurement sensitivity. Your testimony is welcomed.

These panelists will present a good deal of information this morning and we appreciate the opportunity to learn more about this care coordination demonstration, its potential . . . and its potential limitations, early in the process.

Health care is undergoing revolution. Earlier this month, this committee held a hearing on collaborative approaches to the provision of health care, through enhanced partnerships with teaching universities and other entities, such as DoD. These innovative partnerships have already proven their value in delivering America's veterans efficient health care of the highest quality. But these affiliations are only part of the solution to ensuring wide and timely access to quality care.

Project HERO, which stands for Healthcare Effectiveness through Resource Optimization, is an outgrowth of the Conference Report on VA's FY 2006 appropriation. Its stated objectives are to:

- Increase the efficiency of VHA processes associated with purchasing care from outside sources,
- Reduce the growth of costs associated with purchased care,
- Implement management systems and processes that foster quality and patient, safety, and make contracted providers virtual, high-quality extensions of VHA,
- Control administrative costs and limit administrative growth,
- Increase net collections of medical care revenues where applicable, and
- Increase enrollee satisfaction with VHA services.

In other words, Project HERO should help us learn how to improve some of the contracted care we now provide, and the way we provide it. My understanding is that HERO is *not* intended to undermine our affiliations, or lead to expanded outsourcing or the replacement of existing VA facilities.

With that in mind, open to the possibilities, but cognizant of the importance of preserving the quality associated with VA health care, I now look forward to hearing more on this demonstration project.

Statement of Congressman Michaud
House Veterans Affairs Committee
Hearing on Project HERO
March 29, 2006

Chairman Buyer, I want to thank you for holding this hearing on the Contract Care Coordination Demonstration project: Project HERO.

This project could make a significant change in how VA administers the $2 billion spent on care provided to veterans through a fee basis.

Because the scope, focus, cost, and duration of this project have not specifically been authorized by this Committee, this hearing is very important.

I appreciate that because we are in the beginning stages of this project most of the parameters are undefined. While VA may not know at this time if this is a $2 million or a $2 billion demonstration project, I believe it is important to clarify the cost of this demonstration and projected savings VA hopes to achieve by better coordinating fee basis care.

With respect to this demonstration project, we have a balancing act.

We want to encourage bold thinking about ways to enhance quality and cost efficiency, but we must also exercise responsible stewardship to ensure accountability and performance.

Mr. Chairman, as Chair of the Oversight and Investigations Subcommittee you were a leader in examining how poor contract management can ruin even the best ideas.

With CoreFLS, VA attempted an innovative idea to generate synergies through an integrated system that combined logistical, billing and other management functions.

But we know that the result did not come close to meeting expectations.

At its inception, the VA did not clearly define what it needed from its contractor. VA in effect invited the contractor to make government decisions without the necessary independent evaluation to ensure success.

Mr. Chairman, it is my hope that with this hearing and in our future actions as authorizers we can help VA flesh out a clear focus of the scope, cost, projected

cost savings, and quality performance measures for this project to advance quality of care for veterans.

I am also interested in learning how this program will work in conjunction with the implementation of the CARES recommendations; in particular, how we can reduce VA's costs for purchased care by moving forward on establishing needed new Community Based Outpatient Clinics and outreach centers.

I have repeatedly raised the need for moving forward on the priority CBOCs identified by the Secretary in the CARES decision. These new CBOCs and outreach centers are central to meeting the current and future demand for veterans' primary and specialty health care.

I am also concerned that lack of staff is a factor that drives VA facilities to fee basis care.

It is my hope that we will embrace best practices, maintain the high standard of care wherever veterans receive their care. Best practices and high quality of care, not ideology, should drive our decisions.

The testimony from the veterans service organizations which produce the *Independent Budget* state that they do support more proactive management of fee and contract services to provide greater continuity of care for veterans, better record-keeping, higher quality outcomes and reduced expense to the VA.

The *Independent Budget* groups, however, testify that they are concerned by the lack of specificity of this demonstration.

The American Legion raised similar concerns about the scope and scale of this demonstration.

They are concerned that this is a step towards turning the VA into an insurer for health care rather than a provider of care in a unique and integrated system. I share these concerns. It is my hope that this hearing will put to rest any fears that VA has strayed from the limited recommendations of the *IB*.

As we encourage innovation at the VA we must also equally encourage the VA to coordinate with the veterans service organizations to address these concerns.

Mr. Chairman, I thank you for holding this important first hearing on Project Hero.

Rep. Corrine Brown
Statement
Full Committee Hearing-
Enhanced Access to the Department of Veterans Affairs Health Care – Project HERO
(Healthcare Effectiveness through Resource Optimization) demonstration pilot
March 29, 2006
10:30 am 334 Cannon HOB

Mr. Chairman:

I first want to say that yesterday, our Esteemed Ranking Member announced his retirement and I want to add my voice to those extolling his praises and voice my admiration to his hard work for veterans in general and this committee specifically.

I know that without his diligence our committee would not have been half as

productive as it has been and I know that next year this committee will be less because of his absence.

I want to thank the Chairman for his attention to this pilot program, considering that it was only in the last VA appropriations bill that this pilot program was ordered.

Project HERO is a demonstration project that will be tested in VISN 8, which includes my home state of Florida.

I am concerned this is a first step toward outsourcing and eventually eliminating care for rural and poor veterans and who have no other recourse for care.

I am concerned the high level of care that the VA has been known for will suffer and that jobs that should be done in the VA will be forced out and the reasoning will be lack of staff. Staff that would be there, but were outsourced.

I understand that is not your intention, but this will remain a concern of mine as

long as there are veterans who are not served, like the current priority 7 and 8 veterans.

Please keep me informed of the process and conclusions of the pilot project occurring in my home state of Florida (I cannot state that enough).

Statement of Representative Stephanie Herseth
House Veterans' Affairs Committee
Project HERO
March 29, 2006

Thank you, Mr. Chairman for holding today's hearing on such an important subject. I also want to thank the witnesses for their participation and their testimony.

As you know, Project HERO (Healthcare Effectiveness through Resource Optimization) is a pilot program aimed at improving the ability of the Department of Veterans Affairs to better care for our nation's veterans, developing relationships with community-based providers, and filling geographic and specialty gaps that may exist in the VA system. As the Representative from South Dakota, one of the largest and most rural districts in the House of Representatives, I am very interested to hear from the VA about its efforts to improve its capacity to care for veterans in geographic areas where the VA has limited resources.

I often hear from my constituents about the challenges of having to drive hundreds of miles to a VA medical center for health care. Many of these veterans are elderly and ailing - making traveling long distances especially difficult. I hope today's hearing will provide valuable insight and opportunity to help resolve these challenges faced by veterans living in rural areas.

While I appreciate the VA's efforts to enhance access to quality care, I will continue to monitor the implementation of Project HERO to ensure that

quality standards and performance measurements are not compromised. In addition, I look forward to hearing insurances that investment in Project HERO will not divert resources away from other important tools, such as outreach centers, needed to provide rural veterans with health care services.

Once again, thank you Mr. Chairman for holding this important hearing I look forward to hearing from today's witnesses.

OPENING STATEMENT OF LUIS V. GUTIERREZ HOUSE COMMITTEE ON VETERANS' AFFAIRS

"Enhanced Access to the Department of Veterans Affairs Health Care – Project HERO (Healthcare Effectiveness through Resource Optimization) Demonstration Pilot"

Wednesday, March 29, 2006, 10:30am

Mr. Chairman, before we proceed, I wanted to take a moment and recognize our Ranking Member, Lane Evans, and thank him for his service on our Committee. I have had the honor and the privilege of serving with Lane on the VA Committee since I came to Congress in 1993. He is a good friend, an important ally and an unwavering advocate for Veterans in Illinois and across the nation. While Lane may have been diagnosed with Parkinson's disease, it did not affect his razor sharp intellect or lessen his commitment to the issues he cares about. He has approached his disease with dignity, class and courage, and he has served as an inspiration to others with Parkinson's disease. I am going to miss having my friend on this Committee and my colleague in the Illinois delegation, but you can bet when I need guidance about the best way to protect Illinois veterans, my first call will be to Lane.

Mr. Chairman, thank you for holding this hearing today to investigate the progress the VA has made in developing the HERO demonstration project. I am encouraged that the Committee is looking at Project HERO early in the process, so that we can closely monitor this initiative as it moves forward.

Ensuring access for our veterans to the VA is an important priority that this demonstration project aims to enhance. I recognize there are instances when VA cannot provide a veteran with their care at a VA facility because the VA facility may be geographically inaccessible for the veteran, or the VA facility may not be able to provide the necessary care. In these instances, VA contracts with providers to offer care to these

veterans on a fee-for-service basis. According to the Independent Budget and American Legion, VA currently spends $2 billion or more each year on contract health care from all sources.

