Questions for the Record
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Fiscal Year (FY) 2019 Department of Veterans Affairs (VA)
Budget Request for the Veterans Health Administration (VHA)
March 15, 2018

Question 1: In your budget request, you highlight the fact VA is in the process of changing how it records obligations for health care purchased outside VA which will result in a one-time cost savings of $1.8 billion in FY 2019.

- **In the past, VA has asked Congress for legislative authority to do this? What has changed?**

VA Response: Following consultation with the Office of Management and Budget (OMB), VA determined that this accounting change does not require a change in legislative authorities because VHA has an administrative approval of payment adjudicative-type process and the liability itself (not just the amount) is contingent on the Veteran seeking the treatment authorized. This is consistent with Comptroller General case law opining that the legal liability arises on the date that the claim is approved for payment when a quasi-adjudicative approval process is used. (B-92679, June 30, 1967 (attached), 46 Comp. Gen. 895.) Approval of the claim consummates VA's agreement to pay the allowable charge and the approved claim constitutes the documentary evidence of the obligation required by the recording statute, 31 U.S.C. § 1501.

In the Explanatory Statement accompanying the Consolidated Appropriations Act, 2018, the Committees noted that they "concur with the VA proposal, noting the Comptroller General has opined in the past that VA could determine whether the Government should accept liability for non-VA health care claims following a review and approval process and record obligations upon approval." Joint Explanatory Statement in Book III of the Congressional Record for March 22, 2018 at H2819.

COMPGEN 895.pdf

Question 2: Between FY 17 actual and the revised request for FY 19, the medical support and compliance budget for the Office of Community Care is set to increase by more than 40 percent.

- **Can you elaborate on this increase?**
- **Specifically, what will this increase in funding pay for?**

VA Response: The increase for the medical support and compliance budget covers, in large part, costs for the new Community Care Network (CCN) contract, including implementation fees in FY 2018 and increased administrative fees (based on increased healthcare delivery).

Question 3: While reviewing the FY19 budget request, I noticed that compared to FY17, you are anticipating a nearly 3% decrease in revenue generated in the MCCF for FY19. In fact, the $3.461 billion expected in FY 19 is less than the $3.486 collected in FY 16. Why does VA expect to recover less in FY 19 than it did in FY 16?

VA Response: There have been significant changes in the wider healthcare environment and VA-specific benefit design changes between FY 2016 and FY 2019, which resulted in lowering the collections growth rate. In FY 2016, VA charged outpatient medication copayments at a rate of $8 per 30-day fill for Veterans in Priority Groups 2-6 and $9 per 30-day fill for Veterans in Priority Groups 7-8. There was also an annual copayment cap of $980 for Veterans in Priority Groups 2-6, but no annual copayment cap for Veterans in Priority Groups 7-8. The average copayment expense was nearly $8.50 per script. With the launch of the Tiered Medication Copayment Structure in FY 2017, which resulted in pricing nearly two-thirds of billable generics at $5 per 30-day fill and establishing a copayment cap of $700 per year for all Veterans, the average copayment was reduced to $6.34 per script. This Veteran-focused benefit design change, combined with the impact of Pharmacy utilization trends, reduced potential medication copayment collections for all budget years beyond FY 2016.

In the commercial health insurance market payers are making changes to reimbursement rates for a variety of services. These changes also apply to VA in its role as a provider of healthcare services. Third Party payers are terminating agreements and/or reducing reimbursement to VA. As compared to FY 2016, the Third Party collections growth rates are projected to decline through FY 2018 and begin stabilizing by FY 2019. The MCCF estimates include an adjustment for the projected budget impact of changes to payer agreements. The estimated impact of the changes in reimbursement rates include the compounded effect of reductions in potential Third Party collections of $119M in FY 2018 and $124M in FY 2019.

Question 4: While reviewing the budget request for beneficiary travel, I noted that your FY 19 request is 13% above what you spent in FY17.

- **Is this increase directly related to the increase in care being sent out to the community?**
- **If not, what is driving this increase?**

VA Response: Beneficiary travel is directly related to the volume of care delivered in both our VA facilities and in the community. So we can say for sure that the travel increase is a result of more care being provided across the system. Given the popularity of Choice, it's a fair assumption that program is substantially contributing to the increase. Unfortunately, VA's financial data systems do not discretely identify beneficiary travel associated with Community Care from care provided in VA facilities so it's not possible to attribute specific amounts or percentages to the various venues.

