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VA MISSION ACT: UPDATE ON THE IMPLEMENTATION OF THE COMMUNITY CARE NETWORK

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

FEBRUARY 5, 2020

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VA MISSION ACT: UPDATE ON THE IMPLEMENTATION OF THE COMMUNITY CARE NETWORK

WEDNESDAY, FEBRUARY 5, 2020

UNITED STATES SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:31 a.m., in Room 418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Rounds, Tillis, Sullivan, Blackburn, Loeffler, Tester, Murray, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman MORAN. The Committee will come to order. Good morning, everyone. For our first hearing we are taking on the topic of the implementation of the MISSION Act, something that this Committee and Congress has spent a lot of time on over a long period of time on community Care. And I thank you, Dr. Stone, for you and your team joining us on today's first panel. I also thank the witnesses on our second panel for being here. I look forward to hearing their perspective as well.

I certainly believe that the delivery of quality and timely health care to veterans has been a top priority for this Committee and for me. When our servicemembers leave the military it is our duty to make sure they receive the care that they have earned.

Congress enacted the MISSION Act to transform VA health care into an innovation and responsive 21st century health care system capable of addressing the challenges with veterans today. And I think there is an important point to be made, that the MISSION Act, while we talk about it, and I just did a community care, care of the community, it is much more than just that.

Our hearing today will focus on the efforts of the VA to deploy community care networks. The network is central to the MISSION's Community Care Program.

When I was a Congressman I represented a congressional district size about the same as Illinois. No VA hospital in that congressional district, and so I bring a perspective of distance and travel time to my job in trying to care for veterans. So, in part, I always remain interested in how we care for veterans who live long distances from the VA's presence and how we can expand that presence to them.

The VA recently completed Region 1 deployment of the network, and the first four regions, representing the lower 48 states, are scheduled to be completed by the end of this year. The Committee has concerns about how the VA is building out the network and its ability to meet veteran demand.

Under MISSION's expanded eligibility requirements, the number of patients seeking outside care is supposed to increase from 648,000 to 3.7 million. A recent VA OIG report predicts wait times could worsen once MISSION is in full effect. This is in addition to reports that the VA is still struggling with scheduling delays and paying community providers on time. We want to make sure this does not occur and look forward to working with you, Dr. Stone, and others at the VA, to ensure that.

We must take the opportunity to learn what happens in Region 1 and have an honest conversation about the difficulties that could threaten the network well before it is fully deployed. We owe it to the veterans to get MISSION right the very first time.

I now turn to my friend and Ranking Member, the Senator from Montana, Senator Tester, for his opening statement.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Thank you, Chairman Moran, and I want to thank you for starting this meeting on time. I appreciate that very, very much. And I want to thank the three doctors for being here, especially you, Dr. Stone. I appreciate the meeting we had last week and the conversation you had with my staff and myself.

In the 90 days following implementation of the new Veterans Community Care Program there were nearly 258,000 more referrals for the private sector than in the preceding 90 days. More concerning, there are 283,000 fewer referrals for appointments in the VA during that same period. So referrals for community care went up significantly and referrals for the VA went down significantly.

I am concerned and I hope you are as well, and I need to understand what has happened, and if it is still going on, and if that is the intent. Congress did not create the new Community Care Program to simply supplant VA care with the private sector care, particularly when it takes less time for veterans to schedule appointments to be seen in VA facilities. It was set up to supplement VA care, in cases where the veteran, who is the driver of the situation, wanted to go into the community, for whatever reason that might be.

If the VA is connecting veterans more quickly, why are so many veterans getting their care in the private sector. I am concerned that 43,000 vacancies in the VHA are one of the chief reasons, and we talked about that, but I remain frustrated that VHA is not making effective and aggressive use of the authorities Congress has provided to recruit and retain providers and support staff, particularly in areas that are rural.

I am also concerned by reports that the decision support tool that was supposed to assist veterans and their providers in making decisions on where to get care is being underutilized because providers are choosing not to use it. My understanding is that the purpose of the DST was to review the criteria prescribed in the MISSION Act and determine whether a veteran is eligible and best

served by utilizing private sector care, that it would document the decision rationale in the veteran's health record. However, I understand that the VA will use a new referral process that could complicate referrals even more. I do not understand how creating a team to coordinate a decision is quicker or makes more sense than a veteran and provider making that decision.

I am also concerned that eight months into the program VA does not have a clear understanding of how many appointments have been completed in community care, and just as importantly, how much that costs, with the budget coming out next week. While I understand there is a lag time on medical bills coming in for completed appointments I do not understand how VA does not have an estimate of how much this is costing taxpayers, and with the President's budget coming in next week I do not see how that request will not be met with some skepticism.

I can tell you this. If the request shows a sharp increase for community care and level funding for in-house care, VA needs to justify that and receipts to support that request.

Dr. Stone, I know you are absolutely, unequivocally a straight shooter, and I have no doubt that the policies you advocate are in the best interest of the veterans, and I mean that. But as chief VA witness today, it will fall upon you to convince me, and others on this Committee, that the VA is not simply sending veterans into the community because it is easier.

We also need your assurance that the IT program to support an expanded caregivers' program will be up and running by the end of the summer, which, as you know, is a full year after the VA was initially tasked with completing this project. This is an important project, and it is an important project to get moving. It is a project that Senator Murray and the previous chairman of this Committee wanted to get going, and I would tell you that the work on this is critically important for the veterans who have been waiting to be able to get assistance from the families and have not been able to afford to do that.

So, Mr. Chairman, again I want to thank you for calling this meeting. This is an important meeting. The MISSION Act, I do not need to tell anybody around this table or anybody at that table or any of the veterans sitting in the crowd that it is a very, very, very important piece of legislation, that if implemented properly can be an incredible asset. If implemented improperly, can really take away veterans' care. Thank you.

Chairman MORAN. Senator Tester, thank you for your opening comments. I do not know whether it is a reflection on the United States Senate or a reflection on the fragility of our relationship, but only in this setting can you get a compliment for starting a meeting on time, the only compliment I got from you.

[Laughter.]

Senator TESTER. Listen, I think your wife dressed you very well today.

[Laughter.]

Chairman MORAN. I feel so much better now. I got two compliments from you.

PANEL I

Dr. Stone, as I said earlier, welcome. This is Dr. Richard Stone. He is the Executive in Charge of the Veterans Health Administration. He is accompanied by the following: Dr. Kameron Matthews, Assistant Under Secretary for Health for Community Care, Veterans Health Administration; and Dr. Jennifer MacDonald, the VA MISSION Act Lead, also in Veterans Health Administration.

Dr. Stone, we recognize you for your remarks.

STATEMENT OF RICHARD A. STONE; ACCOMPANIED BY KAMERON MATTHEWS AND JENNIFER MACDONALD

Dr. STONE. Good morning, Mr. Chairman, Ranking Member Tester, and members of the Committee. I appreciate the opportunity to discuss VA's continuing success in implementing the VA MISSION Act of 2018. This continues to be a time of transformative change at VA. The MISSION Act implementation is succeeding and has become part of our core business as we prepare to deploy additional benefits to support veterans and their families.

Alongside our DoD and HHS partners we intend to lead the industry in quality health information exchange, opioid safety, and ultimately care coordination powered by our new joint electronic health record.

Additionally, we will lead in providing services to veterans wherever they are, using the expanded reach of our new Community Care Program. We are building a strategy that will deliver health care excellence for veterans no matter where they choose to live or to seek care.

On June 6th of last year, we successfully launched the new Veterans Community Care Program, a cornerstone of the MISSION Act. As the President promised, the MISSION Act has been good for veterans and good for the VA. Veterans now have enhanced care options and we are streamlining our processes and our technology to make their experience of care even better.

I would like to dispel any misconceptions about privatization. The VA health care system is stable, and we are growing in the amount of care we are delivering, and we continue to approach care delivery as an integrated organization ensuring veterans receive the right care at the right time, whether that be through our direct care system or through our community partners.

Since June 6th of last year, VA has authorized more than 3.85 million episodes of care in the community. But in the first quarter of fiscal year 2020, we provided direct care services to over 315,000 individuals each and every business day. That is 2,100 more individuals receiving care each day than the same period last year. That is more than 3,000 additional appointments every day in the direct care system.

You have given us, through this act, the tools and resources to make us the most accessible health care system in the industry. Our network of 880,000 community-based providers provide an unprecedented range of options for veterans. VA remains committed to strengthening the VA health care system, expanding access, and pushing the boundaries of what is possible in serving our nation's veterans.

I would like to highlight the satisfaction rate veterans are experiencing using this new benefit. Veterans' expression of trust in VHA has risen to 88 percent in the last fiscal year. Similarly, our home telehealth program has had trust scores reaching 91 percent. This indicates successful efforts to provide trusted convenience wherever care is delivered.

Claims payment, timeliness to community providers remains a top priority as we modernize antiquated legacy payment systems. A new claim auto-adjudication system was implemented last month, and VA's third-party administrators under the community care contract, both TriWest and Optum, are paying the vast majority of claims in a timely manner. We are committed to being an excellent partner to the community providers who have expressed trust in us by signing contracts with our network.

Other aspects of VA's modernization and advancement under the MISSION Act include telehealth, the new scholarship program, the education debt reduction program. These are tools that you have provided us, in telehealth especially, that has allows us to bring provider expertise across state lines. VA recently announced the delivery of telehealth services to more than 900,000 veterans and over 2.6 million episodes of care in the last fiscal year, an increase of 17 percent. The new scholarship program allows us to recruit by providing scholarship funding in exchange for a commitment to serve American veterans.

We knew when we began implementing the VA MISSION Act that we had the potential to make an enormous positive impact for American veterans. Today we have begun to demonstrate that potential. We will continue to work to improve veterans' access to timely high-quality care in VA facilities both in person and virtually, and we will augment this, when appropriate, with excellent choices through our robust network of community partners.

I am very proud of the future that we are building on behalf of America's veterans and their families, and sincerely appreciate this Committee's continued support.

Mr. Chairman, this concludes my statement. My colleagues and I are prepared to answer any questions that you may have.

Chairman MORAN. Dr. Stone, thank you very much. Thanks for your opening statement and your presence here today.

The VA worked hard to find the best practices in the private sector and other federal health care delivery systems to land on where we are and the best standards for veterans' access to primary care, mental health, and specialty care. I am frustrated when I discovered that the contracts for Regions 1 to 4 do not incorporate the standards outlined in the MISSION Act.

My view is—I do not think this is controversial or disputed—is that those contracts must reflect the law, and perhaps the VA, although I would be skeptical that you could, could convince me that those are not the right standards, but I do not think that is a discretionary call for the VA. And so I am disappointed that the standards in the contact for Regions 1 and 4 do not reflect that.

The consequence, I think, is longer wait times, drive times for veterans that I represent. It is an example of where a requirement by law, that this Committee worked diligently to determine what it should be, is not being complied with by the VA.

I suppose, on one hand—let me say it this way. I am pleased to discover in the contracts with Region 5 the standards of the MISSION Act are incorporated in the contract. So my hope is that this means that the VA is going to now incorporate those standards in the contracts for the previous Regions 1 through 4.

So Dr. Stone, can you and your colleagues tell me what I should know about my frustration?

Dr. STONE. Senator, I appreciate this discussion because I think there is a difference in interpretation of the law, and I think we need to resolve that. I think we are getting closer. You know, when I was with DoD we went through multiple versions of TriCare before. Now we are on seven or eight, and we are getting it right.

But I think that we have demonstrated in Region 5 that we need to place into the contracts access standards. Unfortunately, in highly rural areas, including in your own state, we are finding that even though our penetration of the market is higher than Medicare participation, in many counties, that we still would not meet either the 30- and 60-minute drive time or the 20- and 28-day standard. The American health care system is just not as robust as what we have committed ourselves to under the Secretary's leadership.

I will defer to Dr. Matthews for additional discussion. I think we can resolve this. I think it is very clear, and you have been very clear on what you would like us to get to. I just do not think that the American commercial health care systems are prepared to comply in the manners that we would like to.

Chairman MORAN. I do not think, Dr. Stone, that there is a requirement that, for example, the region that Kansas is in had a different TPA prior to today. The network is different. The providers are—there are providers that were utilized in the previous network not being utilized or contacted today. I do not think the requirement is, although that creates some—I do not think—let me finish the sentence. I do not think the requirement is that the same providers have to be utilized, or even the same number of providers.

But it does suggest to me that there is more outreach that could be done if the suggestion is that the private sector is not sufficient to meet the needs. The previous TPA was using additional providers than the current TPA, so that says something to me about expanding the network. And then the answer that we have received from the VA is that there is a study to be done, a utilization study, to determine what else needs to be done, and again, I worry that if you wait for a utilization statement, the veterans who are receiving care in the community will not be able to access that care and your utilization study will underestimate, undershow the demand for services and we will be shrinking the opportunities, not at least stabilizing them or increasing them.

Dr. MATTHEWS. Sir, we are definitely in agreement that this is an area that needs to be addressed with regard to providing the consistency between the regions. The background for Region 5, we placed that solicitation publicly after the MISSION Act was passed, so we had the access standards. If you also read the RFP, however, there is a very large section about waiver of those access standards that we actually adopted from the Medicare program, such that when the TPA recognizes that there is not the availability of providers, that they cannot meet those access standards, there is a

level of criteria that they need to provide data upon to set a level of access that they can then produce in the network. And between the TPA and VA, we would then agree that, particular to those counties, to those area, that indeed that would be the standard there.

So the access standards, as Dr. Stone mentioned, would be our ultimate goal, but recognizing that contractually there is no way we could hold the network accountable to a level of adequacy that just does not exist in the industry.

Chairman MORAN. I appreciate that answer. In part, I was pleased to learn about the new standards, the current standards being utilized in Region 5, but you are telling me they could be something less.

Dr. MATTHEWS. Yes.

Chairman MORAN. So maybe a little disappointment, perhaps in the right direction.

But I would conclude by saying that my expectation is that the TPAs in Regions 1 through 4 also have a provision that the standards can be increased or the demand upon them can be increased, and so it works both ways. And I understand that the standards were not in place when the first RFPs were proposed.

Dr. MATTHEWS. Exactly.

Chairman MORAN. We need to get us to the point, in my view, in which we are using the statutory requirements and they are uniform throughout the region. So thank you.

Dr. MACDONALD. Senator, if I may add, I had the privilege, sir, of seeing you stand next to the Secretary and witnessing in person your commitment to access for veterans in western Kansas, and that is a goal we share collectively here with you and with the Committee. We want to make sure that no matter where a veteran chooses to live that they have access to not only our system but to the right care, and we believe that this is a cross-functional strategy.

That is what we are tackling now, that the network adequacy in community care is a piece of this. So is telehealth. So is deploying our providers with the mobile deployment teams that are set forth in the MISSION Act to bring providers to rural areas where they need to be and where they need to meet people's needs in person. We think this is a cross-functional strategy that will need our partners' input as well and your feedback, but we aim to be, as Dr. Stone said in his opening statement, the most accessible and convenient health care system in history. And to do that we need both that network adequacy and the other pieces and tools in the MISSION Act that you have given us.

Chairman MORAN. Thank you, Dr. MacDonald. Thank you, Dr. Matthews. Thank you. Yes, ma'am.

Dr. MATTHEWS. Do you mind if I just give one more clarifying point, because I definitely heard you. This transition between our networks is a critical time. We need to assure that veteran care, first and foremost, is not threatened, that continuity of care is in place, and that we have adequacy to meet those needs.

I just wanted to also highlight, however, that under the Choice program, under PC3, the actual majority of care was not purchased through the network providers. It was purchased through what we

called individual authorizations. A lot of times we were paying at higher rates. These were different sets of contractual agreements, if at all, between the VA and the providers directly.

Moving to the CCN realm is a very different space for a lot of these providers, particularly our home health and dentistry providers, who were never networked with us previously. So we are really bringing on a different relationship than they had previously experienced and sometimes different reimbursement rates than they had previously experienced.

So walking the path between what was formerly, particularly under the Choice network, now PC3, to CCN is not exactly one-to-one.

Chairman MORAN. Thank you. I look forward to resolving this, what I think we all agree is an important issue.

Senator, excuse me for going so long. It does not set a precedent. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and I appreciate your testimony, and I appreciate you talking about adequacy of care. I think we are talking about a different population than general population, and their challenges are greater because they often have multiple issues that they are dealing with. And so I think that is critically important.

As I look at my little local hospital, and I live in a very rural area, it is a great little hospital but I am not sure it could meet the needs of the veteran, just to be flat honest with you, at least not to the level that the VA does. So thank you for that.

Dr. Stone, it is always a challenge to forecast how much funding it is going to cost for community care. There is just no doubt about it. It is a problem forecasting that, because it is an unknown that we have not got the metrics behind it to find out.

In 2017, as you well know, Congress stepped in three times to provide additional funding for the Department so it would not exhaust the Choice program funding. I am concerned that we may be headed down that path again.

Eight months into the new Community Care Program, VA has not provided, or cannot provide, one or the other, the number of referrals that became appointments. I get the number of referrals but we do not know the number of referrals that became appointments. And thus, I do not see how we can figure out how many dollars are associated with those appointments and whether usage is in line with the projections that you and other smart people have developed when this program was set up.

So Dr. Stone, do you have any concerns that the VA may be over budget with this program?

Dr. STONE. Senator, I think you asked the key question that keeps me up at night, and that is that this is a brand new program. In the six months before June 6th we sent 2.7 million episodes of care out. In the six months after, we sent 3.8 million episodes of care out. But we have seen the appointing and the authorizations not turn into bills coming back in. Now we have way better criteria in our regulations on how long a vendor has to bill us. We have followed the Medicare standard that you have got to have the bill in in 180 days, so we can follow this.

Dr. Matthews briefs me on a weekly basis on the volume of referrals and authorizations, but we are still waiting for bills to come in. As we have seen this, it appears the authorizations are beginning to drop. We had predicted that there would be some kicking of the tires for community care and then it would drop off. That appears to be happening.

Now our burn rate through dollars in community care is running just over $1 billion a month. It may reach $1.1 billion. You gave us about $15 billion in the budget. I think we are safe, but part of this has to do with that timeliness of getting our bills paid, which is an absolute commitment that was in my opening statement. And we will keep you informed on a quarterly basis of our burn rate of dollars. But I am confident, at this point, that we are sufficiently funded, that we will not be up here asking for additional dollars.

Senator TESTER. So in a previous program called Choice, one of the problems that I had, and one of the reasons I, quite frankly, beat the third-party provider up, of which we have the two here sitting, that will be on the next panel, is because the providers were not being paid in a prompt time. One hundred 80 days, by my math, is six months, and if the providers are not getting the bills in in six months—and I will bring this up to the next panel--maybe the problem was not the third-party providers.

Dr. STONE. Well, let me say this. It can take a month for us to package a consult for routine care. That is something we are actively working on to fix and to get down to our three-day standard. That has actually been worked on in various sequesters for the last number of months. But at that point it is given to our third-party TPA, who then works to handle this, but it can take another month to get people in. If a provider does not get a—

Senator TESTER. Because you are getting two mics, Dr. Stone? What the heck?

[Laughter.]

Dr. STONE. No. This is me in stereo.

Senator TESTER. That is no problem.

Dr. STONE. This is me in stereo, sir.

Senator TESTER. What is that?

Dr. STONE. This is me in stereo.

Senator TESTER. Yeah, exactly. I get you in both ears.

Dr. STONE. So we are working to get this right. I am as frustrated as you are, but I have to say to you that at this point our budget looks good and looks solid, but on a quarterly basis I think we need to be up here with leadership talking about our burn rate in dollars, and making sure we have got it right.

Now, by the same token, it appears that our funding within the direct care system is correct. But I want to think about the disincentive to a medical center director who, if they are short of funds, or think they are short of funds, can just say, "Well, I am just going to send everything out to the community because it is going to go to Dr. Matthews." And it is one of the weaknesses in the way we bucket funds in the current budgeting process. It is way beyond where you want me to go in a five-minute answer, but I will tell you we struggle with creating the right incentives to get care correct in the way we currently bucket funds.

Senator TESTER. I will be very brief. The quarterly update is critically important and even more if necessary, in my opinion. And I will speak for myself on this, but I think working for flexibility in those dollars to make sure that the veteran is driving the bus, and they are going, that is really going to be critical. So that is all I have got. Thanks. I have got another round of questions but that is all I have got for now.

Chairman MORAN. Thank you, Senator Tester. Dr. Stone, I think it is an awfully important point about the buckets. I can see the incentive process, circumstance being very problematic for the future of this, how we handle this.

Senator Rounds?

SENATOR ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman. Dr. Stone, thank you to you and your colleagues for being here today.

In your written testimony, and then also in your visit with us earlier, you said that the MISSION Act implementation is succeeding and that VA is leading the health care industry forward. With all due respect, when it comes to paying provider claims, I would suggest that I have a very different opinion about what the definition of success should be.

In South Dakota, and Dr. Matthews was kind enough to come to my office last week and we had a chance to visit, South Dakota has got 880,000 people in the entire state. We have got about 8 percent of our population, or thereabouts, is veterans. I have got two providers alone already that have between $5 and $6 million in unpaid bills, and these are through the direct care program.

And I am just curious, these are the large providers. The small providers, the folks that really are part of that community care network that we want to be able to use, they are telling me that in some cases they have over $20,000 in unpaid bills. And when you suggested that you were not getting the bills in a timely fashion and so forth, I am not sure where the hang-up is, but it seems to me that they are billing but we are not paying.

And right now we have got small providers out there that want to provide services to the veterans, and, in fact, they are, but at some point they are going to say, "I cannot afford to do it anymore." The larger guys, they will keep doing it, at least for a period of time. They may be frustrated and they may get angry. But there is something wrong with this thing right now, and we need to nip it as quickly as possible.

Dr. Matthews was in my office and indicated that she would do a short-term attempt to fix on the ones that we have got right now, but, look, this is not the way it is supposed to work. And I just want to disagree with you that this is a successful implementation at this stage of the game.

I would like to know where, if you—in listening to my discussion with you right now, if you can give me your thoughts about where we may be having this disconnect between where my providers are not getting paid and your thoughts that—it almost sounded like you were saying they were not sending the bills in.

Dr. STONE. Senator, I absolutely agree with you that we are not where we should be, and in my opening testimony I said that we

are changing antiquated systems. What I want to reassure you is this is not our third-party administrators. This is not Optum and TriWest. This is internal to VA and this is exactly the work that Dr. Matthews is doing to correct our processes. Our processes do overwhelming oversight to every bill, and it slows the process down.

Now when we came here a year and a half ago we were processing 100,000 claims a month. We are now processing over 1.1 million claims a month, approximately the number that we are getting in each month. But we have got to correct this backlog. So if we get a million claims a month and I say to you we have got a 60- to 90-day backlog, it does not take you very long to figure out how many claims that we are sitting on. That is an inappropriate place to be as a partner to any size business.

Senator ROUNDS. Dr. Stone, I think we are in agreement that it is inappropriate and that our goal should be to eliminate it. What I am looking for is the goal is admirable to eliminate the problem. What I am hoping to hear is what are the steps that are being taken to fix the problem?

Dr. STONE. There are three. Number one, auto- adjudication of the claims, using the eCAMS system and setting up appropriate business rules to auto-adjudicate.

Senator ROUNDS. How long is it going to take to get that done?

Dr. STONE. My view is, and what Kam has reassured me, is that by this summer, within the next 90 days, we will be running really well with eCAMS.

Senator ROUNDS. So that would be a good date for us to target and see whether or not we are making progress.

Dr. STONE. Yes. Absolutely.

Senator ROUNDS. What next?

Dr. STONE. I think the second piece is to change our business rules on overwhelming audit, where we audit every claim, unlike Medicare that audits every 100th claim or every 1,000th claim. I think we can get that. That is being instituted as we speak.

Senator ROUNDS. What is it now and what is it going to, sir?

Dr. STONE. Dr. Matthews?

Dr. MATTHEWS. We actually audit every claim prepayment at this point, just in order to avoid the fraud and waste of overpayment, the incorrect, underpayments. It is a significant amount of work that unfortunately is quite manual. We are trying to balance, of course, having accuracy of payment as opposed to—

Senator ROUNDS. Well, let me just ask, Mr. Chairman, if you do not mind, then what you do, or what is your plan for when you are going to have that process changed, and what will it look like when you are done?

Dr. MATTHEWS. Sure. That actually will be tied in with the auto-adjudication rules that are going into the new—

Senator ROUNDS. So within 90 days.

Dr. MATTHEWS. Yes.

Dr. STONE. I think the third piece is enhanced contracts for outside vendors to pay bills. Even our third- party TPAs use outside companies to help pay bills. That, we just moved over 100 personnel against that contract contractually, to enhance this. I think all of this, you should see a very positive trend over the next 90

days with resolution as we go forward, and that resolution ought to be clear the next time we are talking about this.

