S. HRG. 116–482

VA MISSION ACT: ASSESSING PROGRESS IMPLEMENTING TITLE I

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

OCTOBER 21, 2020

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

45–365 PDF WASHINGTON : 2021

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VA MISSION ACT: ASSESSING PROGRESS IMPLEMENTING TITLE I

WEDNESDAY, OCTOBER 21, 2020

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 a.m., in room SD–106, Dirksen Senate Office Building, and via Webex, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Rounds, Tillis, Blackburn, Loeffler, Tester, Murray, Brown, and Blumenthal and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman MORAN. Good morning, everyone. The Committee will come to order. I welcome our witnesses in person and those that are appearing distantly. We look forward to their testimony and getting a better understanding of where the Department of Veterans Affairs and the third-party administrators are in administering the MISSION Act. Also very interested in hearing more today about the caregivers' implementation as well.

Almost every member of our Committee, though not physically present at the moment, some are joining us in person and others will be joining us. Almost every member of our Committee will be participating, is expected at today's hearing.

The focus of today's hearing is the implementation of Title I under the MISSION Act by the Department of Veterans Affairs relating to veterans' Community Care programs and the program of comprehensive assistance to family caregivers. I scheduled this hearing because of my dissatisfaction with the pace of MISSION implementation. While VA officials were invited to participate in today's hearing to discuss the critical programs they oversee, the Department chose to decline that invitation.

This Committee and the VA shared a common goal to pass the MISSION Act in 2018 to better serve veterans and their families, and we continue to work together to address important issues for our Nation's veterans. I would expect them to be here for this conversation, to share all they have accomplished since the VA was transformed with this legislation, and to discuss what needs to be done to make improvements.

The VA is an integral part of this dialog, which is why I plan to hold subsequent engagements with the VA officials to discussed Title I implementation.

I would be remiss not to recognized the unprecedented challenges of this year due to the COVID–19 pandemic. The dedicated staff on the VA's front lines deserve both our thanks and recognition for their essential role in caring for veterans and fulfilling the VA's fourth mission. However, at a time when accessing health care is of utmost importance, the VA has struggled to uphold the MISSION Act's requirements of providing veterans access to community care.

My staff and I continue to hear complaints from veterans and providers related to poor communications, lapses in continuity of care, and network inadequacies. Third-party administrators like TriWest and Optum, here with us today, are valued and essential partners in the delivery of care to veterans through the Community Care network. They play, you play, an important role in building a robust and resilient Community Care network that is able to provide veterans timely access to care, and to make certain community providers receive prompt payment for the care and services they provide.

When the VA released stringent access standards for community care, I was encouraged to see more veterans would finally be able to access timely quality care closer to home. However, once again, my staff and I have since learned that the VA's contracts with third-party administrators used a completely different set of standards to determine how veterans access care.

Under contract terms, rural and highly rural veterans could be forced to drive up to 3 hours for care, which is completely, totally unacceptable and contradicts the spirit of MISSION. I have discussed this glaring inconsistency with the VA officials for months, but despite VA's assurances, publicly and privately, it is uncertain whether the VA has modified the terms of the contract.

It appears to me that it is possible now for veterans to have a different access for care, certainly than the law, the MISSION Act requires, different than the regulations of the VA, and perhaps different from VISN to VISN, based upon the contract terms of the third-party administrators. As I said, we hope to learn more about this today.

The Community Care network is central to the MISSION Act's aim to transform the VA's health care into an innovative and responsive 21st century health care system, capable of addressing the challenges veterans face today and providing access to the care veterans deserve under the law. As such, I want to ensure that MISSION Act succeeds, and utilization of Community Care Networks is accurately accounted for because there are sufficient number of local providers in the network for veterans to utilize.

Much has changed in our country since the Committee held a hearing on implementation of the Community Care Network earlier this year, but the intent and goal of the MISSION Act has not changed. We remain committed to making certain that veterans who qualify for care in the community are able to get that care without unnecessary scheduling delays through a mature and geographically dispersed network of community providers that hold the VA's access standards, and that those providers are paid in timely manners.

Congress has the responsibility to oversee VA's execution of the laws that govern the agency's responsibility to serve veterans, and I take, with the Committee, takes its responsibilities seriously. I believe some of the VA's most senior leaders might agree with me that while progress may be underway, it must move faster to enable Community Care Networks to serve veterans as we all envisioned. I want to know how the VA is making progress in working with their third-party administrators to transform the VA and offer veterans access to the health care they deserve.

Another essential component of the MISSION Act is the expansion and eligibility for program of comprehensive assistance for family caregivers to all generations of veterans. Many caregivers have been providing essential services for their loved ones without support for years, and in some cases, decades.

As veteran caregivers are often the main caretakers for their loved ones, many can experience depression, anxiety, and other mental health conditions attributed, in part or solely, to their experience of caregiving. The stress associated with caring for a spouse or family member with a set of complex health care needs is a real and present concern for veteran caregivers. It is essential that the VA support for caregivers these mental health challenges be addressed effectively.

MISSION outlined a two-phased process to expand the supportive resources with an anticipated start date of October 1, 2018, for Phase 1. Phase 1 implementation only just began October 1 of this year, 2 years behind schedule. This delayed rollout will result in caregivers needing to wait even longer to be part of the vital support program.

I look forward to hearing the testimony from everyone who will be taking part in today's hearing about the issues that you face in your work to help care for and serve veterans, and steps that the VA can take to make certain both of these important programs are functional and able to deliver good results and outcomes for veteran caregivers.

I apologize. My opening Statement is longer than my usual practice, but I had sufficient desire to say a few things this morning as we begin this hearing, and I now want to yield to the Ranking Member and author, Senator Tester.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Thank you, Mr. Chairman. I want to thank you for holding today's hearing, and I am looking forward to the discussion among our panelist witnesses. But I, like you, am very disappointed the administration chose not to participate in this dialog. I do not know why something as important as implementation of the MISSION Act does not rise to that importance in the VA. Hopefully it is not because they are out campaigning across the country.

The fact is that this Committee has serious issues with the administration on the implementation of the VA MISSION Act, and it is unfortunate that VA could not be here to participate in finding solutions to those problems.

When Congress creates programs to benefit veterans and their families, the expectation is the administration will implement those

programs as Congress intended. You know, the legislative branch is not here just as a nuisance. We actually do things and have expectations. So the executive branch ought to be sending folks here. With the creation of the VA MISSION Act, Congress sought to provide veterans with greater options for community care when the Department could not provide care in a timely manner or when veterans were forced to travel long distances to VA facilities.

The latest data we have from the VA shows that it made more than 4.1 million referrals into the community from the beginning of Fiscal Year 2020 to June. Nationally, it took VA nearly 22 days to schedule health care services in the community after a request was made. That is not acceptable. It is a problem. Veterans should not have to wait for the VA to navigate a bureaucratic process before their appointments are scheduled. Then veterans wait an average of 20 days for their appointments after they have been scheduled. That does not work, man. That dog does not hunt. If the VA was here I would tell them to find a way to reduce the red tape. The administration needs to explain how it plans to bring down the number of days it takes internally to get veterans to the point where they get scheduled for care in the community. In the last year there has not been much improvement in this timeline. Rather than sticking with this broken process, the administration needs to figure out a better path forward.

I have a bill, the Accountability and Department of Veterans Affairs Scheduling and Consulting Management Act, which passed out of Committee last August. It would help the VA to do just that. It would require the VA to take a hard look at its scheduling process and then report how long it takes to get through that process. It would also require scheduling audits and review of grading of positions involved in scheduling, because too often personnel leave these important jobs for better opportunities elsewhere in the VA.

My bill would also help veterans make better-informed decisions on where they can get care, because they would have the information they need to make those decisions. It would also help Congress to exercise oversight of VA scheduling to make sure the Community Care program is working as we intended.

Another area deserving scrutiny is the newly expanded caregivers program. While it has the potential to vastly improve the lives of veterans and their caregivers, many of whom have waited years to receive the same stipends, training, and mental health services that have been available to post-9/11 veterans and their caregivers, I am concerned that the administration too narrowly wrote the rules on eligibility. Modifications that tighten eligibility for the current and expanded program are not MISSION Act driven, and were undertaken solely by the administration in an effort to limit eligibility for this program and for the veterans that it impacts.

I am also concerned that the administration is in a rush to meet a new, self-composed deadline after missing the mark by a year, spent little time preparing stakeholders for when the program would actually go live, causing confusion when it actually did it.

I do want to thank the Elizabeth Dole Foundation for being here today, to shed light on these issues so that we can make sure this program is functioning well for veterans and their caregivers.

With that, Mr. Chairman, I want to thank you again for calling this very important hearing.

Chairman MORAN. Senator Tester, thank you. Now let me introduce our witnesses. Dave McIntyre is the CEO of TriWest. Lt. General Patricia Horoho is the CEO of Optum. Steve Schwab is the CEO of Elizabeth Dole Foundation, Molly Ramsey, Manager of Policy and Programs for the Elizabeth Dole Foundation, and Jennie Beller, Caregiver and Fellow, Elizabeth Dole Foundation.

Thank you all for being here with us today and for providing testimony so that we can better understand the circumstances by which we may help you accomplish your goals of meeting the needs of veterans of our country.

We will now begin the hearing with our first witness, Lt. General Horoho. You are now recognized for 5 minutes to delivery your testimony, and thank you again for being here and thank you for the conversation we had for nearly an hour on Sunday evening.

STATEMENT OF LT. GEN. PATRICIA D. HOROHO

General HOROHO. Good morning, Chairman Moran, Ranking Member Tester, and members of the Committee. I am Patty Horoho, CEO of OptumServe.

I am pleased to join Dave McIntyre and Steve Schwab and his colleagues at the Elizabeth Dole Foundation today. On behalf of the 325,000 employees of the UnitedHealth Group, we are honored to support VA's mission to ensure that our Nation's heroes live their healthiest lives.

Would you like me to start over?

Chairman MORAN. I think it is fine.

General HOROHO. Okay. Good. I had to dig deep into my military voice there. Sorry.

After 33 years of uniformed service, the mission is personal to me and our entire organization. We are veterans. My leadership team has a total of 350 years of service in uniform. Many of us, or our family members, receive care from the VA health system or the community.

Since I last appeared before the Committee, OptumServe completed our implementation across regions 1, 2, and 3. Our responsibility is to build and manage a high-quality provider network. We are managing a network of 830,000 providers across 1.6 million sites of care. We intentionally built a large network so veterans could have their choice from a wide variety of timely care options. To date, the VA has issued more than 1.5 million referrals for care to our network, connecting individual veterans with a high-quality provider, one veteran at a time.

One hundred percent of our contracted network is fully accredited and credentialed. In addition, as compared to the 15 percent benchmark set by the VA, 54 percent of providers assessed are designated as high-performing providers.

The success of our provider network goes beyond the data. Underlying the data are hundreds of thousands of individual connections made between care providers and veterans. We understand that health care is local and the choice of a provider is personal. Our network is dynamic, highly reliable, and responds quickly to the needs on the ground.

Recently, the leadership of the Lexington VA Medical Center expressed gratitude for our assistance in ensuring a veteran who was battling cancer could be treated by the same provider as his wife. We know that caring for our Nation's heroes is more than signing a provider contract or paying a claim. It means caring about the women and the men who have worn the cloth of our Nation, and doing whatever it takes to help them heal.

Every day we work side by side with VAMCs to advance veteran care, review successes, develop action plans, address challenges, and share best practices. These relationships are critical when the unexpected happens. This occurred in August when Hurricane Laura left 200,000 without water and a 1 million without power in Louisiana. Many hospitals were forced to close, and my team jumped into action, leveraging relationships with the Louisiana Hospital Association. We ensured the VAMC had up-to-date information on hospitals where they could safely serve veterans.

Our network is not a national entity. It is a collection of regional care ecosystems designed to be responsive and convenient to veterans. Working with each VAMC, we have prioritized the credentialing of high-quality providers with a history of serving veterans in the community. As a result, we have partnered with 92 percent of priority providers identified by the VA and 93 percent of academic affiliates, including Duke and the University of Kansas. And for the first time in the VA's history of providing care in the community, Optum partnered with the VA to bring the Mayo Clinic into the Community Care Network.

While managing our network is a dynamic process, our restlessness keeps the veteran at the center of everything we do. This month we learned that a veteran was matched with a life-saving heart, more quickly than expected. This evoked our warrior ethos of never leaving a fallen comrade behind. Within 24 hours, this West Virginia veteran received a new heart. Over the last few weeks we began facilitating dozens of life-saving organ transplants. This is the power of one—one organization, working one-on-one with VA staff, VSOs, Congress, caregivers, and many others to advance the health and wellbeing of one veteran at a time.

Mr. Chairman, Ranking Member Tester, and members of the Committee, thank you for the opportunity to appear before you today. As a veteran, former Army surgeon general, wife of a veteran, daughter of a veteran, and the proud mother of an airborne infantry lieutenant, ensuring veterans have a high-quality, credentialed network that meets their needs is important to me and our entire organization.

I look forward to your questions. Thank you.

Chairman MORAN. General, thank you for your testimony, and thank you to you and your family for your service to our Nation. Mr. McIntyre, welcome.

STATEMENT OF DAVID McINTYRE, JR.

Mr. MCINTYRE. Mr. Chairman, Ranking Member Tester, and distinguished members of the Senate Committee on Veterans' Affairs, on behalf of all those associated with TriWest Healthcare Alliance it is an honor to appear before you today, and I am pleased to do

so with Patty and the great folks from the Bob and Elizabeth Dole Foundation.

We have been serving the military and veterans population for nearly 25 years now. We are privileged to have partnered with VA for the past 7 years in helping them respond to the health care needs of veterans, from PC3 to the CHOICE Act, to expansion and the replacing of Health Net, to the MISSION Act. It has been quite a journey.

We have tried to remain nimble and focused on one objective, to support, not compete with, the VA in providing timely, quality care for veterans. Through the use of our proven demand capacity process and leveraging the footprint of our nonprofit owners, we have tailored high-quality networks in collaboration with VA to match the unique demands of each VAMC and their enrolled veterans.

Our network, which will soon contain all academic affiliates for Region 4, has now delivered more than 32 million medical appointments in support of VA to give them needed elasticity. This has included everything from urgent care within 30 minutes of a veteran's home to eye appointments, to primary care, to urology, to women's services, to behavioral health, and just this past weekend, a triple organ transplant to save the life of a hero.

We and VA have collaborated in administering the IVF benefit for hundreds of couples who cannot otherwise have children because of their combat-related wounds. We have customized the network for each one of the couples and their unique circumstances, and lots of babies and proud and grateful parents are the result.

I am pleased to report that due to the team effort between us and VA, we are now processing and paying clean claims, professional and institutional alike, within two weeks, to a level of accuracy in excess of 98 percent. And it will please you, I am sure, Mr. Chairman, to know that the VA is reimbursing us on a timely basis as well.

Along with these successes have come some challenges, especially in the delivery of timely appointments. As you know, early in the year our Nation was hit with COVID, a challenge unprecedented in our lifetimes. Community providers and VA alike reduced the available services as they made changes to keep their staffs and patients safe and preserve capacity for those fighting the virus. It was a daunting situation.

But soon, and since July of this year, we have been scheduling appointments within 5 days for 90 percent of all veterans needing primary care appointments, and they are seen within 26 days from the receipt of the referral, mental health within 27, and specialty care within 28. All who are urgent and emergent in their needs are seen within the MISSION Act standards. There is still a bit of work to do, but we are close, and only 1 percent of the care requests that we have been given have been returned for no network provider.

Getting here has been challenging, but we are close and we will not rest until we, and VA, in Region 4, are delivering on our collective commitment to timely and convenient care. With the implementation of CCN, VA takes over care coordination and appointing. But at VA's request, we have begun supporting the first six VAMCs

in Region 4 with appointing services, and we expect that elasticity soon to be spread to other VA Medical Centers.

And with the recent award of the CCN contract for Region 5, we look forward to doing the same in Alaska, not to replace VA but to enhance it and provide the elasticity needed so that they can serve veterans as you and they believe should be served.

Veterans deserve no less. We applaud your continued leadership, Mr. Chairman and members of the Committee, and direction, as we work toward a common goal that we all are united by— providing timely, quality access to health care for our Nation's veterans. Thank you.

Chairman MORAN. Mr. McIntyre, thank you. I now recognize Mr. Schwab for his testimony.

STATEMENT OF STEVE SCHWAB

Mr. SCHWAB. Chairman Moran, Ranking Member Tester, and members of the Committee, the Elizabeth Dole Foundation is pleased to testify today on the MISSION Act and the expansion of the VA program of comprehensive assistance for family caregivers. Hundreds of thousands of military caregivers are counting on us to get this expansion right, as are the generations of veterans who depend on their care.

The original legislation establishing this program unfairly drew an artificial line between the caregivers of those who served before September 11, 2001, and those who followed them. Our nation must continue to swiftly act to end this disparity in caregiver benefits.

Pre-9/11 caregivers provide a tremendous service on behalf of our Nation, and it exacts an enormous toll on their lives. They have been suffering in the shadows for decades, tending to war wounds compounded by age, and now confronting additional debilitating conditions such as ALS, Alzheimer's, cancer, mobility issues, and so much more.

In 2014, the Elizabeth Dole Foundation released a landmark study by the RAND corporation that found that 10 percent of pre-9/11 caregivers spend more than 40 hours per week providing care. A quarter have taken unpaid time off from work or temporarily stopped working because of their caregiving. More than 13 percent have dropped out of the work force entirely. And the most common pre-9/11 caregivers is a grown child of the veteran. Many of these caregivers fall in the sandwich generation, who simultaneous care for their parent and their children.

These hidden heroes are an unpaid work force contributing nearly $15 billion in care every year, the vast majority of which is provided by pre-9/11 caregivers. And experts agree that a well-supported caregiver is the most important factor to the well-being of a veteran.

Correcting the inequity of caregiving benefits was one of our foundation's first and urgent priorities. We applaud Congress for responding to our call, and we are grateful that Secretary Robert Wilkie and the U.S. Department of Veterans Affairs have carried out this legislation as part of the VA's continued investment in caregivers.

Unfortunately, however, implementation of the expansion has been married by ambiguities and delays that have led to widespread frustration and confusion all across the caregiver population. Our chief concern is the pace of implementation. After more than a year of delays, the VA still intends to roll out benefits in protracted phases, requiring those caring for veterans who served before May 7, 1975, to wait two more years for eligibility—that is 2 years. We understand that the phased approach is specified by law, but these prolonged delays are further straining caregivers.

The VA's Veterans' Families, Caregivers, and Survivors Federal Advisory Committee, chaired by my boss, Senator Elizabeth Dole, recently recommended that Congress provide legislative relief to expedite this timeline. Mr. Chairman, Senator Tester, members of the Committee, Senator Dole hopes action is taken on this very important legislative reform. And even more important, our pre-9/11 caregivers who are being forced to wait even longer to receive their benefits, hope you will take action immediately.

Our foundation also strongly urges the VA to standardize the expansion's implementation. The largest source of caregiver anxiety and dissatisfaction with the PCAFC has always been the inconsistencies between VA centers. Among the areas open to interpretation is the requirement for annual assessments. Some medical centers choose to evaluate caregivers multiple times each year. That causes undue stress among the caregivers over the possibility that they will be dropped from the program.

Additionally, key language about how caregivers are evaluated lacks clarity. We are particularly concerned about the reliance on activities of daily living as the market for how much care a veteran requires. Mandating that caregivers assist with ADLs on a daily basis, or each time they are performed, will likely disqualify those caring for veterans with post-traumatic stress and traumatic brain injury. The abilities of veterans with cognitive injuries can vary over time, even hour by hour. We cannot leave their caregivers unsupported.

At the core of the implementation's challenges is a critical lack of communication. Caregivers have largely learned that the program was officially expanding benefits on October 1st secondhand, through social media or through word of mouth. However, large percentages of the caregiver population do not use social media or participate in online communities. Furthermore, those who do participate in these communities are vulnerable to inaccurate information. The VA must invest in a proactive, comprehensive communications campaign, and engagement with MSOs and VSOs like ourselves, to ensure that all caregivers receive the benefits and communications that they critically need and deserve.

Finally, our foundation calls on the VA to create a permanent head of the VA support program and classify the position as an SES. Currently the position is interim and that is unacceptable. A program of such importance requires an established position of senior leadership.

While we strongly encourage the VA to respond to the recommendations we have presented today, we also praise the Department for its commitment to implementing this historic legislation. We know and we recognize a lot of hard work has been done. It

is a tremendous task. The Elizabeth Dole Foundation and our coalition of partners are standing by and ready to assist in promoting and implementing this program.

Thank you again, Mr. Chairman, Ranking Member Tester, and Committee members for this opportunity to appear before you today. We look forward to continuing our work together. We look forward to your questions today and to supporting our Nation's veteran caregivers.

Chairman MORAN. Mr. Schwab, thank you for your presence here today. Thank you for the work that the Dole Foundation does and accomplishes. Please give our best wishes and gratitude to the caregivers. And as a Kansan but as an American, please give my regards to both Senator Doles for their work in Congress and their retirement from Congress, the work they have done since then on behalf of veterans and America. Let me now turn to your colleague, Mrs. Beller.

STATEMENT OF JENNIE BELLER ACCOMPANIED BY; MOLLY RAMSEY, ELIZABETH DOLE FOUNDATION

Ms. BELLER. Chairman Moran, Ranking Member Tester, and members of the Committee, thank you for inviting me to share my story as you assess the expansion of caregiver benefits under the VA MISSION Act of 2018.

I appear before you today as the caregiver of a veteran. At the same time, I am also a national advocate for military caregivers with the Elizabeth Dole Foundation, and a lawyer who served as a Deputy Attorney General for the State of Indiana.

More than 45 years ago, my husband was exposed to Agent Orange while deployed during the Vietnam War. The exposure caused diabetes, and the diabetes triggered a major stroke. For almost 10 years, Chuck has required 24-hour care. The stroke caused paralysis on the right side of his body, so I assist him with all activities of daily living. Every day begins with me helping him out of bed, moving him into his chair, and getting him dressed. I prepare breakfast, assist with eating, and administer his insulin and other medications. And that's it goes for the day.

Our biggest challenge is Chuck's inability to communicate. His intelligence and memory are intact. However, he can no longer read or write. He understands about 60 percent of what is said, and his speech is completely garbled. As his caregiver, it is my job to help him understand what is going on in any given situation and to make sure that he feels he has been heard, especially in medical appointments.

For my first 5 years as Chuck's caregiver, I did my best to hold my own life together. I was entering some of the most professionally fulfilling years of my life, not to mention the highest earning years. I leaned on the Family Medical Leave Act to help me stay employed, but even with that assistance, I barely had time to sleep. Emotionally, I was devastated by the never-ending cycle of work and caregiving.

Considering the sacrifices I was making as a caregiver, I could not understand why VA benefits were denied to me and millions of other pre-9/11 caregivers, just as I do not understand, now, why we must endure continued delays and drawn-out timelines.

The VA must find ways to streamline the evaluation process. For example, the VA has a decade of medical files demonstrating what my husband needs assistance with everyday and that I am his primary caregiver. Yet to apply for benefits, a VA representative is still required to interview me and my husband, who can barely communicate, for two and a half hours. This lengthy process can add stress and anxiety to both the veteran and caregiver.

I understand that the VA is trying to gather as much information as possible, but it is imperative that interviews accommodate veterans who may not be communicative, like my husband, or who may not be able to sit still for a full interview. I am happy to say, however, that our Caregiver Support Coordinator in Indianapolis was very accommodating for Chuck, and the concern is that we cannot see that through the rest of the VA system.

The VA should also enforce consistency in the evaluation process. Caregivers sharing their application stories in online communities are revealing significant variances between VA locations and between the application instructions and how it is applied. The most concerning of these inconsistencies is the overreliance on activities of daily living as a measure of required care. Caregivers assisting someone with invisible wounds are struggling to prove the value of their care, and I assure you, their care is saving their veterans' lives.

