S. HRG. 116–205

VA MISSION ACT: IMPLEMENTING THE VETERANS COMMUNITY CARE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

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APRIL 10, 2019

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VA MISSION ACT: IMPLEMENTING THE VETERANS COMMUNITY CARE PROGRAM

WEDNESDAY, APRIL 10, 2019

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

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Tester, Murray, Brown, Blumenthal, Manchin, and Sinema.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this hearing of the Veterans' Affairs Committee of the U.S. Senate to order. I appreciate everybody being here today. Dr. Stone, especially, thank you for being here, and your entourage that is with you.

We are glad to have our VSOs here and everyone else here to contribute to the hearing. I appreciate your being here. I want to thank the Committee Members who are here and those that are coming, which will be most of the Committee.

It is a really important hearing. We are going to be talking about the MISSION Act, going into place. The official date it goes in place is actually an interesting date. It is a historic day—June the 6th of this year. The other June the 6th, you will remember, was D-Day, so this is D-Day for the MISSION Act and D-Day for health care in the Veterans Administration, and this is a D-Day hearing, if we might have, to kick that off.

We promised a number of Democrats who came to me, asking me to have this hearing, that we would do it. A number of other Senate Members, as well, have sought it. Everybody wants us to be successful. We want the VA to put this one behind them, to fundamentally change the service they deliver for the better, reliability for the better, participation for the better. So, timely care to a veteran is the primary thing we are providing and we provide a mechanism to do that which is as efficient as possible and avoids a lot of the problems we had in the past.

I will tell you this, though. As one who was here when Bernie Sanders and John McCain were on the conference committee that produced the Choice Act, which was about 5 years ago now, they were trying to do what the MISSION Act does. The Choice Act did not work for a lot of reasons; many of them were intentional, not

by the VA necessarily, but people who did not like Choice or did not like the way we were doing everything else.

The MISSION Act is an amazing piece of legislation. It is comprehensive. It took a lot of testimony, as those of you who came to all of our meetings will tell you, but it worked, and we got the input of the veteran, we got the input of the professional, we got the input of the Veterans Administration, and we have a bill that I think has the opportunity to be mainstream and positive from here on out.

We have no option but for it to be that. I will tell you this—we cannot fail. We cannot afford to take this opportunity and miss the draw. We have got to do it. I am going to see to it that we do what our main job is on the Committee, which is oversight. We have done a lot of bill passing. We have changed regulations and we have changed laws. We have done a lot of that. Now we are going to do oversight. We want to make sure that the outcomes for the veteran are improved, including the times they get seen, the chances they get to be seen, and the choices they get of who sees them. So, I am very interested in seeing that take place.

Let me say one other thing. I am deeply troubled that we had two suicides in Georgia in the last 8 days. We had another one in Texas 2 days ago, if I am not mistaken, and there may have been others. Although that number is not an extraordinary number, vis-a-vis the number we have in total every year, which is about 22,000, but it is a lot. One life lost is too many. This Committee and the VA have been doing an admirable job, a great job, on trying to address the problem.

I am really proud of this Committee because 3 years ago, when you called some of the hotlines around the country you got a busy signal, and that is not good on a hotline, or they would say, "Please leave your voicemail and we will call you tomorrow." Well, if you are in danger for your life, if you are at risk for your life, that was not to happen.

The VA has done a marvelous job of getting its hotlines and its teleconnections as accessible to veterans as you possibly could, and most people—I am not a physician but I will tell you that everybody tells you that when it comes to the act of suicide that the quicker someone who is at risk can talk to a professional, and get to a professional, the return on them saving their life is tremendously better than if it takes a long time to do so.

So, I want for us to continue to do what we have been doing by making access to these professionals as easy as possible, using the benefits of telemedicine, using all the other benefits possible.

What the VA has done is see to it that it had the doctors available to meet that challenge. But, we are sorry for the lives that were lost. We are sorry for the lives that were taken by the person that ended up killing themselves, but we want to make sure that we do not lose focus on ending veteran suicide, which is everybody's issue. It is the Secretary's issue, everybody at VA is for it, and it is everybody's issue in the country, because suicide is a huge problem.

Those deaths did not go by without me noticing them, nor has it gone by me that we have got a job to do as long as we are here,

which is to see to it that we do the best job possible of ending that, to all purposes.

With that said I will turn it over to the Ranking Member, Senator Tester.

OPENING STATEMENT OF HON. JON TESTER, RANKING MEMBER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Chairman Isakson. I would also add to that that I believe those three suicides happened in the last week and all happened on VA property, which makes it particularly gut-wrenching, and I think we will probably get into that a little more today.

Dr. Stone, thanks for being here. I appreciate your service and I appreciate you being here. One of these years I hope to get you confirmed, which will be a good thing. I appreciate you bringing the two docs to your left and your right with you, too. I appreciate you guys' service also.

You know, this Committee worked hand-in-hand with the Administration and veteran service organizations when we developed the MISSION Act. It was the result of compromise, it was a product of years of work, and it was because of the great leadership of our chairman, Chairman Isakson, that we were able to consolidate multiple VA Community Care programs into one streamlined program that makes sense for our veterans, for our community providers, and for our taxpayers.

When the VA could not provide care in a timely manner the aim was to ensure that veterans could access quality care in their communities in a timely manner. In places like Montana, where the VA has failed to place enough emphasis on hiring physicians, the route to community care has always been critical.

But, since the MISSION Act was signed into law I have had concerned that the VA's primary focus would be in supplanting in-house care, as opposed to supplementing that care when it makes most sense for our veterans. The VA is doing so without the benefit of having completed thorough market assessments that would confirm what the community can and cannot actually offer. In our rush, in the VA's rush to open to the private sector, my concern is that the VA is outsourcing its responsibility to ensure veterans receive—and this is what is really important in this whole MISSION Act thing—that they receive timely and high-quality care.

When the VA sends veterans into the community without first knowing if that care can be provided in a timely manner it is outsourcing its responsibility, and when the VA sends veterans into community for care that would be of lower value, it is outsourcing that responsibility.

In writing, the MISSION Act intent was never to send veterans into the community for care that was less timely and of lower quality than the VA can provide. In fact, we have specifically required the VA to ensure that community providers could meet the same access standards the Department established for itself. But, now we find that the VA is establishing one set of rules for itself and no rules for the private sector. I hope we get into that a little bit in today's hearing.

And it is doing so while knowing that, on average, VA outperforms the private sector in terms of timeliness and quality, and you need to be commended for that. Not to mention that the VA is doing this without a firm grasp on how much it will cost the American taxpayers, and it comes on the heels of the VA saying it would consider the performance if its facilities were making resource allocation decisions.

So, on one hand the VA does not have a clear understanding of how much the program will cost, and on the other hand the VA openly states that it would make funding decisions based on whether its facilities are meeting the standards it fails to enforce on the private sector. So, what I see is behavior that smacks of a deliberate effort not to implement the best policy, but to potentially carry out what I think is a political agenda.

Dr. Stone, I know that you are a straight shooter and there is no doubt in my mind that the policies you advocate for are with the best interest of the veterans in mind. But, as the VA chief witness today, you will need to explain why the Department's access standards offer the best option for the veterans. I am not just talking about veterans who opt for the private sector. I am also talking about veterans who utilize VA care.

You will also need to ensure the Committee that the program you are implementing will be ready to go on June 6. Right now it is not clear whether the technology the VA needs to carry out this program, such as the decision support tool, will be ready for implementation. And not just ready for use, but with the VA personnel appropriately trained on how it works. And, if it is not ready to go, and folks have not been adequately trained, does the VA have a viable backup in place? The VA has had a full year to get this program up and running. If veterans are going to see a delay in care because the program is not ready to go, I think the best time to tell us that is today.

I want to thank you, Mr. Chairman, for calling what may be one of the most important VA Committee hearings this year.

I cannot thank you enough, Dr. Stone, for your patience and for you being here today. Thank you.

Chairman ISAKSON. Thank you, Senator Tester. I appreciate your support throughout this process. I am glad our witnesses are here today. I will introduce our first panel.

First is Dr. Richard Stone, Executive in Charge of the Veterans Health Administration, and Executive in Charge is a pretty good title. It means the buck stops there. We are glad to have you here today to talk to us about the implementation of the MISSION plan, and we are particularly glad to have Dr. Kameron Matthews. Dr. Matthews, thank you for being here today. And we are glad to have Dr. Jennifer MacDonald, VA MISSION Act Lead, L-e-a-d, which means you are at the head of the parade, the tip of the spear. We are glad to have both of you here today to support Dr. Stone.

Dr. Stone, the podium is yours for 5 minutes, or more if you need it, because we want to leave here with all the information we have asked for.

STATEMENT OF RICHARD STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KAMERON MATTHEWS, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, AND JENNIFER MACDONALD, M.D., VA MISSION ACT LEAD, VETERANS HEALTH ADMINISTRATION

Dr. STONE. Good afternoon, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Thank you. Thanks for the opportunity to discuss the new Veterans Community Care Program under the MISSION Act. I am accompanied today by Kameron Matthews, M.D., who is the Deputy Under Secretary for Community Care, and Jennifer MacDonald, also a VA physician, who is the lead for the MISSION Act implementation.

The MISSION Act is an unprecedented opportunity to enhance veterans' empowerment over their own health care. Under the MISSION Act, veterans and their families will be able to choose the balance of VA-coordinated care that is right for them.

VA published regulations in February of this year with our proposed access standards for the new Community Care Program that will begin June 6. These designated access standards implement eligibility criteria that will determine whether a veteran who is under VA's care is eligible for care in the community.

The proposed access standards support VA's goal of putting decisions regarding health care in veterans' hands and making sure that veterans have access to care when and where they are needed.

VA's process for developing these designated access standards was not arbitrary. VA sought public written comment about the best design for this program and we held a public meeting to provide an additional opportunity for direct public comment. We carefully analyzed a wide range of Federal, State, and commercial systems. We collected best practices and determined these standards with the best interests of veterans and their health care needs as the primary deciding factor.

From this process, the designated access standards we have proposed for Community Care under the MISSION Act are as follows:

- For primary and mental health care, VA proposes a 30-minute average drive time standard, the same standard as is used in the TRICARE Prime and the same standard as is used by at least nine State Medicaid programs.
- For specialty care, VA is proposing a 60-minute average drive time standard that is also the same as TRICARE Prime and multiple State programs.

VA further proposes appointment wait time standards of 20 days for primary and mental health care, and we propose also 28 days' wait time for specialty care. Veterans who cannot access care within these standards are eligible to choose either community providers or they may opt to continue to receive their care at a VA medical facility with their VA provider.

These access standards will guide veterans and their providers in making choices about receiving care in the community. Veterans will have more choices, but VA will remain the integrator of vet-

eran health care. Evidence has shown that even with more options veterans will continue to choose VA for their health care.

So, while we increase veteran empowerment and choice, we are continuing to invest in our direct care delivery system. The tools that you have provided under the MISSION Act ensure that high-quality direct care is readily accessible for veterans who choose it. VA's recent achievements in expanding access to health care are supported by new authorities under the MISSION Act that focus on our underserved facilities, recruitment, and the retention of our health care providers.

We are, in fact, the only health care system in the industry to make robust information about quality and access to health care fully transparent. Study after study has demonstrated that VA actually has shorter wait times, has higher quality, and has higher customer satisfaction when compared to the private sector. VA also provides a nationwide system of VA health care providers who are experienced with and devoted to veteran-specific health needs.

We are committed to build the trust of America's veterans in VA health care, and we will continue to work to improve our patients' access to timely, high-quality care while providing veterans with more choice to access care where and when they need it.

Your continued support is essential to providing this care for veterans and their families. Chairman Isakson, Ranking Member Tester, this concludes my statements. My colleagues and I are prepared to answer any questions that you may have.

[The prepared statement of Dr. Stone follows:]

PREPARED STATEMENT OF RICHARD A. STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF AFFAIRS

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE. Thank you for the opportunity to discuss the implementation plans for the new Veterans Community Care Program required by section 101 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. I am accompanied today by Dr. Kameron Matthews, Deputy Under Secretary for Health for Community Care and Dr. Jennifer MacDonald, Veterans Health Administration (VHA) MISSION Act Lead.

INTRODUCTION

Under President Trump, VA is embarking on the largest transformation and modernization of VA's health care system in the Department's recent history. The VA MISSION Act will transform elements of VA's health care system, providing Veterans with greater access to community care. But that increased access to community care is just one of the many ways the VA MISSION Act will change our Department and help VA better serve Veterans.

TRANSITION TO VETERANS COMMUNITY CARE PROGRAM

The Veterans Choice Program, which was established in 2014 in response to the access crisis at VA, expanded VA's authority to provide Veterans with access to care in their communities. At that time, access to care was a critical concern in many locations nationwide. The criteria for the Veterans Choice Program are primarily centered on VA in-house wait times of 30 days or more or a Veterans' residence being more than 40 miles from the closest VA medical facility with a full-time primary care physician.

The Choice Program came at a critical time for VA, and it has allowed us to serve over two million Veterans in communities across the country since it was established. During that time, VA has also continuously worked to improve Veterans' access to care in VA facilities and has made dramatic improvements in access during this time. Improved access to care in VA facilities and continued input from Veterans using VA community care programs enabled VA to identify opportunities to serve Veterans. VA learned that an expanded community care program supplements

VA care and better reflects the dynamic realities of health care and the needs of Veterans in their local markets. We are using the authority granted by the VA MISSION Act to give Veterans and VA providers more choices about how to ensure Veterans have access to the care they need.

VA published a proposed rulemaking on February 22, 2019, that sets forth the proposed criteria for the new Veterans Community Care Program, which includes designated access standards. These designated access standards implement one of six eligibility criteria established by Congress that will determine whether a Veteran is eligible for community care to supplement the care that they are provided inside the VA health care system. The proposed designated access standards support VA's goal of putting decisions regarding care in Veterans' hands and making sure Veterans have access to care when and where they need it, through either a VA facility or community provider.

It is important to note that the proposed Veterans Community Care Program does not supplant VA's mission to provide care in VA facilities to Veterans who have earned it. Over the past few years, VA has invested heavily in its direct delivery system, leading to reduced wait times for care in VA facilities. VA will work to ensure that care provided through VA facilities will remain the primary way by which enrolled Veterans receive health care and will remain the focus of VA's efforts. VA's proposed access standards will complement existing VA care by providing Veterans with greater choice to receive care in the community based on their individual needs and preferences.

PROPOSED DESIGNATED ACCESS STANDARDS

VA's proposed designated access standards are based on consultations with and an analysis of the practices of Federal agencies, including the Department of Defense (DOD), the Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid Services, private sector organizations, and other non-governmental entities. Last summer, VA published a Notice in the *Federal Register* seeking public comments, and last July, VA held a public meeting to provide an additional opportunity for public comment.

By collecting information from both Government and commercial health plans, VA developed proposed access standards that will best meet the medical needs of Veterans. Based on this analysis, VA determined that the designated access standards should include appointment wait-time standards and average drive-time standards. The appointment wait-time and average drive-time standards VA proposes are based on recognized standards in other Government programs and non-governmental organizations. VA did not propose to limit the designated access standards to certain services but instead proposed to include all primary care, mental health, non-institutional extended care, and specialty care services. We realized that the access standards needed to be simple and consistently applied. The designated access standards VA has proposed for implementation in June 2019 include the following:

- For primary care, mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive-time standard.
- For specialty care, VA is proposing a 60-minute average drive-time standard.
- VA is proposing appointment wait-time standards of 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request. These standards would apply unless a Veteran agreed to a later date in consultation with their VA health care providers. Eligible Veterans who cannot access care within the above standards would be able to choose between eligible community providers and care at a VA medical facility.

ADDITIONAL PROPOSED ELIGIBILITY CRITERIA

As stated previously, the designated access standards are one of a few ways that Veterans and their providers might decide that getting care in the community best serves a Veteran's needs. VA has proposed the following additional eligibility standards for the Veterans Community Care Program:

- VA does not offer the required care or services;
- VA does not operate a full-service medical facility in the state in which the Veteran resides;
- The Veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;
- The Veteran and the referring clinician determine it is in the best medical interest of the Veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria VA proposes to establish; or
- The Veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.

MISSION COMMUNITY CARE IT, CONTRACT, AND OTHER PROJECTS STATUS AND TIMELINES

The VHA Office of Community Care (OCC) has been developing and deploying improvements to the Community Care Program to improve the experiences of Veterans, community providers, and VA staff. Work began in 2016 to develop a standardized operating model for the community care staff working in VA medical centers (VAMC) and in recent years, tools and technologies have been developed to support the upcoming implementation of the Community Care Network contracts. The operating model provides a standardized way to manage consults, referrals and authorizations, and perform care coordination to ensure good customer service.

Even before the VA MISSION Act passed, OCC worked closely with VA's Office of Information and Technology (OIT) to discuss expected information technology (IT) requirements and systems that would either be impacted by the new law or created entirely as a result of the law. Since passage of the VA MISSION Act, OCC has worked closely with OIT to develop new tools such as a Decision Support Tool to aid VA staff in making community care eligibility determinations, as well to support enhancements to existing tools that will ensure that the capabilities necessary to implement the VA MISSION Act will be in place.

Secretary Wilkie has made important decisions to ensure the availability of a provider network that meets the needs of Veterans as required by the VA MISSION Act. The expansion and extension of the TriWest contract ensures access to a network of providers for community care for our Veterans while VA undergoes the transition to the Community Care Network (CCN) contracts. After multiple delays, prior to Secretary Wilkie's arrival at VA, the acquisition process is on track. Community Care Network Regions 1 through 3 were awarded at the end of December 2018. VA has solicited proposals for Regions 4, 5, and 6. While Regions 2 and 3 awards are under protest, we are moving forward with implementation of Region 1 and expect to start health care delivery in our pilot sites at the end of June.

URGENT (WALK-IN) CARE

In addition to access to the Veterans Community Care Program, eligible Veterans will have access to urgent (walk-in) care that gives them the choice to receive certain services when and where they need them. To access this new benefit, Veterans will select a provider in VA's Community Care Network and may be charged a copayment. The proposed regulations for the urgent care provision were published in the *Federal Register* on January 31, 2019. VA is currently finalizing the regulation after review of public comments.

VETERANS' CARE IS OUR MISSION

With study after study demonstrating that VA actually has shorter wait times and higher quality when compared to the private sector, along with a nationwide system of VA health care providers who are experienced with and devoted to Veterans' specific needs, evidence shows that Veterans will continue to choose VA for their health care.

As stated above, VA has made dramatic improvements to timeliness of care it provides to Veterans through the VA health care system since the access crisis in 2014. For example:

• VA completed over 58 million Veteran appointments in VA facilities in Fiscal Year (FY) 2018, an increase of 3.4 million since 2014, meaning the amount of care VA is providing through its medical facilities is increasing and will continue to increase.

• VA has drastically cut wait times for primary care and two of three specialty care areas, which are now shorter than in the private sector. In 2017, the VA had a mean wait time that was 12 days shorter than wait times in the private sector (VA had a mean wait time of 17.7 days versus 29.8 days in the private sector). This was true in primary care, in which the VA had a mean wait time of 20 days versus the private sector that had 40.7 days. In dermatology, where the mean VA wait time was 15.6 days and the private sector was 32.6 days, and cardiology where the mean VA wait time was 15.3 days and the private sector was 22.8 days.[1]

• VA cut the time it takes to complete an urgent specialty appointment from an average of 19 days from referral in FY 2014 to 2.1 days in FY 2018. That is a de-

[1] Penn, M. (2019, January 18). Comparison of Wait Times for New Patients Between the Private Sector and VA medical centers. Retrieved April 5, 2019, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917

crease of 88.9 percent. In the month of December 2018, the national average was 1.5 days.

• All VAMCs and Community-Based Outpatient Clinics (CBOC) now offer same-day services in primary care and mental health care. Same day services are for Veterans who are in crisis or have an urgent clinical need. This care might be provided over the telephone, via a face-to-face appointment, or by obtaining a prescription. This might also include making an appointment in specialty care.

• VA launched VEText in 2018, sending more than 71 million appointment reminders to Veterans reducing the no-show rate from 13.7 percent to 11.7 percent, leading to more than 1 million additional appointments for other Veterans.

• Veterans can now directly schedule appointments in Mental Health, Audiology, Optometry, Podiatry, Nutrition, and Wheelchair-Amputation Care clinics without a referral from Primary Care.

CONCLUSION

Veterans' care is our mission. We are committed to rebuilding the trust of Veterans and will continue to work to improve Veterans' access to timely, high-quality care from VA facilities, while providing Veterans with more choice to access care where and when they need it. Your continued support is essential to providing this care for Veterans and their families. Chairman Isakson, this concludes my testimony. My colleagues and I are prepared to answer any questions you and other Members of the Committee may have.

Chairman ISAKSON. Thank you very much, Dr. Stone. I want to start out by turning to the Ranking Member to go ahead. I want to let you go to the first question.

Senator TESTER. Well, this is probably a question that you are as interested in as I am, Mr. Chairman. It deals with the issues of suicide, and particularly the issues that happened in this last week when we had three veterans commit suicide on VA campus.

Senator Moran and I authored major mental health legislation last month to address the significant number of veterans who are suffering from mental health conditions and are dying from suicide. We believe that we need an all-hands-on-deck approach to addressing this problem, sooner rather than later.

So, given these suicides that occurred on VA campuses, is there anything that is being done to make it easier for VA staff to recognize veterans in crisis outside the exam room?

Dr. STONE. Senator, there are—there has been more than 260 suicide attempts or suicides on our campuses. Two hundred forty of them have been interrupted where we have saved 240 veterans.

Senator TESTER. Amen.

Dr. STONE. Unfortunately, more than 20 have been able to complete suicide on our campuses. Every one of these is a gut-wrenching experience for our 24,000 mental health providers and all of us that work for VA.

Stopping suicide is not something that is going to occur just on our campuses, and as the President has signed the Executive Order that places our Secretary in the lead for an interdisciplinary approach with all of American society to attempt to control this epidemic of suicides, we look forward to working on an interagency basis and with you.

But I would ask, with your forbearance, if we could just take a moment, and if you have got a cell phone on you, if you would take that cell phone out and put the following telephone number in—1–800–273–8255. 1–800–273–8255. That is the Veteran Crisis Line.

Now most lay people will say, "I do not know what to do if a veteran is in crisis. I am not a trained medical professional. What do I do?" Well, as a matter of fact, suicide often occurs when there is

just intense loneliness. Picking up the phone and reaching out, or calling the Crisis Line, saying, "What do I do?" could stop a suicide and save a life.

I wish it was as simple as me saying I could do more patrols in a parking lot that would stop this epidemic, but some of those suicides have occurred with suicide notes saying "I have come here to the campus because I know you will take care of me, and I know you will take care of my family."

Where have we failed that veteran? Where have we, as a community and society, failed that veteran is a very complex question, but I would hope with these comments and for your—thank you for your forbearance in allowing me to give the number out for our Crisis Line.

Senator TESTER. No, I appreciate that, Doctor. I would just say that I do not think there is anybody that certainly serves in the Senate, certainly not on this Committee, that this is not one of the big issues that it is hard to find answers for.

So, as you are in your position, and the folks to your left and to your right are in their position, and this Committee, along with the Veterans' Affairs Committee in the House did some amazing work last Congress, is there anything else that you need from us to address the issue of suicide, and mental health, generally?

Dr. STONE. One of the things we need to be able to work our way through is three suicides a day occur in never-activated guardsmen and reservists. So, they have never been activated to Federal service so, therefore, are not considered a veteran.

Senator TESTER. Right.

Dr. STONE. That usually occurs after age 30 and before age 50, so their service may have ended a long time ago, but reaching never-activated guardsman and reservists is something that I think we need to talk our way through, of how we should view those. If we can take and extend emergency services to other than honorable discharges we sure ought to be able to offer those services to the never-activated guardsman and reservist.

Senator TESTER. Great, Mr. Chairman.

Chairman ISAKSON. Senator Moran.

Senator MORAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Are you ready?

Senator MORAN. I am ready.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Dr. Stone, thank you very much for your presence here on a very important topic. I appreciate and join my colleagues in concern about veterans who commit suicide and I look forward to working with the Chairman and certainly the Ranking Member on the legislation that we introduced. I put Veterans Crisis Line in my iPhone, as you indicated. I never thought about it, but it is an opportunity that if someone presents themselves to me I have someplace to go, and go quickly. So, thank you for highlighting that for me.

I wanted to comment on something I heard you say just a moment ago, and I think it is pretty close to this quote. "Veterans will have more choices, but VA will remain the integrator of veteran health care." I think that is a desired goal on the part of all of us,

and I thought you summarized the MISSION Act with those few words very well.

I remember the testimony of one of the representatives from The American Legion when we had our hearing over in the Visitors Center, and the point that he made on behalf of The American Legion was that care that originates with the VA, even if it occurs in the community, is still Veteran Administration care. The importance to him of that was that the VA, and, therefore, Members of Congress and veteran service organizations, have control—someplace to go to when perhaps something is not quite right, the place that we can still complain, even when something happens in community care—the VA is still in charge.

In many ways the use of your word "integrator" again reaffirms what I heard this representative from The American Legion say about this issue of care in the community. The VA is still in charge. The VA is still the place we can go to influence something that is happening to a veteran that we care about.

I would welcome any comment if you wanted to highlight anything more about that. If not, I will ask you a couple of questions.

Dr. STONE. Senator, I appreciate that. When I returned to the VA last summer people talked about foundational services. What is foundational about the VA? To me, what is absolutely unique about the VA health care system is the lifetime relationship we have with our patients. You are always a veteran, so we have got you for the whole lifetime, and we should be the experts in the complex disabilities that are caused by service.

We know, in our chronic living facilities and in our nursing homes, that over 50 percent of those patients have degenerative disease of the spine, hips, and knees with chronic pain. It is the VA that understands that, therefore, even when we are buying care in the community, we should be the integrator that brings everything together for that veteran.

Senator MORAN. Thank you, Dr. Stone. Can you tell me at least some of the data that you utilized to determine drive times and wait times? What did you learn from the 2017 Merritt Hawkins Survey on wait times across 30 health markets? How did this information then help create the standards that will be utilized under your regulations?

Dr. Matthews?

Dr. MATTHEWS. Thank you very much for that question. We did quite a broad-span market analysis. As Dr. Stone mentioned, we looked not only at public sector, but also a fair number of commercial plans, State insurance departments, marketplace expansion plans, even Medicare Advantage. All of these have wide-ranging approaches to network adequacy; in general, how they build their services for their beneficiaries, for their patients.

In looking at those numbers, we definitely saw some general trends, then did a comparison of our own wait times and accessibility within our facilities, plus did that same sort of look at Merritt Hawkins, as you mentioned. Merritt Hawkins, of course, does a wide span of analysis in different metropolitan areas, some quite large like Boston, some smaller and a bit more suburban, if not closer to the rural side; and there is definitely no general trends

of wait times across the board. So, that was not really much to rest on.

So, instead, by again looking at the different comparison of plans, what we were hoping to do was to stick with an industry standard so that our veterans, perhaps even used to the same sort of standards that they had through TRICARE, through even other private payers, might have an expectation, one that is quite reasonable, about when they could actually receive care within a specific wait time or distance from their home address.

Senator MORAN. So, it is safe to say—I mean, I should be comforted by this, what you just said, I assume, because that means that decisions that are being made about what the access standards should be are based upon information across the board from other health care providers and other networks to make certain we are doing as well or better on behalf of veterans, that there is a science, in a sense, behind the decisions that were made in access standards?

Dr. MATTHEWS. That is accurate.

Senator MORAN. I also hope that means that we can better predict costs into the fair. Is that more than a hope? Is that more than an aspiration? It will improve the VA's ability to estimate its costs?

Dr. MATTHEWS. That is also accurate.

Senator MORAN. Mr. Chairman, my time has expired. However, I want to point out that Emily Wilson has been one of my staff members on veterans' affairs issues for the last 4 years, and this will be her last hearing, so I wanted to acknowledge her publicly, as a person who has cared greatly for veterans in Kansas and across the country. She has been an integral part of our work on this Committee. She is off to help folks at the Department of Defense and she will be missed. Emily, thank you for your service.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Moran.

Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman.

Chairman ISAKSON. Senator Murray, let me interrupt for 1 second. I see a vote has just been called. Is that correct?

STAFF. I do not know.

Chairman ISAKSON. Not yet, or is about to be called?

Senator MURRAY. I will just ask two questions then.

Chairman ISAKSON. Well, no. I was just going to say, when it is, Senator Tester left to be there and then I will go replace him. We are going to keep the Committee meeting going.

Senator MURRAY. OK. Great.

Chairman ISAKSON. Thank you.

Senator MURRAY. Thank you, Dr. Stone. Dr. Stone, the VA seems really eager to move forward with closing facilities, but has so far been unable to explain what criteria will be used in making those decisions. VA has not described if or how it will make investments in improving or expanding care in the VA system, and this year's budget request certain does not prioritize that.

A fundamental principle guiding our work in this space since the original Choice Act is that expanding Community Care has to be

done in tandem with investments in the VA health system. So, I wanted to ask you, when will we see a comprehensive strategy to build and strengthen the VA system for the long term?

Dr. STONE. Part of the MISSION Act is that we provide to you, by the 6th of June, our first look at a strategic plan. That strategic plan cannot be informed by our market area assessments because they will not be finished until midyear 2020. So, although we have got 31 market area assessments currently to be completed, the next two waves of those market area assessments will not finish up for about a year.

Senator MURRAY. Well, what specific criteria are you actually using in evaluating the market assessments?

Dr. STONE. So, there are more than 1,500 different data points to evaluate the markets, everything from the demand signal from our veterans, to how many veterans are going to live in a community, what is their age, and what their predicted demand for health care would be, what their reliance on the VA will be. As you know, our veterans, about 80 percent of them, have other health insurance so they split between their other health insurance and us. Right now, about 38 percent of their care we provide, about 62 percent is provided by their other health insurance, on average.

We will look at those data points. We will also look at the relative age of our facilities, what the potential investment needs to be, and are we in the right place? We talked about San Francisco. In San Francisco we have a beautiful site on top of a mountain, but there is not a veteran in San Francisco in that area. They have to drive about 2 hours to get to us. Are we in the right location?

Senator MURRAY. OK. I understand that. If you could just get us what the specific criteria is so we understand how you are making these decisions.