Senator ROUNDS. Thank you. Thank you, Mr. Chairman. I will just say this. As long as those third-party payers get paid by the VA, it will work. But if you are not paying the third-party payers on time, it will not work very long.

Dr. STONE. And it is my understanding, and I am sure you will ask the TPAs sitting behind us, are we paying our bills on time, and it is my perception we are.

Senator ROUNDS. I have already asked the question, sir.

Dr. STONE. Thank you, sir.

Senator ROUNDS. Thank you.

Chairman MORAN. Senator Rounds, thank you very much. Senator Manchin?

SENATOR MANCHIN

Senator MANCHIN. Thank you. Thank you, Senator Moran. Thank you all of you for being here.

I have got two questions. Dr. Stone, I think you know the first question, concerning the VA deaths. We have over 11 murders at the VA hospital in Clarksburg, West Virginia. It has been a year and a half, and maybe you can update me a little bit. I get calls every day still yet from families. And I know you were kind enough to come in and we talked about it, and I appreciate that, but if you have any new, updated messages or information that I can give to the families in West Virginia I would appreciate it.

Dr. STONE. Senator Manchin, you and I share our abhorrence of what occurred here, and I appreciate the time you gave me in your office to have a discussion of this. I cannot give you additional information.

Senator MANCHIN. Timelines?

Dr. STONE. I am subject to the same restrictions that you are. I meet with the IG every two weeks, and this is all in the hands of—

Senator MANCHIN. I have that the U.S. attorney, the one who was on the case, has left and there is another?

Dr. STONE. I am not aware of that.

Senator MANCHIN. You are not sure?

Dr. STONE. I am not aware of that. I can also tell you that I find out most through either the plaintiff's attorney or the media of what is going on here.

Senator MANCHIN. Well, and I hope—

Dr. STONE. And what I can assure you is that we believe that this is a safe site for veterans to receive care. You and I had that discussion.

Senator MANCHIN. Right.

Dr. STONE. We believe it is a safe site. We believe that we have discharged the employee that was involved in this, and we look forward to resolution. But the continuing pain in this community is intolerable.

Senator MANCHIN. It is just unbelievable, for the families who might have lost a loved one during that period of time that is in question, and if that person has died they still believe it could be attributed to the care they were getting. It is just very hard. And

a year and a half. You have to admit to yourself no family should go through that.

So I am not here chastising. I am basically saying that the corrections that you tell me have been made, I have not had complaints since then from the patients and from our veterans, and I appreciate that. But I just do not have answers, and my heart bleeds for the families I just do not have answers for.

Dr. STONE. Senator, I appreciate the leadership you have shown in this and the manner in which you have handled it, and I appreciate the time you have given me in discussing it honestly.

Senator MANCHIN. Please, and we will talk further privately.

Dr. STONE. Thank you, sir.

Senator MANCHIN. Okay. As far as on the MISSION Act, sir, I had my doubts about MISSION Act. I have got to be honest with all of you. I thought it was a back door to privatizing VA and I am very, very much concerned about that. I am on high alert, if you will. I have got 112 jobs unfilled in the VA in West Virginia, in my four VA hospitals, and some of those are in the most critical care. And to outsource that would not assure, in rural areas, that they are going to get the care outside. A veteran wants to get care in a veteran hospital. They feel secure there. They feel good. People understand their concerns, their needs, and where they come from. So my concern has been basically of not staffing in the specialties that we need and also the care that we can give.

I will give you an example. We did outside—there was outside immune work done, and we could do it inside if we had basically the necessary equipment that it took for the investment. I think you and I talked about that, that they were able to do it for about one-third of the price and do it much quicker.

So I know the veterans hospitals in my area are capable of doing this work, and the veterans are much satisfied with it. But I also understand, and I appreciate the intent of MISSION was if you do not have it, shouldn't the veteran have the opportunity to have the best care? And I still feel very strongly. I am just concerned that we are abdicating our responsibility.

Dr. STONE. Let us talk just then a little bit about what we are sending out. Ninety percent of the increase in consultations that are going out to the community are specialty care. We are not seeing an increase—

Senator MANCHIN. I do not mean to interrupt you because I know our time is limited. But on that, do we have a good review process of the doctor who evaluates? Because I am understanding, if I am a veteran, I come in to the VA center, they evaluate me and decide where the best care would be. Is there anyone evaluating the evaluation doctor or that process is accurate?

Dr. MACDONALD. Yes, Senator, and actually this is an area of intense focus for us right now. As we have briefed Committee staff, we are pursuing what we are terming our referral coordination initiative. This is modernizing the way we process referrals, modernizing the experience the veteran has, and as clinicians sitting up here, I think we all understand walking out of a visit and waiting for the phone call about when that next step in care will have—will happen, the uncertainty of that.

We are changing that and bringing ourselves in line with industry best practice, and instead having a referral coordination team take care of that veteran immediately, do today's work today, as is a best practice, pass on the uncertainty and instead give the veteran certainty about when that care will happen and what that next step will be.

Senator MANCHIN. We would love to give you the input we are receiving, because we are not getting those same types of reports that you might, and we will give you the concerns that we have of how they have been evaluated and how they have been basically passed on.

Dr. MACDONALD. Glad to hear that, Senator.

Senator MANCHIN. And it might be of help. I hope it does.

Dr. MACDONALD. We are confident and we are actually very encouraged to hear that when most veterans are interacting with the new initiative, our referral coordination teams, that they are telling us that they want to be with VA, that they want to stay with us and have that continuity.

Senator MANCHIN. They tell me this all the time. I just wanted to reiterate to you all and make sure we are doing everything we can to get the service within the VA system.

Dr. MACDONALD. Absolutely.

Senator MANCHIN. And this should not be a privatization move at all, in no way, shape, or form.

Dr. MACDONALD. Absolutely, and glad to discuss further, Senator.

Senator MANCHIN. Thank you. Thank you.

Chairman MORAN. Senator Brown.

SENATOR BROWN

Senator BROWN. Thank you, Mr. Chairman. Dr. Stone, thank you for the work you have done with our office, especially in Cincinnati. Thank you.

I want to build on Senator Manchin's questions with the same skepticism about sort of where this has all gone and the desire for some, many in the Administration and the Senate to privatize, as they want to privatize Social Security and the prison system and public education, all the things. I heard the President talk about failing government schools. That term just—I mean, I—most of us, certainly the three of you believe in public service as we all should.

The two topics I want to more specifically address for Dr. Stone, the quality of care veterans receive in the community and ensuring VA medical centers have the resources they need to fulfill their missions. And similar to what Senator Manchin asked, but when we voted for the MISSION Act we never intended to have community care at the expense of VA care, especially when VA typically outperforms community health care facilities. And what Senator Manchin said about the comfort veterans feel when they are Wade Park, or they are at the Dayton VA, and the wonderful veterans hospitals around the country.

But I have heard VA facilities in my state, and I am going to guess throughout the country, have a budget deficit, and because of that deficit employees are going to be let go. My question is, Dr. Stone, are VHA medical facilities operating with a budget deficit?

Dr. STONE. Sir, they are not. There is no budget deficit. There is no hiring freeze.

Senator BROWN. Have you changed your patient care model?

Dr. STONE. So here is what happened. When we stood up the new Community Care Program we loaded enough money, and we talked about this a little earlier, we loaded enough money into the Community Care Program that if I run short it will be a lot easier for me to come up and look at you and say, "I have got to pull money out of the purchased care and put it into the direct care system." So we actually budgeted right on target, and we are performing right on target. In fact, last week we went into a budget burn sequester with all of our leaders of each of the regions. In 15 of the 18 VISNs we are right on target. In three we are burning a little hot, and I expect them to bring this——

Senator BROWN. So let me—sorry to interrupt you——

Dr. STONE. And let me just finish this statement before you go ahead. We are about 1 percent off of where we need to be in those three regions.

Senator BROWN. So if you have not changed the patient model and you do not have a budget deficit, how does a facility let 100 employees go over the course of three years and not see a degradation of services to veterans?

Dr. STONE. I am not aware that there are 100 employees that have been let go. Now there are some openings and there is some strategic hiring. Let me talk to you about that. One of our biggest problems is very high-cost specialists exceed the reimbursement—the pay caps that we have.

So a neurosurgeon or a gastroenterologist, a gastroenterologist can finish their residency and come out and command a $375,000 salary. We are capped at $400,000. So we have trouble recruiting in certain very high-cost specialties because of the pay caps, and it is something we are going to have to deal with.

I have got over 300 specialists that are at their pay caps today, so there is no sense of us hiring a neurosurgeon nurse to support a neurosurgeon if I cannot hire the neurosurgeon.

In California alone, one of the really high-cost markets for us, I have got over 400 nursing openings because we cannot compete. So we were just at UCLA and Los Angeles last week, working on the homeless issue. UCLA, across the highway from our campus, is picking off huge numbers of our nurses because we just cannot compete because of the pay caps.

Senator BROWN. I guess I am not entirely convinced.

An unrelated topic. A year ago you told this Committee the Department was 90 days away from a recommendation on bladder cancer and hypertension and Parkinson's related to Agent Orange exposure. We have not forgotten. It has been over 300 days. We find the Department's response to reporting requirement by the end of the year appropriations package deficient. The science is there. Veterans deserve their benefits. You need to move on that.

Dr. STONE. Senator, I think what I said was that I had reached my recommendation to the Secretary, and the Secretary would make a decision. I think he has worked his way through that. I think he has made some statements on the additional data that we

are requiring, and I will defer to the Secretary to make the Department's definitive decision on that.

Senator BROWN. So why is it taking so long? Why is the Secretary so slow?

Dr. STONE. I think specifically we are dealing with, especially in hypertension, a condition that affects 70 percent plus of over 65-year-old males in America. And so when you look at numbers on the Vietnam veteran population that exceed that by 5 to 6 percent, you really begin to wonder, what are we dealing with? Is it Agent Orange exposure or is it the fact that this may be a different demographic group? And I think we are struggling through that. So, therefore, the two studies that are still in motion and waiting for peer review and publication will either confirm this or not.

Senator BROWN. So an administration that wants to give—and I do not put you in this category because you are not sort of in that position, but an administration that is very willing to give tax cuts for the richest people in the country cannot find their way to slightly err on the side of taking care of people who served their country in Tet, in other times in Vietnam, apparently.

Dr. STONE. Senator, I would say to you that what you should expect from me is me to base my decisions on good science.

Senator BROWN. And I think you have, so thank you.

Dr. STONE. Thank you, sir.

Chairman MORAN. Senator Brown, thank you. Senator Tillis.

SENATOR TILLIS

Senator TILLIS. Thank you, Mr. Chairman. Thank you all for being here. I was watching, Mr. Stone, and the Committee in my office before I came over, and in your opening statement you made a comment about very positive satisfaction levels. Would you repeat that again, where you are right now? I thought—did you say 80 percent?

Dr. STONE. We are at 88 percent, 88 percent for our routine, direct, face-to-face care of do I trust VA with my care and the care that I am getting. It is at 88 percent. We are at 91 percent for home care.

Senator TILLIS. Yeah. So how does that compare against private sector benchmarks?

Dr. STONE. It is above private sector benchmarks.

Senator TILLIS. Yeah. I think that is something that is always important to bring up here. Every once in a while I will go out in a public setting and I will hear someone say, "We do not want our health care system to be like the VA." I said, ″Hell, I wish it was." I wish that we were achieving the same levels of satisfaction. It does not mean that we do not have work to do. It does not mean you are not going to run into kinks in the implementation of MISSION. But you all have a very positive story to tell, and I am particularly proud of VISN 6 and all the work that they are doing down in the Southeast and specifically in North Carolina.

In fact, I am going to ask you some other questions about the implementation, but I think we just did a first- ever donation after a circulatory death surgery. It was a referral out of the VA for a veteran down at Duke University Hospital. Are you familiar with that case?

Dr. STONE. I am, sir.

Senator TILLIS. Tell everybody else a little bit about it.

Dr. STONE. Kam, do you want to talk about that? You got it?

Dr. MATTHEWS. Senator, with Ms. Seekins' leadership in that VISN——

Senator TILLIS. It was amazing.

Dr. MATTHEWS. ——as you said, this was an unprecedented occurrence. And this really goes in line with the way that the health of our transplant program has been prioritized. We are seeing additional access for veterans in the community but we are also seeing veterans continue to choose VA and continue to choose, as you highlighted with Duke, the partnerships and the academic affiliates that VA has as a part of our transplant program.

Senator TILLIS. Yeah. So I, for one, just want to let everybody know they are doing great work out there, and I like the way that you are going about making hiring decisions. You are right. It makes no sense to have support clinicians in place if the specialists cannot be hired. That is just good business sense. I am glad to see you are executing that way and I am proud of the Secretary and all of you all, incidentally, for the work that you have done on making the VA a preferred place to work in the Federal Government. It is great work, and that stems from leadership.

I do want to echo, Senator Moran raised a question about provider networks as we do the implementation from TriWest to Optum. And I am not going to point to an immediate concern now, at least within my state, but I think it is something that we have got to watch very closely as we roll it out and make sure that our veterans have access to the providers they prefer. It has got to be within the components of the contract.

But to the point Senator Moran made, it may mean that we need to look at it, and as you all said, provide some waivers, if necessary, to roll out and make sure we are primarily focused on the main thing. The main thing is satisfying the vet.

Also, I wondered whether or not you all do any surveys on provider satisfaction. Do you all do that?

Dr. STONE. Internal to our system or those providers that are under contract?

Senator TILLIS. Either one or both. It is just, you know, how happy are they working with the VA?

Dr. STONE. In our all-employee survey providers are singled out, and we are actually exceeding the benchmarks in the private sector for most categories.

Senator TILLIS. I know you all have run into a few—I like the way you all have been proactive, particularly on reimbursements. When we have a problem, it looks like you are reaching out and really coaching the providers on how to submit the paperwork properly. That is good.

One question that I had is it seems as though it generally a once-and-done with the provider once they understand the process, but what more could we do to maybe even avoid that first interaction through education, portal access, whatever kind of tools we can use to expedite the transition?

Dr. MATTHEWS. Senator, we are actually on our second generation portal for providers to be able to sign into and look at their

claims and understand at what stage of the process they are in. We also have regular monthly webinars where our finance team is reaching out and working with different finance teams or even admin staff at different health systems, and then there is that one-on-one interaction. We really are increasing our provider engagement in that way.

Ultimately, though, however, is also the larger transformation, not just automating how we process claims but to simplify the process, so there is not a confusion on where to send the claim. There is perhaps one clearing house. We are looking at that longer-term strategy as well.

Senator TILLIS. Well, thank you all for the great work. I am going to submit a number of questions for the record that are more technical in nature, and, Mr. Chairman, I appreciate you encouraging me and Senator Tester to continue the check-in on the electronic health record and some of the transformation. I know we will be reaching out to set up a meeting in our office so that we can just talk through the program office and see how you are doing at the implementation level. Thank you.

Chairman MORAN. Senator Tillis, thank you. Senator Murray.

SENATOR MURRAY

Senator MURRAY. Thank you, Mr. Chairman. Dr. Stone, as you well know, it is really important to me to make sure that we are providing care for veterans who are facing fertility challenges as a result of their service. But I want you to know I am continuing to her about obstacles for veterans who are trying to access this care. I am hearing that providers and veterans are unaware if the care is available, I hear about long delays in processing and approving the requests, and I have even heard about providers who are putting their own opinions ahead of the veteran and actually refusing to give them access to treatment.

It is really critically that after these veterans have sacrificed so much in their service they are fully supported, and fertility challenges are difficult enough without having to fight a bureaucracy to access care that they have earned and that they are entitled to. And as we all know, delays in this means sometimes they cannot access care and have kids.

So I do not want to hear about this anymore and I want to know what the VA is doing to address those barriers and make sure veterans get the care when they need it.

Dr. MATTHEWS. Senator, this is such a critical point. We do have very structured guidelines, referral practices, so that the local staff, the local providers do have instruction on how to make these referrals, how to actually review fertility for service connection, because, of course, there are very strict rules on how we actually can provide fertility services.

But as you are hearing of these individual cases, our office can definitely make moves to make sure that these individual veterans do receive the services that they deserve and are warranted to receive.

Over the last year or so there has only been about 400 or so cases. There are very small numbers nationwide. So we do have the capability to really dig in on each and every one of those and make

sure not only that they are evaluated appropriately but that we also have a provider in network that can actually provide those services.

Senator MURRAY. Okay. Those are great words but I want to see them put into action, and I want you to know that we are hearing that that is not happening across the country.

Dr. STONE. And Senator, with each and every one of those, if we could have direct contact we would appreciate it.

Senator MURRAY. We do.

Dr. STONE. Because when a patient comes to you it often can take a little bit of time. We need that direct contact and appreciate the relationship that we have, that you will bring that to us.

Senator MURRAY. I will do that. All right.

Dr. Stone, another topic. Implementing the expansion of the Caregiver Program, as you well know, is significantly behind schedule. We have talked about this before. I have significant concerns over any proposal that would cut eligibility or limit service to our veterans and their caregivers. And I do want to thank you for being transparent and up front with me about the VA's status when we met in December.

But it is time to get this program moving. Our veterans are waiting. These services can make a tremendous difference in their quality of life. So I want to ask today, when will we see the proposed caregivers' regulations and will they propose any curtailing of services or eligibility?

Dr. STONE. Dr. MacDonald has been working this actively, but let me say to you that it should be this month that you will see the regulations.

Senator MURRAY. This month, as in February?

Dr. STONE. As in February. Yes, ma'am.

Dr. MACDONALD. Senator, the expansion of this program, as you know, is something we have welcomed in VA for a long time. We are thrilled to be able to provide this benefit equitably across all areas of care, and especially to be expanding first to those pre-1975 veterans, those Vietnam- era veterans who we know have a significant need set, and who we know face a burden of illness that is often higher, on average, than the cohort that we have previously served in the post-9/11 generation, individual by individual. Certainly any burden of illness can be high, but we know that this cohort is significant, both in their own burden of illness and in the average age, as we anticipate, of the caregivers caring for them. Oftentimes this is a spouse who is delivering that care, day in and day out. Sometimes it is another family member.

But we expect the average age of these caregivers to be over 70. And by design, this program will meet the needs of each of these eras equitably. You will see us expand in a way that is consistent and builds upon the more than 15 programs that serve this population now. The stipend program that is specifically expanding, we are hiring more than 680 staff across the nation, and have hired them at the regional level, at the VISN level. In every region they are already in place, ahead of the expansion, which we anticipate this summer.

In addition, we have 50 percent, more than 50 percent now of the support staff on board, and we are in strong partnership with IT,

stronger than ever before. And we anticipate that both the regulation, as it becomes final, as Dr. Stone said it will publish this month, but as it becomes final this summer that will come in line with the IT systems being delivered, and then this program will expand this summer.

And we anticipate, also, reaching back to those veterans and caregiver pairs who have already reached out to us and expected this, as you said, on October 1st. We will be reaching back to all of those veterans who applied and guiding them through the process, if they still want to be part of the program when the expansion happens.

Senator MURRAY. Okay. We will be watching for that, and stay in touch. I am out of time but I did want to just say that I am hearing a lot of concern about the Department's referral process to community care and quality and coordination. I will be submitting a question on that and I hope to get an answer as quickly as possible.

Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Murray. Senator Sullivan.

SENATOR SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman, and Dr. Stone, I am glad that you are going to be making it up to Alaska sometime this spring. I appreciate that. I think you will be impressed with the VA operations in the state. Dr. Ballard is doing a great time. And you will get a good understanding for our need for new or expanded spaces that can accommodate not just the uptick in personnel but as a result of recruiting initial doctors and staff, which has been very positive, the increased traffic of veterans seeking services, I think Secretary Wilkie saw this on his recent visit. My hope is that your visit will also encourage you and your VHA leadership team for operations and management to reassess the way regional budget allocation models are setup to reflect booming growth.

So let me ask Dr. Matthews, I know you are aware that Region 5—and the Chairman, I appreciate, just touched on this—is several months behind Regions 1 through 4 in terms of CCN deployment, though TriWest is bridging in the interim, and we appreciate that. And in fee for the contract was solicited back in October of last year. What is the current timeline for awarding the contract?

Dr. MATTHEWS. We are in the middle of the final stages of acquisition so we should be announcing in the coming month or two.

Senator SULLIVAN. Can you just—again, the Chairman just touched on it—can you go into a little bit more detail of why Alaska was pulled into its own network in the first place?

Dr. MATTHEWS. Sure. So Region 4 was the original geography that we attempted to award, but VA did not find an offer of value. There was a lot built into that RFP that we then opted to amend. So we not only removed Alaska, when you look at the managed care industry there are not players that cover, from a network standpoint, Texas as well as Alaska. So that was a very large geography. Alaska tends to have actually just a couple of managed care players in that space, and they are solely in Alaska.

So by removing Alaska we wanted to make sure we had a more focused offer that was really focused on the needs of your constituents. We also did the same with the Pacific territories. They were also bucketed into Region 6. So it was really just an idea to get better offers.

Senator SULLIVAN. Well, look, we appreciate that, and I know you were taking input from a number of us on that issue. And when you are reexamining the Alaska market and drafting a new contract for the second RFP, how much input were you getting from the local VA leadership, which integrated into the final product?

Dr. MATTHEWS. Dr. Ballard, other members of his team, as well as the VISN staff, were all included in that integrated project team. We also had multiple consultations with several of the tribes.

Senator SULLIVAN. Great.

Dr. MATTHEWS. Tribal leaders joined us at at least two different meetings, and I was able to join as well, to discuss just what this RFP looked like, what the critical nature of the relationships within Alaska, just because, again, they do differ from other states. So we did a great deal of input in order to build this final RFP.

Senator SULLIVAN. Well, again, I appreciate that. You know, our Alaska Native veterans are a very, very high proportion, and we talked about that in the last hearing, and then Alaska native health care has a lot of reach into some of our more very remote communities. You know, we have over 200 communities that are not even connected by roads. That is a challenge that no other state faces.

Dr. Matthews, how confident are you that the TPAs who have submitted bids for the Region 5 CCN contract will actually be able to meet the terms of it?

Dr. MATTHEWS. Unfortunately, I cannot speak to that, just because it is a confidential acquisition process that I am not a part of.

Senator SULLIVAN. Okay. So anyone else? Dr. Stone, can you talk to that at all? I mean, I do not want to get into confidential info, but we want to make sure that all the work that you have done on the Region 5 issue is actually going to bear fruit. And if we do not think it will, what would be the alternative?

Dr. STONE. We are optimistic, and we are in that very sensitive stage of acquisition, and we need to be very careful with our comments.

Senator SULLIVAN. Okay.

Dr. STONE. But I can say that the Secretary and I were over with the Secretary of Defense last week, talking about the uniqueness of the Alaskan delivery market, the role the DoD plays with us, the role of the Alaska Native health care system, and it was specifically an expression of our concern that as DoD evolves their health care system that we wanted to make sure there was no disruption with the very close relationship that our leader, Dr. Ballard, has had within the Alaskan delivery system.

But it is unique. You have helped me understand how unique it is, and now on my third attempt to get up to Alaska I am hopeful that we will actually do it this spring.

Senator SULLIVAN. Well, we look forward to welcoming you there, and I appreciate your comments on the uniqueness. But it does provide opportunities. We obviously have a big DoD presence there, which is growing quite significantly, more vets per capita than any state in the country, but also as you mentioned quite a solid and well-performing Alaska Native health system with reach, that the partnership with the VA we always see as a good opportunity to make the goal of what we all want, which is better health care for our vets.

So thanks very much. I look forward to seeing you in Alaska.

Dr. MACDONALD. Senator, if I may very briefly follow on to what you just said about the uniqueness of Alaska, following onto our discussion earlier, in answer to the Chairman's question, this is where the tools in the MISSION Act need to come together with the other tools we have in VA. The Region 5 network itself will be a step forward, and those partnerships, including the tribal entities, as you mentioned, will be critically important to access in that area.

Additionally, VISN 20, of which Alaska is part, is leading in the telehealth space, and leading in deploying our health care providers into areas where veterans need to see them in person. We very much believe that the tools you have given us in the MISSION Act—telehealth, the network, the recruitment and retention tools that we now have—need to come together and synthesize in order to meet access for folks who choose to live further away and would not have access necessarily to a brick-and-mortar facility. We need this to be cross-functional and meet them where they are, and your region is a primary example of how that strategy will come together.

Senator SULLIVAN. Great. Thank you very much. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Sullivan. Senator Blumenthal.

SENATOR BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. I noted, unless I am mistaken, Dr. Stone, there is no mention in your testimony of mental health care. Yesterday in the State of the Union, actually during the day, I hosted a family whose son and nephew, Tyler Reeb, was a Marine Corps sniper, had three tours in Iraq and Afghanistan. He came back suffering from the invisible wounds of war and took his own life, all- too-common story.