Question 5: VA has submitted a legislative proposal to raise the cap on minor construction projects from $10 million to $20 million. I understand that this proposal would increase VA's flexibility in undertaking projects to improve medical facilities. However, local medical facility officials' history of mismanaging minor construction projects, as documented in VA IG reports, raises concerns about their ability to take on even larger projects. For example, in 2017 the IG reported that plans for a $9.7 million parking garage were reduced from 425 spaces to 25 spaces before the project was cancelled.

- **What assurance can VA give this Committee that it has made improvements to its minor construction program so as to avoid delays, cost increases and possible anti-deficiency violations?**

VA Response: The proposed increase in the construction threshold as referenced will provide flexibility for VHA Minor Construction projects.

It will enable VHA to deliver these projects faster for delivery of healthcare services to our Nation's Veterans and at a lesser total cost to taxpayers. In order to better manage the execution of these high-value/high-complexity projects, as well as all VHA Non-Recurring Maintenance (NRM) and Minor Construction projects, VHA has already instituted a quarterly review of all active NRM and Minor Construction projects on current fiscal year operating plans, to provide oversight and monitor the acquisition schedule and obligation of contract awards. Annual operating plans for the NRM and Minor Construction programs are also developed and communicated to the field early in order to commence requirements development and the acquisition process, to increase the likelihood of a successful contract award according to schedule. VHA is also updating its project tracking data, in order to implement improved project prioritization and provide oversight with early warning of schedule and cost issues, which may arise on approved construction projects.

Additionally, VHA will be instituting a project execution risk-mitigation process for the more complex projects, to assure that the overall project execution plan is sound and in

compliance with the respective construction program. For those projects having a complicated scope of work or a significant cost value, such a risk mitigation process will address appropriate staffing, project management, and acquisition strategy to deliver the project timely and within approved budget and scope. Lastly, VHA will utilize various acquisition strategies to identify the best possible firms for technical and construction services, and to ensure timely contract awards. These strategies include the use of existing Multiple Award Task Order Construction Contracts for construction services, Indefinite Delivery/Indefinite Quantity contracts for technical services, and expanded use of Two-Step Design-Build Contracts on appropriate projects. The issuance of task orders against existing contract vehicles takes less time than advertising requirements and establishing new contracts. There is also less risk of an award being made to a contractor that does not have experience with Federal Government terms and conditions, and the unique aspects of working in VA medical centers. By working with contractors that have knowledge of their contracts and Government business processes, there is less risk of errors in pricing or missing completion dates.

Question 6: The Administration's infrastructure plan, released on the same day as the budget, requests authorization for VA to retain proceeds from the sale of properties and exchange existing facilities for construction services to build new facilities. Although this legislative proposal would provide with more flexibility in making capital improvements, we are concerned about another part of the infrastructure plan. This part would amend statute to allow the government to take assets no longer needed directly to market for sale and eliminate requirements to first offer the assets to state and local governments and some no-profits for public benefit.

- **Dr. Clancy, do you support the Administration's proposal to eliminate the right of first refusal for unneeded VA properties?**

VA Response: VA needs the ability to streamline the real property disposition process and retain and utilize the resulting proceeds and capital through direct sale or exchange. This will allow VA to reduce the amount spent on maintaining unneeded assets, and provide greater access to care for our Nation's Veterans. VA appreciates the role Public Benefit Conveyances play in helping state and local entities gain opportunities to access VA's underutilized real property, and VA will continue to actively engage with our community partners to ensure productive use of former VA land.

Question 7: Some external researchers have suggested VA create an integrated clinical trial network for PTSD and TBI that could help to track the progress of

PTSD/TBI research and assist VA researchers in navigating both VA and external research opportunities.

- **Do you believe this would be a cost-effective way to support VA research into PTSD and TBI?**

VA Response: Yes, VA utilizes its clinical trial network through the Cooperative Studies Program to support large multi-site clinical trials. VA's Post-Traumatic Stress Disorder (PTSD) Psychopharmacology Initiative was launched last year and will continue to work toward identifying and confirming effective medications for PTSD in conjunction with industry partners. VA is looking to support additional Phase II studies to find whether a medication has a beneficial effect on PTSD symptoms.

Question 8: One barrier to external partnerships in support of VA research is the use of fragmented and untimely Institutional Review Boards (IRB).

- **Do you believe that the creation of one centralized IRB within VA would be more conducive to external partnerships? If not, how can VA enhance its current process so that it is more timely and easier to navigate by potential, external research partners?**

VA Response: VA has a central IRB that for the past year has been reviewing industry sponsored multi-site studies. There are other barriers to working with external partners; and IRB is just a small part to increasing efficiencies. VA, together with the National Association of Veterans' Research and Education Foundations (NAVREF), sponsored a Clinical Trials Summit on April 12, 2018, to hear from potential external research partners barriers they have encountered. In response to the Summit, VA will design a system to overcome identified barriers and make the clinical trial process easier to navigate and more efficient in bringing important trials to Veterans.