Dr. STONE. We are required by the statute, in publishing regulation that will lay all of that out, and we are required to share that with you before we publish them.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO RICHARD STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The criteria referenced in MISSION Section 203(a) requires the Secretary, "no later than February 1, 2021, and after consulting with Veterans Service Organizations, publish in the *Federal Register* and transmit to the Committees on Veterans Affairs of the Senate and the House of Representatives the criteria proposed to be issued by the Department of Veterans Affairs in assessing and making recommendations regarding the modernization or realignment of facilities of the Veterans Health administration."

Currently, the market assessments use the "Vision" and "Guiding Principles" developed and endorsed by the Executive In Charge to aid in the conduct of the market assessment work and associated development of potential opportunities. We anticipate using these Guiding Principles as a stepping stone as the criteria are created in close collaboration with the Office of Construction and Facilities Management, the Office of Asset Enterprise Management. There is a close partnership with these offices, and a collaborative sub-committee of the Market Assessment IPT that's been stood up to address Capital and Facility specific ideas that evolve as the market assessment work continues.

Senator MURRAY. OK. I appreciate that.

I also wanted to ask you, a high-quality decision support tool is critical to the success of the community care program. Given VA's

track record on scheduling I am very concerned that a manual process is going to result in widespread delays and mistakes, yet the U.S. Digital Service (USDS) found some serious flaws in VA's development of the decision support tool, including that the VA did not even begin actively developing it until January. That is 6 months after the MISSION Act was signed.

USDS actually recommended scrapping the current decision support tool and making a different approach to address the most complicated eligibility criteria first, and they recommended ensuring veterans can see their eligibility themselves and for VA to create a process to resolve those disagreements.

Time is running out before the Community Care Program is set to launch. I wanted to ask you if you have fully implemented all of the U.S. Digital Service recommendations, and second, will the decision support tool that meets those recommendations be ready when the Community Care Program goes live?

Dr. MATTHEWS. Thank you for that question. We definitely appreciated USDS's input with regard to the decision support tool. We are still moving forward with OINT's development of the tool. We have had multiple demos, including the interfaces that the decision support tool actually supports, and we actually have already started trainings on an online and virtual basis of providers in the field as well as program officer leaders.

So, we do have full intent to have DST deployed by June 6.

Senator MURRAY. Have you implemented all the USDS recommendations?

Dr. MATTHEWS. No, we have not.

Dr. MACDONALD. Senator, if I may add, we invited USDS to the table, the Department did, in an aim to have all of the talent available to veterans at the table to implement this with excellence and with an ease of these tools enabling these actions for our providers moving forward. We very much appreciated the devotion and the energy that they showed in doing the discovery sprint in a short 2 weeks' time. It is difficult to understand some of the complexities in our IT system. They brought a lot of expertise to the table that needed further discussion with our IT individuals.

That has taken place and we have learned and grown from the report. We have worked in collaboration with them to make sure that the tool we are delivering on June 6 is excellent and does save providers time such that providers, as we sit here and engage with veterans, that we have more time to focus on the veteran in front of us.

Senator MURRAY. OK.

Dr. MACDONALD. And, yes, training has begun, Senator.

Senator MURRAY. OK. Thank you. My time has run out but I would like to include in the record the report by the USDS, Mr. Chairman.

[The U.S. Digital Service report was received and is being held in Committee files.]

Dr. STONE. With your tolerance, Mr. Chairman, let me just add one thing. You have got three doctors here talking about IT systems. That is probably dangerous.

U.S. Digital Services brought up some very interesting ideas on API interfaces that could lead us into a wave of the future. I think

you are going to see a traditional approach to the first phase of this, for June 6.

Senator MURRAY. Done by hand?

Dr. STONE. No, no, no; a traditional automated approach. But then, there is an additional ability to integrate, that Digital Services brought up, that we would be happy to share with you, or our IT people share with you offline, that moves this to the next level and potentially gets us to a veteran-facing tool that might have huge value for the future.

Senator MURRAY. OK. Thank you.

Dr. STONE. Thank you, Mr. Chairman.

Chairman ISAKSON. Dr. Stone, let me just interrupt for 1 second and then we are going to go to Senator Boozman. If I am not correct, please correct me. But, I was going to ask a question a little later. I have been waiting but you just prompted me to go ahead and ask one right now.

I was going to ask, are you going to be ready June 6 to deliver what the MISSION Act asks for? Are you going to have all the tasks that you have been given done? And from the answers you have given, as well as some others we received, the answer to that question already is no. And, I do not say that negatively. I am just saying it sounds to me you are at a sprint. It is a big pill to swallow, and there is a lot to be done.

One of those things with the VA is the technology issue, which you are all dealing with. And one of the great things people like me can do is complain about technology, while I cannot do anything about it because I do not understand it.

Here is what I do understand. We have to respect the fact that there are technology programs. We learned from trying to make the Cerner decision that the only way to fix that problem, in terms of medical IT, was to get a totally new system. The VA is populated with a lot of systems that were bought that are now old and antiquated. Some are inoperable. Some have difficulties doing the tasks themselves.

Are you going to be able to be as functional as you want to be, given what you have got, given the resources you have, knowing that down the line you are going to have to get more equipment and better equipment to replace it?

I am sorry for the long question, but I wanted to——

Dr. STONE. Sir, this is as complex a legislation as you could possibly have. The automated systems to run Community Care require 11 different software systems, 10 of which we have got in the field today. The 11th, the decision support tool, sort of brings them all together. Some were fielded as far back as last fall; some we are fielding as we speak.

Are we going to get it all right? No. Are we going to deliver care on June 6? Yes. The question is are we going to be as efficient as we should be? Are there going to be wait times that will grow because of this? We are confident that we are doing everything we possibly can to hit June 6 running.

Today we will deliver about 310,000 visits in our direct care system. We will also buy 50,000 visits today. On June 6, our anticipation is those numbers will be about the same. So, we will have about 360,000 contacts, or one-third of a million contacts with vet-

erans that day. We will get this right, and we will get better every day. I am not going to sit before you and say we are going to have everything right on June 6. There will be something that does not go in the right direction and we have got to get corrected.

Chairman ISAKSON. And, part of our job is to help you do that. I personally appreciate the thoroughness and the candor of that answer.

Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman. I want to follow up on that. We do appreciate all of you and appreciate your hard work. We have got three excellent doctors here and you have got a bunch of Committee Members that have been around for a while. We have seen roll-outs in the past in the VA, and they have been kind of rough. In fact, we have seen roll-outs in government, period, in all kinds of different things, and they have been pretty rough also.

The problem is that the Committee has become the backstop, you know, in regard to pushing things along and providing the resources if we do have a problem.

In Arkansas there is a lot of excitement about the MISSION Act. I have talked to countless veterans and VSOs, private sector health care providers around Arkansas. So, there is a lot of looking forward to it. To be honest, they do not have much information yet.

I guess a question would be with the implementation only 9 weeks away, what is the plan for engaging providers who are currently providing community care? Again, they do not understand what is going on. What is being communicated to them about the changes, and should they expect to see—what should they expect to see and the timeline?

Dr. MACDONALD. Thank you for that question, Senator. Any change at this scale in a system our size must be taken seriously. And, at the core of our approach to the MISSION Act is, of course, veteran centricity, but also we think about our providers and our employees undertaking this change. We want to make sure that they not only have the tools in their hand that they need to implement this, but that they have the knowledge and the awareness of why we are doing this: that this is a new era of veteran empowerment; that they are able to sit down with a veteran, one-to-one, as we do as physicians, and say to that veteran, "I am able to help you make a choice that is in your best medical interest."

We have started communicating on that front. We have given the field a toolkit to use, and we have launched training as well on the key tools that are new to them, specifically the decision support tool. Just in this past month, and accelerating over the next couple of months, through and beyond June 6, Senator, we will continue that campaign.

Senator BOOZMAN. OK. How about outreach to veterans? Are we outreaching? Do they know what to expect on June 6? Are we doing anything proactive in that regard to the veteran community?

Dr. MACDONALD. Absolutely, Senator, and actually Section 121 of the MISSION Act directs us to do exactly that. We have developed a robust plan to reach veterans across all eras and in various mo-

dalities as different eras may need. So not just through print materials, not just a poster in a facility, but also online and in other spaces where they may need information about VA, about the new benefits, care, and services that they can receive under the MISSION Act.

We are also engaging and very much appreciate our veteran service organization partners as they have offered to have several of their delegates trained such that the message and education can be amplified for the veterans that they encounter.

Senator BOOZMAN. Arkansas is in Region 3 of the Community Care Network, so we are impacted by the CCN contract that was awarded but is under protest. We understand that the VA has worked with the current third-party administrator to act as a backstop until the CCN contracts are up and running.

How will that impact veterans and providers in Arkansas? What is expected the current TPA, including terms of scheduling and processing of payments? When will the transition be complete and what, if anything, will change for the veterans and community providers between the original contract, the interim plan, and the new contract?

Dr. MATTHEWS. Great question. A lot of information packed in there.

We are ecstatic that TriWest really stepped to the plate and became a partner for us nationwide through June, until such time as Region 3 in Arkansas and, of course, Region 2, as well, until such time as those contracts come out of protest, and, actually, until the new contract is deployed, TriWest will continue to stand by us as a partner, is working with us to modify their contract, to accept the new mission requirements so that there will be a seamless administration of this program, regardless of which third-party administrator we are working with.

There are differences between the Community Care Network contract, which is still pending for Regions 2 and 3, and, of course, TriWest, but TriWest has really come to the plate to make them more streamlined, because, of course, their contract originally included the Choice Program. So, we are quickly folding down the Choice Program in their contractual language, and again, our hope and TriWest's full intent is to make it as seamless of a transition as possible, when indeed that transition occurs to the next contractor. As of June 6, TriWest will be offering services in Regions 2 and 3.

Senator BOOZMAN. Good. Thank you very much. We do appreciate your hard work. I think I can speak on behalf of the Committee, we really do want to help you. This is a huge undertaking and it is just going to take everybody working together to get it done. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator Blumenthal.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I want to thank you for having this hearing, and, as usual, conducting it and

the Committee in a bipartisan way, which is really the hallmark of the Veterans' Affairs Committee. So, as always, my appreciation.

This epidemic of veteran suicide is hardly new. You would agree with me, wouldn't you, Dr. Stone?

Dr. STONE. I would, sir.

Senator BLUMENTHAL. Tragically so, one of my first major pieces of legislation here, years ago, was the Clay Hunt Veteran Suicide Prevention Act, which I created with the late John McCain, Senator McCain of Arizona. And, I am a supporter of the Tester-Moran act, the measure that has been proposed, and other measures. But, the fact of the matter is that 20 veterans every day, maybe more, in the greatest country in the history of the world, continue to take their own lives.

The mantra that we have heard from the VA, again and again and again, over the years, prior to your coming here, has been, "Well, they are outside the system. They are not part of the VA health care system," which, of course, begs the question of "what are you doing to reach them?" That is why it is important that you stress the Suicide Prevention Line. That is why it is important that the VA use all of the resources, not just a fraction, that we have appropriated for outreach. Unfortunately, the VA, over the years, has failed to use those resources. We had a hearing with Secretary Wilkie, when I think a lot of us expressed our profound dissatisfaction with that failure.

But, the question is very pertinent today because in the MISSION Act a lot of veterans will be going outside the VA health care medical system, for lack of a better term. They will be going to non-VA doctors. The reason why they love the VA health care system is because it knows them. It is schooled and trained in how to care for veterans. I can tell you about Connecticut; our veterans deeply appreciate the quality of care that they receive in West Haven.

So, my question to you is, assuming that a lot of veterans are now going to be going to other docs, what standards will be imposed to assure that those doctors are trained to recognize the symptoms of potential suicide—depression, Post Traumatic Stress? I may not be using the right scientific and medical language but I think you know where I am going with this question.

Dr. STONE. Sir, I appreciate the way you have characterized this because it is exactly the problem. There is not another health care system other than the VA that understands the complexity of service or the fact that if you go down to the World War II memorial and you look at one of the Honor Flight groups, it does not take you very long to pull the scab off of the traumatic events from 70 years ago of one of those veterans.

This is not something that we can simply give a course to a private physician, and it is why we must be the integrator of care. We can buy transactions of care, whether it be for psychiatric illness, we can buy a transaction of care, but the veteran needs to be integrated into our system for a full understanding of the complexity of these problems, and how difficult they are to care for, and that they have a lifetime problem.

Senator BLUMENTHAL. Maybe the answer to my question—and I am just thinking out loud here—is to say that certain kinds of issues and challenges should be referred back to the VA health

care system. If it takes 35 minutes or 65 minutes to drive to a VA facility, you know, maybe that is better than 15 minutes to someone who is going to say, you know, "You are waking up with sweats and anger? Take two aspirin and call me in a week."

Dr. STONE. I think you have characterized that well and that is why these discussions are best done between a provider and a patient, and then the best interest of that patient is taken into effect.

If I might, and with your permission, Ranking Member Tester, we are in the process of recording local public service announcements. One of your members, Senator Sullivan, has taken advantage of that. I think the Chairman is also scheduled to do one of those. We would ask each of you to consider whether a public service announcement that we can reach out into your communities would be very helpful to us.

Senator BLUMENTHAL. I will commit to do it right now.

Dr. STONE. Thank you, sir.

Senator BLUMENTHAL. As many times and as often, as widely, wherever you would like to do it.

Dr. STONE. We will work with your staff and extend that same invitation to each of you, because your connections to your communities is what we need. And, this is not just about the six that are engaged with us in health care; this is how do we reach the 14 that are not engaged with us. We cannot just say, "Well, they were not in our health care system." We must be able to reach out. This is the beauty of the President's Executive Order, placing us in the centerpiece of trying to correct this across all 20 that are doing self-harm.

Senator BLUMENTHAL. While I have you here I need to just say, although it is not directly related, when Secretary Wilkie was sitting where you are in our last hearing I asked him about the West Haven surgical equipment processing facility, which he committed would be available, the mobile facility, by June. I hope that is still your expectation and your promise.

Dr. STONE. Sir, it is my promise. They have gone to two shifts. After our last discussion they have gone to two shifts a day of sterilization. I know they have struggled with their vendor to meet the June date. Their numbers are coming up. We are monitoring their numbers on a weekly basis. I know what I promised you and what the Secretary promised you. That is the right thing to do. The veterans in that community deserve to be cared for where they want.

Senator BLUMENTHAL. Thank you, and I would just like to know if that date is going to slip that you let me know, because I will do some public service announcements—unsolicited public service announcements for the vendors.

Dr. STONE. Thank you.

Senator TESTER [presiding]. Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, and because we are about 12 minutes into a vote I have two questions, two main questions for you, Dr. Stone. I am going to just read the questions and then have to leave to go vote. My staff is here and the record will reflect it. It is a little rude, but it is the only way I can figure out how I can do it, so thanks.

Thanks to the Chairman and Ranking Member for having this oversight hearing. It is really, really important.

We passed VA MISSION Act, as you know. It contained a comprehensive overhaul of the Community Care authorities into a new Veterans Community Care Program. We have tried to learn from our mistakes made in the Choice Program about arbitrary eligibility criteria relating to wait times and driving distances, all of which you know. We tried to provide veterans the best source of information for whether they should research Community Care consultation with their own VA provider.

Over 10 months, the VA has neglected to inform veterans and VSOs and Congress in the most transparent way, often limiting the information provided regarding resources and decisions. VA, in our mind, has failed to incorporate feedback from VSOs and health care providers prior to unveiling the proposed access standards a couple of months ago, in February.

By VA's own analysis, VA facilities scored 59 out of 100 when assessed for whether they could meet the expanded requirements set forth related to scheduling and care coordination. My office, like others, I assume, have received lots of calls and letters during the Choice Program related to scheduling and care coordination, as you know.

The questions are this. I would like to know how VA plans to meet veterans' needs and ensure that the proposed access standards do not lead to further privatization of the VA by pushing more veterans into the community because VA lacks internal administrative and medical capacity, and also explain how you plan to hold community providers to the same access and quality standards as the VA, per the MISSION Act requirements.

That is one set of questions; again, I apologize for doing this. I wanted to follow up, though, after listening to Senator Blumenthal—we are concerned that the VA access standards, coupled with less resources for internal VA staffing, could, over time, lead to a hollowing out of VA facilities and, in turn, need more Community Care. Our intent was never to have Community Care displace the VA.

I think there are some with the political philosophy in this body that would like to do that. It does not serve veterans. It certainly undermines what the VSOs want. Understanding many VA facilities provide exceptional specialized care, Senator Blumenthal and I worked on the Veterans Community in Section 133 of the MISSION Act, which stipulates that VA must establish competency standards, as you know.

The other question I have is how will VA craft a program that allows veterans to go into the community when deemed necessary by their provider without compromising or draining resources from the critical fields within the Veterans Administration?

So, if you would just—the three of you take those questions. The general and Ann are here to listen and it will be reflected in the Committee record. So, thank you so much.

Dr. MATTHEWS. Thank you very much for that question. The first section of your question with regard to the readiness of our facilities to move forward with the changes really over the last year and a half the Office of Community Care, as well as operations in man-

agement have been working with facilities to assure that they are moving forward with the appropriate staffing that would be necessary to take back a lot of these scheduling and care coordination services. That requires, of course, hiring of staff over time, and the majority of facilities have done so.

As we moved away from the HealthNet contract—as many of you, I am sure, remember and wish to forget—we actually did see a swift uptake of a lot of those services by the facilities themselves. I mean, Ranking Member, your State alone has jumped into that task quite well, and the former HealthNet areas did indeed take up that challenge. There are a small number now, numbering 17, facilities that are using TriWest to assist with scheduling for the short term. As they move into the new IT systems, with regard to automated referrals, automated authorizations, their workload will change and decrease, and indeed they will move away from having to do a lot of the administrative minutiae and focus on that care coordination, scheduling for the veterans, if indeed that is what they request.

We fully anticipate that the 17 sites will be moving away from TriWest scheduling assistance by this summer, and as we deploy into the Community Care Network all facilities will be providing these services on their own.

The readiness score is really—the 59 out of 100 that the Senator quoted was a national average. We have that broken down at the facility level, even at the VISN level, so network directors are also accountable, and we are monitoring those on a weekly basis, just to assure, again, that their administrative services are coming up to bar. We are seeing increasing scores across the board.

With regard to the competency standards that the Senator mentioned, Section 133 of the MISSION Act, of course, required that VA institute competency standards for community providers for veteran-specific conditions, specifically PTSD, military sexual trauma, and Traumatic Brain Injury. We have been working with, of course, our renowned subject matter experts within VA.

We have those competency standards defined and we will be including those in the TriWest contract so that moving forward the network providers who, of course, treat those issues—so, of course, focusing more on mental health, just because of those named conditions, but also, in the future, contracts as well as Community Care Network deploys will be modifying those contracts as well. It is difficult to modify the contracts before they are actually awarded, so there is, unfortunately, a delay on how those will get implemented, because we would have to work with the actual awardee in order to do so.

We fully expect that the third-party administrators help us enforce these competency standards, make sure, of course, that providers are meeting quality assurances as far as credentialing, but this additional specialty training and focus is necessary to treat veterans. We can see it as a continuation, of course, of our ability in the VA, but in a supplemental fashion, and so the requirement of these standards is well appreciated, and community providers are responding accordingly.

Dr. MACDONALD. Additionally, on Section 133, we are providing general training for providers in addition to the specific PTSD,

Traumatic Brain Injury, and military sexual trauma training that will be provided for mental health providers. We are providing general training that specifically elevates military culture and ensures that when a veteran chooses to be seen in the community that that community provider has a consciousness of what that veteran has experienced. Included in that general training, as well, is suicide prevention, yet another way we are aiming to amplify this message and ensure that even beyond VA, even beyond our direct system, that veterans are receiving the best care possible and that providers are well informed and able to respond when there is a need.

One additional note, to the Senator's question about the direct care and community care and the equivalence of standards across both. We very much believe that in VA it is our responsibility to be in the lead on wait times and on quality. We see ourselves as one integrated system with a direct care aspect and a community care aspect.

It is our responsibility, as Dr. Stone has highlighted, to be the integrator of care across those two systems and to ensure that wherever a veteran is empowered to seek that balance of their care that is right for them that they are receiving that quality and timeliness, and, therefore, we aim to be in the lead and setting the standard for that.

Senator TESTER. Before I go to Senator Sinema, a couple of things on the previous questions that I asked.

Dr. Stone, you brought up the fact that guard and reservists that had not been deployed do not have access to the VA. I have got a bill that will fix that. It is S. 711, I believe it is. If we could get your support or your input on that, that would be much appreciated.

And, the other point that I just kind of wanted to clear up before I move to Senator Sinema is that Dr. MacDonald, you had mentioned that the VSOs had been offered training opportunities on the tool. Which VSOs?

Dr. MACDONALD. Senator, at breakfast with the VSOs who regularly join Dr. Stone, we had a discussion about this and they actually, themselves, offered to have their delegates trained. I am happy to take that for the record and get you a specific list.

Senator TESTER. That would be good. That way we can double back with the VSOs whom you have offered it and see if they have taken you up on it.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The following organizations were present: AMVETS, American Legion, DAV, PVA, VFW, VVA, MOAA, WWP, NACVSO, NASDVA, MOPH, AFSA. VA will be working with these organizations moving forward to identify training opportunities. We have subsequently offered training to all VSOs who regularly engage with VA, and initial MISSION Act and Community Care training was conducted via Adobe Connect May 6, 2019.

Senator Sinema.

HON. KYRSTEN SINEMA, U.S. SENATOR FROM ARIZONA

Senator SINEMA. Thank you, Mr. Chairman, and thank you for the witnesses and your testimony today.

As Americans, the blessings we enjoy every day are the direct result of the sacrifices that are made by our Nation's veterans. I was actually just reminded of this fact last month. I had the privilege of re-enlisting my little brother, Gunner's Mate First Class Sterling Sinema, into the Navy. I am reminded that together we must ensure that our veterans receive the benefits and care they have earned, including quality mental health services and timely medical attention they deserve.

We know, particularly in Arizona, that veterans can carry the scars of service, both visible and invisible, for years after they transition into civilian life. As the individuals responsible for providing care to former servicemembers, I know each of you understand the incredible responsibility that you bear.

The MISSION Act represents the most deliberate and significant update to the veterans health system in decades, and I am committed to partnering with the VA to ensure that we get it right. Many of the problems the MISSION Act was designed to address, including the national wait time crisis, as you know, were first identified in my home State of Arizona.

Dr. Stone, Secretary Wilkie has already accepted my invitation, but I hope that you will also accept my invitation to visit our facilities in Arizona to ensure the VA's effort to implement the MISSION Act is successful. We want to address extended wait times, but also include a plan to resource facilities that right now do not meet the new standards.

For instance, at the Hayden VA medical center in Phoenix the wait time for a new patient is 43 days, and in Kingman, AZ, new patients are facing a 47-day wait for services.

So, I am interested in supporting policies that get veterans in front of medical providers faster, but the long-term health of the VA depends on providing the clinical and support staff all the tools that they need to meet the standards that you all have set for them.

So, Dr. Stone, my first question is I know that you already agree that the overwhelming majority of the staff at VA medical centers in my State of Arizona are dedicated to ensuring that veterans get the care they need. But, for the facilities that cannot currently meet the access standards that you all have established, how do you plan to provide the resources that clinical and support staff need in order to meet the assessment standards that the VA has established? And what percentage of existing patients will be eligible, under the wait time standards, and what percentage of eligible veterans do you think will choose to receive community care if those wait time standards are not met swiftly?

Dr. STONE. Let me take the easy part of that question, and that is, yes, I accept your invitation to come out to Phoenix.

Senator SINEMA. Wonderful. Come soon. It is getting hot.

Dr. STONE. Thank you.

I think, second, we have taken a hard look at these wait time standards, as the Secretary has identified them. In some areas of the delivery system we are doing very well and in others we are struggling. Your communities are growing so quickly——

Senator SINEMA. Yes.

Dr. STONE [continuing]. That we have had a very difficult time keeping up with the demand. And as you have identified, Senator, you know, it was Phoenix that was the centerpiece of what was wrong with our bureaucracy and our ability to respond to rapid growth. That community is still growing, at dramatic levels, and our ability to grow new space and a new footprint is inhibited by a bureaucracy that can take us 4 to 7 years to open a new footprint in leased space.

But, let me defer to Dr. MacDonald who can talk a little bit about these access standards as well as sort of where we are doing well and where we are struggling, plus how we are approaching it.

Senator SINEMA. Thank you.

Dr. MACDONALD. Yes, I will first highlight, Senator, that we have a core focus on primary care and mental health. In primary care, more than half of our facilities are meeting our wait time standards right now, but we intend for that to be all of our facilities meeting the wait time standards.

In mental health we are meeting that standard in 139 of 141 facilities, but again, 139 out of 141 is not enough. We want it to be 141. We want it to be everywhere such that every veteran has access.

The MISSION Act did give us new authorities and new ability to deliver on that promise, which we intend to provide across the Nation, in every space, no matter how rurally or in an urban setting a veteran chooses to live. The MISSION Act gave us new ability for recruitment, retention, and relocation authority such that we can hire providers into areas where that has traditionally been challenging.

It also gave us, in Section 151, anywhere-to-anywhere telehealth, and we are pairing that with the underserved facility work that MISSION Act also requires, such that we have a comprehensive strategy to grow and build services in those facilities that have traditionally struggled to find providers.

In addition to that, there is a productivity initiative underway in VA such that we are maximizing and using every bookable hour of the staff that we currently have available. So, on both aspects, the investment and productivity first and the growth beyond that through the new authorities in MISSION Act, we intend to grow those services no matter where a veteran lives.

Senator SINEMA. I appreciate that response.

One of the concerns that we continue to see in Arizona is that, as you mentioned, Dr. Stone, and, Dr. MacDonald, as you also noted, Arizona is a particularly difficult place to meet those standards because of the rapid growth. And in our more urban settings, particularly in Phoenix, we have additional growth during the winter months by snowbirds who visit Arizona and seek their care at our facilities.

One of the things we have struggled with is that we do not see an influx of additional staffing during those winter months but we see a huge increase in our percentage of veterans who want to receive care.

Right now, in Arizona, it is around 50 percent of veterans who get their care from the VA, and if we see that continue to increase, which I know the VA is working to invite more veterans, particu-

larly younger veterans to receive their care at the VA, while we also continue to have this influx of snowbirds, which will grow, not shrink, over the years, I think it would be wise for the VA to provide special consideration to communities that have unusual growth during certain times of the year, because of the nature of, well, living in the greatest State in the country.

Dr. STONE. I agree with you completely. It is one of the reasons that we have increased our funding in telehealth so dramatically and why what you gave us in Federal supremacy and our ability to really conduct telehealth across the Nation, from any place in the Nation, is so essential for us. You know, we had about 750,000 veterans that took advantage of telehealth last year. We are going to get up to about 20 percent of our veteran population in order to respond to these demographic moves.

But, it goes back to one of the opening questions that was asked by the Ranking Member: how do we approach the sustainment of the system? You know, I lived, early in my life, in a time where people lived in communities forever. They did not change. There were generational houses, from generation to generation. That does not happen anymore. We have to have the ability to follow where veterans are, though we are not very good at it. And, there are a number of areas that we can discuss, well beyond the few minutes that I am over, sir, on this—in order to discuss sort of how to respond to these demographic moves that are so dramatic in your State.

Senator SINEMA. I appreciate that.

Mr. Chairman, My time has expired. If I might, as I prepare to head to the floor to vote, I would also just want to emphasize the importance of ensuring that we are utilizing all the tools the MISSION Act gave for locality pay. In places like Kingman, AZ, and our Prescott VA Hospital, we are unable to recruit and retain the highest quality staff that we need because of the remoteness of the location.

As you know, in Arizona, while 65 percent of our population lives in Maricopa County and has access to the Phoenix VA, the other individuals live so far away from these facilities that it is difficult to get to a VA facility, and it is incredibly difficult to find highly-qualified individuals who want to work in those remote locations. So, it is really important for us to ensure that these employees are compensated fairly to do the difficult work they are doing in these remote parts of our country.

Dr. STONE. Senator, you are right. I think you have given us the tools, though. I think the tools—not just locality pay but enhanced educational loan repayment that you have given us all add to our ability to get this done. We are also deep in discussions with a number of medical schools, including the historically black colleges and universities, to support positions that might allow us to draw people in, and especially to the great areas of your State that need care.

Senator SINEMA. Thank you so much. Thank you, Mr. Chairman.

Senator TESTER. Thank you, Senator. A couple more questions and then we will get to the next panel.

Dr. Stone, we have talked before, and it has been talked about at this Committee meeting, about quality of care and timeliness of

care. I think in your opening statement you pointed out the fact that you guys keep track of that stuff, but a lot of folks in the private sector, it is hard to get that information. Would that be a fair characterization of what you said?

Dr. STONE. Sir, not to belabor my answer but it is a fair characterization, yet if I might add——

Senator TESTER. Yeah.

Dr. STONE [continuing]. I have great respect for our commercial colleagues.

Senator TESTER. Absolutely. Yeah, yeah.

Dr. STONE. Yet, they are not held to the standard that we are, nor—you know, a veteran can look at us pretty easily and figure out what is happening in our institution.

Senator TESTER. So, the question revolves around the idea that we are doing this whole MISSION Act for the sole purpose of timely quality care. And, if we do not have that private sector information it may be better for that veteran to stay with VA care and have that appointment, even though it is past the 20-day period or the 28-day period.

When do you think you will know, as somebody who is going to integrate this health care, on how long it will take for the private sector to see a veteran, on average, so you can inform the veteran, so that they are not thinking, "Well, I am going to go to the community care and get taken care of," when, in fact, they might have to wait longer than they would have waited if they had just stayed with the VA.

Dr. STONE. Right now wait times are not transparent across the Nation and in the commercial sector. We will gather that data in real time.

Senator TESTER. Do you have any idea when that data might——

Dr. STONE. In 180 days. About 6 months.

Senator TESTER. About 6 months. OK.

So, let's talk about what happens when something goes wrong. If you are at a VA facility, you file an 1151, which allows for compensation for injuries. It is fairly transparent and people know what is going on. When a veteran goes into the community for care, something goes wrong—correct me if I am wrong—I think the veterans are on their own to seek redress. And, if I am wrong, you correct me on that.

Dr. MATTHEWS. I would be happy to correct you, sir.

Senator TESTER. Sure.

Dr. MATTHEWS. We have actually instituted, over the last 12 months, a new patient safety structure that involves not only our traditional patient safety team in the facilities but the community care staff to work with our third-party administrators to do the appropriate investigations and oversight of any issues that arise while a veteran is receiving care in the community. A lot of this, of course, hinges on the partnership with that provider. They may not be willing to share information. But moving forward we will be actually requiring that as part of participation in our relationships, contractually, that they take part in these patient safety conversations.

