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**STATEMENT OF  
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COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
APRIL 10, 2019**

Chairman Isakson, Ranking Member Tester, Distinguished Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing to examine the Department of Veterans Affairs (VA) progress in implementing title I of Public Law (P.L.) 115-182, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018.

DAV is a non-profit veterans service organization comprised of over one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Today's hearing is critically important to our organization as most of our members choose and rely heavily or entirely on VA health care.

Mr. Chairman, as you know, DAV worked closely with this Committee, Congress and VA in helping to craft and enact the VA MISSION Act, and we continue to believe that – if fully and faithfully implemented – this landmark law can improve both the access to and quality of veterans health care. However, with just eight weeks before the new law is set to take full effect – we are not confident VA will be ready by June 6, 2019 to fully implement new wait and drive time access standards that will significantly enlarge VA's community care program.

While many parts of the law can and should move forward – particularly the urgent care benefit, caregiver assistance expansion and existing access standards contemplated in the VA MISSION Act – the new designated access standards proposed by VA are not yet ready to be rolled out. Based on recent VA reports to Congress on access and quality standards, as well as the U.S. Digital Services report on VA's progress of implementation, it has become clear that VA is not yet prepared, nor likely to be prepared within eight weeks, to implement significantly more complex and expansive access standards without risking serious disruption to veterans health care. VA does not yet have sufficient resources nor operational plans in place to ensure seamless clinical care coordination for the increased number of veterans who can and will seek care through the new Veterans Community Care Program (VCCP) established by the MISSION Act. Therefore, until VA can certify to veterans and to Congress that it

can meet the proposed lower wait time access standards; has properly tested and can successfully operationalize the new drive-time standards with minimal disruption; and safely coordinate the clinical care of the increased number of veterans who use the VCCP networks, VA should continue to use the existing access standards of the Veterans Choice program.

Title I of the VA MISSION Act, requires VA to establish an integrated community care program by June 6, 2019—just eight weeks from today. The VA MISSION Act was enacted into law on June 6, 2018, and since that time, VA has issued requests for information from the public on health care access standards,<sup>1</sup> health care quality standards,<sup>2</sup> and for the Program of Comprehensive Assistance for Family Caregivers.<sup>3</sup> VA has also issue a change of agency practice pertaining to medical records confidentiality under 38 U.S.C. 7332,<sup>4</sup> and has proposed rules for Urgent Care<sup>5</sup> and the Veterans Community Care Program.<sup>6</sup>

DAV has tried to engage VA on nearly all of these issues in a multitude of meetings but the Department continues to limit the amount of information they share. We also continue to be kept at arm's length, limiting the information the agency should use when developing policies and procedures—information such as the veterans' perspective steeped in considerable institutional knowledge and experience, constructive advice and prudent recommendations—that defines a truly collaborative stakeholder relationship. From our vantage point, we believe VA is indeed making progress in implementing title I of the VA MISSION Act of 2018, but the Department seems unlikely to meet the June 6 deadline set by law without sacrificing quality and endangering veterans' health outcomes.

For example, we are pleased with VA's quick work to implement Section 105 of the VA MISSION Act by proposing regulations for the new urgent care benefit for veterans – a policy DAV has long advocated for – which will help provide veterans with additional local access for non-emergency care.

However, we strongly oppose VA's proposal to charge service-connected disabled veterans a copayment per urgent care visit, beginning with the 4th visit in any calendar year. VA posits in the preamble of the proposed regulation that it will dismiss the longstanding and principled covenant not to charge copayments to service-connected disabled veterans who were injured or made ill defending our nation by simply noting that “[c]opayments are a common feature of health care, including VA health care. They are an important mechanism for guiding behavior to ensure that patients receive care at an appropriate location.”<sup>7</sup>

Rather than respecting this hallowed promise not to impose the cost of care on service-connected veterans and finding a solution to address its concerns regarding

