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STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Chairman Moran, Ranking Member Tester, Distinguished Members of the Committee:

DAV (Disabled American Veterans) congratulates you, Senator Moran on your confirmation as the 12th Chair of the Senate Veterans' Affairs Committee. We look forward to your leadership and to working collaboratively with you and your staff on behalf of our nation's wounded, ill and injured veterans.

Thank you for inviting DAV to testify at this hearing to examine the implementation of the new Veterans Community Care Program, which went live on June 6, 2019, and VA's new urgent care benefit in accordance with Public Law (P.L.) 115-182, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018.

Comprised of more than one million wartime service-disabled veterans, DAV is a congressionally chartered non-profit national veterans service organization that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. We are pleased to offer our views on the Veterans Community Care program.

VA Urgent Care Benefit

All throughout the 114th Congress, DAV worked closely with this Committee and VA to amend the medical benefits package administered by the Department to include urgent care. We were pleased VA agreed to include urgent care in its plan to consolidate all non-Department provider programs required under section 4002 of P.L. 114-41, and that Congress included DAV's recommendation to finally provide veterans an urgent care benefit under section 105 of the VA MISSION Act of 2018.

The need for this new benefit has become abundantly clear with over 170,000 urgent care visits made by veterans across the country. The urgent care benefit is intended to offer eligible veterans convenient care for non-emergent health care needs from qualifying non-VA entities or providers. Eligible veterans include any enrolled veteran who is waiting or was furnished care by VA within the preceding 24 months. Qualifying non-VA urgent care

providers include any non-VA entity that has entered into a contract, agreement, or other arrangement with VA to provide urgent care. [1]

We applaud TriWest Health Care Alliance's (TriWest) efforts to build a network of over 6,400 urgent care providers nationwide. According to TriWest, they are nearing their maximum achievable goal of 92 percent of veterans to have access to an urgent care or retail clinic, if one exists, within a 30-minute drive. Moreover, TriWest developed a new online training course and simple to use quick reference guide for network urgent care providers to understand the processes and procedures on the VA urgent care benefit. We are pleased to report DAV members who have used this benefit have expressed positive comments about their experience from their eligibility determination at the point of service and satisfaction with the care they received. In addition, we have not received any reports to date of inappropriate billing of veterans using the VA urgent care benefit.

The responsibilities for the urgent care benefit[2] transitioned from TriWest to Optum Public Sector Solutions, Inc. (Optum) for Region 1 of the Community Care Network (CCN) on February 1, 2020—without a transition period. We are cautiously optimistic the Urgent Care provider network administered by Optum is at least as robust and the process be as seamless an experience for veterans that seek such care. To date however, VA has not provided us any information on the timing for the transition of responsibilities for the urgent care benefit for Regions 2 and 3.

It is notable that VA, in its final rule, did not make this benefit available as part of the Veteran Community Care Program. The Department specifically cites Senate Report 115-212 to support this decision to provide veterans access to convenient care. The Senate report however also directs VA "to ensure adequate coverage, so that all veterans have the option of utilizing this convenient, walk-in care." Yet current regulations are silent on how the Department is to "ensure adequate coverage."

VA should ensure Optum's incoming network of urgent care providers does not contain any gaps of urgent care centers and retail clinics that would otherwise reduce veterans access to urgent care. We also look forward to VA's testimony today that should help determine how many of the approximately 9,000 urgent care centers and 3,000 retail clinics in the United States are part of VA's Urgent Care Network to ensure sufficient coverage to the enrolled veteran population.

Mr. Chairman, DAV vehemently opposes VA's decision to charge urgent care copayments to service-connected veterans, who are generally not required to pay copayments under other VA health care programs. In DAV's view, service-connected disabled veterans have already paid through their service and sacrifice and should not have additional copayment or cost-sharing requirements imposed by the federal government.

[1] 38 U.S.C. §1725A was further amended by P.L. 115-251 to allow walk-in care providers to have a contract, agreement or other arrangement with VA and aligned the copayment requirements accordingly.

[2] Includes filling of prescriptions for urgent care written by qualifying non-VA entities or providers, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system. It also includes paying for urgently needed over-the-counter drugs, medical and surgical supplies, durable medical equipment and medical devices.

The Senate report, which the VA cites in its final rule imposing copayment on service-connected veterans, also instructs the urgent care "copayment [be] determined by a sliding copayment scale as established by the Secretary." To date, VA has not provided such sliding copayment scale.

While we appreciate VA's desire to incentivize appropriate health behavior from veteran patients, we strongly urge VA to provide positive rather than punitive incentives. Instead of charging veterans who have become ill or injured due to military service to limit their use of the urgent care benefit, VA should take a more veteran-centric approach to controlling costs. The Department should establish a national nurse advice line to, among other things, curtail overreliance on costly emergency room care.

The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line.

