



## **Health Care for Veterans: Where Things Stand & Next Steps**

**Ascension**

**Alliance for Health Reform**

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MARILYN SERAFINI: Hello, everyone, we are going to go ahead and get started. I'm Marilyn Serafini with the Alliance for Health Reform and on behalf of our honorary Co-Chairmen, Senators Blunt and Cardin, I would like to welcome you to today's briefing on veterans' healthcare. The Veterans Choice Act became law in 2014, creating a pathway for some veterans to receive some of their healthcare through the private sector. There has been a debate about how best to deliver healthcare to veterans for quite some time and the last two years have provided some experience to consider as policymakers here in Washington decide how to proceed going forward.

Today, our speakers are going to help us to understand the complex system through which veterans receive their care and how that is changing given the unique needs of veterans. I would like to thank our sponsor for today's event, Ascension Health, and I'm going to turn over the mic now for a few minutes to Mark Hayes for a few words.

MARK HAYES: Well, welcome, I'm going to be very brief, I just want to thank you all so much for coming to this important briefing on a very important issue. Ascension is very pleased to be a sponsor of this briefing, because the care for our nation's veterans is so important and it's this issue that combines both veterans' issues and healthcare issues and so it's a great issue for the allies sometimes in different offices to meet each other that we don't always interact. But it is a great opportunity, we have a great panel this morning. Ascension is the largest non-profit health system in the United States and the largest Catholic system in the world and we participate in the Veterans Choice Program because we see caring for our nation's veterans, those who have served, alongside the VA as something that is very central to our mission. And so we are very pleased to participate in the program and are looking forward to what we will learn this morning. So thank you all for being here.

MARILYN SERAFINI: Thank you, Mark. So if you are following at home on CSPAN, you are welcome also to follow and of course those here in the room, you are welcome to follow and participate in the Twitter conversation. The [#VeteransHealth](#). You can also use Twitter to post questions to the panelists after each of them speaks – after we go through the line of all of them speaking, we will turn to your questions and you will be able to ask questions in several different ways. You can pose your questions via Twitter – again, [#VeteransHealth](#). We have two microphones in the room. And you also, in your packets, have a green card and you are welcome to write your questions on the green card and our staff will be around to pick those up and they will bring them here to me and I will present those questions to the panelists.

Also, if you are not with us here in the room today, you can find the speaker's presentations and also other resources at our website, [allhealth.org](http://allhealth.org).

So now I am going to introduce our panelists today. First we have Sherman Gillums Jr, he is Executive Director of the Paralyzed Veterans of America. He served our country in the Marines for over a decade. After 9-11 as he was preparing to deploy for Afghanistan, Sherman sustain a cervical spine injury that ended his military career. Since then he has

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served his fellow veterans through his work at the Paralyzed Veterans of America. So thank you, Sherman, for your service to our country.

Next we have Dr. Baligh Yehia, he is the Deputy Undersecretary for Health for Community Care at the Veterans Health Administration. Before joining the VA, Dr. Yehia was a leading expert at HIV medicine at the University of Pennsylvania.

David McIntyre, Jr is President and CEO of TriWest Healthcare Alliance, which he founded in 1996.

Carrie Farmer is a Senior Policy Researcher and Associate Director for the Behavioral and Policy Sciences Department at the Rand Corporations. Her areas of research include access to and quality of behavior healthcare for military service members and veterans, as well as treatment and recovery from traumatic brain injuries.

Finally, we have John Kerndl, he is Senior Vice President and Operations Chief Financial Officer for LifePoint Health. He oversees operations support and planning departments that provide direct assistance to LifePoints hospitals and providers.

So we are going to start off first with Sherman Gillums. So, I turn it over to you.

SHERMAN GILLUMS: Thank you, Marilyn. Good afternoon everyone. These pictures show me at the bookends of my military career. A 17-year-old private first class that became the 29-year-old commission officer that you see on the slide. And at that time, I didn't know much about what being a veteran meant, nor did I really care. I never set foot in a VA Medical Center, much less receive care from a VA provider. So any opinion I had had of the VA Healthcare System, would have been based on second hand knowledge at best, outright ignorance at worst. And our problem today is that we have too many in media and government who share the same lack of informed insight, yet they insist they know what is best for veterans in terms of delivering healthcare. So hopefully we can change that in this forum today and here is why.

Because this happens. Car accidents, training mishaps, combat injuries, illnesses and other infliction inherent to the hazards of military service. This was my car after I was extricated from the vehicle 14 years ago. What followed was an emergency spine surgery, three days of intraocular intubation while I was unconscious, 11 more days of intensive care until I stabilized and my very first contact with the VA Medical Center where I would start my rehabilitation journey. There was virtually no decision that was my own. My life was literally in the hands and judgement of others. The same is true of those service members who will suffer similar fates in the future, as well as veterans today who have seen war and profound mental and physical hardship. So here are the questions: What will the VA of the future look like for them? What will change? Will it be better or worse? More importantly, who will decide? Will that decision be wholly based on public outrage and reaction to isolated incidences? Will political pundits and decision makers look beyond statistics and headlines and at least have set foot in several VA hospitals and spoken with numerous veterans to inform their thinking? So this is me

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now, a byproduct of VA healthcare. One of many who have filtered through the system, seen first-hand what needs to improve – and there are things that need to improve – and know by experience what makes it unique. A veteran-centric system of healthcare that cannot easily be replicated in a private or community sector as they are currently constructed. There is more work to do. This version of me has used care only covered through TriCare. I have also accessed emergency rooms and urgent care centers when a VA wasn't readily available and on balance, the providers were all competent and compassionate. They were responsive to my needs. But there was a disconnect that was stark. For example, as I would have to recall as much of relevant medical history as I could, while fighting a debilitating fever due to infection, because my records weren't available. Or I would be left sitting in a waiting room in line behind a cast of characters from all parts of society as just another guy in a wheelchair who needed medical care. After the episode of care, while still dealing with what ailed me, I would also have to drive myself to the nearest drug store, hoping they carried my prescription and more than one instance I had to bounce around to several drug stores or simply wait for the medication because it was out of stock. This is what non-veteran-centric fragmented healthcare looks like when taken out of the abstract for the veterans who will be impacted.

So let's take a look at who will be impacted today and in the future as VA healthcare evolves. For most, getting dental care, eye glasses, hearing aids, x-rays, urgent and emergency care in a more timely manner, is a good thing. But let's not underestimate what that means for the men and women in my circumstances or worse. You see the numbers on the slide. To me, they are not just statistics. These are veterans whose quality of life is a matter of life in death in many cases for the rest of their lives. Here is a problem for those who advocate for complete privatization, yet agree that VA's should retain the function of providing specialized services. I keep hearing them say, well, VA can just do what it does best and privatize the rest. But that will not work and here is why: Having a spinal cord injury or poly trauma doesn't mean that I won't get cancer, have a heart attack, develop diabetes or suffer depression and need what is referred to as tertiary care. Which augments and sustains those specialized services that VA does well. Within the VA system, veterans access those other consultative services such as oncology, surgery, urology, cardiology, neurology and are still closely followed by a specialized care team because of the interdisciplinary framework that is unique to VA. That is why you simply cannot separate them, in fact, specialized services would erode should demand for tertiary services be driven completely to the private sector.

So with this busy slide in front of you, we will turn now to a discussion on the attributes that make VA healthcare unique based on my 14 years of experience as a user of that care. That is our focus today. The slide lays out all the characteristics of both tertiary and specialized care that most who [unintelligible] likely do not know. So here is a bit of education. I would like to draw your attention to a few, starting with the ones in the red boxes. Did you know veterans who seek emergency medical care in the private sector do not have to pay the expenses for them, provided a request to cover unauthorized medical expenses is timely provided. That is not so in the private sector. Eligible veterans who have medical appointments are reimbursed for their mileage and travel provided, unless it

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is provided by VA or a contractor. That is not so in the private sector. Enrolled veterans can receive seamless access to prosthetics, pharmacy services, VA benefits assistance and peer support during appointments, making it a more veteran centric experience they would receive anywhere else. That is not so in the private sector. And now, eligible veterans do have a choice through the Choice Act and that is a good thing, because they can seek care from alternate providers, if timely VA care is not available, which is great as a component of VA healthcare, but not as a replacement.