Question 9: Has the VHA considered referring Veterans residing in the Pacific outlying areas to nearby foreign medical facilities for care? If not, would you consider the option and possible challenges to providing Veterans the option of obtaining care in foreign medical facilities, including whether authority is needed, and whether existing programs that provide health care to our soldiers, their families, or of U.S. government workers working overseas would work for our Veterans?

VA Response: VA's authority to furnish hospital care and medical services to Veterans outside a state (as defined in 38 U.S.C. § 101(20)) is found in 38 U.S.C. § 1724, as implemented by 38 C.F.R. § 17.35 and VHA Handbook 1601F.05. Together these

authorities constitute VA's Foreign Medical Program (FMP). Under the FMP, VA may furnish such care and services to Veterans who are sojourning or residing outside the United States without regard to citizenship if: (1) the necessary treatment is for a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability; or (2) the Veteran is participating in a rehabilitation program under chapter 31 of title 38, United States Code, and requires care for any of the reasons enumerated in 38 C.F.R § 17.47(i)(2). Under the FMP, eligible Veterans independently seek needed care from medical care providers in their community without the need for a VA referral; eligible Veterans then seek payment or reimbursement for the costs of that care under the FMP.

It is also unclear what is meant by the general reference to "Pacific outlying areas." The United States still has territories or possessions in the Pacific. Even though such territories or possessions fall within the statutory definition of a "state," Veterans who reside there and who travel to a foreign non-VA medical facility for care would only be eligible for reimbursement under the FMP. To expand the FMP to include Veterans beyond the cohorts described above or to include additional treatment purposes would require legislation. The FMP is available, however, to eligible Veterans residing or living outside a state (in a sovereign Pacific state or nation).

Question 10: Following the cancellation of the Region 4 VA Community Care Network procurement, what are VA's plans for the U.S territories in the Pacific under CCN?

VA Response: There is a pre-solicitation on the Federal Business Opportunities website; it is posted below:

https://www.fbo.gov/index?s=opportunity&mode=form&id=97627658296fb9fb2b9c2c030851ac34&tab=core&_cview=0

- **Does VA plan to carve them out of the Region 4 RFP, and if so, how does VA intend to meet the community care needs of Veterans in the territories?**

  VA Response: The scope of the solicitation has changed since the initial release of CCN Solicitation Number: VA79116R0086. Notable changes to the Solicitation include the removal of Alaska, Northern Marianas Islands, Guam and American Samoa from the geographical composition. Those locations will be managed under separate contracts/processes outside of the CCN.

- **How will VA ensure the progress that has been made via Choice is not lost if the Pacific territories are carved out of the CCN procurement?**

  VA Response: As a result of the previously referenced change, the successful existing processes used to serve our Veterans in the Pacific territories and specifically Northern Marianas Islands will continue and not be integrated with CCN.

Question 11: What can the VA do under current authorities to resolve the staffing and resource constraints preventing Veterans in the Northern Marianas from participating in the Program of Comprehensive Assistance to Family Caregivers and other programs?

VA Response: There are multiple aspects of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) that cannot currently be provided to Veterans living in the Commonwealth of the Norther Mariana Islands (CNMI). These include the requirement for VA to provide specific services to caregivers, including mental health services and respite care. Additionally, under PCAFC, VA staff is required to conduct initial eligibility assessments and ongoing monitoring. VA does not currently have the ability to provide these services in the CNMI.

Question 12: I understand that a candidate for the Licensed Clinical Social Worker position in Saipan has accepted the position and is going through the credentialing process.

- **What services will the Licensed Clinical Social Worker be providing to Northern Marianas veterans?**

  VA Response: We are pleased about the recruitment of a licensed VA social worker, now in the VA credentialing process, who will be supporting the Saipan VA clinic. The social worker will be working collaboratively with the VA primary care provider and other consultative providers, such as mental health, to address and facilitate Veterans' needs as part of their prescribed care plans. VA social workers are experts in matching required resources and solutions for Veterans and their families in support of care and treatment plans. They are familiar with many community and non-profit organizations and resources as well, and work to help Veterans achieve their highest level possible in areas including the activities of daily living.