Project HERO aims to better manage this spending and improve the quality of care our veterans receive when they have to turn outside the VA for care. This is a laudable goal, however, there are many unanswered questions that remain. We still do not know the scope, size, cost and duration of this pilot project. We also do not know what the projected savings are for this project. We have seen the Administration submit projected costs savings and "management efficiencies" in their annual budget presentations before. Savings like these have yet to materialize and the GAO has found many of them to be nothing more than budgeting gimmicks. I hope this will not be the case with Project HERO and I feel this initial hearing is a step in the right direction.

As we look more closely at contracted care and this pilot project, I also want to share a larger concern of mine. We must ensure that this pilot project does not steer VA away from providing care to veterans and instead turn the VA into an insurer of care. Outsourcing care of veterans would be devastating to the VA and would tarnish President Lincoln's promise, "To care for him who shall have borne the battle and for his widow, and his orphan." Many of us are committed to this goal and hopefully this initial hearing will give this Committee the opportunity to conduct proper oversight on the VA to make sure the VA stays committed to this goal. Thank you, Mr. Chairman.

Statement of Congresswoman Shelley Berkley
Committee on Veterans' Affairs
March 29, 2006

Thank you, Mr. Chairman, for having a hearing on this important topic. I read the *Independent Budget* letter with great interest and I share many of their concerns regarding Project HERO. We just do not know enough about Project HERO. How will this project work? How long will the project last? What is the cost of the program? Will project HERO be VISN-wide?

I'm delighted to welcome Congressman Osborne to the committee and am interested to hear his thoughts on the best way to provide care under Project HERO. Should veterans be able to go to any doctor, hospital or clinic or should they have to go to one location? While I represent an urban part of the country, I understand that many veterans in rural areas, such as those in your district, are in need of care.

However, I wonder how project HERO will work with the VA system. The care provided to veterans by VA contractors is usually disconnected from VA quality standards, electronic medical records, clinical guidelines, and continuum of VA provided care. Given this, how will the VA hold private providers to VA standards and guidelines? Also, I would like to know if project HERO will divert money away from VA facilities. This project should not be used as a way to start dismantling VA health care.

Regarding the *Independent Budget* letter, I would like to see Dr. Perlin's response to this letter. I will need my questions answered before I can support this project.

Thank you for being here today and I look forward to hearing from you.

Statement of Representative Tom Osborne (R-NE)
Before the House Committee on Veterans' Affairs
Project HERO
March 29, 2006

Mr. Chairman and Members of the Committee, thank you for holding a hearing on improving and enhancing access to quality care for our nation's veterans through care coordination demonstrations. I appreciate the Committee providing me with the opportunity to testify about veterans' access to care. I would like to thank the Chairman for his leadership on this very important issue.

Access to health care is one of the greatest obstacles facing veterans in my district, the Third District of Nebraska, as well as many veterans across the nation. Nebraska's Third District encompasses 64,000 miles, most of which I have driven. Now compare that to the total mileage veterans in Veterans Integrated Service Network (VISN) 23 travel. The VISN 23 service area exceeds 390,000 square miles and includes Iowa, Minnesota, Nebraska, North Dakota, and South Dakota, and portions of the states of Illinois, Kansas, Missouri, Wisconsin, and Wyoming. Veterans in VISN 23 are traveling thousands of miles for medical care.

At each stop I make in my district, veterans continue to express to me their concern about traveling hours for medical care. Many travel one to two hours to receive primary medical care, while some veterans who live in the western part of Nebraska must travel at least four days in order to have testing done in Omaha at the veteran's hospital. For example, a veteran who lives in Ainsworth, Nebraska must travel almost 4 hours to Grand Island where they catch a van, and then drive an additional 160 miles, almost 3 hours, to Omaha.

Many veterans in my district are elderly and encounter difficulty, or find it impossible, to travel long distances to receive health care. If a veteran has to cancel an appointment, it may take months to reschedule. Because of the difficulties in obtaining care, many veterans put off preventative and even necessary treatment, which results in poorer health and eventually increased costs in health care.

I recently received a letter from the widow of a World War II veteran who resides in my district. Her husband had served 44 months in the

military, including 39 months overseas during World War II. In recent years this veteran suffered from poor circulation and lung problems as a result of the years spent serving his country. Because of this man's poor health condition and physical limitations, and the distance he lived from a VA medical facility, he was not able to travel the great distance necessary to access the care he needed on a regular basis. He passed away in a local community hospital in 2005. This is unacceptable given the medical capabilities we have available today.

Most veterans in Nebraska appreciate and are satisfied with the services and care they receive at VA facilities. However, traveling great distances through inclement weather, such as the snowstorm that dropped two feet of snow in parts of Nebraska last week, is dangerous and physically taxing for many veterans; particularly when we have high quality health care facilities in many parts of the state.

After looking at various options to address these problems, I introduced H.R. 1741, the Rural Veterans Access to Care Act. H.R. 1741 would establish a pilot program to assist highly rural or geographically remote veterans who are enrolled in the VA in obtaining primary health care at a medical facility closer to home. The legislation requires the Secretary of the VA to use the authority to contract with non-Department facilities in order to furnish routine medical services to enrolled veterans who are classified as highly rural or geographically remote.

I believe VISN-wide care coordination demonstrations will address many of the issues that my legislation is intended to address with regard to access to care. Veterans nationwide, not only those living in geographically remote areas, will receive more effective and efficient care through these demonstrations. These veterans would be able to access health care in a more timely fashion, instead of waiting six months to one year for an appointment for routine medical care. They would also be closer to their health care providers, rather than traveling hundreds of miles, sometimes through inclement weather, for an appointment with the VA.

Although I believe the demonstrations can be an effective way to provide reliable, quality care to veterans in these areas, I understand that the contracts have not yet been written and all the demonstration requirements have not yet been completely defined. However, I hope today's hearing will provide a valuable opportunity for everyone to get a better sense of what can

be accomplished through the demonstrations and give the department a greater sense of what veteran needs can and should be addressed through the demos.

While I believe it is critically important to provide additional access points throughout the Veterans Integrated Service Networks that have been selected for the demonstration, I think we should also demand that quality standards be effectively maintained. After all, my interest, like yours Mr. Chairman, is to provide timely, quality care to those who have served and are eligible for VA care.

Once again, I would like to thank the Chairman for the opportunity to appear before the Committee as it explores greater access to quality care for veterans. It is important for us to consider the hardships that our veterans have faced while serving our country. The older men and women among them are in the twilight of their lives and need medical services that can be provided closer to home. Many of them made huge sacrifices on our behalf to defend our great country and I believe it is time that we improve their access to health care. I look forward to working with everyone on this committee, and those in the VA, so that together we can fashion a demonstration project that responds to the geographical and clinical needs of our nation's veterans.

Again, thank you for giving me the opportunity to provide my testimony on the very important issue.

WRITTEN STATEMENT

OF

MICHAEL KUSSMAN, MD, MS, MACP

PRINCIPAL UNDER SECRETARY FOR HEALTH VETERANS HEALTH ADMINISTRATION

BEFORE

THE HOUSE VETERANS AFFAIRS COMMITTEE

IMPROVING AND ENHANCING ACCESS TO QUALITY CARE FOR OUR NATION'S VETERANS THROUGH CARE COORDINATION DEMONSTRATIONS – PROJECT HERO

MARCH 29, 2006

**

Good morning, Mr. Chairman and other distinguished members of the Committee. I am honored to be here today to share with you the progress, advances and future direction of the Department of Veterans Affairs (VA) Project HERO (Healthcare Effectiveness through Resource Optimization) pilot program. Accompanying me today is Mr. C. Mark Loper, Veterans Health Administration's (VHA's) Chief Business Officer.

Project HERO is a pilot program aimed at improving the ability of VA's patient-focused health care system to care for the Department's 7.7 million enrolled veterans. Under the program, VA will improve its capacity to care for its veterans at the more than 1,400 sites of care it currently operates. The Department will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. The ultimate goal of Project HERO is to ensure that all care delivered by VA – whether through VA providers or through our community partners – is of the same quality and consistency for veterans, regardless of where care is delivered.

The overall goal is to maximize the care we provide directly. VA's care is high in quality and less costly when we deliver it directly. Only when we cannot provide care directly should we purchase care.

BACKGROUND

VA developed Project HERO in November 2005 in response to language in the Conference Report (H. Rep 109-305) associated with VA's 2006 Appropriations Act, Public Law 109-114. The Appropriations Conference Report directed the Department to implement care management

strategies that have proven valuable in the broader public and private sectors. Through Project HERO, the Department will ensure that care purchased for enrollees from community providers is cost-effective and complementary to the larger VHA system of care, while preserving and sustaining our partnerships with university affiliates. As requested in the Appropriations Conference Report, VA will establish at least three care management demonstration programs through competitive award and will collaborate with industry, academic and other organizations to incorporate a variety of public-private partnerships.