Resolving these issues is critical because caregivers are counting on these benefits. The VA's financial assistance is not insignificant to caregivers who have to choose between caring for their veterans or paying the bills. I loved my career, but I would have died if I continued working while caregiving for Chuck, and then Chuck would have died shortly thereafter.

However, it is not just about the financial assistance that is invaluable. If allowed into this program, I will have someone who is there to help me during my caregiver journey. These benefits are lifelines to the caregivers, and without the love and support from a family member or friend, a veteran may not survive. This is how important caregivers are to their veterans, and that is why allocating these benefits as quickly as possible is so vital.

Despite the challenges I outlined today, I would like to commend both Congress and the U.S. Department of Veterans Affairs for remaining committed to correcting the inequity in VA caregiver benefits. For many years, veteran caregivers have felt voiceless. Today, we finally feel heard.

Chairman MORAN. Thank you very much for your testimony and thank you for your husband's service and your care and concern for him and for other veterans and their caregivers.

I think now we are ready to begin the questions. Before I do that I wanted to highlight something that I failed to say in my opening remarks. Since we met last, the President has signed in to law legislation passed by the House and passed by the Senate, our own John Scott Hannon Veterans Mental Health Care Improvement Act, and to my colleagues on the Committee, for your help in accomplishing that goal, I wanted to express my gratitude.

Let me begin with a couple of questions for both the general and Mr. McIntyre. Has the VA reached out to your companies to discuss modifications related to access standards? Mr. McIntyre?

Mr. MCINTYRE. We have been implementing a series of changes to our contracts since we started the implementation of Region 4. That follows the work that was done originally with Optum. And to this point there is no modification currently being negotiated formally as to the access standards.

Chairman MORAN. General, I will come to you. Maybe it is just easier if I ask a series of questions which are directed to both of you. You are making progress in improving, I think what you are saying, is the access, the timeliness, the access standards. Why are you doing so if it is not included in your contract?

Mr. MCINTYRE. We sought, from day one, to build a network that was in keeping with the access standards that are envisioned in the MISSION Act. And the award of Region 4 was done in such a way that it predated the opportunity for the VA to make an adjustment to the contract before award. So I thought it made most sense for us to start on a trajectory line with that in mind. The Region 5 contract that just got awarded for Alaska to our company includes the MISSION Act standards.

When COVID hit we suspended a bit of our work to more broadly build the network in favor of making sure that we protected the base that needed to be built, and we are now getting back to closing out the work on the MISSION Act standards as well as refining the dental network, which has been, as Senator Tester and others from Region 4 know, a little bit more complicated than was initially anticipated.

Chairman MORAN. It is my concern that veterans have different access standards depending upon what third-party administrators' contract says and what that third-party administrator is doing. Now what you indicated is in the most recent negotiations, the MISSION Act standards are included, but in other contracts they are not. Therefore, depending upon what VISN you live in, you are operating under a different standard?

Mr. MCINTYRE. The MISSION Act standards were included in 5, because that was most recently awarded. That gave the VA enough time to modify that contract before award. That was not in the case in Region 4, and so, therefore, we are stretching ourselves voluntarily in the direction of the MISSION Act standards for the network build for Region 4.

Chairman MORAN. General, your response to those questions?

General HOROHO. Thank you, Senator. So when we received our contracts for Regions 1, 2, and 3, it was before the MISSION Act went into law, and so 6 months after we had the awards it went into law, so those standards were not part of the contracts.

However, when we looked at the contracts we kind of looked at it through three different lenses—one, to have a bigger network, two, to have a bigger chance for availability, and three, to have bigger veteran choice. So we intentionally went and overbuilt the network. We realized that approximately 200,000 veterans leave the military every year, and so we did not want to build the network just where veterans are today, but we wanted to have a robust enough network that we have capacity and providers in the right place at the right time for the veterans for the future.

And so we are not in active conversations with the VA on modification, but that has not stopped us from wanting to make sure that we have the most robust network available.

So we kind of look at it through two lenses. One is a retrospective lens, where we look at the referrals and through the claims process, and we look to see how long it took for a veteran to be able to get an appointment, and then we look within that area to make sure that we are in access standards. We then look prospectively and look at geo-mapping where the veteran lives and where the providers are, to make sure that we have really robust drive time as well as availability for care.

And so internally we have monitored ourselves on what Secretary Wilkie had put out for the access standards of 30 minutes for primary care and behavioral health and then 60 minutes for specialty care. So internally we monitor that and we are actually very close to meeting that standard across primary care, behavioral health, and specialty, except for the area of dental, where we have—we are probably about 79 percent with dental. But everything else we are close to 90 percent or higher.

Chairman MORAN. Your contracts, the ones that were negotiated before the MISSION Act took effect and therefore do not include the MISSION Act standards, last for how long? The contract length before they are renegotiated is how long?

General HOROHO. Eight years.

Chairman MORAN. And you have no indication that the VA—let me ask a more neutral question. Do you have any indication, one way or the other, whether the VA is interested in implanting a contract, modifying your contracts, to meet those standards, to include those standards?

General HOROHO. Senator, we have given them all of our data and information that they would need for them to make that decision, and right now we are not in active discussions.

Chairman MORAN. And now I may be editorializing, but correct me if I am wrong. So if you both are working in the direction, third-party administrators are working to meet the standards of the MISSION Act, what is the reason for those not to be included in the contract? And in the absence of contract, the reason we have standards is so that a veteran, regardless of where he or she lives, operates under the same rules. So in VISN 5 there is a different standard for a veteran than a veteran in Region or VISN 3. Is there any reason that makes any sense?

General HOROHO. Maybe if I can frame it in how we are operating every single day. And so one of the things that we have realized is health care is local. And so we work every single day with each local VAMC on the ground to identify where they have got gaps in care, where they are having access-to-care issues, and ensuring that we have a robust enough network to be able to support the demands of each one of those VAMCs.

And so consistency, from a veteran's perspective, I think is very important, so I think I am in agreement with you. And we believe that the intent is for veterans to be able to get care where they need it, when they need it, which is part of why we are driving to have the most robust network.

Chairman MORAN. Thank you for that answer. I want Mr. McIntyre to respond and then I need to move on. But I would say that I agree with you, General, that care is local. I believe that. But a 3-hour drive is a 3-hour drive wherever you live in this country. Mr. McIntyre?

Mr. MCINTYRE. For the networks that we built, we have sought to understand both what the footprint of the veteran is and what the footprint of the VA Medical Center is—their capacity, not just their capability. And then we seek to build the elasticity that they are going to need.

With regard to your question about modifications, we have done 100 modifications since we started in this space, and I think there will probably be a day when it makes sense for VA to modify our contracts, the ones we currently have, to layer in the standards so that we can measure appropriately between us how we are doing in meeting those standards.

I was refreshed to see that the MISSION Act standards are layered into the Region 5 contract, and I think that is probably an indication of where VA intends to go, but I have not asked them that question.

Chairman MORAN. Thank you very much. Thank you both. I apologize to my colleagues for running over time significantly. I will try to make up for it.

I do not know whether Senator Tester has returned from another committee meeting. If so, I will recognize him. If not, I recognize Senator Murray.

Senator TESTER. I am here.

Chairman MORAN. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and it's Okay if you run over time once in a while. You have been very gracious.

So I want to thank everybody for testifying. I appreciate your testimony. I am going to start with you, Mr. McIntyre, because you are kind of a big deal in Montana, and I want to talk a little bit about dental network rates and access to preferred dental providers. It is a concern that I hear consistently from veterans across the State.

So my State staff tells me that calls and emails from veterans are concerned that regular dental providers not in the TriWest network have eclipsed those about eligibility for dental care through the VA. So the chief concern appears to be the dentists believe the network rates are too low.

So what I would like to have you do, Dave, is walk me through how you and the VA established dental rates in Region 4, and the adequacy of the dental network in Montana. In particular, are the rates in Montana the same that you pay in more urban areas where there might be more general dentists than specialists, and does that make sense?

Mr. MCINTYRE. Great question, Senator Tester. It is good to see you. We are building the network in Montana. As I said, it has been a little more complicated than we initially expected. The reason for that, in part, is there is no fee schedule that is national for dental services for the VA. They were local fee schedules. In some cases they varied substantially, market to market. And what we were asked by VA to do in the dental space was to attempt to put

together a network that reflected the market rates in those environments.

So what we have sought to do is to involve our dental subcontractor, Delta Dental, which has a wide footprint across the geographic expanse of Montana and the rest of Region 4, to leverage their engagement in the marketplace and to convert over to a fee schedule that is consistent and to build out that network. In some cases, the market rate that they are paying for dental services is different than what the VA was paying historically, and that is where part of the rub has occurred. And we and VA are collaborating, market by market, to make sure that we are able to make appropriate adjustments and complete the network.

Senator TESTER. So I just want you to add on to that. In what circumstances would you pay more than the rates are right now?

Mr. MCINTYRE. More than the rates in the market, or more than the rates——

Senator TESTER. No, more than the rates—so let's assume for a second that the problem is, in fact, that the network rates are too low. Let's make that assumption. What circumstances would cause you to raise those current rates?

Mr. MCINTYRE. If a higher rate was necessary to make sure that we could build a complete dental network in your State. This is——

Senator TESTER. Okay. I appreciate that. So do you feel, at this point in time, that the rates have not been a limiting factor on you building that network?

Mr. MCINTYRE. I think that it has been a bit of a challenge, but it is one that we and VA are working through to attempt to respond to the local conditions in the market to make sure that we can build a sufficient network that veterans need to be able to rely on.

Senator TESTER. Okay. General, Horoho, would you like to add anything to this topic?

General HOROHO. Yes, sir, I would. So when you look at dental, the challenge is in a couple of areas. One, approximately 12 percent of the veteran population is eligible for dental, but that data is not readily available, and so you really have to build the dental network to support the 6 million veterans that are there. And many of them, actually, operate in a fee-for-service model and are not dependent on a managed care model. So each dentist, there are different rates for the subspecialty versus general dentistry.

And so what we have found is that we have had to pay up to 150 percent for some of our contracts to be able to ensure that we can have a robust enough dental capability within that marketplace. So when we look across our three regions for wait times, Region 1 is about 27 days; Region 2, 21 days; and Region 3, about 13 days. And so it is a negotiation, market by market.

Senator TESTER. I want to thank you both for your explanation, and I want to point out to the Chairman that I only went 25 seconds over.

I yield. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Tester. I now recognize Senator Cassidy. Doctor?

SENATOR BILL CASSIDY

Senator CASSIDY. You got me now.

Chairman MORAN. Yes, sir.

Senator CASSIDY. I think you do. Great. Thank you. Thank you both.

You know, one of the issues that I am sure you have heard of is the timely and accurate claims processing. And so there is a system back home that says that from about June 2019 to about June 2020 there is just a whole batch of claims that they have not been compensated on.

Now, subsequent to that, it has gone Okay, but there are these claims there. I say that because we are all aware of the impact that COVID has had on hospital cash-flow, and so obviously they are still in business but nonetheless part of what keeps them in business is paying attention to stuff like this.

And so can you give us some perspective on how TPAs are going to handle this? And if you addressed this in your opening remarks I apologize. I had to log off for just a little bit.

Mr. MCINTYRE. I will take that, Patty, if that is Okay, because I filled the breach, our company did, before you arrived in Louisiana. There is a requirement currently that providers file claims within 180 days of delivery of service. That is half the time given for Medicare and half the time given for TRICARE and most other programs.

What has happened to them, unfortunately, is further complicated because of the fact that sometimes VA ordered the work, sometimes Health Net ordered the work, and sometimes we ordered the work. And so there has been a complication on the part of providers of where to file.

The VA and we have worked extensively over the last couple of months to put a process in place that is going to allow every provider that falls into the gap that you have so articulately identified, Senator, that will allow them to refile the claims, have them processed, and paid. And we have the resources to do that, on the dollar side, and the VA will reimburse us.

This just started at the beginning of October. There has been common outreach between us and VA of that fact, and there are now 1,367 claims that have been refiled that otherwise were denied for timely filing in the last couple of weeks.

So we look forward to working with you, VA and ourselves, to make sure that your constituents are aware of what to do and how the process will work, so that they can get reimbursed for the services that they have delivered.

Senator CASSIDY. Okay. So we can followup directly with you should there be a continued concern or a problem on their side, because, of course, they think they filed directly.

Mr. Chairman, I cannot see the clock, so you tell me when I am out of time.

Let me address this to Optum. The MISSION Act authorized the new urgent care benefit for veterans, which I was strongly supportive of, because it expanded options for care and made sure that folks get urgent care where they needed it. TriCare has established a nationwide network of 7,200 urgent care providers, I am told

serving 92 percent of enrolled veterans, and I thank the VA and TriWest for establishing this.

Now Optum is the TPA for Region 3 and is in my State of Louisiana. So I gather that Optum's urgent care network is not as robust. And since obviously I care about this—I was the one that sponsored the legislation—what steps is Optum taking to ensure a robust network of urgent care providers, at least comparable to TriWest?

General HOROHO. Thank you, Senator. So we established urgent care and we did that in the midst of COVID. We actually have 6,600 urgent care centers across all three regions, and so across those regions, in Region 1, 98 percent accessibility and availability, 91 percent in Region 2, and 95 percent in Region 3. And we have seen where those have been utilized during COVID, because we also had some of them that used tele-urgent care, where those that wanted to access care were able to do that remotely as well.

Senator CASSIDY. Okay. So then what I have been informed is that your network is as robust, and for whatever reason, as Humphrey Bogart once said, "I was misinformed." Okay. Well, that is good news.

Just returning to the other, I will just emphasize that I am told that providers are unaware of a process to resubmit those claims. So the degree to which you all can publicize that I think would benefit probably not just my folks but others. But thank you for that, sir.

With that I yield back, Mr. Chair.

Mr. MCINTYRE. Mr. Chairman, if I might?

Chairman MORAN. Mr. McIntyre.

Mr. MCINTYRE. I will commit that I will reach out to every office that is on this Committee to inform you of the communications that VA and we have put together, and to help you understand the information that might be used to outreach to providers in your State, and make Patty aware of the same thing, because our commitment before we fully leave the areas that she stood up is that all of the claims are paid, even those that were not otherwise done on our watch but might have been done in the HealthNet space.

General HOROHO. And, Mr. Chairman, if I could just add to that so we get a complete scenario on it, what we have done internally as well. So we are paying claims on average in 11.9 days. But when we get claims that are actually either TriWest or if it is HealthNet, at that time, we have got an internal specific denial code. So we just do not deny them. What we do is we put the code on it so that it gets routed back to the provider. And we work closely with TriWest to make sure that that works well, as well as working with the VA. So we try to take away the friction from our providers.

Chairman MORAN. Dr. Cassidy, thanks for raising these topics.

I now recognize Senator Murray.

SENATOR PATTY MURRAY

Senator MURRAY. Mr. Chairman, thank you very much. I appreciate it. And Mr. Schwab, thank you for your incredibly important testimony and your recommendations today.

I really want to thank the Elizabeth Dole Foundation for their dedication to our veteran caregivers. And Mrs. Beller, thank you for all you do, both as an advocate and a caregiver. I am so grateful to my colleagues for their support in passing the caregivers legislation as part of the VA MISSION Act to finally expand the program to veterans of all eras. But now we have got to get this expansion right and make sure that current participants are not getting unfairly pushed out of the program.

Back in May, I joined Senator Tester in a public comment letter to the VA regarding the agency's proposed changes to the caregivers program, which would restrict the eligibility and potentially remove some veterans from the programs. In the law, we set the criteria to include eligibility for veterans who need assistance with at least one activity of daily living, and we included other eligibility criteria such as supervision, protection, or instruction to make sure those with the invisible wounds of war, who need assistance, can get it.

However, VA's new rule goes beyond Congress's intent to further limit eligibility. So, Mr. Schwab, I wanted to ask you, do you believe that the VA is defining eligibility too narrowly when compared to the eligibility in the specifications outlined in our law, and how will those new limitations on eligibility to veterans rated at 70 percent service connected affect our veterans?

Mr. SCHWAB. Senator Murray, thank you for the question and thank you for your leadership going back years on advocating for the expansion of this program. You were among the first Members of Congress certainly to be with us at the Foundation and calling for the expansion of the program, and you have worked so hard on it. We appreciate that.

Your question is super important and something I highlighted in my testimony. The program, even before expansion was inconsistent, at best, in integrating, including, and caring for folks who are caring for a veteran with mental and emotional health care wounds and injuries.

Yes, we do believe that the VA has gone beyond the interpretation in the ways that it is implementing eligibility for folks who are caring for mental and emotional wounds. I think that my colleague, Molly, if I could refer to her, Senator, could expound on this point as well. Molly?

Ms. RAMSEY. Yes. Thank you so much, Steve, and thank you so much, Senator Murray for everything for our caregivers and with the Elizabeth Dole Foundation.

As Steve mentioned, we do believe that the VA has gone a little further than the intention of what was put into the initial caregiver bill and VA MISSION Act. We are hopeful that they treat invisible wounds such as PTSD, TBIs, any other neurological or emotional or mental illnesses or wounds as equally as the physical need for ADLs, or physical assistance with ADLs.

We have been told that the VA are weighing safety and supervision as equally as the physical assistance with activities of daily living each time. However, some caregivers that we have in our network, that we are working with, have expressed concerns of that.

You bring up a good point also of the 70 percent requirement. That was something that we were surprised to see. In the initial impact analysis that the VA provided, they did try to assure the community that 95 percent of what they are considering legacy participants, as well veterans who were already receiving care under the VA health system would meet that qualification. However, that is possibly the lower bar of eligibility requirements. There are those functional assessment needs, and then as Jennie Beller so eloquently put, the 2-hour interview process. Those are the higher parts of the eligibility requirements that are concerned with.

Senator MURRAY. Okay, well thank you. And, Mrs. Beller, thank you for your testimony today. Let me just say we have got to get this right and I am not going to give up. And thank you for your recommendations. I look forward to working with you. We have got to keep working on this, so I very much appreciate it.

I just have a few seconds left and I wanted to ask about IVF to Mr. McIntyre. This is really important to me that veterans facing fertility challenges as a result of their service have the smoothest experience possible in connecting with the IVF provider that best matches their family's needs. And I continue to have concerns about approvals from the VA being delayed, and I am troubled by how it will affect the scheduling process for these families.

To that end, I have heard that the VA will soon be assuming full responsibility for scheduling appointments with community providers as opposed to the network administrators scheduling these. Mr. McIntyre, I just want to ask quickly, what have you found to be most important in getting this done in a customized way that fits each couple?

Mr. MCINTYRE. Senator, thank you for that question and your leadership with this important topic. It is true that the VA is going to be taking over the functions related to IVF. It, as you say, has to be done very customized, and we anticipate that they are ramping up to do that. We will continue to do the network piece which is customized fully for the needs of the couple when we come to understand what their authorization is and what their circumstances are. And at this point the VA is planning to do the scheduling of them, but Washington State is one of the areas that we expect the VA to look to us for elasticity on appointing, and if we can helpful with the appointing on the IVF side to assist them, we certainly will do so.

Senator MURRAY. Okay. Mr. Chairman, I have additional questions that I want to submit for the record, and I appreciate you allowing me to go over time.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. [Presiding.] Without objection. Thank you.

Senator BOOZMAN. I want to thank Chairman Moran and Senator Tester for having the hearing. I cannot imagine anything more important than about increasing the quality of care and maintaining the quality of care that we have, and again, going forward, and then also access to care, which is really what this is all about.

I know that we have had a really significant backlog regarding reimbursement in the past. We have worked hard to—VA has

worked hard to get that down. General, recognizing that the MISSION Act changed the reimbursement plan for providers, placing a heavier burden on TPAs like OptumServe up front, can you provide the Committee an update on how the VA is reimbursing you for care to community care providers and your network, and are there any challenges that you are facing that we can be helpful with. I think that is really the bottom line. Yes, you are not going lot have your providers if they do not get paid in a timely fashion.

General HOROHO. I could not agree more, and prior to launching the three regions, one of the significant hurdles of getting providers into the network was because of the challenges of the past. I can report to you today that I think we are in a very good place. We are paying providers first, which is a change, and we are paying them on average in 11.9 days, almost 99 percent of the time. And then the VA is actually reimbursing us around 7–9 days.

So that system is working right now, and we keep a very close eye on it, because it is how we retain high-quality providers.

Senator BOOZMAN. Very good. Again, Optum now is in Arkansas and has taken over, which is, again, great.

There is concern about people that are under other providers that have had, you know, a long-term relationship with them. For a veteran whose current provider is not in the network, what does this transition look like? How can you—how can we, how can you help provide continuous care for veterans under these circumstances?

General HOROHO. Thank you, Senator, for that question. Continuity of care, which we both know is so very, very important—and health care is a very personal relationship with your provider—one of the things that we have done is we have actually asked the VA to prospectively identify those individuals that do have a relationship, that there are ongoing authorizations, and then the analysis to see whether or not there is a gap in the provider being in our network. And then where there is, we can look to evaluate does that provider meet the new standards of being a fully credentialed provider, meeting all those standards. Then we are able to bring them into the network.

When we meet every single month with 109 VAMCs we actually talk about gaps in care. We talk about, you know, where they need us. We talk about veterans' concerns. And so that is another place where that can come in. And then actually the VA has given us their priority providers as well, for us to bring those into the network.

Senator BOOZMAN. Very good. We understand that it takes time to build community care networks, to best serve veterans. Based on your testimony, General, it appears that OptumServe has been able to quickly create a network that serves almost all veterans in Region 3, and that is very commendable. You Stated that for Region 3, 95 percent of veterans are able to reach an in-network urgent care facility within a 30-minute average drive time. This is partially a credit to OptumServe's ability to efficiently accredit health care providers as part of your network.

In terms of the process, what is the average timeline for a health care provider to receive accreditation by OptumServe? Is this some-

thing that can be improved on? Is there anything that we can do as a committee to help in that regard?

General HOROHO. So, thank you, Senator. Early on, when we were first standing up Region 1, we had a challenge in that area because we were bringing on hundreds of thousands of providers, and so it really was a large volume going through our system. We are now in much better shape, having fully operationalized Regions 1, 2, and 3. So our average is 14 days. Sometimes there is some specialty, like vision, that may take a little bit, you know, currently averaging 45 days. But that process is actually working extremely well right now. So I do not think there is any assistance that we need from Congress.

Senator BOOZMAN. Okay. Thank you very much. And now we will go to Senator Blumenthal, I think.

[Pause.]

Senator BOOZMAN. Well, we are going to go to Senator Rounds.

SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman. Since Optum is actually handling the processes within South Dakota, I would like to address most of my questions to General Horoho. First of all, I would like to thank you for your service to our country.

General HOROHO. Thank you.

Senator ROUNDS. And I appreciate your continued service as your work with Optum.

There seems to be a little bit of a disconnect between what you have shared with us today regarding the working environment that you find yourself in with the VA, who have decided, unfortunately, not to participate in this hearing, and also with regard to what our folks on the ground in South Dakota have been sharing with us about the availability of the networks that you have been building and the networks that were there prior to your participation. And I want to visit a little bit about this disconnect I am hearing today.

I have heard from both large and small providers that they literally have been extremely frustrated with the amount of bureaucracy that it takes to actually get into the network, and once in the network to actually get paid. On at least three occasions, a veteran's local VA medical center has referred them, unfortunately, to a TriWest network provider who had been there with years of service but they are being denied then once they have been there.

And it appears to be just simply administrative delays in getting them moved into Optum's network. And in this particular case, those veterans were denied access to care by those providers because they were not in the network anymore, and that most certainly is something, that as you have indicated earlier, and just as we had a discussion here today, is something not acceptable, and that continuity of care is critical.

What I am going to ask is, I think we have got to have an analysis of whether or not what we are seeing on the ground, in terms of ground truth, versus having perhaps a 90 or a 90 or a 95 percent success rate, that is leaving out those critical numbers in the middle that somehow suggest that there are people that are getting left behind. And it appears to be a bureaucracy problem, and what I would like to do is to discuss, at least hear from you, what you

are seeing in terms of what is stopping, or perhaps is the most frustrating part for you. And I am sure there are frustrating parts about your working with the VA and then trying to get through with your team these former providers, to get them in.

