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# COMMISSION ON CARE

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## MEETING MINUTES FOR OCTOBER 6, 2015

The Commission on Care convened its meeting on October 6, 2015, at the Capital Hilton, 1001 16<sup>th</sup> Street, NW, in Washington, DC.

### **Commissioners Present:**

Nancy M. Schlichting – Chairperson  
Delos M. Cosgrove – Vice Chairperson  
Michael Blecker  
David P. Blom  
David W. Gorman  
Thomas E. Harvey  
Stewart M. Hickey  
Joyce M. Johnson  
Ikram U. Khan  
Phillip Longman  
Darin Selnick  
Martin R. Steele  
Marshall W. Webster

### **Commission on Care Staff Present:**

Susan M. Webman – Executive Director  
John Goodrich – Executive Assistant  
Sharon Gilles – Designated Federal Officer (DFO)

### **Department of Veteran Affairs (VA) Presenters:**

Richard Allman – Chief Consultant, Geriatrics and Extended Care Services, Veterans Health Administration (VHA)  
Kristin Cunningham – Director, Business Policy, Chief Business Office, VHA  
Joseph Dalpiaz – Regional Director, VHA  
Robert Jesse – Chief Academic Affiliations Officer, VHA  
Stephanie Mardon – Chief Business Officer, VHA  
Gene Migliaccio – Deputy Chief Business Officer for Purchased Care, VHA  
Karen Sanders – Deputy Chief Academic Affiliation Officer, VHA  
Baligh Yehia – Senior Health Advisor to the Secretary

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**The Commission on Care meeting opened at 8:36 a.m.**

### **Welcome/Opening Remarks**

Nancy Schlichting (Chairperson) opened the meeting, welcomed everyone present, and gave an overview of the agenda.

### **VHA Organization**

John Goodrich provided an overview of the organizational chart of VHA. He explained the roles of the various offices within VHA, their relation to other offices, and how VHA is structured to carry out its mission. The Commission discussed the structure of the organizational chart and posed questions to Mr. Goodrich. Items discussed included:

- Strengths and limitations of the current structure
- VHA's emphasis on Care in the Community and its place within the organizational chart
- The role and structure of specific groups and offices within the chart, including:
  - National Leadership Council
  - Nursing
  - Healthcare technology
  - Mental health
  - Deputy Undersecretary for Health for Operations and Management
- How VA Central Office communicates with the field
- Reporting lines and how communication happens within the organizational chart
- The scale, effectiveness, and number of past reorganizations of VHA
- Alignment between the operations and policy arms of VHA

### **Eligibility**

Kristin Cunningham and Stephanie Mardon provided an overview of eligibility enrollment for VHA. The current enrollment system was implemented with the Veterans' Health Care Eligibility Reform Act of 1996. While the previous system had mainly been inpatient and only served service-connected veterans, the Act expanded VHA's reach to include veterans suffering from conditions as a result of their service (called special authorities groups) as well as non-service connected veterans who qualified based on low income. It mandated that certain types of care be available and establish priority groups to identify veterans based on their types of service connection, special authorities, and income. While not every veteran is required to enroll, VHA asks every veteran to fill out a health benefit application (10-EZ form) to help gather information about the veteran population. Once veterans are enrolled, they are enrolled for life. VA does have the authority to disenroll veterans if VHA is unable to accommodate them; however, that has never happened.

The Veterans Benefits Administration (VBA) determines the degree of service-connectedness of veterans' injuries upon application, determines which priority groups veterans fall under, and further adjudicates claims. The priority group classification the veteran receives is based upon factors such as the degree of service-connected disabilities, employability, special authorities, income, and other program eligibility. Approximately 10 percent of VHA patients are non-veterans, and fall under the categories of having an emergent condition; spouses and dependents of veterans disabled 100 percent or who die from service-related injuries (through the CHAMPVA program); caregivers of veterans (through the Caregivers and Veterans Omnibus Health Services Act of 2010); and family members in limited circumstances. The

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Commission discussed the eligibility system and requirements for VHA and posed questions to the presenters. Items discussed included:

- The process and methodology used by the VBA in determining the degree of service-connected disability ratings
- Who are non-veterans that are eligible to receive care
- Co-pays and other forms of insurance (e.g., Medicare, Medicaid)
- Procedures for obtaining current information about enrollees and informing enrollees about benefits
- Resources and staffing requirements for carrying out the eligibility process
- The current status of the reorganization of the Consolidated Patient Accounting Centers and the status of account collections