VA will develop specific regional action plans that focus on purchasing care in a manner that is cost effective, high-quality and complementary to the larger VA system of care. VA will develop relationships with community-based providers to fill any gaps that may exist in the Department's current provider base. These gaps may include geographic areas or specialties where the Department's provider base is limited or has insufficient capacity. Relationships also may be developed with community-based providers when specific medical expertise or technology is not available in the Department. Veterans will continue to have a range of choices, and will have greater clarity in decision-making because of the Department's commitment to partner *only* with high-value providers that meet or exceed the Department's standards of care.

KEY PARTNERSHIPS

Through Project HERO, VA will collaborate with industry, academic, and other organizations, engaging them both as thought leaders and potential vendors. VA's industry, academic, and other partners will bring fresh ideas and leading strategies, tools and capabilities to address specific objectives in each demonstration site.

VA will work with industry, academic, and other partners as thought leaders to explore care and business management strategies that have proven valuable in the broader public and private sectors. These innovative partnerships will enable strategic leadership for the design of care initiatives that are focused on cost, quality and service. VA will partner with industry, academic, and other organizations as contractors to provide solutions to address Project HERO's objectives and specific focus areas within our participating networks. Partners will be acquired through a competitive process based on best-value, and each partners' ability to offer solutions that are complementary to the VA system and that have proven valuable in the public and private sectors. Together, VA and our partners will collaborate to achieve specific and challenging health system objectives and provide better care for all veterans.

The VA care management approach and focus on value will allow VA to implement management systems and processes that foster quality and patient safety and make contracted providers virtual, high quality extensions of VA. Project HERO will control administrative costs and the rate of cost growth associated with care provided by community partners through performance based monitoring and evaluation of all contracts with partners.

To maintain high quality of care and veteran satisfaction, VA will ensure that its partners understand and abide by the mission of the Department. Partners selected to participate in this demonstration project will be required to demonstrate flexibility and adaptability to respond to diverse customer needs and a willingness to learn and accommodate VA's unique mission. Progress toward established goals and objectives will be measured using a performance-based evaluation methodology and framework that are under development by the Project HERO team. This program evaluation component will provide a rigorous and scientific means of measuring results relative to VA-established performance metrics.

This collaborative approach is anticipated to increase enrollee satisfaction through improved access and interfacing between the VA and community based outpatient clinics.

PROJECT HERO ACCOMPLISHMENTS

VA has started developing the Project HERO demonstrations, and significant progress has been made to reach our goal of funding objectives-oriented demonstrations at different sites around the country by the end of calendar year 2006. Objectives have been developed for Project HERO and four sites have been selected to pilot the demonstration. VA has established a management structure for the program and begun developing the approach, methodology, and performance criteria to measure the return on investment.

Objectives

Project HERO's demonstration objectives have been defined and communicated to a number of key stakeholders, including the VA's National Leadership Board, VSOs, industry, and academia. In addition, Congress soon will be briefed on these objectives. Project HERO objectives include the following:

- Increase the efficiency of VHA processes associated with purchasing care from commercial or other external sources;
- Reduce the rate of cost growth associated with purchased care;
- Implement management systems and processes that foster quality and patient safety and make contracted providers virtual, high quality extensions of the VHA;
- Control administrative costs and limit administrative cost growth;
- Increase net collections of medical care revenues where applicable;
- Increase enrollee satisfaction with VHA services;
- Sustain partnerships with university affiliates; and,
- Move toward the integration of the use of VA's electronic health record with the episode of care in the contracted setting. This is integral to our ability to manage care in contracted settings.

These objectives will continue to be refined to construct measurable outcomes as we gain additional input from industry and academia.

Selection of VISN Sites

After carefully considering feedback received from the National Leadership Board, VA staff and the Veterans Service Organizations, we are proud to announce that four Veterans Integrated Service Networks or VISNs have been chosen to pilot Project HERO demonstrations. Veterans in these VISNs will be among the first in the nation to benefit from Project HERO:

- Florida and Southern Georgia (VISN 8 -- VA Sunshine Healthcare Network);
- Oklahoma, Arkansas, Louisiana, Mississippi and portions of the states of Texas, Missouri, Alabama, and Florida (VISN 16 -- South Central VA Health Care Network);
- Washington state, Oregon, most of the state of Idaho, and one county each in Montana and California (VISN 20 -- Northwest Network); and
- Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and portions of northern Kansas, Missouri, western Illinois, Wisconsin, and eastern Wyoming (VISN 23 -- VA Midwest Health Care Network).

The VISNs selected are among those with the highest expenditures for community-based care, particularly relative to the number of enrollees in the VISN. In addition, these VISNs are some of the larger VA networks, together representing 25% of total enrollment and 30% of annual out of network expenditures. These selection factors were used to ensure the demonstration results are

representative of the larger VA population and to facilitate measurement of proof of concept under Project HERO. While the Department initially will establish the demonstration in selected regions, positive results may lead to expansion of this program to additional regions.

VISN-level teams and management structures are being established to ensure the timely and successful implementation of Project HERO. VISN 16, the South Central VA Care Network, will hold its first team meeting on April 4, 2006. The other VISNs are expected to hold their initial team meetings shortly thereafter.

Establishment of Program Structure

We have created a Program Management Office that is led by a professional program manager. An acquisition team has also been appointed to oversee and manage the Project HERO procurement, in coordination with the Office of Acquisition & Material Management (OA&MM). VA field activities and headquarters have provided additional support to the Program Management Office and the acquisition teams. An Executive Leadership Board and Steering Committee have been chartered and convened to guide Project HERO's strategy and design. VISN-level teams and management structures are being formed in the demonstration sites, and additional specialized functional teams also have been established to support Project HERO.

Over the past two months, the Project HERO team has briefed a number of key stakeholders, including VA's National Leadership Board, VSOs, and representatives of Congress, industry and academia. A broad comprehensive communication strategy is being developed to ensure that all internal and external stakeholders are apprised of Project HERO's milestones and status.

Veterans Service Organizations

On March 2, 2006, VA met with VSO Leadership to discuss Project HERO's objectives and VSO concerns. Open dialogue occurred during this productive meeting. On March 24, 2006, VA again met with representatives from the VSO's. VA is aware that VSO's have raised some concerns with project HERO. We want to assure them that our goal is to provide the highest quality health care to America's veterans. This is in no way an effort to outsource VA care.

In an effort to sustain on-going communication, a member of VHA's Chief Business Office (CBO) leadership now attends the Under Secretary for Health's VSO Monthly Meeting to ensure that the VSOs are kept abreast of current project developments and informed about the potential impact of Project HERO on veterans' health care. We look forward to continued collaboration with our VSO partners throughout this demonstration project.

Program Collaboration with Key Partners

VA began the process of collaborating with others by conducting a forum for industry and academia on February 2, 2006 to introduce Project HERO and invite input on Project HERO's demonstration objectives. The CBO's communication plan included postings on the FedBizOpps web-site, advertisements in five major newspapers, invitations to VSOs, and handouts to 3,000 attendees at the Department of Defense's January 2006 TRICARE conference. Over 150 participants attended this forum, including representatives from health care companies, independent consulting companies, information technology companies, and Government, VSOs and academia. Organizations interested in partnering with VA on Project HERO have been invited to submit statements of corporate capabilities in response to a questionnaire posted to the Project HERO web site (http://www.va.gov/hac/hero/). Additional events are anticipated and follow-up communications are planned to encourage on-going involvement and collaboration throughout Project HERO.

In addition, because of the primary importance of preserving and sustaining our partnerships with academic affiliates, a VA executive with a strong health service administration background has been brought on board to ensure that our academic affiliates are aware of this new initiative and fully engaged in the process. We anticipate that our academic affiliates will play a pivotal role in designing Project HERO programs, and will serve as partners in delivering solutions. Each of our academic health system partners will be engaged in Project HERO and encouraged to participate by providing feedback and guidance.

NEXT STEPS

VA has made great progress regarding this important effort, positioning ourselves to implement a care demonstration program on schedule as outlined in the Appropriations Conference Report. Critical milestones have been identified for the program, and a strict timeline has been established to meet our end of the year deadline for a contract award. In anticipation of

the request for solutions release in late summer 2006, we have begun defining project sub-objectives and conducting market research to develop a statement of objectives and finalize the acquisition planning and pre-solicitation phase. We anticipate beginning the competitive phase in late summer for completion in early to mid fall of 2006. The evaluation and award phase will be a two part process. During the first phase, we will evaluate each of the sources based on established criteria and then select the best solution. Contract awards are planned to be issued by the end of 2006. Once the awards are issued, the performance management phase will begin and each awardee will be monitored according to established performance measures currently being developed.

CONCLUSION

In summary, Project HERO is an opportunity for entities to engage and partner in the transformation of VA health care. Project HERO is an innovative approach to health care that will bring together partners from industry, academia, the community and VSOs to optimize our use of VA resources and ensure that all care provided to veterans is also VA-managed.

VA looks forward to the collaborative partnerships this demonstration affords for enhancing our clinical and business operations for veterans. We are moving forward with the Project HERO demonstration and thank you for your continuing interest in this most important initiative.