Senator TESTER. OK. Let's say something goes upside down in the private sector. What does a veteran do?

Dr. MATTHEWS. A veteran definitely speaks either to their patient advocate, their primary care provider, reports it through any means necessary within the facility. The facility staff is trained to take that incident report and start initial investigation through the patient safety structure so that we can actually gather information to assure that veteran is not facing harm.

Senator TESTER. OK. So, if it is with the VA they can file a compensation claim. Can they file a compensation claim with the VA if something goes badly in the private sector?

Dr. MATTHEWS. I would need to get back to you on that, sir. I would need to check our liability and all that.

Senator TESTER. Or does the contract specifically state you can file the claim with the VA and the VA would get the money from the person who screwed up?

Dr. STONE. Sir, we are going to get that for you, but I think you have got to go through the tort system. I think that this is——

Senator TESTER. So, they would be outside the VA.

Dr. STONE. I think so.

Senator TESTER. The veteran would be outside the VA.

Dr. STONE. My impression—and we are going to correct this if I am wrong——

Senator TESTER. No, no.

Dr. STONE [continuing]. But, my impression is you have got to go through the tort system.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Treatment by a non-VA physician at a non-VA facility under the MISSION Act would not qualify for section 1151 benefits. We note in relation to both VA's current community care authorities and the MISSION Act that, in *Ollis* v. *Shulkin*, 857 F.3d 1338 (Fed. Cir. 2017), the court carved out a limited exception pertaining to negligent referrals to non-VA providers in relation to the "event not reasonably foreseeable" provision of 1151. VA employees acting within the scope of their employment are protected by the Federal Tort Claims Act, which is an injured person's exclusive remedy in such a scenario; contractors are not protected from personal liability by the Federal Tort Claims Act. Veterans injured by non-VA providers may pursue a tort claim in accordance with state law, and non-VA providers have protection through their own insurance coverage.

Senator TESTER. Well, I think that is also information the veteran needs to know if something goes wrong. It becomes a little bit more complicated, in my opinion. I am not a veteran, but it sure appears that way to me.

Well, I want to thank you all for being here. I certainly appreciate it. Sorry about the herky-jerkiness of this hearing with the votes going on, but it is the nature of the beast. Nothing personal, OK?

We are going to stay in touch and make sure that we continue to be involved as you implement, and hopefully, as always, you will communicate back to us when you need help. This is a big step for the VA. I think we took a big step in Congress last year, and now we have got to make sure it works. If it does not work then you and I are both in trouble, right?

Thank you all very much.

If you have something to say, Dr. Stone, you can.

Dr. STONE. Just our thanks. Thank you, sir.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO RICHARD STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Do you believe that the MISSION Act will improve the quality of Veteran care?

Response. Yes. The Department of Veterans Affairs (VA) is leveraging the authorities in the VA MISSION Act of 2018 (MISSION Act) to grow into an optimized, Veteran-centric network of care and services. VA is one integrated system with direct and community aspects of care delivery, and the MISSION Act strengthens VA's ability to deliver excellence in both arenas. Veteran empowerment is at the core of VA's approach, and eligible Veterans will now be able to choose the balance in the system that is right for them. The MISSION Act also enables VA to deliver unprecedented access and a range of care options through our facilities and in the community. In addition, it strengthens our ability to furnish care through telehealth. Veterans served by VA uniquely face the physical and psychological impacts of military service and leveraging these new authorities to enhance care and meet Veterans where they are is critical to Veteran experience and health outcomes. The MISSION Act further enhances VA's ability to manage the complex care many Veterans need, and VA aims to lead the U.S. health care industry in care coordination.

Question 2. At this point, what challenges do you anticipate to encounter when MISSION Act takes effect?

Response. Any change in an organization of VA's scale must be approached with detailed strategy and unwavering focus. VA is committed to delivering on this significant implementation on June 6, 2019, and we have prioritized this effort among leaders and staff at all levels across the country. With robust implementation planning, thorough training, and dedicated leadership attention, VA expects to minimize challenges related to new process implementation. VA will work to immediately address any issues that may arise and will continue to enhance delivery of care beyond the initial date of implementation.

Senator TESTER. Absolutely. We will have the next panel come up and I will introduce you as we do the transfer. [Pause.]

I have been told that they are waiting on the second vote so I think Chairman Isakson will be here as soon as they call that vote and he casts it and then whistles back here to the hearing room.

In the meantime, I think we are going to get started with the statements. I want to introduce the witnesses for Panel II.

First we have Sharon Silas, who is the Acting Director for Health Care from the Government Accounting Office, otherwise known as the GAO. Then, we have Adrian Atizado, who is the Deputy National Legislative Director for the DAV, the Disabled American Veterans. Next, we have Merideth Randles, who is a Principal and Consulting Actuary for Milliman.

I think we will start with you, Ms. Silas, with your opening statement. I am not going to cut you off, but if you could try to keep it to 5 minutes and your entire written statement will be made a part of the record.

Thank you all for being here. We look forward to hearing your statements.

Ms. Silas?

STATEMENT OF SHARON SILAS, ACTING DIRECTOR FOR HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. SILAS. Thank you. Chairman Isakson, Ranking Member Tester, and Members of the Committee, thank you for the opportunity to be heard today to discuss the findings from two of our reports on the Veterans Choice Program, the challenges that the VA has faced in implementing that program and the lessons learned that can help inform the implementation of the new Veterans Community Care Program, or VCCP.

Congress established the Choice Program in 2014 to address longstanding challenges with veterans' access to health care services at VA medical facilities. In 2018, Congress passed the MISSION Act, establishing the VCCP, which requires VA to consolidate the Choice Program with other Community Care Programs by June 6, 2019. GAO believes that VA's experience implementing and administering the Choice Program over the last 4 years can help inform the agency's implementation of the new VCCP.

Specifically, in 2018, we issued two reports and made a total of 12 recommendations addressing issues with the implementation and administration of the Choice Program. These reports offer a detailed review of the program and identify a number of operational and oversight weaknesses with the process for referring and scheduling veterans' medical appointments, as well as ensuring timely payments to community providers.

First, in our June 2018 report, we identified numerous factors that adversely affected veterans' access to care through the Choice Program. For example, from the onset, VA's implementation of the program included an unnecessarily complex referral and appointment scheduling process that made it nearly impossible to meet VA's statutory requirement that veterans see a provider within 30 days when a clinician deemed the care was necessary.

Specifically we found that veterans could potentially wait up to 70 calendar days to receive care if staff took the maximum allowed time to complete the referral and appointment scheduling process established by the VA.

In addition to relying on an overly complex referral and appointment system, VA did not have enough trained staff, nor the tools, or the technology for the staff to efficiently coordinate and communicate across the program. The program also experienced insufficient contractor networks of community providers to meet veterans' health care needs.

Second, we found that VA could not systematically monitor the timeliness of veterans' access to care through the Choice Program because it lacked complete, reliable data to do so. The data limitations GAO identified included, for example, incomplete data on the timeliness of processing referrals and authorizations for care, and inaccuracies with the dates used to measure the timeliness of care.

Although VA has taken actions to help address some of these issues we have identified, not all issues have been fully resolved. Based on these findings, we made 10 recommendations focused on improving VA's monitoring of access to care and wait times, more clearly communicating changes to policy and guidance, and facilitating seamless information sharing throughout the program. All 10 recommendations from this report remain open.

In September 2018, we also reported on the timeliness of payments of claims to Choice providers, which are important to guaranteeing that a sufficient number of providers participate in the contractors' networks.

Although VA has taken actions to address challenges related to paying providers, such as updating its payment system and educating providers on the claims processing requirements, we still identified concerns. For example, we found that 9 of 15 providers included in our review continued to experience problems contacting

the VA to resolve medical claims issues. However, VA told us that they do not collect data on, or monitor contractor compliance with meeting customer service requirements. Based on this review, we made two recommendations that continue to remain open.

VA has told us that they have taken steps to address all 12 of our recommendations in preparation for the implementation of the VCCP. However, many of those recommendations rely on the implementation of new IT systems and awarding six new contracts for the program, of which three have been recently awarded.

In summary, launching the VCCP in 2019 is a large and complex undertaking which comes with many risks and challenges. VA's experience with the Choice Program provides an opportunity to avoid the missteps made with the implementation of that program, and from the onset ensure that there are enough trained staff and the proper processes, policies, and technology in place to effectively monitor the VCCP and ensure that the program is providing veterans with timely access to care.

This concludes my prepared statement. I would be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Silas follows:]

PREPARED STATEMENT OF SHARON SILAS, ACTING DIRECTOR FOR HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony
Before the Committee on
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VETERANS HEALTH CARE

VA Needs to Address Challenges as It Implements the Veterans Community Care Program

Statement of Sharon M. Silas, Acting Director
Health Care

GAO-19-507T

GAO Highlights

Highlights of GAO-19-507T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

April 10, 2019

VETERANS HEALTH CARE

VA Needs to Address Challenges as It Implements the Veterans Community Care Program

Why GAO Did This Study

In June 2018, Congress passed the VA MISSION Act of 2018, which requires VA to establish a permanent community care program. VA plans to consolidate the Choice Program and its other VA community care programs into one community care program—the VCCP. This legislation helps address some of the challenges faced by the Choice Program and VA's other community care programs. VA's implementation of the VCCP can benefit from the lessons learned under the Choice Program. Ignoring these lessons learned increases VA's risk for not being able to ensure that all veterans receive timely access to care in the community and that community providers are reimbursed in a timely manner.

This testimony focuses on lessons learned from the Choice Program, including recommendations GAO has made to VA to help ensure (1) veterans' timely access to care under the VCCP (2) effective monitoring of veterans' access to care under the VCCP, and (3) timely payments to community providers under the VCCP. This testimony is based on GAO reports on the Choice Program that were issued in June 2018 and September 2018.

What GAO Recommends

GAO has made 12 recommendations to VA to improve its management and oversight of the Choice Program and the VCCP. VA generally agreed with all but one of GAO's recommendations. GAO continues to believe that all of the recommendations are warranted. As of April 2019, these recommendations have not been implemented.

View GAO-19-507T. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Choice Program (Choice Program) allows eligible veterans to obtain health care services from providers not directly employed by VA (community providers). The program is largely managed by third party administrators (TPA), who are responsible for establishing provider networks, scheduling veterans' appointments, and paying providers. GAO has identified the following challenges to the Choice Program that VA needs to address as it implements its new Veterans Community Care Program (VCCP).

Factors that adversely affected veterans' timely access to care. GAO found that numerous factors adversely affected veterans' timely access to care through the Choice Program. These factors included (1) administrative burden caused by complexities of referral and appointment scheduling processes; (2) poor communication between VA and its medical facilities; and (3) inadequacies in the networks of community providers established by the TPAs, including an insufficient number, mix, or geographic distribution of community providers. VA has taken steps intended to help address these factors, however, some have not been fully addressed. In June 2018, GAO made five recommendations to VA, including that VA establish a system that will facilitate care coordination and exchanges of information among VA medical facilities, VA clinicians, TPAs, community providers, and veterans. VA agreed or agreed in principle with all five recommendations, but has not yet implemented them.

Unavailable and unreliable data. GAO found that VA cannot systematically monitor the timeliness of veterans' access to Choice Program care because it lacks complete, reliable data to do so. The data limitations GAO identified included a lack of data on the timeliness of accepting referrals and opting veterans in to the program, inaccurate data on clinically indicated dates (which are used to measure the timeliness of care), and unreliable data on the timeliness of urgent care. In June 2018, GAO made five recommendations to VA, including that VA implement mechanisms to allow VA to systematically monitor the amount of time taken to prepare referrals, schedule appointments, and complete appointments. VA agreed with four of the five recommendations, but has not yet implemented them.

Untimely payments to community providers. GAO identified three key factors that affected timeliness of payments to community providers under the Choice Program. These factors included (1) VA's untimely payments to TPAs, which in turn extended the length of time TPAs took to pay providers' claims; (2) Choice Program reimbursement requirements, which led to claim denials; and (3) inadequate provider education on filing claims. GAO found that VA has taken actions to address the factors, such as amending certain reimbursement requirements. However, two of these factors have not been fully addressed. In September 2018, GAO made two recommendations to VA, including that VA collect data on and monitor compliance with its requirements pertaining to customer service for community providers. VA agreed with the recommendations, but has not yet implemented them.

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

I am pleased to be here today to discuss the challenges the Department of Veterans Affairs (VA) has faced in implementing the Veterans Choice Program (Choice Program) that VA needs to address as it plans and implements its new community care program.[1]

In June 2018, the VA MISSION Act of 2018 was enacted and required VA to establish a permanent community care program. VA plans to consolidate the Choice Program and its other VA community care programs into one community care program—the Veterans Community Care Program (VCCP).[2] This legislation helps address some of the challenges faced by VA in ensuring timely access to care through the Choice Program and VA's other community care programs.

My testimony today focuses on lessons learned from the Choice Program, including recommendations we have made to VA to help ensure

1. veterans' timely access to care under the VCCP,
2. effective monitoring of veterans' access to care under the VCCP, and
3. timely payments to community providers under the VCCP.

My remarks are based on our work examining the Choice Program; specifically, our reports issued in June 2018 and September 2018 and recommendations therein.[3] These reports provide details on our scope and methodology. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing

[1]The Veterans Access, Choice, and Accountability Act of 2014 created the Choice Program as a temporary program to address problems with veterans' timely access to care at VA medical facilities. Under the Choice Program, when eligible veterans face long wait times, lengthy travel distances, or other challenges accessing care at VA medical facilities, they may obtain health care services from community providers—that is, providers who are not directly employed by VA. Pub. L. No. 113-146, 128 Stat. 1754 (2014). The Choice Program's authority sunsets on June 6, 2019.

[2]Pub. L. No. 115-182, tit. I, 132 Stat. 1393 (2018).

[3]See GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, GAO-18-281 (Washington, D.C.: June 4, 2018) and GAO, *Veterans Choice Program: Further Improvements Needed to Help Ensure Timely Payments to Community Providers*, GAO-18-671 (Washington, D.C.: Sept. 28, 2018).

standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Veterans Access, Choice, and Accountability Act of 2014 provided up to $10 billion in funding for veterans to obtain health care services from community providers through the Choice Program when veterans faced long wait times, lengthy travel distances, or other challenges accessing care at VA medical facilities.[4] The temporary authority and funding for the Choice Program was separate from other previously existing programs through which VA has the option to purchase care from community providers. Legislation enacted in April, August, and December of 2017 and June 2018 extended the Choice Program and provided an additional $9.4 billion for the Veterans Choice Fund.[5] Authority for the Choice Program will sunset on June 6, 2019.[6]

Responsibilities of the Choice Program's Third Party Administrators

In October 2014, VA modified its existing contracts with two contractors—referred to as third party administrators (TPA)—that were administering another VA community care program to add certain administrative responsibilities associated with the Choice Program. For the Choice Program, each of the two TPAs—Health Net and TriWest—was responsible for managing networks of community providers who deliver care in a specific multi-state region. Specifically, the TPAs were

[4]Pub. L. No. 113-146, §§ 101, 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

[5]An Act to amend the Veterans Access, Choice, and Accountability Act of 2014 to modify the termination date for the Veterans Choice Program, and for other purposes, Pub. L. No. 115-26, § 1, 131 Stat. 129 (2017). VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, § 101, 131 Stat. 958, 959 (2017) (providing an additional $2.1 billion for the Veterans Choice Fund); An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes, Pub. L. No. 115-96. Div. D, § 4001, 131 Stat. 2044, 2052-53 (2017) (providing an additional $2.1 billion for the Veterans Choice Fund) and Pub. L. No. 115-182, tit. V, § 510, 132 Stat. 1393,__ (2018) (providing an additional $5.2 billion for the Veterans Choice Fund).

[6]Pub. L. No. 115-182, tit. I, § 143, 132 Stat. 1393, __ (2018), amending section 101(p) of the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. at 1763.

responsible for establishing networks of community providers, scheduling appointments with community providers for eligible veterans, and paying community providers for their services. Health Net's contract for administering the Choice Program ended on September 30, 2018, with TriWest continuing to administer the Choice Program in its region and the region previously administered by HealthNet until the program ends.

Process for Choice Program Appointment Scheduling

Through policies and standard operating procedures for VA medical facilities and contracts with the TPAs, VA established processes for referring and scheduling appointments through the Choice Program: one process for time-eligible veterans and another for distance-eligible veterans.[7] Table 1 provides an overview of the appointment scheduling process that applies when a veteran is referred to the Choice Program because the veteran is time-eligible—that is, the next available medical appointment with a VA clinician is more than 30 days from the veteran's preferred date or, in the absence of such a date, the date the veteran's physician determines he or she should be seen.

[7]For the purposes of this statement, the terms "time-eligible" and "distance-eligible" refer to the Choice Program processes used to schedule veterans' appointments. VA uses the time-eligible appointment scheduling process when the services needed are not available at a VA medical facility or are not available within allowable wait times. We did not evaluate VA's determination that veterans for whom services were unavailable were eligible for the Choice Program. VA uses the distance-eligible appointment scheduling process when veterans reside more than 40 miles from a VA medical facility or meet other travel-related criteria. Data we obtained from the TPAs indicate that VA and the TPAs used the time-eligible appointment scheduling process about 90 percent of the time from fiscal year 2015 through fiscal year 2016 (the first 2 years of the Choice Program's implementation).

Table 1: Process for Veterans to Obtain Department of Veterans Affairs (VA) Choice Program Care if They Are Time-Eligible

Steps of the Choice Program scheduling process	Completed by VA medical facility staff	Completed by Choice Program third party administrator (TPA) staff	Completed by the veteran
A VA clinician determines the veteran needs care.	✓		
VA medical facility staff confirm the veteran's eligibility for Choice Program care and begin contacting the veteran to offer a referral to the Choice Program.	✓		
The veteran agrees to be referred to the Choice Program.			✓
VA medical facility staff compile relevant clinical information (including a description of the specific services and type of medical specialist the veteran needs) and submit the veteran's referral to the TPA.	✓		
TPA staff review the veteran's Choice Program referral to ensure it contains information needed to proceed with appointment scheduling and accept the referral if the information is sufficient.		✓	
TPA staff contact the veteran by telephone to confirm that he or she wants to opt in to the Choice Program. If the veteran is not reached by telephone, the TPA sends a letter requesting that the veteran contact the TPA to opt in to the program.		✓	
If the veteran opts in to the Choice Program, TPA staff create an authorization and begin efforts to schedule an appointment with a community provider.		✓	
TPA staff schedule an appointment with a community provider. The authorization (which contains relevant clinical information, a description of authorized services, and a period of validity) is sent to the community provider. The veteran is informed of the date and time of the appointment.		✓	
The veteran attends the initial appointment with the Choice Program community provider.			✓

Legend:
✓ = responsibility for process step.
Source: GAO analysis of VA documents. | GAO-19-507T

Note: VA uses the time-eligible appointment scheduling process when the services needed are not available at a VA medical facility or are not available within allowable wait times.

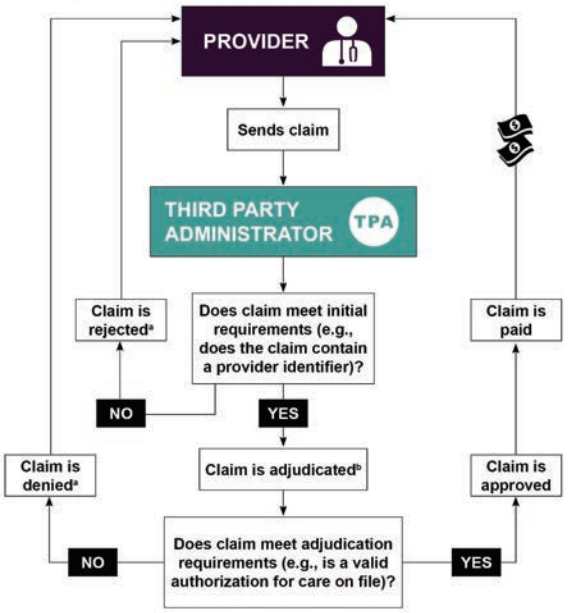
When veterans reside more than 40 miles from a VA medical facility or meet other travel-related criteria, VA uses the appointment scheduling process it developed for distance-eligible veterans. The process for distance-eligible veterans differs from that for time-eligible veterans in that VA medical facilities do not prepare a referral and send it to the TPA.

Instead, distance-eligible veterans contact the TPA directly to request Choice Program care.

Choice Program Claim Processing and Payment

VA's Choice Program TPA processes claims it receives from community providers for the care they deliver to veterans and pays providers for approved claims. Figure 1 provides an overview of the steps the TPA follows for processing claims and paying community providers.

Figure 1: Steps the TPA Follows to Process and Pay Claims from Community Providers for Care Delivered Under the Veterans Choice Program



Source: GAO analysis of third party administrator (TPA) information | GAO-19-507T

[a]According to TPA officials, rejected claims are claims returned up front to providers due to, for example, the use of invalid claim forms and missing provider identification numbers. Denied claims are claims that contain the necessary data elements but do not pass required claim processing steps, which, for example, verify the veteran's eligibility for the Veterans Choice Program, that a valid authorization for care is on file, and that the claim is not a duplicate.

[b]Claim adjudication refers to the process of reviewing a claim and making the decision to approve or deny it. Claims being adjudicated are either classified as clean or non-clean claims. Clean claims are claims that contain all required data elements, while non-clean claims are those claims that are missing required data elements that the TPA must obtain before the claim is paid.

To be reimbursed for its payments to providers, the TPA in turn submits electronic invoices—or requests for payment—to VA. The TPA generates an invoice for every claim it receives from community providers and pays. VA reviews the TPA's invoices and either approves or rejects them. Invoices may be rejected, for example, if care provided was not authorized. Approved invoices are paid, whereas rejected invoices are returned to the TPA. Under the Prompt Payment Act, VA is required to pay its TPAs within 30 days of receipt of a clean Choice Program invoice.[8]

VA's Planned Veterans Community Care Program

The VA MISSION Act of 2018, among other things, requires VA to establish a permanent community care program no later than 1 year after passage of the Act (June 6, 2019) and authorizes VA to utilize a TPA for claims processing. VA refers to the consolidated program as the VCCP. In December 2016, prior to enactment of the VA MISSION Act of 2018, VA issued a request for proposals for contractors to help administer the VCCP. The VCCP will be similar to the current Choice Program in certain respects. For example, under the VCCP, TPAs will be responsible for establishing regional networks of community providers and processing and paying those providers' claims. However, unlike the Choice Program, under the VCCP, VA is planning to have medical facilities—not the TPAs—generally be responsible for scheduling veterans' appointments with community providers. VA awarded contracts for administering the VCCP in three of six regions on December 28, 2018. As of April 3, 2019, VA had not yet awarded contracts for the remaining three regions.

Generally, all veterans enrolled in the VA health care system would be able to qualify for care through the VCCP when (1) VA does not offer the care or service required by the veteran; (2) the veteran resides in a state without a full-service VA medical facility; (3) the veteran would have been eligible under the 40-mile criterion of the Choice Program before June 6, 2018; (4) VA cannot provide the veteran with care and services that comply with its designated access standards; or (5) the veteran and the veteran's referring clinician agree that it is in the best interest of the veteran to receive care in the community. In January 2019, VA proposed new access standards for the VCCP based on average drive times and wait times:

[8]31 U.S.C. § 3903(a)(1); 5 C.F.R. part 1315.

- For primary care, mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive time standard.
- For specialty care, VA is proposing a 60-minute average drive time standard.
- VA is proposing appointment wait-time standards of 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request with certain exceptions.[9]

Eligible veterans who cannot access care within those standards would be able to choose between eligible community providers and care at a VA medical facility. VA expects to issue the final regulation establishing access standards for the VCCP by June 2019.

VA Needs to Address Various Factors That Adversely Affected Veterans' Access to Care through the Choice Program to Help Ensure Timely Care under the VCCP

In June 2018, we reported that numerous factors adversely affected veterans' timely access to care through the Choice Program and could affect implementation of the VCCP.[10] These factors included the following: (1) administrative burden caused by complexities of VA's referral and appointment scheduling processes; (2) poor communication between VA and its medical facilities; and (3) inadequacies in the networks of community providers established by the TPAs, including an insufficient number, mix, or geographic distribution of community providers. VA has taken steps to help address these factors; however, not all access factors have been fully addressed. For example, to help address administrative burden and improve the process of coordinating veterans' Choice Program care, VA established a secure e-mail system and a mechanism for TPAs and community providers to remotely access veterans' VA electronic health records. However, these mechanisms only facilitate a one-way transfer of necessary information. They do not provide a means by which VA medical facilities or veterans can view the TPAs' step-by-step progress in scheduling appointments or electronically receive medical documentation associated with Choice Program appointments.

We made five recommendations to VA to address the factors that adversely affected veterans' access to Choice Program care. VA agreed

[9]84 Fed. Reg. 5629 (Feb. 22, 2019).

[10]See GAO-18-281.

or agreed in principle with all five recommendations. Our recommendations and the steps, if any, VA has taken in response to these recommendations are described in table 2.

Table 2: GAO Recommendations for Addressing Factors Adversely Affecting Veterans' Access to Care and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should (1) establish oversight mechanisms to ensure that VA is collecting reliable data on the reasons that VA medical facility or third party administrator (TPA) staff are unsuccessful in scheduling veterans' appointments through the Veterans Community Care Program (VCCP), and (2) demonstrate that it has corrected any identified deficiencies.[a]	VA agreed with our recommendation and stated that it has developed a mechanism for capturing unsuccessful scheduling attempts. According to VA, this mechanism will be incorporated into its new Health Share Referral Manager system, which VA expects will be fully implemented across all VA medical facilities by September 2019. The exact oversight mechanism and ability to identify and correct deficiencies are still being established.
The Secretary of Veterans Affairs should ensure that the contracts for the VCCP include performance metrics that will allow VA to monitor average driving times between veterans' homes and the practice locations of community providers that participate in the TPAs' networks.	VA agreed with our recommendation and stated that its Veterans Community Care Network contract request for proposals includes performance metrics that will allow VA to monitor average driving times between veterans' homes and the practice locations of community providers that participate in the TPAs' networks.
The Secretary of Veterans Affairs should establish a system for the VCCP to help facilitate seamless, efficient information sharing among VA medical facilities, VA clinicians, TPAs, community providers, and veterans. Specifically, this system should allow all of these entities to electronically exchange information for the purposes of care coordination.	VA agreed with our recommendation and stated that its new Health Share Referral Manager system, which VA expects will be fully implemented across all medical facilities by September 2019, will be a key component of an overall system that will facilitate information sharing among medical facilities, VA clinicians, TPAs, community providers, and veterans. VA expects to implement this recommendation by September 2019.
The Under Secretary for Health should conduct a comprehensive evaluation of the outcomes of the two appointment scheduling pilots it established at the Alaska and Fargo VA Health Care Systems (where VA medical facility staff, rather than TPA staff, are responsible for scheduling veterans' Choice Program appointments), which should include a comparison of the timeliness with which VA medical facility staff and TPA staff completed each step of the Choice Program appointment scheduling process, as well as the overall timeliness with which veterans received appointments.	VA agreed with our recommendation. VA's new Health Share Referral Manager system, which VA expects will be fully implemented across all medical facilities by September 2019, will enable VA to assess the timeliness of appointment scheduling. VA expects to implement this recommendation by October 2019.
The Under Secretary for Health should issue a comprehensive policy directive and operations manual for the VCCP and ensure that these documents are reviewed and updated in a timely manner after any significant changes to the program occur.	VA agreed in principle with this recommendation and stated that the VA Office of Community Care will consider whether new policy directives are needed after the VCCP has been implemented and interim challenges to implementation have been resolved.

Source: GAO-18-281 and GAO analysis of Department of Veterans Affairs (VA) information. | GAO-19-507T

[a]The report in which we made these recommendations, refers to the VCCP as the consolidated community care program VA plans to implement, because the name of the program had not yet been

announced. See GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, GAO-18-281 (Washington, D.C.: June 4, 2018).

VA Needs Complete and Reliable Data to Effectively Monitor Veterans' Access to Care under the VCCP

In June 2018, we reported that VA cannot systematically monitor the timeliness of veterans' access to Choice Program care because it lacks complete, reliable data to do so.[11] VA will need to address these data limitations in order to effectively monitor the care delivered to veterans through the VCCP. The data limitations we identified included the following:

- **A lack of data on the timeliness of accepting referrals and opting veterans in to the program.** We found that the data VA uses to monitor the timeliness of Choice Program appointments do not capture the time it takes VA medical facilities to prepare veterans' referrals and send them to the TPAs, nor do they capture the time spent by the TPAs in accepting VA medical facilities' referrals and opting veterans in to the Choice Program. VA had implemented an interim solution to monitor overall wait times that relies on VA medical facility staff consistently and accurately entering unique identification numbers on VA clinicians' requests for care and on Choice Program referrals, a process that is prone to error.

- **Inaccuracy of clinically indicated dates.** We found that clinically indicated dates (used to measure the timeliness of care) are sometimes changed by VA medical facility staff before they send Choice Program referrals to the TPAs, which could mask veterans' true wait times. We found that VA medical facility staff entered later clinically indicated dates on referrals for about 23 percent of the 196 authorizations we reviewed.[12] It is unclear if VA medical facility staff mistakenly entered incorrect dates manually, or if they inappropriately entered later dates when the VA medical facility was delayed in contacting the veteran, compiling relevant clinical information, and sending the referral to the TPA.

[11]See GAO-18-281.

[12]We manually reviewed a random, non-generalizable sample of 196 Choice Program authorizations. The authorizations were created for veterans at 6 selected VA medical facilities who were referred to the program between January and April of 2016, the most recent period for which data were available when we began our review. The sample of authorizations included 55 for routine care, 53 for urgent care, and 88 that the TPAs returned without scheduling appointments.

• **Unreliable data on the timeliness of urgent care.** We found that VA medical facilities and TPAs do not always categorize Choice Program referrals and authorizations in accordance with the contractual definition for urgent care. According to the contracts, a referral is to be marked as "urgent," and an appointment is to take place within 2 business days of the TPA accepting it, when a VA clinician has determined that the needed care is (1) essential to evaluate and stabilize the veteran's condition, and (2) if delayed would likely result in unacceptable morbidity or pain. We reviewed a sample of 53 urgent care authorizations and determined that about 28 percent of the authorizations were originally marked as routine care authorizations but were changed to urgent by VA medical facility or TPA staff, in an effort to administratively expedite appointment scheduling.