Finally, I would like to close with comments on the most overlooked aspect of collaboration between VA and the private sector when discussing healthcare for veterans. Title 38 of the United States code, the authority that governs the delivery of VA benefits including healthcare, protects veterans through due process provisions, medical malpractice rights, congressional oversight, and a credited representation and no cost. But what many do not know, is that Title 38 authority and protection do not follow the veteran who opts for care under the Choice Act. Congress would not have the jurisdiction to compel testimony for private sector CEOs whose healthcare systems are found to have gained the numbers or have hidden weightiness. Maybe we are wrongly assuming it never happened. Moreover, veterans will have to rely on the courts for readdress if healthcare goes awry, if they can afford it. If effective and sustainable collaboration is to happen, this absolutely must be addressed. As long as these veterans know that, that's the reality, then we have given them not just a choice, but an informed choice, beyond simply hoping for the best. If they chose VA for their healthcare, it needs to be a viable choice. Thank you.

(Applause)

MARILYN SERAFINI: Thank you, Sherman. Now we will turn to Dr. Yehia

BALIGH YEHIA: Thank you very much. That was just an amazing firsthand experience of some of the care that is provided in VA. Just a little bit about myself, I'm a practicing physician within the VA. When I'm not seeing patients as often as I would like these days, I'm in DC leading VA's Office of Community Care. One of the other really key pieces about kind of my journey with VA is I trained in VA. I was a medical student down in Gainesville, Florida and then a fellow at the University of Pennsylvania at the Philadelphia VA and as many of you may know, 70% of all of America's doctors at some point, interact with a VA and that is another really key feature of the system, not only taking care of our veterans, but also training the next generation of nurses, doctors, and other healthcare professionals that will take care of all of Americans. To Sherman's point, at the end of the day what we want to see as a vision for VA and VA healthcare, is what we call an integrated healthcare system. It's a system that includes VA healthcare providers and clinics as well as leverages, expertise from the private sector. Unlike many other healthcare entities in the United States that are limited by their geographic markets, so if you are starting a clinic, its – what you actually do is, patients come to you. VA is completely opposite. We go to where the patients are. Where the veterans live. And our veterans live in every corner of the United States. Some highly rural places, some highly urban places, but they span the entire geography of America. And in those circumstances,

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we cannot have a brick and mortar facility in every one of those individual locations. So we have to leverage community partnerships and they really are about partnerships, not just the purchase of care. Partnerships that allow us to provide healthcare to veterans in those areas. So at the end of the day, what we want to do is build an integrated healthcare network and I know that the Alliance puts on a lot of these various programs and they focus on Medicare and so a Medicare corollary would be an accountable care organization. This is really where we are looking to build, which is a network that is highly coordinated, integrated and includes both VA and community providers. Because really we need both aspects to meet the full spectrum of needs for our veteran population.

So how do we get there? We really start with the veteran in the middle. So VA and VA community care has been ongoing a transformation really since the Choice Act came about and about a year ago, we presented a plan to Congress called our plan to consolidate care. Right now, we have multiple ways of purchasing care in the community. And it's important to note that VA has really been partnering with community providers for decades upon decades, while the Choice Act might have put a little bit of spotlight on our ability to purchase care, we purchase way more care outside of the Choice Act than within the Choice Act. And we have been doing that for years and years and years. A perfect example is our great partnerships that we have with Academic Medical Centers, which started about 70 years ago. We were able to not only share clinical knowledge, but also research and training expertise. So this is not new to VA. This ability to partner with different providers across the country. And like I said, they span the spectrum from academic, community providers, federal institutions like DOD or Indian Health Service, to FQACs to your regular mom and pop shops across the country. So how do we get to this integrated healthcare network? We really need to focus on the veteran and what we did is we actually talk to veterans, visited the different facilities, and community providers, and we mapped the veteran's journey through community care. And it really starts with eligibility. We need to have a very clear set of eligibility criteria that makes it easy to understand that what veterans and community providers and our VA staff to administer. Right now, because of these various programs, it creates confusion. The benefit that veterans have earned and deserve is not clear in the community. And so we have to be very specific about who is eligible and who is not and hopefully make it a fair and equitable system and communicate that. That also translates to our community providers. Because of all the various programs that exist which have different eligibility criteria, our community partners sometimes don't know if they are seeing a veteran that will be covered by VA or not. And that creates problems with payments. If they take care of an individual that we are not by law able to take care of. Second is a referral and authorization process, which is, how do we make sure that we get our veterans that are accessing community care, timely access to that? And this really has to do with making sure that we are able to leverage electronic exchanges of information so that the doctor knows clearly what veteran they are seeing and the reason for that and the veteran also knows why they are seeing that doctor and when they are supposed to see them.

Now, care coordination; I always kind of state as really where the magic happens here. This is the golden nugget that if we are able to get this right, will serve a model not only for our healthcare system, but for all of American medicine. American medicine now, as

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we are moving in the era of value based payments and to more integrated networks, this is the thing that still, folks are trying to figure out. Because you cannot live in your own institutions anymore, you have to work with other community partners, whether they are for delivering healthcare or delivering community resources like housing or transportation, in order to actually take care of patients. And so at VA, I think we are uniquely positioned to start to address this because of our ability of integrating care between the community and within our own healthcare system and we are hoping to leverage more electronic health information exchanges, portals to share medical records more seamlessly between VA and the community.

The next one is the community care network, which is who is this network of providers that we work with? This really does get to the idea of informed choice. Right now we have a broad network of providers, more than 350,000 partners that we work with in VA to deliver healthcare in the community of veterans. But we want to make sure that the veteran is empowered to make informed decisions about the providers they want to see. And this is the same movement that all American medicine is getting to, which is how do we get our community network to be able to report on quality, satisfaction, value, so that veterans are able to choose a provider that makes sense for them. That this is a – healthcare is a very personal matter, how do you choose a provider that actually meets their needs? Part of this is also identifying what we call in VA, is our preferred providers. We know that our providers in the VA, by interacting with veterans, really understand military cultural competency and some of the very unique circumstances and conditions that our veteran population has. And when I was practicing in a private sector, there just really isn't enough volume or touchpoints that you have with veterans to really understand all the different nuances. So we want our preferred providers to not only be delivering excellent quality, high levels of satisfaction and good value, but also have expertise in military cultural competency and be aware of veteran issues. And I think that way we can start to help our veteran population really understand and choose a provider that meets their needs.

Next is provider is payment. And this is critically important, especially being a practicing physician as we view our providers and partners. And in order to be good partners to our providers, we have to pay timely and accurately, and this is something that VA continues to work on. Because of the multiple ways that we have of buying care today, it creates a lot of confusion and I will just give you one example. When the Choice Act was passed, VA by law was required to send out about 9 million cards to individuals. These cards look like health insurance cards. We have encountered many veterans that have taken that card to a community provider, the provider worked on the assumption that this veteran was eligible and delivered care, but then on the backend when we got claims, we were not able to pay those clinicians because they were not – they did not meet those criteria. So we have to have very clear eligibility criteria that is simple, no red tape, make it very easy for folks to understand so that the community and the veteran know exactly what is eligible and what isn't and then us at VA can do our part to make sure that we pay timely and accurately. And then wrapped throughout all of that is a focus on the customer, on customer service on our veterans and that makes sure that we are able to get information to them in a quick and timely manner.

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So that is really our journey at VA right now on how we are tackling to improve community care. It is focused on the veteran with the touchpoints that are important to them and then spooling up projects to be able to move the needle in each of those areas. For almost every one of those areas, we also need to partner with Congress to make sure that we make the system less complicated than what it is. When you are trying to run a program and keeping the veteran in the middle, it makes it hard when actually there is not one program, there is seven or eight programs. So we have to get to that one program that make sense for our key population.