The fact that it is so common is really an indictment of our health care system, and I wonder if you could tell me whether you have seen any changes in the quality of care, whether there are new kinds of treatments and diagnoses, whether the community health care that is offered through the MISSION Act is improving the situation, and whether we can do better to help our veterans before they come out of the service, removing some of the stigma and seeking health care, mental health care so that it is integrated with community service once they are back in the civilian world?

Dr. STONE. Senator, this is, I think, for all of us, one of the most frustrating things we deal with. You have given us a doubling of our mental health provider budget. We spend almost $10 billion a

year. We now have over 25,000 providers in mental health within VA. Access to VA mental health services is same-day access, across our entire delivery system, but yet we have not changed the trajectory and the number of suicides and self-harm that is created.

I talked extensively in previous testimonies about the fact that this is not simply a mental health problem. This is a problem of isolation and loneliness and hopelessness that really cries out to the rest of American society. It is why the President, in his Executive order, called for the development of the PREVENTS Task Force and why the PREVENTS Task Force will present a plan that will integrate a community response, not dissimilar to what you saw in homelessness, that has driven down veteran homelessness by 50 percent.

VA cannot solve suicide alone, and if you gave us another $10 billion for mental health and we hired every single graduate of every single program it does not undo the intense loneliness that leads to this.

Senator BLUMENTHAL. You do not think the problem is one of more psychiatrists and more trained professionals?

Dr. STONE. I do not. I do not, and I think we have demonstrated that. I think what this is——

Senator BLUMENTHAL. And do you think

Dr. STONE. ——and I think we demonstrate that in the extraordinary difference in rates of suicide in areas like Montana, like Alaska, that have dramatically higher suicide rates than does New York City and Los Angeles. There is something about interpersonal contact that is protective, and it is why it is so important for us to maintain the mental health delivery system and the camaraderie that is developed in active duty that must continue when we leave. And it is why veterans choose us. You go into the lobbies of every one of our hospitals. Veterans stay there. There is a sense of community that is really important.

I think it is also—and I know I am going on too long on this, but give me just one more second on this answer. There is a chance for us, in the transition program, to re-examine how we interrelate with the veteran. Right now it is up to the veteran, when they go through what we call our TAP program, whether they engage with us. We would like to consider an opt-out program where every veteran is enrolled in VA health care, unless they choose to opt out. I think it would help us a lot.

And the dramatic change, when I came off of active duty, from being in a cohesive community to what I experience now, I have talked about before, and I will not repeat. But I appreciate your tolerance of that prolonged answer.

Senator BLUMENTHAL. Well, I thank you for that answer, and my time has expired so I cannot pursue some of the questions it raises. But I agree completely that the VA is sought after and welcomed by the veterans' community because of that sense of camaraderie, whatever the ailment that is being treated. That is one of the reasons that they come to the VA. And so I welcome your approach and I would like to follow up on it, and particularly, if you are willing to do so, meet with the Reeb family, because they have some ideas about how Tyler Reeb could have been saved.

Dr. STONE. I would, and I would welcome that meeting. Thank you. We will contact your office to schedule that.

Senator BLUMENTHAL. Thank you. Thanks very much. Thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Blumenthal. Senator Hirono.

SENATOR HIRONO

Senator HIRONO. Thank you very much. I appreciate this discussion on suicide prevention because it has been a concern for many of us for, well, for all of us, I would say. So you mentioned, Dr. Stone, the prevention—PREVENTS Task Force? PREVENTS Task Force—what is that? They are supposed to be coming up with an integrated community plan for addressing——

Dr. STONE. This is part, Senator, of the President's Executive order, as we look towards the community approach.

Senator HIRONO. I think that is a great idea, so I would like to have more information about who is leading this task force and when are they coming up with their recommendations.

Dr. STONE. This is, yeah, Dr. Barbara Van Dahlen, and this is an all-of-government approach to a different view, using a public health approach to suicide. And it really goes back to my previous comments, that this is not about really hiring more mental health professionals. This is really about an all-of-society approach, just like we did with the homeless problem.

Senator HIRONO. I understand and I applaud that much, much more of a whole-person approach to suicide prevention, knowing also that most of the suicides of veterans who take their own lives are not part of the VA. They have not engaged with the VA. So I really like your opt-out approach. So are you going to be implementing that?

Dr. STONE. So we just yesterday had additional discussions of that. This will require some help, and we will work our way through, from your level, how to actually implement that.

In addition, we have been talking about some pilot programs and expanding access through our Class 7 and Class 8 veterans that would not normally have accessibility at the same level to enhance that accessibility. And we are working on a pilot in VISN 8 on that, which is our Florida/South Georgia region.

Senator HIRONO. So anything you can do to pretty much enroll all veterans in the VA rather than expecting them to show up, and doing that, I am all for, and if we need to change the legislation I hope you have something in mind.

The Director of the VA Pacific Islands Health Care System recently departed her position, and in the last six years, five to six years, you have had three different directors. And usually it takes quite a while for a new person to be hired, and clearly we need somebody in that position who can connect with the community, including, of course, engaging with our neighbor island veteran populations, because, as you know, Hawaii is comprised of seven inhabited islands.

So I would like to know from you what is the status of the search for a new director for Hawaii? When can we expect a new person to come on board?

Dr. STONE. I would be happy to take that one for the record, and let me tell you only why. I have had a number of discussions with potential candidates who are interested in that. It is a very attractive site for a number of our leaders to go to. It is a bit of a dance when it comes to making sure that we are covering all areas properly and do not leave another area short.

But a number of our leaders within the system are interested in that job, and I will take that, if you do not mind, for the record, and get you the exact details of how close we are.

Senator HIRONO. Yes, because the director in Hawaii also takes care of the veterans in Guam, right? I mean, this is a big job and we need somebody in there. And, of course, you mentioned before that recruitment and retention is an issue for the VA and you cannot compete with the private sector. But if there are things that we have to do to enable you to better compete. Although one would think that working for the VA, you know, you can appeal to a sense of community, of being part of providing care for people who have sacrificed for us. I mean, there are these non- financial aspects one would think that would, I hope, be part of your recruitment effort.

Dr. STONE. I think it is. I think it is what has drawn all three of us to this job, these jobs, this sense of being part of something greater than ourselves.

Senator HIRONO. So you do put that out as part of your——

Dr. STONE. Well, we do, but we also need to recognize that a young resident coming out of their training does not always have the same connection that we would like to the mission of selfless service. And I am not demeaning in any way, but——

Senator HIRONO. Yes. More is the pity.

I just have—my time is running out so I wanted to ask you one more question, Dr. Stone. Mr. Atizado—he is on the next panel—mentioned that Disabled Veterans of America has heard from veterans that they are being offered access to community care network providers without being fully informed of their options to receive care in the VA.

So are you making sure that the veterans know that they can actually get care in the VA without having to go out into the community?

Dr. MACDONALD. Senator, thank you so much for raising this, and we are so grateful for our veteran service organization partners and feedback on this. We have heard this from actually several veteran service organizations.

As you heard me mention earlier about our referral coordination initiative, we want to make sure that veterans are empowered with their options. That has been at the center of our approach to the MISSION Act from the beginning. And I think we can safely say we have empowered people with their community care options. They are aware that that is an option.

What we are hearing from veterans, proudly so, is that they want to know more about what additional VA options they have. Can they use telehealth? Can they use an e-consult? What additional options do they have in the VA, even if they have to drive a little further?

That is beautiful news to our ears. We are proud that veterans want to stay with us, and that is why we are implementing that

new initiative. That will get us down to three business days in scheduling people for care, empower them to schedule where they want to schedule, including if it is with us, and guide veterans through that process and really give them a list of options, which may be beyond their facility—that may be in their region and that may be nationally, via telehealth. We are taking this very seriously and taking that feedback to heart from our veteran service organizations, partners, and what we are hearing directly from veterans themselves in our facilities.

Senator HIRONO. Yeah. So what we are hearing is that they are not receiving the full range of options, and when you talk about empowerment, a lot of empowerment has to do with having the information necessary for them to make a decision.

I do have some other questions for the record, which I will submit. Thank you, Mr. Chairman.

Chairman Moran. Senator Blackburn.

SENATOR BLACKBURN

Senator Blackburn. Thank you, Mr. Chairman, and I want to thank you all for being here. This is an issue that, in Tennessee, we talk a lot about, to our state director and our veteran facility directors. And we recently had a pretty poignant telephone call about some of this, because the wait times in Tennessee are exceeding the national average. Mountain Home facility, which is the best, the most highly rated facility in Tennessee, the wait times have increased since the implementation of community care.

So you get that push and pull from veterans and from the providers there within the VA system that they feel like they do not want you leaving the VA system and going to the community because they are making it difficult. The VA is making it difficult for you to have your choice and have your options. And I know that you all have had some discussion before I got in here, from the Chairman, about this.

And one of the things that we talked about with RCTs, and this movement, is this going to be done from existing staff or is it going to be done from new hires, and what is the training process so that the veteran is the first consideration, not a byproduct but the first consideration?

Dr. MACDONALD. Thank you so much for that question, Senator. You raise a critical issue about referral timeliness. It is first critically important to understanding that over the past several years VA has become extremely adept in delivering urgent care, and by urgent care I mean when a referral is urgent, when the care is needed now, and we need to get that veteran to care we deliver that in less than two days. Actually, it is continuing to go down and we are at 1.4 days. We deliver that internally and in the community right away, and we get those needs met.

Where we have work to do is in our routine referrals, as you mentioned, and we have that work to do across the system.

Senator BLACKBURN. And let me interrupt you right there please, and ask you, when we discuss this with our center directors, what they will say is, "Well, it is because of the contract and because of the MISSION access, MISSION Act standards." So are you modi-

fying those contracts, or where is the flexibility in that so that you are moving these forward and getting those wait times down?

Dr. MACDONALD. Senator, this is two-fold, and it is about process. It is about our internal process. In the past, processes were fragmented between our internal traditional care system and community care. We are solving that by putting, as you said, the veteran is the priority. The veteran is at the center. They are empowered, as we were talking about earlier with their options.

When they have that range of options presented to them, immediately, again, doing today's work today, we are driving that wait time down to the three business days to process that scheduling.

Senator Blackburn. What is your timeline for getting it down to within a day?

Dr. MACDONALD. Already, on Monday, all of our facilities conducted a stand-down, and——

Senator BLACKBURN. What is your timeline?

Dr. MACDONALD. By July, ma'am.

Senator BLACKBURN. By July.

Dr. MACDONALD. Yes.

Senator BLACKBURN. Okay. Let me move on in my minute and a half left, and I know Senator Rounds talked to you about reimbursement. And we hear from people in small practices, not the big providers but the small practices, that they are not being reimbursed properly and there is a tremendous amount of delinquent payments that are there.

So how many community care reimbursement claims are backlogged, what is causing that backlog, and what is your timeline for clearing that backlog?

Dr. MATTHEWS. Thank you, Senator, for that question. Currently, nationwide, our backlog, meaning aged claims beyond 30 or 45 days, depending on the population of claims, is 2.5 million claims. Our inventory as a whole is about 3.4 million, so there is always going to be some inventory because they have not aged yet. But that backlog is about 2.5 million. I do have a breakdown and can share it with each of you what your particular state backlog is, both by numbers as well as billed charged.

But yes, this has been an ongoing legacy issue for the claims submitted to the VA.

Senator BLACKBURN. What is your timeline for clearing the backlog?

Dr. MATTHEWS. By the end of this fiscal year.

Senator BLACKBURN. The end of this fiscal year. And then your turnaround time per payment is expected to be what—15 days? 30 days?

Dr. MATTHEWS. No. Our goal is definitely short of 30 days.

Senator BLACKBURN. Short of 30 days.

Dr. MATTHEWS. Yes.

Senator BLACKBURN. Okay. Thank you. I yield back.

Chairman MORAN. Thank you, Senator Blackburn. There is some interest in additional questions but we have a second panel that we think is also very important. Dr. Stone and Dr. MacDonald and Dr. Matthews, you have been very helpful to us. I appreciate the directness of your answers. We are going to turn to the second panel. I would guess that there would be, including from me, several

questions for the record that we will submit to you. Thank you for your service.

Dr. STONE. Mr. Chairman, thank you very much. Ranking Member Tester, thank you. I appreciate the courtesy shown to us.

Chairman MORAN. You are welcome.

PANEL II

We will call that second panel, which consists of Adrian Atizado, the Deputy National Legislative Director for the Disabled American Veterans; Lieutenant General Patricia D. Horoho, CEO of OptumServe; and David J. McIntyre, President and CEO of TriWest Health Alliance.

[Pause.]

Chairman MORAN. Welcome to the three of you. I thank you very much for agreeing to testify. We are grateful for your presence. I think it is particularly valuable that you were here to hear the testimony of Dr. Stone and his colleagues, and with that I would turn to Mr. Atizado for your opening statement.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Chairman Moran, Ranking Member Tester, distinguished members of the Committee, first of all I would like to congratulate you, Senator Moran, for your confirmation as the 12th Chair of this illustrious Committee. We look forward to working with you and your staff, sir, over your tenure here, to collaboratively work over the issues and make the lives of our ill and injured veterans better.

Chairman MORAN. I look forward to that too, as well. Thank you.

Mr. ATIZADO. I want to thank you again for inviting DAV to testify at this hearing to examine the implementation of the new urgent care benefit and Veteran Community Care Program as envisioned by the VA MISSION Act that was passed a couple of years ago. Comprised of more than 1 million wartime service-disabled veterans, DAV is a congressionally chartered nonprofit veteran service organization. We are dedicated to a single purpose which is to empower veterans to lead high-quality lives with respect and dignity.

DAV is grateful for the support that this Committee and VA led to veterans, that led to veterans having access to urgent care furnished by the Department. Section 105 of the VA MISSION Act can be tracked to a 2016 resolution that was adopted by our members, asking for urgent care to be included in VA's medical benefits package. And today the need for this benefit is abundantly clear, with over 170,000 urgent care visits made by veterans across the country.

Much of the success can be attributed to TriWest's efforts to build a network of over 6,400 urgent care providers as well as training them to understand the process and the procedures. And we are pleased to report that DAV members who have used this benefit express positive comments about their experiences, from the eligibility determination of the point of sight to actually the care that they receive, and not having been billed by it, which is extraordinary, I must say.

We are hopeful the transition of the urgent care in Region 1 from TriWest to Optum will be as robust a network and a process that is as seamless as veterans have experienced thus far.

Mr. Chairman, it should come as no surprise, though, the DAV vehemently opposes VA's decision to charge copayments to service-connected veterans for urgent care. This is a discretionary authority given to the Secretary, which he then exercised. In DAV's view, service-connected veterans have already paid any such costs for their service and sacrifice, yet VA breached this principle without attempting other means to achieve their desired ends.

I would like to turn now, at this point, to Section 101 of the VA MISSION Act. According to VA, the Veteran Community Care Program, which is embodied in Section 1 of the law, will be administered through a Community Care Network contract across five of six regions by the end of this year, and DAV recognizes the implementation of this program as a tremendous effort, and recognizes it is a massive undertaking, and its TPA partners, with TriWest and Optum, will really be needed. This partnership is critical for this program to work.

To help bridge this transition, as mentioned in this hearing earlier, VA has leveraged the PC3 through a contract and the Choice contract with TriWest helped bridge this transition. This is critically important. While DAV is unable to fully assess the progress to implement a high- performing integrated network, which is what the law envisions, we continue to hear, as was mentioned by Senator Hirono, issues—as well as the other Senators—from both veterans, VA providers themselves across the country, as well as community providers.

Mr. Chairman, we bring these issues to light so that VA and its partners can work together to systematically and holistically improve this critical program, and not treat it as one-off issues that they need to tackle as it comes up. VA is learning institution. Its partners should be, as well, and this program should reflect that. They should not only measure but they should also be able to manage and identify them in the system.

To this end, we remain concerned about implementation of the required care coordination and competency standards of non-VA health care providers as required in Sections 101 and 133 of the VA MISSION Act. To carry out the care coordination piece, VA medical centers are assuming all responsibility in appointment and scheduling all eligible veterans, and I respect Senator Hirono's comments about the staffing requirements for these.

We also have not received fully sufficient information to assess the status of implementing the competency standards, in other words, the quality of care that veterans receive both inside and outside the VA health care system. Ignoring these standards short-changes veterans and taxpayers of what otherwise should be high-quality and high-value care. It could also fragment veterans' care. This is something that should not be happening in a high-performance health care network.

Mr. Chairman, this is my time, and I appreciate the opportunity. I will take any questions from this Committee. Thank you.

Chairman MORAN. I thank you so very much. Lieutenant General, welcome. Thank you very much. I look forward to your testimony.

STATEMENT OF LIEUTENANT GENERAL PATRICIA D. HOROHO

Lieutenant General HOROHO. Thank you. Good morning, Chairman Moran, Ranking Member Tester, and members of the Committee. I am Patty Horoho, CEO of OptumServe. On behalf of the more than 325,000 men and women of UnitedHealth Group, we are honored to be part of this mission. We have a long history of serving our nation's military and veterans, and we are deeply committed to standing up the community care network that honors the sacrifices made by our nation's heroes.

Half of Optum serves community care program staff, our veterans, and most of us have family members who are veterans. This experience is enhanced through extensive quantitative and qualitative research we perform to better understand veterans and their lives and their experience with navigating the health care system.

We met with 125 veterans in their homes over five states. We completed a national survey of 5,500 veterans, and then we mapped veterans' experience and steps in getting care, called the journey mapping. This research uncovered valuable insights and informed us on how the process would work better for veterans, for the VA, and community providers.

Taking in these insights that places the veteran at the center of our planning, we are equally dedicated to excellence in execution. Center to our responsibilities and community care is delivering a network of high-quality health providers from which the VA medical staff and veterans can choose. We began by leveraging the 1.3 million providers in the National UnitedHealthcare and Optum provider networks, but our network strategy did not end there. We worked with the VA to identify quality providers. We have a history and a desire to care for our veterans.

Six months ago, we began health care delivery at two sites in Region 1. Today, in Region 1, our company has built a network that includes more than 178,000 unique health systems and providers across more than 309,000 care sites. And since we completed Region 1 implementation activities in December, the network has grown by more than 10 percent, which includes more than 18,000 unique providers, over 44,000 sites of care.

Taking a data-driven approach, we will continue to implement and evolve the network as we assess the needs of our veterans in Regions 1, 2, and 3.

We also care deeply about delivering a seamless experience for community care providers, including paying community care providers for care that they have delivered. This is a critical element to the success of our network. It demonstrates that Optum is a reliable partner and increases provider confidence in continuing to participate in our network. As of today, we have processed more than 150,000 claims and paid claims in an average of 11.9 days.

Another critical element to the success of our network is resolving provider issues as soon as possible. As of today, we have received 35,000 calls to our customer service center from VA staff and providers, with an average speed to answer of 3.6 seconds, and

our customer service staff have resolved more than 99 percent of the issues, first time, first call.

Throughout the entire provider experience we are providing them information that they need to take action. It begins with letters, calls, in-person meetings. After they have joined we provide training on how this new network operates. This occurs through webinars, in-person trainings, virtual town halls, and provider expos. We also provide regular updates, education materials, and on-demand videos to providers, either directly or through our online portal. We are restless in our desire to do more and learning, and leaning far forward to identify new ways and new methods to communicate.

In conclusion, what is important six months into health care delivery is that veterans are getting care from our network, providers are promptly getting paid, and we continue to adapt and build our networks across all three regions, continuing our strong partnership with the VA and TriWest.

I am committed to continue to deepen our partnership with veterans, with Congress, veteran service organizations, and other important stakeholders. We understand your interest in ensuring the community care networks meet our veterans' needs and we share this interest. I am equally committed to continuing our open lines of communications and regular engagements with the VSO community, including Adrian's wonderful organization, and I am very proud to serve alongside you.

As a veteran, former Army sergeant general, and commanding general of the U.S. Army Medical Command, wife of a veteran, daughter of a veteran, and now the proud mother of an airborne infantry officer, getting this implementation right is important to us. We understand firsthand the compassion the VA medical staff bring to veterans, and the importance of coordinated care across the health system. This mission is personal and important to us. We understand why getting this right is so vital.

Mr. Chairman, congratulations on your new role leading this Committee. Thank you for what you and the entire Committee do every day to support our veterans, and thank you for this opportunity to testify.

Chairman MORAN. Thank you for your testimony, and thank you, General, for your and your family's service.

Mr. McIntyre?

STATEMENT OF DAVID J. McINTYRE

Mr. MCINTYRE. Good morning, Chairman Moran, Ranking Member Tester, and members of the Committee. I am Dave McIntyre. I am the President and CEO of TriWest Healthcare Alliance. Thanks for the invitation to appear today. I ask that my written testimony be submitted for the record.

Chairman MORAN. Without objection.

Mr. MCINTYRE. Our company stands at the doorstep of implementing the new CCN contract in Region 4, which begins on April 7th in Montana and eastern Colorado, and will continue through the summer. Lots of work is underway between us and VA, at the local level and at the national level, to make sure that we are

ready to execute in our areas of responsibility, including making sure that the provider network is set for CCN.

But as most of you know, we at TriWest Healthcare Alliance have been on quite a journey the last six years, because you, we, and VA have traveled much of it together. The earliest days of this privileged work were extremely challenging, but our north star was two fully engaged members of the Arizona congressional delegation, one of whom for which the MISSION Act is partially named, and the other one who now serves on this Committee. From moment one they were fully and completely engaged, seeking an understanding of what was going on and pragmatic solutions to what needed to be done to make sure that Phoenicians who served their country were going to get what they were owed.

But the focus was not unique to Arizona. It was true across the nation. And it was true between branches of government and the veterans' community, including the great organization that Adrian is from. By working together, we brought things to a place of reasonable stability in the half of the country for which our company had the privilege of serving alongside VA, in terms of community care. We paid our claims, we assisted with appointing, we made sure that networks were available, and we performed other administrative functions, while you and VA worked at crafting the long-term blueprint for the future of VA, which is embodied in the MISSION Act.

Then we all found ourselves in a position where a company walked away from its commitments, leaving VA, veterans, and community providers in the other half of the country without the support that they were to have had. Senator Tester, I will always remember your graciousness in taking a meeting request from me when I was trying to decide whether we were going to accept the request of Dr. Stone to lean forward and plug the gap and build the bridge in the other part of the country. It was a rather intense conversation. It was very frank. Frankly, it is the roadmap on which all of us at TriWest, in full partnership with VA, have adhered.

Not only that, I was impressed that when I said yes to Dr. Stone, you, in turn, said, "I am going to lean forward and I am going to be your partner, as is my staff in this process." You leaned out vulnerably and told the providers in your state that this would all work and that they could trust and have confidence that at the end of the day we were going to get it right.

In fact, three weeks ago I found myself in Montana, as I am often, but I was there at the side of my 85-year-old veteran father as he decided to take on the role of secret shopper in one of Montana's fine cardiac units, and they did one heck of a job, just as they have been doing for veterans ever since we went live in Montana on December 7, 2018, 90 days after we said we would assault that cliff.

As a proud American humbled to be of service to our nation's heroes in support of VA, along with all who are associated with TriWest, I tell you this story because it is a story that all of you are a part of, minus the flame that has at times been trained on my backside. But it is repeated for every member on this Com-

mittee, because we built that bridge together in the other half of the country.

It was done to strengthen, not weaken, VA. And great providers from across this country, some 685,000 on our watch, with 1.3 million care sites of access, leaned forward. They have delivered care. They have delivered more than 20 million appointments in support of VA. In fact, because of them, we have returned less than 2 percent of care requests for no network provider.

We paid claims—18 days on average, 10 days in the area of expansion—to an accuracy rate greater than 96 percent. With the exception of the last couple of months, because of a fee hold issue tied to an update in the payment rates, we have delivered on what we said we would do. We are almost out of the back end of that challenge.

As Adrian said, we stood up the urgent care benefit—175,000 encounters have now occurred.

So we are getting ready for the implementation of the CCN contract. We are proudly leaning forward. We are working at the side of the VA. We have sat market by market by market over the last month and a half to two months, and reviewed what the demand profile is going to look like for the care needs in the community in each market, with our colleagues in VA. We have now factored that into the setting of our network, and the deployment of that network construction is underway with Montana and Denver being first. And we will be up and operational on April 7th.

Thanks for your leadership. Thanks for your partnership. Thanks for your fully engaged involvement in support of veterans. It has been our privilege to serve at your side the last six years. Thank you.

Chairman MORAN. Mr. McIntyre, thank you very much. Let me start where I started with the first panel, dealing with access standards under the MISSION Act. I realize that the Optum contract was entered into before the MISSION Act standards were in place. I was pleased that the contract that was negotiated for Region 5 included those MISSION Act standards. I learned from Dr. Stone and his colleagues that while that seemingly is good news I also learned that that may be something that can be waived.