And finally, and I will let you answer, I would like to know what it is that are the guidelines, and are they published, for being an acceptable provider in your network that might have excluded those from the previous network. Thanks.

General HOROHO. Yes. Thank you, Senator, and I will absolutely, myself and the team, will come and meet with you and kind of lay out the data for your area so that we can have a further in-depth conversation on it.

But if I can kind of address some of the concerns that you raised, I will address first what it takes to become in the network. And so when we started to roll out Community Care, what we went forward with is not trying to replicate the network that was PC3 Choice, because Community Care changed the standards and made it a mandate to ensure that the entire network was fully credentialed.

So not only did they have to be licensed but we had to do prime source verification on the national practitioner data bank. We had to look at their education. We looked at their licensing. We made sure that there were not any challenges and issues, either from any agency that was out there. If they meet those requirements and if there is a gap in care, absolutely we attempt to bring them into the network. Or if it is a continuity of care issue we attempt to bring them into the network. And so that has been the standard and that is what it takes to get into our network.

The other piece that I want to bring out to some of the frustration that you have raised is we, in Regions 1, 2, and 3, we actually do not do the scheduling. The scheduling is done by the VA. And so when they go into the data bank the first priority is to look at those practitioners that are part of Regions 1, 2, and 3, to be able to schedule those appointments. And so part of the transition, we just finished going live in June of this year with all three of the regions, and so some of that frustration may have been when there was the overlap, which we did for all the right reasons for the veteran, is when we went live we did a 30-day overlap with TriWest to ensure that there was no gap in care during that transition. But that also allowed the VA to look into a system and see the current Optum providers as well as the TriWest, and they may have scheduled one or the other, which then tied into claims being put into the system that could have caused some of the confusion.

But we can do a deep dive with you on all of your data that is there.

Senator ROUNDS. Thank you, and look, I think what you are pointing out here is that we do have a problem with this transition, and I think the folks that are holding the bag on this are veterans that very well may have been denied care. And I do not think it has been a once-in-a-while issue. I think it has happened on several different occasions. I think we are going to have to go the extra step to cut through that bureaucratic red tape, like another part of this that we are going to have to talk about.

I like the idea that TriWest has come up with, where they are going to go back in and allow for a revisit on those claims that are over 180 days old. And I would like for your commitment as well, that you will do the same thing. Because we are going to have that problem. We have got folks out there that have got claims that are over that time period. They provided the services.

It looks to me like this transition has not been super clean, and nor would we expect to necessarily be super clean, but I do not want those providers holding the bag and I most certainly do not want our veterans on the short end of being able to get services with the individuals that have been appropriately providing them with services in the past. I think that means that as you transition into this I do think you are going to have to go the extra mile, with focus on those veterans.

I would sure like your commitment that you will look at that 180-day rule, the same as TriWest, and that you will work through to make sure these veterans have that continuity of care where we have a problem. If you can give me that commitment I think we can move forward.

General HOROHO. Senator, I can already tell you we are doing that right now. So every one of the claims that get denied, we actually look to see what was the reason before it goes back to the provider. We have been using an internal specific denial code to make sure that it gets routed appropriately. That did not happen at the very beginning. But when we realized the confusion that was occurring with, just like TriWest, realized the confusion that was occurring when you had multiple third-party administrators in one market until it was fully transitioned. So we have made that commitment, and we are doing that. So you have got my commitment that it will continue.

Senator ROUNDS. I am assuming, has that change just occurred in the last week or so?

General HOROHO. No. We have been doing that, actually, probably for the last several months.

Senator BOOZMAN. Thank you, Senator Rounds. And again——

Senator ROUNDS. Thank you, Mr. Chairman.

Senator BOOZMAN. Well, thank you, Senator Rounds, and again, that really is an important point.

Senator Blumenthal?

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thanks for being here, to all of you. I am disappointed, as Senator Moran and Tester have expressed, that the VA is not here. I am also disappointed that the VA has apparently declined to answer a number of the questions that we have asked regarding the racial disparity in the impact of COVID–19 on our veterans. Seven months into this devastating pandemic, 3,667 VA patients have died, which is a devastating average of about 17 veterans every day.

Right now we are apparently at the beginning of another surge. There has been a 50 percent increase in active cases at the VA compared to last month. I will say that I am proud of the VA facility in West Haven because they have done prompt testing with rapid results, using the PCR process. It could be a model for the

whole country. And the infection rate at our VA facility has been much lower than the national average. And I want to point out that there is some good news, even amidst some of the more discouraging facts.

But the results of a recent VA study have shown that Black and Hispanic veterans are twice as likely as White veterans to test positive for COVID at the VA. My guess is that not only infection rates but also death rates show the same disparities.

The VA has refused to communicate with Congress about this issue. Questions sent to the VA in June were completely ignored, as was a followup letter sent by the Committee in August. I joined my colleagues in expressing grave dissatisfaction with this refusal to answer our questions. The VA does a tremendous disservice to veterans when it refuses to communicate with Members of Congress who represent them and have a responsibility for oversight, and then refuse to come to hearings, as it has done today.

So I would like to ask all of you, but particularly General Horoho, how the COVID–19 pandemic has affected your operations. In particular, at the facilities in your network had adequate access to COVID–19 tests, reliable tests, and with prompt results and personal protective equipment?

General HOROHO. Thank you, Senator. If I could take 1 second before I answer that and just talk about health disparities, because that has been so important. So one of the things that OptumServe, my company is actually a data analytics consulting health services and a logistics and technology company. We developed a health disparity data analytical tool that we have been using since COVID started, that we can go down to the zip code level and identify those Americans that are disadvantaged or at high risk for COVID–19 based on their health disparities.

Then we have done "Stop COVID" where our company has done philanthropic work of providing those testings for free, as well as education wraparound packages to help them with that.

We have also reached out to the VA and offered that capability, to be able to utilize that as well, because I agree with you, it is a population that is extremely vulnerable.

And to answer your other question, a couple of things that we did as an enterprise, when we looked at our network being so tied to our enterprise network and making sure that providers are, one, financially stable enough to keep their operations going was important. And so we have accelerated nearly $2 billion in payments to doctors and hospitals that are also serving veterans so that we made sure that financially they were stable. We donated over $100 million to support COVID–19-impacted, at-risk communities.

And then we worked in partnership with HHS to help disburse over $100 billion of the CARES Act provider relief, and we did that because we knew this robust network of 830,000 practitioners are not only providing care for veterans, but they are providing care for Americans. And we wanted to make sure that was stable.

What we are seeing is that we utilized a lot of, and leveraged a lot of telehealth. Prior to COVID, only about 12, well, 12 to 16 actually used telehealth as referrals, and then now we are up to 12,000 a month. And so most of those were behavioral health,

about 31 percent, and we are starting to see the systems really coming back to normal and being able to improve access.

Senator BLUMENTHAL. Thank you very much.

Senator Rounds [Presiding.] Thank you, Senator Blumenthal. On behalf of the Chairman, Senator Blackburn. Senator Blackburn?

SENATOR MARSHA BLACKBURN

Senator BLACKBURN. There we go. All right. Thank you all so much. I appreciate your coming for the hearing, and I really want to thank the Elizabeth Dole Foundation for their leadership on caregiver advocacy. I will tell you, this is something that from our veterans we hear a good bit about, so we thank you for that.

OptumServe began managing the Community Care Network in Tennessee earlier this year, and let me say right now, I really agree with Chairman Moran's Statement that we are disappointed the VA declined to participate in this, and look at the progress that we have had with this network.

I will tell you, I am optimistic that we are going to be able to expand here to our veterans, especially those in the rural areas that are qualifying for care. And we are seeing an increasing number of those that retire out from Fort Campbell. They choose to stay in Tennessee because of its geographic location, also because no State income tax. And the Community Care is something that is vital for them.

And I want to focus today on the caregivers. We know, in the past, and we have had some problems in Tennessee, with the VA booting veterans and their caregivers from the program without justification and without them knowing why they got kicked off the program. Senator Peters and I have the TEAM Caregivers Act that would put into law some guidelines and bring some specificity to this program, to be sure it does not continue to happen. We think those standards are going to be vital. And it also takes steps to recognize the caregivers to a veteran's—their access to the veterans' electronic health record.

Mr. Schwab, in your testimony, you mentioned that caregivers are hidden heroes. And we know that they are heroes, but I will tell you they ought not to be hidden, certainly when it comes to having access to that veteran's medical records. Because this is one of the issues that we have in having that precise, timely coverage. So let's work together and be sure that they are not going to be hidden heroes.

Let me ask you a question, Mr. Schwab. In Tennessee, with our caregiver program, what we see is we have many that are there because of PTSD and traumatic brain injury, and really what we term invisible wounds. And let's talk about the activities of daily living criteria that have been set by the VA, and talk to me about how that could negatively impact veterans' eligibility for the caregiver program.

Mr. SCHWAB. Thank you for the question, Senator Blackburn, and thank you for the work. Your recent legislative call for consistency, access to health records is vital.

I will echo something I said in my testimony and that we responded with in our answer earlier. The definitions that have been established around ADLs with respect to mental and emotional

wounds, for caregivers care of those conditions across veterans, it is causing inconsistency around eligibility. I am going to ask my colleague, Molly, to expand on this point, for your purposes as well. But standardization of those conditions is really, really important. We are going to continue to see people being booted in and out of the program, as you have been seeing in Tennessee.

So, Molly, do you want to add a little bit to that?

Ms. RAMSEY. Yes, absolutely. Thank you so much, Senator Blackburn, for that wonderful question.

With the requirement of assistance with activities of daily living, each time at least one activity of daily living is performed, that definitely focuses more on the physical needs of the veteran. However, the VA has worded "as well as safety and supervision on a daily basis."

We know caregivers and veterans, and I even know one with my father, who that assistance each time, daily basis, you could go a couple of days of having great days where your veteran is able to remember to not touch a warm mug of coffee after being put into the microwave. They are able to do that some days, but maybe not on a Wednesday, just because that is how TBIs and PTSD can work. And also there are instances where someone may be able to transfer themselves from their wheelchair to, say, to use the rest room, or to the chair, or to their bed. But there may be some times where they are not able to do that.

Each time we understand can and will be limited, and I think it would be great if the VA could help clarify, especially to the caregivers, because to them that seems a little bit of a gray area, especially with the fluctuation of needs of assistance that they deal with every day. And then especially for the PTSD and TBI, other neurological and emotional caregivers, monitoring triggers every single day is something that many of our caregivers do. And it is not the safety and supervision necessarily, but it is just making sure that they are able to function, be able to be home for families, be able to be parents or grandparents, or just be able to be a spouse or a friend.

So those are the things that we are hearing from caregivers within our network. And again, we look forward to working with your office. We wholeheartedly support the legislation with you your members.

Senator BLACKBURN. Well, thank you. And I think you can see Senator Murray has questioned the issue too, with her questions, that lack of standardization and the lack of the caregiver to understand why there are these ambiguous reasons of them discharges. A veteran can be rated 100 percent disabled and then still be moved out of the caregiver program, and it is just—it is very frustrating. And it is going to be important that we get these straightened out.

I know there are others to ask questions. Ms. Beller, first of all, thank you for your husband's service and for your dedication and service to our country. I appreciate how you talked through the daily routine as you gave your testimony.

What I would like to hear from you, very quickly, is talk to me about what has changed for you since you became a caregiver, appropriately recognized, and then talk about the uncertainties that

exist with the program and your fear or concerns with the program. And you have got about a minute.

Ms. BELLER. Okay. For me, my life has drastically changed. I left my career, and that changed a whole lot of just the way our life operated. But Chuck's care required that.

In my situation, in attempting to enter the program, I have applied, I have been interviews. Chuck's situation is such that he is almost exclusively all the ADLs, and he needs a lot of care. We are a very obvious situation. What is so concerning is the people that, as you mentioned correctly, that have the invisible wounds, that are literally, their protection of their veteran and maintaining trigger levels and keeping things calm, are keeping that veteran alive, in preventing the spirals that can lead to suicide, and keeping that veteran safe.

What I am hearing on social media networks is exactly what you said, that people are being dropped, they are not communicating. It is as if their work is not valued, and that is very concerning because their value is as great as what I do for my husband, if not greater.

Senator BLACKBURN. Thank you. Thank you, Mr. Chairman.

Mr. SCHWAB. Senator Blackburn, if I could just add one point, because you brought up a very important notion in your earlier comment. A really large program that we are advocating for across the VA is called the Campaign for Inclusive Care. And one of the very fundamental issues that caregivers like Jennie face is an inconsistent set of protocols that clinicians use to interact with caregivers.

Molly mentioned when a veteran goes through a disability rating interview, that veteran may be having a particularly good day on that interview. The caregiver is not always let in the room when those questions are being rendered, when those answers are dependent upon the level of benefits that they are going to receive.

Our campaign and our protocols call for caregivers always being included in the room. That means that when a husband or a wife feels like they are having a good day, their spouse is by their side to say, "But you know what, Jimmy?" or "You know what, Susie, you've been having a couple of bad weeks before we walked in today, and last week you had one of your mental or emotional episodes, that it is really important for the VA to be aware of."

So that is why your bill, and legislation like the legislation you have put forward, is so important, to create fundamental levels of consistencies in the ways that the VA is interacting with veterans and their caregivers, and we really appreciate your continued leadership on this issue.

Senator BLACKBURN. Thank you. I appreciate that, and my apologies for my time running over. Thank you, Mr. Chairman.

Chairman Moran [Presiding.] Senator Blackburn, thank you, and the bill that you were discussing cleared on the hotline just yesterday or today. So progress in that regard as well.

I think Senator Brown is next, and then that may be, other than my ability to wrap up, the concluding questioning.

Senator Brown?

SENATOR SHERROD BROWN

Senator BROWN. Thank you, Senator Moran, Chairman Moran, and Ranking Member Tester. I appreciate you calling this hearing. I have some important questions I would like to ask the Department. It is too bad they declined to attend. It seems to have been too much par for the course.

Mr. Schwab, I appreciate what you just said in response to Senator Blackburn about caregivers being in the room. I had not really thought that through the way you said it, and that is kind of the point of hearings, to learn from witnesses. Thanks.

My first questions are for Mr. Schwab and Mrs. Beller. Thank you. Thanks for your testimony. Expanding the caregiver support program has been a Committee priority since, really for a decade. During roundtable discussions and meetings throughout Ohio, I do a number of roundtables with veterans. My staff does even more than I do, where they just sit around the table and listen to veterans who need this critical support. And wives and children caring for aging family members know that this kind of help is immensely helpful to them.

The program is already a year behind schedule, as we know. Veterans who served after 1975, or before 9/11, will have to wait another 2 years. This should not be the case. The VA should be here to answer our questions about the delays in implementation.

So a question for each of you, Mr. Schwab and Ms. Beller. In your testimony, Mr. Schwab, you discussed the need for greater communication between the VA and veterans community it serves. My understanding is VA ignored input from that community before finalizing the new rule to expand the caregiver program. In addition to the ADL threshold, what is the one thing that you wish VA had included in the final rule, Mr. Schwab?

Mr. SCHWAB. Senator Brown, that is a great question, and thank you for it, and thank you for the work that you have been doing across your State to listen to veterans and their caregivers. It is really appreciated.

I would suggest that evaluation and consistency around evaluating eligibility is probably our No. 1 concern, and an ongoing concern with the implementation of the MISSION Act. As I addressed in my testimony, Senator—and we would love your support on this—my boss, Senator Elizabeth Dole, your former colleague, former member of the Senate, has put forward a recommendation in her work chairing, in August, a group of leaders at the VA to introduce legislation to speed up this expansion. The MISSION Act called for a phased expansion of caregiver benefits, and as you rightly noted, that expansion is way behind, which means there are a lot of veterans being left out right now.

We would love a legislative solution to knock out that phased eligibility and just include everybody in the expansion in the next phase.

Senator BROWN. Thank you, Mr. Schwab. Ms. Beller, I just really want to make a comment to you. First, thank you for your years of service to our country and to Chuck. You have waited far too long, as others have said, for the conditional assistance and support. I appreciate your testimony where you outlined the stress that caregivers and veterans go through during the application

process. Mr. Schwab's insight into that also, the additional meetings and interviews, when the medical records illustrates the support needed. So thank you for your speaking out and the courage you have shown and the service you have given, and we appreciate the testimony of all four of you. Thanks so much.

Thank you, Mr. Chairman.

Chairman MORAN. Senator Brown, thank you. There are no other Senators?

I have a few questions for our witnesses. Let me start with caregivers. Mr. Schwab, I have seen the RAND report that was commissioned by the Elizabeth Dole Foundation, supporting research studies in regard to caregiver mental health concerns. It was published back in 2014. I also know that this topic was discussed during the fifth annual national convention that you held last week—maybe this week, earlier this week.

And I am just asking for a direction. What is it that you would ask of this Committee in regard to the mental health and wellbeing of caregivers? What more needs to be done? Is it just related to implementation of the act, or is there something that is missing? And I would highlight that this Committee has indicated, and I think is attempting to fulfill, our stated priority of mental health and suicide prevention for veterans. And your testimony, your presence today is a reminder, to me, at least, that we need to make certain that when we talk about mental health, suicide prevention, certainly for veterans, we also ought to include in our thought process, and policy deliberations, the caregivers that are helpful to them.

What would you like for me to know?

Mr. SCHWAB. Mr. Chairman, thank you for that question. I would say three things in response. First, I would ask the Committee again to consider legislative removal of the phased expansion of the MISSION Act so that all caregivers, all pre-9/11 caregivers receive their benefits right away.

Around your question on mental health, as you noted we commissioned and published a study in 2014, that is almost six, 7 years old by now, but the data still rings true. One of the things the study called for was more robust longitudinal studies, research, and data, on the situation facing caregivers. We do not have a great deal of data. In fact, we have really zero longitudinal data on the effects of caregiving on military caregivers, the spouses, families, friends, siblings, and other loved ones, who are providing this free, at-home care. It is a new civic, and patriotic responsibility that will be here forever. And we need to invest, this Committee needs to invest, the VA and DoD need to invest in understanding the implications of that care and service on those loved ones.

Mr. Chairman, something you said that I want to put an exclamation point on around suicide, is that caregivers are the last line of defense in preventing veteran suicide. We believe, at the Elizabeth Dole Foundation, that enough is not being done to understand the unique roles that caregivers can play in prevention. And so we would welcome wider dialog, perhaps a roundtable with this Committee, and a number of caregivers and other organizations, to talk about ways that the VA, that DoD can more directly support the mental health needs of caregivers.

One way to do that right away is to embrace and expand upon the Campaign for Inclusive Care, that I mentioned earlier, where we are working with VA to implement, now system-wide, a series of trainings and protocols that will encourage clinicians to engage with and support caregivers throughout the care process, because right now it is a very disjoined engagement. There are really no requirements for the ways that clinicians and caregivers work with those providers.

So those are the three things, Mr. Chairman, that I would suggest are really vital and important for the Committee to consider.

Chairman MORAN. I wasn't sure whose phone that was. I was going to scowl at one of my colleagues, but if it is you it is just fine. Thank you for your testimony. Thank you for your three suggestions.

Let me ask Mrs. Beller a similar question about mental health and suicide prevention in regard to caregivers. You heard what Mr. Schwab said. One of the challenges I think we face is lack of professionals, and the John Hannon Act attempts to get resources to community providers, which I think is a—to stand up new programs to help, particularly in rural or isolated places. What would you ask of me to be of help in regard to the mental health and wellbeing, suicide prevention, not only of the veteran but also of the caregiver?

Ms. BELLER. Well, I think what you said about providing more resources for mental health issues. You know, candidly, I have been to counseling a couple of times during this 10-year journey, just to build resilience and to make sure that I am capable and healthy of taking care of my veteran. And that is so critical, because there are studies or indications that the caregiver can develop secondary PTSD. That is especially in situations dealing with TBI and PTSD in the veteran.

So these issues are very real. I know of caregivers who have actually committed suicide, because it is very isolating and a very lonely occupation. But fortunately with organizations like the Elizabeth Dole Foundation, that is helping to raise awareness and alleviate some of the struggles.

Chairman MORAN. Thank you for that answer. You are a very articulate and compelling witness, and I very much appreciate your presence with us today. Thank you for doing an additional task of testifying before our Committee.

Let me return, at least briefly, to the network issues. Neither one of you indicate that you have any knowledge of whether or not the VA is going to move in the effort to modify their contract. If I misunderstood or you have additional information than what you have told me I would like to know, if you have any indication that the VA has decided not to modify their contract.

I would then add this question, perhaps this argument. The VA has testified to our Committee that they have sufficient budget resources to modify the contracts. It is not a budget issue. You both testified—I think this is a fair summary—that your networks are expanding voluntarily to meet those standards. So what could you say would be a justification for not having a uniform standard as suggested by the MISSION Act? What am I missing here? General?

General HOROHO. Senator, just to share maybe some of the conversations, I think not to speak for the VA but to share conversations from the VA.

Chairman MORAN. Okay.

General HOROHO. Is I think some of their concerns are in, when you look at the shortage of providers in some geographical areas and you look at Veterans Choice, because some veterans are willing to drive a distance to see either a particular provider or one that is part of the VA or one that is part of Community Care, that there is a perception that it would be overbuilding by some of the stringent drive times in some geographical areas. And I think that is part of their hesitancy for moving in that direction.

We have looked at it through the lens of what we spoke about, is wanting to ensure that we blanketed a geographical area as much as we can, that we have utilized utilization data to really tailor it to where we believe the veterans are living, from, you know, geo-mapping them to providers in our network. But I think that is part of the concerns that they have raised, and I cannot speak to other concerns, but I can share that one.

Chairman MORAN. Mr. McIntyre?

Mr. MCINTYRE. I believe that a retrospective look at demand prior to enabling enhanced access makes it very hard to accurately predict what people like to do with their decisions, if they are given the opportunity. And so as General Horoho said, we are developing a network that is matched to what we believe, based on our analytics and the 7-year journey with VA, what likely is going to be sufficient to make sure there is enhanced access and availability where it is needed.

You know, probably the best example of the collective success that has been birthed between Congress, the VA, and the community, rests in Harlingen, Texas, where you used to have to drive 7 hours for care, beyond what a CBOC could do, or go without. Today, four community hospitals and all the providers in that community are at the side of that CBOC. The CBOC's expanded and no one drives or goes without, and every kind of care is available in that surrounding area, and more than 400,000 appointments have been done in the valley in Texas, in that comprehensive network.

Chairman MORAN. Thank you for outlining what the goal is and indicating that it can be achieved.

You know, perhaps it appears that I am harping just on insisting that the VA comply with the MISSION Act. And yet you demonstrate—and that is not my point here. I think where the concern is that if we do not build to those standards that veterans will potentially—some veterans will become discouraged, not able to get the care they need, and we are back to—if we want to convince veterans that the MISSION Act, the successor to the Choice Act, is here to stay and it is for their benefit, then we have to build to a standard that does not discourage anyone from using Choice, using MISSION.

And the fact that the two of you, your networks have indicated you are going to build to those standards, demonstrates to me why there is value of having standards. If we did not have those words in the MISSION Act, I do not know what you would be building

to. I guess you would be building to what the VA insists that you build to, under your contract. But in my view you would be missing the opportunity to further serve veterans who live rural or have a particular reason why they need care closer to home.

So it is confusing to me, because the VA has indicated, in their testimony and in their conversations with me, they are pursuing this, but more recent stories indicate that the VA is not interested in increasing the standards within the contracts. And so while it is about the provisions of the MISSION Act being utilized by the VA, it is much more about caring for veterans and making certain that they have confidence that the MISSION Act is fulfilling the needs of those veterans when they did not see it with Choice, in some circumstances.

So I want my veterans, in Kansas, and across the country, I want veterans to know we have now got them in a position in which they can access the care that they need, and is close to home. And if we fail them one more time, in reality or in image, we are doing a disservice, one more thing to distrust, that while they say I got a benefit but I do not feel it or see it.