We made five recommendations to VA on improving the completeness and accuracy of data on veterans' wait times for care. VA agreed with four of the five recommendations. Our recommendations and the steps VA has taken in response to these recommendations are described in table 3.

Table 3: GAO Recommendations for Improving the Timeliness and Accuracy of Data on Veterans' Wait Times for Care and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should establish an achievable wait-time goal for the Veterans Consolidated Community Care Program (VCCP) that will permit VA to monitor whether veterans are receiving VA community care within time frames that are comparable to the amount of time they would otherwise wait to receive care at VA medical facilities.[a]	VA agreed with our recommendation and has proposed wait-time standards for the VCCP. VA stated that, as its new standards are implemented, there will be transparency on the wait times for obtaining an appointment in the community, which will allow providers and veterans to make a more informed decision on where to obtain care based on medical need and timeliness of the appointment. According to VA, VA staff are meeting weekly to review current processes and determine if further updates are needed. VA expects to implement this recommendation by June 2019.
The Under Secretary for Health should design an appointment scheduling process for the VCCP that sets forth time frames within which (1) veterans' referrals must be processed, (2) veterans' appointments must be scheduled, and (3) veterans' appointments must occur, which are consistent with the wait-time goal VA has established for the program.	VA agreed with our recommendation and stated that it is developing a decision support tool to help determine how to deliver care in a timely and convenient manner. Among other features, the tool will display both VA clinic availability and the veteran's eligibility for community care, so administrative and clinical staff can work with the veteran to make an informed decision on when and where the requested care could be best delivered. According to VA, VA staff are meeting weekly to review current processes and determine if further updates are needed. VA expects to implement this recommendation by June 2019.
The Under Secretary for Health should establish a mechanism that will allow VA to systematically monitor the average number of days it takes for medical facilities to prepare referrals, for medical facilities or third-party administrators (TPA) to schedule veterans' appointments, and for veterans' appointments to occur, under the VCCP.	VA agreed with our recommendation and stated that it is developing a mechanism to systematically monitor the average number of days it takes for medical facilities to prepare referrals, for medical facilities or TPAs to schedule veterans' appointments, and for veterans' appointments to occur, under the VCCP. According to VA, this mechanism will be incorporated into its new Health Share Referral Manager system, which VA expects will be fully implemented across all VA medical facilities by September 2019.
The Under Secretary for Health should implement a mechanism to prevent veterans' clinically indicated dates from being modified by individuals other than VA clinicians when veterans are referred to the VCCP.	VA agreed with our recommendation and stated that its new Health Share Referral Manager system, which VA expects will be fully implemented across all VA medical facilities by September 2019, will interface with the existing consult package that has been modified to allow a VA clinician to enter the clinically indicated date while restricting schedulers from making alterations to it.
The Under Secretary for Health should implement a mechanism to separate clinically urgent referrals and authorizations from those for which the VA medical facility or the TPA has decided to expedite appointment scheduling for administrative reasons.	VA did not agree with this recommendation and stated there will no longer be a need to separate clinically urgent referrals for care from those that need expediting under the VCCP. However, we maintain that our recommendation is warranted. In particular, we found that VA's data did not always accurately reflect the timeliness of urgent care because both VA medical center and TPA staff inappropriately re-categorized some routine care referrals and authorizations as urgent ones for reasons unrelated to the veterans' health conditions.

Source: GAO-18-281 and GAO analysis of Department of Veterans Affairs (VA) information. | GAO-19-507T

[a]The report in which we made these recommendations, refers to the VCCP as the consolidated community care program VA plans to implement, because the name of the program had not yet been announced. See GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, GAO-18-281 (Washington, D.C.: June 4, 2018).

Further Improvements Are Needed to Help Ensure Timely Payments to Community Providers

In September 2018, we reported that three key factors affected timeliness of payments to community providers under the Choice Program and that if unaddressed could affect provider payment timeliness for the VCCP.[13] These factors included the following: (1) VA's untimely payments to TPAs, which in turn extended the length of time TPAs took to pay community providers' claims; (2) Choice Program reimbursement requirements, which led to claim denials; and (3) inadequate provider education on filing claims. We reported that VA has taken some actions to address these factors. For example, VA updated its payment system and related processes to pay TPAs more quickly. According to VA data, as of July 2018, VA was paying at least 90 percent of the TPAs' invoices within 7 days, a significant increase from the 50 percent timely payments VA made to TPAs between November 2014 and September 2016. In addition, VA and the TPAs had taken steps to amend certain reimbursement requirements and improve provider education to help providers resolve claims processing issues.

However, we found that VA has not fully addressed two of these factors. First, with respect to reimbursement requirements, VA does not have complete data allowing it to effectively monitor adherence with its policy for VA medical facilities to perform timely reviews and approvals of secondary authorization requests. Community providers request secondary authorization requests when veterans need health care services that exceed the period or scope of the original authorization. Incomplete data impacted VA's ability to meet the requirement. When VA medical facilities delay these reviews and approvals, community providers may have to delay care or deliver care that is not authorized, which in turn increases the likelihood that the providers' claims will be denied and the providers will not be paid. Second, with respect to provider education on filing claims, VA requires the TPAs to establish a customer call center to respond to calls from veterans and non-VA providers. However, VA does not enforce the contractual requirement for responding to calls from community providers and allows the TPAs to prioritize calls from veterans over calls from community providers. Consequently, VA is not collecting data, monitoring, or enforcing compliance with its contractual requirements for the TPAs to provide timely customer service to providers. As a result, VA does not have information on the extent to which community providers face challenges when contacting the TPAs

[13]See GAO-18-671.

about claims payment issues, which could contribute to the amount of time it takes to receive reimbursement for services.

To address remaining factors that affect provider payment timeliness, we made two recommendations to VA. VA agreed with both recommendations. Our recommendations and the steps VA has taken in response to these recommendations are described in table 4.

Table 4: GAO Recommendations on Improving the Timeliness of Payments to Community Providers and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
Once VA's new software for managing authorizations has been fully implemented, the Undersecretary for Health should monitor data on secondary authorization request approval decision time frames to ensure VA medical facilities are in adherence with VA policy, assess the reasons for nonadherence with the policy, and take corrective actions as necessary.	VA agreed with our recommendation and stated that it has already taken steps to improve compliance with secondary authorization request approval timeframes.by identifying challenges, agreeing on improvement actions, and providing training. According to VA, its new Health Share Referral Manager system, which VA expects will be fully implemented across all medical facilities by September 2019, will automate secondary authorization request reporting and tracking. According to VA, it will utilize this new system to ensure compliance with secondary authorization request approval time frames.
The Undersecretary for Health should collect data and monitor compliance with the Choice Program contractual requirements pertaining to customer service for community providers, and take corrective actions as necessary.	VA agreed with our recommendation and stated that it currently does not have the ability to monitor and assess the performance of customer service operations under the Choice Program contracts. VA has included additional requirements for customer service in the Veterans Community Care Network request for proposals and plans to monitor compliance with these requirements under the Veterans Community Care Program. VA expects to implement this recommendation by December 2019.

Source: GAO-18-671 and GAO analysis of Department of Veterans Affairs (VA) information. | GAO-19-507T

In summary, consolidating its existing community care programs into the VCCP and launching this new program in June 2019 is a large and complex undertaking, which comes with many risks and challenges for VA. Heeding the lessons learned from its implementation and management of the Choice Program will better position VA to ensure veterans receive timely access to care under the VCCP and avoid past challenges such as delays in scheduling appointments and untimely payments to community providers. Continued oversight of VA's implementation of the VCCP will be critical given the scale of change and the associated risks. We stand ready to assist this Committee with this continued oversight.

Chairman Isakson, Ranking Member Tester, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or silass@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Marcia Mann (Assistant Director), Michael Zose (Analyst-in-Charge), Jacquelyn Hamilton, Christina Ritchie, Kate Tussey, and Emilie Weisser.

Senator TESTER. Thank you, Ms. Silas. And, before I get to Mr. Atizado I just want to say—I want to thank Dr. Matthews and Dr. MacDonald for staying here for this panel. Oftentimes agencies leave when a second panel comes in. It is important that you are here to listen, so thank you for being here.

Mr. Atizado, you are up next.

STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Thank you, Senator Tester. Ranking Member Tester, Chairman Isakson, distinguished Members of the Com-

mittee, first, I would like to thank you for inviting DAV to testify at this hearing to examine VA's progress in implementing the Veteran Choice Program required by the MISSION Act. As we all know, it is due by June 6.

DAV is a non-profit veteran service organization. We are comprised of over one million wartime service-disabled veterans, and today's hearing is critical for us and our membership because most of our members not only choose but they rely—if not most as well as entirely on the VA for care.

As you know, DAV worked closely with this Committee, with Congress, and VA in helping not only to craft, but enact the VA MISSION Act. We continue to believe that, if fully and faithfully implemented, this landmark law will move us beyond just giving veterans choice, that it can and should empower veterans to make more informed decisions. But, it appears VA's proposed rules may not achieve these goals.

Title I requires VA to be the primary provider and coordinator of care in a high-performing integrated network which combines the strengths of VA as well as the best of which the community can offer. This is all, of course, to offer veterans seamless access to high-quality as well as coordinated care in a timely manner.

VA is making progress implementing Title I of the VA MISSION Act, but with less than 8 weeks before the new law is set to take full effect we do not believe that the new wait and drive-time eligibility standards can be easily and efficiently implemented without serious risk.

We base our assessment on several factors that raise doubt, including VA's performance in successfully developing IT solutions on time, as well as the USDS—U.S. Digital Services—report on VA's compliance with Section 101 of the MISSION Act, VA's performance in implementing, operating, and improving the Veterans Choice Program, including GAO's reports on problematic weaknesses in the operation and oversight of the Choice Program, as well as VA's performance in accurately measuring wait times.

As my co-panel just mentioned, there is a misalignment with the timeline for transition to the Veteran Community Care Program with only three of the six regional contracts having been awarded. We have considered VA's proposed rule and its inconsistencies with the law; and within the proposed regulations itself it is lacking several basic elements that are important to our veterans, especially as it is required by the MISSION Act. These are things such as requiring private providers to meet the same time, same distance, and quality standards required of VA.

The proposed rule is insufficiently justified and uses assumptions that are far from reality. We have serious doubts VA will have the sufficient resources, staffing, and clinical space, as well as the executable plan to train and educate all those involved to have a smooth and successful transition to the new Community Care Program.

Simply, VA's proposed rules raise more questions than answers to us and leaves out critical pieces that would otherwise ensure veterans who meet the new eligibility standards are, in fact, able to receive timely, highest quality, and coordinated care.

Weighing all these factors, we believe VA is not, nor will likely be sufficiently prepared within 8 weeks without compromising some form of quality and risking unnecessary disruptions in receiving the care ill and injured veterans need.

Just to be clear, the majority of the law can and should move forward, particularly the urgent care benefit, expansion of the caregiver program, and the improved organ donor and transplant program. Moreover, VA should move forward with other access standards required by the MISSION Act, as the grandfathered 40-mile rule when services are not available at the VA facility, when veterans experience unusual and excessive burdens in traveling, and when it is in the veteran's best interest.

However, we believe this Committee must consider whether VA should withdraw the proposed wait and drive-time standards or otherwise delay its implementation until VA has tested and certified that this new standard is not only feasible but sustainable, and that both VA and private providers can meet these standards together.

With what is at stake for ill and injured veterans across the country, we believe it is far better to get this right than to rush forward and play catch-up when things do not work.

Mr. Chairman and Members of the Committee, thank you again for allowing DAV to testify at this important hearing. I would be happy to answer any questions you have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, DISTINGUISHED MEMBERS OF THE COMMITTEE: Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing to examine the Department of Veterans Affairs (VA) progress in implementing title I of Public Law (P.L.) 115–182, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018.

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

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

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

creased number of veterans who use the VCCP networks, VA should continue to use the existing access standards of the Veterans Choice program.

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

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

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

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

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

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

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

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

other individual discover that sensitive information has been used beyond the purposes for which it was disclosed, and what the process is once the VA is so notified.

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

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

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

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

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

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

For fiscal year 2014, VHA received the highest ever funding level of $54 billion in advance appropriations, with additional funds from the Consolidated Appropriations Act enacted in January 2014. However, by April 2014, the waiting list scandal and access crisis erupted at the Phoenix VA Medical Center (VAMC) and by August, Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014, was enacted to establish, in 90 days, the temporary Veterans Choice Program. The purpose of the Act was to mitigate the crisis by ensuring veterans had access to care in the community paid for by VA while strengthening the VA health care system. This new program was set to expire until such time as the initial $10 billion deposited in the Veterans Choice Fund estimated to be expended by mid-August 2017.

This Committee is well aware of the troubled implementation and execution of the Veterans Choice Program, ranging from the adequacy of the provider networks, par-

ticipating providers not being paid timely, veterans experiencing as long if not longer waiting times seeking care in the community as well as being chased by collection agencies because the community providers were just not being paid for authorized care. Moreover, our calls to ensure the taxpayers are getting the best value for the resources appropriated, and for true care coordination and transparency in the quality of care veterans are receiving from community providers have not been adequately answered.

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

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

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

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

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

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

As opposed to avoiding complicated and ambiguous procedures to be implemented with administrative simplicity in determining veterans' eligibility for community care, VA has proposed rules expanding both the number and complexity of eligibility based on six criteria.[12] One of these six designated criteria is also the subject of nu-

[8] P.L. 115–46
[9] P.L. 115–96
[10] https://docs.house.gov/billsthisweek/20170724/S. 114.pdf
[11] P.L. 113–175, Public Law 113- 235, Public Law 114–19, Public Law 114–41, Public Law 115–26.
[12] VA proposed 38 CFR § 17.4010(a)(1)-(5)

merous substantive comments from the public and from elected officials. The wait time assumptions are suspect and drive time criteria is opaque and predisposed to result in arbitrary eligibility determinations, all of which will also likely contribute to dangerous fiscal uncertainty.[13]

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

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

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

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

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

To this end, we are compelled to question how and when VA will make public the tiered network of community providers intended "[t]o promote the provision of high-quality and high-value hospital care, medical services, and extended care services under this section,"[15] as well as establishing a monitoring system for the quality of care and services provided through the network of community providers.[16]

Correspondingly, the same provisions in the VA MISSION Act requiring identification and stratification of providers also intends for all providers in the high-performing integrated networks be held to the same standards—for both access and quality. More specifically, we believe at minimum those standards the VA is held to should equally be applied to community providers. Not holding VA and its community provider partners to the same standards could lead to delayed care, lower

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[13] VA proposed 38 CFR § 17.4040

[14] Congressional Submission VA Budget Request for FY 2020 Funding and FY 2021 Advance Appropriations, Volume II: Medical Programs and Information Technology Programs; Page: VHA–174.

[15] 38 U.S.C. § 1703(g)

[16] 38 U.S.C. § 1703(h)

quality care and worse health outcomes for veterans. It appears instead VA is creating a double standard allowing community providers to meet lower and nonspecific access and quality requirements.

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

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

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

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

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

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

Senator TESTER. Thank you, Mr. Atizado.

Ms. Randles, you are up.

STATEMENT OF MERIDETH RANDLES, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN

Ms. RANDLES. Good afternoon, Chairman Isakson, Ranking Member Tester, and distinguished Members of the Committee. Thank you for the opportunity to discuss Milliman's role in the development of the Department of Veterans Affairs expenditure estimates associated with the MISSION Act Community Care access standards.

My name is Merideth Randles and I am a principal and consulting actuary with Milliman, an international firm of actuaries and consultants. Our firm is broadly acknowledged to be the leading consulting firm to health care insurers and providers in the United States.

Health care utilization and expenditure projections are at the core of the actuarial consulting that we, as health care actuaries, provide to our clients. As a firm, we have served thousands of clients in the area of health care modeling through in-depth expertise

around the specific needs, characteristics, and health care delivery environment of the population at risk.

I am a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries. I began consulting with VHA in 1995, and was involved with the inception of the Enrollee Health Care Projection Model, VA's actuarial health care forecasting model, in 1998. This involvement continued as the model became integral to VHA's budget formulation and strategic planning processes. I have supported VA in the valuation of a multitude of legislation, policies, and program initiatives, as well as briefings to governmental stakeholders.

VA's Enrollee Health Care Projection Model was used to estimate the cost for the MISSION Act access standards. This model is a health care demand projection model and uses actuarial methods to project veteran enrollment, utilization of VA health care, both specifically for VA facility and community care and the associated costs of that care.

The methodology underpinning the model is similar to approaches used by private health insurers, Medicare, and Medicaid. The model incorporates detailed demographic data specific to the VA Enrollee Health Care population, health care trends, economic conditions, and other drivers of change in the health care utilization and costs.

As the model was first developed in 1998, the current model is now informed by 20 years of VA experience, along with the expertise of VA's actuarian consultants at Milliman. The model is updated annually with emerging experience data and used to produce multiple enrollment, utilization, and expenditure scenarios each year. These scenarios are widely used by VA for important stakeholder needs, and the model now supports 90 percent of VA's medical care budget.

The VA system is different from most health care programs in that, as referenced earlier, over 80 percent of veteran enrollees have other health insurance such as Medicare or employer-sponsored insurance. Therefore, VA is often called upon to provide only a portion of a veteran's health care needs. The term "reliance" in this context refers to the portion of enrollee's total health care need that they expected to receive through VA, at either a VA-operated facility or through community care, rather than through other health care sources.

Fiscal year 2017 experience data indicates that through both VA facility care and community care VA provided 36 percent of the health care services used by enrollees, while other health insurance provided the remaining 64 percent.

Upon separation from the military, veterans navigate the U.S. health care system in a fashion similar to the general population, with the notable exception that they also have access to VA. Given this choice, current reliance levels are a testament to how many veterans value the care and services VA has to offer.

Every percentage point increase in reliance represents significant budgetary resource requirements. In estimating the impact from MISSION, we considered the experience of the Choice 40-mile enrollees. These enrollees received enhanced eligibility to access care in the community, and, by definition, have limited geographic ac-

cess to VA facility care, as compared to the average enrollee. Therefore, it is reasonable to assume that enrollees eligible for similar access under MISSION's drive-time standards will have similar utilization and reliance behaviors.

Since 2015, ambulatory inpatient utilization has increased significantly for these Choice enrollees, and is expected to increase further. But, I will emphasize that this utilization growth is for all VA-sponsored care, both within VA facilities and in community care. Further, utilization of VA facility care by these Choice enrollees has been stable and did not decline over this period. Finally, there have been no material impacts on enrollment due to the Choice Program.

I have provided extensive details regarding the actuarial methodology developed for the MISSION impact estimates within my written testimony, and I welcome your questions. Thank you.

[The prepared statement of Ms. Randles follows:]

PREPARED STATEMENT OF MERIDETH RANDLES, FSA, MAAA, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN, INC.

GOOD AFTERNOON, CHAIRMAN ISAKSON, SENATOR TESTER, AND DISTINGUISHED MEMBERS OF THE COMMITTEE. I am pleased to be here today to discuss Milliman's role in the development of the Department of Veterans Affairs' (VA's) expenditure estimates associated with the MISSION Act community care access standards.

ABOUT MILLIMAN

My name is Merideth Randles and I am a principal and consulting actuary with Milliman, an international firm of actuaries and consultants. Milliman has been evaluating financial risk for clients since 1947. Our firm is broadly acknowledged to be the leading consulting firm to health care insurers and providers in the United States. Health care utilization and expenditure projections are at the core of the actuarial consulting that we, as health actuaries, provide to our clients. As a firm, we have served thousands of clients in the area of health care modeling, and with each effort accounting for the specific needs, characteristics, and health care delivery environment of the population at risk.

Our health care clients consist of the majority of the health insurers in the Nation, including Blue Cross Blue Shield plans, health maintenance organizations (HMOs), and health insurance companies. In addition, our consultants provide cost modeling services to many health care providers, including hospitals, physician groups, pharmacy benefit managers, and other provider organizations. Our firm contracts with a number of governmental agencies to assist them with health care cost forecasting, including state Medicaid programs, state mental health agencies, state employee plans, state insurance departments, numerous county and municipal entities, and Federal agencies, such as the Department of Defense, Centers for Medicaid and Medicare Services (CMS) and notably, the Department of Veterans Affairs.

I have 24 years of health actuarial experience and I have been consulting with Milliman for the entirety of my career. I am a Fellow in the Society of Actuaries (FSA) and a member of the Academy of Actuaries (MAAA). I have been involved with the Veterans Health Administration (VHA) as a consultant since 1995 when they first began exploring ideas on how to plan for and estimate the impact of eligibility reform legislation. I was involved with the inception of the Enrollee Health Care Projection Model (EHCPM), VA's actuarial health care forecasting model, in 1998, and continued this involvement as the EHCPM became integral to VHA's budget formulation process and was used to support other key initiatives, such as Capital Asset Realignment for Enhanced Services (CARES) and the President's Commission on Care. I have supported VA in the evaluation of a multitude of legislation, policies, and program initiatives, as well as briefings to veteran service organizations (VSOs) and governmental stakeholders such as the Office of Management and Budget (OMB), Government Accountability Office (GAO), Congressional Budget Office (CBO), Executive Office of the President (EoP) and congressional staff.

Over the years, VA and Milliman have developed a strong partnership. Milliman brings specialized expertise, access to extensive amounts of data, and first-rate research to the modeling effort. VA experts provide valuable input, analysis, and subject matter expertise used to develop the model assumptions and related projections.

In addition, VA experience data is incorporated into many of the analyses. This partnership of subject matter experts and data from both VA and Milliman is a powerful combination that provides VA with the best resources to develop utilization and cost estimates for the veteran enrollee population. In particular, this collaborative experience has led to a deep and extensive understanding of the veteran enrollee population and the dynamics driving their use of health care, both inside and outside of VA.

The remaining testimony presents an overview of the Enrollee Health Care Projection Model (EHCPM) as well as a brief section defining the concept of veteran reliance on VA, which is foundational to the evaluation of the proposed MISSION standards. The discussion then proceeds into specific details regarding the methodology and assumptions used to estimate the expenditure impacts associated with MISSION.

VA'S ENROLLEE HEALTH CARE PROJECTION MODEL

The VA EHCPM was used to estimate the costs of care for the MISSION Act access standards. The EHCPM is a health care demand projection model and uses actuarial methods and approaches to project veteran enrollment, utilization of VA health care (VA facility and community care), and the associated expenditures of providing that care. The modeling approaches underpinning the EHCPM are similar to approaches used by private insurers, Medicare, and Medicaid. The EHCPM incorporates detailed demographic data specific to the VA enrollee population, health care trends, economic conditions, and other drivers of change in health care costs and utilization. As the EHCPM was first begun in 1998 with the onset of VA's enrollment eligibility reform and adoption of a comprehensive medical benefits package, the current model is now informed by 20 years of VA experience and the expertise of VA's actuarial consultants at Milliman. The EHCPM is updated with emerging experience data annually and used to produce multiple enrollment, utilization, and expenditure scenarios each year. These scenarios are widely used by VA for important stakeholder needs, such as:

- Supporting 90% of VA's medical care budget (some budget elements are external to the model, such as construction and equipment).
- Informing strategic planning, including the Market Assessments.
- Use by the Commission on Care to cost proposed system changes.
- Generating key data provided to Congressional Budget Office to support independent costing.
- Producing projections integral to programmatic planning, policy development, and legislative costing.

Currently, the EHCPM projects utilization and costs for more than 120 health care services. In addition to the full range of services provided under a typical commercial or Medicare health plan, VA offers several specialized services without direct counterparts in most health care systems including specialized mental health services, other VA programs, and longer-term nursing home care or home-based care, known as long-term services and supports (LTSS).

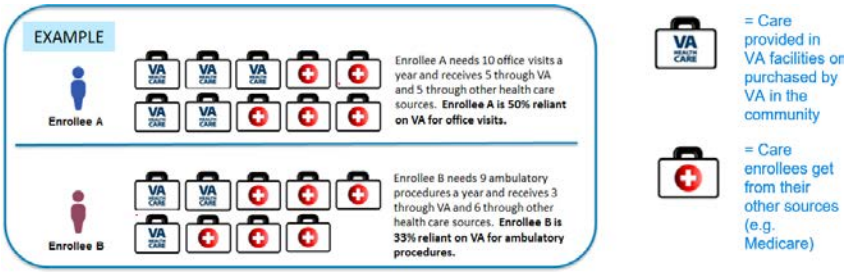
The EHCPM projections are based on the expected utilization of health care services for veteran enrollees. Therefore, the projections start by first estimating who is expected to enroll each year from the veteran population. These projections are made at a detailed level, including age band, gender, priority level, county of residence, and special conflict status. These detailed enrollee projections then become the membership base upon which estimates of total health care utilization are built. Similarly, the utilization and cost estimates are then built specifically for VA facility and community care at a detailed demographic and service level. Future projections reflect the expected demographic changes in the enrollee population, health care trends, VA program implementation, and current policy decisions.

Within the EHCPM utilization is projected for each service using units particular to each service, such as visits, procedures, bed days, etc. In addition, each service is represented using relative value units (RVUs). RVUs are an industry standard metric used to represent the relative intensity of resources required to provide a service as compared to another. For example, a flu shot has fewer associated RVUs than an outpatient surgery, though both are counted as a VA appointment. Therefore, RVUs provide a more accurate representation of workload and cost impact than appointments. Moreover, they provide an accurate way for different services to be aggregated and measured over time. Throughout this testimony, many of the system-wide assessments of workload trends and VA use are measured based on RVUs.

VETERAN ENROLLEE RELIANCE ON VA

The VA system is different from most health care programs in that veteran enrollees generally do not obtain all of their health care through VA because most enrollees have other health care insurance (OHI). In fact, over 80% of veteran enrollees have other health insurance in addition to VA health care. This is mainly comprised of coverage via Medicare, commercial insurers, TRICARE, Medicaid, and Indian Health Service (IHS). Given that most veterans are able to choose among multiple health care providers, this means that VA often is called upon to provide only a portion of a veteran's health care needs. The term reliance in this context refers to the portion of an enrollee's total health care need that he or she is expected to receive through VA at either a VA operated facility or through community care, rather than through other health care sources. Reliance is measured at the enrollee and service level, as enrollee reliance behavior varies from enrollee to enrollee as well as from service to service for any given enrollee. Figure 1 illustrates the measurement of reliance for a particular type of service for two enrollees.

FIGURE 1—MEASURING ENROLLEE RELIANCE ON VA HEALTH CARE

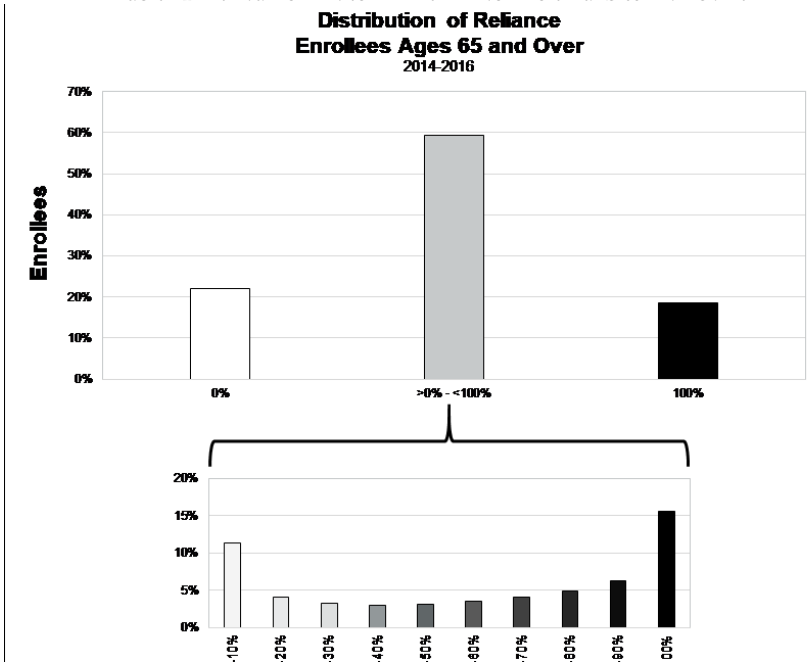


Reliance refers to the portion of an enrollee's total health care need that he or she is expected to receive through VA (facility or community care) rather than through other health care sources

Formal enrollment for VA eligibility began in fiscal year (FY1999). Since that time, VA's master enrollment file (MEF), as well as the comprehensive set of all health care encounters recorded within the VA system has been analyzed on an annual basis. In addition to this, several years ago, VA collaborated with CMS to merge the Medicare fee-for-service (FFS) claims experience for veteran enrollees with VA's encounter data, allowing for a complete capture of enrollee health care between the two health care systems. The resulting dataset provides an invaluable insight into the level of overall health care utilization demanded by enrollees, as well as the portion of this care provided by VA and the portion provided by Medicare.

While some enrollees use VA exclusively for all of their health care needs, roughly half of the Medicare eligible enrollee population accesses health care services from both VA (either a VA facility or community care) and Medicare during the same year. Over the three-year period from 2014 to 2016, nearly 60% of enrollees ages 65 and over (approximately half of the enrollee population) used both VA care and non-VA care, while approximately 20% did not use any VA care and an additional 20% used VA exclusively for all of their care. Further, for those enrollees who utilize both sources of care, there is a wide range of partially reliant users, as some enrollees only obtain a few services from VA and others get almost all of their health care services from VA. The range of these outcomes is presented in Figure 2.

FIGURE 2—RANGE OF ENROLLEE RELIANCE FOR AGES 65 AND OVER



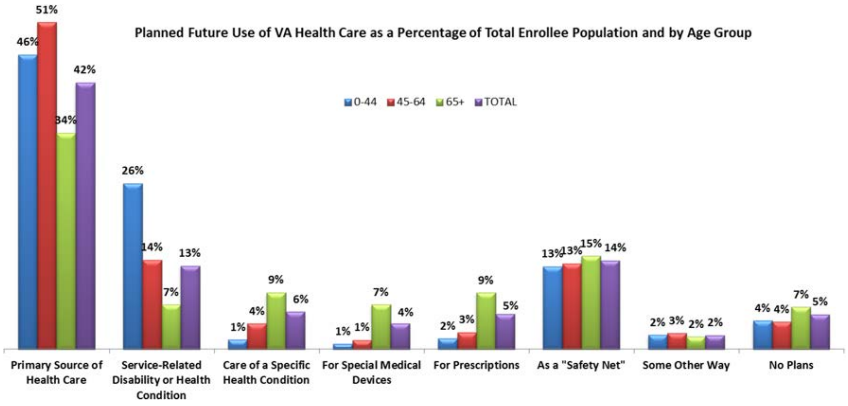
WHY DO VETERANS CHOOSE VA?