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<sup>1</sup> 83 Fed. Reg. 30818 – 30819, Jun 29, 2018; 83 Fed. Reg. 30819 – 30821, Jun 29, 2018.  
<sup>2</sup> 83 Fed. Reg. 42983 – 42984, Aug 24, 2018; 83 Fed. Reg. 42982 – 42983, Aug 24, 2018.  
<sup>3</sup> 83 Fed. Reg. 60966 – 60968, Nov 27, 2018.  
<sup>4</sup> 84 Fed. Reg. 407 – 407, Jan 28, 2019.  
<sup>5</sup> 84 Fed. Reg. 627 – 633, Jan 31, 2019.  
<sup>6</sup> 84 Fed. Reg. 5629 – 5650, Feb 22, 2019.  
<sup>7</sup> 84 Fed. Reg. 627 at 630.

patient behavior, we believe VA chose poorly not to adopt a solution used in the Department of Defense's (DoD's) urgent care program, which we discussed at length with the leadership of VA. DoD's program offers a Nurse Advice Line available 24 hours a day, 7 days a week at no cost to direct beneficiaries to address patient behavior and help them seek the most appropriate level of health care needed to treat the medical conditions of the beneficiaries, including urgent care services. The success of this advice line in DoD has potentially greater benefit in the VA health care system, which serves patients that are generally older and more clinically complex. Likewise, staff have access to the veteran's medical records. It is concerning to DAV that VA's decision reflects a priority to advance on what is expedient at the expense of what is right.

Similarly, section 132 of the VA MISSION Act amends 38 U.S.C. 7332, which protects certain sensitive diagnoses (i.e., drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia) from being disclosed unless expressly authorized by the patient, by providing a new exception to the requirement that a patient must expressly authorize VA to disclose medical records containing a sensitive diagnosis. The exception removed VA's requirement when VA is billing a third-party for medical care cost recovery.

When engaging VA on section 132, before the notice to change the Department's practice was issued on January 19, 2019, we inquired how VA would implement and enforce the provision stating "[a]n entity to which a record is disclosed under this subparagraph may not disclose or use such record for a purpose other than that for which the disclosure was made or as permitted by law." Subsequently, VA chose to ignore this provision in the notice to change VA's practice and there has been no notice or publication to date about what the procedures are should a veteran or other individual discover that sensitive information has been used beyond the purposes for which it was disclosed, and what the process is once the VA is so notified.

Other sections in the VA MISSION Act of great importance to DAV and that VA is making progress on is the improvement and expansion of the comprehensive family caregiver support program. We were pleased to hear at the Senate Committee on Veterans' Affairs hearing two weeks ago that VA is still aiming to certify the IT system and initial expansion by the October 1, 2019, deadline. However, we still have concerns as to whether VA will truly be able to meet the deadline, particularly in light of conflicting messages from VA and recent history in delayed implementation of IT solutions for this program.

The VA Caregiver Support Program currently uses the IT system known as the Caregiver Application Tracker (CAT), which was rapidly developed due to time constraints on implementing the program and was not designed to manage a high volume of information as is required today. We are aware VA has requested a reprogramming of nearly \$96 million in Medical Care funding to the IT Systems account, which includes just over \$4 million to continue development and stabilization of CAT, while in its FY 2020 budget submission, VA is requesting \$2.6 million to update the Caregivers Tool (CareT) to support the first phase of expansion.

As this Committee is aware, VA notified Congress in April 2017 that CareT, which at that time was expected to fully automate the application and stipend delivery process for the program, experienced significant delays associated with external dependencies and lost prioritization among competing projects. As a result, a new contract had to be drafted to continue work pushing the delivery of CareT out one year to June 2018. Yet during VA's briefing on its budget request for FY 2020 and 2021, staff announced CareT would likely not be certified until June of 2020. VA is well aware veterans and caregivers have waited for nearly a decade for equal treatment and it is simply unacceptable to ask them to wait longer.

With continued delays in IT development, we question the wisdom of having two different standards in deploying IT solutions supporting the VA Caregiver Support Program projected to serve thousands of veterans and their caregivers compared to the lower standard of deploying the IT solutions supporting the VCCP projected to serve millions of veterans and their caregivers.