In May of 2018, the VA Greater Los Angeles Healthcare System (VAGLAHS) announced an expansion of an effort in collaboration with TriWest allowing enrolled veterans to contact the Veterans Integrated Service Network (VISN) 22 Telephone Advice Nurse Call Line at (877) 252-4866 for an evaluation from a triage nurse and, when appropriate, referral to a non-VA urgent care center. This partnership with non-VA urgent care centers was meant to provide after-hours and weekend urgent care services. Veterans were required to call the nurse line for pre-authorization before each visit.[3] These referrals to non-VA urgent care centers were made in conjunction with VAGLAHS Community-Based Outpatient Clinics and Ambulatory Care Centers in Ventura, Los Angeles and Kern Counties, which provide walk-in urgent care services during regular business hours, as well as primary care, specialty care, and mental health care.

By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance on emergency room care to decrease the current cost-sharing scheme as well as more quickly prompt clinical teams to associate any health information rendered from this encounter. Furthermore, this care delivery design would change the urgent care benefit from an episodic nature to an integrated benefit that is part of VA's continuum of care.

Finally, VA should assess its telehealth program to determine the feasibility of providing virtual urgent care services, particularly for certain veteran patient populations such as chronic care patients. Such a platform combined with a HIPAA[4]-compliant mobile app would allow veterans to connect with VA and schedule a visit online or in person. Also,

[3] www.losangeles.va.gov/pressreleases/VAGLAHS_Increases_Access_to_Care.asp
[4] Health Insurance Portability and Accountability Act of 1996

providing this type of care would allow for easier integration with VA's electronic health record and could help incorporate elements of remote patient monitoring.

VA Veteran Community Care Program

To implement section 101 of the VA MISSION Act of 2018, VA intended to award Community Care Network (CCN) contracts to provide eligible veterans non-VA care when VA determines it is needed across six regional boundaries aligned to state lines, including Alaska and the Pacific Territories. These contracts are to be awarded to Third Party Administrators (TPA) to develop and administer regional provider networks in accordance with the requirements outlined by contract.

On December 28, 2018, Optum was awarded contracts with a base period ending September 30 of the fiscal year in which the award is made and seven one-year options for regions 1, 2, and 3, covering Veteran Service Integrated Networks 1, 2, 4-10, 12, 15, 16, 19 and 23. The contract for region 4, covering VISNs 16, 17, 19-22, was awarded to TriWest on August 7, 2019. Protests filed for these contracts have been dispensed with by the Government Accountability Office (GAO) and work has since resumed. It is our understanding as of this writing, the provider network in Region 1 is complete, deployment in Region 2 and Region 4 is underway. Region 3 will begin in earnest with full network deployment across all 4 regions by the end of 2020. The Request for Proposal (RFP) for region 5 was posted on September 19, 2019 with proposals due on October 21, 2019. According to VA, no RFP will be issued for region 6 and will instead rely on local contracts with the estimated 40 community providers.

In advance of awarding CCN contracts and implementing CCN networks across all six regions, VA's contract with TriWest to expand its network of Patient Centered Community Care and Veteran Choice Program providers across all CCN regions was used as a "bridge contract" to ensure veterans continue to have access to care during the transition to the new Veterans Community Care Program. We understand the current option year for this bridge contract expired September 20, 2019, with one final option year available through September 30, 2020. It is imperative Optum continue developing and deploying its network of providers that at the minimum preserves existing referral patterns so that veterans do not experience any disruption in their treatment plan.

In preparation for this hearing, DAV reviewed our communications with veterans, VA employees, and non-VA providers. While there is insufficient data and other information to fully assess the progress to implement a high-performing integrated network required under the VA MISSION Act of 2018, we continue to hear anecdotally from veterans being offered access to community care network providers without fully informing them of their options in order to make an informed choice. Veterans have indicated to us they were not provided the approximate time to the next available VA provider at the VA facility of their choosing. One veteran indicated he had been offered community care without being given the option to wait and see the VA provider he trusts and with whom he has had a longstanding patient-provider relationship.

We have also heard anecdotally from VA employees where veterans care is being fragmented due in large part to the transition from the Choice program to the Veteran Community Care program. We have reports of veterans arriving at their appointments with Choice providers only to be turned away because they are not CCN providers. One veteran with chronic comorbid conditions was not even notified of this change nor was he notified the network provider he had been seeing over the last year under Choice declined to become a CCN provider. As a 100 percent service-connected disabled veteran, to continue his treatment plan he is now forced to use other health coverage and is incurring out-of-pocket expenses. Another veteran with Multiple Sclerosis who was referred for an evaluation for a new medication therapy to combat the progress of the disease experienced a two-month delay in scheduling the evaluation.

Moreover, we continue to receive requests for assistance from non-VA providers due to delayed or no payments. Generally, the issue stems from the various types of care authorizations (Individual Authorizations, PC3, Choice and CCN), delays with internal VA processing and use of improper procedures. It should be noted here however that the Office of Community Care and TriWest have been very responsive in evaluating the source of the payment issue and educating the providers of the cause as well as expediently paying clean claims.

We are also unable to fully assess the implementation of the Veterans Care Agreements under section 102 of the VA MISSION Act of 2018, as policies and procedures to help guide field implementation are still being developed. We are encouraged that VA's Office of Community Care is working diligently to resolve issues that have been raised.