Upon separation from the military, most veterans navigate the U.S. health care system in a fashion similar to the general population, with the notable exception that they also have access to VA. Given this choice, current reliance levels are a testament to how many veterans value the care and services that VA has to offer. Many factors influence a veteran's decision to choose VA. Some reasons why veterans may choose VA as their source of health care include:

- The no copay or small copay cost (depending on priority level) of obtaining services, medical equipment, and prescriptions, which is a richer benefit than Medicare fee-for-service (FFS) or the average commercial plan.
- Specialized treatment and care coordination for a service-connected disability.
- Specialized programs and supplies, such as residential rehabilitation and compensated work therapy, bed-based blind rehabilitation, Post Traumatic Stress Disorder (PTSD) and military sexual trauma treatment, and hearing aids (most of these services are non-existent outside of VA).
- Dedicated veteran providers and facilities.
- The fellow veteran patient population.
- For approximately 20% of veterans, VA plays a critical role as their only source of health care. For the remaining 80% VA plays a safety net role during loss of OHI.

Even small changes in enrollee reliance behavior represent significant changes in the level of care provision and resource requirement for VA. In recognition of this, VA includes a series of questions related to veteran access of VA within its annual Survey of Enrollees. Figure 3 demonstrates the diversity of ways that enrollees plan to use VA health care in the future.

FIGURE 3—PLANNED FUTURE USE OF VA HEALTH CARE SYSTEM

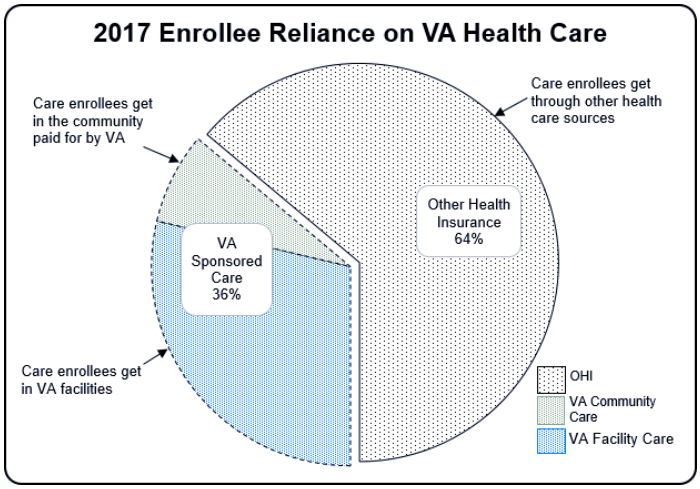


Source: 2017 Survey of Enrollees

CURRENT VA ENROLLEE RELIANCE

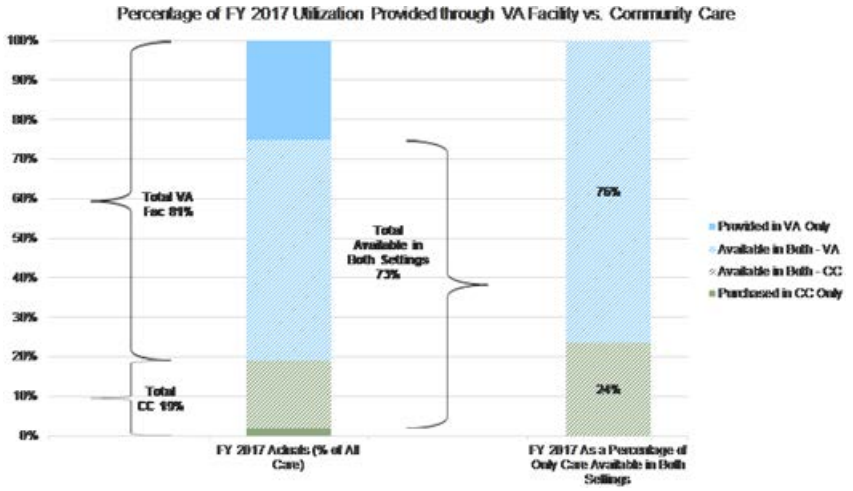
The VA data match with CMS, as well as annual survey data collected across the veteran population, allows us to measure reliance at a health care service level. Aggregating services based on their relative resource requirements using RVUs, it is estimated that overall veteran reliance on VA was 36% in FY 2017. This estimate indicates that VA provided 36% of the health care services used by enrollees and other health insurance provided 64%.

FIGURE 4—2017 ENROLLEE RELIANCE ON VA



The VA sponsored care shown in Figure 4 includes care enrollees get in VA facilities as well as community care. Figure 5 presents the percentage of utilization provided through VA facility care and community care. In FY 2017, 73% of all VA sponsored care used by enrollees was for services available through both VA facilities and community care. Within these services, 24% of health care was purchased in the community and 76% was provided in VA facilities.

FIGURE 5—FY 2017 UTILIZATION PROVIDED THROUGH VA FACILITY VS. COMMUNITY CARE



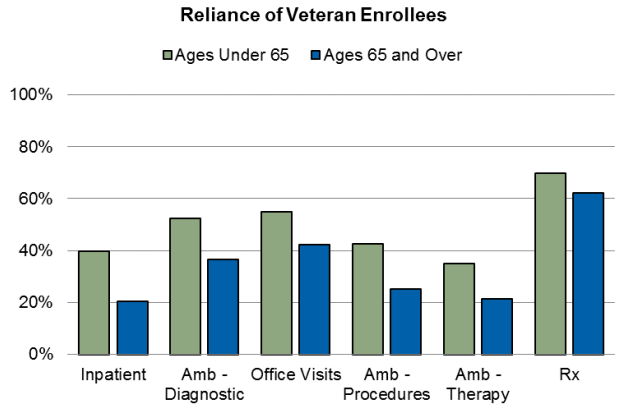
Services only provided in VA accounted for 25% of utilization in FY 2017. These services include services unique to VA such as VA special mental health outpatient and inpatient programs, blind rehabilitation and spinal cord injury programs, recreational therapy, case management, nutritional counseling, and prosthetics and orthotics services, as well as home and community based LTSS and pharmacy and prosthetics products which VA does not purchase in the community.

Services only purchased in the community accounted for 2% of utilization in FY 2017. These services include home and community based LTSS: community adult day health care, home hospice care, home respite care, homemaker/home health aide programs, purchased skilled home care, maternity care and ambulance.

It also is important to note that reliance behavior varies significantly within the veteran enrollee population. Here are some examples from recent reliance studies:

- Average reliance for priority 1a enrollees (70% or more service-connected disability rating) is 50%, while it is 18% for priority 8 (high income, no service-connected disabilities).
- For enrollees under age 65, average reliance on inpatient services is 40%, while reliance on office visits is 55%. For ages 65 and over, average reliance on inpatient services is 20%, while reliance on office visits is 40%.
- Average reliance is 47% for enrollees under age 65, while it is 32% for those ages 65 and over

FIGURE 6—RELIANCE OF VETERAN ENROLLEES BY SERVICE



In conclusion, the above information regarding enrollee reliance behavior demonstrates why legislation, policies, or initiatives that have the potential to impact enrollee reliance must be carefully considered. Even a relatively small shift in reliance represents a substantial increase in VA's budget. Under the current budget environment, every percentage point increase in reliance represents significant resource requirements. For example, doubling reliance from 36% to 72% would necessitate a doubling of VHA's current resource requirements. Given this dynamic, experience has shown that policies that increase access to VA provided care will increase veteran reliance and VA's resource requirements.

MISSION ACCESS STANDARDS COST ESTIMATES

With the passage of the MISSION Act, VA was compelled to establish several standards for implementation. To estimate the impact of these standards, VA and Milliman started with the 2018 VA EHCPM. Thus, the estimates take into account enrollee demographics, health care trends, current enrollee reliance, and other drivers accounted for within the model.

VA evaluated several MISSION Act provisions allowing enrollees access to community care. Two of the standards are when the VA facility does not offer the care required by the enrolled veteran, and the best medical interest provision. For purposes of estimating cost impacts associated with the access standards, these two standards were considered by VA to be a continuation of current practice, so no new expenditures were indicated. The remaining MISSION access provisions are expected to incur new costs. The proposed access standards were published in the *Federal Register* on February 22, 2019. The Regulatory Impact Analysis that accompanies this proposed rule can be found as a supporting document at http://www.regulations.gov and is available on VA's website at http://www.va.gov/orpm/, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date." This notice includes reference to Milliman's expenditure impact analysis of the proposed standards. The projected additional expenditures associated with these standards resulting from the actuarial analysis are repeated below in Figure 7 for reference.

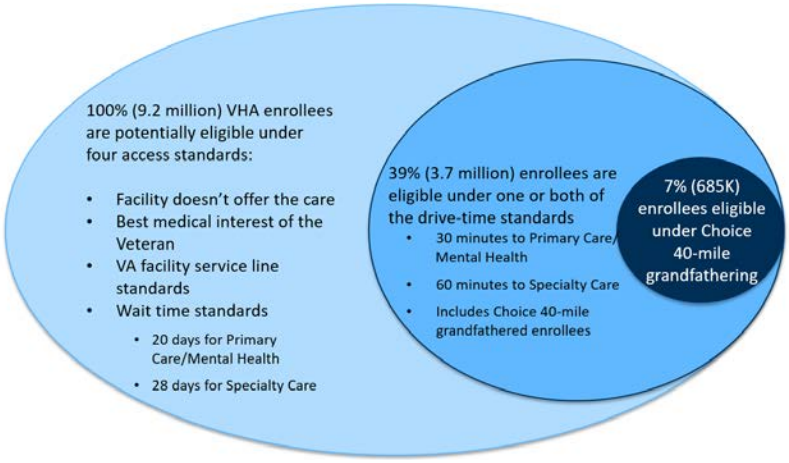
FIGURE 7—ACTUARIAL PRICING OF PROPOSED VA MISSION ACCESS STANDARDS

Projected Additional Expenditures Under Scenario LAV7 (in billions)

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total FY19-23
Grandfathered Choice Enrollees	$0.5	$0.8	$1.0	$1.1	$1.2	$4.5
Cost for CC Due to Deficient VA Facility Quality / Timeliness	$0.0	$0.0	$0.1	$0.1	$0.1	$0.3
Cost Due to Implementing Drive Time/Distance Standards	$0.6	$1.5	$3.0	$3.2	$3.4	$11.6
Cost Due to Implementing Wait Time Standards (applies only to enrollees not already eligible under drive distance standards)	$0.1	$0.3	$0.6	$0.6	$0.7	$2.3
Increase in Expenditures due to MISSION Act Access	$1.1	$2.6	$4.7	$5.0	$5.3	$18.7

An overview of the proportion and count of VA enrollees who are potentially eligible for each standard is provided in Figure 8.

FIGURE 8—VA ENROLLEES ELIGIBLE FOR EACH MISSION STANDARD



GRANDFATHERED CHOICE ENROLLEES

The MISSION legislation allows the grandfathered Choice enrollees to continue to receive community care. These grandfathered enrollees include those eligible under the 40-mile distance access standard as well as enrollees who live in a state with no full-service medical facility. Approximately 685,000, or 7%, of enrollees will be eligible under this provision.

While the explicit grandfathering provisions in the MISSION Act for this population are restricted to a five-state subset after two years, VA assumed that the additional language, allowing for community care when "in the best medical interest of the covered veteran," would effectively allow for a continuation of the 40-mile provision for all those currently eligible under Choice. Therefore, the increases in reliance assumed in FY 2019 and beyond for these enrollees were attributed to the MISSION Act and included in the estimates above.

VA assumes that existing 40-mile enrollees will continue to increase their reliance on VA beyond the increased levels seen under the Choice program. These enrollees are expected to reach approximately 50% reliance on VA for their health care, which is similar to the reliance level for priority 1 enrollees. Further, these enrollees are expected to continue to get care from VA facilities, but growth in reliance due to the 40-mile provision is entirely in community care.

The actual VA health care utilization experience of the grandfathered Choice enrollees since the onset of the Choice program has provided invaluable insight into the reliance changes that are expected to continue for this population into the future. This experience also informed the expectations for the defined group of enrollees that will become eligible for similar community care access under the new drive-time standards. Several of these relevant similarities and outcomes are discussed within the ensuing drive time standard section.

DRIVE TIME STANDARDS

The proposed drive time standards are 30 minutes to primary care/ mental health (PC/MH) and 60 minutes to specialty care (SC). To estimate the enrollees eligible under this standard, VA established where each enrollee lives and their average drive time to primary, secondary, and tertiary VA facilities (using geographic information software), resulting in the following:

- 12% of enrollees are eligible under both standards.
- 20% of enrollees are eligible under the PC/MH standard.
- 31% of enrollees are eligible under the SC standard.
- 39% of enrollees are eligible under one or both standards.

Costs for the drive time standards were produced using the population size of each group and their anticipated increases in the use of different categories of health care services. A detailed discussion of the approach and assumptions taken to estimate the expenditures associated with the drive time standards is included

as Attachment A within this testimony [follows Figure 10 data]. This discussion highlights the commonalities between the proposed drive time standard population and the grandfathered Choice population which informed the utilization and reliance assumptions for these estimates, some of which are presented in Figure 9.

FIGURE 9—USING CHOICE EXPERIENCE TO INFORM MISSION ESTIMATES

Grandfathered Choice Enrollees	Drive Time Eligible Under Both Standards (but not grandfathered)
• Distance eligible (40-miles)	• Drive time eligible (30 min/60min)
• Enhanced access to community care	• Enhanced access to community care
• 7% of enrollee population	• 8% of enrollee population
• Ambulatory utilization increased 46% from FY 2015 through 2018 and is expected to increase further based on recent experience	• Ambulatory utilization expected to increase 50% in total
• Inpatient utilization increased 29% from FY 2015 through 2018 and is expected to increase further based on recent experience	• Inpatient utilization expected to increase 25% in total
• Ultimate reliance levels expected to be approximately 50%	• Ultimate reliance levels expected to be approximately 50%
• Ambulatory and inpatient utilization within VA facilities from FY 2015 through 2018 was stable and did not decline	• Ambulatory and inpatient utilization within VA facilities will continue as projected by the EHCPM (no decline due to MISSION)
• No material impact on enrollment	• No enrollment impact anticipated

Wait Time Standards

The proposed wait time standards are 20 days for primary care/ mental health and 28 days for specialty care. Further, all enrollees may become eligible under the wait time standard because any enrollee may potentially face a wait time for necessary care.

To produce the cost estimates, VA estimated the number of providers that would be required to reduce the primary care/ mental health wait times to the standard. This workload these providers would generate was then translated into community care workload, and then costed at community care rates for the portion of enrollees not already eligible under drive time standards (to avoid double-counting). The 28-day standard for specialty care was determined to be sufficiently close to the current 30-day standard that no additional costs were assumed.

The estimates of the impact of wait time eligibility criteria under the MISSION Act are national level estimates. VA capacity and wait times vary significantly by service and by facility and can change throughout the year, and from year to year, due to the loss of providers, hiring of new providers, increases in productivity, and expansion or renovation of space. Therefore, it is not possible to project the specific services triggering the wait time criteria at the local facility level. However, the national estimates provide credible estimates of the type and volume of services that will need to be purchased in the community. Finally, no adjustments were made to the projected levels of care that these enrollees are expected to receive from VA facilities. It is expected that these enrollees will continue to use VA facility care as projected by the EHCPM.

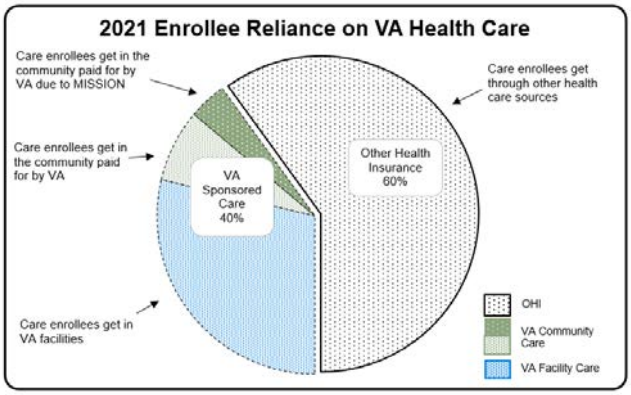
Deficient VA Facility Quality/Timeliness (VA Facility service line quality standards)

Under this provision, enrollees can access community care if they need specific care from a facility and the service line responsible for this care does not meet the quality standard. Thus, all enrollees are potentially eligible for this access. However, the provision will be restricted to a limited number of facilities and service lines each year. VA estimated this provision by assuming it impacts 12 primary care service lines per year (in reality, it would be a mix of service lines). These estimates will change when quality standards are finalized, though as seen in Figure 7 they represent a small fraction of the total estimated MISSION cost impact.

MISSION Standards Impact on Reliance

Implementation of all MISSION access standards is expected to bring the average reliance for the entire enrollee population from 36% to 40% by 2021.

FIGURE 10—MISSION STANDARDS IMPACT ON RELIANCE



The recent experience of those eligible for community care under the Choice 40-mile provision provides valuable insight into the expected utilization response under community care eligibility. Again, referring back to the previous discussion on reliance, most enrollees currently get a significant amount of their health care from the community via other health insurance. To the extent that VA community care eligibility poses little disruption to the care that they are already receiving in the community, VA's low cost sharing compared to their current OHI becomes an incentive to have VA cover the cost of these claims.

The estimates assume VA's Community Care Network (CCN) contract will be implemented in accordance with VA's estimated contract pricing and schedule. If the implementation timing of the contract changes, that change would impact the cost estimates. Administrative costs for the CCN and first-party and third-party collections offsets are not included in the EHCPM-based MISSION estimates.

ATTACHMENT A—DRIVE TIME DISTANCE STANDARD METHODOLOGY DISCUSSION

To give the Committee an understanding of the process and methodology used to arrive at the drive time standard cost estimates, the following section details the development of the projected expenditures of $3.0 billion in FY 2021.

The proposed drive time standards for primary care, preventive care, and mental health are that access be within a 30 minute drive. If this type of care is not available at a VA facility within a 30 minute drive, then the care could be provided within the community—referred to as community care. The equivalent standard proposed for specialty care is 60 minutes. As a point of reference, in FY 2018 the average drive time to a VA facility was 21.6 minutes for primary care and 48.7 minutes for specialty care.

The number of enrollees in each county eligible under each provision were measured by VA. Milliman then calculated the percentage of enrollees nationwide that would be eligible for care under either the primary care or specialty care drive time standards (excluding those currently eligible for community care access under the Choice 40-mile provision), resulting in these estimates for the following five groups of enrollees:

- *Group 1:* 7% of enrollees, eligible for community care due to the Choice 40-mile provision. The expenditure impact of continued community care provisions for these grandfathered Choice enrollees was evaluated separately.
- *Group 2:* 8% of enrollees, eligible for community care due to residing 30 minutes or more from primary care and 60 minutes or more from specialty care.
- *Group 3:* 7% of enrollees, eligible for community care due to residing 30 minutes or more from primary care but not 60 minutes or more from specialty care.
- *Group 4:* 18% of enrollees, eligible for community care due to residing 60 minutes or more from specialty care but not 30 minutes or more from primary care.

• *Group 5:* 60% of enrollees, who are not eligible for community care due to residing within 30 minutes of primary care and within 60 minutes of specialty care.

Naturally, the eligible population increases as the drive time standards (or equivalent distance standards) are reduced. The eligible population was stratified in this manner to allow for estimation of community care utilization impacts in major service categories. For example, Group 2 is expected to increase their use of both primary and specialty care within the community, while Groups 3 and 4 will increase their utilization more intensively in just one of the two areas.

Using Group 2 as an example of the evaluation process, FY 2017 actual workload experience for these enrollees was analyzed to allocate workload into major categories of service, including primary care, specialty care, inpatient and residential care, institutional long-term services and supports (LTSS), home and community based services (HCBS), prescription drugs, and prosthetics. Group 2 will gain access to both primary and specialty care under the drive time standards, making their qualification for community care access similar to the grandfathered Choice enrollees under the 40-mile provision.

At 7% of the enrollee population, the grandfathered Choice enrollees group also is of similar size to Group 2 and the benefits offered to Group 2 enrollees are essentially the same as the 40-mile benefit. Therefore, the utilization and expenditure experience of this population for community care services under the Choice Act is an appropriate reference point for anticipating the expenditures for Group 2 enrollees under MISSION. VA's community care claims experience shows that the Choice 40-mile enrollees increased their overall ambulatory service utilization by 46% from FY 2015 (the onset of Choice) through FY 2018, with the vast majority of this care being provided in the community. However, it also is important to note that VA facility care utilization for this population has not declined over this time. In other words, these enrollees are not transferring VA facility services to the community under the Choice program; rather, VA is covering the claims for care they were already receiving in the community from other health insurers. Further, access to community care under MISSION is expected to be similar to Choice, in that use of community care will be authorized by VA for each episode of care and VA will continue to coordinate overall care for the veteran enrollee.

Given Group 2's similarity to the 40-mile population in terms of community care access for both primary and specialty care, setting Group 2's expected ambulatory care expenditure impact at a 50% increase was deemed appropriate. For primary and secondary care, it is assumed that their current VA utilization, as represented by expenditures, would increase 50%, and that all of this increase would be serviced via community care. The increase in inpatient care expenditures (25%) was set equal to half of the increase in ambulatory specialty care and would also be serviced in the community. The lower increase in inpatient care is because approximately half of inpatient admissions begin as emergency room admissions, so they are not attributable to episodes of care referred to community care. The increase in prescription drug care was set equal to 20% of the increase in ambulatory specialty care. The relatively lower increase reflects the already high levels of reliance on VA for prescription drugs. Evaluation of Groups 3 and 4 were performed similarly, but with varying assumptions regarding the assumed increase in health care service expenditures. The resulting assumed percentage increase in expenditures by enrollee group are presented in the table in Figure 11.

FIGURE 11: ASSUMED PERCENTAGE INCREASE IN EXPENDITURES BY ENROLLEE ELIGIBILITY AND SERVICE

Assumed Percentage Increase in Expenditures by Enrollee Eligibility and Service

	Group 1	Group 2	Group 3	Group 4	Group 5
Eligibility					
40-Mile	Yes	No	No	No	No
30 Minutes to Primary Care	Yes/No	Yes	Yes	No	No
60 Minutes to Secondary Care	Yes/No	Yes	No	Yes	No
Estimated % of Enrollees	7%	8%	7%	18%	60%
Utilization Increase by Service Category Grouping (in FY 2021 and beyond, relative to FY 2017)***					
Primary Care	*	50%	30%	0%	0%
Ambulatory Specialty Care**	*	50%	10%	20%	0%
Inpatient and Residential**	*	25%	5%	10%	0%
Insitutional LTSS	*	0%	0%	0%	0%
HCBS**	*	25%	5%	10%	0%
Prescription Drugs	*	10%	2%	4%	0%
Prosthetics	*	0%	0%	0%	0%

* Enrollees eligible for 40-mile benefit under Choice increase reliance by 3 percentage points in FY 2019, 2 percentage points in FY 2020 and 1 percentage point in FY 2021 in aggregate across all services. The increase varies by service category.

** Services provided only through VA Facility care are not assumed to increase

*** Increase in FY 2019 is 1/6 of FY 2021 values. Increase in FY 2020 is 1/2 of FY 2021 values.

Workload increases in FY 2019 were set equal to one-sixth of the FY 2021 percentage increases shown in Figure 11 to reflect that these provisions will only be in effect for four months in FY 2019 and assuming that not all enrollees will immediately use these provisions at their ultimate level. Workload increases in FY 2020 were set equal to one-half of the FY 2021 percentage increases to recognize that enrollee behavior patterns will not change immediately even if all processes have been fully implemented within VA. The estimated expenditure increases result in an expenditure impact of $3.0 billion in FY 2021 for the proposed drive time standard for Groups 2, 3, and 4 (no expenditure impact was assumed for Group 5 enrollees, who do not qualify for community care under the proposed drive time standards).

From a reliance perspective, these projected expenditure impacts are equivalent to increasing reliance to approximately 130% of starting levels. If the starting reliance for these enrollees matches the overall non–40-mile enrollee reliance of 36% in FY 2017 (exact measures of MISSION enrollee reliance have yet to become available), then this growth would lead to a projected reliance of 47% in FY 2021 (11% additive increase). Including projected enrollee demographic changes, reliance is expected to be approximately 48% in FY 2021. Further, the reliance growth for the populations eligible for just primary or just secondary care (Groups 3 and 4) is estimated to increase reliance to approximately 110% of starting levels by FY 2021. Again, assuming the starting reliance for these enrollees is also 36% in FY 2017, the expected reliance would be approximately 39% in FY 2019 due to the MISSION provisions. Including demographic changes would further increase this to approximately 40%.

LIMITATIONS AND CONSIDERATIONS

This analysis relies in part on data and other listings provided by various personnel at VA. That data has been reviewed for reasonableness and compared to past data submissions and other information, when possible. The information has not been audited by Milliman for accuracy. If the data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete.

Some of the information in this analysis is based on modeling assumptions and historical data. Estimates presented in this report will only be accurate if future experience exactly replicates those data and assumptions used in this analysis. Actual experience will likely vary from this analysis to a degree for a number of reasons.

In addition, many of the modeling variables are assumed to be constant over time. Therefore, emerging experience should be continually monitored to detect whether expectations based on this analysis are appropriate over time.

The results contained in these reports are projections. Actual results will differ from those projected here for many reasons. For example, it is impossible to determine how world events will unfold. Those events that impact the economy and the use of the Nation's military may have a profound impact on enrollment and expenditure projections into the future. It is important that actual enrollment and costs be monitored and the projections updated regularly based on this changing environment.

This report and associated databases were prepared solely to provide assistance to the Department of Veterans Affairs. Neither the Department of Veterans Affairs nor Milliman assume any duty or liability to other parties who receive this work. Milliman recommends any recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product. Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I, Merideth Randles, am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Senator TESTER. Thank you for your testimony. I thank all of you for your testimony. I appreciate it very much.

I think I am going to start with you, Ms. Randles, because actuaries are important.

When you did your projections, our third-party administrator in Montana, and in many other States that had the same third-party administrator, was nothing short of a train wreck. If there would have been a better third-party administrator I think the utilization would have gone up.

Did you allow for—that is my belief as a farmer, not as an actuary, all right? So, did you allow for any of that to impact your projections?

Ms. RANDLES. I think we allowed for it in so much as, as I alluded to in my testimony, when we study the experience of the Choice 40-mile enrollees since fiscal year 2015——

Senator TESTER. Yeah.

Ms. RANDLES [continuing]. Not only has their access in community care increased year over year, but it is not a situation where it increased the first year and plateaued. It is still on a pathway to increase, and we plan on that continuing into the future, during the next three fiscal years.

So, what we think of as kind of enrollee response——

Senator TESTER. Yeah. Got it.

Ms. RANDLES [continuing]. To the new program is continuing to have take-ups.

Senator TESTER. OK. Are you aware what the VA has requested for their Community Care portion of their budget?

Ms. RANDLES. I am specifically aware with what I—the actual estimates that I provided to them.

Senator TESTER. So, that means you have got your estimates and they may be different from their budget.

Ms. RANDLES. Correct.

Senator TESTER. Do we have your estimates?

Ms. RANDLES. I believe my estimates were included in my written testimony.

Senator TESTER. OK. Good.

Ms. RANDLES. One of the tables, yes, as well as in the RAA.

Senator TESTER. Perfect. That answers my question. You do not need to go any further. Thank you very much.

Ms. RANDLES. You are welcome.

Senator TESTER. Mr. Atizado, we know that the VA cares pretty darn good by all the studies that are out there. It is a pretty decent quality, I would say higher than the private sector. Is the DAV concerned that the VA is holding itself accountable for meeting the proposed access standards, but yet the private sector not so much?

Mr. ATIZADO. Certainly, Senator. You know, the thing we would like to avoid is not having this integrated network, which is really the foundation of the MISSION Act, right? If we do not have a network where VA and the community providers are actually working together, meaning working toward the same standard, what ends up happening is veterans may get better care in one place but not in the other, and that is not what we want. That is not what MISSION Act is all about. So, having a double standard is really—has so many adverse effects that can come of that which we would just like to avoid that altogether.

Senator TESTER. All right. Information is going to be critical on this. Are you concerned that many veterans may sign up for the Community Care and not understand that it may not be as timely or as good?

Mr. ATIZADO. That depends on a couple of things, Senator, but yes, that is certainly a concern.

I mentioned earlier, in my oral statement, about wanting to make sure all parties involved in this evolution are educated and trained and understand how things are supposed to happen. One of those things is with regards to coordination of care.

Senator TESTER. Yeah.

Mr. ATIZADO. I think this Committee is well aware of the value of having coordinated care, but it is not regulated. In other words, VA did not propose how that is going to happen. It is such a critical piece of how VA delivers care that not to have it regulated, meaning to put in regulations to us, is, you know, an unfortunate oversight, and we would like to see VA correct that.

Senator TESTER. OK. I have got to scoot, but thank you guys. I have got to go vote, so thank you guys very, very much for your testimony. Ms. Silas, I did not get to you but we probably will later. Thank you.

Ms. SILAS. Thank you.

Chairman ISAKSON [presiding]. I want to thank Senator Tester for burning more time than I intend to. We are not getting any cooperation out of our fellow members over there, and they are playing games, so we apologize for the delay. I appreciate the Ranking Member taking over as chairman for so long. Thank you very much—and you got all your questions answered?

Senator TESTER. We got them.

Chairman ISAKSON. OK. Good. Thanks to all of you. I am so sorry that I missed your testimony and was not here when you made it. I appreciate your being here. Have you all been introduced appropriately?

Ms. SILAS. Yes.

Mr. ATIZADO. Yes.

Ms. RANDLES. Yes.

Chairman ISAKSON. So, you are not upset about your introduction. You are all happy it was appropriate.

Well, I have two quick things and then I want to close, if I can. Number 1, I want to thank Mr. Atizado and his organization for the amount of time they have put into the development of this program, the information that you have submitted before you testified today, and your testimony given today, which I did not hear because I was not here, but I have read, because it was provided to me earlier.

The VSOs are critically important to our entire veteran services that we provide as a country. I am trying to make sure your voices are heard and your interest is heard as much as possible. I have changed some of the methods that we operated under. I have not had as many panels with all the VSOs operating at one time but I have tried to make sure the most appropriate VSOs for each hearing testified like you have today, and I want to thank you for what you have done.

The other VSOs that are here, we are going to take their testimony in writing and submit it for the record, and be reviewed by all the Members of the Committee. Our veteran service organizations are a tremendous voice for the veteran first, and for the country, and we so much appreciate them doing it.