- **Will the Licensed Clinical Social Worker be able to provide the services needed to make the Family Caregiver program available to Northern Marianas Veterans? If yes, how long before the program is up and running? If no, what other staff is needed and can VA community providers, under the oversight/supervision of VA staff in Saipan, Guam or Honolulu, fill the gap?**

  VA Response: There are multiple aspects of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) that cannot be provided to Veterans living in the CNMI. It is important to note that PCAFC is a clinical intervention and program. Under the program, VA is required to provide specific services including mental health services and respite care. Additionally, under PCAFC, VA staff is required to conduct initial eligibility assessments and ongoing monitoring. Additional infrastructure would be needed to support ongoing delivery of these services.

Question 13: Veterans from the Freely Associated States (FAS) have served in the U.S. military for over 50 years. Yet, when FAS Veterans, from Palau, FSM, and RMI return home, they face significant barriers in accessing healthcare services under the VA system. As you may know, FAS Veterans must travel great distances to Guam or Hawaii to access care in the VA and these costs are incurred at Veterans' own expense. Given the high costs for travel and transportation in the Pacific, many FAS Veterans are never able to access VA health care services.

- **How is the VHA prioritizing its funding through the FY 2019 Budget proposal to help address these problems and improve delivery of care for FAS Veterans?**

  VA Response: Please see our response to Question 9, which sets out the legal and program authority for the FMP. Veterans sojourning or residing in sovereign states that are not (or no longer) territories or possessions of the United States may be eligible to participate in the FMP if they meet the FMP's eligibility criteria. However, as explained above, VA's legal authority to provide care to Veterans under the FMP is limited and narrow in scope and purpose. The FY 2019 budget request includes additional funds to support the FMP.

- **What additional steps can the VA be taking to increase coordination with the DOD and community care providers to provide better on-island access to FAS Veterans?**

  VA Response: Unfortunately, this problem is not solved by improved coordination between these parties. Improved access can only be achieved through greater numbers of qualified community medical providers in the Freely Associated States (FAS). Currently, there are too few community medical providers to meet patient demand. This is a matter beyond our control.

  Separate and apart from the FMP, we note that Veterans residing in the FAS who are enrolled in VA's health care system and who travel to the United States to receive their medical care from VA (directly or by contract) are ineligible for beneficiary travel benefits because beneficiary travel program rules exclude foreign travel costs (i.e., beneficiary travel benefits are for travel costs incurred in the United States). See 38 C.F.R. § 70.1(a).

- **What are some immediate steps (including regulatory flexibilities) that the VA can be taking under its existing authorities to expand access to care in FAS?**

  VA Response: While the U.S. military recruits throughout the South Pacific, Congress has defined who is eligible for VA's FMP, as discussed in our response to Question 9. VA's FMP regulation already maximizes the Department's discretionary authority consistent with the law's constraints. VA can take no administrative steps to expand the FMP. Again, legislation would be required to expand coverage under the program to additional Veteran cohorts or to include additional treatment purposes.

- **Would the VA support a pilot program to expand telehealth services in FAS and if so, what statutory changes may be necessary to reduce existing barriers under the Foreign Medical Program?**

  VA Response: The question confuses VA's authority to provide care to Veterans residing in a state pursuant to VA's general treatment authority in 38 U.S.C. § 1710 (as implemented by 38 C.F.R. § 17.38) with VA's authority to furnish hospital care and medical services to Veterans outside a state pursuant to section 1724, again as discussed in our response to

Question 9. These are distinct authorities that do not overlap. VA's Home Telehealth program is a clinical care program available to Veterans who are enrolled in VA's health care system and who are in a state. In contrast, the FMP is a program whereby eligible Veterans obtain needed medical care in a foreign country from a community provider (for covered purposes) without the need for a VA referral and then seek payment or reimbursement from FMP for the costs of that care. Under the FMP, VA has no involvement in how the needed care is delivered by community providers. VA pays the costs of necessary care in whatever form it is delivered to eligible FMP participants; it may include telehealth care, but again the type of modalities used by community providers is not a VA matter. In addition, VA cannot operate a pilot program to deliver unauthorized services.

We realize current law thwarts the desire of many enrolled Veterans who live outside a state, who travel to VA medical facilities in the United States to receive their medical care, and who upon their return home want to be able to communicate or follow-up with their VA providers via telehealth means. We note that furnishing care internationally would be very complex and could be difficult to implement.

- **Can the VA submit to the Committee its current estimates on the number of Veterans who are residing in the FAS, as well as information regarding the percentage of FAS Veterans living in FAS who are utilizing care currently under VA system?**

VA Response: VA is unable to provide either the total count of Veterans in this area or the number of users. However, VA is able to provide the number of enrollees. Enrollment data shows the following counts of unique enrollees for FY 2017 for the FAS:

- 65 in the Federated States of Micronesia;
- 19 in the Marshall Islands; and
- 25 in Palau.