My question is, what is your reaction to what I have been told this morning, and how insistent should I be in that the MISSION Act standards, access standards, be included in your contract, either by amendment or by Optum voluntarily meeting those standards, and how concerned should I be that there may be a waiver in Region 5 of those standards? And what does this ultimately mean to the ability for veterans across the country, particularly those who live in very rural areas, what does it mean for them?

Let me start with Mr. McIntyre, because you have been through both Choice and now MISSION.

Mr. MCINTYRE. Yes, sir. Thank you for the question. I will answer it with regard to Montana, where we are in the process of constructing the network that will exist for CCN Region 4, and Montana leads the deployment of that.

We have gone through a demand capacity process to seek to understand the demand for care that will be going into the community. We used a rather extensive set of tools—and they are very

complex—that we use for urgent care. We are going to be mapping to what those standards are that are contained in the MISSION Act, and it is up to the VA, along with veterans, to decide when they will place care in the community.

Our objective is to make sure that we—to the degree that there are providers available to contract with, because they actually exist in the market—we will be seeking to make sure that there is sufficient supply of all the specialties that are required to be able to comply with the MISSION Act standards.

Chairman MORAN. Thank you. Lieutenant General?

Lieutenant General HOROHO. Thank you, Senator. The intent of the MISSION Act is really to make sure you have a robust network that is available for our veterans to be able to receive care, and it is near where they live. And so with that intent we have been aggressively building a network. When I talked about, in my opening statement, where we have gone live and met the standards of the contract, we actually continue to build our network to make sure that we are close. And I will give a good example.

So we are getting ready to go live in Georgia, which has about 159 counties that are rural, and 150 of those—excuse me, 150 counties that are rural, out of 159. We have met the drive time. We will meet the drive time of 60 minutes versus what would have been in the contract of 100 minutes.

So we are trying very, very hard to continually adapt and build a network and build it upon referral data that we are starting to look at since November time frame.

Chairman MORAN. General, we have had this conversation, my team and your team, as well as us. Is my concern that the failure to utilize the previous network of TriWest in Kansas, and awaiting a utilization study, those two things combined I am worried will find veterans once again experiencing the circumstance in which, one, they had care provided with a particular provider, now no longer available, and, two, the network is, at this point, not as large as it was, regardless of which providers are included in that network. And the end result of that is that—could be that there is a disappointment, again, in the ability to access care. I think, in many instances, veterans were discouraged in their utilization of Choice by experiences that caused them to throw up their arms and say "this is not working."

A significant goal of the VA and this Committee needs to be—and the TPAs—needs to be that there is no immediate dissatisfaction with this program so we do not disappoint our veterans once again. What would you tell me that assures me that that is not going to be the case?

Lieutenant General HOROHO. Senator, thank you for the question. I would say first is that we looked at rolling out community care very different than I think in the past of any other TPA. One is with our partner with TriWest, with the VA and ourselves, we made a commitment to put the veteran in the very center. We also stood up, where we have regular meetings, to be able to share and understand lessons learned, which we have applied. We make sure that in addition to leveraging our high-quality network we have gotten over 1,700 preferred providers that the VA wants us to put into that network.

In particular, we are also talking with TriWest and finding out who are those preferred providers, so that we can reach out to them. And then we have prioritized making sure that when we now look at the referral data we can see who those high-volume providers are and where the veterans are used to going, and we are then prioritizing and reaching out to them to make sure that we get them in our network.

Chairman Moran. Is your answer is that my concerns are unfounded?

Lieutenant General HOROHO. I think, sir, when I look at your area in particular, we are going into your area with over a 97 percent accessibility, and we have not even gone live yet. And so you have my commitment, and all of the leaders on the Committee have my commitment that we are going to do everything possible to build the most robust network to care for our veterans.

Chairman MORAN. Thank you. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I want to thank all three of you for your testimony. I think it was very, very good. And I also want to thank Dr. Matthews and Dr. MacDonald for being here. I think it is really important that folks stick around. I know you can see it on TV, but it is good you are here so you can answer any questions, or they can ask you questions after the fact.

Adrian, I am going to start with you. You heard Senator Hirono ask about whether—ask Dr. Stone whether veterans are getting all the information that they need to make an informed choice on where to get care. What are the factors that are most important for the VA to cover with veterans when making health care choices, and do you believe that the VA has that information to assist veterans in order to make—in using it to make decisions?

Mr. ATIZADO. Thank you for that question, Senator Tester. So I think I will first start to answer that question by really making sure we understand which veteran we are talking about. If we are talking about a relatively healthy veteran, empowering them to make a choice would be a relatively easy lift. But if we are talking about a population which is prevalent, in the population that VA treats, is older, aging, has a lot of complex conditions, they have life-long conditions, the kind of information they are looking for is more meaningful. It would have to be a little bit more information than one that is relatively healthy.

So, for example, if you are suffering from multiple sclerosis, which is a prevalent condition in the veteran patient population, you are looking at information that would be able to tell you, as a patient, would you want to have a life-long relationship with this doctor? Would I rather drive, can I drive, do I have the capability to drive to them if they were far, if they were of that value to me and my life, and how this would affect my ability to be an active member of society?

Now having said that, I understand the previous panel, Dr. MacDonald had talked about the RCT, which really is a kind of care coordination approach in making sure, as she has said, veterans are empowered. I find it curious, though, that what that effort entails is still unknown to me, to DAV. We do not know what that is other than what was mentioned in this hearing. It has been mentioned in passing, almost, but certainly not in full briefing. So

I could not possibly comment on that, although I do understand that this new responsibility that VA is taking on, under the community care contract, as far as scheduling and coordinating this care, is going to be quite different than what VA is doing today. And so I question what that effort is going to be.

So those are the two things I would say about that aspect, about what kind of information a veteran would want and need—it depends on what that veteran is facing in terms of health care needs—and whether VA is going to be able to achieve that kind of coordination.

Senator TESTER. Okay. Thank you. As you know, the VA is undertaking market assessments across the country. As indicated, its teams are meeting with veterans and other stakeholders on the ground in different regions of the country. Can you describe your organization, DAV's involvement in these market assessments, and whether it is locally or whether it is here in D.C., and have you received any briefings on them?

Mr. ATIZADO. Sure. So with regards to the market assessments, Senator, I am not really sure which assessment you are referring to. There are actually two different assessments outlined in the MISSION Act.

Senator TESTER. Pick the one you want. It is for the marketplace, though. Go ahead.

Mr. ATIZADO. So I want to be clear. Both assessments have to be done separately. It appears that VA is trying to do one assessment, which is supposed to serve two different purposes. We believe that is the wrong way to go about it, but nonetheless, to describe our engagement with a market assessment it is probably best described as scarce.

Senator TESTER. As what?

Mr. ATIZADO. Scarce. We have had scarce engagement on the market assessment. We know——

Senator TESTER. That is not a good sign, especially for disabled veterans.

Mr. ATIZADO. No, sir, and especially that the law really intimates a consultative process that we would be more engaged than we are today. We are trying to bring this up to VA as a matter of course. We know they have a lot of things on their plate, but we would really like to have a little bit more engagement.

Senator TESTER. Yeah, and I think it is absolutely necessary, and that is why it is good that the two VA folks are here. You can take that back.

I have—we will pass on them. I am out of time for now.

Chairman MORAN. Senator Tester, thank you. Mr. Adrian, the RCT catches my attention too. I think there is a lot to be learned about what this involves, and I would be happy to work with you as we work with the VA to learn more about it.

Mr. ATIZADO. Yes, sir.

Chairman MORAN. Senator Loeffler.

SENATOR LOEFFLER

Senator LOEFFLER. I want to thank you for your testimony today, for this panel. Lieutenant General Horoho, as Optum prepares for the rollout of the community care network in Georgia in two weeks.

Can you share what outreach has been done with veterans to talk about this transition and to prepare them?

Lieutenant General HOROHO. Thank you, Senator. Our outreach primarily is with the providers and building the network, and then the VA actually is reaching out to the veterans. And so from our outreach with the providers is we reach out to them, we explain what the network—the responsibilities of the network.

We have online training so that they understand that training, they understand the culture of the veteran. We have online training in a portal that they can access that will show them about Psych Hub, because of the high suicide rates, so we try to address that right up front. And we have many other trainings that are there.

And then we do in person, meeting with the contractors and the providers that are coming in, and then we have the call center in which they can call into as well. We are looking forward to actually serving your veterans in your area.

Senator LOEFFLER. Right. Thank you.

Lieutenant General HOROHO. Thank you.

Chairman MORAN. Anything further, Senator Loeffler?

Senator LOEFFLER. Nothing further. Thank you.

Chairman MORAN. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chairman. Thank you all for being here. Mr. Atizado, I want to ask you a question. I know you said in your opening statement you were vehemently opposed to the copay for urgent care.

And I guess the question, in North Carolina, since the MISSION Act was implemented, I think we are ahead of every other state, adjusted for population. We are at nearly 10,000 urgent care visits since it was implemented back in June. And I understand it is a $30 copay after the first three—is that correct?—the first three urgent care visits in a given calendar year?

Mr. ATIZADO. So yes, sir. The copayment schedule includes that. There are some veterans that have to pay on their first visit.

Senator TILLIS. Disability and other factors come into play. Is that correct?

Mr. ATIZADO. Yes, sir.

Senator TILLIS. Service related or not?

Mr. ATIZADO. Yes, sir.

Senator TILLIS. So is the concern with the copay, is it more where that could lead to other policy decisions, or just on its face you think it is inappropriate?

Mr. ATIZADO. Sir, so on its face we think it is inappropriate, and there are a number of reasons, a couple of which I will bring to your attention now. When a veteran is trying to engage a complex health care system, the more standard it is for that patient, the better. So they start having to engage a different part of their health care benefit and having to determine whether or not they have to pay copayments, that adds to a little bit of that confusion, for one. And really the more important one is the principal nature of that.

Senator TILLIS. Yeah. Well, that is what I was wondering. I am just trying to figure out, on the one hand you want to provide that benefit. On the other hand you also want to make sure the lowest

cost, high quality provider that can provide whatever care is in plan. I am assuming that was some of the rationale behind it, but that is something I will look into a little bit later.

Tell me a little bit about what you are doing. You guys do great work and you have helped a lot of veterans through several transitions—PC3, VA Choice, and now MISSION. What are you all doing engaging—in your VSO, what are you doing and what can we learn, what other VSOs could do to help with these transitions?

Mr. ATIZADO. So I think what we are getting ready to do is do a survey of our members. That is going to be a point in time, and I think we are going to do this in a recurring event.

But I think the first thing that should be done is for us to do some inreach with our members to find out, in a general sense, how they are experiencing this program. I can tell you that there are some parts, as mentioned in my testimony, where they are feeling some disruptions. We feel some of them are quite unnecessary.

And once we get the sense of how it is operating, how they are experiencing, then we will take this to VA and see whether or not they are, in fact, identifying and measuring these issues, and then fixing them, in a systematic way. Because doing one-offs, this is an evolution that is going to be going for years. I think that would be a little bit better approach.

If I can just go back real quick to the urgent care benefit, we were very instrumental. We worked with Senator Cramer and this Committee on that provision in the bill. Our proposal at the time was to mimic what DoD's Defense Health Agency was doing with regards to the urgent care benefit, because it would reduce their overall cost in other areas.

How the Defense Health Agency did this was they used a nurse advice line to help manage that need. They would direct the patient to the appropriate venue, preferably the least costly and one that is most responsive to the need, but that is not the approach the VA took on this.

Senator TILLIS. That is something we should talk more about. In my remaining minute, it is less of a question. TriWest has a larger network in Region 1, but larger does not necessarily mean that Optum needs to get to that point. What we will be tracking, as you go through the implementation, are any unserved or underserved areas within North Carolina. It sounds like the analytical approach you are using to figure out where to go to get additional providers should stay ahead of that, but, you know, expect us to continue to reach out and see any areas that may be one-offs. But I hope that in response to the Chairman's question, that you are going to stay ahead of it.

I will also tell you that I make an offering several times a year to any provider whose bills are not getting paid on time in North Carolina. They are a constituent and we treat it like casework. So I am glad to hear that you are doing a good job on reimbursements. That is critically important.

And I am over, but take rate, when you do your analytics you identify another provider that you need to get into the system. What is your success generally in getting that on board?

Lieutenant General HOROHO. Actually, we are having a very high success rate. There are some academic affiliates that it takes a

longer process to get them in, and that is probably where we see the longer timeline. When we see individual ones, they tend to come into our network a little bit easier.

Senator TILLIS. Well, in any instance where you are looking at a provider in North Carolina and we can help, let me know.

Thank you, Mr. Chair.

Lieutenant General HOROHO. Thank you, Senator.

Chairman MORAN. Thank you, Senator Tillis. Senator Sinema.

SENATOR SINEMA

Senator SINEMA. Thank you, Mr. Chairman, and thank you to our witnesses for being here today, especially to my friend David McIntyre, CEO of TriWest, and of course a proud Arizonan.

We are, in large part, here today because in 2014, the Phoenix VA Medical Center was at the center of a national scandal in which veterans experienced dangerously long wait times for medical care. That crisis led to the Choice program and now the community care network established under the MISSION Act.

The VA has made steady progress improving transparency, wait times, and access to care, but much more work needs to be done. I am extremely concerned about the time it takes for an appointment to be scheduled after a VA clinician has referred a veteran for community care and the processes that contribute to that delay. According to VA data provided to the Committee in December, the national average is 27 days between a VA clinician referring a veteran for community care to the scheduling of a veteran's appointment. The average in Arizona is about 25 days across our three VA health systems, and that is unacceptable.

So those data do not account for the wait time between making the appointment to actually seeing the community care provider. These delays have serious consequences for the quality of care and experience that veterans and their caregivers have when engaging with the VA.

For example, Sharon Grassi is an Arizonan, an Elizabeth Dole Foundation fellow, and a caregiver to her son, Derek, an Army veteran who served from 2006 to 2015. He returned home with spine injuries, post-traumatic stress disorder, traumatic brain injuries, and more. Sharon worked closely with my staff outlining the challenges she has had moving in and out of the Choice program, and now the community care network.

In one of her more recent challenges, Derek's VA provider referred him to community care because the VA did not have a specialist he required. But when the order was reviewed within the VA, it was modified without consulting the original clinician and Derek was not assigned to the specialist. This created confusion, delays, and deep frustration for Sharon and her family.

In Sharon's words to me, "The order had been modified without talking to Derek's doctor, without researching his case, understanding the diagnosis, or determining the capability of the facility. In the VA system a doctor's order is transferred to a purchased care team, forwarded to a department head, and given to a voucher examiner before being approved for care, and during this process clinically necessary care is delayed, modified, dropped, or lost. When community care is authorized, communication between pro-

viders is stunted, record management is horrible, and record-sharing a dysfunctional mess."

Sharon praised the Phoenix VA and so many of the providers who have supported Derek, but voiced frustration with the process. She ended her letter to me with relief, because their petition to the Army to change Derek's discharge to medical was granted. He will now use Tricare services moving forward and not the VA.

The VA has a real problem when a caregiver or a veteran are excited to be out of the system and receiving care somewhere else.

So I have got several questions now for our panel. My first is for Mr. Atizado. What is your understanding of the VA's process when a VA clinician refers a veteran into the community care network, and what are you hearing from your members about that process?

Mr. ATIZADO. So, Senator Sinema, thank you for that question. It is disappointing to hear that situation you just described. Unfortunately in our casework it is not an isolated incident. It is absolutely—it is infuriating to hear that a veteran who has agreed on a treatment plan with their provider is changed by some faceless individual. That should not happen. I am sure if you were to ask VA that they would say that that should not happen as well, but the problem is that it does.

I will be honest with you. I do not know what the process is now, because of how community care has changed over the last several years, not to mention there are still a couple of authorities out there which has different processes in place, and now we are talking about another change in how VA does their business, when referring veterans out in the community.

But that should not be the case. That expectation should be preserved. Senator Tester asked about what information veterans would need, and I think that really comes down to that first question, is that VA provider needs to sit with that veteran and know what they want and what they need. You want to talk about veteran-centric? That is it. When they agree on that treatment plan the veteran is not only encouraged to comply with that plan but somehow VA, in this particular instance and in others, does not. I do not understand it.

Anyway, I apologize. Thank you.

Senator SINEMA. No apology is needed. I think we all share this frustration.

Mr. Chairman, my time has expired. I do have further questions for members of the panel. I will just submit those.

Chairman MORAN. Thank you very much.

Senator SINEMA. Thank you.

Chairman MORAN. We are going to do a second, hopefully relatively quick round. Let me—in regard to Senator Sinema's question, and particularly again while the doctors from the VA are here, I think an issue on the wait time is that the VA considers the wait time not to start—in other words, do they comply with the number of days—it does not start until they schedule the appointment. And the issue in my view should be the wait time begins when they make the decision for the referral. So we need to make certain that there is not a significant gap between the decision to refer and then the scheduling of the appointment, which then per-

haps, under somebody's theory, extends the amount of time in which you are either in compliance or not.

I have a question, which causes me to pull up my iPhone. I looked something up because I have tried for a decade. The conversation about mental health—maybe this was Senator Blumenthal—we have, in Kansas, and perhaps it is true in other states, we have something called community mental health centers, and they are created by statute. They are the gatekeeper for our state hospitals, but most importantly they provide mental health services in the community.

According to their website, the way they are defined is "a community mental health center are charged by statute with providing community-based, public mental health services safety net. In addition to providing the full range of outpatient clinical services, Kansas' 26 community mental health centers provide comprehensive mental health rehabilitation services such as psychosocial rehabilitation, community psychiatric support and treatment, peer support, case management, and attendant care."

I have tried for a decade, in fact, before Choice and then under Choice, and now under MISSION, to make certain that a community mental health center qualifies for a referral from the VA for mental health services. I ran out of time to ask the VA this question, but are those community mental health centers being contacted? Are they being offered the opportunity to be a provider in the network? And, I guess finally, the reason this is so important is timing for all health care is critical, but in today's efforts to reduce suicide requires providing mental health services quickly, and I assume where a person lives.

I heard what Dr. Stone said about wrapping people in other people, and it is not always about the mental health professional. It is about being surrounded by people who are going to care for you. Our community mental health centers do that every day for Kansans and they do it in the most rural settings of our state. Can I be assured that they are being included in this network and can provide services under MISSION for veterans?

Mr. MCINTYRE. So Mr. Chairman, if you look at the network that we constructed over the last number of years, many of them are in the network that we have, and as we set for CCN the next network in the states that we will be responsible for, we will be porting them over. Many of them, though, had direct contracts at one point with VA, because some of this care used to move directly. Now it is moving through a consolidated network.

In fact, in the state of Montana, Senator Tester's staff, myself personally, and the VA team on the ground are going to meet together in Montana with the four facilities that fall under that definition, because their direct contract is aging out, and we will be bringing them together into the footprint of the network for Montana as we map demand against supply.

The last thing I would say is you are right. The other Senators that have articulated this were right. It is about human connection. And the bottom line, at the end of the day, is what people say who did not commit the act of suicide but thought about it, I did not do it because I saw someone or I heard someone or I felt like I needed to be there for someone that was on the other side.

We do a lot of mental health appointing in this space for VA. We also run a stress program that we built for the Marine Corps years ago. We have never lost a Marine through that program. We are in the process, as our contribution to suicide prevention, of marrying those two pieces together so that appointing will not just be appointing, it will also be a place that people can go to have lifelines. And we are going to build a 24/7 apparatus against that, just like what we operate for the Marine Corps.

Chairman MORAN. Yes, ma'am.

Lieutenant General HOROHO. Senator, if I could just share, actually, a story. You know, we have our call center and our call center is actually for providers and the VA staff, for any questions that they have got. Well, we had a veteran that called the call center, and one of our techs that answered the phone was talking and realized that he seemed very, very stressed, and started engaging him in conversation. During that conversation, he actually shared that he had a plan to kill himself and had the intent to do that. She was able to be decisively engaged with him, got him care, and actually saved a life.

So when we talk about trying to prevent suicides, it truly is a comprehensive touch point. It is that personal connection. It is making sure that everybody that is serving our veterans, or part of community care, understands the personal engagement and understands warning signs of someone who either has mental, physical, spiritual, emotional, or financial stressors, because all of that plays into someone when they start feeling hopeless.

Chairman MORAN. Thank you. In regard to—I appreciate that story and it is—I mean, humans, as we are, we need somebody who loves and cares for us, and it is important. I would ask you to follow up with me about the issue of community mental health centers in Kansas and being in the network.

Finally, and my time has expired as well, but I want to say that our experience—there are 125 hospitals in Kansas. I visited all of them. I do it on an ongoing, continual basis. And I am always touting the Choice program as an option for particularly those rural hospitals to help meet the needs of their veterans. It does not appear to me that many of them know about the MISSION Act. They have had experiences with Choice. Some of them decided not to participate—continue to participate in Choice because of lack of payment, inability.

Mr. McIntyre was very helpful in making sure our hospitals were reimbursed at a Medicare rate sufficient to cover the cost of providing the service, as they are under Medicare, because of the nature and size of their hospital.

But I would encourage greater efforts, by both the VA and the TPAs, to have outreach and convince the provider that it is something that they can afford to do, because they want to do it.

And then, finally, we have discovered, and we need to take this up because I think with our VISN, because VA's outreach is occurring at the state and local level, the local level as compared to the central office, we have lots of veterans who have little information or understanding of MISSION, and it is always the surprising thing. It is a significant role that VSOs play in trying to get information and opportunities understanding to veterans.

This change is something that I still think that many veterans do not know what their options are, within the VA or the VA's referral to the community.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and then what further complicates that situation are the veterans out there that do not use the VA and are not apprised of those services, and, quite frankly, it turns out bad.

I would say this, generally. The person, the employee that did what that employee did needs to be commended, because a lot of folks would have said, "Gee, this is not in my job description, so what the heck." And so I just—when you get people like that, they need to know that they have done a good job, and in a job that oftentimes many of us would not have done. And so I just think that is important.

Dave, I want to talk about providers getting paid. We both know it is a key component. If you are going to have folks in the network they need to get paid in a timely manner. We have both heard concerns in Montana about late payments. Could you explain to me the process for paying ER claims and non-ER claims? Are they the same? And if they are not the same, what is the difference?

Mr. MCINTYRE. Yeah, you bet. Great question, and there is no question about the fact that when you order care from somebody you are supposed to pay for it, right, and on time, and accurately.

We have some challenges between us and VA at the moment around emergency room care and the claims related to that. The claims for emergency room care were directed to come to us as a corporation for the purpose of paying the providers that we have in network, which is a large network across the country, for emergency room care. You can't pay those claims without the actual authorization itself from VA.

And so we and VA are in the process of discussing right now what do we do about this? How do we make sure that those things are going to be properly processed? Those discussions are underway. They are very accelerated. There was a very late-night conversation two nights ago between myself and the COO for that part of the system in VA for an hour. We were looking at options that were viable. What I told VA is I am not sending those back. I am not denying them. We will go red on performance before we will send things back and put the providers in a do—loop on the other side.

So it is important that this ER stuff is getting handled differently than it was historically. I think people were very well intentioned about what they were thinking might make sense, but it is a process piece that needs to catch up so that we can make sure that we get this right.

Senator TESTER. Okay. Thank you. And are you getting everything that you need from the VA, and can you tell me what the problem is and whether the providers—what kind of timeline for improvement?

Mr. MCINTYRE. So in terms of ER?

Senator TESTER. Yeah.

Mr. MCINTYRE. I was very gratified to get a call two nights ago from the senior leadership to say, "Are you available?" And we

were on the phone from 9:30 to 10:30 at night. I know those people personally because we have done a lot of work in the claims processing space over the last couple of years. Dr. Matthews has been directly engaged, as has Dr. Stone, and I am confident, based on our collective track record, that we will figure out the right answer. We will get this line unkinked, and it will not get kinked again.

Senator TESTER. Good, and thank you, and I once again want to thank you, as I did the first panel, about being here. I appreciate you guys' input. As you know, and as we all know, quite frankly, good communication is the key. And if we have good communication and we know what the problems are I think this Committee will work to try to solve them.

Adrian, I appreciate your testimony and I appreciate the fact that we can do better, and I am talking about we, the VA, can do better, with talking to the veteran service organizations to make sure they are meeting the needs. I have said it many times. We take our direction from the veterans, and, quite frankly, we need to pay attention to what they are saying if we are going to meet their needs. And I thank you for being on the panel.

Chairman MORAN. Senator Tester, thank you. We are just about to wrap up. So that Senator Tester does not have the last word I have something more to say. But his comment is the precipitating factor for saying this about veterans who are not in the system.

So our first effort at trying to provide for Kansans who live long distances from a VA hospital, again, a congressional district the size of Illinois, that had no VA hospital, was outpatient clinics. And we were successful in getting these outpatient clinics in lots of places, in a significant number of places, across Kansas.