I wanted to mention a little bit about how we could move towards a high performing network and this is a concept of this network that I just described of internal VA and external VA partners and you can – this graphic depicts that a little bit. You can see veterans moving around from one location to another and including the VA and our various community partners. And we want to skate where the puck is, which is where is healthcare going in the future and what can we do at VA to position us to make sure that we are meeting the needs of veterans not only today, but also tomorrow. That means evolving from a fee-for-service model to a value based reimbursement model with preferred providers. With CMSs investment in the CMMI and all the various demonstration projects, they are testing out various models that make sense from a value based perspective. We want to participate in those as well. We want to make sure that we are not – our community providers are not driven by just volume, but more towards value. We do need some legislative help in order to be able to do that. We also want to leverage better monitoring of quality utilization patient satisfaction and value. We want to be transparent about the care that we are delivering not only in VA, but in the community. Right now, VA reports publicly and a lot of various markets related to access as well as quality and satisfaction. We want to be able to get that same level from our community providers that our veterans are participating in. Third, we want to transform to a care model that is more personalized and coordinated. Now, inside VA, we leverage a patient centered medical home model where we actually have teams that take care of veterans. We need to be able to leverage that same sort of personalized care as veterans go in and out of the VA. So that will be a unique challenge for us that as I said, also is faced by many healthcare institutions across the country. But being able to match a veteran with the right level of need and so some veterans may just need a navigator to let them know where to go, who to show up, what to bring. Others may need a case manager to help them work all of their multiple appointments, make sure they have transportation. So how do we really get to the needs of our patients and match them up with the right resources and have them follow through their trajectory as they go in and out of the VA. Then lastly, we need to leverage better exchange of information. Right now in American medicine, there are a number of different healthcare providers that all use different electronic health records. You know, VA has been in the business of EHRs for decades and we need to figure out how we can communicate between those different entities and I think we have some innovative ways of doing that by really leveraging some of the community health exchanges that are in existence today and really moving more towards portals that share information.

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So that is just a little bit about maybe the future of VA and where we hope to get to and some of the challenges that we face from a legislative standpoint, but then also I think, opportunities for us to be able to really lead the way in some ways for areas of American medicine. Thank you.

(Applause)

MARILYN SERAFINI: Thank you, Dr. Yehia. Now we will move to David McIntyre of TriWest.

DAVID MCINTYRE: Marilyn, thank you and good afternoon everybody. Thanks for being here. Those of you who represent members of Congress, it's a privilege to serve your constituents because every one of your bosses has veterans as constituents, so that is obviously part of why you are here. It's a privilege to follow Sherman, who did a great job of laying out the population that is the entity, the individual that is responsible for being served by the system and Dr. Yehia, who did a great job laying out where the system is today and where it needs to be going, going forward.

The ask for me was to lay out, how do we get to where we are from a choice perspective? What did that look like and what does the system currently do from a private sector perspective? So I'm going to spend a little bit of time talking about the scaling that was involved to make this happen and where we sit when we look through my end of this lens. And that is, responsible for one half of the country to build the integrated delivery system downtown that mates up next to the VA delivery system. Obviously, as Sherman represents, we have the privilege of serving the best of the best in this country. They are the people who served this country. So the Choice Act was born out of a crisis. I live in Phoenix, Arizona. In April of 2014, we all know what was disclosed in Phoenix. And very quickly, Congress passed legislation and actually funded it at the same time, to give VA money to be able to scale internally, but also to be able to buy more care downtown. They gave the private sector in VA 90 days to stand this up. By the time the rules were actually figured out for what was going to be done, we had 33 days to go from a blank sheet of paper to full startup. That is a very, very short period of time. But when we started, there were no four hour waits on the phone. We were on our way, headed down the track of what needed to be done and we spent a lot of time together trying to figure out where the gaps are between Congress, the VA and the private sector and how do we close those things. Many adjustments had to be made, both policy and operationally and we probably had gone about 75% down the track of closing those gaps, but there is a lot of refinement that still remains to be done, as one would expect. Massive scale had to be built and placement was key. But you had – the greatest challenge was to get people to understand what was actually enacted by Congress. Both within the VA, within Congress itself and among the beneficiary population, as well as by the healthcare provider community, because this was launched very, very quickly. But we sit here today, a little bit past November 5<sup>th</sup> of 2014 when this needed to start and over five million appointments have now occurred through this program. Our company and the network that we built has been responsible for 3.2 million of those.

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So how do you go about building out a network? You have to understand the demand curve. And so we spend a lot of time working with the individual VA medical centers, understanding what demand looked like. If you had never fully delivered on demand, you didn't really understand it. So we tried to work that and map that. And if you look at 2014, this was the network – the blue area is our area of responsibility, because we really didn't have a good sight line as to what the demand picture looked like for what needed to be purchased in the community and matched up next to VA to give it the elasticity that it needed. This is what it looks like now. So if you go backwards, that is what it was in 2014 of January and this is what it is now. Tailored to demand. And the bottom line of it is, very few cases are now returned to VA in our area of responsibility, because there is not a provider available to see that person when the VA itself is unable to deliver that care directly.

I would like to thank Ascension for being part of that network and I would like to thank LifePoint for also being part of that network and the 185 to 190,000 providers spread across 28 states that are delivering care today at the side of VA to give them the elasticity that they need. So in the first month, we served 2000 people. And you can see what the demand curve has looked like. As Dr. Yehia said, the VA has been buying care in the private sector for a very long time. We are owned by two university systems, which gives a lens into the delivery system. And we are owned by a bunch of non-profit blues plans. They buy care, they integrate care, that is the core of what they do. And so you look at this demand curve, we are not at the top of it yet. And yet, about 6000 units of care are being placed a day now, from 2000 a month that was done previously. This is what has happened on the spend side. So at the beginning of Choice, as you start slowly into something like this, it's chiropractic care, podiatry, the lower cost, low acuity things. Now it's brain, its heart, it's digestive systems, it's brain injury, it's cancers. Those things are getting placed in the community in support of VA.

So what are the challenges that remain? When I look at this, I still believe we haven't entirely solved the access equation. And the issue at the end of the day is to make sure that we properly map the demand curve. As Dr. Yehia said, make sure that we have the right providers in the networks and that we are operating in an integrated way or a virtually integrated way to make sure that people have confidence that the providers in the community are the right ones to place the care with. The second one is continued refinement and Dr. Yehia went through the various aspects of what is being refined today. The biggest issue for us at the moment on our side, is to make sure the providers understand what it takes to file a claim properly, and then the process works in a streamline fashion on our side and then as the VA reimburses us for the payment that we make to providers, that that full stream works. We still have work to do. I was here at the start of TriCare when the DOD stood up TriCare almost 20 years ago. I was in the same role then. It took three and a half years for the DOD to engineer claims to get it right. What I'm going to tell you is, the people in VA are incredibly focused in this space and we are making a lot more progress than we made 20 years ago with DOD. In fact, if you go to a place like Rio Grande in Texas, we just finished a triangulated project there to bring the VA together with the hospitals in the community, together with our company, to be able to look at, how do we get claims right between all three of us? And we changed

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the aperture dramatically in as short as five weeks. So we plan to do that successively across the country.

The third thing I would say is, we have a very inhumane dialogue going on in this country around this issue. This isn't about privatizing the VA. That is not a good idea. We as citizens have invested a lot of money in the architecture and the infrastructure of a great system. At the end of the day, this is about resetting a system. That is going to take 10 to 15 years to its end point. And unfortunately folks thought, when you pass a bill, when you fund it, you are done. No, that was just the down payment on getting started. And some of us remember what happened with Walter Reed. It needed to be reset and reengineered. That took 8 years. This is an entire system. And it's about making sure that the people who served in combat the last 10 years, that came from every zip code in this country, have the ability to go back to where they came from and live there and receive care. And if you are in a place like Sherman is, you may need to go to a place that is right next to a VA medical center. But the bottom line is, the system is not really set for that, so this is partly a resetting exercise. And then as Baligh said, making sure that eligibility works more streamlined.

