FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

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STATEMENT OF
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FOR THE RECORD OF
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for this oversight hearing of the Department of Veterans Affairs progress with respect to implementation of the new Veterans Community Care Program, which went live on June 6, 2019, and VA's new urgent care benefit.

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

As this Subcommittee is aware, DAV worked closely with VA to include urgent care as part of its plan required under section 4002 of Public Law (P.L.) 114-41 to consolidate all non-Department provider programs by establishing a new, single program to be known as the "Veterans Choice Program."

We are pleased Congress included DAV's recommendation to provide veterans an urgent care benefit under section 105 of 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.

The urgent care benefit is intended to offer eligible veterans convenient care for certain, limited, non-emergent health care needs from qualifying non-VA entities or providers. Eligible veterans include any enrolled veteran who has received care under chapter 17 of title 38 U.S.C. within the 24-month period preceding the furnishing of care under this section where such care includes: care provided in a VA facility; care authorized by VA performed by a non-VA provider; emergency room care authorized by VA performed by a non-VA provider; care furnished by a State Veterans Home; or urgent care under this proposed section. 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) initial effort and continuing hard work to build a network to what is currently about 6,000 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.

However, we remain disappointed in 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.

While we appreciate VA's desire to incentivize appropriate health behavior, we strongly urge VA to provide positive rather than punitive incentives. Rather than charge veterans who have become ill or injured due to military service in order to limit their use of this urgent care benefit, VA should take a more veteran-centric approach to controlling costs by establishing a national nurse advice line to 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.

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

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

such as chronic care patients. Such a platform combined with a mobile app would allow veterans to connect with VA and schedule a visit online or in person. Also, 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

Regarding the implementation of section 101 (38 U.S.C. §1703) of the VA MISSION Act of 2018, DAV believes it is too early to assess veteran's experience with care furnished in the still-developing Community Care Network (CCN) established under the Veteran Community Care Program.[2] Only 9 out of 142 VA medical facilities are utilizing the CCN as of September 17, 2019.

To implement section 101, VA intends to award Community Care Network (CCN) contracts to provide eligible veterans non-VA care across six regional boundaries aligned to state lines, including Alaska and the Pacific Territories. On December 28, 2018, OptumServe Federal Health Services (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. Subsequently however, protests were filed for regions 2 and 3 VA's work with Optum had to stop while CCN work for region 1 continued. It has been less than five months since the Government Accountability Office (GAO) denied these protest for OptumServe to continue work to deliver on these contracts.

The contract for region 4, covering VISNs 16, 17, 19-22, which was awarded to TriWest on August 7, 2019, is being challenged by Wellpoint Military Care Corporation and remains under protest. The Request for Proposal (RFP) for region 5 was just posted on September 19 with proposals due on October 21, 2019.[3] No RFP has yet been issued for region 6.

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 develop and deploy its network of providers that is at least equal or better that the one it is replacing by the final option year. Our concern regarding region 4 will heighten if the Government Accountability Office decision that is anticipated to be issued by the end of November 2019 sustains the protest with the TriWest bridge contract set to expire ten months later.

[2] Region 1 Phase 1 includes Philadelphia and White River Junction VAMC went live on July 29, 2019. Region 1 Phase 2

[3] www.fbo.gov/notices/6ce4a8fa78d382982974f6d80dd1dd8f

DAV is currently unable to assess the progress of both VA and Optum in implementing the high-performing integrated network required under the VA MISSION Act of 2018 or gather sufficient and valid information from veterans of their experience in using CCN. We requested copies of these contracts withholding sensitive or proprietary information at the time of award. Still, VA cited concerns regarding the protest status of regions 2 and 3 for not releasing copies of the ***any*** awarded contract including region 1. We then requested the contracts' Performance Work Statement (PWS) and the Quality Assurance Surveillance Program (QASP) to better understand the program and communicate to our members what they should expect. Unfortunately, we just received redacted copies of CCN contracts for regions 1 and 4, even though the contract for region 4 is currently under protest.

In our experience, the QASP determines how VA will focus on the level of performance required by the PWS, which at times differ 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.

Further, we are 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 to resolve issues that have been raised.

While CCN is still being developed, it may be helpful for the Subcommittee to review 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, analyze the data and 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 Optum network's deployment schedule.

We remain concerned about the lack of guidance to veterans and VA medical centers regarding 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. For example, 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 an 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 the Subcommittee to ensure CCN achieves the high-performing integrated network envisioned by the VA MISSION Act, 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 are concerned with VA's testimony to this Subcommittee on September 11, 2019, 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.

We urge VA facilities not implement such a policy that would reduce or delay ill and injured veterans access to high-quality 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. Any reduction of these hours would make VA less veteran centric and appear more concerned about themselves than the veterans they are meant to serve.

Madame Chair, this concludes DAV's testimony. Thank you for inviting DAV to submit testimony for the record of today's hearing and we look forward to working with this Subcommittee to ensure veterans continue to receive timely, high quality care from VA and its community partners.