So there is a real consequence to us not meeting the needs of veterans now for a second iteration, maybe a third or fourth iteration of community care. So it does matter, I think, greatly, and we will continue to have this dialog.

Senator Tester has returned. I have one more question, I think, but let me turn to Senator Tester and then I will try to wrap up, as I indicated earlier. I talked too long and the Ranking Member returned in time to have more conversation.

Senator Tester, I was told when I left the Commerce Committee that you had asked every question about long-distance passenger rail service that I asked. I was seen as an annoyance because you and I had the same line of questioning. And then I heard that you were filling in here in the Committee as chairing today's hearing. That immediately caused me to lose interest in being in the Commerce Committee and rushed back just in case you were thinking this was a more long-term circumstance than I am hoping.

Senator TESTER. Mr. Chairman, I would never think that, No. 1, and No. 2, it scares the hell out of me to think that you and I are on the same page when it comes to asking questions. But I do appreciate the opportunity to ask one more question. I will try to make this as painless as possible, because I know this has been a long hearing, and I do appreciate all the witnesses for being here today.

This deals with COVID–19, and this goes to Mr. McIntyre and General Horoho. My understanding is that referrals for community care are on their way back up, and that is after a dip in months after the start of this pandemic. Could you either confirm that or is that right or wrong? Are referrals on their way back up?

Mr. MCINTYRE. I can provide you with the stats for our geographic territory in Region 4. Prior to COVID, we were receiving about 7,300 authorizations for care a day. We, just in the last week, pulled the data and we are now receiving over 7,800 authorization for care on a daily basis. There was, during the height of, I will use "Phase 1" of COVID, some tamping down on the requests, but for the most part the things that we touched, minus

about 10 percent, we were able to get rescheduled and readjusted so the veterans ultimately got their needs met for the work that we touched.

But it is starting to go up, and I think that is going to be a permanent fixture.

Senator TESTER. General?

General HOROHO. Senator, we are seeing about 72,000 referrals a week.

Senator TESTER. Okay. And so that leads me to my next question, and that is how has the pandemic affected the availability of providers in your networks to be able to see veterans? And, Mr. McIntyre, talk about it generally within your region, and if you could, talk about it specifically for Montana.

Mr. MCINTYRE. Yes, Senator Tester, great question. You know, providers have not been immune from the impact, personally or with their staffs. We saw people struggling at the start to figure out how to make sure that there was sufficient supply of services to treat COVID patients directly, and to protect their staffs they tamped down on most voluntary services.

That has now changed. Most providers now opened back up for business, and have been for months. A few providers have gone under, as is true in the rest of the economy, but we are finding, by and large, that people are wanting to see patients, that they are willing to see patients, and that includes in your great State of Montana.

Senator TESTER. Okay. General?

General HOROHO. Sir, very similar trends. One of the things that we did see during COVID was an increased use of telehealth capability. Thirty-one percent of that was for behavioral health. And then I think a little surprising, the second was for pain management, and then followed by physical therapy.

I think what we saw during COVID is the impact that it did have across the health care system, but that it caused a rapid change from face-to-face delivery of care to an accelerated use of telehealth, which we rapidly transitioned to, and I think that made a big difference. The other pieces I testified a little bit earlier to was the large kind of influx of cash, so accelerating payments that we did, to really support the financial status of those providers so they could keep their practice, because that was one of the big challenges as well.

Senator TESTER. Last question, I promise, Mr. Chairman, and we are going to stay on this, General, so I will stick with you and we will let Dave answer second on this one, and it deals with telehealth, and it deals with communities' capacity. If we have learned one thing from this pandemic it is that telehealth is critically important and that we need better broadband service, quite frankly, across this country, but particularly in a rural State like Montana and rural areas around this country.

So, General, could you speak to the Community Care's capacity to provide telehealth service and be able to avoid those face-to-face instances, which is so critically important in this pandemic, when it is not necessary for a veteran to be seen in person, and that they can do it through telehealth? Is that capacity there, generally speaking, or are you feeling some limiting forces in your networks?

General HOROHO. So, Senator, I appreciate the conversation because I think tele capability is one of the things that I would submit came out of this pandemic that has been a good thing, and it really celebrated the use of it. One of my concerns is that as we have been so reliant, as a Nation, on the authorities that HHS and Congress gave to be able to actually have transportability of licensing across State lines, waiver for interState licensing, allowing practice at the top of your license and then those authorities to be able to leverage a network, that was not bound by State lines, made such a huge difference in the ability, I think, of the health care network being able to leverage tele capabilities.

That is one of the things that, if I was asked—you did not specifically ask, but if I could put forth, I do think it is something that if we could make those authorities permanent it would make a big difference in the ability for communities to be able to provide that.

Senator TESTER. Thanks for that. I am sure the Chairman is taking notes and crafting a bill in his mind right now.

Dave, would you want to respond to telehealth and its availability and capacity with your network?

Mr. MCINTYRE. I would agree with Patty. Yes, at the same time I think it is really important for certain types of services where telehealth is leveraged, such as behavioral health, to make sure that that service and the servicing provider is as close to the veteran as possible. Because when they need to go make a physical visit, it is important that they see that person that they have been seeing on the screen. And so we have really tried to put our focus on making sure that we are enabling the existing providers in our network within their own States to have that capacity.

We all remember, or we may remember, that telehealth really was born out of Alaska and Hawaii, and your prior colleagues, Senator Inouye and Senator Stevens, had a lot to do with that, because it is how they brought access to the villages in Hawaii and to the remote islands—I mean, the villages in Alaska and the remote islands in Hawaii. And it is good to see that it is expanding, but the challenge is access to broadband. And hopefully one of the things that, as a Federal Government, is going to be a focus is accelerating the access to broadband in rural areas so that they can use telehealth as robustly as they need to across a great State like Montana.

Senator TESTER. Well, I would just close by saying I agree with both of you and I agree we do need to increase capacity across the board. And I also think that both of you and others can be a tremendous help to Congress when we are talking about allocating dollars for broadband by talking about the challenges that you are facing in the community communities, and particularly in rural areas—well, actually not just rural areas. All areas.

So thank you all for being here, and I will turn it back to you, Mr. Chairman.

Chairman MORAN. Senator Tester, thank you. Let me see if I can wrap up with just a few quick comments and a couple of questions. Senator Tester went down the path of whether or not the providers in your networks were ramping up their capabilities, not post-COVID but latter-term COVID, or I hope latter-term COVID, and I heard your answers. I would highlight for you the indication by

the VA in the beginning of COVID was that a significant number of providers within your network were no longer in business or were unwilling or uncapable of caring for patients. It was not my experience in Kansas. Providers could not understand why they were being denied referrals.

And I would just be interested in knowing if that was your experience, that you could not find providers during COVID, or the VA had made a decision to bring those appointments and referrals—I guess that is not the right word—appointments in house, which I think probably the best place we could have our veteran patients is in their community, as compared to traveling to a VA center during COVID. Was there a real circumstance in which providers said, we are not, or will not, or cannot provide service?

General HOROHO. Senator, we found that our network remained a viable network, and, you know, in the middle of this pandemic we actually went live with two other regions and met the accessibility standards in the high to low 90's. So we had providers signing up. We had them available.

We also, as an enterprise, rolled out ProtectWell, which was a mechanism to ensure, through an app, that our health care providers front-lined were checking every single day on their health, and if they had any symptoms they were not coming to work.

So we had a very healthy network, both from the clinicians being able to provide, and from the practices remaining open.

Chairman MORAN. Thank you. Anything to add?

Mr. MCINTYRE. We, much the same. And we had the unique opportunity to do appointing during that time in support of VA. While a few of the providers were limiting their capacity or were in furlough, we were able to find care for almost all of the patients that were placed in our hands for the purpose of care in the community.

Chairman MORAN. I also would highlight, perhaps for you, the interest there is, of course, veterans and their access to care at a place of their choosing, but it is also detrimental to our networks, or to you as providers, if you are not getting referrals. Just the financial strain that can come from that, we need to keep you viable yourselves.

Let me ask the General a question. It occurred to me, who came with the 180-mile, highly rural standard? Is that something that Optum created, or the Department of Veterans Affairs?

General HOROHO. Optum did not create that, and I will go back to find out exactly who.

[FOLLOW-UP: VA created the 180-minute highly rural standard; it is the requirement set forth by the BA in our VA CCN contracts.]

Chairman MORAN. Okay. Thank you very much.

In regard to Optum, which I am becoming more familiar with, I just would highlight that please continue to pursue more opportunities for specialized care, particularly chiropractic care. We need more network providers closer to home than what we have.

I also would compliment you both. I have had experience with both companies, both third-party administrators in Kansas, and you are very good about helping me and my staff in regard to what we call casework—a veteran calls, writes, a family member tells us

there is a problem, and we have been able to come to you and you have helped solve those problems.

The goal for all of us ought to be that it ought not be a burden upon the veteran to bring a problem—I hate saying this the way it may sound. We are not at all complaining about the work that veterans provide us to try to meet their needs, but we need a system that works in which it is not the responsibility of the veteran to call a Member of Congress to say, "Something is not working here. Can you help me?"

So the ultimate goal—I want to again thank you for the efforts that you have undertaken to meet the needs of veterans as we bring those needs to you, and those concerns, those complaints, those problems are what informs me and my staff to know what we are supposed to be doing in advocating not just for those veterans but for the system in which they are beneficiaries of health care.

We look forward to working with both of you, your colleagues at work, to try to make certain—and the Department of Veterans Affairs—to try to make certain that it is not an issue of who do I complain to because something is not happening as it should. It is how do we make sure the system makes certain that they are provided for to begin with.

So those are challenges that we all will face. Thanks for helping us care for individual veterans. We just continue to work to get the system to meet their needs as well.

Mr. MCINTYRE. Mr. Chairman, your focus in that space, and that of the Ranking Member, and the other members of this Committee is invaluable. And some people find that a nuisance. The reality of what is present in each of those cases allows us, if we choose in working the case, to find where the real gaps are in making this work. And if we focus on that and we adjust the processes and the tools to address those gaps, pretty soon there are not any more gaps.

Chairman MORAN. Well said, Mr. McIntyre. As you were speaking I was thinking there is not usually a veteran who has a unique issue. If a veteran has an issue with how things are working, there are others who do as well, and they may not be people who ever contract me or my staff for help. So we do not let anybody slip through the cracks. We need to fix the problem for the veteran that raises the issue, but we need to fix the problem for everybody else who may not have said anything about it.

I think I am done. I would give all of our witnesses the chance, as is my practice, to say anything that they feel like they need to correct or things they wish they were asked that they did not get a chance to comment on. Is there anything that anybody would like the Committee to know before I adjourn this hearing?

[No response.]

Chairman MORAN. Anyone online, on Zoom—WebEx, that is interested in saying anything further?

Chairman MORAN. Just a thank you to you, Mr. Chairman, and the folks who testified today. I really appreciate their input.

Chairman MORAN. Senator Tester, thank you.

Well, again, thank you for participating today. Thank you to our Committee members and their interest in this, as we try to make

certain we implement Title I of the MISSION Act appropriately. I appreciate hearing from each of you as third-party administrators. I am very pleased to hear more about caregivers, and the testimony I heard today is very useful and I appreciate the challenge that was given us, here are the things that need to be done.

I would now ask unanimous consent that members have five legislative days to revise and extend their remarks and include any extraneous material. If we submit any questions to you please answer them as quickly as possible. There are a couple of things that were said that you will get back with us with information and we welcome that and encourage that.

With that the hearing is now adjourned.

[Whereupon, at 11:46 a.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Senate Veterans' Affairs Committee Hearing
VA MISSION Act: Assessing Progress Implementing Title I

Opening Statement of Chairman Jerry Moran
Wednesday, October 21, 2020

"Good morning, everyone. The committee will come to order.

"The focus of today's hearing is the implementation of Title I under the MISSION Act by the Department of Veterans Affairs, relating to the Veterans Community Care Program and the Program of Comprehensive Assistance for Family Caregivers.

"I scheduled this hearing because of my dissatisfaction with the pace of MISSION implementation. While VA officials were invited to participate in today's hearing to discuss these critical programs they oversee, the Department chose to decline our invitation.

"This committee and the VA shared the common goal to pass the MISSION Act in 2018 to better serve veterans and their families, and we continue to work together to address important issues for our nation's veterans. I would expect them to be here for this conversation, to share all they have accomplished since the VA was transformed with this legislation and to discuss what needs to be improved. The VA is an integral part of this dialogue which is why I plan to schedule a subsequent hearing with VA officials to discuss Title I implementation.

"I would be remiss to not recognize the unprecedented challenges of this year due to the COVID-19 pandemic. The dedicated staff on the VA's frontlines deserve both our thanks and recognition for their essential role in caring for veterans and in fulfilling VA's Fourth Mission. However, at a time when accessing health care is of the utmost importance, the VA has struggled to uphold the MISSION Act's requirement of providing veterans access to community care. My staff and I continue to hear complaints from veterans and providers related to poor communication, lapses in continuity of care, and network inadequacies.

"Third Party Administrators – like TriWest and Optum here with us today – are valued and essential partners in the delivery of care to veterans through the Community Care Network. They play an important role in building a robust and resilient Community Care Network that is able to provide veterans timely access to care and make certain community providers receive prompt payment for the care and services they provide.

"When the VA released stringent access standards for community care, I was encouraged to see more veterans would finally be able to access timely, quality care closer to home. However, my staff and I have since learned that VA's contracts with Third Party Administrators use a completely different set of standards to determine how veterans access care. Under the contract terms, rural and highly rural veterans could be forced to drive up to 3 hours for care—which is completely unacceptable and contradicts the spirit of MISSION. I've discussed this inconsistency with VA officials but despite VA's assurances publicly and privately, it is uncertain whether the VA has modified the terms. We hope to learn more today.

"The Community Care Network is central to the MISSION Act's aim to transform VA health care into an innovative and responsive 21st-century health care system capable of addressing the challenges veterans face today and providing access to the care veterans deserve under this law. As such, I want to ensure that MISSION Act success and utilization of the Community Care Network is accurately accounted for because there are sufficient numbers of local providers in the network for veterans to utilize.

"Much has changed in our country since this committee held a hearing on the implementation of the Community Care Network earlier this year, but the intent and goal of the MISSION Act has not. We remain committed to making certain that veterans who qualify for care in the community are able to get that care, without unnecessary

scheduling delays, through a mature and geographically-dispersed network of community providers that upholds VA's access standards, and that those providers are paid in timely manner.

"Congress has the responsibility to oversee the VA's execution of the laws that govern the agency's responsibility to serve veterans – and we take this responsibility seriously. I believe some of the VA's most senior leaders might agree with me that while progress may be underway, it must move faster to enable the Community Care Network to serve veterans as we all envisioned. I want to know how the VA is making progress in working with their Third Party Administrators to transform the VA and offer veterans access to the health care they deserve.

"Another essential component of the MISSION Act is the expansion of eligibility for the Program of Comprehensive Assistance for Family Caregivers to all generations of veterans. Many caregivers have been providing essential services for their loved ones without this support for years, and in some cases, decades.

"As veteran caregivers are often the main caretakers for their loved ones, many can experience depression, anxiety and other mental health conditions attributed in part or solely to their experience of caregiving. The stress associated with caring for a spouse or family members with complex health care needs is a real and present concern for veteran caregivers. It is essential that in VA's support for caregivers, these mental health challenges be addressed effectively.

"MISSION outlined a two-phase process to expand these supportive resources with an anticipated start date of October 1, 2018 for Phase I. Phase I implementation only just began on October 1 of this year, two years behind schedule. This delayed rollout will result in caregivers needing to wait even longer to be part of this vital support program.

"I look forward to hearing the testimony from everyone who will be taking part in today's hearing about issues that you face in your work to help care for and serve veterans, and steps the VA can take to make certain both of these important programs are functional and able to deliver good results and outcomes for veterans and caregivers."

Statement for the Record

Senate Veterans' Affairs Committee Hearing
VA MISSION Act: Assessing Progress Implementing Title I
Senator Kyrsten Sinema

Thank you Chairman Moran and Ranking Member Tester for holding this hearing and to our witnesses for being here today; I'd like to recognize fellow Arizonan Dave McIntrye, CEO of TriWest, who made the trip to DC to appear before the committee.

Today, I sent a letter to Secretary Wilkie outlining my concerns about the rollout of the recent expansion of VA's Family Caregiver program. This expansion has the potential to assist many pre-9/11 veterans and their caregivers who have been waiting far too long for this support. Yet, on October 1st, the program went live with little notice to Congress, Veteran Service Organizations, or the very veterans and caregivers it is intended to help. Veterans were left struggling to understand whether they were eligible and how to access support.

In my letter, I ask the Secretary to reaffirm VA's commitment to customer service and take three critical steps to ensure the VA is doing everything it can to take the burden off the veteran/caregiver team. This includes launching a coordinate outreach plan with clear information as to who is eligible, proactively identifying veterans who might be eligible and reaching out to them to get them enrolled, and creating a system to assist those veterans and caregivers who are not eligible to ensure they are connected to other resources.

I appreciate the work that the Elizabeth Dole Foundation is doing to support caregivers and the critical contributions of the Elizabeth Dole Foundation fellows. My office has been fortunate to work very closely with the fellows in Arizona. I always appreciate their candor and willingness to share their experiences so that Congress can work to improve how the VA supports veterans the caregivers who support them.

Statement of
Lt. Gen. Patricia D. Horoho, USA, Retired
Chief Executive Officer, OptumServe
Hearing on
"VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

Introduction

Chairman Moran, Ranking Member Tester, and Members of the Committee, I am honored to be here today to discuss our work to implement the U.S. Department of Veterans Affairs (VA) Community Care Network (CCN) in Regions 1, 2 and 3.

On behalf of the more than 325,000 women and men of UnitedHealth Group who work every day to help people live healthier lives and to make the health system work better for everyone, thank you for the opportunity to update you on our partnership with VA, Veterans and their families, providers, Veterans Service Organizations (VSO) and Members of Congress to ensure that our Nation's Veterans have timely access to the best care available, whether inside the VA health care system or in their local communities. Together, we are committed to serve those who have served this great Nation.

After 33 years of uniformed service to our nation, for me, and for each of OptumServe's employees, delivering high-quality care to our Nation's heroes is personal. We are Veterans. In fact, my leadership team has a combined total of more than 350 years of service to our Nation. Many of us – or family members – are patients who obtain care from the VA health system. We view our work as the continuation of our service, and we continue to embody the warrior ethos of leaving no woman or man behind. We are privileged to serve our fellow Veterans as they seek care in the community.

Since I last appeared before the Committee in February 2020, OptumServe has completed our phased implementation across all three Regions and we are continuing our efforts to ensure Veterans have access to timely and high-quality care, while adapting to significant issues facing the entire U.S. health system as a result of the COVID-19 pandemic.

The pandemic has challenged all Americans, including Veterans and providers, and UnitedHealth Group is continuing to respond to support the health system during this unprecedented time. Early on, we waived cost-sharing for COVID-19 testing and treatment for our commercial plans, expanded access to telehealth and mental health services, and accelerated nearly $2 billion in direct payments to providers to support practices so that they could meet the health needs of all Americans. Through our deep technical expertise, at the direction of the U.S. Department of Health & Human Services, our enterprise was enlisted to assist in processing and distributing more than $100 billon in CARES Act support to providers, helping to provide critical stability for providers – large and small – during the pandemic.

Our response to COVID-19 also includes pioneering non-invasive, self-administered COVID-19 testing protocols that streamline testing, reduce PPE usage, increase safety of health care workers and enable the use of alternative testing swabs and viral transport media to broaden access to COVID-19 testing, providing more than $100 million in support of individuals particularly vulnerable to COVID-19 such as health care workers, those living in hot spots, and

seniors. We also donated over 6 million pounds of meals for communities suffering from food insecurity, homelessness and health disparities.

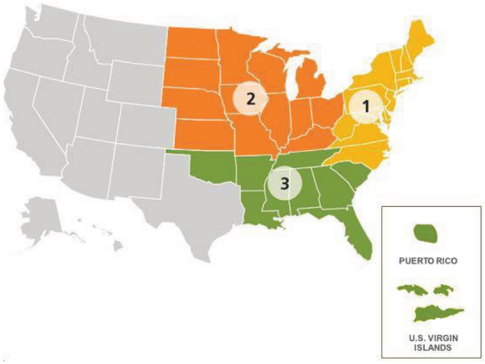
These, and many other efforts, have offered much-needed stability for providers who were able to keep their doors open and continue seeing patients, including VA Community Care Network providers. And this is just a sampling of our efforts to support members, providers, and all Americans as our nation, and the world, continues battling COVID-19. A more comprehensive summary is available on our website.[1]

Despite challenges of COVID-19, across Regions 1, 2 and 3:

- Veterans have received more than 1.6 million authorizations for care and are actively utilizing our high-quality and broad Community Care Network, which has grown by more than 495,000 unique care providers across more than one million sites of care since February;
- Providers are getting paid promptly – in 11.9 days on average – for care they deliver to Veterans; and
- We are continuously deepening the provider network by bringing on academic provider groups and institutions important to Veterans and VA with 92% of priority providers identified by local VA Medical Centers (VAMC) and 93% of academic institutions joining Optum's Community Care Network to date.

Optum's Role in the VA Community Care Network

As you know, OptumServe is privileged to serve as the third-party administrator (TPA) for the VA Community Care Network in Regions 1, 2 and 3, which includes 36 States, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico. OptumServe is now also responsible for managing the urgent care network for the same three Regions. The addition of our urgent care network was fully implemented as of September 1, 2020.



VA Community Care Network Regions Where OptumServe is the TPA

[1] https://www.unitedhealthgroup.com/newsroom/addressing-covid.html

Under these contracts, OptumServe is responsible for:

- **Community care network of providers.** OptumServe leveraged its broad network and relationships across UnitedHealth Group, and beyond, to provide a robust provider network representing the full breadth of health and wellness services f or the VA. We continue to build upon this foundation by contracting with preferred providers requested by our partners within the VA as well as qualified providers who directly inform us of their desire to serve Veterans.
    - **Across all three Regions to support each of the 109 VAMCs and their affiliated hospitals and clinics, OptumServe is managing a network of more than 830,000 providers across more than 1.6 million sites of care.**

- **Claims processing.** OptumServe is responsible for promptly processing claims from providers who care for Veterans as part of the VA Community Care Network. This function is critical to ensuring we sustain the established high-quality provider network.
    - **Through October 16, 2020, OptumServe has adjudicated more than 4.6 million claims in 11.9 days on average.**

- **Call center for VA staff and providers.** VA staff and providers can contact the OptumServe call center to get questions answered about authorizations, claims, and other issues.
    - **Through October 16, 2020, we answered 355,735 calls within our call center with an average speed to answer of 22 seconds.**

- **Online portal for providers, VA staff and Veterans.** OptumServe operates an online portal where providers, VA staff and Veterans can find additional resources including information about claims, explanation of benefits (EOBs), and referral information. Individuals can access the portal at www.vacommunitycare.com. As outlined in the table below, our portal is uniquely built to meet our users' needs:

Portal Features	Veterans	Providers	VA Staff
View Eligibility/Enrollment	✓	✓	✓
View Referrals	✓	✓	✓
View EOBs	✓		
List of in-network pharmacies	✓	✓	✓
Access provider training/resource guides, deployment schedules		✓	
Access claim information	✓	✓	✓
Submit claims		✓	
Ability to Assist Veterans			✓

- **Community Care Experience Teams.** OptumServe's Community Care Experience teams provide on-the-ground support and resources to VAMCs and staff. One team is

aligned to each region, and each team has a team leader, a nurse, a business analyst, and one Veteran Experience Officer (VEO) assigned to each Veteran Integrated Service Network (VISN) within the region. These teams allow Optum to remain well connected with local VISN and VAMC leadership, and each of the VAMC community care offices in order to better meet the needs of the VA at the local level and by extension, the Veterans they serve.