This concludes my written statement, Mr. Chairman. I will be happy to answer any questions you or the Committee members may have.

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

IMPROVING AND ENHANCING ACCESS TO
QUALITY CARE FOR OUR NATION'S VETERANS
THROUGH
VISN-WIDE CARE COORDINATION DEMONSTRATIONS

MARCH 29, 2006

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
IMPROVING AND ENHANCING ACCESS TO
QUALITY CARE FOR OUR NATION'S VETERANS
THROUGH
VISN-WIDE CARE COORDINATION DEMONSTRATIONS

MARCH 29, 2006

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present The American Legion's views on improving access to quality care for this nation's veterans through Veterans Integrated Services Network (VISN) wide care coordination demonstrations. Recognizing that the VA struggles to meet the current demand for health care services and that the Global War on Terrorism is creating a new era of veterans who are turning to the VA for their health care needs, The American Legion supports the ensuring of timely access to quality health care for America's veterans and other eligible beneficiaries.

Over the past several years, the Department of Veterans Affairs (VA) has been shifting from institutional, in-patient based care to a more outpatient or non-institutionalized form of health care. Performance measurements, an award winning safety program, quality of care standards and the electronic medical record system have all played a role in the transformation of VA. Once considered the provider of last resort, VA is now considered by many to be the best health care provider in the nation.

The urban battlefield of the Global War on Terror has created new challenges to the VA health care system. Veterans are returning home with severely debilitating injuries to include; loss of limb(s), traumatic brain injury (TBI), mental conditions, stress reactions, post-traumatic stress disorder (PTSD), spinal cord injury and blindness. These types of injuries are very prevalent in this group of wartime veterans.

In addition to the unique injuries affecting this new era of veterans, the demographic of current deployed forces is also unique. The record number of National Guard and Reserve troops, as well as women veterans who are now serving in combat zones, has helped to create a veterans' population like none other before and VA must be able to treat the unique needs of this population.

The veterans' health care system, charged with caring "for him who shall have borne the battle and his widow and his orphan," must continue to evolve and transform as the needs of the future generation of veterans change. The American Legion's position on the purchasing of care from commercial or other external sources is that it is not in the best interest of VA and, more importantly, America's veterans and their families.

Comprehensive Contract Care Coordination Demonstration Projects

Public Law (P.L.) 109-114 requires VA to establish a comprehensive managed care demonstration program in three VISNs. Specifically, VA has been tasked, without proper funding, to implement care management strategies that have proven valuable in the broader public and private sectors. Additionally, these programs will be designed to satisfy a set of health system objectives related to arranging and managing care by the end of calendar year 2006. VA is to collaborate with academia and private industry to assist in reaching its goal.

VA currently spends about $2 billion a year on care purchased outside of VA. While The American Legion supports the selective use of contracted care in extreme cases where veterans have few or no other options, we object to the broad blanket approach to the outsourcing of care. Each contract proposal should be evaluated based on its enhancement of services, timely access to care, and quality of care for veterans within respective communities.

In those few cases where VA must turn to outside providers to meet demand, strict oversight of the contracting process must exist to ensure that veterans, who are being treated by a non-VA provider, receive the same level of quality and professionalism inherent to the VA health care system. In order to assure complete compliance, VA must routinely monitor all contracted health care services being provided to veterans. VA must also obtain patient satisfaction feedback on the timeliness and quality of care received from veterans sent to contracted services.

The American Legion has some real concerns as to which services will be provided under these projects. While some basic treatments may be handled effectively by outside contractors, the delivery of more specialized care could prove difficult to access outside of the VA health care system. Mental health care, blind treatment, amputee treatment and long-term care are all unique areas of care, which may prove difficult to administer through contracted care.

Generally, many of VA's patients are older, poorer and sicker than the general population. That kind of patient demographic is one that many industry leaders shy away from due to the treatment costs involved. The American Legion is deeply concerned that VA patients would be treated differently than other non-veteran patients. Within the VA health care system, patients are a priority -- not just another customer -- and receive holistic care.

VISN involvement in determining who are the contracted care providers is also a concern. The American Legion would like more information on the selection criteria for the contracted care, such as accreditations and licensing requirements for providers. Details should include hours of availability and specific location of the physical facility in relationship to the VAMC. It is also important to know how many health care positions (FTE) are lost at the VAMC or Community Based Outpatient Clinic(s) as a result of the contracted care.

While The American Legion supports providing veterans timely access to quality health care, it is important that we do not create initiatives that will lead to the dissolution of the very health care system created to care for these heroes. Accessibility delays must be solved by enabling VA to meet its obligation through adequate funding levels, not by turning VA into a third-party payer for care.

Academic Affiliations

The Conference Report 109-305 for Military Quality of Life and Veterans Affairs, and Related Agencies Appropriations Bill, 2006 stated that, "It is essential that care purchased for enrollees from private sector providers be secured in a cost effective manner, in a way that complements the larger Veterans Health Administration system of care, and preserves important agency interest, such as sustaining a partnership with university affiliates."

As one of four statutory missions, VA conducts an education and training program for health professions students and residents to enhance the quality of care provided to patients within the VHA health care system.

VHA has enjoyed a long-standing and exemplary relationship with affiliates since 1946. During the ensuing 60 years, this relationship has grown stronger, continuing today with 107 formal affiliation agreements with VAMCs across the country. There is no doubt that these agreements have a substantial impact on the current and future health workforce of the VA health care system and the nation. Thousands of medical students are trained each year in VA facilities through affiliations. This partnership has decidedly grown into the most comprehensive academic health system partnership in history.

It is crucial that the affiliates be intimately involved with these demonstration programs and that they take advantage of the opportunity to actively participate on VA Executive Steering Committees that will improve health care management strategies. Because they are also an integral part of the VA health care team, the affiliates should be included in all discussions concerning the demonstration projects.

Mr. Chairman, VA provides many specialty services that are not available in the private sector. They are also the experts on war-related injuries, illnesses and diseases. VA understands the exposures that veterans have endured over the years in foreign lands and unfriendly places. This type of expertise is not easily found in the private sector. These demonstration projects will require vigorous oversight. The VA health care system must be maintained as a separate and distinct health care system.

Thank you again for this opportunity to present the views of The American Legion.

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March 29, 2006

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the March 29th hearing, concerning Improving and Enhancing Access to Quality Care for our Nation's Veterans through VISN-Wide Care Coordination Demonstrations.

Sincerely,

Cathleen Wiblemo, Deputy Director
Veterans Affairs and Rehabilitation Commission

BIOGRAPHY
CATHLEEN C. WIBLEMO
DEPUTY DIRECTOR, HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION

Ms. Wiblemo has been with The American Legion National headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of a ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. She is currently a Major in the reserves.

During her military service, Ms. Wiblemo received many awards, most notably the Meritorious Service Medal. In August 1999 she received her Masters of Health Administration from Chapman University.

Ms. Wiblemo is a member of Post 176 in Alexandria, Virginia. Originally from Mitchell, South Dakota, she and her son, Zachary, currently reside in Alexandria, Virginia.

STATEMENT OF
DAVID W. GORMAN
EXECUTIVE DIRECTOR
WASHINGTON HEADQUARTERS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
MARCH 29, 2006

Mr. Chairman and Members of the Committee:

Thank you for requesting the views of the veterans service organizations that produce the annual *Independent Budget (IB)* on the question of VA's efforts to establish a demonstration project, now called "Healthcare Effectiveness through Resource Optimization" (Project HERO). This demonstration project was directed to be carried out by the Conference Report on VA's fiscal year 2006 appropriation, Public Law 109-114. The demonstration project is aimed at coordination of contract care for veterans eligible for outpatient or inpatient services at VA expense provided by private health care providers.

My testimony today is a compendium of the views of the *IB* organizations—AMVETS, Paralyzed Veterans of America (PVA), Veterans of Foreign Wars of the United States (VFW), and my own organization, the Disabled American Veterans (DAV). All of these organizations appreciate this opportunity to testify.

In general, current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support any broad contracting for populations of veterans. The *IB* veterans service organizations (IBVSOs) agree and accept that VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human and technical resources to promote effective, high quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health problems. We are concerned that in an open environment of mixed government and private providers with tight budgets, the contracted element (particularly if it were focused on acute and primary care to large populations) would inevitably grow over time, and place at risk VA's well-recognized qualities as a renowned and comprehensive provider. We believe such a distributed program would not

only become prohibitively expensive, but also could damage VA's health professions affiliations—the bedrock of VA quality care.

We believe the best course for most enrolled veterans in VA health care is VA's providing continuity of care in facilities under the direct jurisdiction of the Secretary of Veterans Affairs. For the past twenty-five years or more all major veterans service organizations have consistently opposed a series of proposals seeking to contract out or to "privatize" VA health care to non-VA providers on a broad or general basis. Specific incidences of such proposals have occurred in the states of Maryland, Minnesota, Oregon and Florida. Ultimately, these ideas were rejected by Congress or the Federal courts. We believe such proposals—ostensibly seeking to expand VA health care services into broader areas serving additional veteran populations at less cost, or providing health care vouchers enabling veterans to choose private providers in lieu of VA programs, in the end only dilute the quality and quantity of VA services for all veteran patients. Given the dire financial straits VA has experienced over several recent fiscal years, this is an important policy to sick and disabled veterans, and to those who represent their interests.