The last thing that I would say to those of you that are staffers here, and I was a staffer a long time ago, back about 20 years ago is when I left Capitol Hill. In the '60s when we passed Medicare and Medicaid, we created them as entitlements. The VA is not an entitlement. The Choice Act makes it a virtual entitlement, that is a good thing. But it's time to step back and figure out whether VA should be the primary payer and whether we ought to think about as a country, the notion that those that served our country the way that veterans did, have the right – first right – to an entitlement. Because a lot of things would end up in a very different place were that the case. And most of their care is actually financed by the federal government. So that would be a challenge to some former colleagues and those that followed me as a staffer.

Lastly, I would say this is about teamwork. So again, I come from the City of Phoenix, that is where the inferno started. On Monday, this billboard was put up in Phoenix. It replaced a billboard that was right outside the VA that said the VA is lying. For nine months the staff that were driving to work saw that every day they went in. There are people that are dishonest, they happened to be in the private sector. They are also in the public sector. But not everybody is dishonest. And the fact of the matter, it was demoralizing. What this billboard shows, that now replaces that one as of Monday, is that it takes a team to deliver for those that served this country. Not to replace VA, but to give it the elasticity of the other needs. 400 providers in the VA Hospital in Phoenix surrounded by 8800 providers in Maricopa County, of every specialty, giving them the elasticity that they need to be able to deliver on care. Thank you very much.

(Applause)

MARILYN SERAFINI: Thank you, David. And now to Carrie Farmer of the Rand Corporation.

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CARRIE FARMER: Thanks, that was great. So I'm going to give a little bit of a different perspective from the research side. So, as something else that happened as part of the Choice Act, was a requirement of an independent assessment of veteran's healthcare. And Rand participated in an independent assessment and I'm going to share some of our findings about the quality of VA care, access to care and then also talk about what we know about quality of care and access to care in the private sector. So starting with quality of care. In our assessment, we looked at – Dr. Yehia mentioned that VA regulatory reports many quality measures as does the private sector and when we compared VA's performance on those quality measures, compared to the private sector – and by private sector in this case, I mean Medicare, commercial HMOs. We compared in a number of different ways. The VA performed as well and in many cases, better than the private sector on these quality measures.

Turning to the timeliness of care, we also examined VA's wait time data. So when we think about timeliness of care, we think about, how long does it take to get an appointment. And in this case, VA measures wait times by how long is it between the preferred date of care. So that is the date that the veteran or their provider would like the appointment to occur and then the date when the appointment actually occurs. So in our analysis of this data, we found that most veterans receive care within two weeks of their preferred date for care. Of course there are a lot of variabilities in these numbers. In Phoenix it was not two weeks for an appointment, but in other parts of the country, the wait time really is much shorter. And on average, the wait time for a primary care appointment is six days.

Another aspect of the access issue is, where do veterans live relative to where their healthcare is? So looking at where veterans live relative to VA facilities, the vast majority live within 40 miles of some kind of VA facility, so this can include a VA Hospital or an outpatient clinic. When you start to look at more specialized needs for care, a smaller proportion of the veteran population lives within 40 miles of a VA facility that can provide that kind of care. So 26% of veterans live within 40 miles of a VA hospital that provides the full spectrum of specialty care.

So what does this mean about VA turning to the community to help fill some of those gaps? What do we know about care in the community? What do we know about healthcare in the U.S.? Overall, we know that the U.S. has a ways to go in improving the quality of care. This study was from 2003, it's one of the landmark studies looking at the quality of care across the United States. And in this case, patients received 50% of all recommended care. This study examined both care for chronic conditions and for acute conditions. Since that time, there has been a lot of work understanding the quality of care. The Institute of Medicine has had a number of studies examining the quality of care in the United States and what we know about overall is that the quality of care in the United States is variable and there is room for improvement across all healthcare conditions.

Dr. Yehia also mentioned military cultural competence. Providers in the community who are serving veterans, need to understand the particular needs of those veterans, what their experience is serving the military are. In a study we conducted in 2014, we did a survey

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of behavioral health providers across the United States and found that less than half regularly asked their patients whether they were veterans or had ever served in the military. Even fewer reported knowing anything about military culture.

Then what do we know about the timeliness of care in the private sector? We actually know very little. It's difficult to compare the timeliness of VA care to the timeliness of care in the private sector. In part, because everybody measures timeliness of care different and there is not one standard in how you measure this. In the couple of studies that we were able to find in the private sector, this measured the time between when a patient called for an appointment and when the appointment occurred. We found that in these studies, the times – those wait times were much longer. So 19 days for a primary care appointment in one study, and 39 days in another study, and again, these studies also had a range. So when you compare that to six days on average in VA, it does suggest that timeliness may not be solved by the private sector.

Finally, when we think about where veterans live relative to the VA, on the slide that I showed earlier, what about where veterans live relative to other providers in their community? So this slide shows, veterans who live far from a VA. So live more than 40 miles from a VA. Among those veterans who live far from a VA facility, 80% live within 40 miles of a primary care provider in their community. But when you look at more specialized needs and even just looking at mental healthcare, less than half – this is 49%, live within 40 miles of a private sector mental health provider. Even fewer live within a 40 miles of a private sector neurologist or endocrinologist. What this means is that this is a challenge for rural healthcare overall. This is not particular to VA and for veterans who live far from a VA facility, opening up the opportunity to seek care in a community isn't necessarily going to solve this problem, because those providers may not exist in their communities either.

So looking at this overall, it really does suggest that private sector care should complement VA care. That VA provides care in most cases with high quality in a timely manner and that the private sector should come in and compliment, not substitute for that care. It's also important, since we know very little about the quality of care for veterans that is provided in the community and the timeliness of care for veterans provided in the community, to really develop a mechanism for monitoring that care to ensure that both in the VA and the care in the community that VA is paying for, is high quality and timely for veterans. I will stop there.

(Applause)

MARILYN SERAFINI: Thank you, Carrie. Before we turn to our final speaker, John Kerndl of LifePoint Health, I would like to invite everybody both in the room and watching on CSPAN, that you can participate in the Twitter conversation, [#VeteransHealth](#) also after John speaks, we are going to open it up to your questions. Again there are three ways in which you can ask questions. You can submit your questions on Twitter using the [#VeteransHealth](#), you can ask questions at the microphones here in the room. Also, in your packets, you have a green card and you can

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write your questions there. So we will hear from John and you can be getting your questions ready in the meantime. John?

JOHN KERNDL: Thank you, Marilyn and thank you all for being here today. Before I get started, I would like to recognize David Critchlow, who is our Vice President of Government Relations, who is here with me today and also available to answer any questions.

I'm going to go through a few slides, start just by identifying LifePoint and who we are. It will frame any comments that I make from a small, non-urban soul community provider perspective. I'm going to walk through some of the volume indicators of the veterans that we are seeing within LifePoint and then talk a little bit about what we see as opportunities to expand the provider base within this program.

So a little bit about LifePoint Health. 72 hospital campuses in 22 states. As I mentioned, we are a non-urban soul community provider. There is a bullet point that says leading healthcare provider in our communities – we are typically the soul healthcare provider or at least acute care provider within our communities. We operate in areas that the closest acute care facility is over 100 miles away. This I found interesting in particular with Carrie's comments about some of the availability to some of these higher end services. These are typically the markets that we serve. We are non-urban, there is not a VA hospital near us in a lot of our markets – most of our markets. There is not another acute care provider near us. So our ability to serve these VA's, these veterans in our community, is very important to us. Avid supporter of Veteran's Access Choice and Accountability Act. This has been a very emotional issue for our leadership teams. A lot of our leadership in our facilities are veterans themselves. They are in small communities; they know the veterans that live there. So this has been very important for them, very emotional for them and they have embraced this entirely. It was interesting – we are very proud of some of the work that they had done in particular with Veteran's Choice, to reach out to their communities and to a certain extent became a resource for veterans to use to identify whether or not they were eligible for it. Have embraced it significantly.

So just some volume statistics of the care that we have provided in 2015. We have provided care for over 15,000 veterans throughout LifePoint facilities. Of those 15,000, 1,200 for inpatient admissions. 4,600 through our emergency rooms. 1,600 outpatient surgeries were performed and more than 7,100 outpatient procedures and tests in 2015. It's up from '14 and continues to grow, which we are very proud of.