- **Managing the Urgent Care Network.** On September 1, 2020, Optum completed the implementation to provide urgent care and retail clinic options for Veterans across Regions 1, 2 and 3. To be eligible for urgent care, Veterans must be enrolled in the VA health care system and have received care through a VA provider or an in-network community provider within the past 24 months.
    - **98% percent of Veterans have access to an in-network urgent care in Region 1 within a 30-minute drive (91% for Region 2 and 95% in Region 3), exceeding the 90% target set by VA.**

Meeting and Exceeding Our Commitments: On-Time Rollout and Continuous Optimization of Operations

On June 19, 2020, OptumServe successfully completed the on-time roll-out as the TPA for Regions 1, 2 and 3. Today, we are delivering the Community Care Network – including the claims management process and prompt payments to providers for care authorizations – across all three Regions. In addition, as of September 1, 2020, OptumServe expanded this network to include an urgent care network in all three Regions. While our transition is complete and all three Regions are fully operational ensuring Veterans can access care in the community, our work does not stop.

We are a restless organization and our efforts on behalf of our Nation's Veterans are dynamic. We are continuing to adjust and strengthen our operations and refine the network by adding providers in partnership with local VA staff and providers. I would highlight progress made to date in key areas of interest to the Committee and other stakeholders:

- ***Building a High-Quality Provider Network***

Central to the Community Care Network is the establishment and operation of a robust network of quality, credentialed health care providers from which VA medical staff and Veterans can choose. Health care is local, and we continue to tailor the network to serve the Veterans and VAMCs that support them in their communities.

Our approach to building the Community Care Network is twofold: We began by leveraging the 1.3 million providers in the national UnitedHealthcare and Optum networks. And, we continue to target qualified community providers and health systems that have a history of working closely with VAMCs and Veterans, so these providers have an opportunity to continue to care for Veterans in their communities.

Our provider on-boarding process helps to ensure that VA CCN providers are both competent and qualified to provide the services within their practice specialty, which is a new requirement under the Community Care Network. For the first time, all providers in the community are now confirmed as credentialed in accordance with nationally recognized standards set forth by the National Committee for Quality Assurance (NCQA), or the appropriate accrediting body, or credentialed consistent with Federal or State regulations. We also confirm through primary-

source verification the provider's education, board certification, license, professional background, malpractice history, and other pertinent data. As a result, the quality of care our Veterans receive in the community has never been higher.

Across all three Regions, OptumServe is managing a network of more than 830,000 providers in more than 1.6 million sites of care.

We are not only meeting our contractual requirements on network adequacy, but we are exceeding them in most areas as our network continues to mature and expand. While there are many ways to evaluate network adequacy, one way is prospectively examining drive times for all eligible Veterans for health services in their area, regardless of whether all eligible Veterans will seek each type of care.

For example, 98% percent of Veterans have access to an in-network urgent care facility in Region 1 within a 30-minute drive from their home (91% for Region 2 and 95% for Region 3), exceeding the 90% target set by VA. The table below provides an overview of average drive times for health services by Region:

	Average Drive Times in Minutes (September 2020)			
	Primary Care	*Specialty Medical*	*Dental*	*Specialty Dental*
Region 1	2.5	11.3	12.0	22.9
Region 2	3.0	15.6	19.7	34.8
Region 3	3.4	20.3	16.6	30.7

An additional measure of quality within our network is the designation of top-quality providers as high performing. Once enough data are captured to measure a provider's or institution's performance against VA-designated quality metrics, and their performance meets or exceeds the performance threshold as determined by VA, they will be identified as a "high-performing provider" (HPP) or "center of excellence" (COE). Using benchmarks to independently measure performance ensures Optum is providing Veterans with a high-quality network of providers and institutions available to provide care.

The target for HPP and COE has been set by VA as 15%. I am proud to share that as of today, 54% of Optum's providers in the Community Care Network in Regions 1, 2 and 3 that have been assessed by VA meet or exceed the VA's quality and performance metrics and bear the HPP designation.

We recognize that network management is a dynamic process that evolves over time. We are committed to working with the provider community, Veterans, Congress and the VA to continuously refine the network to better meet the needs of the VA and Veterans, by leveraging utilization data, analytics, and the interest of qualified providers who have historically been involved in Veteran care.

Of note, in the last few months, new major health systems have joined the network including Emory Healthcare (Georgia), Piedmont Healthcare (North Carolina), Baptist Health (Arkansas), LCMC Health (Louisiana), LSU Healthcare Network (Louisiana), Methodist Le Boheur Healthcare (Tennessee) and Owensboro Health (Kansas), among many others.

- ***Ensuring Prompt Payments for Providers***

In order to maintain the high-quality provider network OptumServe has built, we must continue to ensure providers receive accurate, prompt payments for the health services they deliver. This is critical to the success of our network and vital to building trust between providers and our organization.

Simply put, after a provider cares for a Veteran, the provider bills OptumServe, and OptumServe pays the bill quickly and accurately.

Through October 16, 2020, OptumServe has adjudicated more than 4.6 million claims in 11.9 days on average.

As a restless organization, we continuously evaluate how we do business. We seek and receive feedback from all our stakeholders and strive to optimize our processes and communications by acting upon that feedback. And when questions do arise, as they do with any new program, we work closely with providers to quickly resolve them.

- ***Providing Timely Customer Service to Community Providers and VA Staff***

A knowledgeable and responsive customer service operation is essential when VA staff or providers have questions about the Community Care Network. Our dedicated team is available to answer questions about authorizations, claims and other topics.

Through October 16, 2020 we answered 355,735 calls within our call center with an average speed to answer of 22 seconds.

We continue to focus on providing quality customer service and first call resolution – and learn from our providers experiences to optimize our operations – for providers and VA staff who may need assistance.

<u>Adapting Veteran Care During COVID-19</u>

While the COVID-19 pandemic upended the entire health system, OptumServe has continued to serve Veterans and adapt to the changing environment. Many provider offices were forced to temporarily suspend in-person appointments for routine care, but Veterans' health needs did not stop. In fact, OptumServe continued to receive thousands of referrals for care every day during the first few months of the COVID-19 pandemic when the entire country was adjusting to the new normal.

To respond to the pandemic and the needs of Veterans, we worked with our providers to implement best practices for care consistent with VA guidance. We encouraged telehealth for care when clinically possible and ensured our providers were following the latest guidance on protecting patients and their colleagues. And when appointments were not possible, the referral eligibility period was extended by VA so Veterans could see providers as their local communities began to reopen or when the Veteran themselves felt it was safe.

Telehealth utilization also increased significantly from just 31 telehealth-associated claims received in February to nearly 12,000 claims received

Telehealth Claims

JAN 2020	16
FEB 2020	31
MAR 2020	327
APR 2020	5,303
MAY 2020	8,956
JUN 2020	11,369
JULY 2020	11,925
AUG 2020	7,944
SEP 2020	10,398

in July, of which 31% were for behavioral health services. We continue to see high levels of telehealth utilization and encourage it when clinically appropriate.[2]

Today, we are receiving approximately 72,000 referrals per week across all Regions. We are actively monitoring referral data to adapt our networks as necessary, to ensure the VA and Veterans have a robust network of high-quality community providers available to them to meet their care needs as health systems reopen.

COVID-19 also has implications for the upcoming flu season. Ensuring Veterans can easily access a flu vaccine is a high priority, especially as this benefit is a new responsibility of the VA CCN TPAs. Working with the VA and our network partners, we are managing the increased demand brought about by this change and during the ongoing COVID-19 pandemic. As a result, we went from receiving a total of 11 claims for flu vaccinations last year to more than 48,375 claims since September 1, 2020 so far.

Commitment to Continued Input, Feedback and Sharing with Key Stakeholders

Operational excellence has been foundational to our approach to the implementation of VA Community Care. Also foundational are open lines of communication with key stakeholders of Veterans' care.

To ensure the continued success of this program, we are actively engaging a diverse group of stakeholders. Our efforts include:

- Quarterly engagements with Veterans and Military Service Organizations to ensure the voice of the customer is heard and acted upon;
- Holding a quarterly provider advisory board that is used to solicit feedback to drive actionable results;
- Continuing regular touchpoints with Members of Congress and Committees, and creating a Veteran Advocate Portal so Members of Congress and staff can receive up to date information; and
- Engaging hospital associations at the state and local levels.

These touchpoints are more than an item on a checklist. Rather, they are positively impacting Veterans and those we serve in real ways. **For instance, we quickly engaged with the Louisiana Hospital Association after Hurricane Laura so that local VAMCs had up to date information on which hospitals still had power and water so that Veterans could access the care they needed during the disaster.**

Conclusion

We appreciate the opportunity to appear before the Committee today to provide an update on how OptumServe is assisting the VA with its mission to provide world-class health care to our Nation's Veterans. We understand that health care is local, and we continue to work closely with the VA, VAMCs, Veterans, VSOs and the provider community to tailor our provider network to meet the unique needs of Veterans in their communities.

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[2] The 2020 telehealth claims listed are based on the date the claim was received. Please note claims received will lag the date the care was delivered by up to 180 days, which is the allowable amount of time for providers to submit claims.

We remain committed to the success of the VA Community Care Network and OptumServe's role to deliver access to high-quality health care and a broad network of providers for our nation's Veterans. We are fully invested in this mission and have built a highly reliable organization to ensure its success. We look forward to continued collaboration with the Committee as you ensure our Nation's heroes receive the health care they have earned and richly deserve.

Thank you for the opportunity to be here today. I look forward to your questions.

STATEMENT OF
DAVID J. MCINTYRE, JR. PRESIDENT AND CEO
TRIWEST HEALTHCARE ALLIANCE
Before the
SENATE COMMITTEE ON VETERANS' AFFAIRS
OCTOBER 21, 2020

INTRODUCTION

Chairman Moran, Ranking Member Tester and Distinguished Members of the Committee, for all of us associated with TriWest Healthcare Alliance – from our company's non-profit health plan and university health care system owners to our nearly 2,200 employees, most of whom are Veterans or Veteran family members – it is an honor to appear before you to discuss our experience working in collaboration with the Department of Veterans Affairs (VA) to ensure Veterans have timely access to high quality care in the community when appropriate.

Thank you for your leadership and this Committee's bipartisan approach to enable and equip VA to honor its sacred mission and transform its services to improve care and access for Veterans today, tomorrow and well into the future under the VA MISSION Act. Through service to this great nation, America's Veterans have earned the very best care possible from a robust VA system of care and an integrated community care option when necessary. It is a privilege to be part of this critical journey.

TriWest and the VA Community Care Network

Our role at TriWest is to strengthen and support the overall VA system of care by providing VA with the elasticity it needs to ensure Veterans receive needed health care on a timely and convenient basis. It is a solemn responsibility that we have taken very seriously for the seven years we have been supporting VA's mission. We consider ourselves fortunate to be a part of a dedicated team working together in support of our nation's heroes, and trust that our work to date and in the future will honor those we are privileged to serve. Veterans are always at the center of everything we do!

Over the last several years, we have worked closely with VA under the Patient-Centered Community Care Program (PC3) and the Veterans Choice Program (Choice), as well as to implement components of the MISSION Act. And, we have just rolled out and are now refining VA's Community Care Network (CCN) in collaboration and support of VA. It has been quite a journey.

As the Committee is aware, one leg of the journey even included VA extending our initial PC3 contract in the fall of 2018 and asking us to expand our services in all 50 states, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands until CCN could be fully implemented. We agreed to do so, and ultimately provided VA with access to a consolidated nationwide network of over 710,000 community providers to serve Veterans in all 50 states and territories. That network has now delivered more than 32 million appointments in support of Veterans, providing VA with much needed elasticity.

Throughout, we have collaborated with key stakeholders –VA, the VSOs, network community providers, Congress and, most importantly, with Veterans – with the objective of refining these programs and services to better serve our nation's Veterans. Working together, VA and TriWest have jointly implemented over 100 contract modifications which have greatly enhanced the community care services available to Veterans. A recent CCN contract modification will have us supporting VA by providing appointing services to help supplement appointing services performed directly by VA. This will give VA access to the resources needed to help eliminate backlogs and provide for timely access to care when needed in the community.

We are proud to have earned the opportunity to continue providing vital support to VA in 2020 and beyond as part of VA's Community Care Network – currently in Region 4 and soon in Region 5. By working side-by-side with VA, we successfully rolled out the CCN contract platform over the summer, allowing us to serve more than 3 million Veterans and VA Medical Centers (VAMCs) in all 13 states within Region 4, all while adjusting to unique challenges presented by the novel coronavirus (COVID-19) pandemic and continuing to support some VA facilities outside of Region 4. We and VA then entered the joint refinement phase – which will run six months, through March 2021 – as we support the joint team in quickly making any needed adjustments to the integrated operating model and its tools and processes.

Recently, TriWest was honored to be awarded a contract by VA for CCN Region 5 – the great state of Alaska. TriWest has had the privilege of serving Alaska's Veterans and active duty military and their family members for nearly two decades. TriWest's existing network leverages a long-standing, established network in the state of Alaska that first served TRICARE beneficiaries for 10 years beginning in 2004, and Veterans under VA's Patient-Centered Community Care program beginning in 2014. In the next generation of VA community care in Alaska, CCN Region 5, TriWest will build upon our physical presence working collaboratively with the VA Alaska Healthcare System and its VAMCs and clinics, and engage with Alaska's Tribal Health Programs, to help facilitate a state-wide community care network in Alaska that meets the health care demand of local Veterans, and ensures the timeliness and accuracy of claims payments to providers.

Together, we have achieved many successes and have collaborated to resolve a number of challenges. And, I am confident of our collective ability to achieve success going forward… to the benefit of all stakeholders.

Timely Access to Community Care

As the Committee is aware, one of the primary goals of the MISSION Act was to help ensure Veterans receive timely access to care when such services are unavailable at a VA facility due to

capacity or capability constraints. TriWest works closely with VA to ensure community-based health care is available to Veterans when VA determines it is needed. As shared above, we are pleased to share that from the start of our work at the side of VA, to the end of September 2020, our tailored network of over 710,000 community providers has delivered more than 32 million ***total*** appointments (including initial appointment and follow-up care) in support of VA.

Ensuring VA has the elasticity it needs to deliver timely access to care for Veterans starts with developing a customized network sized in a manner that enhances VA capacity and capabilities. To develop a relevant customized network, TriWest initiated a process with VA to assess demand and determine the distribution and supply of network that would be needed in the community to support that demand. We call it the "Demand Capacity Assessment Process," which, beginning the summer of 2016, was conducted with nearly every VAMC within our service area, both under PC3 and more recently for CCN. We met one on one with each medical center to assess how many providers of each specialty would be needed in addition to the supply of providers working at the VAMC to meet the needs of Veterans in each geographic area. This included not only a projection of the demand that was already known to exist but also that which was anticipated to materialize. We then took the output of this data-driven process and started to tailor the network on a market-by-market basis to meet demand. This targeted approach has resulted in the tailored construction of a network that is optimally fashioned to support Veterans where they reside and in support of each VAMC and Community Based Outpatient Clinic (CBOC) service territory.

Appointment Scheduling

Under CCN, VA has assumed primary responsibility for scheduling Veteran appointments in the community. However, under PC3 and Choice, TriWest scheduled Veterans for care in the community across the vast majority of areas we served from the start of our work alongside VA beginning in 2013. We continue to schedule appointments under PC3 in a limited number of areas, as well as IVF care nationally, and now are assisting VA with appointment scheduling in select VA-defined areas under CCN. This assistance provides optimal flexibility to VA as it matures its tools and processes, and gets a sense of stable demand. We stand ready to support the VAMCs in Region 4, and the Veterans they are charged with supporting, as they determine what, if any, support is needed to clear any current backlogs and ensure none build in the future.

When we started this privileged work seven years ago, we used an outsourced model for much of this critical function of appointing but quickly decided to pivot and bring the work inside after we found it much more challenging than anticipated. The scheduling process is complex and is dependent on various factors and influencers – time required to reach the Veteran; Veteran appointment preferences, such as date/time/provider/distance from home or office; provider availability; and accessibility considerations such as geographic location (mountains, ferries), road conditions and weather conditions, including flooding, snow storms, and even natural disasters. Most recently, we have learned that a pandemic has a substantial impact on scheduling medical appointments.

TriWest has worked diligently to address scheduling issues and has made a number of refinements to our approach in the process – we added additional staff; worked with VA on streamlined referral and authorization processes; created operational "hubs" assigned to support

scheduling for specific geographical areas in order to obtain familiarity with local community providers; developed an entirely new Customer Relationship Management (CRM) system; and embedded TriWest staff at VAMCs to work closely with VA on the referral and scheduling process. These improvements took time and a considerable amount of resources, but ultimately paid off to the benefit of Veterans.

As a result of these changes made and the streamlining of the processes, by early 2017, we were scheduling 90 percent of all appointments within 5 business days of receiving the authorization. And, the number of days for a Veteran to be seen by the provider with which they were scheduled averaged 22 days.

We continued this strong appointing performance until our rapid expansion into the former Third Party Administrator's service areas when the sheer volume of community care authorizations across the country overwhelmed us. Once again, we focused on refining processes and deploying the additional staff needed and returned to our previous scheduling standards.

The collaboration between VA and TriWest, and the commitment of our network of community providers to service the needs of Veterans in support of VA, has delivered very solid results. One such beneficiary of our collective focus was a 86-year old Veteran suffering from insomnia issues that VA wanted to have seen by the neurology department at one of the Mayo Clinic sites in the country. TriWest was able to work with VA and Mayo leadership to help coordinate making it possible for him to be seen at the Mayo Clinic. The Veteran was approved for treatment at the Mayo Clinic earlier this year and a few weeks later he reached out to thank us for all our efforts that made it possible for him to be served at there. He stated it was "the best medical experience he had ever had in his life."

In another instance, TriWest staff regularly participates in Veterans Day parades across our region, to include building a float for the parade in Phoenix. A TriWest staff member assisting with last-minute float preparation sought assistance from a home improvement center employee on Veterans Day who turned out to be an Air Force Veteran recently diagnosed with cancer. The Veteran had been referred through TriWest to a community cancer center for treatment and noted that TriWest had been able to quickly appoint him with his first appointment happening later that day – Veterans Day. He was very thankful for the efforts to get him appointed, and he personally escorted the TriWest staffer to the checkout line, where he asked the cashier to waive the charge for the lumber being purchased as his way of thanking our staff for both his needs and for taking time on Veterans Day to honor all Veterans. That TriWest staff member has kept in touch with this Veteran over the past several months and recently shared that the Veteran has been cancer-free since his treatment last December, spending two months on the road this summer with his wife, traveling the country while remaining socially distant.

Earlier this spring, we encountered numerous unanticipated challenges as the COVID-19 pandemic spread across the country. In response to the pandemic, community providers reduced services at the same time that VA also reduced its throughput to keep Veterans and its staff safe and to respond to the needs of those dealing with the effects of COVID. While we certainly continue to deal with COVID-19 across our CCN Region 4, with certain areas more significantly affected than others, health care providers in the community, like VA, are returning to seeing

patients more broadly. However, they have generally adopted procedures in consideration of the "new normal" that, in some cases, have impacted the volume of appointments they can accommodate. For example, some providers require a COVID-19 test prior to scheduling an appointment and other offices want to talk to Veterans to ensure they want to be seen in person prior to scheduling an appointment. In addition, many community providers have quickly adjusted their practices to include telehealth services.

Community providers who are resuming operations, consistent with CDC guidelines, are again enabling us to return to normal appointment scheduling timelines. For the referrals we have received from VA since July, 90 percent of all initial primary care appointments have occurred within 24 days from receipt of the referral, 90 percent of all initial mental health care appointments have occurred within 27 days of receipt, and 90 percent of all initial specialty care appointments have occurred within 27 days from receipt.

SUCCESSES

Along our journey working in partnership with VA, we and VA, with support from this Committee, have achieved some key successes.

Urgent Care

One of the most significant new benefits for Veterans contained in the MISSION Act was the creation of an urgent care/retail clinic benefit. It allows eligible Veterans to be able to receive care at an urgent care center for non-emergency yet time-sensitive, pressing health care services if they have received care through VA or a community provider within the past 24 months. They can go when they feel it is needed, and when it works for them, including at night and on weekends.

Asked to execute the benefit nationwide following passage of the MISSION Act in 2019, we and VA felt strongly that the benefit needed to be accessible to as many Veterans as possible regardless of where they lived, provided that there was an urgent care center nearby. CVS, who we had done the pilot with in Phoenix, had generally an urban footprint. We needed Walgreens as well, but they do not serve all of the communities in which Veterans live. Many of the rural areas had sites that were stand alone and not part of a broader company.

Solving the challenge required several things. It took cataloguing all sites that existed in the country with which we might contract. We also needed the addresses of all enrolled Veterans. Lastly, our company harnessed sophisticated mapping tools to cross match the rooftops of the eligible Veterans to the parking lot of the urgent care centers within 30 minutes of their homes. In this manner, we were able to pinpoint those urgent care centers we needed under contract in order to provide a network that allowed all to have access where urgent care centers exist.

We developed a national network of over 7,200 urgent care centers and retail locations, providing access to the benefit for more than 92 percent of enrolled Veterans. This exceeds the goal in Medicare of 70 percent access. To make it all work, we then added pharmacy services for urgent medication requirements, created an online urgent care provider locator tool, developed a series of tools and education materials for urgent care providers, and partnered with

VA to perform outreach to Veterans to spread awareness of the new benefit. To ensure support for Veterans, urgent care centers and pharmacies with this newly created feature to VA, we established a support line so help could be provided at the time of the encounter… serving nearly 3,000 calls this month alone.

This benefit was not designed to detract from the VA direct care system, but to provide easy and timely access to certain services. And, with 482,000 claims now paid for services provided in our urgent care network since the rollout of the benefit, it has clearly been an invaluable enhancement to access for Veterans.

The importance of the Urgent Care benefit has been reinforced during the COVID-19 pandemic, as it has served as a critical access point for Veterans who find themselves residing in an area where both VA and community providers have limited capabilities to provide in-person care. Moreover, with the flu season upon us, Veterans enrolled in the VA health care system have been able to make a flu-shot only visit at in-network urgent care locations since October 1st – as well as at network pharmacies, at no cost to them. This critical preventive measure can help reduce flu symptoms, reduce the burden on the health care system, and save medical resources for coronavirus patients. Equally important, VA has indicated it will not count a flu-shot only visit to an in-network urgent care location against the first-three visits per year that determine copayment rates.

Flu Shot Campaign

With health experts emphasizing this year that it is more important than ever to get a flu shot, TriWest has worked closely with VA to communicate the VA flu vaccination program and to educate community providers about it. TriWest network pharmacies in CCN Region 4 have delivered nearly 40,000 flu vaccinations to date. And, our decision to include Walgreens in the Region 4 network not only provided maximal breadth of the pharmacy network, but has helped eliminate confusion for those Veterans who may have had flu shot access under the prior direct contract since Veterans who are used to going to Walgreens are not being turned away.

Behavioral Health

Ensuring our nation's Veterans have access to the full range of timely, high-quality mental health services they have earned and deserve must be our collective mission. Meeting Veterans' ever-growing demand for mental health services is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible. We should strive to not only prevent tragedy from striking, but also afford our Veterans an opportunity to live a healthy, full life.

We commend this Committee for its substantial and aggressive efforts to address behavioral health care for Veterans in a very significant way, most notably the Committee's actions to enact meaningful suicide prevention services. Late last week, the President signed the Commander John Scott Hannon Veterans Mental Health Care Improvement Act into law. This legislation is a most important step toward increasing mental health care options for Veterans – both within VA facilities and through various types of community resources. The enactment of this important new law would not have happened without the strong and tireless leadership of the Members of this Committee. And, we stand ready to support the swift and effective implementation of those

pieces that are envisioned to be folded into our work to support VA in effectively strengthening the safety net for our nation's heroes.