Mr. Chairman, aside from these concerns, we all observe that VA's contract workloads have grown significantly. VA currently spends $2 billion or more each year on contract health care services, from all sources. Unfortunately, VA has not been able to monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health-care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Twice in the *IB* we have recommended that VA implement a program of community contract care coordination that includes integrated clinical and claims information for veterans currently cared for by community-based providers. However, one small element of our concept is now in place. VA's currently authorized "Preferred Pricing Program" allows VA medical facilities to conserve funds when veterans (under the eligibility limitations enumerated earlier) find it necessary today to use non-VA medical services. In this program, VA receives negotiated network discounts through a preexisting preferred pricing program that is organized under contract with VA by HealthNet Federal Services, Inc. However, VA currently has no system in place to direct veteran patients to that network so that VA can:

- receive discounted rates for the services rendered;
- use a mechanism to refer patients to credentialed providers in that network; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs) for several years, if a veteran randomly uses one of HealthNet's preferred providers for care, some facilities have not taken advantage of the cost savings available from this arrangement. Therefore, in many cases, VA facilities have paid more for contracted health care than would be necessary under the HealthNet arrangment.

We are pleased that in response to this discovery pointed out by the IBVSOs, in October 2005, the VA made mandatory VAMC participation in the Preferred Pricing Program. In anticipation of full implementation, VA has reported potential savings of $80 million in spending in fiscal year 2006 alone.

Despite the significant savings that have been achieved through Preferred Pricing Program (more than $53 million since its inception), several major improvements could be made to improve access, quality, and cost of non-VA care. The Preferred Pricing Program is the foundation upon which a more proactively managed VA contract care program could be established that not only would save significantly more money in the purchased care programs, but, more important, would provide the Veterans Health Administration (VHA) a mechanism to fully integrate veterans' community-provided medical care into the VA health care system. By partnering with an experienced contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for taxpayers. The IBVSOs believe the program's features should include:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost effectiveness of their care. Additionally, the care coordination contractor should require providers to meet specific requirements, such as providing timely and complete clinical information to VA, timely submission of reimbursement claims, use of standardized electronic claims, meeting established VA access standards, and complying with overall VA performance standards.
- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical condition, the care coordination contractor could address appropriateness and continuity of care. The result could offer veterans a truly integrated, seamless health care delivery system.
- Improved veteran satisfaction; and
- Optimized workload for VA facilities and their academic affiliates while cost for non-VA care is reduced.

Currently, many veterans are disengaged from the VA health care system when receiving medical services from private nonparticipating physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care.

Prior to the completion and full implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan, it will be crucial for VA to develop an effective care

coordination model that achieves VA's health care and financial objectives. A care coordination contractor could be used to ensure successful implementation of CARES plans in local VA facilities whose inpatient missions are changing, thereby preventing unexpected backlogs. Developing an effective care coordination model would improve patient care quality, optimize use of VA's increasingly limited resources, and prevent overpayments when eligible veterans utilize community contracted care.

Mr. Chairman, the information expressed above is the basis for the *IB* recommendation on coordination of community care. We cannot testify today that, based on our current knowledge of VA's pending demonstration project called "HERO," that VA is developing our recommended model into that demonstration. Both at the Industry Forum hosted by VA in February to announce its plans for HERO and in more recent meetings with VA officials we have expressed concern about the lack of specificity of the shape, scope, size, depth and duration of the coming demonstration. We do not have even a clear sense of the goals of HERO. Within the past week, we have learned the proposed geographical sites for this demonstration (Veterans Integrated Service Networks [VISNs] 8, 16, 20 and 23); however, we have not been briefed on the status of any industry proposals that may be shaping VA's planned solicitation of bids. The IBVSOs are united that whatever emerges from that industry, we believe as representatives of millions of enrolled, sick and disabled veterans, that the VHA needs to coordinate with our community any proposed decision-making on the HERO initiative.

Several times VA has indicated that, in HERO, it is implementing our *IB* community care coordination recommendation. As indicated earlier, we believe we stated our intent clearly—that VA's unmanaged programs in community care were not only expensive and growing but were entirely discontinuous from VA's excellent internal health care programs and were absent the numerous protections and safeguards that are the hallmarks of VA health care today. We believe that more proactive management of fee and contract services by VA can provide greater continuity of care for veterans, better clinical record-keeping, higher quality outcomes and reduced expense to the Department.

We are concerned that in developing this new HERO model, the Department has strayed far off course from the intent of the *IB*'s recommendations for fee and contract care management. Mr. Chairman, as you and other members of this Committee well know, our organizations will strongly support and defend what is recommended in the *IB*; however, until our concerns are allayed about the true nature and goals of HERO, that demonstration project should not be attributed to, or justified by, our recommendation in the *IB*. Based on what we know and considering all that we do not know about HERO at this point, we do not conclude that HERO is consistent with our goals.

It is our hope that the Department will shift the focus of HERO to achieve the goals of the *IB*. We pledge to work with this Committee and with the Under Secretary for Health to secure that goal.

Mr. Chairman, this concludes my testimony, and I will be pleased to consider your questions on this important topic.

DISABLED AMERICAN VETERANS
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FACT SHEET

BIOGRAPHICAL INFORMATION

DAVID W. GORMAN
Executive Director, Washington Headquarters
Disabled American Veterans

David W. Gorman, who lost both legs in Vietnam combat, was appointed Executive Director of the Disabled American Veterans (DAV) Washington Headquarters in 1995. Working at the million-member organization's National Service and Legislative Headquarters in Washington, D.C., his responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House and the U.S. Department of Veterans Affairs (VA).

Mr. Gorman enjoys a reputation as one of the nation's foremost experts regarding VA's complex array of services and programs designed to assist America's veterans and their families. Due to his comprehensive understanding of the VA's inner workings, he has been asked to sit on numerous VA and Congressionally chartered advisory committees, as well as many ad hoc groups, seeking ways to better serve America's veterans.

After attending Cape Cod Community College, Mr. Gorman entered the U.S. Army in 1969, serving with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam where United States forces had suffered extremely high casualties, he stepped on a land mine, leaving him with wounds that required amputation of both legs. Discharged from the Amy in 1970, Mr. Gorman immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and Chapter 12 in Rockville, Md.

Mr. Gorman, became a professional National Service Officer in the DAV's Boston office in 1971, rising to the post of supervisor of the organization's Providence, R.I., office the following year. In 1975, he was assigned to the DAV National Appeals Staff, which represents veterans in claims before the V A Board of Veterans Appeals (BVA) in Washington, D.C. He was later promoted to supervisor of the DAV National Appeals Staff.

In 1981, Mr. Gorman assumed management duties in the DAV's National Service Program at DAV National Service and Legislative Headquarters. He was promoted to Assistant National Legislative Director for Medical Affairs in 1983 and to Deputy National Legislative Director in 1994.

Mr. Gorman is the father of five children. He and his wife, Paula, live in Gaithersburg, Md.

9/05

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

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STATEMENT BY

DAVID J. BAKER

PRESIDENT AND CEO

HUMANA MILITARY HEALTHCARE SERVICES

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

MARCH 29, 2006

On behalf of the dedicated men and women of Humana Military Healthcare Services Inc., I appreciate the opportunity to provide information to the Committee on the Department of Veterans Affairs efforts to improve the delivery of and access to cost effective health care services to our Nation's veterans through Project HERO.

As a veteran, I want to personally thank the entire Committee for its continued support of veterans programs. And as President and CEO of Humana Military Healthcare Services, I appreciate the opportunity to provide input today.

I also wish to extend my appreciation to the Veterans Health Administration for its excellence in providing health and rehabilitative services to our Nation's veterans, and for seeking to develop and employ proven best business practices advancing future health care services and access. I applaud the Department for its efforts and achievements such as:

- Advancement of state of the art medical records program
- CARES programs, realigning the VA's costs and assets
- Increased efficiency in purchasing care at the same time controlling administrative costs
- Development and implementation of a consistent "fee program" for veteran's care received outside of the VA

- Supporting managed care support contractors (MCSCs), as well as Department of Defense (DoD), in providing specialty care and serving as primary care in many locations across the country for our own TRICARE beneficiaries ; and most importantly;

- Increasing the satisfaction of our Nation's veterans by improving access to care and providing quality services.

I know that experienced companies, like ours, have the potential of substantially supporting VHA in achieving its mission and objectives. Whether it is Humana Military – or another partner – I commend VHA officials for moving forward under Project HERO. We at HMHS appreciated the opportunity to share our thoughts with the VHA at the recent VA-hosted industry day, and we look forward to the opportunity to continue assisting the VA leadership as they develop objectives for Project HERO demonstration programs. We are excited about the possibility of being a part of this potentially transformative project.