Assessing Program Performance

While CCN is still being developed and deployed, it may be helpful for the Committee to review in detail VA's Community Care Patient Survey that was initiated in March 2016 to assess veteran experiences with VA Community Care, including care through the Choice Program. This survey includes questions regarding veteran experiences with the process of obtaining non-VA care (eligibility, referral, making the first appointment, billing and out-of-pocket payments), provider communication with the veteran, and very basic provider-patient coordination of care. There is a three- to six-month lag to associate the referral to a non-VA provider and the survey for that non-VA visit, to analyze the data and to generate the report. This delay should be accounted for if the survey is used as a sort of proxy to describe the state of CCN implementation in light of network deployment schedules.

We also expect VA to provide Congress information pertaining to the Performance Work Statement (PWS) and the Quality Assurance Surveillance Program (QASP) contained in CCN contracts. In our experience, the QASP determines how VA will focus on the level of performance required by the PWS, which at times differs from the method used by the contractor to achieve a level of performance. This is where we generally see weaknesses in the validity and reliability of the data and gaps in the surveillance process itself that may

hinder identification of trending issues ill and injured veterans may experience with CCN and formulation of appropriate corrective actions.

Care Coordination and Competency Standards

We remain concerned about implementation of the required care coordination with and competency standards for non-VA health care providers as required under sections 101 and 133 of the VA MISSION Act of 2018. These standards and other provisions are intended to ensure veterans make an informed decision about the care they received from or purchased by VA and that such care meets or exceeds VA quality standards.

A major change in process under CCN, involves VA Medical Centers (VAMCs) taking on certain responsibilities that once belonged to the TPA or otherwise deviates from prior procedures. In this instance, VAMCs will assume all responsibility for appointment and scheduling all eligible veterans to include VA enrolled and mileage eligible (mileage eligible requirements defined by the VA by care coordination scheduling site). TriWest and Optum are to provide a list of providers which VAMCs will use to directly contact and schedule the date and time of the veteran's appointment and provide all the necessary medical documentation directly to the provider. Once the appointment date has been obtained from the provider, the participating VAMC is to submit the appropriate VA Authorization Form to the TPA who shall then provide an authorization for work to their provider prior to services being rendered. DAV has not been provided detailed information pertaining to any additional employees required to assume these new responsibilities in light of the overall trend of meeting workloads in VA.

For example, according to VA's access audit, the ratio of the number of medical appointments made to the number of appointments completed has been decreasing substantially year over year. In FY 2015, of the 5.9 million appointments scheduled, VA completed 4.7 million or 79.6 percent. By FY 2019, of the 10.8 million appointments scheduled, VA has completed nearly 5 million or 46 percent. Over the same timeframe, the VA's ability to see patients within 30 days has decreased and the number of appointments scheduled over 30 has risen from an average of 409,000 in FY 2015 to over 740,000 in FY 2019. We understand the VA MISSION Act of 2018 included provisions to improve VA's internal capacity, but as the Department struggles to see veterans who choose VA, we are concerned VA is not properly staffing its facilities to take on new and critically important responsibilities.

With regards to the competency standards contemplated under the VA MISSION Act of 2018, VA mental health providers caring for veterans with PTSD have to meet strict qualification standards. In addition to graduating from discipline accredited graduate and training programs, the mental health provider must undertake training in suicide prevention and military culture. Certain mental health providers must complete advanced training to provide evidence-based psychotherapy, which includes a three day in-person workshop followed by at least six months of ongoing training and weekly follow-up from an expert who maintains progress notes or audio recording reviews of the provider trainee's clinical sessions. This gold standard training model has been developed and used in VA based on

numerous studies measuring clinical performance and showing sustained quality of care in comparison to mental health providers that participate in one-time training workshops whose practice reverts back to pre-training quality. Ignoring these standards shortchanges veterans and taxpayers of high-quality and high-value care, and fragments what otherwise should be an integrated high-performing health care network.

We urge VA and this Committee to ensure CCN achieves the high-performing integrated network envisioned by the VA MISSION Act of 2018, and that there is no double-standard between VA and non-VA health care providers in terms of the quality and safety of care that ill and injured veterans receive.

Finally, we bring the Committee's attention VA's testimony before the House Veterans' Affairs Subcommittee on Health on September 11, 2019, indicating that implementing two provisions of the MISSION Act—the Veterans Community Care Program under §1703 and the urgent care benefit under §1725A—both of which expand access to timely care, particularly for urgent or emergent conditions—may relieve some of the need for VA facilities to have extended hours of operation.

VA facilities must not implement such a policy that would reduce access or delay needed care when they choose to receive such care in their local VA medical facility. We believe veterans who choose VA should be able to receive care and services at VA. For many veterans, extended operating hours are the only times during their busy lives that they can receive the care they need.

Mr. Chairman, this concludes DAV's testimony. Thank you for inviting DAV to testify at today's hearing and we look forward to working with this Committee to ensure veterans continue to receive timely, high quality care from VA and its community partners.