In my hometown of Hays, the VA opened an outpatient clinic. The VA estimated that 1,200 veterans would access care at that clinic. Within six months, the number was 2,400. And what the difference was is the VA estimated how many veterans in northwest Kansas are driving to Wichita to access care, who will now stop in Hays, which is 2 ° hours closer than Wichita, to where many of them live, and access care through the outpatient clinic.

What was not taken into account were the veterans who were accessing care nowhere. And so the VA—we, as a committee, you, as third-party administrators—have a significant—I would add the VSOs have a significant opportunity here to make sure that fewer and fewer people are in that category of getting care nowhere. And so I offer to you and to the VA and to all the VSOs our help in trying to make sure we get the opportunity available to people who otherwise receive no service from the VA, but are entitled, are eligible.

So it is a constant effort. And again, I have been surprised my entire time in dealing, in having relationships with veterans, how many of them do not know what they are eligible and entitled to do.

Mr. MCINTYRE. Sir, as you work the question of education, and everybody else works that at your side, what I would say is the way we collectively approached urgent care and the construction of that is exactly the way you need to construct the network backbone, whether it is direct system or whether it is purchased on the outside.

And what we did is we took a set of mapping tools, and we looked at demand ratios. We looked at the actual address of a veteran, and we looked at the footprint of where the locations were for providers. And then by ratio we developed what we felt like the network footprint needed to look like for urgent care.

Today, more than 90 percent of veterans have access to urgent care within 30 minutes of their house. That was the requirement. And so that is the same approach we have taken to refine the current network, and the approach that we are going to be taking to the core network.

And I believe, listening to General Horoho talk about the approach that they are taking to try and assess and figure out what the need ultimately is going to look like in the territory that they are walking into, that she will arrive at a place that is similar to where we are. We have a little bit of an advance run because we have been at this the hard way for the last six years, and we and VA, have assessed what that demand profile looks like, where the locations are, what kinds of gaps there are, and we are going to have that at the core of how we are doing network construction for Region 4.

Chairman MORAN. General Horoho, just like I cannot let Senator Tester have the last word, I give you the opportunity to make sure that Mr. McIntyre does not either.

Lieutenant General HOROHO. Thank you, Mr. Chairman. Probably the happiest I have been all day.

[Laughter.]

Lieutenant General HOROHO. What you raise is such a critical issue, and I just want to raise it up a little bit to a higher level.

So about a year and a half ago we looked at doing an executive development program, and one of the ideas that we looked at was individuals that are dual eligible for insurance, right, that are getting commercial insurance but are also eligible for VA and disabilities, and they do not even know they are.

And so we actually put together a program and looked at it, and one of the things that we found is we fail within the commercial sector to ask someone, "Are you a veteran? Have you served?" Because when you do that it changes the conversation in how you provide care.

The second thing, and probably one of the most powerful stories that we shared across our company, is one individual, an Air Force veteran, in his 70s, had never ever applied for disability, did not even know what his opportunities were. We talked with him. They connected him with the VA. He went through the process. He ended up being able to get medication that he could not afford when he did not have his disability, and actually him and his wife made a decision who was going to get medication. He got the medication that went from $400-something a month down to about $4 a month, and he realized that he had the eligibility for burial and insurance.

It completely changed their lives at the age of 70, and I think that is an example, when we talk of this shadow population that has given so much to our country, and they have not tapped into all that they are eligible for.

Chairman MORAN. General Horoho, thank you very much for that example. It is something that I do not know that I had thought about, is the relationship that we—too often we separate disability and health care into two separate components, and the two are, in my mind, in people's minds, unrelated. But there is a huge connection between your disability and your health care well being. So I appreciate that.

Mr. Atizado, one of the things that I take from this hearing is in this outreach the importance of making certain that veterans understand this is not just promoting community care. This is about promoting what is in the best interest of the veteran, that he or she, a decision he or she and their health care provider at the VA make, and the idea that we are not talking about that you are eligible. If we are not talking about that you are eligible for care to continue within the VA, without a referral outside that is a significant error on our part.

And I will work on my communication skills so that we make certain that the options are available, not to be decided by the person who is providing the information but by the veteran and his health care provider determining what is in their best interest, as the MISSION Act requires.

Senator TESTER. Not to let you get the last word in, but part of this—I mean, it is really a good point, and once again thanks for being here, the folks from the VA, because you could have a person that is scheduling these appointments, that says it is a hell of a lot easier to throw them in the community and then I really do not have to worry about them anymore. So this is really an important point to be addressing here today.

And so I just wanted, once again, Mr. Chairman, thank you for your good looks and your leadership.

Chairman Moran. You are using credibility.

[Laughter.]

Chairman MORAN. And a point to follow that is Dr. Stone talking about incentives about referrals. That is, again, something I think is very important, the idea that budgetarily there may be an incentive to send somebody so that it is somebody else's problem, not how it gets paid.

I will conclude. I would ask the witnesses, is there anything that you want to make sure that is on the record? Do you want to say anything, correct anything, something that we failed to ask that would be of value to this hearing?

If not, we are going to conclude the hearing. Members have five days in which to submit additional statements or questions for the record, and we would appreciate your prompt response to those questions.

With that, the hearing is adjourned.

[Whereupon, at 11:59 a.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

United States Senator *for* Kansas

JERRY MORAN

VA MISSION Act: Update on the Community Care Network Implementation

Opening Remarks of U.S. Senator Jerry Moran (R-Kan.)

Wednesday, February 5, 2020 | 9:30 a.m.

As Prepared for Delivery:

Thank you, Dr. Stone, to you and your team for joining us on today's first panel. I would also like to thank the witnesses on the second panel for being with us today.

The delivery of quality and timely health care to veterans has always been a top priority for me. When our service members leave the military, it is our duty to make sure they receive the care they deserve.

Congress enacted the MISSION Act to transform VA health care into an innovative and responsive 21st-century health care system capable of addressing the challenges veterans face today.

Our hearing today will focus on the VA's efforts to deploy the Community Care Network. This network is central to the MISSION's Veterans Community Care Program.

Kansas' Big First Congressional District is as large as the State of Illinois, but lacks a VA Medical Center. For veterans in rural areas in my state, MISSION's Community Care Network is essential for timely healthcare.

The VA recently completed Region 1 deployment of the Network and the first four regions – representing the lower 48 states – are scheduled to be completed by the end of the year.

This committee has concerns about how the VA is building out the network and its ability to meet veteran demand. Under MISSION's expanded eligibility requirements, the number of patients seeking outside care is supposed to increase from 648,000 to 3.7 million.

A recent VA OIG report predicts wait times could worsen once MISSION is in full effect. This is in addition to reports that the VA is still struggling with scheduling delays and paying community providers on time.

We must take the opportunity to learn from Region 1 and have honest conversations about difficulties that could threaten the network ***well before*** it is fully deployed. We owe it to veterans to get MISSION right the first time.

I now turn to the Ranking Member, Senator Tester, for his opening statement.

Statement of Senator Bernie Sanders
Senate Veterans' Affairs Committee Hearing – Update on Implementation of Community Care
February 5, 2020

Chairman Moran, Ranking Member Tester – Thank you for holding today's hearing. The issue of the VA's implementation of community care under the MISSION Act is incredibly important. I have heard from anumber of Vermont veterans who have been impacted by VA's contract with Optum – which is responsible for coordinating private sector care in VISN 1 – and I would guess that every one of my colleagues on this committee has had the same experience.

Because the VA medical center in my home state of Vermont was the first-in-the-nation rural hospital to pilot the Community Care Network, Vermont veterans have experienced more than their fair share of difficulties with this program. When I voted against the MISSION Act, I did so because I feared it was yet another step in the steady march toward the privatization of the VA. I worried about what would happenwhen we put a profiteering corporation like Optum between veterans and the care they needed. I had truly hoped I would be wrong. But unfortunately, from what I've seen and heard from veterans, I was right.

In Vermont, our veterans are struggling to get care in areas where we don't have in-house VA services, like dental care and home health services. In many of these cases, Optum has failed to offer reasonable rates, meaning private sector providers are refusing to sign up. My staff have spoken with dentists who are choosing to provide free care to veterans, rather than accept Optum's rates, which fall far below theirbreak-even. And, because the definition VA agreed to when it came to an "adequate network" is so poor that Veterans are being forced to drive hours for care that they used to get much closer to home. In one instance, a veteran was told to drive two-and-a-half hours to see a dental specialist out of state. In this instance, because the White River Junction VA Medical Center has not been allowed to expand their services to include dental care – something that was approved back in 2014 and then rescinded – this veteran has no choice but to drive the five-hour round trip for care or go without. I have long advocated for every state to have at least one clinic or medical center offer on-site dental care. The MISSION Act hasn't made that unnecessary. It has, infact, made it even more critical.

Another particularly troubling issue for Vermont veterans has been accessing home health care services. Earlier this month, over 80 veterans were nearly kicked off critical home health services. After thedogged hard work of my staff, along with local officials, it was determined that there was an error made in the rate schedule approved for VISN 1. And while that problem was identified nearly three weeks ago, it's my understanding as I sit here today that the corrected rate has still yet to be approved. But all the blame here doesnot lay with VA. And that's because Optum could have chosen to negotiate fair rates with these home care providers, even if those rateswere above VA's rate. To my mind, it is high time that Optum be held responsible for their role in putting veterans' health at risk and correct these dangerous mistakes.

As we talk with the witnesses before us today, I ask my colleagues on this committee to really question whether private sector is the solutionfor our veterans. Study after study have made it clear that VA care is as good or better than the private sector. We also know VA care is often less expensive than private sector care and far, far better coordinated. And, maybe even more importantly, it has been shown that the overwhelming majority of private sector providers are *not prepared* and *not interested* in caring for veterans.

I also believe this committee has got to do a better job of understanding VHA's budget. This may come as a surprise to some of you, but Secretary Wilkie and the Trump Administration are not being honest with this committee. They are not being honest with our veterans, the Veterans Service Organizations, or with the American people. VHA is struggling. They don't have sufficient funding to provide the care and benefits that they're required to under the law. MISSION Act costs are higher than they predicted. Prescription drug costs are increasing by 15 to 20 percent each year – even with VA's mandatory discount – while funding for prescription medications has only increased by three percent. And staff vacancies are going unfilledbecause VA can't compete with private sector salaries and hiring timelines. And in some cases, these positions are left unfilled as a wayto save money. Of course, this further exacerbates wait-times within VA and causes more veterans to be sent to private sector providers forcare.

We have to ask what VA doing about this? It wasn't all that long ago that I was Chairman of this committee. During that time, when VA hadan unexpected expense, they came to Congress and requested supplemental funding. So, is VA coming to Congress now to request more funding? No, they are not. Instead, they are telling hospitals, primary care sites, and mental health providers to do more with less.

These budget shortfalls cannot – and must not – continue.

So, while I look forward to hearing from the witnesses today and hope they are able to answer our questions, I also want to challenge this committee to put politics aside and do what's right by our veterans. Let us work together to deal with the fact that isn't about who pays the bill.
It's about who provides the care. We have got to say that if we are truly committed to caring for our veterans, the best way to do that is toinvest in the VA, not dismantle it bit by bit.
Thank you.

STATEMENT OF
RICHARD A. STONE, M.D.
EXECUTIVE IN CHARGE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

February 5, 2020

Good morning, Chairman Moran, Ranking Member Tester, and Members of the Committee. I appreciate the opportunity to discuss the continued success in implementing 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, VHA's MISSION Act Lead.

Introduction

This is a time of transformative change at VA. MISSION Act implementation is succeeding and has become part of our core business. We are now in a phase of proactive refinement and enhancement. We have moved beyond planning for individual sections and are strategically knitting together the tools you've given us into a future vision for the organization. As we have demonstrated this year, we will lead the U.S. healthcare industry forward. You will see us focus and lead on modernizing our operations, bringing us in line with industry standards in key areas like claims processing and referrals. Alongside our Department of Defense and Department of Health and Human Services partners, we intend to lead the industry in quality, health

information exchange, opioid safety, and ultimately care coordination powered by a joint electronic health record.

And importantly, you will see us lead in meeting Veterans where they are, including in rural areas. We have launched an effort to synergize and augment the range of solutions available to Veterans in these areas, including mobile care teams, telehealth, and the expanded reach of our new community care program. We are building a cohesive strategy that will deliver care for Veterans no matter where they choose to live or seek the care they need.

As your staff have seen, we now leverage VA's first-ever Joint Operations Center to operationalize this type of enterprise strategy - viewing enterprise data and monitoring risks and opportunities across the nation. Business intelligence is driving decisions like never before and, as we have demonstrated this year, business intelligence is centered on an excellent experience of care for Veterans, their families, and the important people in their lives.

Community Care

On June 6, 2019, we successfully launched the new Veterans Community Care Program, a cornerstone of the MISSION Act. Expanded eligibility criteria, improvements to processes and technologies, and a growing network of community providers are just some of the ways that the MISSION Act has improved the options that Veterans have to address their health care needs. Since the launch, VA has placed more than 3.6 million referrals and authorized more than 3.85 million episodes of care. In these early referral patterns, it appears Veterans have improved access to specialty care. Eligibility criteria ensure that the clinical needs of the Veteran are accounted for

and, when appropriate, that a Veteran can work closely with his or her provider to choose the best setting and clinician in his or her best medical interest.

Since implementation, VA has been developing and deploying improvements to the new Veterans Community Care Program that improve the experience of Veterans, community providers, and VA staff. VA is modernizing its information technology (IT) systems to replace a patchwork of old technology and manual processes that slowed down the administration and delivery of community care. Once fully implemented, the new IT systems will speed up all aspects of community care—eligibility, authorizations, appointments, care coordination, claims, payments—while improving overall communication between Veterans, community providers, and VA employees.

We intend to continue this trajectory and make ourselves the most accessible and convenient health care system in history. You have given us the tools to do so. The new streamlined community care program is easier for Veterans and their families to navigate, and our network of more than 880,000 providers, which complements care delivered through VA facilities and by telehealth, provides an unprecedented range of options. VA remains committed to strengthening the VA health care system, expanding access, and pushing the boundaries of what is possible in serving our Nation's Veterans.

Caregiver Program

The Caregiver Support Program's shoulder-to-shoulder partnership with VA's IT colleagues has realized the successful launch of a replacement IT solution, termed the Caregiver Record Management Application (CARMA). This solution supports the administrative needs of the Program of Comprehensive Assistance for Family

Caregivers (PCAFC); the Program of General Caregiver Support Services (PGCSS); and the Caregiver Support Line. The initial phase CARMA was successfully released in October 2019, with a follow up release in December to transition the remaining functionality from the former system to CARMA. Further functionality enhancement to CARMA in Fiscal Year (FY) 2020 will prepare the program for expansion - automating stipend payments, improving functionality that supports PCAFC processes, and solidifying integrations with key VA systems.

In support of achieving the goals of program stabilization and expansion predicated by the MISSION Act, a strategic and expedited staffing plan was initiated to ensure a strong foundational infrastructure on which to expand the program. By August 2019, over 680 positions had been approved for hire. This hiring phase included establishing facility staff such as program coordinators in the field for both PCAFC and PGCSS, as well as establishing Veterans Integrated Service Network (VISN) Leads and VISN Clinical Eligibility and Appeals teams. By the end of December 2019, 40 percent of those positions had already been filled. Completion of full staffing is targeted to occur in time for program expansion in the Summer of 2020.

Urgent Care Benefit

VA has also implemented a robust contracted network of urgent care providers that is a great new benefit for enrolled Veterans who need immediate care for minor injuries and illnesses. As of January 2020, more than 6,400 urgent care centers have joined VA's urgent care network, which is currently managed by TriWest. About 90 percent of the country's Veterans eligible for the urgent care benefit are now covered by a network urgent care provider, and since June of 2019, they have provided care to

Veterans in more than 160,000 visits.

"Anywhere to Anywhere" Telehealth

Another aspect of VA's advancement under the MISSION Act is in telehealth. We can now bring provider expertise across state lines and into Veterans' homes – meeting them where they are. VA recently announced the delivery of telehealth services to more than 900,000 Veterans over 2.6 million episodes of care in FY 2019 – an increase of 17 percent over the previous year. This is extraordinary progress toward giving Veterans more convenient care options without traveling to their provider's office. By the end of FY 2020, all primary care and mental health providers will be able to deliver care to patients, both in-person and via a mobile or Web-based device.

Use of VA Video Connect, which connects Veterans to their care teams through secure video sessions, increased by 235 percent in FY 2019. More than 99,000 Veterans used the app at home, eliminating a trip to the nearest VA facility. More than 200,000 or approximately two-thirds of the 294,000 VA Video Connect appointments in FY 2019 were for telemental health visits.

In October 2019, we also launched ATLAS (Accessing Telehealth through Local Areas Stations) in Eureka, Montana, to provide timely care for Veterans who live long distances from VA medical centers or have poor Internet connectivity at home. Additional locations are scheduled to open as pilot sites in select American Legion posts, Veterans of Foreign Wars posts, and Walmart stores.

New Scholarship Program

In concert with the aforementioned MISSION Act-related achievements, VA has launched a new scholarship pilot program for Veterans pursuing a medical education through a growing number of participating institutions. The program will help VA recruit the best talent to our ranks by providing scholarship funding in exchange for a commitment to practice with VA for 4 years.

In 2020, this program will welcome 18 Veteran medical students at nine universities across the country. In the coming years, we will also expand our education debt reduction program and roll out new scholarships for other health professionals who aspire to serve the Veteran community. This will continue VA's storied history in training the Nation's medical professionals.

Veteran Experience

VHA captures real time Veteran Experience data through a series of electronic surveys sent to Veterans after their appointments. The VHA Outpatient survey was first deployed in 2017. VHA Trust score was at 86 percent in FY 2017 and has risen to 88 percent in FY 2019. Similarly, the Telehealth Trust Score for FY 2019 was 83 percent, with 91 percent in the Home Telehealth Program. This indicates successful efforts to meet Veterans where they are and provide convenience and safety at home.

Conclusion

In conclusion, we knew when we began implementing the MISSION Act of 2018 that we had the potential to make an enormous positive impact for Veterans. More than six months later, we know that is the case – with the new tools you have provided us, VA is helping more Veterans access the care and services they need. We will continue to work to improve Veterans' access to timely, high-quality care in VA facilities and by

virtual means, augmenting this with excellent choices through our robust network of community partners.

I am proud of the future we are building on behalf of Veterans and their families, and this Committee's continued support is essential to ensure it is realized. Mr. Chairman, this concludes my statement. My colleagues and I are prepared to answer any questions you may have.

January 2020
Department of Veterans Affairs

VA Testimony Summary

- Since the launch of the new Veterans Community Care Program, VA has placed more than 3.6 million referrals and authorized more than 3.85 million episodes of care.
- VA is modernizing its information technology systems to replace a patchwork of old technology and manual processes that slowed down the administration and delivery of community care.
- As of August 2019, the Caregiver Support Program had approved 680 positions for hire and by the end of December 2019, 40 percent of those positions had already been filled.
- Completion of full staffing is targeted to occur in time for program expansion in the Summer of 2020.
- As of January 2020, more than 6,400 urgent care centers have joined VA's urgent care network, which is currently managed by TriWest.
- About 90 percent of the country's veterans eligible for the urgent care benefit are now covered by a network urgent care provider, and since June of 2019, they have provided care to Veterans in more than 160,000 visits.
- VA recently announced the delivery of telehealth services to more than 900,000 veterans over 2.6 million episodes of care in FY 2019 – an increase of 17 percent over the previous year.
- By the end of FY 2020, all primary care and mental health providers will be able to deliver care to patients, both in-person and via a mobile or Web-based device.
- VA Video Connect usage increased by 235 percent in FY 2019. More than 99,000 veterans used the app at home, eliminating a trip to the nearest VA facility. More than 200,000 or approximately two-thirds of the 294,000 VA Video Connect appointments in FY 2019 were for telemental health visits.
- In 2020, the new VA scholarship program inducted 18 veteran medical students at nine universities. VA hopes to expand the education debt reduction program and roll out new scholarships for other health professionals who aspire to serve the veteran community.
- The VHA Trust score has risen from 86 percent in FY 2017 to 88 percent in FY 2019. Similary, the Telehealth Trust Score for FY was 83 percent, with 91 percent in the Home Telehealth Program.



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STATEMENT OF
ADRIAN ATIZADO
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
FEBRUARY 5, 2020

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 veteran's 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.

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[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.

DAV Testimony Summary

- DAV applauds the implementation of VA urgent care benefits and notes that TriWest is approaching their maximum achievable goal of 92 percent of veterans to have access to urgent care or retail clinic, if one exists, within a 30-minute drive.
- VA has not provided information on the timing for the transition of urgent care responsibilities for regions 2 and 3. Region 1 will transition from TriWest to Optum in March, 2020.
- VA has yet to provide regulations on how the Department is to "ensure adequate coverage" as required by Senate Report 115-212.
- DAV opposes VA's decision to charge urgent care co-payments to service-connected veterans, who are generally not required to pay copayments under other VA health care programs.
- DAV urges VA to provide positive rather than punitive incentives for appropriate health behavior from veteran patients.
- DAV recommends establishing a national nurse advice line to curtail overreliance on costly emergency room care.
- DAV recommends VA assess its telehealth program to determine the feasibility of providing virtual urgent care services.
- DAV continues to receive requests for assistance from non-VA providers due to delayed or no payments which generally stem from the various types of care authorizations, delays with internal VA processing and use of improper procedures.
- DAV remains 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.
- DAV is concerned VA is not properly staffing its facilities to take on new and critically important responsibilities.
- DAV urges VA and the 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.

Written Testimony of
Lt. Gen. Patricia D. Horoho, USA, Retired
Chief Executive Officer, OptumServe
Before the United States Senate
Committee on Veterans' Affairs
February 5, 2020

Introduction

Chairman Moran, Ranking Member Tester, and members of the Committee, I am Patty Horoho, Chief Executive Officer of OptumServe, and I am honored to be here today to discuss our role in the implementation of the U.S. Department of Veterans Affairs (VA) Community Care Network in Regions 1, 2, and 3.

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

Who We Serve: Our Deep Partnership with Veterans and Federal Agencies

Our Company is focused on working across the health care system to deliver the Quadruple Aim – improving patient satisfaction, lowering health care costs, delivering quality outcomes and improving the patient and provider experience.

OptumServe is the federal health services business of UnitedHealth Group. We bring together the unique capabilities of the entire Company with broad and deep experience in health care services, technology, data analytics and consulting. We partner with the U.S. Departments of Veterans Affairs, Defense, Health & Human Services, and other agencies to help modernize the U.S. health system, and improve the health and well-being of those they serve.

Optum and UnitedHealth Group more broadly have long histories of partnering with the federal government to help accomplish their missions to serve and meet the health care needs of the American people. This includes serving individuals in our armed forces, their families, and Veterans.

OptumServe is honored to support health programs that touch virtually every point in a military service member's or Veteran's journey. It starts when an American son or daughter raises their right hand to take the oath, to ensuring a reservist is medically ready for deployment, to a disability exam when a service member transitions from

active duty to Veteran status, and, now, to the Veteran receiving care through the VA from a community provider.

Our leadership team at OptumServe is comprised of Veterans from every branch of service, and 50% of our Community Care program office staff are Veterans. Early on, we recognized the need to incorporate the voice of the Veteran to ensure we were well-positioned to meet their needs. One year before we were awarded these contracts, we conducted one-on-one interviews with 125 Veterans in their homes and places of work across five states, and completed a national survey of 5,500 Veterans, representative of the Veteran population. This enabled us to gain a deeper understanding of the experience and mindset of Veterans, and how Veteran status impacts health and health-seeking behaviors. Our commitment is also demonstrated not only by meeting our contractual requirements, but also through developing a deep partnership and strong relationship with the VA.

Optum's Role in the VA Community Care Network

Optum is proud to serve as the third-party administrator (TPA) for the VA Community Care Network in Regions 1, 2 and 3, which includes 36 states, the District of Columbia, the U.S. Virgin Islands and Puerto Rico.



VA Community Care Network Regions Where Optum is the TPA

Under these contracts, Optum is responsible for:

- **Community care network of providers.** Optum is leveraging its broad network and relationships across UnitedHealth Group, and beyond, to provide a robust provider network representing the full breadth of health and wellness services for the VA. We build upon this foundation by contracting with preferred providers

requested by our partners within the VA as well as providers who reach out to us directly informing us of their desire to serve the Veteran population.