Company Background

Humana Military Healthcare Services (HMHS) is a wholly owned subsidiary of Humana Inc., one of the nation's largest health benefit companies. Our subsidiary was formed in 1993 to focus exclusively on delivering military health solutions through the TRICARE program. We were awarded our first TRICARE contract in 1995, and we began serving military beneficiaries in 1996.

Today, under a contract with the DoD, our company supports approximately 2.8 million TRICARE-eligible beneficiaries in DoD's South Region of the United States. The South Region includes the states of Georgia, Florida, South Carolina, Alabama, Louisiana, Mississippi, Arkansas, and Oklahoma, as well as most of Tennessee and Texas. Our company is made up of more than 1,400 employees, many of whom are veterans or beneficiaries of the military health system. Additionally, The Department of Veterans Affairs provides primary care for approximately three thousand of our beneficiaries in Florida, Mississippi and Texas.

Simply put, HMHS is committed to ensuring the military community receives access to high quality cost-effective health services when required care is not available in military

hospitals or clinics. We are pleased with our performance over the years, and we know we are valuable Government partners.

Before I comment on our company's role in providing services to the DoD and how our experiences might be instructive to the HERO initiative, I want to briefly discuss the role of demonstration projects in general in formulating health programs and policies for the U.S. Government.

The current set of TRICARE contracts did not spring from whole cloth. Rather, this second generation of contracts is the result of multiple iterations of the original TRICARE support contracts and the lessons learned from multiple demonstration programs including Catchment Area Management (CAM) demonstrations; the Army's "Gateway to Care" concept; the Northwest Region coordinated care program, and others. Demonstration programs allow the government to make a variety of adjustments to legacy programs, observe the outcomes of those changes and to implement change into current programs based on those outcomes. Demonstration programs best serve the policy process when they test real alternative strategies, across significant numbers of participants, for a sufficient period of time, and when they provide a realistic test of the extent to which alternative programs meet or fall short of meeting their objectives. The little we have seen of the approach to Project HERO is encouraging, and we look forward to learning more about specific program objectives as the VA takes its next steps in this important process.

I will focus my comments on three areas: 1) the objectives of our current contract; 2) elements of performance we provide to achieve those objectives; and 3) special considerations related to health care support contracting.

Objectives of Current TRICARE Contracts

When the Department of Defense established TRICARE in the early 1990s, the primary objectives related to care being purchased under the predecessor program, CHAMPUS, were to: control costs; improve access and service; as well as enhance clinical quality. As TRICARE has evolved, contract objectives have been modified and expanded.

Current contracts contain the following broad statement of objectives: *"The Managed Care Support Contractor (MCSC) shall assist the Regional Director and Military Treatment Facility (MTF) Commander in operating an integrated health care delivery system combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical, and administrative support services to eligible beneficiaries."* Supporting this broad statement of the Department's strategic intent are specific objectives:

- Optimize the delivery of health care services in the direct care system,
- Maintain beneficiary satisfaction at the highest level possible, through the delivery of world-class health care, as well as customer friendly program services,
- Attain "best value" in support of the Military Health System mission, utilizing best commercial practices when practical,
- Create minimal disruption of beneficiaries and Military Treatment Facilities during and after transition to the current contracts, and
- Provide ready access to contractor-maintained data to support DoD financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration.

These objectives are important to us, and they guide our actions as we discharge our obligations as a TRICARE contractor.

RECOMMENDATION: ***Based on HMHS' experience with past and current Government contracts in which we are responsible for providing superior health care, the VA may consider emulating the TRICARE proposal and coordination process. This can be accomplished by similarly effecting VA's mission and goals through "Project HERO" demonstration program solicitations.***

Elements of Contractor Performance under TRICARE Managed Care Support Contracts

Like other DoD Managed Care Support Contractors, we perform a wide range of tasks and provide a broad array of contractually-required services to the military community in the South Region of the United States. It may be helpful for the Committee and for the Department of Veterans Affairs to consider the critical components of developing TRICARE services as Project HERO demonstration projects are being designed.

Provider Networks - A key requirement of our contract is the provision of a stable, high-quality, credentialed network of individual and institutional health care providers to complement the clinical services available within MTFs. Networks are critical to achieving access, ensuring clinical quality, controlling costs, delivering best value and promoting high levels of beneficiary satisfaction. Network membership creates a "preferred provider" status that further ensures the delivery of accessible quality services. Our networks have been stable over the years, and that stability fosters collaboration and trust among all stakeholders, including our beneficiaries, military medical professionals, civilian medical staffs, and our company. (The Department of Veterans Affairs plays a significant role as a partner and provider in our network.)

RECOMMENDATION: ***To the extent that Project HERO involves the delivery of health care services by non-VA providers, a strong network of community-based medical professionals should be considered. It is imperative to develop and maintain a substantial network of providers and facilities to ensure access to quality health care.***

Medical Management Services - Another element of our managed care support contracts involves the management of clinical services provided to authorized beneficiaries. The variety of these activities includes: utilization management; case management; disease management; and clinical quality management (performed in concert with DoD medical professionals). Our services often complement similar, high quality programs in selected MTFs, so we customize them in various circumstances. Strong TRICARE medical management programs deliver high value by helping to ensure the appropriate care is delivered, in the appropriate setting, at the appropriate time, for the appropriate cost. These programs strategically deliver and elevate quality, as well as enhance beneficiary satisfaction.

RECOMMENDATION: ***An integrated medical management program must be tailored within each VISN's demographics, and coordinated with the VISN and VA medical professionals.***

Comprehensive Customer Information and Support Services - Today's TRICARE program requires that contractors provide readily accessible customer information services for both beneficiaries and providers, using an array of contemporary channels such as telephone, postal, electronic mail, facsimile and so forth. In addition, our contract requires the operation of walk-in customer service offices called TRICARE Service Centers (TSCs). Each modality drives varying levels of efficiency and cost, balanced against member acceptance and use. The important element is the provision of convenient beneficiary access to our company for information, problem resolution and support.

RECOMMENDATION: ***We highly recommend that Project HERO demonstrations include a requirement that contractor partners provide multiple avenues of access for the veterans they are serving. By establishing immediate and direct access to health service information, quality of care and access to care will increase exponentially because the correct type of care will be expedited through proper communication.***

Eligibility Verification, Enrollment and Billing - In TRICARE, eligibility for services is maintained and updated by the Government in a system called the Defense Enrollment Eligibility Reporting Systems (DEERS). With appropriate security processes and procedures, contractors are able to access the DEERS data base during the course of their operational activities. However, it is important to note that maintenance of the DEERS system is the responsibility of the Government – not the supporting contractors.

As part of its benefit offering, TRICARE also provides a Health Maintenance Organization (HMO) option called TRICARE Prime. The TRICARE Prime option is the only aspect of the program that requires enrollment (and the payment of enrollment fees) as a pre-condition of beneficiary participation. Managed care contractors, like Humana Military, operate all aspects of the TRICARE Prime enrollment system, from updating various systems (including medical management, claim processing, and DEERS itself) to the collection of required enrollment fees for certain classes of beneficiaries.

RECOMMENDATION: ***As the Department of Veterans Affairs partners with private industry under Project HERO, it should retain responsibility to establish and maintain the eligibility data base. The Department should carefully consider how enrollment in special programs and eligibility criteria should be managed. Depending on the structure of the Project HERO program, the DoD model may well be a cost-effective option to emulate.***

Claim Processing - The capacity to pay claims for purchased care services quickly and accurately is critical to the development and maintenance of community-based provider networks. In TRICARE, responsibility for payment of institutional and individual provider claims rests with the MCSCs. However, because TRICARE policies are so complex, all MCSCs have subcontracted this function to one of two fiscal intermediaries (Palmetto Government Benefits Administrators [PGBA] or Wisconsin Physician Service [WPS]), both of whom have years of experience in processing TRICARE claims. Inclusion of this requirement in basic TRICARE contracts (as opposed to carving it out in separate, stand-alone claim processing contracts) is a fundamental element of the overall managed care strategy. Integrating claim processing with comprehensive care management is a key enabler of other managed care techniques, including enrollment, medical management, network development, beneficiary responsibility, coordination of benefits (with other insurance), third party liability determinations, etc. The approach brings single-point accountability for performance in an area of extreme complexity and one that requires consistency and excellence in performance.

Accuracy of claim processing is also important from the standpoint of cost-control. TRICARE uses a basic fee schedule (closely aligned with Medicare) as a basis for all claim payments. In the case of network providers, the schedule of TRICARE Maximum Allowable Costs (TMAC) serves as a basis from which discounted payments are negotiated. For non-network providers, TMAC rates represent the limit of the Government's financial responsibility for specific services. Appropriate determination of non-network versus network status is a requirement of TRICARE claim processing, as is the determination of network contract terms in the case of network providers.