### **2014 Choice Act/2015 Enhancement to Choice/Care in the Community – Current Status**

Kristin Cunningham and Stephanie Mardon provided an overview of the current status of VA Care in the Community. The Care in the Community program allows VA to provide veterans with the full continuum of care when VA doesn't have the available internal resources. Situations that may cause VA to send patients to private-sector providers include when a veteran can't access VA health care, demand in the system exceeds capacity, there is a scarcity of resources, or using the private-sector care helps VA ensure cost effectiveness. Veterans who use the program must be pre-approved by VA (except in the case of emergency). VHA has several national contracts that allow veterans to access high-quality, measurable care, with some facilities within the VHA system having their own sharing agreements.

Care in the Community consists of several external care programs, which include the following:

- Foreign Medical Program, which provides care for service-connected veterans residing or traveling overseas
- Access Received Closer to Home (ARCH), which helps veterans who live far away from VA facilities in 5 VISNs
- Home and Community Based Services, where VA partners with state governments to provide long-term care for veterans
- Non-VA Medical Care Program, which contracts both nationally and locally to provide care to veterans outside of the VHA system
- Sharing agreements/academic affiliates, which include partnerships with other government agencies (e.g., Department of Defense, Indian Health Services)

The Choice Program, which was authorized in August 2014 and began operating in November, also provides for veterans to receive health care from private-sector providers. The program helps veterans who either live more than 40 miles away from a VA facility or would experience wait times for appointments more than 30 days from the clinically intended date.

The Commission discussed the current status of VA Care in the Community and posed questions to the presenters. Items discussed included:

- Length of the approval process for outside care ways to streamline that process
- How VA balances being a provider of care and a payor of care

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- The authorization, access, and quality control issues that arise when providing veterans with care outside of the VHA system
- Specifics of VA programs that provide care for veterans in rural communities
- How VHA addresses time-sensitive needs of patients receiving care via the purchased care program and the barriers that impede veteran access to timely external care
- The qualification criteria and processes of the Choice Program
- How statutory requirements shape VHA's purchased care programs and policies
- VHA's policies regarding specific treatments

### **Care in the Community – Future Status**

Dr. Baligh Yehia, Joseph Dalpiaz, and Gene Migliaccio provided an overview of the future of VA Care in the Community. The VA Budget and Choice Improvement Act of 2015 directed VA to develop a plan to consolidate all non-VA provider programs into a new, single Veterans Choice Program to furnish hospital care and medical services at non-VA facilities for veterans in the patient enrollment system. The plan will address ten congressionally-mandated elements (including eligibility, care coordination, billing and claims, and a transition plan), as well as several supplemental items (legislative proposals necessary to implement the plan, the estimated cost, and budget requirements). Work started several months ago and has focused on five key areas:

- Identifying the groups that VA serves and who is eligible for care in the community
- The referral and authorization process for accessing external care
- Building a high-performing provider network
- Care coordination
- Provider payment processes

The VA team reached out to key stakeholders and hosted an industry health care leadership roundtable to collect information and themes to guide the research. The plan will be transformative in nature, and needs to weave seamlessly into the larger VA transformation of MyVA. Implementation will be phased in over time, and the plan will need to address the problems of purchased care that exist today as well as look towards the future. Care in the community cannot be separated from the rest of VHA, and the plan should spark robust discussions about the future of VA healthcare. The plan is due to Congress by November 1, 2015.

The Commission discussed the methodology and findings of the plan and posed questions to the presenters. Items discussed included:

- How VA will oversee and ensure quality outcomes of care and the importance of moving toward standardized metrics
- The selection process and criteria for establishing VA's provider network partnerships
- VA's core competencies in providing health care and how they factor into outsourcing services to private sector providers
- Existing models/best practices/centers of excellence considered by VA
- The current status and potential future changes to VHA's operating model
- The obligations and challenges that impact care coordination/cost implications

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There is a VHA Integrated Project Team (IPT) for Care in the Community that was formed to develop an acquisition strategy for future purchased care. Comprised of key VA stakeholders, the IPT is five months into its yearlong project develop a replacement for the current purchased care contract (i.e., the Patient Centered Community Care Program (PC3)). Subject matter experts helped IPT frame the language of the new purchased care contract, and the team created seven major subgroups (in the areas of provider networks, data and compliance, claims, medical cost and quality, finance, marketing products, and process integration) to find best practices within industry. Through these efforts, the IPT will identify the shape a new VA purchased care contract should take.