- **Claims processing.** Optum is responsible to promptly processes claims from providers who care for Veterans as part of the VA Community Care Network. This function is critical to ensure we sustain the high quality provider network we are building.
- **Call center for VA staff and providers.** VA staff and providers can contact the Optum call center to get questions answered about authorizations, claims and other issues.
- **A portal for providers, VA staff and Veterans.** Optum operates an online portal where users can find additional resources including claims and referral information. Individuals can access the portal at www.vacommunitycare.com. Our portal is uniquely built for our users' needs, outlined in the chart below:

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

- **Community Care Experience Teams.** These Optum teams provide on-the-ground support and resources to VA Medical Centers and staff. One team is aligned to each region, and each has a team leader, a nurse, a business analyst and one Veteran Experience Officer (VEO) aligned to each Veteran Integrated Service Network (VISN) within the region. While not a requirement, these teams allow Optum to remain better connected with local VISN and VAMC leadership, and each of the VAMC community care offices in order to better meet the needs of the VA at the local level.

We have spent considerable time with our VA partners and within Optum to better understand the processes and potential areas of the Veteran experience that could be improved. Through a process that identifies each step of the Veteran's experience (called journey mapping), we gained valuable insights into the process of getting care, how the process could work better for Veterans, VA staff and community providers. We have used those insights to prioritize and take action. This is critically important because the experience a Veteran has while seeking and receiving care is often perceived to be as important as the quality of the care they receive. From the very first

contact, the experience of care has to be positive, both for our Veterans and for providers.

Performance to Date: Meeting & Exceeding Our Commitments

Optum is on track with our phased implementation plan. We completed the initial roll-out of Region 1 on December 10, 2019, and today we are currently operating the Community Care Network and billing operations in areas across all three regions. We are on schedule to achieve full health care delivery in all regions by June 2020.[1]

At every stage of our year-long implementation, we have dedicated staff either on the ground, virtually or both, to train and assist VA Medical Center staff as questions arise. We also use a command center approach in close collaboration with the VA to monitor the progress of each deployment. The command center allows Optum and the VA to jointly ensure consistent and frequent communication with the VAMC sites, manage issues, and provide continued education and feedback to ensure the system tools and provider network are performing as intended, often making necessary adjustments in real time.

The transition for each area to Optum as the TPA is deliberate and collaborative, with open lines of communication from the leadership level to local VAMC employees:

- Deployment preparation consists of twice monthly meetings with the VA Office of Community Care and the transitioning sites to ensure site-level and Optum provider network readiness. This includes reviewing detailed maps and analysis down to the county and zip code level, consulting with historical referral data and past volume to identify future network needs;
- Approximately 45 days prior to a go-live date, we have initial planning meetings with VAMC leadership. The network is reviewed again and validated, and issues or gaps in network are discussed;
- Approximately 14 days from the go-live date, our advance parties increase the intensity of training and communications. Network progress is reviewed with VA;
- During the go-live week, we host a joint command center in partnership with the VA that monitors progress in real time, and we also provide site-level support teams consisting of both Optum and VA staff at the local level. We provide additional coaching and retraining of VA staff on handling referrals as needed; and,
- At the end of the go-live week, we provide formal exit briefs for each of the VISN's and then provide ongoing supplemental support, including frequent touchpoints with the sites to ensure each VAMC is able to successfully transition to CCN and operate independently.

[1] A full deployment schedule can be found on Optum's Community Care Network portal at www.vacommunitycare.com.

But our work doesn't stop after Optum fully deploys in an area or region. We're not done. Working with local VA staff and providers, we continue to refine operations, and add providers to the network.

With this, I would highlight a few specific area of our transition to date:

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

Central to the Community Care Network is a robust network of quality credentialed health care providers from which VA medical staff and Veterans are able to choose.

While we start with the UnitedHealthcare, Optum, CVS Caremark, and other networks we have deep relationships with today, our network strategy does not end there. We also work closely with our VA partners and others to identify those community providers who have a history of working closely with VA Medical Centers and Veterans in order to give these providers an opportunity to continue to care for Veterans in their community by joining our new network. We are committed to including qualified providers in our network who want to see Veterans.

Our on-boarding process for providers helps to ensure that VA CCN providers are both competent and qualified to provide the services within their practice specialty. All providers in the Community Care Network are credentialed in accordance with nationally recognized standards set forth by the National Committee for Quality Assurance (NCQA), or the appropriate accrediting body, or credentialed consistent with Federal or State regulations. We also obtain primary-source verification of the provider's education, board certification, license, professional background, malpractice history and other pertinent data.

In Region 1 where we have recently completed the transition, Optum has built a network that includes more than 166,000 health systems and providers[2] across more than 235,000 care sites.[3]

As I mentioned earlier, we recognize that network management is a dynamic process and networks evolve over time. When we complete a transition, our work continues, and we continuously refine and build the network to meet the needs of the VA and Veterans. We add providers based on data, analytics, and interest of providers who want to be involved in Veterans' care. For instance, even though we have fully deployed in Region 1, we continue to add new providers, which has resulted in a 10% increase in providers since the December transition. This will continue in every area where we operate.

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

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[2] "Health systems and providers" is a count of unique National Provider Identification (NPI) numbers that includes an individual physician practice, a hospital system, or a group of affiliated practices that may operate one or multiple sites of care.

[3] Data extracted on 1/28/2020.

In addition to delivering a high-quality provider network, we also recognize the need to implement a world-class experience for community providers. Central to achieving this goal is ensuring providers receive accurate, prompt payment for the health services they deliver. This is critical to the success of our network.

With our contract partners, we have built a system that is easy to use and familiar to provider practices. By reducing administrative burdens, we are making it easier for providers to get paid accurately, and on time. Simply put, after a provider cares for a Veteran, they bill Optum, and Optum pays the bill.

As of January 30, Optum has processed more than 140,000 claims, and has paid claims in an average of 11.8 days.

Beyond the data, providers have been expressing appreciation for making the billing and payment system easy to use to quickly get paid for the services they provide. And when issues do arise, as they do with any new program, we work closely with providers to quickly resolve these issues.

- ***Communicating with Providers With Clear, Actionable Information***

Optum utilizes a number of different channels to communicate with providers. It begins during the initial contracting phase, and it is sustained once they are a confirmed network provider. Key touchpoints include, among others:

- Sending letters to providers currently in the UnitedHealthcare and Optum networks on the opportunity to participate in the Community Care Network and action necessary.
- Calls and letters to providers not already participating with UnitedHealthcare or Optum with opportunity to participate in the Community Care Network and action necessary.
- Calls, letters, in person meetings for targeted health systems and providers with large footprints in local and regional areas.
- Personally reaching out through letters, calls and meetings with providers identified by VA and others as high-priority to recruit into the Community Care Network.
- Following recruitment and credentialing, we provide a number of trainings on how the new Community Care Network works. This is done through in-person meetings, webinars, provider expos and virtual town halls.
- Regular updates, educational material and on-demand videos are also available on our provider portal at www.vacommunitycare.com.

And, if providers have a concern that needs to be address, our goal is to provide a resolution as quickly as possible through our customer service channels, mentioned in the next section.

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

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

Through January 29, we have received more than 33,000 calls to our customer service center, with an average speed to answer of 3.65 seconds and 99% of calls are answered within 30 seconds. And, our customer service staff has resolved more than 99% of issues from providers and VA staff during the first call.

We will continue to focus on providing quality customer service to providers and VA staff who need assistance.

Conclusion

We appreciate the opportunity to address the Committee today to outline Optum's role in assisting the VA with its mission to provide world-class health care to our nation's Veterans.

We also appreciate the leadership of this Committee, the Congress, and the VA, in envisioning a program that provides a phased approach to implementation in order to ensure a successful transition for VA staff, contractors, providers, and most importantly, our nation's Veterans. We understand that health care is local and this phased approach enables us to work closely with the VA, VA Medical Centers, and others to deploy our network and capabilities, and ensures success based on the readiness of particular sites, while accounting for relevant local factors.

Leading our collaborative efforts to care for our nation's Veterans is the privilege and responsibility of a lifetime. As a Veteran; retired Soldier; former Army Surgeon General and Commanding General of the U.S. Army Medical Command; wife of a Veteran: daughter of a Veteran who served honorably in World War II, Korea and Vietnam; and now the proud mother of an Army Infantry Airborne Officer; I assure you we are fully committed to the success of the VA Community Care Network and OptumServe's role in ensuring access to care for our nation's Veterans. We are vested in this mission and know that mission failure is not an option.

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

Optum Testimony Summary

- Optum is serving as a third-party administrator for the VA Community Care Network in Regions 1, 2 and 3, which includes 36 states, the District of Columbia, and the U.S. Virgin Islands and Puerto Rico.
- Under contract, Optum is responsible for community care network of providers, claims processing, call center for VA staff and providers, a portal for providers, VA staff and veterans, and community care experience teams.
- Optum is on track with its phased implementation plan, completing the initial roll out of Region 1 on December 10, 2019, and to date they are currently operating the Community Care Network and billing operations in areas across all three regions. Optum is on course to delivering full health care in all region by June 2020.
- In Region 1, Optum has built a network that includes more than 166,000 health systems and providers across more than 235,000 care sites.
- As of January 30, Optum has processed more than 140,000 claims and has paid claims in an average of 11.8 days.
- As of January 29, Optum has received more than 33,000 calls to their customer service center, with an average speed to answer of 3.65 seconds and 99% of calls are answered with 30 seconds, and staff have resolved more than 99% of issues from providers and VA staff during the first call.

Written Testimony
Mr. David J. McIntyre, Jr.
President and CEO of TriWest Healthcare Alliance
Hearing of the Senate Committee on Veterans Affairs
February 5, 2020

Introduction

Chairman Moran, Ranking Member Tester and Distinguished Members of the Committee, it is a privilege to appear before you today as a partner to the Department of Veterans Affairs (VA) for the past 6+ years, working every day to ensure VA has the elasticity in the community to meet the health care needs of Veterans. For all of us associated with TriWest Healthcare Alliance, from our company's non-profit health plan and university health care system owners to our nearly 3,500 employees, many of whom are Veterans or Veteran family members, it is an honor to appear before you and to be engaged in this critical work so that VA might effectively execute the government's commitment to this nation's heroes. We are proud to have earned the opportunity to continue that vital support of VA in 2020 and beyond under the Community Care Network (CCN) contract for Region 4. We appreciate the opportunity to provide a detailed update on our progress partnering with VA to implement CCN in Region 4, as well as our ongoing efforts to meet the current needs of Veterans through our existing Patient-Centered Community Care (PC3) contract and our support of the transition of VA facilities to VA's new partner for CCN Regions 1, 2 and 3.

Thank you for your leadership and complete engagement in making sure we all are focused on the right objectives and are sufficiently stretching ourselves to accomplish that which needs to be done to help reset VA for this generation and the next. It is work worthy of nothing but our very best, and we consider ourselves very fortunate to be a part of the team, led by VA, delivering on this vital mission every day. That team involves dedicated health care providers from both VA and the community, all working together in support of our Nation's heroes!

While we find ourselves at yet another point of transition this year – to the new CCN regions – a transition that will take some time to get right, I would submit that much is moving in the right direction and the system of care that will ultimately exist for all Veterans under the MISSION Act is starting to emerge as we gather here today.

To make my point, I would like to highlight the experiences of two Veterans with whom we recently engaged to demonstrate how this system of care can work well for Veterans using VA. Last summer, one of my staff met a Veteran from Kansas while meeting with Legionnaires at the American Legion National Convention in Indianapolis – a group I was honored to personally address. This Veteran has suffered from severe back pain as a result of a service-related injury and had been dependent on opioid pain medications for over a decade. He had tried several different options to lessen his dependency on these medications, but it wasn't until an encounter with an acupuncturist while on a vacation that he found success in addressing the pain. The Veteran returned to his VA Medical Center and asked about receiving acupuncture through VA and was told that he could be referred out into the community for this treatment. The Veteran

shared that he has since been off ALL opioid pain medications and continues to receive occasional acupuncture treatments. The strongest medication this Veteran now takes for pain is Ibuprofen.

Another example of the effective "team based" effort to serve the needs of Veterans was conveyed to me by a female Veteran who hails from the Phoenix area. Like so many, she epitomizes the greatness of our country and the men and women who wear the uniform. Her father served in the Army and she stated that she was honored to follow in his footsteps. When she came home from her service in Afghanistan, however, she faced many critical health care challenges such as PTSD and Lupus. She proclaimed that "VA saved my life," and that her team of providers, from VA and the community, are doing an effective job of collaborating to keep her as healthy as she can possibly be. This dedicated Veteran-centric partnership, between VA and community health care professionals, is the heart and soul of the work in which we are all engaged under the VA MISSION Act.

Veterans need a robust VA system of care that includes community care options when necessary. Our role at TriWest is not to replace VA, but rather to strengthen VA and ensure that VA and Veterans are always at the core. Our responsibility is to help strengthen VA by providing it with effective elasticity to ensure that Veteran's health care needs can be met on a convenient and timely basis. We are not here to privatize VA!

History of Service to Veterans and Service Members

To best understand the nature of our work and the lessons learned regarding community care, I would like to share with you some background on TriWest's history of service to America's military and Veterans communities. If we are going to understand where we are going and improve health care services for Veterans, we must understand where we have been, what has worked and what must be improved.

TriWest Healthcare Alliance has been privileged to be engaged in the important work of providing Veterans and military beneficiaries with community care services since being awarded its first contract on June 27, 1996. Our first 18 years were spent helping the Department of Defense stand-up, operate and mature the now very successful TRICARE program. Some would say that was simply to prepare us to effectively come to the side of VA for a moment such as this… prepared to be a full partner at VA's side as it sought to effectively meet the needs of those who would come to the doorstep of VA after serving in defense of our Nation at home and abroad. In our book, there is no greater privilege than to be doing our part as grateful citizens during this moment.

Supporting VA Community Care Needs Since 2013

In September 2013, VA selected TriWest as the Patient-Centered Community Care (PC3) Third-Party Administrator (TPA) to support VA community care needs in about half of the country… three PC3 regions encompassing all or parts of 28 states and the Pacific. TriWest rose to the occasion by leveraging our existing networks and strong relationships already in place due to our prior work under the TRICARE program.

In April 2014, just a few short months after we had started that work, the wait list crisis was discovered in our hometown of Phoenix. Congress recognized that the problem was

national in scope and further reform was needed to meet Veteran health care needs. This led to enactment of the Veterans Access, Choice and Accountability Act (VACAA), which included the Veterans Choice Program. Congress gave VA 90 days to stand up the program, and VA asked us to assist them in doing so. We worked diligently with VA to implement the Choice Program, and then with VA and Congress to refine it.

Over a period of 5+ years, more than 90 program improvements and contract modifications were made – to refine the PC3 and Choice programs to better serve the needs of Veterans and arm VA with the tools it needed. Among the improvements:

- Adding primary care network services into the PC3 program and enhancing access standards for women's health.
- Providing IVF case coordination and network practitioners to help wounded Veterans and their spouses start a family.
- Expanding the Choice mental health provider base by eliminating the Medicare participation requirement for psychiatrists, psychologists, Licensed Clinical Social Workers and Advanced Registered Nurse Practitioners.
- Adding outbound calls to Veterans to enable us to proactively reach out to Veterans in need of care rather than having to wait for them to contact us for an appointment, an improvement that increased the timeliness of the appointment making process, thus better ensuring Veterans receive timely care.
- Expanding the provider base for women's health, audiology, pediatrics and optometry, by eliminating Medicare participation and moving to State licensure requirements.
- Embedding TriWest staff to work on the ground in collaboration with VA Medical Center staff.
- Enhancing the TriWest VA Portal to improve functionality of medical documentation and appointment information sharing between TriWest and VA and to help streamline processes, resulting in increased portal utilization and a better and more efficient end-user experience.
- Developing an entirely new Customer Relationship Management (CRM) system at TriWest that was customized to meet our customer service needs, resulting in improved customer service for Veterans.
- Implementing a Behavioral Analytics Call Monitoring System which helps improve staff interactions with customers, VA staff, providers and Veterans.
- Performing full, collaborative demand capacity assessments to determine VA community care network needs and sizing requirements. Our work surrounding these demand capacity assessments is further explained later in this testimony.
- Expanding women Veterans' health services to support VA's fastest growing population.

- Speeding up the payment of provider claims by decoupling the requirement for community providers to deliver medical documentation within specified timelines from claims payment.
- Adding 9 TriWest contact centers/operations hubs within our geographic markets to help better serve local Veterans' needs within their communities.

In the Fall of 2018, VA extended TriWest's initial PC3 contract and asked us if we would agree to stretch ourselves and expand our services in all 50 states, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands until the next generation of VA community care – the Community Care Network (CCN) – could be fully implemented this year. Beginning on December 7, 2018, TriWest expanded services using a phased approach to implementation. We completed the expansion last spring – providing VA with access to a nationwide network of community providers to serve Veterans in all 50 states and territories. In addition to providing VA with a consolidated network of community providers and processing and paying their claims, TriWest also is performing appointment scheduling and providing customer service support in a number of areas as the CCN contracts are implemented. It has been an honor to serve constituents from all of your states and to help stabilize the enterprise across all states as we all awaited the conversion to CCN in Regions 1, 2 and 3… and Optum Public Sector Solutions, Inc. stepped up to join us in this privileged but complicated work.

Stakeholder Communications and Collaboration

As well as working with VA and Congress on program improvements, TriWest also has proactively engaged with Veteran Service Organizations and other Veteran outreach and advocacy groups to gain a better understanding of how we are doing and where refinements might be needed. Examples of the outreach and engagement of TriWest staff – regional directors, operations hub directors, community relations leadership and other TriWest staff – in 2019 include:

- Attendance at over 50 VA Town Halls, with active involvement/outreach to Veterans in attendance.
- Participation in more than 35 Congressional Town Halls/Veteran Resource Fairs/Briefings.
- Distribution of monthly Congressional updates to all congressional (DC) offices across the country with statistical data and general program updates (January 2019 – December 2019).
- Conducting 7 teleconference briefings on expansion efforts with Congressional staff – district/state and DC staff – across 11 VISNs, attended by approximately 350-400 staffers.
- Conducting 7 teleconference briefings on expansion efforts with local and state Veteran Service Organizations, County Veteran Service Officers and Veteran non-profit representatives across 11 VISNs, attended by approximately 300-350 Veteran representatives.

- Participation in Veteran Stand Downs designed to ensure homeless and low-income Veterans are aware of, and educated on, community care benefits.
- Supporting and attending 10 national VSO conventions and VA events between January and December 2019, connecting with thousands of Veterans and providing education and issue support. Events included:
    - Paralyzed Veterans Wheelchair Games
    - VFW, DAV, American Legion and VVA national conventions
    - National Association of State Directors of Veterans Affairs national convention
    - National Veterans Summer Sports Clinic
    - National Disabled Veterans Winter Sports Clinic

Since the beginning of our work on behalf of VA, we also have focused on provider education, seeking to minimize provider confusion and Veterans challenges with community care. In 2019, TriWest has:

- Conducted 526 provider education webinars with a total of 3,911 attendees (April 2019 – December 2019).
- Sent 16 fax blasts to more than 850,000 recipients with topics relating to provider education or provider relations (January 2019 – December 2019).
- Sent 12 monthly Provider Pulse e-newsletters to an average of 50,222 recipients, resulting in an average open rate of 26% (January 2019 – December 2019).

Results to Date

From the beginning of our work in support of VA in 2013, TriWest has worked diligently to approach the work by first understanding and then responding to the specific needs, at all levels – at the local VA medical center, Veterans Integrated Service Network (VISN) and VA central office (VACO). Today, TriWest's provider network – tailored through use of VA demand and capacity assessments – is comprised of over 685,000 individual providers who represent more than 1.3 million access points. This robust network has helped to ensure that minimal authorizations for care had to be returned for no provider being available… less than 2% in fact. TriWest's tailored network has delivered more than 20 million total appointments since the start of this privileged work supporting VA community care.

At its apex, with us serving nationwide, we received more than 350,000 requests for Veteran care in the community per month, are handling approximately 650,000 calls per month, and to date, we have processed and paid over 24 million health care claims to community care providers. Up until a complication with the annual fee update file arriving late, which backed up 400,000 claims… and is close to being fully resolved, we had been processing and paying clean claims, on average, within 18 days in our legacy area, and within just 10 days in the expansion states – with an accuracy rate of 96 percent. And, as you know, we still function without access to a federal bank account from which to draw, so we are paying the claims on the front end and then VA is reimbursing us on the back end. That is working much better than it was when we had more than $200 million being owed our company; however, a few pieces still lack resolution due

to the enormity of VA's list of critical issues to work. We remain hopeful that these pieces still will be resolved, and are enduring and working together in an effort to make things work for Veterans and the providers leaning forward in support of VA.

As TriWest transitions out of CCN Regions 1-3 and ultimately reduces its footprint to CCN Region 4, the volumes of work will re-set accordingly and our focus will be singularly focused on supporting the enterprise and its service to Veterans in that area of the country.

MISSION Act Launch

Thanks in large part to the principled and diligent work of the Senate and House Veterans Affairs Committees in crafting the VA MISSION Act in 2018, you armed VA with the authorities to reset the enterprise and, among other things, move the community care benefit to one that is more streamlined. Shortly after completing our work to expand our services across the country, VA and TriWest turned to collaborating in the implementation of the first community care components of the VA MISSION Act. TriWest and VA program leadership and project management teams met face-to-face on numerous occasions to discuss previous lessons learned and to collaborate on the processes needed for a successful implementation and management of the MISSION Act requirements.

Thanks to the extensive collaboration on VA MISSION Act implementation, this much-needed reform of consolidating VA's various community care programs into a single community care program is now underway and beginning to make a positive difference for Veterans. The consolidation is helping to eliminate redundancies, reduce provider confusion, synchronize standards and rules, streamline processes and innovate vital community care services. Since the launch of the MISSION Act on June 6, over 2.6 million initial appointments have been scheduled with the providers in our community care network.

Urgent Care Benefit

As you well know, one of the most significant new benefits for Veterans contained in the MISSION Act is a new urgent care/retail clinic benefit. Under the law, eligible veterans can now visit an urgent care provider in VA's network for non-emergency yet time-sensitive, pressing health care services if they have received care through VA or a community provider within the past 24 months.

Since the MISSION Act went into effect on June 6, 2019, TriWest has developed a national network of urgent care providers. We also added pharmacy services for urgent medication requirements, created an online urgent care provider locator tool, developed a series of tools and education materials for urgent care providers, and partnered with VA to perform outreach to Veterans to spread awareness of the new benefit. In addition, we proactively sent information packets complete with signage and Frequently Asked Questions (FAQs) to each urgent care facility upon contracting to be in the network. While we continue to work to ensure that Veterans across the country have ready access to urgent care when needed – within 30 minutes of their home – our urgent care network is delivering access to timely care.

Key statistics that demonstrate this fact as of January 2020 include:

- Over 6,500 urgent care and retail locations currently are in our network.
- There have now been more than 175,000 urgent care visits.

- There have been more than 15,000 calls to the Urgent Care support line, which exists to assist Veterans, Urgent Care Centers and Pharmacies that are struggling with the use of the benefit… providing education and technical support at the point of encounter. This was deemed critical by we and VA with a brand new benefit, and with which this population presents differently than any other… given that there is no "card."
- The "2019 VFW Our Care" report, VFW's most recent survey on the state of VA health care, notes that "an overwhelming majority of veterans, 89 percent, indicated that they would recommend community urgent care to other veterans."

Currently, **90 percent of eligible Veterans** have access to at least one urgent care provider within 30 minutes of drive time, access that appropriately and substantially exceeds even Medicare standards (70 percent). That said, we are continuing to add providers until we reach our personal goal of all Veterans having access to an urgent care facility within 30 minutes, if a facility exists in their area and is willing to be available to meet the needs of those heroes who call their community home. For our part, we will continue to stay focused on working at VA's side in refining processes to ensure that they are simple to execute and that provider bills are processed and paid quickly and accurately.

CCN Region 4 Implementation

On August 6, 2019, VA awarded TriWest Healthcare Alliance a CCN contract to administer VA's 13-state Region 4 territory. Under the CCN contract, TriWest is responsible for building and maintaining a network of community health care providers, paying claims and providing customer service.

TriWest and VA conducted a CCN Region 4 kickoff meeting in Denver, CO, in early November 2019. At that meeting, TriWest briefed VA on our CCN Region 4 approach for implementation that included a detailed list of contract interdependencies and clarification questions. Subsequent to the kickoff meeting, TriWest and VA have established a number of joint work groups covering key functional areas such as training, claims and invoicing, network adequacy, customer service, clinical quality and systems integration and testing. These work groups are designed to refine processes, achieve decisions and implement solutions.

Under CCN, there are a number of VA community care process changes, as well as the inclusion of a number of services and benefits that were not a part of PC3 or Choice. These changes require us to re-engineer existing solutions and systems, implement new services and review and test revised processes with VA. The work groups allow VA and TriWest to work on these changes collaboratively, ensuring consistent approaches and understanding.