So where can we improve? Some stats here, and I will talk a little bit, kind of comparing it back to LifePoint. All of our payers, when we look at days to pay, which is when do we get paid for services compared to when we discharge a patient? For all players within LifePoint, including self-pay patients, that is 54 days that we are typically paid. Within our group – and it says Veteran's Choice, but it's the PC3 Program and Veteran's Choice typically takes 113 days on average in our 22 states to get paid. So here is why that is so important: For LifePoint, we have a very strong balance sheet. We have the resources to basically finance this care. Our costs that were paid at Medicare rates, which are almost

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by de facto cost, we have the ability to bridge that gap between paying for the cost of care when we provide it and them being paid 113 days later. If you look at the stats for a critical access hospital, their day's cash on hand are 69 days. Typical hospitals, if you put them all together, it's over 200, but for these small community, independent hospitals, in particular the rural hospitals, they are fairly fragile financially. They only have 69 days on hand. So it's difficult for them, when you provide care, and you are waiting to get paid at cost, where you then become almost a financing arm for these patients. So I think by reducing that, a lot of our sister independent rural hospitals don't participate, just because of the cost issue. So, that's an area that we have looked at a lot within LifePoint. What we have seen, some of it is provider self-inflicted. But I think there are some ways to maybe mirror Medicare – Medicare days to pay are less than 21 days. So what we would welcome in this is the opportunity to work collaboratively and see how we can get those days from 113 down to maybe something closer to Medicare because we believe in the hospitals that we work with, that would be very attractive to them, to get into some of these programs, in these small communities. A lot of them simply can't afford to do that.

So last slide, going forward. Again, strengthening some guidelines around prompt pay it does involve the provider's side. There are things that we do wrong and that we can improve on, but I think coming together and figuring out a way to get through some of the prompt pay issues that we deal with, we believe would bring, especially small providers, into this network and this important program.

(Applause)

MARILYN SERAFINI: Okay, thank you. So we are now going to turn to the Q&A portion of our program and I would like to throw out the first question. We have talked a lot about care within the VA system and also in the private sector. I would love for one or more of our panelists to take us back to square one for a moment and talk about the Choice Program that came about in 2014 and help us to understand who is eligible for this program, how are veterans using it and to what extent are they using it? Do we have everybody using it? What kind of services are they getting? What is the experience like so far?

BALIGH YEHA: Why don't I take that one. So the Choice Program came about approximately two years ago or so and it's a temporary program, so I think this is very important because it actually is set to expire August 7<sup>th</sup> of next year. So we are less than 12 months before this program expires. This is a huge issue, because we actually see kind of the train is coming, and we have served more than a million veterans in this program. So a million veterans have touched the community through this. And so this is one of the things that VA is very concerned about because there are a lot of folks that are receiving care through the program and kind of what happens next. So that is one important point. The second is, this program serves a very specific – has a very specific set of eligibility criteria. As I was mentioning before, we have seven or eight different ways of purchasing care and this is one of them. And their criteria are very targeted, they really can fall into three types of buckets. One is distance and so it's 40 miles right now from a primary care provider. So if you live more than 40 miles from a primary care physician in the VA, you

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are eligible for the Choice Program. Second is, if you cannot get care within the wait time goals of the department and then third is – they are called “unusual and excessive”, so if there is a mountain range or a lake or a stream or very severe weather, we are able to use those exceptions. So those are the three types of veterans that are eligible. As you can imagine, the geographic criteria for the most part is pretty set with a stable type of population. The wait time criteria alter and so an individual may be taking – may be receiving care in the VA for one condition that maybe we can’t provide as timely, so they would go out on an episode of care in the community. But they will get the rest of their care there. So that requires a lot of care coordination. So those are really the three types of criteria.

Now, when we talk about the type of services that we are purchasing in the community, they are pretty common. One of the – probably when I think of the top five and top ten, we send out a lot of optometry, so folks getting eyeglasses. We do send out some orthopedic surgery. We send out a ton of laboratory testing, so maybe someone is getting an MRI, they will get an MRI closer to home than coming to the VA, and laboratory tests. So, it tends to be a little bit of the more locally available specialties, although now, as Dave was mentioning, we are able to get a robust – a more robust network where we can actually refer some of the more complicated procedures, whether they are CT surgeries or neuron surgeries. So that is a little bit of the mix.

DAVID MCINTYRE: So what you are seeing on the experience side on our end is that about 15% of the population is 40 miles in terms of who is utilizing this. About 50% are those that are near a VA medical center and the VA medical center or community based outpatient clinic, does not have the particular service that is needed and the 35% - the remaining 35% is those that couldn’t be seen within 30 days and choose to access the rights. If I could just – for those that are staff members, the expiring in August of the program, it’s very unusual for Congress to authorize an appropriate at the same time. In fact, it usually doesn’t happen outside of black box issues or other types of very rare occurrences. The federal budget rules had to be suspended – the Congressional budget rules, in order to get this through and that is what set the trigger for August 7<sup>th</sup>.

MARILYN SERAFINI: Okay, so let’s turn to the audience now. We have a question. If you could please identify yourself.

AUDIENCE MEMBER: Hi, my name is Regina Leonard, I am a doctoral student from George Mason in Health Policy and Nurse Administration. I have a question – well a comment and a question. With veterans needing more access to care, it would seem plausible that the VA hospital would allow advanced practiced registered nurses, also known as NPs and clinical specialists, to have full practice authority. HR1247, the Veteran’s Access to Quality Care bill, would allow this and help the VA hospital accomplish this goal. How do you foresee utilizing NPs in the future?

BALIGH YEHA: So that is a great question and also a very controversial question as you can imagine as VA is working on its nursing handbook. We actually leverage a lot of nurse practitioners, physician assistants, provider extenders, and so I’m not exactly the

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right person to be able to address this specifically, but what I will say in general is, we do have veterans that live in every corner, as I mentioned, of the United States, and as we were – as a colleague was demonstrating, in some areas, there are not physicians or there is a dearth of those providers. So we might need to leverage more of our nursing – nurse practitioner colleagues and other providers to make sure that we take care of veterans.

JOHN KERNDL: Can I just make a comment to your question as well. Outside of any care that we provide for veterans, for us being in the small communities that we are in, nurse practitioners and physician assistants are a very important part of that provider network in some of these small communities. So we use them very effectively. They provide great care in these small communities and it's a very important part of that provider network in a lot of these communities.

CARRIE FARMER: I also want to jump in to say that one of our recommendations in the independent assessment was indeed that advance practice nurses should practice to the full scope of their license and that the research really shows that there is not a difference in the quality of care between those providers.

MARILYN SERAFINI: Okay, question here?

AUDIENCE MEMBER: I'm Dr. Caroline Poplin, I'm a primary care physician, I have a question for Dr. Yehia and a very quick question for John. The question for Dr. Yehia: I worked for the active duty military for 12 years, seven years at Fort Belvoir. Five years at what was then Bethesda Naval Hospital. The military all that time were working to make their electronic medical record interoperable with the VA. They spent billions of dollars and my understanding is, they have given up. They couldn't make it happen. How are you planning to make things interoperable with all of these community providers who have all kinds of different EHRs? Obviously it can't be the way that we tried to integrate, because that just didn't work.