Now, I am going to go to my two questions real quickly. One of them is a general question.

In the cases of many medical treatments that are provided by the VA—hearing aids, dental surgery, replacements, prostheses—so many different things that are covered, and there are many different medical devices that serve the same need that are made by different manufacturers. When you provide a prosthetic leg or a prosthetic titanium tooth, for example, for implants or whatever it might be, do you mandate how many choices there must be for the product that is used or do you have one certain one that the VA approves? How do you go about that situation of making sure the veterans are exposed to the best possible equipment or device for the problem that they have, and whose choice is that, finally? Am I making good sense?

Mr. Atizado, I will start with you.

Mr. ATIZADO. Sure. Thank you for that question, Senator Isakson. As you know, when it comes to prosthetics items, let's just say for amputees, the prosthetic items that they end up selecting is quite individualized. There is a very intimate relationship between the prosthetist and the veteran patient.

Chairman ISAKSON. Right.

Mr. ATIZADO. They need to know both. They need to know where the veteran is having problems, what they like and what they do not like, what they would like to see more. The prosthetist has a responsibility to try and offer them the best solution or best prosthetic possible. And, it goes on from there. It tends to be quite a long relationship after that.

Chairman ISAKSON. Right.

Mr. ATIZADO. The decision really is a collaborative relationship between the clinician and the veteran, and that is critically important. Otherwise, we have got veterans going around having the

wrong prosthetics can be quite—can have some quite terrible consequences for that amputated limb.

Chairman ISAKSON. Does anybody else want to comment on that question?

All right. Let me ask—yes, ma'am.

Ms. SILAS. Go ahead.

Chairman ISAKSON. OK. Let me ask a second question. I am 74 years old so I am in that age group where hearing aids are becoming a common need in a lot of cases. I have a 102-year-old mother-in-law, where my wife is today. My father-in-law passed away at 99 years and 11 months, was a World War II veteran. He had a hearing aid. I have had more horror stories to tell about hearing aids than you have got time to listen.

However, unlike a prosthesis, where you understand the differences because of the anatomy, a hearing aid is a hearing aid. But, there are lots of different problems with hearing aids categorically. Some of them you cannot find. Some of them are too small to handle, all that type of thing. Are there any choices that you give the veterans to choose from or do they get the hearing aid that the VA recommends, or you recommend as a provider? I will ask any of you to address how we should do that, or how we do it.

Ms. Silas, any comment?

Ms. SILAS. I was just going to defer to my fellow panelists, as I do not think I am in the best position to respond to the question.

Ms. RANDLES. I am not in a position to respond to the choice that the veteran is given. From the perspective of the Enrollee Health Care Projection Model, both for hearing aids and in prosthetics, we actively engage with the program leads within VA, each year and on an ongoing basis, to find out what kind of devices and trends are emerging, so they can be built into the forecast to appropriately account for those within the budget formulation.

Chairman ISAKSON. And that takes place periodically, as a function of the VA. Correct?

Ms. RANDLES. Exactly. With every annual model update those conversations take place.

Chairman ISAKSON. Well, thank you very much.

Is there anything that you have not been asked or that you have not had the chance to say that you would like for us to know, from any one of these three panelists?

Yes, sir.

Mr. ATIZADO. If I could make one last comment, Senator. One of the things that I did not mention in my oral statement that I just noticed as I glanced over in my oral statement, but is in our written statement, is the idea that veterans in this new Community Care Program, the idea of them having an informed decision. One of the things that we were hoping VA would propose in its regulation is just that—what kind of information that veterans would like to see from this network so they can make the right choice, I think is what you are trying to drive at.

Chairman ISAKSON. Precisely.

Mr. ATIZADO. There are a couple of things that our members, generally, or veterans generally, ask for. For example, if an elder, aging veteran who has complex chronic conditions wants to be seen in the community, the first thing I would make sure the veteran

would want to know is that you probably want to go see a geriatrician, not just a regular primary care physician, because of their conditions.

So, if there is not this kind of a discussion between a doctor, at the very beginning, as far as what the veteran should probably look for, then we are really doing them a disservice.

Now when they do find a specific doctor, there are a couple of things that patients like to see. I am sure everybody here would agree. They want to make sure that the doctor they are seeing is not only licensed but beyond that, that they have the training and competency standards to provide, say, for example, specific evidence-based advanced training that we know works for the condition that the veteran is going into the community for; that the patient knows the interpersonal skills of the clinician. Are they good with the patients? Do the patients like the doctors? Does the doctor have good communication skills? This basic information, as far as the patient or consumer would like to see, a sort of doctor scorecard.

That is what we were hoping VA would provide our veterans when we wrote these provisions in the MISSION Act, about being able to compare and contrast between providers, not only in VA but comparing VA providers with private providers. Unfortunately, that is missing here in the proposed rule.

Chairman ISAKSON. I appreciate your comment. I think what you are talking about is not only having a choice but making an informed choice. Is that correct?

Mr. ATIZADO. Yes, sir.

Chairman ISAKSON. Thank you very much for your testimony.

Senator Moran has not asked questions of this panel yet. Senator Moran, you are recognized.

Senator MORAN. Chairman, thank you very much.

Ms. Silas, there was a 2018 GAO report that found the VA could not systematically monitor the timeliness of veterans' access to care through Choice because it lacked the reliable data to do so.

In a conversation in the appropriations process for Department of Defense, Vice Admiral Bono, who leads the Department of Defense Health Administration, said, "The DHA believes that these military health system-wide access standards ensure a consistent experience of care and access for beneficiaries," and that "different health systems must adapt standards that meet unique needs of the patients they serve. The specific standards we at DOD selected are perhaps not as important as the fact that the standards exist. We evaluate ourselves against the standards we set, and we share our performance with the people we serve."

My question is, do you believe that the MISSION Act's requirements for strategic planning for market assessments and new access standards would help put the VA on a system—help create a system that—of consistent experience of care and develop more reliable and available data?

Ms. SILAS. Thank you, Senator. I believe all of those efforts can make a difference, but I think based on the review that we did on the Choice Program, I think there are some additional actions that have to be taken to ensure that there is reliable data, including putting in processes that are not overly complex and putting out

consistently comprehensive guidance and policies that the staff can be trained on, and communicating that information consistently throughout the program.

Then, last, putting in information technology to support the program. In our recommendations from our reports on Choice last year, as I mentioned in my opening statement, that all of our recommendations remain open and they are reliant on two key actions from VA. One is awarding all six of the contracts. The other is implementing the information technologies to support the program. And the two key systems—the decision support tool and the health share referral manager system—are estimated to be implemented later this year, but I think we need to wait and see if they make the schedule for that.

Senator MORAN. Both of those recommendations, and the understanding that they are open, just as I—I mean, I assume you would agree that just as they are necessary to improve Choice they would be necessary and helpful in improving the implementation and supports of care for veterans in MISSION.

Ms. SILAS. Yes, sir. We conducted the work on the Choice Program, knowing that the program was temporary and would be ending and be followed by an implementation of a program—a permanent program. So, the audit work that we conducted for both of those reviews was doing that with that in mind. Our findings and recommendations were to provide opportunities, lessons learned, for VA so they could help inform the implementation of the new program.

Senator MORAN. One of the things—and I would have asked the question—I had prepared to ask a question of the VA witnesses, had we not had votes and I had been absent—about the implementation of MISSION and what kind of information is being provided to the VA in the field.

Our case work certainly indicates that we get a certain direction from VA Central, but the folks who are implementing the decisions that have been made here, in Kansas, they do not know what the instructions are. We have been encouraging the VA to provide a handbook, a set of very straightforward kind of conversation, for their employees, for the staff at the VA around the country, to better help implement MISSION Act. There is more than just putting these regulations in place. How they are explained to veterans at home is a significant and critical piece.

Let me just quickly ask Ms. Randles, your modeling is not only a project for veteran enrollment utilization for VA health care but helps to inform the VA in strategic planning. Is this interconnected process valuable for modeling projections to—let me do this differently.

Mr. Chairman, I am out of time. Do you want me to finish this, or——

Ms. Randles, modeling for the MISSION Act. The cost impact of access standards is due to increased enrollee reliance, but I want to note what your statement says, and it was something—I think this is pretty close—care is not being transferred from VA facilities to the community. The cost is due to care that was previously paid for by other payers that the VA is now paying for, which I believe tells us that the MISSION Act is increasing reliance on the VA for

care, both in-house and in the community, as opposed to Medicare or private insurance.

Is that something you were attempting to convey? And what I think the importance of that is—I mean, I saw this when we opened a CBOC, when the VA opened a CBOC in my hometown. The VA estimated that there would be 1,200 veterans who would access care at that CBOC. Within 6 months it was 2,400, double the amount. The difference was the VA estimated the number of veterans in that area of our State who would now, instead of going to Wichita, use the CBOC. What they never accounted for was the veterans who were not accessing care anywhere. I think that is part of the point that you are making is that there are people who are getting care outside the VA that we are now bringing home to the VA.

Ms. RANDLES. Yes, that is correct. People who are getting care exclusively outside of VA but also part of their care, that over half of the veteran enrollees utilize the VA system in any given year, both VA and community care, as well as their other health insurance. And so the expansion of the MISSION Act estimates as an increase in reliance fulfilled through community care reflects an expectation that more of that care would come under the integration of VA in providing the care both within VA facilities in and in community care.

Senator MORAN. Is there another sentence that would follow that, that would answer the question, and that is good?

Ms. RANDLES. Well, it certainly opens up access, in terms of more reliance indicates that VA is courting more of the care for the veteran.

Senator MORAN. Thank you. Thank you, Chairman.

Chairman ISAKSON. Thank you.

Senator Manchin.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman. I appreciate you holding this hearing.

Chairman ISAKSON. You are welcome.

Senator MANCHIN. I have some concerns, and my concern [inaudible off microphone] want to. That is what is out there and that is what I face every day, where I really have a high population base per capita. There is no way in the world that I have any veteran that wants VA to be privatized. They like the care they get at the VA.

Drive time—where is the song about West Virginia—Take Me Home, Country Roads. I can take you home 17 different ways, to your house, on a country road in West Virginia. One can take 35 minutes; one can take 20; one can take 45. But, I will get you home. There is no standard set, and that is an $11 billion cost item, just to drive.

We are rolling this out in less than 8 weeks, and they are saying here that some of the GAO recommendations you are implementing do not go into effect until later this year, but we are still rolling it out in 8 week. I do not know what the hurry is. I do not know why we are pushing this. We have got—my goodness, we still have big issues with Choice and CareT and everything else.

I mean, my main concern is how can I get the best care to my veterans? Anyway, I know that is in your heart too, or you would not be in these positions you are in. But, I do not know if we are forcing something on you and telling you to go down this path, but I can assure that the veterans and all the veteran representative groups are scared to death that this is basically the door opening to privatization, especially when 50 percent of the people can be affected by drive time. It makes no sense at all.

Anybody want to talk to that one? You can punt if you want to. I have got another one too.

Mr. ATIZADO. Senator Manchin, I appreciate your comments. I can certainly agree that our veterans in West Virginia love the VA. We understand that it is a very different—they present as very complex patients compared to the other veterans in the region. So, your veterans in the State of West Virginia have very different needs, so applying a general standard to a very different population can have some very undesirable results.

But, I think the thing that I want to key in on your comments, Senator Manchin, is that I think veterans who choose to go to VA should be allowed the opportunity to be seen by VA, not say, "Well, I want to choose VA but since you cannot see me, well, you are going to send me outside." That is not really their first choice.

So, that is what we are really trying to focus on, is that when they come to VA and want to be seen at the VA facility that they get seen at the VA facility, and not just say, "Well, since we are not meeting the standard that does not really apply anywhere else——"

Senator MANCHIN. With all this technology today the private sector is going to prey on our veterans like you have never seen. I truly believe that in my heart. That is a whole 'nother cash cow for them.

Mr. ATIZADO. I cannot speak to that, Senator Manchin, but I can tell you this——

Senator MANCHIN. Let me ask you this.

Mr. ATIZADO [continuing]. If a veteran is to go to the private sector—I do not want to—I would like to make clear that DAV is not opposed to veterans going into the private sector.

Senator MANCHIN. Oh, no. I know we are not. We are trying to make sure they get the best care wherever they need it.

Mr. ATIZADO. That is exactly right, the best care, and that is what we are trying to focus on in this hearing, and in the regulations we proposed.

Senator MANCHIN. I am trying to say if we keep our veteran hospitals and our CBOCs and our clinics up to snuff, doing their job, they are going to get the best care right there. And what happens, we have allowed a lot of things to fall below standards, showing that we cannot give them the care, and we have got to go outside into private care. That is what my concern is.

And here is the other thing. To me, managed care—we should be managing some of our—you know, some of our more sickly and more critical illnesses, to where they are getting that best care, specialized care.

I just—I am really worried about this, Mr. Chairman. I know that you have a tremendous population base also of veterans, and

I do not know if you have heard it as much from yours, but I can tell you ours are very, very concerned, because now we are just starting to get some veteran CBOCs. We have got portable clinics. They are getting the care and they love it, and now they are going to say we are starting all over again. I do not know.

Do you want to jump in?

Ms. RANDLES. I would just reiterate, as I said before, from a data perspective, since the onset of the Choice Program, those enrollees who did become eligible for enhanced community access under Choice, the 40-milers, we have watched their utilization grow, both within the community but it has also been stable within the VA facility. So, over this 3 to 4-year period their use of the VA facilities has been stable and has not declined. It has actually had a slight increase over this period as well.

The other thing I would say is when we sort veteran patients into VA facility or Community Care they do not fall into one bucket or the other. The vast majority of the enrollees are utilizing VA facility care and Community Care services, paid for by VA, and coordinated by VA, during the fiscal year. So, they are being served by both care delivery systems.

Senator MANCHIN. The other thing I wanted to touch one, which just adds to the concerns that we have, I understand there are 40,000 vacancies in the VA—40,000? What effort are we trying to do to fill those, or are we basically taking this approach because we cannot fill them?

Does anybody want to take that one?

I will give you one part. I am going to help you a little bit here.

Our CBOC in Parkersburg, WV, which is one of our larger little towns—beautiful, on the river, the Ohio River—they are having a lot of trouble hiring and retaining providers, and it is hard for them, and all of my VA facilities, really, to compete with the higher salaries in other States, which we have not made those adjustments.

So, I mean, we are leaving—we are with a skeleton crew. We cannot give the services. We can justify they need to go to the private because they can get the better care, because we are not paying competent wages.

Mr. ATIZADO. Senator Manchin, if I could tag onto that, I know your time is running. But first I want to——

Senator MANCHIN. We are OK. Answer this and then——

Chairman ISAKSON. I am actually enjoying what is going on with this. [Laughter.]

I am going to take advantage of it in just a second. So, you all go ahead and finish your little exercise.

Mr. ATIZADO. So, I want to thank this Committee for taking a very bold approach in rolling back one of the key components that VA uses to help attract and retain and recruit highly-qualified candidates, and that is what Senator Sinema was referring to when she was here, at the hearing. It is the recruitment relocation retention bonus program that VA has. That is a very important tool that recruiters have, across the VA health care system, when they see a good candidate, a strong candidate, a compassionate candidate, that wants to work in a VA and take care of our veterans. We are so thankful this was passed and took that cap off. We are so glad

this Committee gave the VA additional financial tools to help entice candidates to come in, whether it is debt reduction or scholarships.

Senator MANCHIN. Let me ask you that, on debt reduction, because I have got an awful lot of medical schools—I have got three medical schools, and I asked them all, I said, "Are they recruiting out with you all? Are they coming at you hard?" I have got nursing schools. Are you recruiting in nursing schools? They do not see rapid or active recruitment going on.

So, we might have put flyers out. We have might have done something but we have not actively gotten in and gone after—because some of these people want to reduce their debt. They want to bet out of debt, and they just—they are looking for ways of public service. And who knows? We might find people that really love the care they are giving and stay right with us. It is something we should be—there is so much more we can do.

Let me just say, about the Committee, though, our Chairman here. Our Chairman—this is going to be the best Committee you have got. It is the best Committee I serve on because it is bipartisan, truly bipartisan, because of our Chairman and our Ranking Member. All we care about—this is the one Committee that keeps us all together and bipartisan. It is the veterans.

But, there are few that have a mindset that the private sector is always the way to go. That is except the type of care that a veteran deserves. It may be the private sector does not have really the resources, or they do not have the incentive for the return on investment that might come from a veteran that you might get in the private sector, so we have to be very care of that. So, we are very cautious. I have not found a veteran yet that wants to go to private care, but they will when they cannot get the care. I am concerned that we are not giving the care because it is kind of a back door, it forces them to go to private. That is the problem I am dealing with, which is hard.

Mr. Chairman, thank you for indulging me. You and I have a passion. I appreciate it, man. You have been going at this and I appreciate it.

Chairman ISAKSON. Well, I am glad you came and I am glad we closed with this exercise, and I want to comment on it. Is that all——

Senator MANCHIN. They are, too.

Chairman ISAKSON. Yeah. Everybody—you know, the mind can only absorb what the seat can endure, and I think all of us have had enough of that for a while.

Anyway, I want to thank you for your comments and thank you all for being here. Let me make a couple of comments on the privatization deal.

I have been here since this whole thing started. This is almost my 15th year in the U.S. Senate. John McCain really kind of kicked off the idea of veterans' Choice when he was coming to the Committee, to get us to address the subject, because veterans were having some problems. And, you know, we did not just create it out of the air because there was not a need. There was a need for more doctors to serve veterans. At the time maybe we did it by making Choice available. We came up with a 30-mile rule—I mean, the 30-

day rule and 40-mile rule and these other thresholds, and now we are getting a new rule for access, which is a 20-day rule and the 28-day rule, or whatever they are.

We tried to find those magic things to say, well, the veteran can go to the VA or if this happens, if they meet this criteria, we can let them go to the private sector. We have had some bad experiences, which you are going to have with any big program, but we also learned a lot.

I think we learned two things. One, we learned that we are not giving our VA hospitals and doctors and directors and VISN directors the money and the access they need to go out and recruit in the private sector, and we were getting killed. I want to thank you for mentioning—you brought it up, Joe—what we did pass a couple of years ago, where they now have the ability in a lot of disciplines to go out and hire in a competitive manner, in the private sector, and that is great. We do have 40,000 vacancies in various places in the government because people do not want to work there.

I would add, if we are always talking about privatizing something, I am not going to apply to work there if I do not know whether it is going to be public or private. So, we are our own worst enemies sometimes if we talk too much about alternative operations other than the one we have. That is not a criticism. That is just a point to make.

The second thing is, I asked the question about hearing aids and other medical devices. I had a veteran who wanted to know if there is choice of somebody to provide the service they need medically but also provide what they need for their disease or their injury or their difficulty, to be better in the future than they are today. That depends o constantly looking at what is new to come, what is there, and what they can bring new to our veterans. You are never going to get the best of that unless you have some private participation as well as the VA.

We are not going to privatize the VA. It is not my job to say we are or we are not. As Chairman of the Committee I cannot see any way you could privatize it, nor do I see any way you could treat our veterans by taking away the option of having a private sector choice. We have just got to make sure the private choice option they make is the best option for the veteran, and that we are doing the things we have to do in running that system, to be sure the doctors that are in that system get paid, and that we are demanding the best out of both—our employees as well as the private sector—without discrimination, without prejudice, or without anything else.

I think we can do that. I think the system wants to do that, and I think the attitudes within the VA are better today toward making ourselves better than finding some reason to put off doing this Choice thing because we do not like the idea of what it may become.

I hear loud and clear the fear that people have, and I know what some say in the private sector. I also know veterans who say they have had bad experiences in the VA, and Lord knows we have had some of those as well. But, I appreciate you bringing up the point, and thank you for complimenting us on what we did as a Committee. We are going to continue to try to do those things as a

Committee to give tools to our VISNs, our hospital directors, and our other administrators, to figure out how to fill the vacancies we have got and hire the best people that we can.

With that said, do you want to say something more, Joe?

Senator MANCHIN. Yeah. I just wanted to follow up. You know, our affection for our dear, departed friend, John McCain, goes deep on both sides, very deep. The scandal that went on that caused all this to start, this dialog—you all remember that—and John was trying to react. We all reacted. We acted very quickly. We were embarrassed by it and wanted to fix it. Sometimes we are not the best at fixing; we will overfix. And, rather than getting rid of the bad apples and changing the system so you could not scam it and could not get bonuses and could not play the games they were playing, we went to a whole 'nother area, which is where all this started.

I am going to give you a perfect example. In the VA hospital in Clarksburg, WV, the Johnson Hospital, an autoclave—an autoclave is what sterilizes the operating equipment. You would think that someone would know that this one was on its last leg; we ought to get another one. It went down and they could not do any operations. Now you are asking me, how can that happen? How does that happen? And, they would start sending patients out to have the routine procedures done that we had been doing right there.

We were doing another procedure for pulmonary exams. Private sector was charging us $700 to send them out and do pulmonary. We raised holy hell to get the equipment to do the exams in the VA. We were doing them for less than $100. We know we can do it, but for some reason—I do not know who is in charge of that—really, the audit and the equipment and the update and just the operation of these procedures, because that is what is happening to us, and that is the biggest fear they have. They said, "Well, I need the care and I would like to get it at the VA, but they do not have it anymore" or "This is not working."

Does that make sense? That is what we are working with, Mr. Chairman. That is what we are afraid of. If we can keep that up, and they have the best of Choice, which is truly a choice, if I can get the same service at the Woody Williams VA Center in Huntington that I can get at CMC, Charleston Medical Center, I am fine with that. I am fine with that. We are not giving them that choice because we are not staying up to speed.

That is my two cents. Thank you.

Chairman ISAKSON. Well, I appreciate the input and I appreciate your testifying today. Our job here is to make sure the VA serves the veteran but also serves the taxpayer of the United States of America, that they are getting the best bang for their dollar as well. And, many taxpayers are also veterans, so we are in good shape—well, most of them are not veterans, but the 1 percent of them that are veterans deserve the very best choice, and this Committee is going to see to it that they get it.

I appreciate the input we have had. We have got some challenges to go. I want to underwrite what Dr. Stone said. We are going to technically be ready by June 6, but practically, because we all know that because of the incumbent systems that are inherited, because of changes with technology that have to be made, there are

lots of things we are going to have to do, to stumble before we walk.

But, our goal is to walk and then run to do so successfully. This Committee is going to support the VA and support our veteran service organizations. We are going to be the Dumbos of the whole Congress. We are going to listen to the suggestions that we get and make sure we are doing the best thing we can do for our veterans.

So, on behalf of all the veterans in America and the people of the United States of America who send us up here, thank you all for participating, and be reminded that everybody has got 5 days—all Members have 5 days to submit additional questions or additional information they want to go for the record.

Unless there is any other business before this Committee we stand adjourned.

[Whereupon, at 4:34 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO SHARON M. SILAS, ACTING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. In June 2018, GAO published a report to assess access-related challenges of VA care under the Veterans Choice Program. In that report, GAO stated that in spite of the requirement to receive care within 30 days under Choice, veteran patients could have to wait up to 70 days for care. The report stated that one of the primary factors leading to a delay in care is due to an insufficient number, mix, or geographic distribution of community providers. Is this true?

Response. Yes, this is correct. According to VA medical center managers and third party administrator (TPA) officials we interviewed, the TPAs' inadequate networks of community providers affected both the timeliness with which veterans received Choice Program care and the extent to which veterans were able to access community providers located close to their homes. We found that establishing adequate networks of Choice Program providers in rural areas has been particularly difficult. In September 2015, about 11 months after the Choice Program was implemented, VA contracting officials sent corrective action letters to both TPAs, citing network adequacy (i.e., the number and mix of specialists and the geographic distribution of network providers) as a concern. The overall number of community providers participating in the TPAs' Choice Program networks nationwide grew dramatically over the following year-from almost 39,000 providers in September 2015 to more than 161,000 providers as of September 2016. However, at the time of our review, managers at five of the six selected VA medical centers told us that they still observed TPA network inadequacies that impeded veterans' access to Choice Program care. Similarly, managers at three VA medical centers in our sample said that key community providers-including large academic medical centers-have refused to join the TPAs' networks or dropped out of the networks after joining them, often because the TPAs had not paid them in a timely manner for the services they provided.

Question 2. Do you agree that the MISSION Act access standards established by the VA will help to address this challenge?

Response. VA's proposed access standards for the Veterans Community Care Program (VCCP) would allow veterans to receive care from community providers when the services needed are not available at a VA medical facility within allowable wait times or when veterans' average drive time from a VA medical facility exceeds 30 minutes for primary care, mental health, and non-institutional extended care or 60 minutes for specialty care. To help ensure the adequacy of provider networks under the VCCP, in our June 2018 report, we recommended that the Secretary of Veterans Affairs ensure that the contracts for the VCCP include performance metrics that will allow VA to monitor average driving times between veterans' homes and the practice locations of community providers that participate in the TPAs' networks. VA agreed with our recommendation and has taken steps to implement it. In April 2019, we reported that VA's Veterans Community Care Network contract request for proposals includes performance metrics that will allow VA to monitor average driving times between veterans' homes and the practice locations of community providers that participate in the TPAs' networks.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO MERIDETH RANDLES, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN

Question 1. On veteran reliance on VA care, can you please explain the difference you see and project in enrollee demographics?

Question 1a. Do you see greater reliance on VA care from rural veterans or is it about the same as non-rural veterans?

Response. Reliance is studied and modeled geographically by market areas defined by VA. These markets, which typically reflect catchment areas around VA medical centers, may contain both urban and rural enrollees. However, we can relay some reliance observations for the Choice 40-mile eligible population (Choice enrollees), which by means of their eligibility, represent a largely rural subset of the enrollee population. In FY 2017, the aggregate reliance (both VA facility and community care) for these Choice enrollees was slightly less than the average enrollee—within two percentage points, though the difference in reliance between 40-mile Choice enrollees and other enrollees was larger prior to the introduction of Choice.

Question 1b. Is there a greater reliance on community care through the VA for rural veterans?

Response. When considering reliance specifically for community care, the proportion of total reliance attributed to community care for these Choice enrollees was 27% while the outcome for all enrollees was 17%. In other words, there was a greater reliance on community care through VA for Choice enrollees as compared to the average enrollee.

Question 1c. How does geography and where a veteran resides play a role on reliance on VA care, within the VA or in the community?

Response. A study of reliance and drive times conducted on FY 2008 enrollee experience data indicated that as drive times to VA care are reduced, there was an increase on enrollee reliance. Further, the study indicated that changes in drive time to specialty secondary care generally had the largest impact on reliance while changes to primary care drive times generally had the least impact. This study did not discriminate between care provided at VA facilities versus community care obtained through VA.

Question 2. What or who is the "defined group of enrollees eligible under new drive-time standards and grandfathered Choice 40-mile enrollee standards" and what are your cost projections for this group?

You have estimated that 39% of veteran enrollees—about 3.7 million veterans—are eligible for community care under either the 30 minute drive time access standard for Primary and Mental Health care or the 60 minute drive time access standard for Specialty care. But, this percentage and figure also includes those veterans who are the 40-miler's and grandfathered into MISSION. Breaking this down—for those 5 states that were granted this grandfathering exemption where the new access standards will not apply to them, there are 685,000 veterans who will be eligible for care in the community regardless of the new drive time or wait time standards. Those 685,000 veterans account for almost 19% of the total 3.7 million veterans eligible for care in the community, correct?

Response. Yes, the 685,000 grandfathered 40-mile Choice enrollees are included in the 3.7 million veterans eligible for community care under MISSION. The remaining 3 million veterans are eligible for community care through the proposed drive time access standards of 30 minute drive time for Primary and Mental Health care or the 60 minute drive time access standard for Specialty care. The MISSION Access standards Regulatory Impact Analysis (RIA) published by the Department of Veterans Affairs on February 15, 2019, also contains a table (below) detailing the enrollee groups associated with each MISSION eligibility provision.

Table: Assumed Percentage Increase in Utilization by Enrollee Eligibility Cohort and Service

	Eligibility Cohort				
	Grandfathered Choice Program Eligible	Drive Time Provision			All Other (Wait Time Potentially Impacted)
		Primary Care/ Mental Health/ Specialty Care Eligible	Primary Care/ Mental Health Only Eligible	Specialty Care Only Eligible	
Drive-Time or Distance Criteria	>40 miles from a VA facility with a primary care provider and special provisions for AK, HI, NH	>30 min. avg. drive-time from VA primary care/mental health >60 min. avg. drive-time from VA specialty care	>30 min. avg. drive-time from VA primary care/mental health ≤60 min. avg. drive-time from VA specialty care	≤30 min avg. drive time from VA primary care/mental health, >60 min. avg. drive-time from VA specialty care	N/A
Estimated % of All Enrollees (numbers may not add due to rounding)	7%	8%	7%	18%	60%
Estimated # of Unique Eligible Enrollees in FY 2019	684,000	711,000	629,000	1,641,000	5,520,000

A P P E N D I X

PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, On behalf of the over 700,000 Federal and D.C. employees represented by the American Federation of Government Employees (AFGE), AFL–CIO, including the over 250,000 frontline employees of the Department of Veterans Affairs (VA) represented by AFGE, we write today to provide our comments on the state of the VA MISSION Act implementation as well as the harm expanded private sector intrusion will have on the VA's ability to deliver high quality, timely care to veterans. We want to take this opportunity to repeat our concerns about the VA MISSION Act, its proposed access standards, expansion of walk-in clinics, and the negative impact this law will have on the VA workforce and the veteran patient population across the country. Without taking substantially more time to analyze the large-scale impact of this law, including the proposed access standards and new walk-in clinic program, the VA MISSION Act will lead to an irreversible dismantling and weakening of VA's exemplary, uniquely veteran-centric health care system.

While there are significant problems with the substance of the new law that must be considered, the first and most obvious problem is the secretive, unacceptable nature of the rule writing process. For example, the proposed access standards were created behind closed doors without any input from Congressional leadership, the veterans service organization (VSO) community, or representatives of the in-house frontline workforce. By writing this proposal without input from stakeholders the VA has made even more controversial an already controversial issue. Problems that are entirely foreseeable could have been mitigated if Congress, VSOs, and the VA workforce had been permitted to participate in the drafting process. That did not happen and, therefore the VA should withdraw the proposed rule and redraft the proposal in a more inclusive manner.

One of the most serious shortcomings of the access standards created by the CHOICE program was the arbitrary 30 day/40-mile rule. Under this program if a veteran's VA had a 30 day wait, or if s/he lived 40 miles or more away from the nearest VA, that veteran was authorized to seek care in the private sector. Under the CHOICE standards, approximately 8 percent of veterans were eligible to go into the private sector.