As VA has been implementing title I of the VA MISSION Act, we see these types of decisions being repeated. In the VA health care system, too many veterans are experiencing uneven and delayed access to high quality veteran-centered care. There just simply are not enough clinical teams and clinical space to care for our nation's veterans. Even before the Veterans Choice program was established, VA facilities had limitations on the services it could offer due to a variety of factors, including the size of facilities and the types of providers that can be recruited. VA's legacy purchased care programs such as fee basis, now commonly referred to as Individual Authorizations, were generally used to address a VA facility's shortcomings such as limited availability of clinical services, the distance that veterans would have to travel to receive care at a VA facility, and the amount of time veterans had to wait for an appointment.

Additionally, the manner in which VA historically referred veterans to community care was fragmented. VA did not track how long it took for veterans to be seen when referred to a community provider, whether the quality of care they received in the community is equal or better than VA, how such care impacted veterans' health outcomes, or veterans' satisfaction. We frequently heard complaints that due to limited resources, VA providers were not allowed to send veterans to the community, resulting in delayed access to needed care. DAV and our *Independent Budget* (IB) partners called for increased resources, improving how VA uses community care by creating a high-performing integrated health care network, and asked Congress and the VA to ensure a veteran, with the help of their VA clinical team—not government bureaucrats—decide when and from whom they should receive care in the community.

For fiscal year 2014, VHA received the highest ever funding level of \$54 billion in advance appropriations, with additional funds from the Consolidated Appropriations Act enacted in January 2014. However, by April 2014, the waiting list scandal and access crisis erupted at the Phoenix VA Medical Center (VAMC) and by August, P.L. 113-146, the Veterans Access, Choice, and Accountability Act of 2014, was enacted to establish,

in 90 days, the temporary Veterans Choice Program. The purpose of the Act was to mitigate the crisis by ensuring veterans had access to care in the community paid for by VA while strengthening the VA health care system. This new program was set to expire until such time as the initial \$10 billion deposited in the Veterans Choice Fund estimated to be expended by mid-August 2017.

This Committee is well aware of the troubled implementation and execution of the Veterans Choice Program, ranging from the adequacy of the provider networks, participating providers not being paid timely, veterans experiencing as long if not longer waiting times seeking care in the community as well as being chased by collection agencies because the community providers were just not being paid for authorized care. Moreover, our calls to ensure the taxpayers are getting the best value for the resources appropriated, and for true care coordination and transparency in the quality of care veterans are receiving from community providers have not been adequately answered.

The multitude of reports from the Government Accountability Office (GAO) review since the inception of the Veterans Choice Program bear out the difficulties of hasty implementation. Of note was GAO's report observing the tracking and of obligations and projected utilization leading to the VA's FY 2015 funding gap of \$2.75 billion. While VA developed new processes to prevent funding gaps for 2016, the agency was still unable to adequately project its resource needs, resulting in another funding crisis. This Committee's unwavering commitment to ensure veterans' health care needs are met had to react under emergency circumstances on not one, but two separate occasions to provide VA \$2.1 billion in August 2017<sup>8</sup> and another \$2.1 billion just a few months later in December 2017.<sup>9</sup>

We remember distinctly the first funding crisis when then-VA Secretary Shulkin made clear in public statements and congressional testimony that the Veterans Choice Program would likely run out of money before the end of FY 2017. In response, Congress' deliberations included a proposal to appropriate \$2.0 billion to the Veterans Choice Program, which would be offset from other programs in VA's budget.<sup>10</sup> DAV, along with eight other veterans service organizations (VSOs) sent a letter to Congress opposing the terms of the legislation and thankfully, leaders of this Committee and in the House Veterans' Affairs Committee found a compromise without penalizing veterans by cutting other earned benefits.

The lessons here are clear, there are some in Congress willing to shift resources from VA programs to pay for veterans to see a private doctor if they are facing long waits or travel distances. It seems disingenuous to say on one hand that VA programs are fully funded and on the other, provide an additional \$10 billion to send veterans who cannot be seen by VA in a timely manner to get the medical care they need in the private sector. In addition, VA's ability to estimate and make projections for the Veterans Choice Program remains suspect.