BALIGH YEHA: Thank you, that is an excellent question. I don't think they have given up quite yet. But the point that you are describing is really an American medicine issue, which is there is healthcare systems across the country, there is a market out there for electronic health records, it's competitive, everyone has different records. So we have to think of it differently than what we have done before. We are doing a couple things at VA that show a lot of promise. Number one is really leveraging community health exchanges; we are now part of about 80 health exchanges across the country. A lot of these are individual communities that get together – the hospital systems in that area say, we are going to share information. There is a standard template of what data they get and so we share records with – we have veterans that have coded of more than half a million that are now participating in these different exchanges. Number two, knowing that not everyone is going to always have the same record. The question is, well, how can you share information between the records? And what we have been able to do with our military treatment facilities, DOD partners and now transferring that knowledge to the community, is having something that is a viewer of the records. So you can actually get a “view only” read of the record and not able to kind of alter it, because that belongs in

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your healthcare system. So in DOD we have something called the Joint Legacy Viewer, where we are able to actually have a read-only view of the DOD record. It actually is integrated. So it's not like we look at the DOD record here, we look at the VA record, when we look at the community viewer, it is an integrated record and we now have these all over the country and we are taking that knowledge and doing that and testing it out in a couple locations with community providers. We are now testing in the State of New York, North Carolina and Washington, where we are working with specific community partners and giving them access to a read-only view of the VA record and that way they can – as a practicing doctor, if I wanted to look at the MRI or the EKG, I can look at it through this web-based portal. And so I'm envisioning more of those sort of tools, portals that connect a system, rather than trying to get everyone in the same system, which I don't think is practical in the short term.

AUDIENCE MEMBER: And my question for John: Is your system for-profit or not for-profit?

JOHN KERNDL: We are for-profit.

MARILYN SERAFINI: Thank you. We have several questions about the use of other tools such as telemedicine and how the VA is using telemedicine or other tools like home and community based services to provide access to care for rural vets and those with mobility issues. And how can Congress help to encourage this?

BALIGH YEHA: Why don't I start and I would love Dave to also comment. VA is actually really at the tip of the sphere when it comes to telehealth. We have a number of telehealth hubs and have been doing various versions of telehealth for a long time. It's exactly for that, Marilyn, which is, we want to make sure that we can provide access and reach in certain areas that we may not be able to actually have a brick and mortar building. And so we are leveraging more and more telehealth to be able to – in all kinds of specialties, by the way, not only in primary care, but mental healthcare, dermatology, so we are kind of also looking at, what other fields that traditionally have not even been done through a telehealth venue, can we do? So we are doing that. There are a couple things that could really help VA with being able to share information, especially with communities' providers, whether they are telehealth or not. There are a couple statutes that prevent VA from sharing medical records and these were developed decades ago and they are above and beyond the HIPAA requirements, but VA is not allowed to share records if someone identifies as having HIV, sickle cell or a mental health or substance abuse condition. So you are taking a big chunk of our patient population that may have one of those conditions and in my mind, it's almost as a stigmatization that we have to get them to sign a separate form above and beyond the normal HIPAA compliance to be able to send it over to their doctor in the community. That has really limited our ability to coordinate care, whether it is through the telehealth venue or through traditional in-person venue. So that is one thing that I think doesn't necessarily cost any money, it's removing a barrier, it helps provide higher quality care that is coordinated and it's outlined in our plan to consolidate care. So that is one thing that I think they can do.

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DAVID MCINTYRE: I would completely concur with what Dr. Yehia said, in terms of taking down those barriers. When we were doing work at the site of the DOD in Colorado at the height of the wars, we actually placed in facilities in Colorado Springs, inpatient patients for mental health, because the military hospital there did not have an inpatient unit. And we actually force grand rounds that were joint. So we required the sharing. And in sharing of that information is really, really important to making sure that the patient encounter is proper and that you plug the gaps that might otherwise exist. Starting next week, we will be standing up a series of pilots that will roll out in two markets and expand from there, that will put us behind the tip of the sphere, which is the VA. But we will actually do telemental health. It will start with medication management in a particular market, to help give them more supply. And then it will also do psychotherapy on that same backbone that will allow us to test out in both urban and rural areas, how we jointly want to make sure that people are taken care of and leverage supply in the private sector when it's not available in the VA. And I would just say that making sure that providers are understanding of who a veteran is and then we select carefully who we place people with, is really, really important. And so we have put a million dollars into a non-profit that is actually constructing the teaching information that will be made available to providers all over this country as it relates to understanding a veteran, but also the evidence based therapy training the VA and DOD have specialized in and actually make that available from a distance perspective with a coaching apparatus on the backend that we designed in concert with VA and DOD and that information will be available free of charge to providers all over this country that want to step forward and be helpful.

SHERMAN GILLUMS: I agree with Baligh and Dave that telemedicine and home based healthcare is a great force multiplier. Particularly in the area of mental health. I have seen many veterans who had trouble with accessing benefit from it and I know there was some licensing issues that had to be worked out. Somebody from San Diego might want their same provider and not mesh well with somebody in another area. I do want to caution though, it's not a panacea. I think the optimal form of healthcare is person to person and in some instances I know that – I'm always hearing from nurses who talk about, for example, the [unintelligible]. You can see it on a screen, but it's not the same as appreciating how bad it is when you are there and you see it in person. So I'm always happy to see my doctor once a year when I do my annual exams in person. So there is something that doesn't necessarily get lost, but we don't want to see it as end all be all for all types of care. But it is a great force multiplier for opening care to veterans who need services.

MARILYN SERAFINI: We have a question at the mic.

AUDIENCE MEMBER: Hi, thank you all for being here today. Dr. Taylor Winkelman, Senator Markey's office. It would seem to me that as scary as the 2017 – August 7<sup>th</sup> deadline – is, it also provides us with an opportunity to introduce changes to the program and as a veteran who remembers what it was like living 98 miles away from a facility before Veteran's Choice came in, I certainly can relate to the benefits and the challenges that we face. Mr. Gillums, I suspect that you would recommend something to extend

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Title 38 protection, but what would your asks be for improving this, assuming that we could get a better, more cohesive vision put together?

SHERMAN GILLUMS: One big area – or I should say a gap in the Choice Act, and I think it was mentioned here, for those of us who need specialized service, it does no good to be 40 miles from a CBOC – a community based outpatient clinic, or at Fort Belvoir, if they can't provide a service. It's going to cost money, it will, but if you truly intend to open access to all veterans, that has to be looked at. So if I live two hours from a spinal cord injury center, and I can't get there timely or I can't get an appointment timely, maybe there is a spinal cord injury expert in the private sector that can do a test or run some test that I need or take care of an acute issue and then I will follow up. But that was a gaping hole. I would never be eligible because the care that I would need wouldn't be at the DCVA or wouldn't be at the Fort Belvoir CBOC. So that would be one area that I would hope that if we go down this road again, someone would take a look at that.

BALIGH YEHA: I really appreciate that question because we actually laid out our vision of where we want choice to evolve and that is in our plan to consolidate care that should be available to all on the website. We have to actually not just extend it past this date, there has to be changes. This program, as Dave was describing, came very rapidly, was implemented rapidly, in partnership with Congress, we were able to change the law four times already, which is great, but we have a number of other asks to make the program work better for veterans and I will just list a couple. Number one is this primary payer issue. In some circumstances, our non-service connected veterans, they have to rely on their other health insurance. So what does that mean? It means they have to pay their copays to the other health insurance, their deductibles, their premiums, and no other program in VA works that way. So it's exposing them to some financial costs that they never had before and a lot of them were very upset about that, not knowing that they had to pay those specific portions. Two, we need to be able to really work better with community partners, especially in rural areas. Right now, the Choice Law limits VA at Medicare. And so while Medicare rates, the payment rate makes sense in some locales, it doesn't in others. And so we need to be able to have some flexibility to be able to partner with providers and pay them a higher rate, because a lot of times we definitely have some issues in the payment area. Sometimes it's not the slow, it's that it's too low. And so we have to be able to get to flexibility in payments and move towards those value-based payments. And then I mentioned a couple of the other things of being able to coordinate care better by allowing us to share information. And really, the ultimate thing is, we have to evolve this program. We have invested a lot of infrastructure, our partners have invested a lot of infrastructure, we have learned a lot. It has to evolve. I don't think it should be completely scraped and start from new, because we will go through the same exact growing pains that we did two years ago. So, it's how do we continue to take what is there and turn it into a program that really make sense for our veterans, for our community partners, and for the VA.

MARILYN SERAFINI: I imagine some of our other panelists have ideas about what needs to happen with this program?