Unfortunately, the new proposed standards drastically increase the diversion of more VA care into the private sector. Under the proposed rule, if a veteran's nearest VA has a 20-day wait time for primary care (including mental health) or a 28-day wait time for specialty care the patient will be sent to the private sector. We also have strong concerns that if a veteran finds the wait time is too long outside of the VA, that veteran will have to go through an unnecessarily burdensome process to come back inside of the VA. This is not "choice" or "access;" it is a one-way ticket to a fully outsourced VA. Similarly, if a veteran can certify that he or she has an average drivetime of 30-minutes for primary care and one-hour drivetime for specialty care, that also triggers a private sector referral. According to the VA's own Economic Regulatory Impact Analysis the total number of veterans eligible to receive private sector care is estimated to increase from 8 percent to 39 percent if this proposed rule goes into effect. The Committee must demand that the VA withdraw and re-write this proposed rule.

Equally troubling is that if these new access standards are implemented, they will perpetuate the egregious double standard already inflicted upon VA providers (who have to meet stricter competency standards than private sector providers treating veterans). The private sector will not have to meet the same or even similar access standards. There is no metric in place that will guarantee that a veteran who qualifies for a private sector referral will not be sent out into the "community" to wait

20 days or more for primary care or drive 30 minutes or longer. Without providing an equal playing field the VA is setting itself up to fail and continues the push toward outright privatization.

Another major aspect of this law that is problematic is the expanded access to walk-in clinics for a veteran to receive their care. It's important to look at the Department's past performance with walk-in clinics to articulate our fears with this new proposal. For example, when then-Secretary Shulkin authorized the use of CVS Minute Clinics as a pilot program in 2017 the Department exercised virtually no oversight of the providers. It is premature to allow open access to walk-in clinics without studying the cost associated with these walk-in providers and the quality of care they provide. Since the CVS pilot has at least a year of data for examination, at a minimum, an estimate of how much this program will cost is needed, as well as information compiled on patient outcomes. Yet, unfortunately, no such study has been conducted prior to pushing implementation.

The thought that veterans could use walk-in clinics for mental health services gives AFGE significant pause. We cannot conceive of any appropriate instance when mental health treatment would be suitably provided in a walk-in clinic. The VA is the national leader in integrating primary care and mental health; walk-in clinics will result in inferior, fragmented mental health care by providers with significantly less veteran centric training and accountability. This will most certainly lead to negative health outcomes for veterans. Instead of outsourcing this vital component of veteran care, the VA should be working to build internal mental health capacity.

While it is encouraging to see the Department move toward placing a copayment on walk-in clinics after the third visit in a calendar year, more needs to be done to show this will be a deterrent. Currently there is no insight into how copayments will impact utilization or harm the veteran population. The underlying law also gives the Secretary full discretion to waive copayments. This poses a problem: if the Secretary routinely waives the copayments there will be no disincentive to using these clinics.

Ultimately, none of this would be necessary if the VA would commit to building internal capacity and provide adequate money for staffing and internal resources. In order for the VA to be fully operational it must be fully staffed. In addition to creating a new, permanent private sector care program, the VA MISSION Act also requires the Department to publish data on vacancies and hiring. Since the first set of data was published on August 31, 2018, the number of vacant positions at the VA has steadily increased. As of the most recent reporting the total number of unfilled positions at the VA is nearly 49,000—with nearly 43,000 of those positions located in VHA. Instead of finding ways to justify sending patients outside of the VA to receive their care, the VA should be laser focused on hiring more fulltime professionals who want to make a career out of serving the veterans.

AFGE insists that the VA stop rushing to implement the MISSION Act and start over, with more provisions in place to ensure the integrity of the program and more oversight of cost and quality. The VA MISSION Act represents a truly massive change to the future of the VA, and its rollout should not be fast tracked, and implementation should not proceed before critical data on market capacity, provider quality and wait times are collected.

Thank you for the opportunity to explain our concerns as it relates to implementing the VA MISSION Act and we look forward to working with the Committee to ensure that the VA workforce is able to grow, thrive, and continue providing world-class care and services to our Nation's heroes.

PREPARED STATEMENT OF DAN CALDWELL, EXECUTIVE DIRECTOR, CONCERNED VETERANS FOR AMERICA

TESTIMONY

Five years ago to the day, we learned that dozens of veterans died on secret wait lists waiting to receive health care appointments at the Phoenix VA Medical Center.

In the weeks that followed, the media reported alarming details about how the Phoenix VA and other VA facilities across the United States used secret wait lists to game the system and hide the number of veterans left waiting weeks and months to receive medical care.

That summer, Concerned Veterans for America along with dozens of other veterans organizations agreed an alternative option for veterans to access care in the community was necessary.

This led to the passage of the Veterans Access, Choice, and Accountability Act of 2014 which created the Veterans Choice Program. The temporary new program was

intended to give veterans more choice and reduce wait times, however, it faced significant challenges and limitations.

Four years later, Congress passed the landmark VA MISSION Act of 2018 to consolidate the VA's community care programs into one permanent program.

Instead of repeating the mistakes of the Veterans Choice Program and using arbitrary eligibility criteria for non-VA care, the VA MISSION Act directs the VA to structure the new Veterans Community Care Program and eligibility standards to reflect best practices used in the private sector and other government-run health care programs with the goal of delivering the best medical outcomes.

In February, the VA released the Proposed Rule (PR) for the new Veterans Community Care Program access standards. CVA believes these access standards mark significant progress toward modernizing the VA's delivery of health care.

Proposed Designated Access Standards

The VA's interpretation of "designated access standard" to include all types of care delivered through the Veterans Health Administration rightly reflects the flexibility given to the VA in the law. The VA is clearly given discretion to determine the clinical services eligible for community care in the VA's access standards in Section 1703B(a) of the VA MISSION Act.

TRICARE Prime-type Access Standards

Last summer CVA responded to the VA's Request for Information and expressed our support for TRICARE Prime-type access standards based on drive time, wait time, and the type of care needed.[1]

As a managed care option for military families, TRICARE Prime allows individuals access to military health system facilities while also offering the ability to refer patients to community providers if the established access to care standards cannot be met in-network. This style of network closely mirrors the current VA health care system and how the VA has utilized various community care authorization authorities over the years, including before the Choice Program even existed.

The TRICARE Prime-style standards CVA supports reflect how access standards are applied across other Federal programs and industry practice.

According to the August 2014 Military Health System Review report, there are no national benchmarks or scientific evidence to recommend specific access standards. Based on their review of over a dozen major health care providers in Appendix 3.6[2] of the report, the current TRICARE Prime access to care standards closely align with industry standards for urgent, routine, and specialty care. Additionally, data collected by the Department of Health and Human Services in a 2014 report[3] found over 30 states have drive time or mileage requirements for primary care under Medicaid.

From the very beginning, the Choice Program's mileage criteria for eligibility was arbitrary, poorly calculated, and difficult to fairly implement. In the PR, the VA outlines how shifting from mileage to drive time reflects standard industry practice. CVA agrees using drive time as a standard for eligibility will improve access to outside care for both rural and urban veterans.

Many of today's veterans who are entering the VA health care system are accustomed to the TRICARE Prime system and understand its access to care standards. Integrating those same standards into the Veterans Health Administration (VHA) is an opportunity to streamline care for our veterans. By utilizing standards that account for the differences between routine care, specialty, and urgent care while also using drive time as a measurement tool, much-needed clarity can be brought into VHA.

Application of Access Standards to Community Care

In our comment to the PR in the *Federal Register*,[4] CVA noted the application of access standards in the private sector is inherently different from how Federal and state agencies utilize access standards.

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[1] Concerned Veterans for America, "Comment on Requests for Information: Health Care Access Standards," July 27, 2018,https://www.regulations.gov/document?D=VA–2018-VACO–0001–1183

[2] Military Health System Review Report, August 2014. Appendix 3.6 http://archive.defense.gov/pubs/140930_MHS_Review_Final_Report_Appendices.pdf#page=198

[3] Office of the Inspector General, Department of Health and Human Services, "State Standards for Access to Care in Medicaid Managed Care," September 25, 2014. https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

[4] Concerned Veterans for America, "Comment on Proposed Rule: Veterans Community Care Program," March 25, 2019, https://www.regulations.gov/document?D=VA-2019-VHA-0008-22815

For the VHA, access standards are the mechanism to provide the option of choice in the community if the VA cannot meet those standards. In the private sector, patients already have full choice and access standards are a mechanism to measure performance and network capacity, not eligibility. We agree with the VA's assessment in their PR and in the Economic Regulatory Impact Analysis that measuring access standards used by Federal and state agencies is a better comparison tool.

Additionally, recognizing private health care providers are not comparable to Federal entities, a broad application of the proposed access standards onto all community care providers would lead to unintended consequences. Under the VA MISSION Act, non-VA providers are required to comply with the established access standards, however, CVA believes the strict disqualification of community care providers based on access standards would be unwise.

For example, in areas where there is a shortage of medical providers, a primary care provider that is a 45-minute drive is still a more attractive option for a veteran who might otherwise face a 60-minute drive to a VA clinic.

The VA should make every effort to apply the access standards in a reasonable manner that provides flexibility to non-VA providers and ultimately puts the needs of veterans first.

Misinformation Regarding Implementation

Significant incorrect claims have been circulated about the VA MISSION Act that do not accurately reflect the actual text of the law or the PR.

Neither the PR nor the VA MISSION Act dismantle the VHA. The VA will continue to serve as the primary location where eligible veterans receive health care services. However, in the 21st Century with an increasingly diverse and geographically scattered veteran population, the VA is not always the best option for every veteran. Providing a permanent program to coordinate non-VA care will ensure the VA continues to provide the best medical care to our veterans.

The PR will not divert funding from VA facilities to community care needs. The VA MISSION Act does require the VA to conduct market assessments and examine the VA's current infrastructure and adjust and realign as necessary, however, the VA does not have the authority to reprogram Federal dollars without the explicit authorization of Congress.

Delaying Implementation

Concerns have arisen from Members of Congress regarding the VA's readiness for implementing the necessary IT systems to manage the new VA Community Care Program.

Since passage of the VA MISSION Act, CVA has tirelessly advocated for robust congressional oversight to ensure the VA is meeting internal deadlines to develop and test systems prior to implementation. The VA should be held to the deadlines established by Congress in the VA MISSION Act, however, if modifications to the rollout need to be made, that is a conversation for Congress and the VA to engage in and come to a mutually agreed upon decision.

One thing is clear, the rollout should not be delayed as a political ploy to undermine the VA MISSION Act. Congress should act in good faith to assist the VA and support the successful implementation of the VA MISSION Act.

CONCLUSION

The VA's proposed access standards mark significant progress toward modernizing the VA's delivery of health care.

If a veteran is eligible under the VA MISSION Act for community care, the final decision will always be left up to the veteran. Nothing in the VA MISSION Act mandates a veteran receive care in the community. Protecting the VA bureaucracy and VA bureaucrats is nowhere in the VA's mission statement and the chief responsibility of the VA health care system is to deliver quality care to our Nation's veterans.

Veterans who choose to serve their country in uniform should be able to choose their doctor when they take off their uniform, especially if their local VA facility cannot deliver quality care in a timely or accessible manner. When veterans do not have choice, you get the Phoenix VA in 2014.

What happened at the Phoenix VA hospital is inexcusable and five years later, Congress and the VA must get implementation of the VA MISSION Act right.

PREPARED STATEMENT FROM THE DEFENSE HEALTH AGENCY,
DEPARTMENT OF DEFENSE

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, I am pleased to represent the Defense Health Agency (DHA) and share our approach to improving the patient experience in the Department of Defense (DOD), to include establishing and monitoring access to care standards for military beneficiaries. We have been fortunate to work closely with our colleagues in the Department of Veterans Affairs (VA) over the past year as they develop standards in support of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) of 2018.

While our core access standards have been in place for 25 years, we have continuously learned and adapted our approach as beneficiary expectations and needs have changed. While I recognize that the VA population is less concentrated around military installations than our own, we share some similarities in serving a dispersed beneficiary population with a mixture of medical facilities we operate, complemented by a network of contracted medical services to support locations where facilities have limited scope of services for our beneficiaries. I will provide a brief history on how we established these standards, and our experience in managing compliance with these standards both for our military hospitals and clinics and for providers in our TRICARE network.

When TRICARE was first established in 1993, patients were provided with choices in health care plans—TRICARE Prime, TRICARE Extra, and TRICARE Standard. The TRICARE Prime option functioned similar to a health maintenance organization (HMO) model. Patients were provided with a primary care manager, responsible for all of the patient's primary care needs, and would manage referrals to specialists. In 1994, DOD established access to care standards as an important incentive to attract beneficiaries to select TRICARE Prime as their health plan choice. Although the TRICARE choices were redefined to just two options in the National Defense Authorization Act for Fiscal Year 2017—TRICARE Prime and TRICARE Select—the core access standards are focused on TRICARE Prime. The TRICARE Select health option is similar to a Preferred Provider/Fee-for-Service (PPO/FFS) option in the civilian market. Beneficiaries who select this option have much greater freedom-of-choice to select any authorized provider with higher out-of-pocket expenses associated with that episode of care.

Also in 2017, with our new T–2017 next generation of TRICARE contracts, we transitioned from three net-work regions, to two regions consisting of HealthNet (West) and Humana Military (East). This provides for a simpler and more streamlined net-work of managed care providers.

The Military Health System (MHS) model is unique. The MHS is comprised of a direct care system—military-operated hospitals and clinics, staffed by uniformed or government civilian employees, and a purchased care system—civilian outpatient and inpatient, private sector providers. The purchased care system both augments the direct care system around military installations, and serves as the primary choice for care in those locations where there is no military medical presence. MHS access standards for TRICARE Prime enrollees apply in either setting. The access standards are also the same for all beneficiary categories, i.e. active duty, active duty family member and retirees.

Access standards for our beneficiares are based on both distance—the travel time to reach both primary care and specialty providers—and timeliness of appointments. A primary care network provider should be reachable within 30 minutes drive time from an enrollee's residence, and specialty care network providers should be reachable within 60 minutes drive time from an enrollee's residence. Appointing timeliness standards are as follows: urgent care appointments must be available within 24 hours; routine primary and behavioral health care within seven days; well-patients within 28 days; and specialty care visits within 28 days (or sooner as directed by the provider).

The premise of these access standards is simple. If our military treatment facilities (MTF) or our civilian network providers cannot provide an appointment to our TRICARE Prime enrollees within the allotted standards, our patients have the freedom to request a referral to another network provider, or a non-network provider when a network provider is unavailable.

If a provider is not available within 100 miles of patient's residence, TRICARE will cover the travel costs for the patient. TRICARE will reimburse for mileage expenses in a privately-owned vehicle according to government mileage rates, rental car coverage (if needed), and overnight lodging and meal expenses that are covered up to the approved local per diem rates. The DHA believes that these MHS-wide access standards ensure a consistent experience of care and access for beneficiaries.

These standards are embedded both within our DOD regulatory and policymaking documents, and included in our TRICARE contracts.

The MHS has taken a number of steps over the last several years to further enhance the patient experience and improve access to care throughout the system. We expanded hours of operation in many military clinics to better accommodate families. We introduced a 24/7 global nurse advice line that is integrated with appointing so that patients needing a follow-on health care appointment can be accommodated during their original call. We improved access to urgent care by allowing enrollees to use urgent care centers in the TRICARE network without requiring a referral from their primary care managers. Furthermore, we established enrollment capacity and provider productivity standards, with appropriate adjustments for readiness and other training demands in our MTFs, to optimize internal clinical operations, and better support our patient care needs.

The DHA has invested resources to create a performance management system that provides leaders and staff at all levels of the MHS with insight into access, quality, satisfaction, and cost measures. Information can be viewed at the MHS, Military Department, Medical Market, MTF, and Provider level. While less granular, we also monitor performance of our civilian TRICARE network providers, largely through patient surveys that assess satisfaction with timeliness and other care delivery measures. These measures are transparent to MTF commanders and staff at other military hospitals and clinics, allowing leaders to compare their performance with their peers. Key performance measures are also shared with the public at the enterprise level through www.health.mil, and at the local level through individual MTF websites. We also provide an annual "Evaluation of the TRICARE Program" report to Congress. Going forward, we intend to further integrate these performance measures between our direct and purchased care systems to provide our beneficiaries with an even more transparent and seamless integrated health care delivery system.

To ensure transparency with other key stakeholders, the DHA meets monthly with representatives from our military and veterans service organizations to review a wide range of policy and performance matters. Often, representatives from each of our Managed Care Support Contract (MCSC) are in attendance at these meetings to receive feedback from our beneficiaries and share efforts they have made to respond to beneficiary concerns. We review our performance on issues such as network adequacy, access to care, and satisfaction. These meetings provide another opportunity for review and information that help us adjust policies and programs to meet the needs of our beneficiaries.

We recognize that population size, individual health status, family circumstances, geographic location (to include residing in medically underserved communities), and cost considerations vary across the country—for health systems and for patients. Different health systems must adapt standards that meet the unique needs of the patients they serve. The specific standards we selected are perhaps not as important as the fact that the standards exist. We evaluate ourselves against the standards we set. And we share our performance with the people we serve.

I hope this brief overview of our approach to patient experience and access to care is helpful to your deliberations. Our DHA staff is committed to sharing our lessons learned and performance management approaches with our VA partners, and continue to meet regularly with them to assist in any manner that is helpful. I welcome the opportunity to provide any additional detail the Committee may require. Thank you for allowing me to share this information with you.

PREPARED STATEMENT OF NURSES ORGANIZATION OF VETERANS AFFAIRS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE,
On behalf of the Nurses Organization of Veterans Affairs (NOVA) we thank you for allowing us to submit our views on today's important hearing.

As nurses who provide the coordination and care for millions of Veterans throughout the VA Health Care System, we believe we have a unique voice and ground level view of how VA care should look and perform in the future.

Since the passage of the VA MISSION Act in June 2018, NOVA has voiced its concerns about how the Veterans Community Care Program (VCCP), to include new access standards, would change internal VA systems, but more importantly, if it continues to provide the "right" care for our Veteran patients.

The rollout of access standards for the VCCP, did little to alleviate our concerns. The new standards set arbitrary wait times and drive-times that do not take into consideration "quality of care" and access to providers who would be subject to the same high standards as VA demands. This creates a double standard under which

"community care" is held to a lower standard while seemingly offering Veterans "choice," but at what cost?

We believe all care provided the Veteran patient must demonstrate and meet access and quality standards whether they choose to receive care in the community, under the VCCP or remain at a VA Medical Center, or other VA facility.

The credentials, training, competency and performance standards that VHA requires of its own clinicians should be the benchmark for providers in the VCCP. Yet, the proposed standards for the program indicate that the minimal qualification and quality standards used to contract providers for the Veterans Choice Program will remain unchanged. Choice was nothing if not a lesson in contract negotiations gone terribly wrong.

NOVA members who coordinate care for non-VA care/Choice programs reported a myriad of problems being made by outside providers that led to delays in care, the wrong care given, or in many cases, the Veteran not being seen by an outside provider at all. Failure to ask the question "access to what kind of care?" can compromise the health and well-being of Veterans.

One of the core justifications for the MISSION Act was to give Veterans comparative information on the quality of VHA and non-VA provider care in order to make health care decisions. While robust metrics exist for a limited number of inpatient process measures, there are very few accurate ones for outcome measures. Almost no measures exist that compare the quality of individual providers or clinics in the private sector to those within VHA.

The regulations state that provider quality ratings will be published, but most of the relevant comparative information that Veterans need to make health care decisions will not be available.

How can Veterans make an educated choice on their health care if this information is not available?

We are also troubled by the lack of attention to internal VHA staffing needs with respect to implementing the VCCP. It is widely known, that VHA has over 45,000 vacancies—nurses are among many of those positions unfilled.

For the VCCP to be implemented properly, staff within VHA will be responsible for making appointments, coordinating care, obtaining documentation, collecting Veteran copayments, discussing options with Veterans, etc. But there is no assessment of, or accommodation made for extra staff needed to perform this huge expansion of workload. No consideration has been made as to how the VA is going to case manage all the Veterans that will be going out into the community. Those coordinating outside care are struggling with enough staff to keep up and balance changes in contracts, IT solutions and other workforce issues within VCCP.

NOVA asks that given this, how can new duties be effectively undertaken without significant numbers of additional staff? If these duties are executed by diverting staff from other clinical care needs—it has been mentioned that Patient Aligned Care Teams (PACT) would carry out some of these functions—remaining staff will become overburdened with more appointments in shorter periods of time, which could sacrifice timely access to quality care. VA's own report to Congress (required by the MISSION Act) on quality standards, recognized fragmentation of care is at risk. Shouldn't some of the burden in fact be borne by non-VA providers who are being paid to care for Veterans? VA can, and should make this a condition of contracting with non-VA primary care providers.

VA's own Impact Analysis recognizes that meeting the wait time regulation would require significant increase in staffing, but never considers adding FTEs to VHA to meet those standards. Is there consideration to provide grants or funding to hire more nurses and support staff to satisfy increases assessed under VCCP?

The Impact Analysis predicted that the new access standards would significantly increase the number of Veterans who receive VCCP care, all of which must be reimbursed by VA. *The Independent Budget* (*IB*), which NOVA has endorsed, notes that the Administration's budget proposal falls far short of covering associated VCCP costs.[1]

The *IB* is asking for $18.1billion in medical community care for FY 2020 which includes current services, estimated spending (not including full cost of wait time and drive time access standards which VA estimates will increase by 29% for PCP and 14% for Mental Health) under Choice and VA MISSION Act.

The importance of VA properly estimating community care costs is critical and we would remind the Committee that Congress had to twice provide "emergency funding" for Choice due to improper forecasting the demand for care among Veterans. We are confident that Congress does not want to repeat past mistakes and put VHA

[1] *The Independent Budget* Statement on VA's FY 2020 Budget Request at www.independentbudget.org

funding in jeopardy in the coming fiscal years. We stand by the *IB* estimates and ask that funding for community care be allocated separately and adequately to not deplete VHA funds.

NOVA recognizes and understands that community providers are a crucial part of an integrated network designed to provide care where there are shortages. Providers should be used to supplant VA care, not replace it, and be held accountable for performance, quality, and timeliness of care and services. Most importantly, VA must remain the first point of access and coordinator of all care.

VA provides high quality care to millions of Veterans across the country, many of whom have indicated through surveys* that they prefer to use VA because they believe the quality of care is higher and that VA's ability to treat service-connected conditions is unmatched by any care in the private sector.

As Congress and VA move toward final implementation of the VCCP, we ask that they consider a delay until such time that access and quality standards for the program are equal for both internal and external care. Care that is fair, accountable and of the highest quality is what Veterans deserve now and into the future.

Thank you for allowing us to submit our comments and recommendations.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to offer our views on the Department of Veterans Affairs' (VA) proposed access standards for community care as required by the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018.

On June 6, 2018, President Trump signed into law the VA MISSION Act, one of the most significant pieces of legislation in recent decades impacting veterans health care. If implemented correctly, the VA MISSION Act could drastically improve how VA delivers health care to our Nation's veterans. However, if implemented poorly, it could result in veterans, community providers, and Congress, losing confidence in the VA health care system and its ability to deliver timely quality health care to veterans.

The VA MISSION Act consolidated VA's authority to provide community care, including through the Choice Program, into a new program, the Veterans Community Care Program (VCCP). As part of the process of implementing the VCCP, the law required VA to develop access standards for furnishing hospital care, medical services, or extended care services to covered veterans in the community. The law also required VA to craft these access standards in a manner that provides relevant, comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care.

On July 30, 2018, PVA submitted comments to VA in response to its request for information regarding the development of access standards for the VCCP. In our comments, we expressed the importance of VA avoiding the problems in implementing the VA MISSION Act that plagued the roll out of the Veterans Choice Program. In addition, we requested that VA require that a spinal cord injured veteran's primary care provider be the informed coordinator of the veteran's care.

At the end of January 2019, VA announced the proposed access standards for VCCP. The standards for accessing community care were based on average drive times and appointment wait times. For primary care, mental health, and non-institutional extended care services, VA proposed a 30-minute average drive time standard. For specialty care, VA proposed a 60-minute average drive time standard. VA's proposed appointment wait-time standard is 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request with certain exceptions.

In PVA's comments to VA's proposed rule on implementation of the VCCP, we noted that the proposed rule's detail explaining eligibility and access standards would be useless if the new decision support tool was not ready on June 6. We also noted that the proposed access standards based on average drive times and appointment wait times are just as arbitrary as the 30 day/40 mile rule under the Choice program. In addition, VA's proposed regulations were short on specifics about how drive times would be determined. We also requested that VA resist calls to reduce proposed wait times to 14 days and instead focus on meeting its proposed 20-day standard.

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*VFW 2015, 2017, 2018 surveys relayed in its "Our Care Report" at https://www.vfw.org/advocacy/va-health-care-watch shows large numbers of Veterans prefer VA care.

At this time, we remain quite concerned that the decision support tool needed to efficiently and effectively determine eligibility will not be ready for deployment by VCCP's implementation on June 6. On March 1, the U.S. Digital Service (USDS) issued a report entitled, "MISSION Act: Community Care." The report voiced serious concerns about VA's proposed access standards and the status of VA's decision support tool for eligibility determinations. According to USDS, "Much of the data necessary to determine eligibility is currently housed across several legacy VA systems that don't interoperate, creating an inefficient and highly manual determination process." [1] USDS further stated that the decision support tool "could streamline the eligibility determination by connecting to these legacy VA systems to gather data on the Veteran and produce a determination." [2] Unfortunately, USDS found "significant risks surrounding software development timing, integration dependencies, and usability." [3]

We believe that there is significant potential for confusion among VA personnel and veterans regarding eligibility for community care. VA has responded to these concerns by noting that they are working on implementing the rollout process which includes training, policies, and tools that will ensure there is consistency for veterans, their families, and support teams. We concur that these requirements are essential, however, due to time constraints, there may not be sufficient time to rollout this information to all stakeholders.

PVA believes VA has failed in its mission to ensure VA's proposed access standards are clear and allow covered veterans to make informed decisions about their health care. As the final implementation of VCCP moves closer, we are very concerned about VA's reliance on modernized health care IT to successfully execute it. Considering the VA's past and current failures with IT programs, it is a very risky assumption that VA can get this right, particularly with the target implementation date less than two months away. We want to make sure that the VCCP is successful and believe that moving forward with untested IT would be unhelpful to veterans needing access to care.

As a result, we believe that VA should delay implementation of the new access standards based on drive times and wait times until VA can certify that the requisite IT solutions have been properly implemented and that VA can successfully roll out eligibility determinations based on these standards. In the meantime, VA should maintain the access standards of the Choice program. The remainder of the VA MISSION Act's eligibility standards and requirements should move forward as laid out in the law.

Finally, VA's proposed rule also invited comments on the possibility of VA considering the development of access standards for the care provided by Centers of Excellence or foundational services for possible inclusion in the VCCP. PVA would vigorously oppose any effort to move Spinal Cord Injury/Disorder (SCI/D) care into the VCCP. VA's health care system is the world leader in the treatment of spinal cord injuries and disorders. Through regular assessment, we know this level of care is unmatched in the civilian sector; thus, opening this line of service via the VCCP would result in the provision of lesser quality care when compared to that which is received at VA's SCI/D centers.

PVA is committed to working with VA and Congress for the successful implementation of the VA MISSION Act and its many provisions like the VCCP. Congress and VA must work together to ensure the longevity of the VA health care system for our members, and all veterans with catastrophic disabilities, who depend on that system. The proper balance of access to community care, coordinated by VA, is an important part of ensuring the long-term success of VA's system of care.

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[1] Chris Eldredge, Lauryn Fantano, Natalie Kates, Rick Lee, Sheri Trivedi, & Aaron Wieczorek, USDS Discovery Sprint Report, MISSION Act: Community Care 6 (2019), available at https://www.documentcloud.org/documents/5766330-USDS-Mission-Act-Report.html (last visited March 26, 2019).

[2] Id.

[3] Id.

PREPARED STATEMENT OF CARRIE M. FARMER AND TERRI TANIELIAN,
THE RAND CORPORATION

Testimony

Ensuring Access to Timely, High-Quality Health Care for Veterans

Insights from RAND Research

Carrie M. Farmer and Terri Tanielian

CT-508
Testimony submitted to the Senate Committee on Veterans' Affairs on April 10, 2019

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Ensuring Access to Timely, High-Quality Health Care for Veterans: Insights from RAND Research

Testimony of Carrie M. Farmer and Terri Tanielian[1]
The RAND Corporation[2]

Before the Committee on Veterans' Affairs
United States Senate

April 10, 2019

More than 9 million veterans are enrolled to receive health care from the U.S. Department of Veterans Affairs (VA). To serve this population, VA operates the nation's largest integrated health system, with 172 VA Medical Centers and 1,069 outpatient clinics across the country.[3] Although the size of the overall veteran population in the United States has been decreasing over time, the number of veterans receiving VA health care has been increasing. Several factors have led to this increased demand, including the influx of a new era of veterans with significant service-connected health problems. In response to concerns driven in large part by the media response to 2014 incidents at the Phoenix VA, that VA was unable to meet veteran demand for health care in a timely manner, Congress passed several bills to expand veterans' ability to receive health care from the private sector (community care), paid for by VA. Historically, VA had always supplemented the care it delivers with services purchased from the private sector through a series of local individual arrangements managed by VA Medical Centers. Over the past decade, several new initiatives to pilot partnerships with provider networks had been implemented as a more centralized means of coordinating care between VA and private-sector providers. Most recently, the Veterans Choice Program was implemented in 2014 as a temporary measure to allow veterans waiting more than 30 days for an appointment or living more than 40 miles from a VA facility to access private-sector care. This program is due to sunset in June. The VA MISSION Act, which consolidates existing VA

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[1] The opinions and conclusions expressed in this testimony are the authors' alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

[2] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

[3] U.S. Department of Veterans Affairs, "Veterans Health Administration," webpage, updated December 27, 2018 (https://www.va.gov/health/aboutVHA.asp).

community care programs and expands veterans' eligibility for such care, was signed into law in 2018 and is scheduled for implementation on June 6, 2019. In addition to consolidating the mechanisms through which VA purchases care, the legislation required VA to set specific eligibility rules for veterans utilizing such care, centered on access and quality standards of care furnished by VA. Veteran advocacy organizations, health care provider groups, members of the media, and others have spoken out about the proposed standards, both against and in defense of them. Those defending the standards have also been critical about how VA has managed community care for veterans and its ability to provide timely access or high-quality care. To help inform the committee about the timeliness and quality of VA care, we are offering some insights from relevant research.