The Commission discussed the IPT's charge and posed questions to the presenters. Items discussed included:

- What functions will be purchased
- The statutes that affect VHA's insurance procedures
- How VA creates a stronger partnership model with major players in health care markets
- The pros and cons of renting out an existing health care network versus developing an internal network (e.g., Medicare, Accountable Care Organizations)
- The differences between local and national health care networks
- Lessons learned from PC3 and how VHA can improve future experiences with purchased care
- How the Commission can assist – e.g., think Federal impact, not just VA; focus on what VA does well

### **Academic Affiliations**

Drs. Robert Jesse and Karen Sanders provided an overview of the Office of Academic Affiliations (OAA) within VHA. An influx of veterans in the post-World War II years, combined with a lack of capacity to handle the influx, led to VA Policy Memorandum 2 in 1946, which directed VA to affiliate with medical schools to help provide a higher standard of medical care to veterans. The primary objectives of the OAA are to oversee and enhance academic relationships, develop alliances with different kinds of external bodies, increase the number of clinical trainees that come through VA, foster excellence and innovation in the learning environment, and provide a crucial pipeline for future VA staff.

Every year, VA trains more than 120,000 clinicians, across 40 different health professions, providing stipend support of \$900 million. The Department has affiliations with 135 of 141 American allopathic medical schools and 35 of 40 osteopathic medical campuses. Through these programs, OAA develops the policies of the training mission of VA, as well as serves as the public face of VA to many external organizations and bodies. OAA also has helped develop key innovations in medical training through programs such as the Chief Residency in Quality and Safety, the VA Nursing Academy, physical therapy residencies, and licensed professional mental health counselor training.

Academic affiliations benefit VA by developing higher quality staff, providing access to state-of-the-art health care knowledge, increasing recruitment and retention from the training pool, and, most importantly, ensuring higher quality care and better outcomes for veterans. OAA programs serve as integral parts of training health care providers in the United States, and provide an experience for VA that is proven to be of huge value. The Commission discussed the mission of

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the OAA and specifics about its various programs, and posed questions to the presenters. Items discussed included:

- The effect of outsourcing care to external providers on VA education programs
- The scope of practice for specific services within VHA
- VHA quality control methods for monitoring trainees
- How to ensure physician continuity for patients, and the effect of rotations on ongoing treatments
- How to acquire information about trainees who continue to work in the VHA system
- The balance between patient care and IT security in VHA

### **Long-Term Care**

Richard Allman provided an overview of VHA's programs in geriatrics and extended care (GEC). The mission of GEC is to honor veteran preferences for health independence and wellbeing in the face of aging, disability, or serious illness by advancing expertise, programs, and partnerships. In the coming decades, the number of VA enrollees over the age of 65 is projected to increase, with the percentage of those that are highly-service connected increasing as well. This will put additional strain on GEC services, which already account for approximately 30 to 50 percent of the cost of the VHA healthcare system. To address these rising costs, VA plans to reduce the amount of money spent on nursing home care, and instead allocate it to home- and community-based services.

Overall, GEC has three strategic priorities:

- Ensure veterans' access to the main lines of business, which include palliative care, geriatrics, and long-term services and supports
- Balance the portfolio of programs in GEC, by increasing the amount of support available for home- and community-based settings
- Improve care coordination, which is especially important among a population whose health needs often span different disciplines

Dr. Allman closed with an overview of specific programs within GEC. The Commission discussed the mission of the Office and specifics about its various programs, and posed questions to the presenters. Items discussed included:

- Process/wait times for authorization and enrolling in an extended care facility and issues that complicate the process
- The differences between VHA and Medicare long-term services and partnerships with Program of All-Inclusive Care for the Elderly (PACE) organizations within GEC
- How the Veteran-Directed Home and Community-Based Services program helps veterans receive long-term care in the community

**Closing remarks/comments were made and the DFO adjourned the meeting of the Commission on Care at 5:31 p.m.**