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JOHN KERNDL: You know, I'm going to really repeat what Mr. Gillum said. The issue around the 40 miles and the primary care facility, as an example, really is an issue that we deal with all the time. And so a veteran will not qualify under the Choice Law because there may be a VA center within 40 miles. But the VA center may not have a surgical suite, they may not have some high end diagnostic work. So we have a veteran that is three miles away from one of our facilities where we will have an MRI, we will have a surgical suite, if they need a surgery and we have been able to work through those issues, but it's always one off negotiations with the veteran's administration to try to keep that veteran close to home and provide that care. So that has been an issue and I think absolutely, there is very close facilities to a lot of these veterans that meet the care of need that they have, but they are not able to utilize it because of the 40-mile rule that is applied.

BALIGH YEHA: Just to comment on that piece, because this is one of those things that we have to be aware of what it could mean and so sometimes we talk about 40 miles from a primary care doctor versus 40 miles from where you can get the service and a lot of folks outside of the VA have also done those modeling's. It definitely would have a very large financial impact. Apart from that, to Sherman's point earlier, we have to be careful about referral patterns and in order to provide really high quality care for example in our – for our service connected veterans or TBI patients, if we cannot provide wrap-around services, because a lot of those being delivered somewhere else than in the system, outside the system, then it becomes hard to actually gain competency and recruit doctors in those areas. So I think it is definitely worthwhile looking at and figuring out how we can get flexibility for serving veterans that need to be seen. Because in some circumstances, one mile is too far. Or two days' wait is too long. So we need some flexibility built into the system, but I do raise some concerns about completely being about to open that up, because what that will actually do is detract from the folks that actually are using it and want to use it, because you might not be able to build out those wrap around services if you don't have the specific volume or expertise to be able to do that.

DAVID MCINTYRE: So I would concur with the notion that thinking about completely open accesses probably not the right place to end up. We have invested in a lot of infrastructure and making that infrastructure stronger and making sure that it has sufficient supply to meet the need is going to be important. But for the last 15 years, we have deployed people from every zip code in this country and the mix of use of the Guard in reserve has been very different than at any other conflict we have ever been involved in and many of them want to go back home. And they don't want to have to displace where they are. And they may want to take a year or two off and they have a right to do that. And they have a benefit that they have earned. And so making sure that they actually have access to care that is in a reasonable distance, I think we would all agree makes sense, but it is thinking about how do we draw the parameters right? Then from a spend perspective, I think Congress just needs to decide, how does it want to deal with the responsibly that comes with the tail of conflict? And there is a lot of money that is paid in travel and then there is a lot of money that ends up being paid when someone doesn't get what they need on a timely basis. Because when they are really sick, it's more expensive.

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And so I would say that for certain types of things, you absolutely want to be in a VA facility, you absolutely want to be in a top notch academic facility, regardless of where you live in a state. But then there are other things where you really could get the orthopedic service across the state from where a VA facility is and I think you all will sort through those things and we look forward, on our end, doing whatever needs to be done to make sure we flex properly to make that work.

CARRIE FARMER: To pick up on what Dave just said, that you know, in some ways there really needs to be a bigger conversation about what is the obligation to veterans and if the decision is that we continue as it is and that VA has an annual budget that is submitted two years in advance, every time there is an increase in demand beyond what was expected or projected, there are going to be access problems and there are going to have to be decisions to stay within those budgets. So and this is going to be true for community care as well. Because the ability to constrain those costs, particularly if you increase the eligibility, is going to be difficult. So really thinking in the big picture of what do we – what is our responsibility to veterans, what is our commitment and how are we going to pay for that?

MARILYN SERAFINI: Several questioners want to know how to get claims paid faster.

BALIGH YEHA: I will start and I would love others to comment. This is probably one of the things that I spend a big chunk of my day on, especially as a doctor. When one of our partners delivers care, they deserve to be paid on time and accurately. What we are realizing as we do more of these deep dives, is there is a number of kind of root cause issue here that have to be addressed to make sure that we are able to timely pay our providers. One gets back to the eligibility piece, which is, when we have six, seven, eight different programs, all with different eligibility criteria, if you don't match them up exactly right and you are providing care for a non-service connected condition in this case or a veteran that lives 38 miles, not 40 miles, then we don't have the authority as the department to cover the bill. And that is really unfortunate because the criteria are so – there are so many of them and they vary, that many times, a veteran receives care that isn't authorized or that we don't have the ability to pay. So that is one thing, is how do we get to a simple set of eligibility criteria that is very clear to our patients and to our providers, that there isn't any ambiguity. In Medicare it's pretty simple. You turn a certain age, you have a card, you are good to go. Or if you have a private health insurance plan. They know what benefits are available. We need to be able to get to that level of clarity and if we are going to continue to have seven, eight, different programs that are all operating differently, it's going to be hard for our patients and for our providers to know that. Number two, we have to make some adjustments to the laws. Many times today, probably the biggest area where I get complaints about provider payments, really relates to ER care. ER care – and we proposed a fix to this in our plan to consolidate care, is very fragmented. In some circumstances, VA is the primary payer, which is for service connected patients. For our service connected condition. In other circumstances we are the payer of last resort for non-service connected care. And also, by law and statute, we pay 70% of the Medicare rate. Well, when we talked to a lot of the doctors and we sit down with them and we are examining AR's, we actually did pay and its considered

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payment in full, but they still carry a little bit of chunk of that on their accounts receivable and that is something that we would not be able to pay until we actually get some of the laws changed. So that is where I see a lot of consternation, is really around this unauthorized care, where we have to figure out if they are service connected or not and we are not allowed to pay the full Medicare price, by statute and so we proposed a fix to this of making VA the primary payer, so we are able to pay the bill and really getting us more towards in line with what the rest of the industry does. It does require some legal changes and some investment and some funds to do that. And thirdly, if we are able to then really get the good criteria, iron out the kinks in the ER system, that will then allow us to start to automate more and more and more. And leverage community partners. It is very hard to automate, like Medicare does, when you actually have to go to the medical record, which is what we have to do in ER care, to determine if that specific service that was provided in the Emergency Room, was for a service connected condition. You can't really do that by computer. You actually have to see – did a veteran have a – was he seen for a knee injury? Is that knee injury service connected? Way too complicated. I don't want our team to continue doing that all the time. It takes a long time. A time drag. We want to be able to get to a system where if a veteran goes into the community, the doctors there and the hospital systems know exactly what is offered and what they are able to deliver. The veteran knows if they have any obligations and then we on the back end can then automate it and pay it. So I think this is a great opportunity for us for progress, however we need help. We cannot – at the VA, we cannot meet the standard that we want to meet if we are just doing it by ourselves. We need some help from our legal and Congressional colleagues.

DAVID MCINTYRE: So as an entity that is now responsible for paying for 3.2 million appointments, I will tell you, we don't collectively have this right yet. And if you go back to the start of TriCare 20 years ago with the DOD, about three months in, it became obvious that the DOD had never paid its claims properly. And Dr. Yehia walked into a scenario, he didn't create it. And some of the history in this space, that dates back a long time, is that the VA was paying its claims market by market by market by market. That is not a very effective way to do it. It's hard to get to core competency. And at the end of the day, what they have done in Choice now is to consolidate what that looks like, that was a very needed change. So what they did is they took all the claims and they aimed them in one direction on the government side. The second thing is, when you are in an institution, you have to file properly. When you are a provider, you have to file properly. No one wants to be in a place where claims get denied. Or where they are slow. Because then at the end of the day, we have to go find another provider in order to send the next veteran. That is not in anybody interest anywhere. So paying timely and paying accurately is everyone's interest in this process. But what I will tell you is, from a provider perspective, having done a lot of the work 20 years ago at the start of TriCare to help the DOD get this right, and then get it right across the system, to make it the fastest and most accurate payer of those types of programs, you also have to pay one way. And right now, if the care moves directly from the VA to the community, they pay one way. They file one way. If it moves through Choice, it goes down a different way. So now imagine being the billing office, trying to figure out, well which place do I send this? How does this work? Rather than it all goes through one consolidated pipe. So that is