Our comments derive from a series of studies about the VA health care system and community care for veterans conducted by the RAND Corporation over the past few years. In this statement, we highlight some notable findings and recommendations from this work in an effort to help the committee evaluate implementation of the VA MISSION Act and its potential effects on veterans' access to timely, high-quality health care.

We primarily draw on research studies that examined the different dimensions of veterans' access to high-quality care. We first discuss research findings regarding veterans' access to timely care, based on wait times and geographic distance. Then, we discuss findings related to veterans' access to and receipt of care that meets criteria for other dimensions of high-quality care, such as safety and effectiveness. We also discuss the limitations in existing research with regard to the readiness of private-sector providers to meet similar standards of timeliness and quality and offer several recommendations for how best to monitor and assess how changing the standards of access to VA community care might affect veterans.

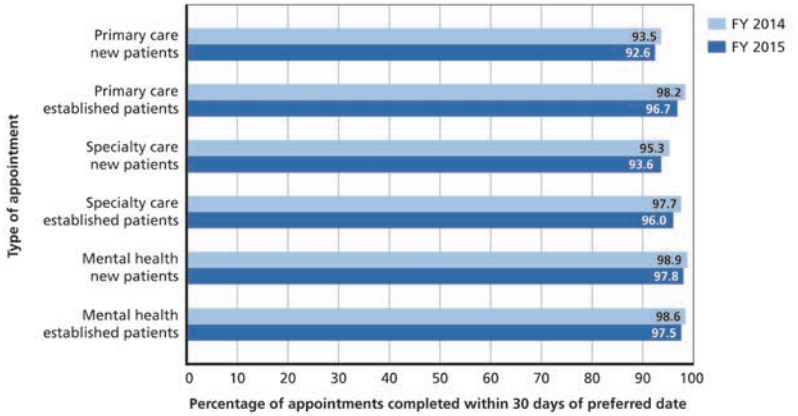
Most VA-Enrolled Veterans Can Access Timely, High-Quality Health Care from VA Providers, But Not All

The VA MISSION Act's proposed rules set forth new standards for eligibility for VA community care based on appointment wait times and geographic distance, as well as other factors. Under the proposed wait-time eligibility rules, VA-enrolled veterans would be eligible for VA community care if their wait time for a VA appointment is greater than 20 days from the date of request, for primary care and mental health care, and 28 days from the date of request for specialty care. Under the Veterans Choice Program, veterans are currently eligible for VA community care if their wait time is greater than 30 days from their preferred date for the appointment. Changing the standard from "preferred date" to "date of request" has unknown consequences for VA community care eligibility—in most cases, it is reasonable to assume that the "preferred date" and "date of request" would be the same, as it is likely that most veterans want to be seen as soon as possible.

In our 2015 assessment of VA's capacity to furnish health care to veterans, we found that most VA appointments met VA timeliness standards; however, there was variation in timeliness

across the VA system, with poor performance for some VA facilities.[4] As shown in Figure 1, most veterans completed their appointments within current VA timeliness standards of 30 days of the preferred date—that is, the date recommended by the physician or that the veteran preferred. We found that the average number of days that veterans waited for appointments varied tremendously across VA facilities (see Figure 2). At 91 top-performing VA facilities, more than 96 percent of new primary care patients received appointments within 30 days of the preferred date. However, 14 VA facilities were far below this benchmark, with less than 84 percent of patients receiving appointments within 30 days of the preferred date.

Figure 1. Percentage of VA Appointments Completed Within 30 Days of Preferred Date, First Half of FY 2014 and First Half of FY 2015



SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed VA wait-time data for the first half of fiscal year (FY) 2014 and the first half of FY 2015 obtained from the Veterans Health Administration (VHA) Support Service Center by the MITRE Corporation.

Since our 2015 study, VA has continued to assess and publish wait times for appointments. As of March 2019, 93 percent of VA appointments were within 30 days of the preferred date, and average wait times were 4.2 days from the preferred date for primary care, 5.5 days for mental health care, and 10.4 days for specialty care.[5]

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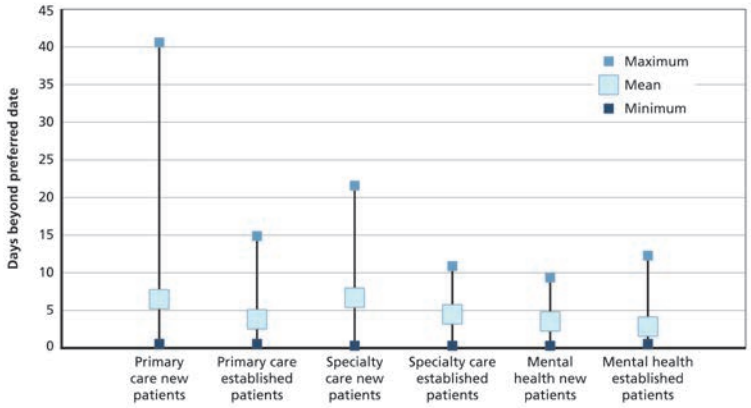
[4] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*, Santa Monica, Calif., RR-1165/2-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z2.html).

[5] U.S. Department of Veterans Affairs, "Pending Appointment and Electronic Wait List Summary—National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date," spreadsheet, March 2019 (https://www.va.gov/HEALTH/docs/DR113_032019_Public_Data_Pending_Appointments.pdf).

Figure 2. Variation Across VA Facilities in Number of Days Waited for an Appointment Following Preferred Date, First Half of FY 2015



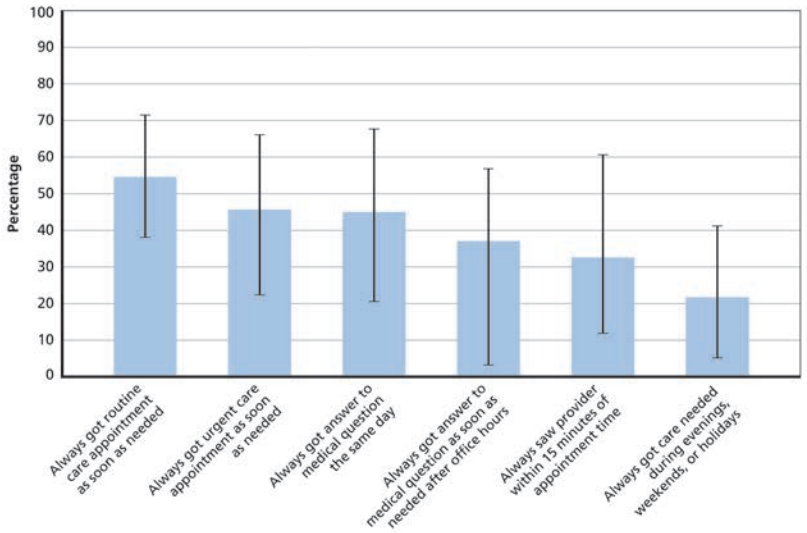
SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed VA wait-time data for the first half of FY 2015 obtained from the VHA Support Service Center by the MITRE Corporation.

There has been criticism that VA's wait-time metric is arbitrary. However, no single standard or benchmark for wait times has been established on a national basis for the private sector. Different systems of care set different expectations, particularly for urgent primary care or mental health care. For example, the California Department of Managed Health Care applies a wait-time standard of 48 hours for an urgent care appointment. In 2014, VA asked the Institute of Medicine to evaluate existing timeliness measures and recommend a national standard. In its report, the Institute of Medicine declined to offer a single standard, instead recommending patient-centered principles around measuring and assessing timeliness and highlighting that few alternatives exist to VA's current approach.[6]

Given the challenges with wait-time metrics, and the importance of veterans' perspectives on the timeliness of care, our 2015 assessment also examined veterans' experience with receiving VA care "as soon as needed," using data from the VA Survey of Healthcare Experiences of Patients (SHEP). RAND found that 55 percent reported always getting routine care as soon as needed, and 46 percent reported always getting urgent care as soon as needed (Figure 3).

[6] Institute of Medicine, *Transforming Health Care Scheduling and Access: Getting to Now*, Washington, D.C.: National Academies Press, June 2015.

Figure 3. VA Facility Average of Percentage of Veterans Responding "Always" to Access Questions on the SHEP, FY 2014



SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. Facility-level patient experience data for VA patients are from the SHEP–Patient Centered Medical Home in FY 2014, obtained from the VA Office of Performance Measurement.
NOTES: The height of the bar is equal to the mean percentage of patients who responded "always" to each question. The line extending from the top of the bar represents the range of values at the VA facility level, from the minimum (worst-performing facility) to the maximum (best-performing facility).

The VA SHEP survey questions are identical to those included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a survey used to assess patient experiences of care in other health systems. We compared patient-reported timeliness of care within VA with private-sector practices, using data from the CAHPS Database. The CAHPS data include a *voluntarily participating* set of private-sector medical practices, likely overrepresenting high-performing practices. To account for the nonrepresentativeness of private-sector practices in the CAHPS Database when comparing VA with private-sector patient-reported access, we compared the top-performing VA facilities and the 75th percentile of VA facilities with average practices in the CAHPS Database. We found that the top-performing VA facilities scored comparably to average private-sector practices with regard to the proportion of patients reporting that they always got a routine care appointment as soon as needed (69 percent for top-performing VA facilities and 72 percent for CAHPS Database practices). VA facilities at the 75th percentile of VA performance scored substantially worse (61 percent reporting always getting a routine care appointment as soon as needed) than average CAHPS Database practices on this metric.

This finding highlights the need for a nuanced assessment of timeliness that accounts for patient experience; although VA is providing care that, in most cases, meets the wait-time standard, many veterans do not feel as though they are able to get care as soon as needed.

Most VA Enrollees Live Within 30 Minutes of VA Primary and Mental Health Care

A critical factor for defining eligibility for private-sector care has always been the distance between the veteran's residence and a VA facility. In the proposed rules released by VA, eligibility for private-sector care incorporates driving distance into its standards for access under the MISSION Act. The proposed rules allow veterans who have longer than a 30-minute drive time to a VA provider for primary and mental health care, or 60-minute drive time for specialty care, to access community care. In our 2015 study, we calculated drive times from VA enrollees' residential addresses to the closest VA medical facility, taking into account the types of care provided at each facility. Drive times vary considerably across the country, but our research found that mean drive time for VA enrollees to VA primary care is 24.5 minutes and VA mental health care is 25.3 minutes (see Table 1).[7] Although mean drive time to VA specialty care depends on the type of care, for most types of care, mean drive time is less than 60 minutes.

Table 1. Average Drive Time for VA Enrollees to a VA Source of Care

Type of Service	Mean Drive Time (minutes)	Standard Deviation
Primary care	24.5	23
Mental health care	25.3	24.3
Methadone	42.5	41.8
Traumatic brain injury specialty care	46.9	43.2
Colonoscopy	50.3	44.9
Ophthalmology clinic	54	46.5
Emergency department	55.8	47.7
Coronary care unit	55.9	47.8
Gynecological surgery	56.2	48.8
Interventional cardiology	62.7	52.9

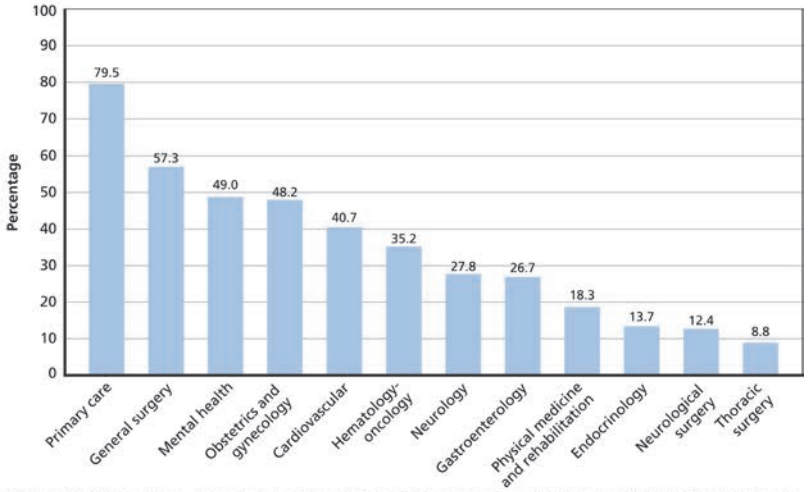
SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

For veterans who face long drive times to VA care, our research suggests that expanding access to non-VA providers can help those seeking routine and emergency care. For those needing advanced and specialized care, increasing access to non-VA providers might not make much of a difference. In our analyses, nearly all veterans (96 percent) who lived more than 40

[7] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans: Appendixes C–G*, Santa Monica, Calif., RR-1165/2-VA, 2015, Appendix D. These estimates were from the VA Planning Systems Support Group (PSSG) Enrollee File and an April 2015 extract from the VA Site Tracking (VAST) system.

miles from VA medical facilities could drive to community and emergency care at non-VA hospitals within 40 miles,[8] but access to more-advanced care at academic and teaching hospitals was much lower: Only 15 percent lived within 40 miles of a teaching hospital, and only 3 percent lived within 40 miles of an academic hospital. These veterans were also less likely to have geographic access to a range of highly specialized care at non-VA hospitals, including many cardiology, surgery, and oncology services (see Figure 4). As depicted in Figure 4, we examined the proportion of veterans who lived more than 40 miles from a VA facility but who lived within 40 miles of a non-VA provider, by specialty. Nearly 80 percent of veterans who live more than 40 miles from VA medical facilities also live within 40 miles of a non-VA primary care provider, yet this percentage drops markedly for other specialties. Of note, only 18.3 percent of veterans living more than 40 miles away from a VA facility also live within 40 miles to non-VA physical medicine and rehabilitation services. Thus, even with the new drive-time standard allowing these veterans to access community care, veterans living far from VA facilities may still face long drive times to non-VA providers of the same services.

Figure 4. Geographic Access to Non-VA Physicians Among Enrollees Residing More Than 40 Miles from VA Medical Facilities, by Specialty, 2013



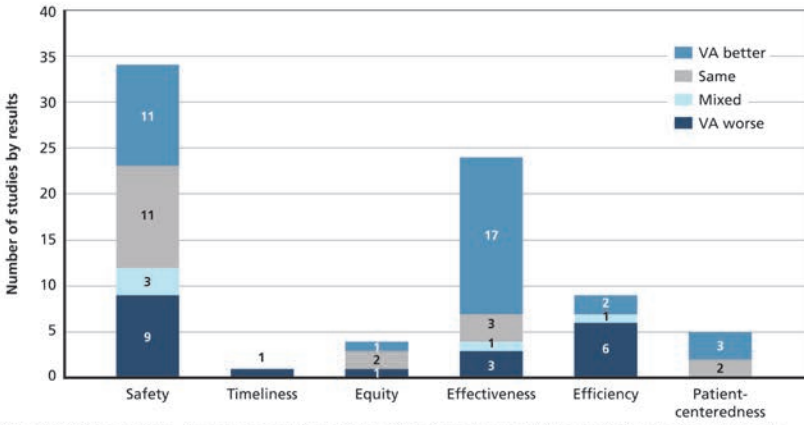
SOURCES: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed the SK&A Office-Based Physician Database, VA Site Tracking System, and VA Planning Systems Support Group Enrollee file.

[8] Our analysis was based on Veterans Choice Program standards of 40-mile drive distance.

Quality of VA Care Is Similar or Better Than the Private Sector

Assessing the quality of VA care is an integral part of assessing veterans' access to care. *Health care quality* refers to performance along several domains, including safety, timeliness, equity, effectiveness, efficiency, and patient-centeredness.[9] Over the course of the past several decades, the quality of care provided by the VA health care system has been studied more extensively than many other health care systems. In our 2015 study, we summarized the available evidence from published studies appearing in the prior ten years (since 2005) that compared the quality of care provided by the VA and non-VA health care systems. As shown in Figure 5, there was variation in the total number of studies published per dimension; however, for the most part, in these studies VA performed the same or better relative to a non-VA comparison group.

Figure 5. Number of Studies in a Systematic Review, by Quality Dimension and VA Performance, Compared with Non-VA



SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. RAND conducted a systematic review of studies on quality of care in VA compared with non-VA settings.
NOTES: Categories are defined as follows: VA better = VA quality of care shown to be better than non-VA, or a mix of same and better; mixed = for studies with multiple quality measures, VA care was better than non-VA on some and worse on others; same = quality of care in VA and non-VA did not differ; VA worse = VA quality of care was shown to be worse than non-VA, or a mix of worse and same.

VA currently uses multiple quality-monitoring systems—tailored for different care settings and audiences—to collect and report information about the health of veterans and the care

[9] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academy of Sciences, March 2001.

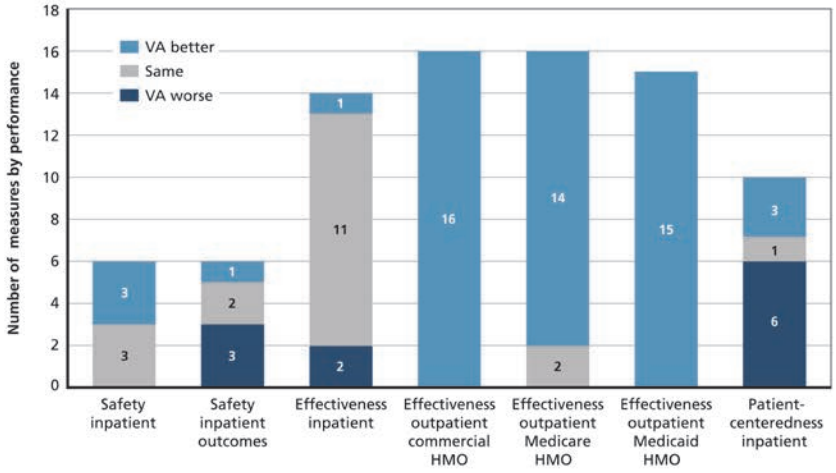
provided to them. By all accounts, VA has an extensive set of measures for most conditions and purposes. Across the U.S. health care system, quality reporting requirements have expanded, and measurement has become more complicated.[10] To assess VA's quality of care compared with non-VA health care systems, we analyzed publicly reported quality data from VA and non-VA health care systems for six quality measures of inpatient safety, six for inpatient safety outcomes, 30 for effectiveness (14 inpatient and 16 outpatient), and 11 for patient-centeredness in the inpatient setting. Measures of efficiency, equity, and timeliness were not analyzed because similar measures were not available for non-VA providers.

As shown in Figure 6, our analysis indicated that, on most publicly reported measures, on average, the quality of VA outpatient care was better than the quality of non-VA outpatient care, and, on average, the quality of VA inpatient care was the same as or better than the quality of non-VA inpatient care. Some measures of patient experience and three measures of readmission indicated lower quality, on average, at VA hospitals than at non-VA hospitals. We also found considerable variation in quality across VA facilities and even greater variation among providers in non-VA health care systems. More detail about our methods and the detailed findings are available in the 2015 study.[11]

[10] Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress*, Washington, D.C.: National Academies Press, April 2015.

[11] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

Figure 6. VA Versus Non-VA Quality of Care, by Type of Quality Measure



SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. RAND summarized results of VA to non-VA comparisons.
NOTES: Categories are defined on the basis of statistical tests for difference in means with $p < 0.05$ or less: VA better = VA quality of care shown to be better than non-VA; same = quality of care in VA and non-VA did not differ; VA worse = VA quality of care was shown to be worse than non-VA. Non-VA comparison data were not available for outpatient measures of patient-centeredness.

Little Is Known About the Timeliness and Quality of VA Community Care

To our knowledge, there has been no systematic analysis of the timeliness or quality of care that veterans receive through VA community care programs. In fact, it is not currently possible to accurately measure and monitor the timeliness of VA community care; a June 2018 Government Accountability Office (GAO) report found that VA did not have mechanisms to capture data on how long veterans waited for a Veterans Choice Program appointment once a referral had been made.[12] Media reports suggest that veterans experience long delays and difficulties making appointments for VA care in the private sector. This is not surprising. A 2013 study in Massachusetts reported average waits of 39 days between an initial call to make a new-patient appointment and the appointment date for family medicine, 50 days for internal medicine,

[12] Government Accountability Office, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, Washington, D.C., June 2018 (https://www.gao.gov/assets/700/692271.pdf).

and between 22 and 37 days for specialty appointments.[13] More recently, a 2017 study of private-sector health care wait times in 15 major metropolitan markets assessed the average number of days between an initial call to make a new-patient appointment and the appointment date.[14] Across these markets, the average wait time for a new appointment with a physician was 24.1 days, which is an increase of 30 percent from 2014. A 2019 article in *JAMA Network Open* comparing wait times in VA with the private sector found that the mean private-sector wait time for a new appointment was 29.8 days (compared with 17.7 days for VA).[15]

Part of the unknown is whether VA community care providers are taking new patients—a critical aspect of accessing care and not something VA currently reports. In a study funded by the New York State Health Foundation, RAND conducted a survey of licensed health care providers in New York state to assess their readiness for treating veterans with service-connected health problems.[16] We found that nearly all (92.1 percent) providers who responded to our survey reported that they were taking new patients, and more than half (62.6 percent) reported that they had new-patient appointments available within two weeks. However, only 19.4 percent reported being aware of the Veterans Choice Program, and, of those, only 10.8 percent reported that they were currently treating veterans with VA community care coverage. It is unclear whether providers who are part of the VA community care networks have appointment availability and, in practice, how easy it is for VA-enrolled veterans to make appointments with private-sector providers. Although not necessarily generalizable to VA community care, a recently published study by West Virginia University researchers used a "secret shopper" method to make new primary care appointments in California and found that secret shoppers were able to make new primary care appointments only about 30 percent of the time, despite these providers being listed by health plans as accepting new patients.[17]

Information about the quality of care delivered through VA community care providers is also missing. That VA performs as well or better than the private sector on most measures of health care quality has been well documented in numerous studies, including our 2015 study.[18] What is

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[13] Massachusetts Medical Society, "MMS Study Shows Patient Wait Times for Primary Care Still Long," July 15, 2013 (http://www.massmed.org/News-and-Publications/MMS-News-Releases/MMS-Study-Shows-Patient-Wait-Times-for-Primary-Care-Still-Long/#.XKvc9C2ZMmJ).

[14] Merritt Hawkins, *2017: Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*, Dallas, 2017 (https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf).

[15] Madeline Penn, Saurabha Bhatnagar, SreyRam Kuy, Steven Lieberman, Shereef Elnahal, Carolyn Clancy, and David Shulkin, "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *JAMA Network Open*, Vol. 2, No. 1, 2019, p. e187096.

[16] Terri Tanielian, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, *Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans*, Santa Monica, Calif.: RAND Corporation, RR-2298-NYSHF, 2018 (https://www.rand.org/pubs/research_reports/RR2298.html).

[17] Simon F. Haeder, David L. Weimer, and Dana B. Mukamel, "Secret Shoppers Find Access to Providers and Network Accuracy Lacking for Those in Marketplace and Commercial Plans," *Health Affairs*, July 2016 (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1554).

[18] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

unknown is whether veterans receiving care through VA community care receive care that meets these high standards. One example of this concern is screening for health risks common to veterans. Among other required screenings, VA mandates annual screenings for depression and alcohol use—and studies have found high rates of compliance, with 90 percent of veterans receiving screening for unhealthy alcohol use during a VA health care visit[19] and 82 percent receiving screening for suicide risk.[20]

Without consolidated comparable data on the care that veterans receive in the private sector, it is difficult to examine how often veterans receive these types of screenings in community-based settings. To partially understand what veterans might experience in the private sector, we conducted a population-based survey of all licensed health care professionals in New York state. In that study, 42 percent reported "seldomly" or "never" screening patients for suicidal ideation or risk, much lower than the mandated levels for VA providers. Although we do not know whether the findings from this study of providers in New York are generalizable to providers in other states or to providers who are part of the VA community care network, the concern remains that it is unknown whether non-VA providers provide care at the same level of quality as VA providers.

An important component of quality for VA community care is whether non-VA providers are prepared to treat VA-enrolled veterans, who tend to be sicker, on average, than nonveterans.[21] The VA health care system was established primarily to address the needs of veterans who had experienced significant service-connected health related problems, including those considered catastrophically disabled. Several studies have demonstrated that veterans who are enrolled in VA have higher rates of chronic, disabling conditions, many of which are due to their military service or aging. Veterans enrolled in the VA health care system also tend to be poorer than non–VA-enrolled veterans and their civilian counterparts. The VA health care system has been systematically, over time, designed to serve this unique population, even as Congress expanded eligibility for enrollment to other veterans with less complicated health or economic needs. The VA health care system has also prioritized creating settings in which veterans feel welcome by providers who understand military culture. It is unclear the extent to which the veterans eligible for community care under the new MISSION Act rules will experience similar settings in the private sector.

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[19] K. A. Bradley, E. C. Williams, C. E. Achtmeyer, B. Volpp, B. J. Collins, and D. R. Kivlahan, "Implementation of Evidence-Based Alcohol Screening in the Veterans Health Administration," *American Journal of Managed Care*, Vol. 12, 2006, pp. 597–606.

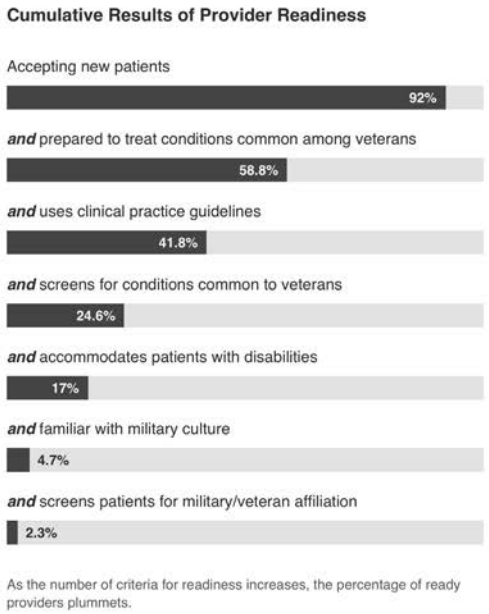
[20] Katherine E. Watkins, Harold Alan Pincus, Brad Smith, Susan M. Paddock, Thomas E. Mannle Jr., Abigail Woodroffe, Jake Solomon, Melony E. Sorbero, Carrie M. Farmer, Kimberly A. Hepner, David M. Adamson, Lanna Forrest, and Catherine Call, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report*, Santa Monica, Calif.: RAND Corporation, TR-956-VHA, 2011 (https://www.rand.org/pubs/technical_reports/TR956.html).

[21] RAND Corporation, *Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs*, Santa Monica, Calif., RR-1165/1-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z1.html).

In our study of New York state health care providers, only 2.3 percent met all our criteria for being ready to treat veterans—for example, 19 percent regularly screened their patients for veteran affiliation, and 27 percent reported being familiar with military culture (see Figure 7). Although VA has developed numerous trainings and materials for non-VA providers, we found low participation in such training among New York state providers (about 12 percent had participated in military culture training).

Without additional information about the capacity of the private health care setting to meet the same access and quality standards that VA sets for itself, it is unclear whether offering more veterans access to private-sector care would yield the desired results for improving access and quality.

Figure 7. Findings on Provider Readiness in New York State



SOURCE: Terri Tanielian, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, *Are Private Health Care Providers Ready to Treat Veterans? Evidence from New York State*, Santa Monica, Calif.: RAND Corporation, RB-10006-NYSHF, 2018 (https://www.rand.org/pubs/research_briefs/RB10006.html).

VA Should Carefully Monitor Access and Quality of Community Care

Although VA has long purchased care from the private sector when it is unable to provide certain services through its medical facilities, in recent years, the amount of VA-purchased care has grown substantially. In FY 2014, VHA spent $6 billion on purchased care;[22] in its FY 2020 budget request, VA estimated purchased-care costs of $15.3 billion.[23] The costs and associated utilization of VA community care is poised to grow substantially with the implementation of the MISSION Act. To ensure that veterans receive timely, high-quality care that is as least as good as the care VA provides itself, the quality and timeliness of this care must be measured and regularly monitored. Although the MISSION Act called for specific standards around quality to also be employed in determining eligibility for community care, the proposed rules released in March 2019 did not specify how these would be defined.

To reduce provider and system burden, access and quality measurement for VA community care could be harmonized with approaches used in other federal health care systems, which are in most cases purchasing care from the same providers. In our 2018 study of VA- and the U.S. Department of Defense–purchased care, we found that about half of the providers participating in the VA Community Care Network (at that time, under the Patient-Centered Community Care and Veterans Choice programs) were also part of the TRICARE network.[24] It is likely that almost all of these providers also accept Medicare. Because the Department of Defense and the Centers for Medicare and Medicaid Services (CMS) have existing mechanisms in place to measure and report on the quality of care delivered by these providers, VA may be able to align community care quality measurement with these approaches.

In addition to implementing more-rigorous approaches to examine access and quality of care within the private health care sector, it will be important to also systematically assess veterans' experiences with VA community care, and specifically their experiences with the customer support and care they receive from providers contracted through the new Community Care Network. This could include expanding existing surveys of health care enrollees and users, such as SHEP, to focus specifically on care in the community. These types of assessments will be critical if we are to understand whether expanding veterans' ability to seek care in the community has had a meaningful impact (positive or negative) on their access to high-quality care. As these assessments are considered, we would also encourage VA to examine all dimensions of quality, not just timeliness. Thus, in addition to monitoring wait times and driving distances for specific types of care, this will require ensuring that objective measures of safety, effectiveness, equity, efficiency, and patient-centeredness are included.

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[22] RAND Corporation, *Authorities and Mechanisms for Purchased Care at the Department of Veterans Affairs*, Santa Monica, Calif., RR-1165/3-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z3.html).

[23] U.S. Department of Veterans Affairs, *Congressional Submission: FY 2020 Funding and FY 2021 Advance Appropriations*, Vol. 2: *Medical Programs and Information Technology Programs*, Washington, D.C., 2019 (https://www.va.gov/budget/docs/summary/fy2020VAbudgetVolumeIImedicalProgramsAndInformationTechnolog.pdf).

[24] Carrie M. Farmer, Terri Tanielian, Christine Buttorff, Phillip Carter, Samantha Cherney, Erin L. Duffy, Susan D. Hosek, Lisa H. Jaycox, Ammarah Mahmud, Nicholas M. Pace, Lauren Skrabala, and Christopher Whaley, *Integrating Department of Defense and Department of Veterans Affairs Purchased Care: Preliminary Feasibility Assessment*, Santa Monica, Calif.: RAND Corporation, RR-2762-DHA/VHA, 2018 (https://www.rand.org/pubs/research_reports/RR2762.html).