TriWest already has undertaken a number of steps to more effectively deliver needed behavioral health services to Veterans. We have invested in and are training our community mental health providers in evidenced-based therapies that are known to be maximally effective in meeting the needs of Veterans. Known as Operation Treat a Veteran, this collaboration between TriWest, the Department of Veterans Affairs, the Center for Deployment Psychology, and PsychArmor Institute offers evidence-based training to all community-based network providers in the areas we serve and covers two broad topics: Military Lifestyle and Culture; and Evidence-based Psychotherapy.

We also have expanded the availability of community-based tele-mental health care services for Veterans. Well before the coronavirus pandemic, TriWest designed and deployed a tele-behavioral health platform to connect community behavioral health providers with Veterans in need of counseling who desire the use of this tested modality of care delivery. The initial rollout of this initiative was in Phoenix, San Diego and Texas, and now has been expanded across the areas we serve. As we all know, telehealth services have been invaluable during the pandemic. TriWest is well prepared to support the tele-mental health needs of Veterans across CCN Region 4 and the other areas we continue to serve.

We also are one of the founding members of the "Be Connected" effort, birthed in the state of Arizona, which ties together the state with VA and social services organizations to provide a tight knit fabric to identify and serve those at risk of suicide. This successful and innovative program has impacted suicide rates positively by eliminating suicides for three years in a row in the local Arizona National Guard.

We look forward to doing more in this critical space in the years ahead, and again, we very much appreciate this Committee's leadership in confronting this critical issue.

IVF

While it is a privilege for TriWest to serve all Veterans, we take special pride in our effective efforts over the past three years to support Veterans and their spouses who qualify for VA's in-vitro fertilization (IVF) benefit. TriWest has developed a very personalized and customized approach to supporting Veteran couples authorized to receive these services. Since 2017, TriWest has coordinated IVF care for over 530 Veteran couples across the country, to include seeking their preferences in community providers and focusing our contracting efforts to meet those needs. Our dedicated IVF staffing for administrative and clinical care coordination for these couples and our close coordination with VA's centralized IVF program office (which was stood up in late 2018 and patterned off of TriWest's IVF case coordination model) have been praised by Veterans and providers.

In one instance, the TriWest IVF team was presented with an IVF authorization for a couple located in Oklahoma who due to the Veteran's service-related injuries was unable to start a family without IVF assistance. The TriWest IVF team reached out to initiate contact and to seek the couple's provider preference, as TriWest and its leadership have always believed that an

effort as personal and emotional as IVF should start by respecting the reality that most couples conduct research and meet with providers to find the IVF provider they believe can best support their specific needs. This couple had a provider of choice, which TriWest was able to contract and appoint in a timely fashion for all of the IVF-related procedures. It is now 2 ½ years later, this couple is now a family of five, with two pregnancies and deliveries (the second being twins) completed through this IVF benefit.

Another Veteran couple recently reached out to us to share their joy in their new family member, stating, "Thank you for all the support in the past couple of years to make our dream come true and (we are) definitely looking forward to work with you again when we are getting ready for a sibling for our child."

Claims Processing and Payment

At TriWest, we and our non-profit owners value the care our network of community providers delivers to Veterans. We know that paying them promptly and accurately plays a key role in their willingness to participate in the VA Community Care Network and is our obligation to those who agree to serve. To date, we have processed and paid over 35 million claims to health care providers for the care they have delivered to Veterans in support of VA and its critical mission, and have worked hard to arrive at a place where we are processing and paying their clean claims within two weeks to an accuracy rate of 98 percent. This is in half the time required. VA also has worked hard to refine its processes so that it is now reimbursing us effectively and timely for the nearly $900 million we pay providers each month.

Achieving this level of claims payment performance has not been easy; it has taken close collaboration with VA to get to where we are today. As you may know, we pay our network provider claims ***prior*** to being paid by VA. Only after we have paid a community provider for care delivered to a Veteran do we invoice VA for that care. Over the years, there have been a number of challenges with claims processing – some due to the limited amount of time VA had to stand up PC3 and Choice and some due to system issues and/or limitations – both VA's and our own. But, by working together we have been able to resolve much of that which was proving to be a challenge to the timely processing and payment of claims and in turn the timely processing and payment of invoices. We have worked hard to get here, and VA and TriWest are committed to ensuring that we sustain the record of timely claims payment to VA community health care providers.

CHALLENGES

As we moved forward with implementing CCN, we and VA have leveraged our past experience and lessons learned to refine implementation planning processes and approach. The collaborative effort included a phased structure for implementation, which provided an opportunity to review how the deployment played out and to apply lessons learned from one phase during the next phase of deployment. VA also established a virtual joint command center, which facilitated "just-in-time" resolution of implementation challenges and an approach to refinement. The feedback we received from the VA field staff regarding the structured and collaborative approach to which we held was positive.

Some implementation challenges that we have worked together aggressively to address, or are continuing to be resolved, include:

Overall Network Contracting

Unfortunately, the coronavirus pandemic hit shortly before we began implementation of CCN and substantially complicated our continued efforts to build and refine our network. Provider practices and facilities across CCN Region 4, as well as the rest of the nation, substantially reduced operations and office staff and in some cases, closed down entirely. Practices that remained open focused their efforts on taking care of patients; they also focused on pursuing outstanding claims in order to cover the cost of continued operations. This made getting providers to sign and return final agreements or to complete credentialing documents very challenging. We doubled down on our efforts to obtain necessary documentation while also trying to be mindful of the current environment in which these provider practices are operating.

While most health care practices have resumed operations in accordance with CDC guidelines, many still have not returned to previous staffing levels. As a result, we continue to encounter provider reluctance to participate in CCN because they simply do not have the staff needed for administrative requirements associated with participation.

One key challenge we hear from community providers is the statutory requirement that CCN providers file claims for services rendered to VA within 180 days. The 180-day timely-filing requirement previously created challenges under PC3, particularly since there were numerous changes with claims payers (VA, then Health Net, back to VA, then TriWest). The changes created provider confusion, resulting in claims being sent to the incorrect payer. While this issue is now being addressed collaboratively by VA and TriWest, many providers are still somewhat reluctant to commit to this standard, as they are more accustomed to the industry standard of 365 days and have their systems and processes mapped accordingly. In fact, we would recommend VA and the Committee seriously consider modifying this VA-programs unique requirement to bring it in line with other government programs such as TRICARE and Medicare. It would ease a source of great frustration for big systems and the academic medical center community.

Dental

As the Committee is aware, the MISSION Act consolidated several VA community care programs under VA's new Community Care Network. Many of the services that have been consolidated under CCN were not previously covered under the community care programs TriWest administered; these services generally were provided to Veterans through direct agreements between VA and the community providers. Dental is one such service.

As with any substantial change in how programs or services are administered, the transition of dental services to the consolidated CCN has caused some confusion with community providers, dental staff at VA facilities and ultimately Veterans. We have partnered with VA to address these challenges, working together to better educate VA staff and community dentists on the new structure, including an approach to payment rates for community providers (negotiated rates versus the VA allowable rate structure). The confusion around rate payment in particular created some hesitancy among dentists to join the network, which initially affected dental network access levels. However, after an in-depth assessment performed by our dental network partner

and TriWest, I am happy to report that we have successfully deployed a strategy for addressing dental network gaps and as of the end of August, our dental network access exceeds 90 percent.

Unskilled Home Health

Another service newly provided under CCN is unskilled home health. Much like the dental discussion above, the move from direct agreements with VA to a consolidated approach under CCN has not been without its challenges. Payment rates for unskilled home health also have created provider confusion even though the rates are set by VA.

We are aggressively working to build an unskilled home health network that is tailored to the needs of each VAMC and the Veterans who reside in its service area, with a goal of making sure that the individual providers whom Veterans have relied on to provide care are available to be used under CCN. We are not required to do so, but we believe this to be critical to care continuity for Veterans and responsive to their safety concerns during this time of COVID threat and intend to meet this critical objective.

Acupuncture

The MISSION Act requires VA to pay up to 100 percent of Medicare, when Medicare rates exist for the services covered by VA. When there is no Medicare rate, our contract instructs us to pay the VA allowable. Until recently, Medicare did not cover acupuncture services and therefore there were no Medicare rates for acupuncture. However, earlier this year, Medicare did establish a limited acupuncture benefit for specific back pain and established rates to correspond with these services. As required by the statute, VA instructed TriWest to use these newly-established Medicare rates for a defined set of acupuncture services. This change in rate structure has generated a fair amount of concern among community-based acupuncturists. Some of that concern has been elevated to the congressional level. Again, TriWest is bound by both the contract and statute to apply Medicare rates when they exist.

CONCLUSION

Chairman Moran, Ranking Member Tester, and Distinguished Members of the Committee, I salute you for placing a high priority on the critical issue of ensuring Veterans have timely access to care – both within VA facilities and when needed in the community. Our nation's Veterans are our personal heroes. They have risked their lives to protect American values and society, so when their lives are at risk here at home, it is our moral obligation and privilege to serve and protect them. They have had our back as a country, so now we have a duty to have theirs.

It is TriWest's great honor to help VA deliver on its commitment to Veterans on behalf of a grateful nation. The partnership between VA and TriWest has progressed and matured substantially over the past seven years into a dynamic relationship in which we both continue to refine and strengthen operational processes, efficiencies, and communication. The work is complex and challenging, but those of us associated with TriWest and in VA all are very focused, and I am very proud of the work we are doing together and our accomplishments thus far. Working at the side and in support of the leadership of VA and the staff at all levels has been and remains a privilege. They are a group of very dedicated citizens working tirelessly and as solid partners to execute what you have envisioned as the future of VA, embodied in the

MISSION Act. And, I am confident that the trajectory we are on will continue to improve this program in CCN Regions 4 and 5 and provide the high-quality community care Veterans have earned and deserve.

No health care system in the country has more expertise than VA in addressing the health care needs of Veterans. The work ahead should not be to reduce or replace the VA system, but to enhance it and to supplement VA by providing it the elasticity to effectively deliver on the care needs in the community, when and where needed.

After all, ensuring our nation's Veterans have access to the full range of timely, high-quality health care services they need must be our collective mission. Meeting our Veterans' ever-growing demand for care is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible that affords our Veterans an opportunity to live a healthy, full life.

Through our nearly quarter of a century operating in support of the Department of Defense and VA, we have developed crucial experience in helping these systems implement and mature their programs to provide timely and convenient access to quality health care services. We are committed to providing Congress our full support as we continue our work alongside VA, helping Veterans access high quality care in the community. For us, this is sacred work. Our mission is to find and serve those in need, ensuring they have access to the right services and health care providers while also supporting community care providers fully as they serve the needs of our nation's heroes.

Together, we can succeed, and we must succeed in this mission, because our Veterans and their families deserve no less!

Thank you.

STATEMENT OF
STEVE SCHWAB,
CHIEF EXECUTIVE OFFICER OF THE ELIZABETH DOLE FOUNDATION
BEFORE THE SENATE VETERANS' AFFAIRS COMMITTEE,
UNITED STATES SENATE ON
VA MISSION ACT: ASSESSING PROGRESS
IMPLEMENTING TITLE I

October 21, 2020

Chairman Moran, Ranking Member Tester, and Members of the Committee, the Elizabeth Dole Foundation is pleased to testify today on the expansion of the VA Program of Comprehensive Assistance for Family Caregivers. Hundreds of thousands of military caregivers are counting on us to get this expansion right, as are the generations of veterans who depend on their care.

The original legislation establishing this program unfairly drew an artificial line between the caregivers of those who served before September 11, 2001, and those who followed them. Our nation must continue to swiftly act to end this disparity in caregiver benefits.

Pre-9/11 caregivers provide a tremendous service on behalf of our nation, and it exacts an enormous toll on their lives. In 2014, the Elizabeth Dole Foundation released a landmark study by the RAND Corporation that found:

- Ten percent of pre-9/11 caregivers spend more than 40 hours per week providing care.
- A quarter have taken unpaid time off from work or temporarily stopped working because of their caregiving. More than 13 percent have dropped out of the workforce entirely.
- The most common pre-9/11 caregiver is a grown child of the veteran. Many of these caregivers fall in the "sandwich generation" who simultaneously care for their parent and children.

These hidden heroes are an unpaid workforce contributing nearly $15 billion in care every year—the vast majority of which is provided by pre-9/11 caregivers. And, experts agree that a well-supported caregiver is the most important factor to the well-being of a veteran.

Correcting the inequity of caregiver benefits was one of our Foundation's first and most urgent priorities. We applaud Congress for responding to our call, and we are grateful that Secretary Robert Wilkie and the U.S. Department of Veterans Affairs have carried out this legislation as part of the VA's continued investment in caregivers.

Unfortunately, implementation of the expansion has been marred by ambiguities and delays that have led to widespread frustration and confusion among the caregiver population.

Our chief concern is the pace of implementation. After more than a year of delays, the VA still intends to roll-out benefits in protracted phases, requiring those caring for veterans who served

after May 7, 1975 to wait two more years for eligibility. We understand the phased approach is specified by law, but these prolonged delays are further straining caregivers. The VA's *Veterans' Families, Caregivers and Survivors Federal Advisory Committee*, chaired by my boss Senator Elizabeth Dole, recently recommended that Congress provide legislative relief to expedite this timeline. Mr. Chairman, Senator Tester…Senator Dole hopes action is taken on this very important recommendation. And even more important, our pre-9/11 caregivers who are being forced to wait even longer to receive their benefits hope you take action immediately.

Our Foundation also strongly urges the VA to standardize the expansion's implementation. The largest source of caregiver anxiety and dissatisfaction with the PCAFC has always been the inconsistencies between VA centers. Among the areas open to interpretation is the requirement for annual assessments. Some medical centers choose to evaluate caregivers multiple times each year, which causes undue stress among these caregivers over the possibility that they will be dropped from the program.

Additionally, key language about how caregivers are evaluated lacks clarity. We are particularly concerned about the reliance on Activities of Daily Living as the marker for how much care a veteran requires. Mandating that caregivers assist with ADLs on a "daily basis" or "each time they are performed" will likely disqualify those caring for veterans with post-traumatic stress and traumatic brain injury. The abilities of veterans with cognitive injuries can vary over time, even hour-by-hour. We cannot leave their caregivers unsupported.

At the core of the implementation's challenges is a critical lack of communication. Caregivers have largely learned that the program was officially expanding benefits on October 1st second-hand, through social media and word of mouth. However, large percentages of the caregiver population do not use social media or participate in online communities. Furthermore, those who do participate in these communities are vulnerable to inaccurate information. The VA must invest in a proactive, comprehensive communications campaign to ensure all caregivers receive the benefits they critically need and deserve.

Finally, our Foundation calls on the VA to create a permanent head of the VA caregiver support program and classify the position as an SES. A program of such importance requires an established position of senior leadership.

While we strongly encourage the VA to respond to the recommendations we have presented today, we also praise the Department for its commitment to implementing this historic legislation. We know it is a tremendous task. The Elizabeth Dole Foundation and our coalition of partners are standing by to assist in promoting the program—if the VA should ask.

Thank you again for this opportunity to appear before you today. We look forward to continuing to work together to support our nation's veteran caregivers.

STATEMENT OF
JENNIE BELLER,
DOLE CAREGIVER FELLOW WITH THE ELIZABETH DOLE FOUNDATION
AND VETERAN CAREGIVER,
BEFORE THE
SENATE VETERANS' AFFAIRS COMMITTEE,

October 21, 2020

Chairman Moran, Ranking Member Tester, and Members of the Committee, thank you for inviting me to share my story as you assess the expansion of VA caregiver benefits under the VA MISSION Act of 2018.

I appear before you today as the caregiver of a veteran. At the same time, I am also a national advocate for military caregivers with the Elizabeth Dole Foundation, and a lawyer who served as a Deputy Attorney General for the State of Indiana.

More than 40 years ago, my husband Chuck was exposed to Agent Orange while deployed during the Vietnam War. The exposure caused diabetes, and the diabetes triggered a stroke.

For the last ten years, Chuck has required 24-hour care. The stroke caused paralysis on the right side of his body, so I assist him with his Activities of Daily Living. Every day begins with me helping him out of bed, moving him into his chair, and assisting him with showering.

Once I get Chuck dressed, I put on his battle gear, which are the braces for his shoulder, hand, and leg. Then, I prepare his breakfast, assist him with eating, and administer his insulin and other medications. At this point, the morning has only just started, but it continues like this for the rest of the day.

Our biggest challenge is Chuck's inability to communicate. His intelligence and memory are unaffected, but he can no longer read or write. He understands about 60 percent of what is said to him. When he attempts to speak, his words come out garbled. As his caregiver, it is my job to help him understand what is going on in any given situation and make him feel that he has been heard, especially during medical appointments.

For my first five years as Chuck's caregiver, I did my best to hold on to my old life. I was entering some of the most professionally fulfilling years of my career, not to mention the highest earning years as a lawyer. I leaned on the Family Medical Leave Act to help me stay employed, but even with that assistance, I barely had time to sleep and fell into destructive self-care habits. Emotionally, I was devastated by the never-ending cycle of caregiving.

Considering the sacrifices I was making as a caregiver, I could never understand why VA benefits were denied to me and the millions of other pre-9/11 caregivers, just as I do not understand, now, why we must endure continued delays and drawn-out timelines.

The VA must find ways to streamline the evaluation process. For example, the VA has a decade of medical files demonstrating that my husband needs assistance with every Activity of Daily Living and that I am his primary caregiver. Yet, to apply for benefits, a VA representative was still required to interview me and my husband—who can barely communicate—for two and a half hours. This lengthy process can add stress and anxiety to both the veteran and caregiver. I understand that the VA is trying to gather as much information about the caregiver, veteran, and their home but it is imperative that the interviews accommodate veterans who may not be communicative, like my husband, or who may not be able to sit for the full two and a half hour interview. I am happy to say that our Caregiver Support Coordinator was very accommodating of Chuck and I but can we say the same across the rest of the VA system?

If you multiply the process across the tens of thousands of applications, these efforts could add up to further delays.

The VA should also enforce consistency in the evaluation process. Caregivers sharing their application stories in online communities are revealing significant variances between VA locations, and between the application instructions and how it is put into practice. The most concerning of these inconsistencies is the overreliance on activities of daily living as a measure of required care. Caregivers assisting someone with invisible wounds are struggling to prove the value of their care, and I assure you, their care is saving their veterans' lives.

Resolving these issues is critical because caregivers are counting on these benefits. The VA's financial assistance is not insignificant to caregivers who have to choose between caring for their veteran or paying the bills. I loved my career, but I had to drop out of the workforce. I would have died if I continued working while caregiving, and Chuck would have died shortly after I was gone. However, it's not just about the financial assistance that is invaluable. If allowed into this program, I will have someone who is there to help me in my caregiver journey. These benefits are lifelines to the caregivers and without the love and care from a family member or friend, a veteran may not survive. That is how important caregivers are to their veterans, and that is why allocating these benefits as quickly as possible is so vital.

Despite the challenges I outlined today, I would like to commend both Congress and the U.S. Department of Veterans Affairs for remaining committed to correcting the inequity in VA caregiver benefits. For many years, veteran caregivers have felt voiceless. Today, we finally feel heard.

National Service & Legislative
Headquarters
807 Maine Avenue SW
Washington, DC 20024-2410
Phone: 202-554-3501
Fax: 202-554-3581

STATEMENT OF
JOY J. ILEM
DAV NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
OCTOBER 21, 2020

Chairman Moran, Ranking Member Tester and members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for today's hearing examining the Department of Veterans Affairs (VA) status and progress implementing Title I of the VA MISSION Act (Public Law 115-182) which was signed into law on June 6, 2018 and became effective one year later on June 6, 2019. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

The MISSION Act was a comprehensive, bipartisan law designed to improve veterans' access to timely and high-quality health care. The law replaced the Veterans Choice Program with a new community care program with VA as the primary provider and coordinator of health care. It also increased VA's own capacity to deliver health care; developed a long-range plan to modernize and realign VA's health care infrastructure, and expanded VA's comprehensive caregiver assistance program to veterans of all eras.

In January 2019, DAV and our *Independent Budget* (IB) partners (PVA, VFW) released the *Veterans Agenda for the 116th Congress*, which designated a single critical issue: "Fully and Faithfully Implementing the VA MISSION Act." That report included 26 recommendations to ensure that the law would be fulfilled as intended. In January 2020, the IB released a *Special Report on the Status of Implementation of the VA MISSION Act*, which assessed the progress made by VA and Congress towards fulfilling both the letter and the spirit of the law. At that time, the IB concluded that only one of 26 recommendations had been fulfilled; 11 had not been fulfilled; and the status of 14 remained to be determined because it was either too soon or there was insufficient information to properly assess.

VETERANS COMMUNITY CARE PROGRAM

Title I of the MISSION Act established the new Veterans Community Care Program (VCCP), which consolidated seven existing community care authorities, including the Veterans Choice Program. The VCCP established new eligibility criteria for

community care, including new access standards to address both wait times and distance. DAV and other stakeholders envisioned that VCCP would create new integrated veterans care networks (VCNs) comprised of VA and community health care providers in order to provide enrolled veterans with seamless access to timely and high-quality health care. Although the law took effect in June 2019, the VCCP's implementation was slowed by VA's contract negotiations with third party administrators (TPAs) and the TPAs subsequent need to select providers for its new networks and establish rudimentary procedures for billing, collecting and sharing information with VA. Shortly afterward, COVID-19 forced VA and the rest of the health care industry including its new VCCP providers to modify medical care delivery. Like other providers around the globe, VA and TPAs cancelled most non-emergency care during the height of the outbreak. It has since significantly increased telehealth capacity to replace some in-person medical care. To date, many providers are still operating in a more limited capacity than prior to the outbreak and there are many appointments that must be rescheduled. Until the pandemic has ended and normal patient care patterns have resumed, it is hard to determine exactly how well the new VCNs are providing care and meeting veterans expectations and demands.

Scheduling and Wait Times

VA is currently having difficulty scheduling community care appointments in a timely manner. Earlier this year, the VA Office of Inspector General (OIG) reported that veterans seeking care from community providers could face even longer wait times under the MISSION Act than under the prior Choice program. Again, the pandemic has confounded the ability for VA to understand the extent of this problem since VA, like many other health care providers, cancelled non-urgent appointments for several months, creating a significant backlog of scheduling requirements and unmet veteran health care needs.

Last month the Government Accountability Office (GAO) reported that VA did not have any wait-time performance measures or standards for the maximum amount of time for veterans to receive care from VCN providers. Further, GAO noted that in its 2018 report on wait times it had, "…recommended that as VA implemented the VCCP, it should establish an achievable wait-time goal for veterans to receive care. VA agreed with [the GAO] recommendation; however, the VCCP has been operational since June 2019 and this recommendation remains unimplemented," according to GAO.

To improve scheduling problems and provide veterans with a consistent referral experience, VA developed its Referral Coordination Initiative (RCI); however, VA testified in the House last month that the RCI's implementation has been delayed due to COVID-19. Based on conversations with several veterans and VA employees, there is strong anecdotal evidence to suggest that VA's current community care scheduling operations are understaffed and disorganized.

Access, Quality and Competency Standards

While VA must meet specific standards for wait times, drive times and quality metrics, private, non-VA providers in the VCNs do not have to meet the same requirements. DAV and other stakeholders are concerned that this disparity could result in veterans receiving a lower standard of care ultimately impacting health outcomes when receiving VCN care compared to care directly provided by VA.

We continue to assert that the MISSION Act was unambiguous in its requirement that both access and quality standards must be equally applied to VA and non-VA providers. Section 104 states that VA "…shall ensure health care providers specified under section 1703(c) [i.e. - VCN providers] are able to comply with the applicable access standards established by the Secretary." The law further states that VA, "…shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, **including through non-Department health care providers** [emphasis added] pursuant to section 1703 of this title." However, VA did not include such requirements when promulgating access and quality standards, instead choosing to use contracting processes to establish such standards. Further, VA stated it did not always provide equitable standards in contracts out of concern that private providers might not be willing to adhere to the same clinical standards and training requirements that VA providers must meet. We continue to find this argument specious and call for the law's clear language and intention to be followed. Veterans must be assured that VCNs are held to the same quality and access standards that VA must comply with.