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something that needs to get fixed. We did a project in Harlingen, Texas, Dr. Yehia, his team. Myself. The members of Congress from that area. And the hospitals in that area. It's an area where a lot of care moves downtown of all types, because they have a community based outpatient clinic and the rest of the work is done downtown and has been that way for a long time. Some of the hospitals of those four had a 50% denial rate on their claims. They did not know how to file accurately. Within five weeks, together we dropped it to 10%. That takes their historical pattern of payment and changes it dramatically. And so we all own a part of this responsibility. It starts with the provider filing accurately. Then it goes to us making sure that we have processes that work. And that it is streamlined and consistent, so you do it one way. Then it is making sure that it cycles back. What I will tell you is, from my perspective as an actor that spent time in the DOD space back 20 years ago, the same issues existed then and they got fixed. So those that are in the provider community that are learning forward, thanks for doing that. Thanks for hanging in there. Because what I'm going to tell you from my perspective, what I have seen with my sleeves rolled up, is that the VA team is right at my side and there is no separation with what we are trying to accomplish. And the way this works is, we pay the bill. And then the VA pays us. So we all want it to work right. And together, I think we will be able to figure out what those pieces are as Dr. Yehia said, that need to be changed. But there is some other pragmatic components that have to be have changed as well in order to make this work right at the end of the day and we are picking a couple of markets to test those things in together and then we will take what we learn out of those and apply them to the rest of the enterprise.

JOHN KERNDL: I would just expand on some of David's comments. I do agree completely with the one pipeline. As a provider, we are used to dealing with very [unintelligible] payer rules. Every payer is different. Medicare is a great example; it is very tight around certain treatments that you provide a Medicare recipient as to what the diagnosis has to be to get those paid. But as providers, we know what those rules are. Other systems that we can incorporate into our admitting processes and so we know when a Medicare recipient comes in for certain tests, exactly what that diagnosis has to be and can deal with it real time. As you can imagine, all the private payers have their own rules, but they are consistent rules of that payer and we can develop systems and processes to deal with them. So I think to the extent that there is one pipeline, one set of rules, areas that the providers can then develop their processes and systems around, I think it would be very beneficial.

MARILYN SERAFINI: Folks, we have time for one or two more questions. As we are winding down, I would love to ask you to please fill out the blue evaluation form in your folders before you leave us today. So let's turn now to a question at the mic.

AUDIENCE MEMBER: Hello, I'm Shannon Firth, I'm with *Med Page Today*. I wanted to ask you about the Commission on Care Report that was put out a few months ago. I wanted to get your response to two of those recommendations; one was for an independent advisory board and one was to eliminate the time and distance requirements for the Choice Program. The first idea is obviously pretty controversial and possibly

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unconstitutional. But I still wanted to see, hypothetically, what would be the impact of either of those two changes. Dr. Yehia and anyone else who wants to comment?

BALIGH YEHA: Sure, I will comment more on the latter. So, the Secretary and the President kind of put out our response to the Commission and in the President's response to the Commission on Care, they actually call out our plan to consolidate care as kind of an alternative approach to some of the recommendations in the Commission. Most of those recommendations were a little bit of Mom and apple pie, like we want to be able to do those and you pointed out to the ones that were most controversial. But we believe our plan, that lays out really getting all these different programs into one, coming up with an eligibility criterion that makes sense, but also allows some flexibility so that when myself as a doctor, I'm seeing a patient in front of me, can make a decision about – oh, actually you would be better served at this institution in the community, is important. Getting to that single way of being able to do referrals, building that high network, we were able to create partnerships that makes sense for them, monitoring quality utilization and then really getting to timely payments, wrapped around customer service. So all of that is really laid out in our consolidation plan, which is what the department and the administration is putting forward as kind of an alternative to some of those specific recommendations. And in there, it actually also lays out what we need to do that. What are the specific legislative changes that are required and also what is the budget that is required to do that? And I think that is a really good starting point of where we hope to get to.

CARRIE FARMER: I can comment on the second recommendation. Eliminating the time and distance requirements effectively opens up purchase care to all veterans who are enrolled in VA. So just looking at the numbers, there are 21 million veterans in the United States. 9 million are enrolled in VA, 6 million use VA healthcare in a given year. Most veterans who enrolled in VA healthcare also have some other choice of health insurance. So they have Medicare, they may have private insurance through their employer, or some other – they might have TriCare, they have other sources of health insurance and they choose whether to use VA healthcare or their other source of insurance based on a number of factors, one of which is cost and access – things like that. So if you open up purchase care to the whole veteran population, what you certainly are going to see is a giant increase in demand. And so some of those three million veterans who are enrolled in VA care and aren't using VA healthcare, are going to start using VA healthcare, because now they can go to their local doctor and VA will pay for it. In fact, they probably are not going to face a co-pay because it's through their VA benefit and they are not facing a co-pay. So the choice of seeing your same doctor, VA will pay for it, no co-pay, you go through your private insurance and you have a co-pay or a deductible, it's kind of a no-brainer and just the number of people using VA healthcare will increase. So that is sort of one thing to consider, and the costs of that will be quite significant. The other thing to consider, and this is sort of the big picture question of thinking about, do we maintain our VA healthcare system as it is, do we transition to more of a private sector model, is you can't really have both with full, open access to either. The reason for that is, as you move, as people choose to use private sector VA care, fewer people will be using the VA healthcare facilities. So a lot of you are working

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on healthcare and you fully understand that as volume decreases, the quality of care decreases and there is a certain tipping point at which it is not sensible or reasonable to maintain those facilities. And as VA facilities close, it just furthers the move into the private sector. And that decision, from my perspective, really needs to be a thought out decision. It needs to be decided and not just something that happens as a death spiral of VA facilities closing because of movement into the private sector.

**BALIGH YEHIA:** If I can follow up on what Carrie is saying, because you said that so eloquently. When folks sometimes think about “privatizing the VA” and just giving everyone a card, as a clinician, again, what is missing there is care coordination. So when you think about Medicare and the way that that program works, for the most part it is like a reimbursement system. You go out, you handle your own care and then the government pays the bill. But what is missing from a clinical perspective, from a relationship perspective is, how do you help folks navigate a very complicated American healthcare system and making sure that their needs are met? And I think the greater extent that there is just people doing it all on their own, well it might work for a small segment of the population, for many folks it doesn’t work. So I think that is very important, to think about it from the clinical perspective, which is, from a veteran centric patient care approach, do we want to have a coordinated system or do we want just everyone to kind of do it by themselves?

**MARILYN SERAFINI:** Okay, thank you. We are – do you have a question? Go ahead.

**AUDIENCE MEMBER:** My question is about what is going on in technology space as far as companies like Apple and other app development companies that are giving patients the opportunity to be in control of their own medical data. I would like to know, has the VA considered partnering with Apple or any other innovative technology companies in the Silcom Valley that will allow veterans to have their own medical data with them so that when they go visit providers, they can have a dialogue based on the information that they have.

**BALIGH YEHIA:** Yes, in fact, we have been doing that for a while. Who has heard of Blue Button? Blue Button is exactly that. It is a very easy way to be able to download an electronic version of your entire health record, the veteran can take it, do whatever they want with it, share it with their community providers that they choose and so we actually have an entire digital services team at VA that leverages folks from such as Silicon Valley that are thinking of creative ways that we can partner and continue to exchange information. So, absolutely. Blue Button.

**SHERMAN GILLUM:** There is also an interface called My Healthy Vet, where Blue Button is housed and I was pleasantly surprised when I accessed it and not only can you talk to your doctor on a secure network, we ordered prescription meds, you can get your medical records in PDF format and also military records. So where you have to file a claim or advise somebody to file a claim for certain benefits, first thing we do is get them to sign up for My Healthy Vet and the Blue Button. It works wonderfully.

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MARILYN SERAFINI: Aright. We have reached the end of our time. So a few thank yous and again, a plea to fill out your blue evaluation form. So first I would like to thank the supporter for today's briefing, Ascension Health, and I would like to thank our panelists for a very informed conversation and also thank you to all of you being here today.

(Applause)

BALIGH YEHIA: And Marilyn, thank you!