RECOMMENDATIONS: ***With over 10 years of TRICARE experience, we would make the following recommendations to the VA pertaining to claims processing and the payment for community-provided health care services:***

- ***The VA should not attempt to accomplish its own claim processing, and should instead include this as a part of its contracted approach to Project HERO;***
- ***Responsibility should be assigned to the prime contractor responsible for the provision of integrated claims oversight and service support; and***
- ***Payments should be based on one fee schedule. Medicare is the logical model.***

Access to Contractor Data - As noted above, one of the core objectives of the TRICARE program is to ensure the DoD has ready access to contractor-maintained data to support financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration. Since the DOD and VA share many common characteristics, it would seem that a similar strategy would apply to Project HERO.

RECOMMENDATION: ***Project HERO should include a provision related to access to contractor-generated and contractor-maintained information.***

Special Considerations Related to Health Care Support Contracting

Since I have provided insight concerning potential areas of functional overlap between current TRICARE contracts and the Project HERO initiative, an examination of contract structure may also be of benefit. To that end, I offer the following for consideration.

Risk Sharing - Though the form has changed over time, a key element of both the current and previous TRICARE managed care support contracts has involved the sharing of health care cost risk. Risk sharing with private industry experts provides a tangible incentive for contractor partners to assist the Government in controlling costs, and it adds a measure of predictability to the equation. Typically, positive and negative risk sharing has involved balanced percentages; that is, the potential positive effects have typically mirrored the potential negative ones. Depending on the ultimate structure of Project HERO, the VA may wish to consider the inclusion of a risk sharing component.

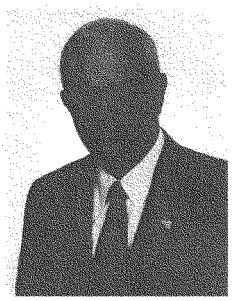
Objective Standards of Performance - For each functional element noted above, VHA should attach objective measures of outcomes – related to its strategic intents and specific objectives – against which to subsequently measure performance. For example, in TRICARE, there are specific standards related to networks (in terms of adequacy and beneficiary access); customer service (related to telephone responsiveness, waiting times for walk-ins, etc.); claim processing (including speed and accuracy of payment); and so forth. The VA would do well to ensure that any contracts under Project HERO similarly contain objective standards and defined measures of performance. In the process, the Department should avoid the inclusion of performance standards that leave no room for reasonable levels of random variation. Any process that mandates 100% success of inter-related complex systems will be challenged to succeed.

Award Fees and Performance Guarantees - The Federal Acquisition Regulation (FAR) allows for the inclusion of award fees (to reward performance excellence) and performance guarantees (to penalize poor performance) in service contracts. VHA should consider inclusion of both award fees and performance guarantees in any contractual relationships it establishes. In the process it is important to understand that, in order for award fees and performance guarantees to provide meaningful incentives, they must be: balanced; objective; measurable; achievable; and reasonable. The absence of any of these factors can create both distrust and disincentives in achieving performance excellence. Consulting with DoD colleagues regarding the successes and failures associated with establishing award fees and performance guarantees, would serve the VHA well.

Establishing and Maintaining Collaborative Relationships - The key to successfully establishing a successful Project HERO program will be the development of long-term relationships with industry partners. Such relationships should be built on trust, mutual respect, and a willingness to maximize outcomes – together as partners – for the benefit of the Nation's veterans. As problems emerge (and they *will* emerge), there must be a willingness on both sides to engage in open dialogue and make adjustments for a unified outcome.

Conclusion

In conclusion, please allow me to again thank you, Mr. Chairman and Members of the Committee for the opportunity to appear before you and submit my written testimony. Providing high quality, cost-effective health care service to veterans is imperative during this critical time in our country's history. We, at Humana Military, look forward to working with the Congress and the VA to assist in any way we can.



DAVID J. BAKER
President and Chief Executive Officer,
Humana Military Healthcare Services (HMHS)

Dave Baker serves as President and Chief Executive Officer of Humana Military Healthcare Services.

Following a distinguished active duty career of 27 years in the USAF Medical Service Corps, Dave joined HMHS as the Region 3 Executive Director in 1996. In this capacity, he was responsible for all HMHS field operations in Georgia, Florida, and South Carolina. In 1999, he became the Humana Military's Chief Operating Officer, and in January 2000, he assumed his current position.

Dave holds an MBA in Health and Hospital Administration from the University of Florida and BS degree in Business Administration from the University of Maryland. He is also a graduate of the Executive Program in Health Care Management of the Ohio State University. While on active duty, Dave completed the Interagency Institute for Federal Health Care Executives, Air War College, Air Command and Staff College and Squadron Officer School.

Raised in an Air Force family, he is the only TRICARE CEO who is a life-long beneficiary of the military health system.

HUMANA MILITARY HEALTHCARE SERVICES – DISLOSURE STATEMENT
TESTIMONY BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
BY
DAVID J. BAKER, PRESIDENT & CEO
MARCH 29, 2006

Contract (Contracting Office) Effective Dates	Contract Number	Amount of Contracts During the Last Three Fiscal Years
TRICARE Regions 3 & 4 (TRICARE Management Activity) 07/1/96 – 7/31/04	MDA906-96-C-0002	$8,870,000,000
TRICARE Regions 2 & 5 (TRICARE Management Activity) 06/01/01 – 06/31/04	MDA906-97-C-0005	$4,180,000,000
TRICARE Next Generation of Contracts, South Region (TRICARE Management Activity) 08/01/04 - Present	MDA906-03-C-0010	$5,060,456,790
TRICARE Puerto Rico (TRICARE Management Activity) 05/01/04 -Present	H94002-04-D-0003	$9,759,000
Patient Appointment Services - Bridge Contract for Tidewater Area (Army Medical Command Healthcare Acquisition Activity) 07/01/04 - 06/30/05	W81K04-04-P-0026	$4,586,000
Patient Appointment Services - Bridge Contract for Wright Patterson Air Force Base – WPAFB (Army Medical Command Healthcare Acquisition Activity) 07/01/04 - 06/30/05	W81K04-04-P-0028	$1,883,000
Patient Appointment Services - Bridge Contract for Keesler Air Force Base (Chief, Acquisition & Material Management, James A. Haley Veterans Hospital, Tampa FL) 07/01/04 - 06/30/05	V673(90F)P0010	$747,000
Delivery Indefinite Quantity Type (IDIQ) Contract for Patient Appointment Services (PAS) - Basic Contract & Task Orders (T.O.) for Fort Bragg & WPAFB (Army Medical Command Healthcare Acquisition Activity) 04/01/05 – Present	W81K04-05-D-7002 T.O. 0001 for Fort Bragg T.O. 0002 for WPAFB	$6,525,000
MATO PAS Task Order (T.O.) for Keesler AFB (81st Contracting Squadron, Keesler AFB) 07/01/05 – Present	W81K04-05-D-7002-RC01	$4,837,000
MATO PAS Task Order (T.O.) for Colorado Springs Multi-Service Market Office (10 MSG/LGC – Multi-Service Market Office, Colorado Springs) 07/01/05 – Present	FA7000-05-F-0049	$13,268,000
Multiple Award Task Order (MATO) Barksdale, AFB (2D Medical Group, Barksdale AFB, LA) 09/30/05 – Present	T.O. 6G01	$1,899,570
General Surgeon Services for Veterans Administration Outpatient Clinic, Austin, TX (Department of Veterans Affairs, Central Texas Veterans Health Care System) 01/08/03 – 03/31/05	V674P-3482	$118,000
Ireland Army Community Hospital, Ft. Knox, KY –Direct Contract Dermatologist Physician Services (MEDDAC, Property Management, Ft. Knox, KY 10/01/05 – Present	W9124D-05-C-0045	$247,722
Ireland Army Community Hospital, Ft. Knox, KY –Diagnostic Radiologist Services (MEDDAC, Property Management, Ft. Knox, KY 11/01/05 – Present	W9124D-06-C-0001	$1,586,870

BLINDED VETERANS ASSOCIATION TESTIMONY

PRESENTED BY

THOMAS ZAMPIERI, PH.D.
DIRECTOR
GOVERNMENT RELATIONS

BEFORE THE HOUSE VETERANS AFFAIRS COMMITTEE

MARCH 29, 2006

The Blinded Veterans Association (BVA) is the only Congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Mr. Chairman and members of the House Veterans Affairs Committee, on behalf of BVA, I thank you for this opportunity to present BVA's legislative views on Project Healthcare Effectiveness through Resource Optimization (HERO) of 2006. We all should strive for the same goal, that of improving access to a high quality, fully-integrated system of VA health care and benefits for America's veterans.

Since the end of World War II, when a small group of blinded veterans formed BVA, the Association has grown to include blinded veterans from several wars and conflicts. BVA has just celebrated this month its 61st anniversary of continuous service to America's blinded veterans. It is vital that all VA services focus on making a positive difference in the quality of life for the men and women who have sacrificed so much for our freedom.