In addition, Section 133 (b)(2) required all non-VA health care providers joining the VCN to meet competency standards and requirements and that they be required to complete training, "…on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise." Although training on military culture and evidence-based treatments is available to community partners, VA interpreted this provision narrowly and did not mandate the training for VCN providers. We continue to call for non-VA providers to be held to all the same standards as VA providers, including completion of training on certain conditions which are prevalent in the veteran population, including post-traumatic stress due to combat and/or military sexual trauma and traumatic brain injury.

Strategic Plan to Establish Veterans Care Networks

Section 106 of the of the MISSION Act required VA to conduct market assessments of both VA and non-VA provider health care capacity, and to use that information to design a "Strategic Plan to Meet Health Care Demand" due to Congress no later than June 6, 2019; VA is required to re-evaluate the market assessments and plan every four years. The strategic plan would determine veterans' needs and preferences for receiving health care in each distinct geographical market, assess both VA and non-VA ability to meet that demand, and develop a plan that best optimizes existing and future resources to deliver that care. Based on this plan, VA would then

determine what health care services it would provide directly and which it would purchase through the VCNs. Regrettably, VA missed this deadline and has yet to provide a timeline to meet this requirement.

In addition, Section 203 of the MISSION Act required a second set of "capacity and commercial market assessments" to inform the Asset and Infrastructure Review (AIR) process, which is just now beginning. Although the law clearly intended these to be two separate and distinct assessments, VA is conducting only one set of market assessments to satisfy both statutory requirements, which it will use to produce its national strategic plan and national realignment strategy for the AIR process. However, Congress intentionally called for two sets of market assessments in order to first guide the development of local VCNs, and then only after these VCNs had been established and provided sufficient time to stabilize would the AIR process begin with its market assessments. This two-pronged approach would more accurately capture data reflecting changes to veterans' patterns of seeking care under the new eligibility criteria once the VCNs were fully operational and after capacity enhancements in the VA MISSION Act were fully implemented.

The MISSION Act also required VA to conduct market assessments with full transparency and in consultation with VSOs and veterans who use the VA health care system. Yet, since the law was enacted in 2018 through this summer, DAV and other VSOs engaged in very little consultation with VA about the market assessments. We do want to note, however, that VA has recently begun engaging stakeholders in a much more robust and collaborative manner which we appreciate and hope will continue. We also expect VA to engage with local veterans and VSOs to ensure that veterans preferences remain paramount as VA develops its national strategic and realignment plans.

Clinical Care Coordination

One of the foundational principles underlying the MISSION Act was that VA remain the primary provider and coordinator of health care. Care coordination includes scheduling appointments, transferring medical records and ensuring proper payment to providers. VA's Referral Coordination Initiative and Health Share Referral Manager (HSRM)—a secure, web-based system to generate and submit referrals and authorizations to community providers, are both critical elements in the process.

However, the most critical factor is clinical care coordination. The VA health care system is among the world's leaders in health care coordination with its Patient-Aligned Care Teams (PACT) model, which use a team of health professionals, led by a VA clinician, working collaboratively with the veteran to meet of his or her health care needs. The PACT provides patient-driven, proactive, personalized, team-based care focused on wellness and disease prevention to improve health care outcomes and veteran satisfaction. Seamless clinical care coordination is the cornerstone of health care quality and the primary reason why health care experts regularly report that VA care is as good as or better than care provided in the private sector care.

In our opinion, the ultimate success of VA's community care programs and the MISSION Act will be how well VA maintains seamless care coordination for veterans moving back and forth between VA and non-VA providers. The challenge for VA is to replicate the PACT clinical care coordination and between VA and VCN providers.

Walk-in and Urgent Care

Section 105 of the MISSION created a new community care walk-in care benefit to address non-urgent or routine preventative care, such as flu shots. The law provided VA with a discretionary authority to charge copayments, including from service-disabled veterans after their third visit to a VCN urgent care facility in one calendar year. In all other circumstances, VA is prohibited from collecting such copayments from veterans receiving care related to a service-connected disability or from veterans with at least a 50 percent disability rating from VA, regardless of whether such care is received in a VA or VCN facility. Therefore, we continue to call on VA and Congress to remove this copayment requirement for service-disabled veterans.

CAREGIVER SUPPORT PROGRAM EXPANSION

One of the key elements of the MISSION Act was the expansion of VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) to include caregivers of veterans from all eras, expanding on the current eligibility by including those severely injured prior September 11, 2001. The law required VA to implement a new caregiver IT system by October 1, 2018 and certify that the IT system was ready to manage the expanded caregiver program no later than October 1, 2019. Upon certification, the first phase of expansion would begin for those injured on or before May 7, 1975; the second phase would begin two years later for those injured between May 8, 1975 through September 10, 2001.

Despite having 16 months from enactment of the law to the required certification date, VA failed to meet this critical deadline, which ultimately became a full year delay for the first phase of the expansion to October 1, 2020. On that date, VA announced that the new IT system, the Caregiver Records Management Application (CARMA) was certified and fully operational following final user acceptance testing, and that veterans could begin applying online or through the mail. VA also announced that hundreds of new caregiver support program staff and management, including for its Centralized Eligibility and Appeals Teams (CEATs), had been hired and trained to process new applications, conduct reassessments of existing participants and provide clinical appeals.

With implementation of phase one of the caregiver program expansion earlier this month, VA has now fulfilled three additional recommendations; however, most other recommendations pertaining to community care have not changed over the past 8 months, in part due to delays and disruptions caused by the COVID-19 pandemic.

After a decade of waiting for this program to be expanded to family caregivers of veterans from earlier eras, we are pleased that VA is finally moving ahead. We have heard from a number of our members who applied for this benefit on the first day and reported they have already been contacted by VA staff to review their applications and begin the assessment process. We would note, however, that VA had advised DAV and other VSOs that they would announce the certification date in advance in order to allow VSOs sufficient time for us to inform veterans about the application process but unfortunately there was very little advance notice. Applying promptly could be important for many veterans and caregivers since the regulations implementing the law specified that some caregiver benefits, including the stipend, could be granted retroactively back to the date of application.

Moving forward it is imperative that VA be fully transparent and forthcoming by providing timely, comprehensive information about the expansion in order to allow Congress, VSOs and other stakeholders to perform appropriate outreach to veterans and provide oversight of the process.

Enact Legislation to Complete Caregiver Phase Two Expansion in 2021

Because VA was not timely in meeting deadlines to begin the first phase of the caregiver expansion, the anticipated start date for second phase (veterans injured between 1975 and 2001) is now also delayed by a year to October 1, 2022. DAV believes that VA and Congress should move the second phase of the caregiver expansion back to the intended date of October 1, 2021. During a recent VA-VSO call on the status of the CARMA IT system, VA stated that once it was operational for phase one, CARMA would not require any additional functionality or capacity to handle the increased workload from phase two. In fact, other than hiring 700 additional personnel – which can easily be accomplished over the next year – there is no real reason for the two-year wait. Congress clearly intended the second phase to occur by October 2021 and we believe that veterans and their caregivers should not have to wait an extra year to begin receiving this critical benefit.

Eligibility Criteria Based on Inability to Perform Activities of Daily Living (ADL)

The final caregiver regulations promulgated on July 31, 2020, which took effect on October 1, made a number of positive changes to more equitably provide caregiver support to veterans and their family caregivers. In particular, DAV was very pleased that VA's new definition of "serious injury" will expand eligibility to veterans who have serious service-related disabilities from diseases, illnesses and other conditions, not just from wounds and injuries. In addition, VA will no longer require a connection between the need for personal care services and the qualifying serious injury. This change recognizes that assessing the personal care needs of veterans based solely on service-connected conditions can be extremely difficult, particularly when co-morbid conditions frequently contribute to a veteran's functional limitations.

However, there are also new eligibility requirements that we are concerned will unfairly prevent deserving veterans with great caregiver needs from entering the program. Specifically, the new regulations state that in order to determine if a veteran is in need of caregiver services, VA must determine that the veteran is unable to perform an activity of daily living (ADL), which includes dressing, bathing, grooming, adjusting prosthetics, toileting, feeding, walking and transferring. The regulation further states that "Inability to perform an activity of daily living (ADL) means a veteran or servicemember requires personal care services **each time** [emphasis added] he or she completes…" that ADL. DAV and a number of other stakeholders opposed this requirement as an unreasonable and arbitrary standard.

For example, severely disabled veterans with musculoskeletal and/or neurological conditions that limit muscle endurance may have sufficient muscle strength at certain times of the day to complete a specific ADL without assistance, but due to having to repeat the ADL throughout the course of the day would eventually require assistance. In this example the veteran would be found ineligible under the established standard. There are also situations where a veteran's condition makes it difficult to move certain muscles after periods of inactivity, including sleeping, and require assistance with transferring and ambulating, but after that assistance, they may be able to perform those same ADLs without assistance later in the day. There are also severe disabilities that relapse and remit, or wax and wane, without regularity, thereby leaving the veteran in need of personal care services. Congress must carefully monitor how consistently and accurately VA makes these determinations about requiring assistance "each time" and consider revising the law to allow eligibility for veterans who require assistance with ADLs "most of the time" or "consistently."

Caregiver Clinical Appeals' Processing, Notification and Tracking

As mentioned above, VA has established Centralized Eligibility and Appeals Teams (CEATs) in each VISN to process new applications for caregiver benefits, conduct reassessments under the new rules for existing program participants, and consider appeals of their decisions. A primary purpose of establishing the CEATs was to provide more consistent and standardized decisions for caregiver program applicants. If a veteran or caregiver does not agree with the decision of the CEAT in their VISN, they may seek a clinical appeal that should be filed through their local VA patient advocate. The clinical appeal will be considered by the CEAT located in an alternate VISN, and that VISN's Chief Medical Officer will make the decision based on the recommendations of that CEAT. If the veteran or caregiver is still not satisfied with the outcome of their first clinical appeal, they may file for a second clinical appeal, which would be reviewed by a second alternate CEAT in another VISN with the decision made by that VISN's CMO.

In order to help determine how well this new caregiver appeals process is working, VA should be required to provide monthly reports on the number of such appeals, the disposition of these appeals, and the reasons for affirming or overturning eligibility determinations. We also have concerns about the notification and tracking

processes for such appeals. VA should be required to provide a standardized notification letter with eligibility decisions. For those who are denied, the notification should offer sufficient information to empower the veteran or caregiver to determine if and how to appeal that denial. Such notification must include a clear statement of the applicable laws and regulations; the factors and evidence considered; a clear explanation of the reasons and bases for the decision; an explanation of any additional evidence required to overturn denial; and a clear explanation of the process for filing a clinical appeal of the decision. The notification should be modeled after the decision notification provided to veteran claimants under 38 USC 5104(b).

According to VA, caregiver eligibility appeals will be entered into its Patient Advocate Tracking System (PATS), along with documentation of the appeal in the veteran's electronic health record. VA must ensure that the PATS system is sufficiently robust to handle the expected workload of appeals and that it is accessible to veterans and their representatives to track their appeals. VA must also ensure it seamlessly integrates with both the CARMA system and new EHR system.

Mr. Chairman, the success of the VA MISSION Act will depend heavily on the ability of VA and Congress to ensure the law is implemented as intended by all of the stakeholders involved in the law's creation. We continue to call on VA to improve its transparency as well as expand its consultation and collaboration with VSOs. Over the past eight months, the COVID-19 pandemic has significantly impaired VA's ability to implement some elements of the MISSION Act. VA and Congress must recognize those impacts as well as the changes in health care delivery that will be needed in the future. We must all allow VA sufficient time to analyze these lessons and when appropriate incorporate them into the ongoing implementation process of the VA MISSION Act.

In closing, we thank the Committee for inviting DAV to share our views on this issue and submit testimony for today's hearing.

STATEMENT OF
Tish Hollingsworth, Vice President of
Reimbursement, The Kansas Hospital Association
Before the
SENATE COMMITTEE ON VETERANS' AFFAIRS
WITH RESPECT TO

"VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

Chairman Moran and members of the Committee, on behalf of the Kansas Hospital Association and our member hospitals, it is a pleasure to submit a statement for the record for a Senate Committee on Veterans' Affairs hearing entitled "VA MISSION Act: Assessing Progress Implementing Title I". The Kansas Hospital Association is a voluntary, non-profit organization existing to be the leading advocate and resource for members. KHA membership includes 217 member facilities, of which 122 are full-service, community hospitals. Founded in 1910, KHA's vision is Optimal Health for Kansas.

First and foremost, KHA would like to thank the Committee for their leadership in restructuring the Veteran's Administration program to link community providers with Veterans to ensure the delivery of more timely and high-quality health care in their local communities by creating the VA Community Care Network. When fully transitioned, the VA CCN will modernize the health care delivery system by allowing Veterans more choices for care while at the same time streamlining and developing updated electronic capabilities for health care providers to provide care, bill and receive payment more timely manner.

The focus around my statement will be concerning the educational opportunities and the collaboration efforts that KHA lead for our membership surrounding this transition. Understanding the complexity of this transition, KHA early on took an active role in working with Senator Moran's office, the VA, TriWest, and UnitedHealthcare/Optum to ensure our membership had the opportunity to develop the knowledge and resources needed for the magnitude of this change. While the volume of Veteran patients and the number of hospital staff resources vary widely among our members, the commitment to provide quality health care at the local level for our Veterans does not.

In April of 2019, Dr. Mark Upton, Deputy Assistant Under Secretary for Health for Community Care, Veterans Health Administration, traveled to Wichita, Kansas, to provide an overview of the transition to the VA CCN to a group of our hospital chief financial officers and patient account managers. From that point on, Dr. Upton took the time to work with KHA and groups of our members to understand

the current challenges of the VA program and to request input on what was needed to ensure a successful transition. In March of 2020, Dr. Upton worked with his staff to create an in-person event at two of our local VA Hospitals for the roll out of the VA CCN in Kansas and Missouri. That event was to provide an opportunity for our local healthcare providers to receive timely information regarding the VA CCN and included representatives from not only the VA, but also TriWest and UHC/Optum. The event had to be cancelled due to COVID-19, however, KHA worked these partners to provide a virtual update to our membership in April. At KHA's invitation, Dr. Upton arranged for staff from the VA Office of Community Care to provide a virtual meeting with the American Hospital Association's Allied Accounting and Financial Specialist Group in October, to ensure other State Hospital Associations received the necessary connections to assist their membership in the transition. Furthermore, since we first met in April of 2019, Dr. Upton has taken time to reach out to me to periodically "check in" to see if there were any concerns among our membership.

We have provided our membership with additional opportunities to develop relationships with local VA representatives, TriWest and UHC/Optum through in-person meetings as well as virtual meetings. The responsiveness and collaboration among these three agencies to develop joint educational programs for our membership to provide a better level of understanding of the current and upcoming changes regarding the VA CCN program has been commendable and well received. At any point, I know that KHA and our members have points of contact that can assist with concerns.

As with any transition of this magnitude, there have been challenges. Some of our members have reported concerns in understanding the complexity of the new referral process, with contracting and credentialing, as well with the transition from TriWest to VA CCN. Our members, many of which are very small and rural hospitals, are challenged with limited staff that also must keep up with the changes for many other payers (i.e., Medicare, Blue Cross, Workers Compensation, Medicare Advantage, etc.), which adds to the stress and time restraints needed to fully understand the changes of the VA CCN. In addition, COVID-19 has consumed many resources in all areas of our hospitals, taking priority over many other activities. However, due to the partnerships developed and the willingness on many fronts to work together to make the VA CCN successful, we are hopeful the challenges can be overcome.

There has been much progress made in the past year: electronic resources for education, treatment authorization, and billing; streamlining of processes; and on-line tools and resources to aid the Veterans and the healthcare providers. Some recent comments received from our members include:

- The Veterans need more education regarding their benefits. The Veteran is not issued an "insurance card" or other means of identity to assist them in a better understanding of which program is covering their service. Without proper and consistent education to the Veteran, the responsibility falls on the healthcare providers which places further time restraints on their ability to care for patients.
- Access to the VA Portals. There have been some recent challenges with the VA portals being down, which limits the provider's ability to check eligibility, claim status and authorization.

Our Kansas hospitals want to provide the needed medical care for our Veterans. With the transition to the VA CCN we now have the privilege to "serve" the Veterans at our local hospitals and clinics.

PO Box 66353 Washington DC 20035
Web: www.vmfp.org

STATEMENT OF

Thomas Bandzul, Esq.Legislative Counsel of
Veterans and Military Families for Progress
Jack Krueger, President
Veterans and Military Families for Progress

Before the

Senate Veterans' Affairs Committee

VA MISSION Act: Assessing Progress

Implementing Title I

October 21, 2020

Chairman Moran, Ranking Member Tester, and all the distinguished Senators of this Committee. On behalf of Veterans and Military Families for Progress and our small constituency of Veterans and their families, I wish to thank you for giving us the opportunity to submit our Comments for the Record regarding the Department of Veterans' Affairs (VA) MISSION Act (VA MISSION Act of 2018, Public Law (P.L.) 115-182) to become affective in 2019 and the ensuing problems and issues.

In the past, VMFP has been critical of the overall impact and lack of progress on the MISSION Act, the high cost of the programs and the inability of VA to properly budget, provide oversight, and actually DELIVER care to Veterans on a timely basis for either direct care, exams or any of the other medical needs of Veterans. Our members have seen little improvement since the passage of the MISSION Act and the highly rural Veterans have seen no improvement thru either VA or the Indian Health Services (IHS).

Since the passing of the MISSION Act into law in June of 2018, the VA made

several excuses as to why it wasn't ready; CHOICE was still the law, we have no money, we have no infrastructure, and the list went on to the tune of more than $93M[1] supplement that was passed to help with the implementation and cost overruns. It's almost two- and one-half years later and it still needs help and has literally unaccounted[2] billions have been spent with still nothing more to show for it than was available in certain areas for care and access than was available in 2017.

There has been a history of Veterans' complaints regarding simple access to care in recent years. "The GAO found numerous factors adversely affected veterans' timely access to care through the Choice Program."[3]. The most significant barrier was the inability to find providers willing to take such drastic cuts in per patient payments. Other factors were a combination of the overly burdensome qualification process, administrative burdens in reporting systems and insurance claiming processes along with the low number of Veterans in their community in need of their services. The more rural the community, the more difficult it is to find any kind of provider, regardless of the providers' acceptance of CHOICE or MISSION.

In our view these vast sums of money would have been better spent by VA on in-house VA care rather than outside care. The processes the VA has implemented appear to provide a significant financial windfall for private insurance. In the 2017 Survey of Veteran Enrollees' Health and Use of Health Care Data Findings Report[4], 5.5% of the Veterans surveyed said they have no plans to use Veterans Health Administration care (VHA) facilities. This potentially represents 555,000 Veterans using something else. At an estimated cost of $11.3B[5], this averages out to $20,400 per patient just to implement MISSION. We do not believe this is a wise use of the taxpayers' dollars.

The Veterans Independent Budget, Special Report on the Status of the Implementation of the MISSION Act – Critical Issues Update; June 18, 2020 cites many failures and omissions on the part of VA to provide the services promised over the several years of discussions it took to write this law. Based on their review and findings, we would suggest a very close look at how the dollars have been spent, since it appears that significant sums have been overspent in the MISSION Act to date. The Office of Inspector General (OIG), the Veterans Service Organizations (VSOs), and I sure, many Senators and Congressman and Congresswomen are wondering where and on what these sums are spent with little return for our Veterans.

VA's award of sole source, no bid contracts, their failure to implement and budget MISSION and the low level of service providers using MISSION or CHOICE would

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[1] Congressional Research Service 7-5700 www.crs.gov R45047

[2] S.2372 - VA MISSION Act of 2018 - (Sec. 512) The budgetary effects of this bill shall not be entered on statutory or Senate PAYGO scorecards

[3] GAO-19-507T: Published: April, 2019

[4] GAO Supplemental Report Potential Spending on Veterans' Health Care, 2018–2028 – Nov. 2019

[5] The Veterans Affairs Office on Pubs.

suggest the need for careful review of the ability of this organization to properly care for the new Veterans arriving from the Iraq Afghanistan and the other places in the Middle East returning from service in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) or other specific, un-named operations as part of the Gulf War(s). They are concerned with the inability of VA to either process Disability Claims on a timely and accurate basis or provide proper medical care.

It is a well-established fact that over 75% of the people who use VA as their primary source of health care are more than satisfied. VA's ability to manage and process education claims is superior to any private sector operation processing grants of scholarships. After a Veteran is allowed to have access to health care for psychological or other personal issues, they receive the absolute best care possible. Yet the major problems remaining at VA are interoperability with Department of Defense (DoD), processing a disability claim and obtaining proper local care for a Veteran in their own community. While we are aware that the first two issues, are not a topic of today's hearing, they are a factor in Veterans obtaining the care that they need.

Dr. Deming, an eminent scholar and teacher, was once quoted as saying, "It's the process; not the people" when referring to something in need of correction. It is our belief that the processes used in MISSION are critically flawed and the costs are out of control. We further believe there are not, have not been, nor will be any significant benefits accruing to our Veterans. Once again, the private sector is reaping significant profits while the government is seeing very little in return on their investment. Serious consideration should be given to alternatives as suggested by VHA several years ago as well as providing VHA with funding at a level consistent with the outstanding abilities and performance of its dedicated and professional staff.

In conclusion, VMFP like many other VSOs, has a deep concern about the processes used to provide health care outside of VA to our Veterans. It is unfortunately a problem that continues and seems to be generating problems rather than solving them. We strongly believe the VA can provide services at a much lower cost with the use of greater efficiencies in providing health care claims and adjudicating claims in general. We strongly urge that the Committees in both chambers of Congress move to expeditiously review MISSION and its problems as outlined in the Independent Budget Supplemental Report and give serious considerate to having a complete review by the OIG.

VMFP and all its members are very thankful for the opportunity to voice our concerns and be allowed to submit this statement for the record. As always, we are ready to help in any way we can for easing the needs of our Veterans.

About Veterans and Military Families for Progress

VMFP is organized in the District of Columbia as a not for profit corporation under the laws governed under the Nonprofit Corporation Act.

Our primary objective is to be an advocate on behalf of veterans, military members, and their families for progressive legislation and initiatives that reflect their experience and concerns, and which support the organization's goals. We support candidates for political office who support the organization's goals and educate veterans, military members, their families, and the public-at-large as to the rights and needs of veterans, military members and their families. We also reach out to and support veterans, military members and their families and demand the responsible use of the military in United States Foreign Policy.

VMFPs primary mission is to:

a) Advocate on behalf of veterans, military members, and their families for progressive legislation and initiatives that reflect their experience and concerns, and which support the organization's goals.

b) Support candidates for political office who support the organization's goals.

c) Educate veterans, military members, their families, and the public-at-large as to the rights and needs of veterans, military members and their families.

d) Reach out to and support veterans, military members and their families.

e) Demand the responsible use of the military in United States Foreign Policy.

f) Raise and expend funds and conduct such other activities as may be reasonable and necessary to implement other lawful projects and objectives authorized by the Board of Directors.

g) Have and exercise any and all powers and privileges now or hereafter conferred by formed under such laws.

QUESTIONS FOR THE RECORD

Submitted by Senator Cramer

"Hearing on VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

For Lt. Gen. Patricia D. Horoho, CEO, OptumServe

Question 1. **As the CEO of Optum, which is responsible for North Dakota in region 2, how has the process of recruiting healthcare providers been going these past few months? And how has COVID-19 effected the recruiting process?**

Response: Across Regions 1, 2 and 3, OptumServe has built a network of more than 830,000 providers and health systems across more than 1.6 million care sites. While we are meeting contractual obligations set forth by the VA, OptumServe has encountered some contracting delays in all three regions due to the impacts of COVID-19 on providers. In North Dakota, the pandemic impacted network growth primarily with Dental and Complementary and Integrated Health Services (CIHS) providers (e.g. acupuncture and chiropractic), largely due to office closures. While we have seen a reduction of these impacts as providers reopened their offices, we continue to monitor impacts to the network in our work with the local VA Medical Centers (VAMC) as the ongoing COVID-19 pandemic environment remains dynamic.