In addition to conducting focused work group sessions and working to re-architect our systems and processes to make them CCN ready, TriWest and VA also have been with the leadership of each VISN and VAMC to assess the Veteran's community care needs in their respective markets to ensure that we will have a network optimally tailored to support them. Through our years of working in collaboration with VA, we know it is essential to customize the network of community care providers according to the demand and referral patterns of each VA facility. That approach enables the network to effectively supplement VA's internal capacity, providing VA, and ultimately Veterans, access to the right care at the right time from the right provider.

To develop a customized network sized for VA in each market and tailored to its specific needs, TriWest initiated a process with VA to assess demand and determine the distribution and supply of network that would be needed in the community to support that demand. We call it the "Demand Capacity Assessment Process." We first leveraged this approach with VA in 2014, for a process over Memorial Day weekend in preparation for assisting the Phoenix VA in working off the backlog of nearly 15,000 Veterans waiting in line for care. This tool allowed us to assess the demand and determine the needed providers and level of staffing to assist the Phoenix VA in successfully eliminating the initial backlog by the end of August 2014.

Beginning the summer of 2016, we conducted demand capacity assessments with nearly every VAMC within our PC3 service area. Armed with the Demand Capacity Assessment Tool, we and the VAMCs in our geographic areas of responsibility worked to assess demand and then mapped the supply of providers that would be needed in each community to supplement VA care. We met one on one with each medical center to assess how many providers of each specialty would be needed in addition to the supply of providers working at the VAMC to meet the needs of Veterans in each geographic area. This included not only a projection of the demand that was already known to exist but also that which was anticipated to materialize. We then took the output of this data-driven process and started to tailor the network on a market-by-market basis to meet demand. We already have begun demand capacity assessments in CCN Region 4, are constructing the network build sheets for each of the markets and have formally launched the CCN Region 4 contracting effort.

TriWest and VA continue to work on implementation schedule details, but have set April 7, 2020, as the start of health care delivery and July 14, 2020, as the date for full healthcare delivery. The sequencing and timing of the deployment for all Region 4 VA facilities has not been finalized, but we do know that Montana and Denver will be first. We are working vigorously to finish the setting of the provider network in those markets for the start of the CCN implementation in Region 4.

Prior to the start of healthcare deliver, TriWest will demonstrate to VA a number of key capabilities, including:

- Appropriate toll-free lines have been established
- A caller can call in to the lines and be routed to the correct call center representative
- Electronic messaging is available
- Website capabilities are available and functioning
- Support for English and Spanish speaking and hearing/vision impaired callers is available both telephonically and online
- Warm Transfer capabilities are available

Deployment will start in the two geographic locations listed above – Montana and Denver – on April 7, 2020. Following the start of healthcare delivery in these two locations, working with VA, we will conduct lessons learned and refine processes, as needed, before continuing deployments across the region.

In addition to our CCN Region 4 transition-in efforts, TriWest also is working with VA and Optum to transition out of community care and urgent care services in CCN Regions 1-3. We have been working closely to ensure this transition is as smooth as possible.

Remaining Focused

As we move forward with CCN implementation, we will remain focused on addressing challenges, refining our processes and approach, and adding manpower where needed. Some early challenges we remain focused on addressing include:

- The volume of care requests being received has greatly exceeded VA projections – by about 20 percent overall, with increased demand for behavioral health being the most substantial. This higher than anticipated volume has resulted in some Veterans seeking community care to experience appointing delays as it takes manpower to appoint and when demand increases substantially without warning, it creates complication.
- The complication to provider network development that comes when there are claims processing challenges. We have worked very hard over the years of this work to get to a place of solid performance, but have recently found ourselves challenged in a few areas:
    - Late arrival of VA fee schedule: Providers are paid in line with Medicare or a VA fee schedule, depending on the service. Each year, we receive an update in the fee schedules. Unfortunately, the one for this year arrived unusually late which necessitated that we pend nearly 400,000 claims. I am pleased to report that due to the hard work of many, this backlog is within days of being completely worked off, and we expect to be back to our solid claims performance within the next few weeks.
    - Emergency Room claims: In an effort to effectively address VA claims payment challenges, we agreed to process and pay emergency room claims for VA. VA notified providers across the country to send emergency room claims to us. However, in order to process these claims, we must first receive an authorization from VA. The relatively short notice in this process change has created some confusion and has resulted in less timely receipt of the authorizations. Hence, we are currently holding emergency room claims for which we had no authorization from VA while we seek to gain them so that we can process and pay the claims. We hope to have this resolved soon so that this backlog can be remedied. This approach seemed preferable to all versus denying claims and creating even more challenge and delay for the provider community as providers had to refile the claims.
    - Urgent care facilities: In processing and paying claims for this new benefit, we have determined that claims will process easier if we use an "exclusion" versus "inclusion" method for the codes used for services. This change is being programmed and will bring the claims processing performance to the high standard we have worked hard to achieve for this critical component of our work. It should be complete in the next couple of weeks.

We are working aggressively to address these challenges, in coordination with VA. Efforts to resolve these issues include:

- Close collaboration with VA to refine volume projections, along with implementation of an aggressive staffing and training plan to address appointing delays.
- A firm commitment to timely claims payment, VA assistance in addressing old/outstanding claims payment issues and engagement of congressional Members and staff to encourage apprehensive providers at the local level to consider participating to serve Veterans. We continue to collaborate very closely with VA to address the claims challenges discussed above, and we also are working very closely with our claims processor to burn down any claims backlogs as quickly as possible.
- TriWest senior leadership engagement and outreach with key VA preferred providers to assist in closing remaining network gaps.

Conclusion

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

It is the honor of our lives to be engaged in this privileged work on behalf of a grateful nation. The partnership between VA and TriWest has progressed and matured substantially over the past 6+ years. It is a dynamic relationship in which we both continue to refine and strengthen operational processes, efficiencies, and communication. The work is complex and challenging, and there always seems to be more work to be done. Those of us associated with TriWest and in VA all are very focused, and I am very proud of the work we are doing together and all that we have accomplished thus far. And, I am confident that the trajectory on which we all are on will continue to improve this program in CCN Region 4 and provide the high-quality community care Veterans have earned and deserve.

No health care system in the country has more expertise than VA in addressing the health care needs of Veterans. The work ahead should not be to reduce or replace the VA system, but to learn from it and to supplement VA care in the community, when and where necessary. After all, ensuring our nation's Veterans have access to the full range of timely, high-quality health care services they need must be our collective mission. Meeting our Veterans' ever-growing demand for care is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible that affords our Veterans an opportunity to live a healthy, full life.

Through our nearly quarter of a century operation in support of the two systems that exist to serve those who serve, we have developed substantial experience in helping these systems implement and mature their programs to provide timely and convenient access to quality health care services. Just as we have done since 1996, we are committed to providing Congress our full support and cooperation as we continue our work alongside VA on the shared privileged mission of protecting the lives of our nation's heroes. Helping Veterans access high quality care in the

community is the most sacred work in health care. For us, it is service first and then business. Our mission is to find and serve those in need, ensuring they have access to the right services with the right provider and supporting providers fully as they serve the needs of our nation's heroes.

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

TriWest Testimony Summary

- TriWest serves as a third-party administrator to support VA community care needs in 3 regions encompassing all or parts of 28 states and the Pacific.
- In the Fall of 2018, VA extended TriWest's initial contract to cover all 50 states, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands until the next generation of VA community care could be fully implemented this year.
- Beginning in December 2018, TriWest began expanding services using a phased approach to implementation and completed the expansion last spring providing VA with access to a nationwide network of community providers to serve veterans in all 50 states and territories.
- In addition to providing VA with a consolidated network of community providers and processing and paying their claims, TriWest also is performing appointment scheduling and providing customer service support in a number of areas as the CCN contracts are implemented.
- Today, TriWest's provider network – tailored through use of VA demand and capacity assessments – is comprised of over 685,000 individual providers who represent more than 1.3 million access points.
- TriWest has delivered more than 20 million total appointments since the start of supporting VA community care.
- At its peak, TriWest received more than 350,000 requests for veteran care in the community per month, handled approximately 650,000 calls per month, and to date, has processed and paid over 24 million health care claims to community care providers.
- Up until the VA annual fee schedule arrived late this year, TriWest had been processing and paying claims, on average, within 18 days in their legacy area, and within 10 days in the expansion states – with an accuracy rate of 96 percent.
- With the implementation of the VA MISSION Act on June 6, TriWest has scheduled over 2.6 million initial appointments in their community care network.
- As of January 2020, TriWest provides over 6,500 urgent care and retail locations in their network through the MISSION Act which has resulted in 175,000 urgent care visits. There have been more than 15,000 calls to the Urgent Care support line as well.
- Currently, through TriWest's network, 90 percent of eligible veterans have access to at least one urgent care provider within 30 minutes of drive.
- TriWest was awarded a CCN contract to Region 4 in August of 2019. TriWest and VA plan to implement the start of health care delivery by April 7, 2020 in the region and full healthcare delivery by July 14, 2020.
- The volume of care requests to TriWest has exceeded VA projections by about 20 percent overall, with increased demand for behavioral health being the most substantial.
- Challenges to TriWest currently include the late arrival of VA fee schedule, emergency room claims, and urgent care facilities.

Response by OptumServe to Questions of Senator Jerry Moran

Question 1. **The VA's Community Care Network contracts with Optum call for a CCN Communications Plan as a contract deliverable. Can you describe your company's CCN Communications Plan in detail?**

RESPONSE: Optum's CCN Communications plan, in partnership with the VA Community Care Communications Team and VA Leadership, has been developed to ensure strategic messages are shared with all stakeholder groups in a timely and efficient manner. While the Department of Veterans Affairs has responsibility for direct communications with Veterans, highlights of these communications efforts across stakeholder groups include:

Objectives and Desired Outcomes:

- Frequent meetings and reports keep VA Staff and other stakeholders informed of VA CCN performance, quality, availability, cost and other fundamental indicators of performance.
- Optum's Portal provides Veterans with tools to assist in accessing their own information on the VA Community Care Network, including referrals, claims, explanation of benefits and eligibility information.
- Optum responds to all Congressional inquiries within five business days from the date of receipt. Optum uses each inquiry as an opportunity to fully engage and educate offices on VA CCN, as well as a mechanism to conduct a review of processes to identify any systemic changes that need to be implemented.
- Optum's Provider Portal provides the tools needed to fully prepare community providers to offer culturally competent care to Veterans. Additionally, Optum's Portal allows providers to learn about and register to join VA CCN, billing information and the ability to submit claims online, and provides access to training and other helpful resources.
- Optum has a robust provider outreach program during the contracting, onboarding and go-live stages through various tactics including phone calls, letters, in-person meetings, and webinars to ensure provider readiness to serve Veterans under Community Care.
- Optum leverages relationships with Veteran Service Organizations (VSO) to both listen to the needs of Veterans, as well as create a forum to disseminate critical information to assist VSOs.
- Optum works to ensure media outlets have accurate information about the VA Community Care Network.
- Optum participates in meetings with other CCN contractors to support an integrated approach to delivering care.
- Optum continues to collaborate with VA staff and remains aligned on communication priorities.

Key Stakeholders:

Identified below are key stakeholders with highlights of how Optum has been actively

engaged since June 26, 2020 when CCN Region 1 first deployed.

- Veterans Service Organizations (VSOs), Veterans, family members, and caregivers:
  - Optum hosted teleconference with interested VSO leaders by phone on December 13, 2019, to provide information/education related to VA CCN.
  - Optum hosted in-person VSO leaders in Washington D.C. on March 3, 2020, to provide information on VA CCN and answer questions.
  - Participated on a panel discussing quality of care for our military and Veterans at a January 2020 Blue Star Families event to share information on the CCN program.
- VA Staff at the national and local levels:
  - Weekly meetings with VA senior leadership to ensure alignment.
  - Forty-five days prior to go-live for each VAMC, Optum we hosts a meeting with leadership and the community care office to discuss network, VA systems and the conduct of the upcoming deployment for their site.
  - Two weeks prior to "go-live" Optum hosts an "advanced party check-in" on site with each VAMC to again validate that the site is prepared to deploy.
  - During the week of "go-live" a joint command center is hosted by Optum and VA to manage the deployment. Optum and VA staff are on the ground at each of the sites going live to assist in real time with any concerns or challenges the VAMC staff may have during the deployment.
  - Four to six weeks after go-live, Optum hosts weekly calls to identify areas of opportunity.
  - Monthly virtual Network Adequacy Meetings with an in-person meeting each quarter are hosted with each VAMC.
- Community providers:
  - Letters are sent to providers in each phase prior to go-live reminding them that they are participating in VA CCN and to ensure they have received complete information regarding the process for claims adjudication information, training and resource materials.
  - Urgent Care communications sent ahead of rollout to all VA CCN UC providers.
  - Engaged with hospital associations in partnership with local VAMC, VISN leadership or VA Office of Community Care.
  - Attended provider vendor expositions and town halls to provide information and education to participating providers.
- Members of Congress and State Legislators:
  - Hosted in-person briefings on the Hill and invited Members and their staff from the states in our territories within Region 1 and 2. Similar briefing being planned for Region 3.
  - Continue to meet with individual members, their staffs as well as committee staff.
  - Dedicated Government Relations Department established to respond to congressional inquiries with a 5-day turnaround time.
- Other CCN region contractors:
  - Weekly meeting with TriWest and VA to identify and mitigate risks to ensure seamless transition for Veterans and providers.

Question 2. **Optum has indicated that it will use data collected from the Choice Program to determine how to best serve veterans in specific regions. As veterans begin to seek community care in regions served by Optum, does your company have a plan to bring additional providers into your network that were not originallyincluded?**

RESPONSE: Yes, Optum continues to accept eligible providers after our "go-live" date upon successful execution of a VA CCN provider agreement that contains all required terms and conditions, such as credentialing, accreditation and other quality measures, and mandatory administrative and training requirements.

Optum is committed to building a high-quality and robust network of community providers throughout Regions 1, 2, and 3. Optum began developing its network over a year ago by engaging our existing UnitedHealthcare Networks through contract amendments as well as active recruitment of new providers across all three regions. Optum has partnered closely with VA in a data driven approach in order to prioritize outreach and ensure inclusion of VA's priority providers. We build our network to meet the accessibility needs of all Veterans in the region and contract with priority providers as identified by VA which includes frequently used providers, those that provide for specific Veteran needs and academic affiliates.

Question 2a. **Can you please describe this process and expectations?**

RESPONSE: By tracking utilization trends in real-time, Optum continues to monitor the accessibility of catchment areas (a catchment is the geographical area serviced by a VA facility) for all specialties to identify geographies where additional providers of a particular specialty may be needed. Once a need for a specific specialty provider type has been identified, we would determine if additional providers of that specialty are present on a non- participating basis and initiate contracting to fulfill the need.

Response by OptumServe to Questions of Senator Kevin Cramer

Question 1. **In your testimony you outlined the process for "going live" with a new health network. This process includes a sequence of meetings starting 45 days prior to the go-live date to work out any potential issues. North Dakota's network will be going live throughout this year. Regarding the rollout of North Dakota's network: How have you addressed issues that came up in your meetings prior to going live? Have you met with any tribal leaders through this process and how do you plan to address the unique issues that face Native American veterans?**

RESPONSE: Approximately forty-five days prior to Optum's implementation in a particular phase, VA and Optum begin a weekly meeting cadence. During these meetings, a number of topics are discussed including:

- Onboarding status for key and academic providers.
- Planning and coordination for the CCN implementation. This includes identifying which VA locations would benefit from on-site support versus virtual support from Optum and VA. Please note, in-person support typically includes the VA's "go-team" as well as an Optum Veteran Engagement Officer (VEO).
- Determining the location for the joint VA/Optum command center.

Optum is leveraging UnitedHealth Group's existing relationship with Tribal Leaders on the Spirit Lake Reservation in North Dakota to gain a better understanding of the unique needs of Veterans in their community and across North Dakota. Should a need for a specific specialty provider type be identified, Optum will determine if additional providers of that specialty are present on a non-participating basis and initiate contracting to fulfill the need.

Knowing the unique needs of this population, including heart disease, cancer, diabetes, alcohol and drug disorder syndrome, suicide and others that are more prevalent than in the general population (as reported by the Indian Health Service), Optum continues to monitor the network to ensure that the VA is able to address this population's unique healthneeds through the Community Care Network.

Question 2. **As you serve North Dakota, do you commit to working withmy office to address any issues brought to our attention by Veterans and providers, including delayed payments and surprise billing?**

RESPONSE: Yes, Optum is committed to working with you and all Congressional offices to resolve all issues brought to our attention by Veterans or providers relatedto VA CCN. As of March 10, 2020, Optum is processing and paying claims on average within thirteen (13) days. We appreciated the opportunity to have our Government Relations team connect with your office and look forward to addressingany issues raised by your constituent service team.

Response by OptumServe to Questions of Senator Bernie Sanders

Question 1. **When does Optum include a provider on its network map?**

RESPONSE: Once a provider is contracted and their onboarding is complete, their information is provided to VA to make available within VA data systems.

Question 1a. **Is a provider listed on the map if that provider is not accepting new patients?**

RESPONSE: No, if Optum is aware that a provider is not accepting new patients they are not included on the network map. It is important to note that a provider's availability is subject to change and if a provider does not notify Optum that they are not accepting new patients there is the potential that they could appear on the network map.

Question 1b. **Is that provider listed on the map if they are not accepting any patients?**

RESPONSE: No, if Optum is aware a provider not accepting any patients, the provider is not included on Optum's network map.

Question 1c. **Is that provider listed on the map if they have not yet been credentialed?**

RESPONSE: No, a provider that has not yet been credentialed is not included on Optum's network map.

Question 2. **What is the furthest a veteran has been required to travel for care under the CCN?**

RESPONSE: VA CCN was established to meet the needs of Veterans where they are, which means both at home or when they are traveling away from home. Network adequacy is the measurement of the average drive time and appointment availability based on claims data. VA and Optum continue to collaborate on Network Adequacy reporting needs and requirements. Once the requirements have been finalized, Optum will begin reporting this data monthly to VA. Please find below in Table 1 the Network Adequacy Drive Time Standards which Optum will be measured against.

Preliminary analysis by Optum of initial referral data related to drive times, indicates the presence of outliers, such as Veterans who winter away from their home of record (also known as the snow-bird effect), traveling for business or pleasure, or referrals for specialty care only offered at specific sites within the United States. For reference, please find below in Table 2 preliminary data for Veterans that received care less than 150 minutes away from their home of record, thereby removing outliers due to travel or the snow-bird effect.

Table 1 Network Adequacy Drive Time Standards

Drive Time	Primary Care	General (Specialty) Care	Complimentary and Integrative Health Services	General Dentistry	Specialty Dentistry
Urban	30 minutes	45 minutes	45 minutes	30 minutes	45 minutes
Rural	45 minutes	100 minutes	100 minutes	45 minutes	100 minutes
Highly Rural	60 minutes	180 minutes	180 minutes	90 minutes	180 minutes

Table 2 Preliminary Data for Region 1 & 2: Referral Data from June 26, 2019 – January 20, 2020					
Average Drive Time (Minutes)	Primary Care	General (Specialty) Care	Complimentary and Integrative Health Services	General Dentistry	Specialty Dentistry
Urban	11.4 minutes	16.0 minutes	16.8 minutes	15.6 minutes	28.5 minutes
Rural	12.1 minutes	27.4 minutes	17.1 minutes	24.1 minutes	29.4 minutes
Highly Rural	16.7 minutes	46.8 minutes	No referrals	18.8 minutes	No referrals

Question 3. **Can you confirm that Optum is required to pay private sector providers rates that are no less than VA's approved rates but may provide rates as high as required to achieve network adequacy?**

RESPONSE: All of Optum's provider contracts for VA CCN are compliant with VA approved rates. All medical, behavioral and CIHS providers are contracted under the reimbursement schedule as specified in our CCN prime contracts that begins with 100% of Medicare, then 100% of the applicable VA Fee Schedule (when a service does not have a Medicare allowable) and lastly 100% of billed charges (when a service does not have an allowable for Medicare or the applicable VA Fee Schedule). Home infusion providers receive 85% of billed charges rather than 100% in accordance with the prime contracts. Regarding reimbursement for dental services, VA reimburses Optum based on a contractually set fee schedule reflective of market rates.

Question 4. **What is the greatest variance in rates between similar providers in a similar geographic area?**

RESPONSE: See above response.

Question 5. **What percentage of providers contracted by Optum through the CCN are part of OptumCare?**

RESPONSE: The total volume of VA CCN providers that are also part of OptumCare is estimated to be less than 2.5% and is not anticipated to increase.

Question 5a. **What is the total number of OptumCare providers contracted through the CCN?**

RESPONSE: As of January 9, 2020, the total number of OptumCare providers in Regions 1, 2 and3 was less than 9,000. It is important to note that Optum employs providers in the following VA CCN states located in Regions 1, 2 and 3: Connecticut, Florida, Indiana, Massachusetts, New Jersey, New York, and Ohio.

Question 5b. **Please provide the rate paid to OptumCare physicians compared with theaverage rate paid to non-Optum owned physicians by specialty.**

RESPONSE: There are no reimbursement differences for OptumCare and non-OptumCare physicians.

Question 6. **As you know, LHI – a subsidiary of Optum – is a major contractor for compensation and pension examinations. We have that when a veteran asks to reschedule an appointment for one of these C&P exams, LHI is coding it as a refusal, rather than a reschedule. Is that correct? Is it also correct that when VA receives information that a veteran has refused a C&P exam, that the veteran's**

claim is denied by VA?

RESPONSE: The Veterans Benefit Administration (VBA) Medical Disability Examination contract requires that vendors (LHI, QTC and VES) allow only one reschedule by a Veteran unless an event such as a weather-related emergency prevents attendance. The VBA MDE contract also requires that vendors complete all assigned examinations for a single Veteran in twenty days. If a Veteran chooses to reschedule an appointment, it must be rescheduled within the twenty day period.

There are two options available for the vendor to respond in the VBA's examination management system in the event of an unsuccessful reschedule attempt: "Veteran Refusal" and "Veteran Unavailable". If the Veteran is unable to schedule in the twenty day period or they attempt to reschedule more than one time then they should be identified as "Veteran Unavailable". If they do not want to schedule with LHI at all then it is "Veteran Refused".

Optum does not have a direct line of sight into the process that occurs once a request is canceled and returned incomplete to the VBA. Additionally, Optum is not aware of publicly available or direct communication that is sent to a Veteran surrounding the scheduling process.

Question 7. **In order to help a veteran determine whether to receive care within VA orgo to the private sector, VA staff must be able to give veterans information on wait- times and quality metrics for these private sector providers. To date, Optum has not made this information available to VA medical center staff.**

RESPONSE: VA staff obtains appointment availability from private sector providers when reaching out to identify scheduling capability. The CCN prime contracts do not require Optum to provide the VA with specific details on appointment availability of private sector providers. However, in the following table we have shared the wait time standard and the average time a Veteran has waited to see a community provider in Regions 1 and 2 from June 26, 2019 – January 20, 2020. Please note the average was calculated based on the date Optum received the referral from VA and date indicated by the provider on the corresponding claim for services.

Optum began providing CCN High-Performing Provider quality metrics to VA on August 28, 2019 and provides monthly updates. Listed below is the section of the CCN contract regarding High-Performing providers.

Table 3 Network Standard for an appointment once a referral has been generated

	Primary Care	General Care	Complimentary and Integrative Health Services	General Dentistry	Specialty Dentistry
Standard	30 days	30 days	30 days	30 days	30 days
Average as of January 20, 2020	15 days	13.3 days	10.2 days	12.9 days	12.3 days

Section 3.4: Identification of High-Performing Providers: The Contractor will assist VA with the development of CCN Healthcare Services Network Quality and Performance Criteria during implementation. Attachment G Rev 1, "CCN Healthcare Services Network Quality and Performance Criteria Template" contains quality and performance metrics the VA is interested in measuring; however, the thresholds and additional metrics will be determined during implementation based on the Contractors industry best practice. The Contractor must always use the Quality and Performance Metrics to assist VA in identifying High Performing Providers. The Contractor must always provide CCN providers with the Quality and Performance Criteria agreed

to by VA in accordance with the Schedule of Deliverables. The Contractor must always request CCN providers submit quality and performance data identified in Attachment G Rev 1, "CCN Healthcare Services Network Quality and Performance Criteria Template" to be considered a high performing provider within the CCN. For purposes of identifying and designating a provider as described in this section, the Contractor may provide additional internal provider performance data along with publicly available performance data that are applicable to that provider. The Contractor must always monitor and review the performance of CCN Healthcare Services Network providers and take corrective action when necessary. The Contractor must always provide high performing provider quality and performance data to VA monthly.

Question 7a. **When do you expect to provide this information to VA?**

RESPONSE: With respect to quality metrics for providers, they are delivered monthly to the Office of Community Care (OCC) and to each VAMC through the data included in the Master Provider File and made available in PPMS.