What is very alarming with Project HERO, Mr. Chairman, is that this issue has emerged and is receiving attention during all of the current budgetary problems of the past two years. BVA is convinced that there is insufficient funding to meet the increasing enrollment and waiting lists for the remainder of the FY 2006 budget year, yet we now find VA rushing to use even more scarce financial resources in contracting out services to large, private corporate-managed health care associations. Project HERO was created by VHA as a response to appropriations language without any hearings, stakeholder input, or legislative authorizing committee oversight or debate. VHA continues to discuss so called "efficiencies" while trying to convince VSOs of "great potential savings of millions" by initiating Project HERO. These "potential savings" appear to be little more than games that, upfront, are questionable and difficult to demonstrate, much like the efficiencies that GAO investigators had difficulty locating in recent research. Now VHA is informing VSOs that this program will increase access and allow for more "efficient delivery" of "private corporate contracted care" in three separate demonstration projects. BVA is concerned this initiative could profoundly negatively impact the budget, not only for the remainder of FY 2006 but for FY 2007 owing to the many pitfalls of the current discretionary process.

The continuously negative VA budget model will influence specialized programs for blinded veterans and will be reflected in the other special disabilities programs that must fight for every dollar. Although many claim that Congress repaired the FY 2006 problem, more than 37 full-time Blind Rehabilitation Center FTEEs are today not filled, resulting in long waiting times for more than 1,212 blinded veterans attempting to access care in such centers. The fact is that these centers are presently experiencing financial problems. The inability to fill these blind center positions leaves them, in some cases, to operate at only 78 percent occupancy.

If current vital programs are not fully funded, BVA seriously doubts that diversion of funds into private HMOs will improve the situation. If VHA is not fiscally healthy, the specialized programs for "service-connected veterans" will certainly not be healthy either. While VHA staff attempted to brief the VSOs about the developing plans for Project HERO, there has certainly been a lack of information regarding size, specific types of health care provided to veterans, primary care services verses specialist care, and what will determine

which veterans are even enrolled (other than general geography being the deciding point). There seems to be more questions than answers about what is occurring. It almost seems that the delegation of authority to VHA, and now to managed-care organizations, to start down this path has been too easy. How to decide who acquires these contracted services, and then who will be held clinically and legally accountable for this population of veterans health care, are issues that this Committee should resolve before authorizing the rapid implementation of such a complex demonstration project.

In rolling out this project, VHA has frequently referenced the section of the Independent Budget (IB) that recommended changes in the fee-basis system and current contracting of services as justification for it. Nevertheless, the IB recommended that "contracted care be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care or geographically inaccessible to the veteran, and in certain emergency situations so as not to endanger VA facilities' ability to maintain a full range of specialized services for all veterans." The idea behind Project HERO is now being advanced as "enrolling veterans in entire geographical regions" into managed care contracted for all medical services. This idea is different from the concept of improving the current system of preferred providers so that VA's integrated clinical and claims information technology system becomes the most efficient, cost effective, and high-quality process possible.

The IB stressed that participating preferred providers should use a preferred provider pricing program to receive discounted rates for services rendered to veterans, and that a mechanism should be developed so that only credentialed, high quality providers are utilized in contracted care. Customized provider networks should complement the capabilities of and capacity of each VA Medical Center and not replace those as the veterans' first choice of care. The VA health care system has undergone tremendous changes in the past decade, bringing it recent high acclaim for its leadership in quality and for its utilization of information technology in advancing care for our Nation's veterans. Looking ahead, based on our personal experience, we should be extremely cautious about any demonstration program that is rapidly implemented to comply with Congressional language allowing the participating contracted networks to help develop the program.

Reforms haven been implemented by private, for-profit managed care health organizations outside of VA during the past couple of decades. These reforms, some critics would argue, have caused consumer revolts. The critics also claim that such reforms have forced many new federal and state regulations, more tort claims with court decisions, still rising premiums, and an increase in for-profit corporate mergers. Strategic plans are frequently based on the best economic interests of investors, not the consumers. In 1999, state legislatures introduced 27,000 health care bills to establish such requirements as 48-hour hospital stays for maternity childbirth and emergency room-mandated care. Many of these bills also required appeals processes for patients who had been denied care or services or who had been denied reimbursement for such care and services in an attempt to prevent widespread abuses of patients within large, for-profit HMOs. Ironically, here we are with plans for Project HERO, surrounded by some of these same health care organizations who wish to "demonstrate their efficiencies" by taking care of veterans who are in the VA system!

Stories of health care providers within HMOs being forced to order profitable laboratory or technological tests in order to increase revenue have not been uncommon. Demands to increase productivity by mandating minimum numbers of daily encounters in order to generate sufficient revenue have also occurred. Many HMOs have their own formulary for consumers that could result in problems with VA's restrictive national formulary system if veterans are prescribed medications that are inconsistent with VA's formulary. Although VA administrators may claim that these are easy issues to address, history might dispute such a claim if only there is a review of the track record of the current problematic fee-basis system of contracted care and of the profits of managed care organizations during the past decade.

VA is faced with unique and complex social challenges, one of which is an aging population with multiple conditions that often require the taking of many medications. In many cases there are difficult economic circumstances, a diversity of disabilities, and unique mental health problems. All of these challenges abound within the environment of a discretionary budgeting system. Projecting that Project HERO will result in hundreds of millions in savings, produced by contracting with managed- care organizations, must be viewed with suspicion. Reforms driven by cost-conscious market forces without adequate oversight are often complex, chaotic, and disabling to those caught up in these changes. According to the chaos theory, a small change in input can quickly translate into overwhelming differences in output. As has already has been demonstrated in this country's history, any changes in the three basic tenets of health care delivery—quality, access, and cost—results in significant changes in one or more of the others.

What veterans request from their Members of Congress is the ability to obtain local primary care services in certain geographical locations where no VA-based outpatient services currently exist. They also request that the provider have the technological ability to interact with the VA facility that has provided them with specialized services, medications, or diagnostic care. They expect their care to be coordinated and accessible, and to originate with qualified clinical providers. Having an elderly or disabled veteran who has difficulty traveling long distances for VA care receive locally contracted care and preventative medical services is an extremely different proposition than opening "enrollment of all veterans in a widespread geographical area" to for-profit managed-care organizations. In an industry in which well-compensated CEOs search for competitive advantages in the marketplace, one must ask why so many non-profit health care management organizations would be lined up in a bid for these contracts—unless of course the profit margins were going to meet the needs of the bottom line as a first priority. The question must then be asked: What does such a scenario ultimately mean for veterans?

BVA supports the Independent Budget's recommendations that changes be made to the previous fee-basis contracted care system as follows:

1. Veterans' electronic medical records are properly updated with data regarding any care provided by non-VA providers.
2. The change process should fully involve an integrated, seamless continuum of care that facilitates improved health care delivery and access to care.

3. Providers should be properly credentialed and certified.
4. Contracted health care services must be able to move a veteran from outpatient clinic care to ambulatory care diagnostic services, and into all other VA medical care service, while avoiding fragmentation of the care.
5. Oversight be transparent, effective, and protect the veteran from abuse.

Once again, Mr. Chairman, thank you for this opportunity to present BVA's legislative views on Project HERO. BVA is extremely proud of its 61 years of continuous service to blinded veterans and all of the accomplishments the organization has enjoyed. Health care problems confronting the nation are complex. The future of managed-care organizations, once considered the answer to many of the issues, has dimmed considerably as rising costs still dominate almost every decision. Veterans who served and defended this country deserve to be more than pawns used to increase market shares for the bottom-line of a corporate contract. We expect this Committee to, at a minimum, require VA to present quarterly updates on numbers of veterans in contracted care, on types of medical services being provided, on costs per geographic area, and on veteran consumer satisfaction surveys regarding all services provided by Project HERO. Equally important for all veterans treated under this program are reports on the information technology transfer of data records from the contracted care providers into the VA health care records.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Blinded Veterans Association

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federals services or governmental programs.

BVA is a 501c(3) congressionally chartered, nonprofit membership organization.

THOMAS ZAMPIERI BIOGRAPHY

Thomas Zampieri is a graduate of the Hahnemann University Physician Assistant Program (June 1978). He obtained a Bachelor of Science degree from State University of New York and graduated with a Masters Degree in political science from the University of St. Thomas in Houston, Texas, in May 2003. Mr. Zampieri recently completed his political science Ph.D. dissertation and was awarded his degree by Lacrosse University. He is employed as the National Director of Government Relations for the Blinded Veterans Association, a congressionally chartered veterans service organization founded in 1945.

Mr. Zampieri served on active duty as a medic in the U.S. Army from 1972 to 1975. Upon completing Physician Assistant training, he served from September 1978 until August 2000 as an Army National Guard Physician Assistant, retiring at the rank of Major. During this time, he was involved in several military medical training programs and schools, successfully completing the Army Flight Surgeon Aeromedical Course at Fort Rucker in 1989 and the U.S. Army Medical Department's Advanced Officer Course at Fort Sam Houston Texas in 1992.

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