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<sup>8</sup> P.L. 115-46

<sup>9</sup> P.L. 115-96

<sup>10</sup> <https://docs.house.gov/billssthisweek/20170724/S114.pdf>

Over the course of 18 months following enactment, laws were passed making several technical changes<sup>11</sup> to the statutory authority for the Veterans Choice Program; however, we are still helping veterans who are being chased by collection agencies or otherwise being directly billed by community providers because they have not been paid for the care they provided to veterans under the Veterans Choice Program.

In light of this, we had expected VA to propose regulations that would make clear how VA will establish and operate what Congress, the veteran community and the VA all agreed was the next evolution in the Department's efforts to purchase care for veterans in the private sector: a high-performing integrated network that combines the strength of the VA health care system with the best of community care to offer seamless access and coordinated care. Instead, the regulation creates more questions than answers.

It appears VA's proposed rules lack several basic elements important to veterans, such as simple and transparent processes for determining eligibility for care in the community, how veterans care will be coordinated, how veterans will be provided information about the quality of community providers in the network so they can make an informed decision. Veterans are most interested in information about a provider's track record on the condition for which they are seeking care as well as interpersonal skills, identifying the best providers in the community, and determining the adequacy of the network of community providers. Finally, there must be a process in place to hold accountable and the community provider to the same standards to limit exposing veterans to disparities in care.

As opposed to avoiding complicated and ambiguous procedures to be implemented with administrative simplicity in determining veterans' eligibility for community care, VA has proposed rules expanding both the number and complexity of eligibility based on six criteria.<sup>12</sup> One of these six designated criteria is also the subject of numerous substantive comments from the public and from elected officials. The wait time assumptions are suspect and drive time criteria is opaque and predisposed to result in arbitrary eligibility determinations, all of which will also likely contribute to dangerous fiscal uncertainty.<sup>13</sup>

For example, VA's cost estimate for wait time assumes a 29 percent increase in primary care providers and a 14 percent increase in mental health providers. VA also estimates no additional expenditures for the 28-day appointment time for specialty care because it is sufficiently similar to the 30-day access provision under the Veterans Choice Program. However, VA's budget request for FY 2020 shows an increase of only 1,068 physicians and 2,943 registered nurses, which for the sake of discussion we will assume are all advanced practice nurses—a mere 4.8 percent increase.<sup>14</sup> For its FY 2021 request, VA will increase staffing for these two categories by 5.3 percent. These

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<sup>11</sup> P.L. 113-175, P.L. 113- 235, P.L. 114-19, P.L. 114-41, P.L. 115-26.

<sup>12</sup> VA proposed 38 C.F.R. § 17.4010(a)(1)-(5)

<sup>13</sup> VA proposed 38 C.F.R. § 17.4040

<sup>14</sup> Congressional Submission VA Budget Request for FY 2020 Funding and FY 2021 Advance Appropriations, Volume II: Medical Programs and Information Technology Programs; Page: VHA-174.

diverging assumptions will likely exacerbate VA's miscalculation of the workload, required staffing, and cost estimate for its designated wait time standard.

VA also proposes to use an average drive-time criteria rather than distance, to provide "a more consistent standard of access for urban and rural Veterans." VA proposes to use a proprietary software not generally available to the public and the proposed rules do not adequately explain how "average drive time" will be calculated for the purposes of eligibility for the Veterans Community Care Program—an apparent lack of transparency that appears to guard against independent evaluation.

It is also unfortunate VA is unnecessarily proposing a new and untested drive time criteria in lieu of using an existing criteria and improving upon it. Specifically, the distance criteria under the Veterans Choice Program had been steadily improved over the years. The remaining concern over this criteria is to change the distance calculated from the veteran's residence to a VA health care provider for the required care or service. The administrative simplicity and transparency of this criteria are compelling arguments against the newly proposed drive time standard.