Question 2. **I am concerned about how our Veterans have been able to access the Community Care Network during this transition period. Are you seeing pre COVID-19 levels of participation yet? If not, what is slowing this recovery?**

Response: Yes, OptumServe is experiencing pre-COVID-19 levels of participation by Veterans in the Community Care Network (CCN). When OptumServe was initially awarded the CCN contracts in December 2018, the Department of Veterans Affairs (VA) indicated OptumServe should anticipate a 45 percent increase in referral volume in Fiscal Year 2019 compared to Fiscal Year 2018 based on a Government Accountability Office (GAO) assessment that was completed. Based on the 2018 utilization data OptumServe received from VA, OptumServe anticipated an average of 309,000 referrals per month. In the last 30 days, OptumServe has received over 336,000 referrals across all three regions. This increase in referrals represents a 58 percent increase over FY 2018 utilization and an increase of 9 percent over projected referral volume.

Question 3. **My understanding is that roughly 94% of Veterans in North Dakota that have used the Community Care Network were able to do so within the drive time limit. Is that correct?**

Response: Yes, 94 percent of North Dakota's Veterans who have received care in the community have been able to access that care within the contractual drive time limitsset for general care, primary care, general dental care and pharmacy services. Of note,

OptumServe is experiencing higher referral volumes than anticipated in North Dakota. Based on a projected increase of 45 percent (described in Question 2), OptumServe anticipated approximately 5,100 referrals but received over 6,800 referrals over the last 30 days.

Question 4. **How do the North Dakota provider and veteran participation statistics compare to the other states in region 2? How does North Dakota compare to other states in regions 1 and 3? Is there anything our national or North Dakota VA is notaccomplishing that you would like to see remedied?**

Response: While North Dakota has the fewest enrolled Veterans by state in Region 2, it has the highest volume of referrals per enrolled Veteran. There are currently over 27,900 enrolled North Dakota Veterans and since Optum deployed CCN in North Dakota on February 19, 2020, there have been more than 28,000 referrals approved by VA for care in the community. North Dakota currently has the second highest number of participating providers – over 5,700 unique providers – by state, per enrolled Veteran in Region 2.

As compared to states in all three regions, North Dakota is in the top one-third of authorized referrals, number of claims received, and number of unique providers per Veteran.

OptumServe appreciates the continued partnership with VA at all levels, including in North Dakota, to address issues that arise in all three regions. OptumServe also appreciates the continued support of your office in maintaining an open dialogue to ensure programmatic success in serving enrolled Veterans.

Question 5. **How has the communication been between your company, Optum, and the VA? I am concerned about the fact that your contract does not match what hasbeen passed in statute through the MISSION Act (understanding that these contracts were drawn and signed before the MISSION Act was put into law). Whatis your plan, and the VA's plan, to address this?**

Response: OptumServe established and maintains a collaborative relationship with VA at all levels, including during the implementation and ongoing administration of CCNin Regions 1, 2 and 3. OptumServe understands and appreciates Congress's intent to ensure Veterans have timely access to the best care available, whether inside the VA health care system or in their local communities. As noted previously, MISSION Act access standards were made effective six months after the December 2018 award to OptumServe of contracts to manage care in the community for Veterans in Regions 1, 2 and 3. While MISSION Act standards have not yet been modified into OptumServe's existing contracts, we continue to exceed our contractual commitments to build a broad network of community providers across all three regions and work towards the intent of the MISSION Act. While OptumServe's efforts on behalf of the VA and our nation's Veterans are dynamic, to date, OptumServe has created a high-quality network of

credentialed providers which includes 92 percent of VA priority providers and academic institutions, and 54 percent of providers are designated by VA as high-performing providers. OptumServe also expanded benefits enabling 91 percent of Veterans access to an in-network urgent care facility in Region 2 within a 30-minute drive from their home, and enabled 98 percent and 95 percent of Veterans access to an in-network urgent care facility within a 30-minute drive in Regions 1 and 3 respectively. In North Dakota, Veterans are experiencing an average drive time of 19 minutes for primary care, 31 minutes for specialty care and 27 minutes for dental care. OptumServe is committed to continuing to work with the VA to provide data and analysis to support their decision-making process and will continue to work with VA to modify our contractually defined adequacy standards.

Question 6. **What can we do, from the VA Committee, to support your efforts in order to best help our Veterans? Are there any gaps? And if so, how can we addressand help fill in those gaps?**

Response: OptumServe appreciates the continued partnership with VA, with your office and with the Committee to address issues that arise in the three regions in which OptumServe is privileged to serve. We look forward to continuing our regular dialogue with your office, the Committee and the VA as we work together to ensure programmatic success in serving Veterans. Although the COVID-19 pandemic presents significant challenges to our nation's health care systems, one area where your continued support would benefit all Veterans is permanently maintaining certain telehealth flexibilities beyond the Public Health Emergency declared regarding COVID-19. One of the important developments during the pandemic is how Veterans are accessing care. In fact, OptumServe experienced exponential growth in telehealth utilization this year increasing from only 16 claims received in January 2020 to over 12,000 claims received in October 2020. Veterans are receiving telehealth services across multiple clinical care specialties including behavioral health, pain management, physical therapy, cardiology imaging, and urgent and emergent care, which are currently the most highly utilized specialties. In response to the pandemic, temporary flexibilities were authorized by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid (CMS) which allowed transportability of a provider's license across states lines and expanded access to additional modalities for care delivery. Maintaining these flexibilities on a permanent basis would enable Veterans to continue to maximize telehealth services and ensure a sufficient supply of providers to meet Veterans' care needs.

QUESTIONS FOR THE RECORD

Submitted by Senator Loeffler

"Hearing on VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

For Lt. Gen. Patricia D. Horoho, CEO of OptumServe:

First, I want to thank the Trump Administration for its commitment to serving the men and women who have served and sacrificed for our country. Under its leadership, the Department of Veterans Affairs (VA) has taken considerable steps to improve the way in which veterans receive the care they need and benefits they deserve.

I also want to echo the Chairman in commending the front line staff at the Veterans Health Administration (VHA) for all they have done to serve our nation's veterans and their communities during the pandemic.

Question 1. **Leading up to the rollout of the new community care network(CCN) inRegion 3, my office heard from providers who were concerned about the delay in claims processing they experienced under the Veterans Choice Program. Reports suggest that this delay caused some community providers to delay or reconsider enrolling in the new network.**

It is my understanding that Optum has adjudicated over 18,000 provider claimswithin an average of 11 days since the new CCN went live in Georgia.

What steps are you taking to ensure that the timely processing of claims remains thestandard across the new network?

Response: OptumServe continuously monitors claims adjudication to ensure providers receive accurate, prompt payment for care delivered, which is critical to maintaining a high-quality provider network. OptumServe examines the payment process daily to ensure continued timely payment of claims. As of November 18, 2020, claims are being adjudicated on average in 11 days after receipt, across all three regions.

OptumServe is committed to ensuring a positive provider experience by promptly adjudicating claims accurately and efficiently. As a key part of our efforts to achieve this objective, OptumServe offers webinars, in-person training courses, provider expos, and virtual town halls, which have resulted in over 370,000 providers participating in our trainings to date. OptumServe also established an online portal, www.vacommunitycare.com, to provide educational materials on enrollment, referrals, claims submission process, provider training, and resource guides. Providers may also contact OptumServe's VA CCN Customer Service Center with any additional questions.

Question 2. **As the new networks continue to roll out across the country, reports suggest that veterans are experiencing long wait times for community care referrals. Under your contract with the VA, is there a set timeframe by which a veteran must be seen after a referral has beenmade?**

Response: OptumServe's primary responsibilities are to build and manage a high-quality network of community care providers which VA can use to schedule appointments, and to pay providers promptly for the care Veterans receive from providers in the community. Referrals for care are generated by VA Medical Centers, who also coordinate the appointment directly with the Veteran and provider.
OptumServe's VA CCN contract also includes an appointment availability timeliness standard of 30 days on average which is measured from the date the provider receives the referral to the date of an appointment for care. Based on OptumServe's analysis, appointments are being completed in Georgia in 12 days on average, consistent with this standard. We monitor these data daily and will continue to ensure the provider network is prepared to meet the dynamic needs of the VA and the Veterans we collectively serve.

QUESTIONS FOR THE RECORD

Submitted by Senator Manchin

"Hearing on VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

For Optum CEO Lt. Gen Patricia Horoho

I've been hearing from Veterans across West Virginia who believe there aren't enough community providers as part of the network, and that's led to increased wait time for appointments to see specialists

Question 1. **Do you believe the community network in West Virginia is providingVeterans with as good or better care than the VA?**

Response: OptumServe is committed to providing a robust, high-quality network of community providers to serve as a direct extension of the care a Veteran receives from VA providers. Congress's efforts to strengthen and improve care for our nation's Veterans includes care in the community where providers are now required to meet heightened quality standards to ensure Veterans receive high-quality care from providers. OptumServe continues to optimize the network of available providers through a data-driven approach based on Veteran utilization and specific care needs as identified by VA. Additionally, OptumServe monitors and reviews the performance of our fully credentialed network of providers and institutions to identify those that meet or exceed performance thresholds as assessed by the VA. Individual providers and groups meeting or exceeding the performance thresholds are designated as a High Performing Provider (HPP). Similarly, institutions are designated as a Center of Excellence (COE). OptumServe is exceeding the contractual target of 15 percent of the network qualifying as an HPP in all three regions, with 54 percent of the network meeting the HPP requirements. As of November 2020, there are 1,700 individual HPPs and 700 group HPPs in the West Virginia market with COEs located in Bridgeport, Morgantown, Princeton, Ripley, Romney and Weston.

Question 2. **What is Optum doing to increase the number of community care providers available to Veterans in West Virginia, especially in areas where hospitalsare closing?**

Response: OptumServe currently has more than 10,700 medical and dental providers throughout the state of West Virginia. On average, West Virginia's Veterans are currently accessing primary care within a 19-minute drive from their homes and specialty-care within a 24-minute drive. Utilizing a data-driven approach, OptumServe proactively works to pursue and identify additional providers that can improve access to care for Veterans. In scenarios where there are hospital closures,

OptumServe will assess the provider network represented by a closing hospital and determine whether there is an adequate network of existing providers currently participating. If a need is identified from this analysis, OptumServe would leverage commercial relationships and initiate contracting efforts to ensure Veterans have continued access to specific types of providers.

Question 3. **How is Optum communicating gaps in the network to the VA?**

Response: In addition to daily interactions between OptumServe and VA at the local level, OptumServe holds monthly network adequacy meetings with each VA Medical Center (VAMC). These meetings focus on anticipated changes in Veteran demand for care as well as VA capacity to provide care and network utilization reviews. The monthly meetings also allow for coordination of provider recruitment needs throughout the catchment. OptumServe utilizes internal reporting, VAMC demand utilization data and direct feedback to ensure that we are proactively meeting the care needs of our nation's Veterans throughout the 36 states, Washington, D.C., and two territories we are privileged to serve, including West Virginia. OptumServe is committed to maintaining and refining a robust network of community providers in West Virginia where Veterans are currently receiving primary care within an average drive time of 19 minutes, specialty care within 23 minutes and dental care within 23 minutes.

My case team has been working with Veterans who are experiencing billing issues.

Question 4. **Are local hospitals that are authorized under the Community Care Program notified that, when dealing with Veterans, billing should be sent to Optumfirst? In some cases, the bills were sent to Medicare first, which complicates the billing process and worried Veterans that they would have to pay a portion of the bill.**

Response: OptumServe is committed to provider education and ensuring timely and efficient billing processes to facilitate a positive Veteran and provider experience. OptumServe offers webinars, in-person training courses, provider expos, and virtual town halls, which have resulted in over 370,000 providers participating in our trainings to date. OptumServe also established an online portal, www.vacommunitycare.com, to provide educational materials on enrollment, referrals, claims submission process, provider training, and resource guides. If a provider experiences a billing issue, OptumServe provides educational trainings which encourage providers to review each Veteran's VA approved referral to identify where to submit a claim (e.g. Optum, VA). This approach is also described in the Provider Manual which is provided to each contracted provider and is also accessible through the online link above (click "I am a Provider">"Training & Guides" > VA CCN Provider Manual"). Providers may also contact OptumServe's VA CCN Customer Service Center with any additional questions.

For The Elizabeth Dole Foundation

The number of Veterans enrolled in the Caregiver program is expected to double with the recent expansion.

Question 1: **Do you have any sense how the VA is handling the number of applications and avoiding any sort of typical VA backlog?**

Response: In conversations we have had with the VA Caregiver Support Office, they have cited receiving more than ten thousand applications since October 1, 2020. To handle this influx of applications, the VA continues to assurethe VSO community that they have hired additional staff to ensure they can keep up with demand. Anecdotally, we have heard from our caregiver community that VA social workers and nurses have been approved to work after business hours to ensure necessary evaluations are completed in a timely manner. With the increased staffing and allowing for additional hours, we feel that VA is making the appropriate steps to avoid any sort of backlog or delay in communication. These efforts should continue in the immediate short term to ensure applicants are assessed in a timely manner.

Question 2. **Building off of my last question, the Phase 1 expansion of the Program of Comprehensive Assistance for Family Caregivers to include Veterans injured on or before May 7, 1975 was delayed by a year due to technical difficulties. This has subsequently pushed back Phase 2 expansion,which includes Veterans injured between May 7, 1975 and September 11, 2001. Do you think that the VA would be able to handle honoring the timeline before delays and begin Phase 2 in October 2021?**

Response: Under the new rule, VA has stated that Phase 2 expansion will not happen until October 2022. However, given the urgent needs of Phase 2 era Veterans, we have asked the VA to expedite this timeline and open the program toPhase 2 veterans and caregivers by October 2021. Given VA's assurances about recently hired staff to support expansion, as well as their commitment to continuehiring efforts, we believe that an expedited Phase 2 implementation is feasible.
Phase 2 Veterans and their caregivers have waited long enough to access these much-needed services; they should not have to experience any more delays if theIT system is up and running.

Question 3. **Some Veteran-specific issues like PTSD, brain trauma, and mental health are sometimes difficult to identify and quantify. Are you concerned that Veterans with these conditions could slip through the cracks**

with the VA's 70% or higher disability rate requirement for the Caregiver program?

Response: Neurological, emotional, and mental wounds or illnesses are extremely difficult to diagnose and require a great deal of support from caregivers who are on the front lines of caring for these Veterans. We join our caregiver community in expressing concerns regarding the 70% eligibility requirement. We are specifically concerned about evaluations for veterans that may meet the 70% disability requirement, but do not require physical assistance with Activities of Daily Living (ADL). Veterans with PTSD, neurological, emotional, or mental wounds or illnesses may need varying levels of physical assistance. While their caregivers may not provide physical assistance every timean ADL is completed, they often need to be available to assist the veteran in certain instances. How these mental and emotional challenges manifest with physical needs is not always clear. We are concerned that the interpretation of the physical assistance requirements may result in caregivers who care for Veterans with PTSD and other neurological or emotional wounds of war being denied or dropped from the program.

QUESTIONS FOR THE RECORD

Submitted by Senator Murray

"Hearing on VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

For TriWest Health Alliance CEO Dave McIntyre:

Community Care

According to data provided by VA, it takes a long time to get an appointment scheduled. For example, it takes 53 days from when a referral is made through Puget Sound to when care is delivered, which is well above the national average. Veterans in Washington state are not able to access care in a timely manner.

Question 1. **Have there been any specific changes or burdens on availability of care through the network, including from COVID-19, that are causing these longer wait times?**

Response: Earlier this spring, we encountered unanticipated challenges as the COVID-19 pandemic spread across the country. In response to the pandemic, some community providers reduced services at the same time that VA also reduced its throughput to keep Veterans and its staff safe and to respond to the needs of those dealing with the effects of COVID. That said, we remained able to find care for almost all of the Veterans VA referred to us for care in the community.

While we certainly continue to deal with COVID-19-related challenges across the Community Care Network (CCN) in Region 4 -- with certain areas more significantly affected than others -- health care providers in the community, like the Department of Veterans Affairs (VA), have largely returned to seeing patients more broadly. However, they have generally adopted procedures in consideration of the "new normal" that, in some cases, have impacted the volume of appointments they can accommodate. For example, some providers require a COVID-19 test prior to scheduling an appointment, while other offices want to talk to Veterans to ensure they want to be seen in person prior to scheduling an appointment. In addition, many community providers have quickly adjusted their practices to include telehealth services.

Community providers who are resuming operations, consistent with CDC guidelines, are again enabling us to return to normal appointment scheduling timelines. For the referrals we have received from VA since July, 90 percent of all initial primary care appointments have occurred within 24 days from receipt of the referral, 90 percent of all initial mental health care appointments have occurred within 27 days of receipt and 90 percent of all initial specialty care appointments have been completed within 27 days from receipt.

Correspondingly for Puget Sound, 90 percent of all initial primary care appointments have occurred within 27 days from receipt of the referral, 90 percent of all initial mental health care appointments have occurred within 25 days of receipt and 90 percent of all initial specialty care appointments were completed within 29 days from receipt. In addition, our

robust network of community providers has helped to ensure that less than 1 percent of all referrals in Region 4, as well as from Puget Sound, have been returned for network reasons.

Question 2. **What impact do VA's processes have on wait times for Community Care?**

Response: From the beginning of our work in support of VA in 2013, TriWest has worked diligently to focus first on understanding and then responding to specific needs at all levels – Veteran patients, Veteran Service Organizations, local VA Medical Centers (VAMCs), Veterans Integrated Service Networks (VISNs), VHA Office of Community Care (OCC) and VA Central Office. Identifying and addressing specific needs and priorities is critical to improving the overall Veteran experience. Our efforts working diligently with VA under Patient Centered Community Care (PC3) and Choice to consistently refine and streamline community care processes yielded tremendous results.

Under PC3 and Choice, TriWest scheduled Veterans for care in the community across the vast majority of areas we served. Through our close collaboration with VA at all levels, we developed a solid appreciation for the complexity of the scheduling process. Successful appointing is dependent on various factors and influencers – the amount of time required to reach the Veteran; Veteran appointment preferences, such as date/time/provider/distance from home or office; provider availability; and accessibility considerations such as geographic location (mountains, ferries), road conditions and weather conditions, including flooding, snow storms, and even natural disasters. Using the understanding we gained from these collaborative efforts, we refined approaches to patient scheduling to increase effectiveness. For example, we created operational "hubs" assigned to support scheduling for specific geographical areas in order to obtain familiarity with local community providers; embedded TriWest staff at VA Medical Centers to work closely with VA on the referral and scheduling process; and developed an entirely new Customer Relationship Management (CRM) system. These improvements took time and a considerable amount of resources, but ultimately paid off to the benefit of Veterans. As a result of these changes and the streamlining of the processes, by early 2017, we were scheduling 90 percent of all appointments within 5 business days of receiving the authorization from a Veteran's VAMC. And, the number of days for a Veteran to be seen by the community provider with which they were scheduled averaged 22 days.

Under CCN, VA has assumed primary responsibility for scheduling Veteran appointments in the community. However, we continue to schedule appointments under PC3 in a limited number of areas, as well as IVF care nationally, and now are assisting VA with appointment scheduling in select VA-defined areas under CCN. One notable scheduling process change under CCN is the use of new VA tools such as HealthShare Referral Manager (HSRM). As with any new process or system, it takes time to develop proficiency with the new approach. We have had to train our staff on the new process and have made refinements in our

approach as we have become more familiar with it. We assume VA staff also has had to make adjustments to these new tools and processes.

In addition, we have learned that a pandemic has a substantial impact on scheduling medical appointments, and we have had to make adjustments alongside VA to keep track of Veterans care referrals and authorizations. As VA begins to take on the responsibility for scheduling Veteran appointments, we stand ready to support the VAMCs in Region 4, and the Veterans they are charged with supporting, as they determine what, if any, support is needed to clear any current backlogs and ensure none build in the future.

QUESTIONS FOR THE RECORD

Submitted by Senator Sinema

"Hearing on VA MISSION Act: Assessing Progress Implementing Title I"

October 21, 2020

For Mr. Steve Schwab, CEO, The Elizabeth Dole Foundation

Question 1. **What steps has the VA taken to engage the Elizabeth Dole Foundation and other stakeholders over the last two years as they've moved toward implementing the expansion of the Family Caregiver program?**

Response: Since publishing the Interim Rule in March 2020, the VA hosted two meetings to discuss the changes and updated language. Engagement prior to the publishing of the Interim Rule in March was sporadic. By not fulling engaging us and other members of the VSO Community, the VA is severely limiting their ability to effectively communicate program changes to veteran caregiver audiences.

Question 1a. **What lessons should VA or Congress take away to ensure maximum stakeholder engagement in this and other critical programs at VA moving forward?**

Response: The VSO and veteran nonprofit communities stand ready to support the VA and Congress in disseminating information to key stakeholders in advance of program rollouts or policy changes. Unfortunately, the VA has not fully maximized this engagement to their benefit. The October 1, 2020 expansion should have been clearly communicated to the VSO community well in advance (via embargoed press release or other form of communication). With advance notice and engagement by VA, the Elizabeth Dole Foundation and others in the VSO community could have supported VA's outreach efforts and fielded inquiries in advance so caregivers and their veterans weren't caught off guard with the expansion.

Question 2. **Looking beyond the expansion of the Family Caregiver program, what opportunities exist at the VA to allow caregivers to regularly engage VA both locally and nationally to engage VA, share their experiences, and overall help improve customer service for veterans through caregiver engagement? How can VA improve these efforts?**

Response: The Elizabeth Dole Foundation launched a joint initiative with the Department of Veterans Affairs to educate providers on the important role caregivers can play when considered part of the medical team. The Campaign for Inclusive Care was launched in January and we're very excited to be taking it national after a successful pilot phase. This initiative helps give caregivers a platform to provide valuable input to the medical treatment and provide insight to their experiences with the veteran outside of the VA. By encouraging this type of

communication, caregivers will be more willing to share more of their other experiences with the VA as a whole.

The VA should also work with local VA Caregiver Support Teams at VA Medical Centers to ensure staff is regularly engaging with the caregiver community. Caregiver Support Coordinators can hold regular meetings and other events at the Medical Center to better connect with families in need. Building off the success of the Veterans Experience Office, we recommend that the VA consider Caregivers as key customers as they are a critical source of around the clock care for veterans.

Question 3. **Both you and Ms. Beller spoke about the varied experiences of caregivers at different VA medical centers with the initial roll out of the expansion of the Family Caregiver program. Can you outline more specifically how the VA shared with caregivers prior to and following the launch of the program, what information the VA shared, and how that has varied locally? What feedback mechanisms have VA offered to caregivers locally or nationally to clarify confusing, unclear, or varying information?**

Response: The VA's formal communications regarding the expansion was mostly done through the Final Rule and through official press releases that accompanied the Rule. Most often,we heard that caregivers were notified about the expansion via social media from private caregiver groups and through notifications from veteran and caregiver organizations. This underscores the need for VA to better communication with EDF and others in the VSO community so we can ensure accurate information is communicated in a timely manner.

We did hear from a limited number of caregivers who were notified by local VA Medical Center Staff, but that varied across VISNs and the VA Medical System. As a best practice, we had reports of some VA Caregiver Support Staff reaching out to local caregivers encouraging them to apply to the program given the new eligibility requirements. We applaud the staff at the various VA Medical Centers for these outreach efforts and encourage other VA Medical Centers to model communications after this best practice.

Additionally, we are encouraged by the stories we are hearing about some VA social work staff conducting the assessments and asking for regular feedback so they can improve their service delivery. This kind of communication is reflective of true partnership between the VA, nonprofit organizations, veterans, and caregivers. Open communication and being open to feedback are the bests way for this program to function and we stand ready to support any plans the Congress or the VA has in making this expansion a success.

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