DAV continues to insist that the high-performing integrated network contemplated under the VA MISSION Act allow the best providers in VA and in the community to be identified. We believe veterans would be most interested in a type of physician score card: one that reports information about a provider's track record on the condition(s) for which the veteran is seeking care as well as the information on the provider's interpersonal skills.

Unfortunately, VA's proposed regulations do not speak to this critical aspect of the VA MISSION Act. Without these physician level quality measures, we believe at minimum, the regulations should require competency standards. VA and community providers in the high-performing integrated network should meet the same qualification standards for each discrete discipline. We strongly recommend network providers must complete a general training course on military culture, suicide prevention, and on other key issues in providing care such as VA's Opioid Safety Initiative. These courses should be free and available online counting towards continuing medical education requirements. Providers treating mental health conditions prevalent in the veteran population such as posttraumatic stress disorder, conditions related to military sexual trauma or traumatic brain injury should be required to complete condition-specific courses covering assessment, evidence-based treatment, management of comorbid conditions, and information on complementary VA resources. We believe it is reasonable to have exemptions to these required training courses for individuals with direct and relevant VA or military experience or training.

To this end, we are compelled to question how and when VA will make public the tiered network of community providers intended "[t]o promote the provision of high-quality and high-value hospital care, medical services, and extended care services

under this section,”<sup>15</sup> as well as establishing a monitoring system for the quality of care and services provided through the network of community providers.<sup>16</sup>

Correspondingly, the same provisions in the VA MISSION Act requiring identification and stratification of providers also intends for all providers in the high-performing integrated networks be held to the same standards – for both access and quality. More specifically, we believe at minimum those standards the VA is held to should equally be applied to community providers. Not holding VA and its community provider partners to the same standards could lead to delayed care, lower quality care and worse health outcomes for veterans. It appears instead VA is creating a double standard allowing community providers to meet lower and nonspecific access and quality requirements.

VA has bundled care coordination for the VCCP in to the Administrative Costs of the program totaling \$588 million over 5 years. However, the proposed regulation is largely silent on what veterans should expect in terms of care coordination. In its preamble, VA indicates it will continue to sharpen its focus on directly providing those services that are most important to the coordination and management of a veteran's overall medical and health needs. Some aspects of care coordination are described in terms of managing authorizations and episodes of care in the community as well as identification of a “VA care coordination team” for a veteran opting for care in the community, but little else is provided detailing this critical part of care.

Seamless care coordination is one of the most common and frustrating issues veterans experience today when seeking care in the community through the Veterans Choice Program. We find it objectionable that VA asserts itself as the coordinator of veterans medical and health needs, yet does not correspondingly treat such a vital and distinctive component of VA's health care delivery system. We believe elevating the expectation of providing care coordination to all enrolled veterans through regulation is the first step VA should take.

In conclusion, we are forced to question whether VA's progress in implementing title I of the VA MISSION Act, which requires the establishment and operation of an integrated high-performing network that will improve veterans' health outcomes and quality of life, is gained at the expense of other critical factors to meet the June 6 deadline set in law.

It is not clear the proposed VCCP will improve veterans' health care outcomes. Likewise, there is no assurance of care coordination beyond the sharing of medical information, and no assurance of funding or staffing to ensure veterans they will be treated fairly and equally in terms of eligibility determinations, the quality of care they receive and the timeliness of such care.

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<sup>15</sup> 38 U.S.C. § 1703(g)

<sup>16</sup> 38 U.S.C. § 1703(h)

Prior to rolling out this program on June 6, VA should be able to demonstrate community providers in the VCCP meet the same access and quality standards to which VA holds itself accountable. VA should guarantee the integrated network can meet a new and shorter wait time access standard prior to designation. VA should first test and evaluate new drive time access standards prior to designation. The Secretary should certify that VA has the necessary funding, staffing, information technology and clinical care coordination plans in place prior to making the new Access Standards effective. Until VA is able to satisfy these requirements, we believe the current access standards under the Veterans Choice Program should be adopted.

Mr. Chairman, that concludes my testimony and I would be happy to answer any questions that you or Members of the Committee may have.