Question 7b. **Why has this not been done to this date?**

RESPONSE: Beginning on August 28, 2019, Optum has been providing quality metrics to the OCC and to each VAMC through the data included in the Master Provider File and made available in PPMS.

Question 7c. **Does Optum currently provide these data to other health care providers orpayers, including private insurers, Medicare or Medicaid?**

RESPONSE: Regarding other lines of Optum business, we do provide proprietary contract specific quality metrics to the appropriate business owner.

Question 8. **Do you have the ability to terminate a CCN contract with a provider if that provider hasbeen found to fail to meet quality standards, is part of a never-event, or malpractice?**

RESPONSE: Yes, Optum has the ability to terminate a provider in the CCN.

Question 8a. **If so, have you done so to date?**

RESPONSE: Yes, there has been one instance where Optum terminated a provider agreement for a provider participating in the CCN.

Question 8b. **If this ability does not exist in the contract, why not?**

RESPONSE: Optum does have the ability to terminate a provider in the CCN.

Question 8c. **How do you track information on quality and safety performance of contracted providers?**

RESPONSE: Optum currently tracks quality and performance of our provider network through multiple quality and performance initiatives as well as reporting elements required by the CCN prime contracts.

Optum is required by the CCN prime contracts to credential the CCN providers, and Optum's credentialing program is required to be accredited. Optum utilizes national accrediting organizational standards, such as those established by the National Committee for Quality Assurance (NCQA). As required by the CCN prime contracts, monthly auditing of Optum's credentialing is performed and reported to VA.

Optum uses the Quality and Performance Metrics to assist VA in identifying High Performing Providers and monitors and reviews the performance of all CCN providers, taking corrective action when necessary. Optum is providing this data to VA in a monthly report.

The CCN prime contracts also include a Clinical Quality Monitoring requirement, pursuant to which Optum must develop and submit a written Clinical Quality Monitoring Plan (CQMP) to VA. Optum's CQMP includes the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement and peer review. The CQMP must also include a detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care under CCN.

Relevant excerpts from the prime contract(s) pertaining to quality and safety performance include those copied below:

Section 3.4: Identification of High-Performing Providers the Contractor will assist VA with the development of CCN Healthcare Services Network Quality and Performance Criteria during implementation. Attachment G Rev 1, "CCN Healthcare Services Network Quality and Performance Criteria Template" contains quality and performance metrics the VA is interested in measuring; however, the thresholds and additional metrics will be determined during implementation based on the Contractors industry best practice. The Contractor must always use the Quality and Performance Metrics to assist VA in identifying High Performing Providers. The Contractor must always provide CCN providers with the Quality and Performance Criteria agreed to by VA in accordance with the Schedule of Deliverables. The Contractor must always request CCN providers submit quality and performance data identified in Attachment G Rev 1, "CCN Healthcare Services Network Quality and Performance Criteria Template" to be considered a high performing provider within the CCN. For purposes of identifying and designating a provider as described in this section, the Contractor may provide additional internal provider performance data along with publicly available performance data that are applicable to that provider. The Contractor must always monitor and review the performance of CCN Healthcare Services Network providers

and take corrective action when necessary. The Contractor must always provide high performing provider quality and performance data to VA monthly.

Section 3.7.1: The Contractor must always confirm that CCN Healthcare Services Network providers and facilities are credentialed in accordance with the requirements set forth by the nationally recognized accrediting organization for the Contractor's credentialing program unless the accrediting organization's standards are not applicable to such services, facilities and providers.

The Contractor must always confirm that all services, facilities, and providers are in compliance with all applicable federal and state regulatory requirements. Any provider on the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) exclusionary list must always be prohibited from network participation. See: http://oig.hhs.gov/exclusions/index.asp for further details.

In accordance with requirements outlined in the OIG's Compliance Program Guidance for Hospitals (https://oig.hhs.gov/compliance/compliance-guidance/index.asp), the Contractor must always confirm that all services, facilities, and providers, as applicable, have a compliance program in place that includes the seven (7) elements of an effective compliance program:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a Compliance Officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

The Contractor must always be responsible for ensuring that CCN providers who are not credentialed under an accredited credentialing process have the following documentation:

- Proof of identity by obtaining a government issued photo identification and I-9 documentation;
- Education and training, if applicable (unskilled home health excluded);
- Have an active, unrestricted license in the state in which the service is performed, if applicable (unskilled home health excluded);
- Have a current NPI number, if applicable (unskilled home health excluded);
- Tax Identification Number;
- Maintain professional liability insurance in an amount in accordance with the laws of the state in which the care is provided;
- Have a Drug Enforcement Agency (DEA) number, if they prescribe controlled substances;
- Work History;
- Criminal Background Disclosure;
- Professional References; and
- Operate within the scope of their license.

The Contractor must always ensure that all inpatient facilities maintain Joint Commission accreditation or accreditation by the American Osteopathic Association (AOA), when applicable. The Contractor must always ensure that rehabilitation facilities maintain accreditation with Commission on Accreditation of Rehabilitation Facilities (CARF), at a minimum. Rehabilitation facilities who maintain a Joint Commission accreditation are not required to maintain a CARF accreditation as well. The accreditation requirement may be waived by the CO, who will

coordinate with the Contractor and facility for facilities that do not have a preexisting requirement for accreditation because of federal and/or state requirements. For cases in which this requirement is waived, the Contractor must always note the omission and submit proposed alternative qualification standards so as to ensure a like standard of quality to the CO and COR. If a provider is or has been licensed, registered, or certified in more than one state, the Contractor must always confirm that the provider certifies that none of those states has terminated such license, registration, or certification for cause, and that the provider has not involuntarily relinquished such license, registration, or certification in any of those states after being notified in writing by that state of potential termination for cause.

The Contractor must always notify VA and take necessary actions to remove any CCN Healthcare Services Network provider if any state in which the provider is licensed, registered, or certified, terminates such license, registration, or certification for cause. The Contractor must always notify VA of any action against the provider's state license immediately in writing.

The Contractor must always report in writing, as soon as possible, but not later than fifteen (15) days after the Contractor is notified, to the CO/COR (via email) and the Contractor's peer review committee, the loss of or other adverse impact to a CCN Healthcare Services Network provider's certification, credentialing, privileging, or licensing. Loss of facility accreditation status must always be reported as soon as the Contractor is notified. The report must always contain information detailing the reasons for and circumstances related to the loss or adverse impact. The report must always be sent to the CO and COR. The Contractor must always immediately cease referrals submitted for Veterans to such provider until such time circumstances contributing to the event or loss have been resolved. The Contractor may submit a request with supporting rationale for the
re-listing of such provider/facility. The Contractor must always act to support coordination of transfers or other care transitions for Veterans under the care of the de-listed provider/facility, subject to the approval of the CO/COR, to minimize, to the maximum extent possible, the impact on the Veteran.

The Contractor must always provide an annual attestation, in accordance with the Schedule of Deliverables, certifying that all accreditation, certification, credentialing, privileging/competency measures, and licensing requirements required under this contract are met for network providers performing services under this contract.

Section 14.1: Clinical Quality Monitoring Plan (CQMP) The Contractor must develop and submit a written Clinical Quality Monitoring Plan (CQMP) to VA. The CQMP must include an articulation of the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement, and peer review. The Contractor's CQMP must include a detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care under this contract. The Contractor must provide a copy of its CQMP to VA in accordance with the Schedule of Deliverables.

Response by OptumServe to Questions of Senator Kyrsten Sinema

Question 1. **The VSO community and other stakeholders have expressed concerns that clinicians in the VA Community Care Network are not being held to the same high standard of care to which VA clinicians are being held. How are you addressing this concern as you build the network to ensure that providers provide an equally high standard of care?**

RESPONSE: UnitedHealth Group has a long history of delivering a clinical quality program that conducts monitoring, measuring, and improving provider quality and patient safety. Optum is required by the CCN prime contracts to credential the CCN providers, and Optum's credentialing program is required to be accredited. Optum utilizes national accrediting organizational standards, such as those established by NCQA. As required by the CCN prime contracts,monthly auditing of Optum's credentialing is performed and reported to VA.

Optum uses the Quality and Performance Metrics to assist VA in identifying High Performing Providers and monitors and reviews the performance of CCN providers, taking corrective action when necessary. Optum provides this data to VA in a monthly report.

The Clinical Quality Monitoring of the prime contracts requires that Optum develop and submit a written Clinical Quality Monitoring Plan (CQMP) to VA. Optum's CQMP includes the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement and peer review. The CQMP also includes a detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care under CCN.

Question 2. **A large goal of the Community Care Network is to ensure that veterans who want or need more timely access to medical care are getting it through the network. How is OptumServe defining and tracking the veteran wait time to help ensure that this goal is being met?**

RESPONSE: Wait times are calculated based on Optum's receipt of VA's referral and the successful completion of the Veteran's initial appointment for care which is indicated by the provider when they submit the clean claim to Optum. Provided below is relevant prime contract language regarding Network Adequacy.

Section 3.6 Network Adequacy Management the Contractor must detail the approach for creating and maintaining an adequate CCN in a Network Adequacy Plan. The Contractor must always address all network adequacy requirements under the CCN; the CCN Healthcare Services Network, the CCN CIHS Network, dental, and pharmacy within the Network Adequacy Plan. The CCN must always be customized for each VA Facility catchment area per Attachment A Rev 2, "VA Medical Center Catchment Area by CCN Region." The Contractor must obtain approval of the Network Adequacy Plan from VA in accordance with the Schedule of Deliverables. The Contractor must always monitor CCN performance against the network adequacy standards set forth in Section 3.1, "Network Establishment and Maintenance," as part of the Network Adequacy Plan. The Contractor must always provide Network Adequacy Performance Reports in accordance with the Schedule of Deliverables. The Contractor must always record performance, including any performance deficiencies, and submit the performance record as part of a Network Adequacy Performance Report to VA. Network adequacy performance is measured independently for Urban, Rural, and Highly Rural Location. The Network Adequacy Performance Reports must always include the following elements for the CCN Healthcare Services Network, CCN CIHS Network, dental, and pharmacy: (i) average drive time, calculated per claim received and calculated using Bing Maps or other geomapping utility approved by VA based on the distance between Veteran address maintained in the eligibility data and the rendering provider's physical address without factoring in allocations for traffic conditions; (ii) average appointment availability to evaluate wait times, calculated using the date the referral is sent to provider from VA and actual appointment date on the first claim associated with that referral; (iii) any further analysis that takes into

consideration any rescheduled, cancelled, or missed appointments and/or Veteran or CCN provider complaint data received regarding drive time or appointment availability standards; (iv) any gaps in network adequacy for average drive time and appointment availability, categorized by healthcare service category and geographic location to include an Urban, Rural, or Highly Rural Location indicator; and (v) documentation of rescheduled, cancelled, or missed appointments. The Contractor must always develop and submit to VA a Network Adequacy CAP for Contractor resolution of any performance deficiencies identified by the Contractor or VA in accordance with the Schedule of Deliverables. The Contractor's Network Adequacy CAPs must always include the reason(s) for the performance deficiency and timeline for the Contractor to correct the deficiency. The Contractor must always conduct monthly face-to-face network adequacy meetings with individual VA Facilities and VA stakeholders (at a location to be determined by VA) to evaluate network performance, anticipated changes in network demand, and to review the deliverables listed in Section 3.6, "Network Adequacy Management." The Contractor must always prioritize VA capacity needs to meet network adequacy requirements. VA and the Contractor maintain the ability to request ad hoc meetings to discuss identified issues. Any such ad hoc meetings must always be unlimited until full HCD is reached; then limited to no more than two (2) times per month for each additional option period. VA and the Contractor may mutually agree to an alternate schedule of meetings once full HCD is achieved.

> *Question 3.* **There has long been an issue with the challenges of sharing medical records with community care partners. Based on constituent feedback, this challenge persists with the Community Care Network. Veterans and their caregivers are frustrated when they find that the coordination between VA and the community provider is leading to added work on their part. What is OptumServe hearing from its provider network regarding challenges in medical record sharing, communication, and coordination with VA?**

RESPONSE: Optum's VA CCN providers have indicated an improved overall experience through CCN. More specifically, claims are being processed quickly and don't require additional authorizations for care under CCN as there is a blanket authorization for a series of services under a Specific Episode of Care (SEOC). As of March 9, clean claims are being paid on average within thirteen days.

We have not received feedback from our CCN providers or VA related to medical documentation as of the time of this submission.

Response by Department of Veterans Affairs to Questions of Senator Jerry Moran

PLEASE NOTE: The responses provided by the Department of Veterans Affairs are accurate as of May 28, 2020 following significant delays during the COVID-19 pandemic. Updates will be provided as requested in the form of an RFI to the Committee when necessary.

OCLA responded to Chairman Moran's questions in the form of an RFI on 4/9/2020 per SVAC request.

Dr. Richard A. Stone, Executive in Charge, Veterans Health Administration

Question 1. **VHA Central Office is leaving it to VA Medical Centers/facilities to conductveteran outreach for regional deployments of the Community Care Network. Why isn't the VHA Central Office taking charge of veteran outreach, so veteran notifications are standardized across the board?**

Question 2. **What enhancements and upgrades are scheduled for the Decision SupportTool (DST)?**

Question 2a. **Do you have a project plan with milestones/due dates and who is the Lead forimplementation of the plan?**

Question 2b. **Can you share the detailed project plan with the Committee?**

Question 3. **Does VA have a standard policy for referring rural veterans to CommunityMental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) under existing Community Care contracts for mental health care? Are the CMHCs andFQHCs included in the current Community Care network?**

Question 4. **Many Critical Access Hospitals (CAHs) across the U.S. have Inpatient Psychiatric Units (IPUs) which do not count toward the CAH's 25-bed maximum, in order for individuals to receive inpatient rehabilitation and psychiatric services in theircommunities.**

Question 4a. **Does VA have any existing partnerships at the national, VISN, or local level with these CAHs? If VA does not have any current partnerships, would VA be open toexploring the possibility of including the CAH's in the Community Care network for inpatient psychiatric care for rural veterans?**

Question 4b. **Since CMS, specifically Medicare, is the payer for these IPU services in CAHs, would this present a payment issue for VA if the Department were to refer ruralveterans to a CAH for these services?**

Response by Department Veterans Affairs to Questions of Senator Jon Tester

Question 1. **In its dental pilot proposal, VA anticipated relatively few costs since veterans will be connected with pro bono or discounted dental care in the community. However, VA's Chief Innovation Officer recently indicated that the pilot program would use blockchain to pay community providers with "utility tokens" and they could then "convert the tokens to cash." There was no mentionof this technology, "utility tokens," or VA providing compensation to providers inVA's Federal Register notice or VA's briefing to Committee staff. Could you clarify whether community providers will be paid for providing dental services to veterans through this pilot program, whether through "tokens" or otherwise?**

VA Response: The community providers participating in the dental pilot will not be paid by VA for providing pro-bono or discounted dental services to Veterans.

Question 2. **Is VA authorized to pay for dental services for these veterans who arenot eligible for in-house dental care at VA?**

VA Response: Dental services, unless provided in accordance with eligibility requirements, cannot be provided by VA in-house or in the community.

Question 3. **Was each facility provided an increased budget to meet this newobligation?**

VA Response: Within the overall appropriated amount distributed through the VERA process, VISNs were funded for increased care coordination requirements.

Question 4. **It was recently relayed to me that Cerner's software is missing the "community care" component and that is as a factor for delaying the EHR go-livein Spokane. What is the missing community care component of the EHR and wasit originally planned for the Spokane IOC go-live (capability set one)?**

VA Response: VA delayed the IOC go-live due to identification that the new EHR solution required more systems configuration to execute the planned user training at the Mann-Grandstaff VA Medical Center in Spokane, Washington. VA is taking every precaution to deliver an effective system for our clinicians and users, and we are committed to getting this right for Veterans.

The MISSION Act of 2018 was not yet passed when VA signed its electronic health record (EHR) contract with Cerner and community care was not a part of Cerner's commercial off-the-shelf product. VA's new electronic health record (EHR) solution will include multiple capabilities that support community care. Through a series of national and local workshops, VA clinical end-users designed and validated workflows to ensure

that community care capabilities, including Referral Management, would meet VA's unique needs.

Question 4a. **Does the "community care" EHR component deal with scheduling community care appointments, transmitting patient health information between community providers in VA, or other factors? If yes, please explain.**

VA Response: Yes. Initial workflows will integrate the new EHR solution with existing VA systems to support scheduling and tracking of Community Care appointments. Plans are also underway to enhance health information sharing between VA and Community Care Providers.

Question 5. **We have heard from several home health and hospice providers about issues with their network availability being loaded into a contractor's provider directory. What is VA doing to ensure that veterans have access to high-quality home health and hospice care in the community and ensuring thatthe contractors get these providers loaded into the system in a timely manner?**

VA Response: VA conducts outreach to assist community agencies, including home health and hospice providers, with providing the proper and required documentation needed for contractors to ensure they are visible in the provider directory. Service providers work closely with their contracted third-party administrator (TPA) to ensure this required information is provided. The TPA then completes credentialing and data validation and uploads the provider's data to make it visible in the system, after completion of credentialing and data validation. VA's direct engagement and outreach with these agencies and with TPAs helps to ensure Veterans have access to a range of high-quality providers.

Question 6. **How are the Geriatric and Extended Care needs of elderly and frail veterans who wish to remain at home and in their respective communities being addressed by VA currently?**

VA Response: The skilled home care and personal care service needs of Veterans are generally identified by the Veteran's primary care provider (PCP) and patient aligned care team (PACT) members. If the Veteran needs assistance with daily living activities, the PACT will conduct an evaluation to help determine how many hours of care are needed and which programs are optimal. Eligible Veterans can then choose from a list of options that best meet their needs: the Program of General Caregiver Support Services;, home health aide services from an agency; respite care; community adult day health care; or Veteran Directed Care which allows Veterans to hire their own workers. If skilled home health care services are required for a short period of time, or care is needed on a daily basis over a longer period, PACT or other VA staff will arrange for agency care. If the Veteran requires ongoing care and monitoring of serious medical conditions, PACT may also make a referral to the Home-Based Primary Care and/or

Home Telehealth, VA-staffed programs providing primary care and virtual case management in the home.

Question 6a. **Does VA see a need for greater partnerships between VA andcommunity organizations to address these needs?**

VA Response: VA is always looking to expand its partnerships with community organizations to assist in meeting the long-term services and supports needs of Veterans. VHA's Veteran Community Partnership (VCP) program is an excellent example. VCP has trained 61 VAMCs on formalizing partnerships, and further expansion is planned. VA medical centers have also been able to improve access to community services for aging and disabled Veterans through the VDC program, which is operated under contract with State and local aging and disability network agencies.

Question 7: **Are the community care network contractors charged with seeking out Geriatric and Extended Care providers or organizations that can assist VHA inaddressing non-institutional care, including hospice care, for eligible elderly and frail veterans?**

VA Response: Yes, the network includes both skilled and unskilled care for Geriatric and Extended Care Services to include home care, adult day care and hospice services. Hospice/palliative care and specific geriatric care are a basic medical benefit covered under the CCN; the contractor must ensure inclusion of such health services in the network.

Response by Department of Veterans Affairs to Questions of Senator John Boozman

Currently, Northwest Arkansas VA went live with Optum on January 7th of this year and they are currently still transitioning. Optum's Network is lacking hospital contracts – there is not a contracted hospital in the Optum Network for Northwest Arkansas. This makes sending Veterans to the community for complex surgeries very difficult. In order to alleviate this issue, the VA continues to use TriWest, which they are authorized to use through April 16th.

Question 1. **What is VA doing to find a resolution to this contracting issue?**

VA Response: The PC3/TriWest network is available to Fayetteville (AR) VAMC for use until March 9, 2020. VA and CCN Optum are working closely to analyze Veterans' referral patterns and historical utilization to identify highly utilized providers and specialties in high demand to customize and optimize the network for the facility. Since the CCN roll out in early January Optum has secured contracts with several hospitals which include University of Arkansas, Washington Regional Hospital and Freeman Neosho Hospital. University of Arkansas and Freeman Neosho Hospital are currently undergoing the onboarding process (ie credentialing etc.) to become available for VAMC staff to use for future referrals. Washington Regional Hospital has completed the onboarding process and is available today for Veteran care. A part of the challenge with Fayetteville (AR) VAMC is that its catchment area includes multiple States (e.g., AR, MO, KS, OK) and CCN regions (e.g., Region 2 and 3). Due to the phased deployment approach within the region and different deployment timelines across regions, some parts of the large Fayetteville VAMC catchment area have not yet gone live with CCN.

Question 2. **If a resolution is not identified by April 16th, will VA grant a waiver forthe Northwest Arkansas VA to continue using TriWest until all issues are resolved?**

VA Response: CCN Optum continues to refine its network to meet the demands and needs of the individual VAMCs. VA evaluates waiver requests to extend the PC3/TriWest network coverage on a case by case basis and will follow the same process for the Northwest Arkansas VA.

Response by Department of Veterans Affairs to Questions of Senator Mike Rounds

Question 1. **Section 102 of the MISSION Act authorizes VA to enter into agreements, known as Veterans Care Agreements (VCAs), with certain community care providers that are not part of VA's contracted Community CareNetwork. According to VA's website, VCAs are intended to be used in limited situations when contracted services through VA's community care network are either not provided or not sufficient to ensure eligible Veterans can get the carethey need. In its community care literature, VA instructs providers interested in establishing a VCA to contact their local VA medical facility to initiate the process. However, healthcare advocates in South Dakota report that long-term care providers that want to enter into VCAs are concerned by the lack of information and guidance from local VA medical centers. In light of this in-state feedback, please provide a response to the following: Can you share one or two examples where VCAs are currently in place?**

VA Response: South Dakota transitioned from PC3 to CCN in the Spring of 2020. The most recent data available is July, 2020 for this response. At that time, CCN accounted for approximately 46% of all referrals, VCAs accounted for approximately 7% of referrals, and as all stations were not transitioned to CCN in July 2020, PC3 accounted for 34% of all other referrals. The remaining referrals were issued either through Department of Defense, Indian Health Services, or other local facility contracts. At a national level 7% of referrals are VCAs as of July and decreasing as CCN continues to build a stronger network. The largest use of VCAs are for example dental and home health aides which are part of CCN thus the 7% will continue to decrease

Question 1a. **What process did the VA and the provider use to establish these agreements?**

VA Response: VA conducts thorough analysis of network utilization on an ongoing basis, and VA Medical Centers review previously utilized providers to determine which of these require outreach to establish VCAs. VA Medical Center staff then conduct outreach and begin educating providers on the transition to a VCAs and the need for the agreement.

Question 1b. **What is the VA Community Care office doing to educate and supportlocal VA medical facilities on VCAs, so that these facilities can successfully inform and guide providers through the process of establishing an agreement?**

VA Response: VA has provided numerous trainings to VA Medical Center staff on the VCA process, developed outreach materials, and has distributed the requirements for a provider to establish a VCA. In addition, a comprehensive guide was developed for the VA Medical Center staff to utilize when establishing VCAs. Reference sheets for community providers were also developed to provide information on VCAs.

Question 2. **A Community Care Network (CCN) contract will provide communitynursing home (CNH) care for up to 100 days for the purpose of rehabilitation. However, many veterans, like those with higher service-connected disability ratings, often require more than 100 days of care. To meet their needs, can a CNH maintain a CCN contract and a Veterans Care Agreement at the same time inorder to provide care to a veteran for more than 100 days without having to change nursing home facilities?**

VA Response: Yes, it is critically important for nursing homes under the CCN contract to also have a local VA contract, or if necessary, a Veteran Care Agreement, to ensure continuity of a Veteran's care.

Response by Department of Veterans Affairs to Questions of Senator Kevin Cramer

Question 1. **Currently, Optum's contract standards do not meet the MISSION Act's minimum care standards. Do you commit to working with Optum to bring the contract standards into compliance with the MISSION Act?**

VA Response: Yes. The CCN contractual network adequacy was based on prior utilization patterns, Veteran population, and industry standard metrics for network sizing. VA contracted with Optum prior to passage of the MISSION Act and knew Optum's contracts would have to be modified to adjust for new utilization of community care after MISSION was implemented. VA also knew that it would take time for Optum to build out its network. VA planned appropriately for phased rollout and will work with Optum to adjust the network based on Veteran utilization rates.

Question 1a. **What is your timeline to accomplish this?**

VA Response: VA is working closely with Optum to continually improve the CCN network in Regions 1-3. VA continues to pay attention to each market's needs and is focused along with Optum on enrolling critical community partners including academic affiliates. VA expects Optum to achieve full health care delivery within Regions 1-2 by the contract milestone dates. Optum will continue its work to build a high-quality network in Region 3 and VA will inform all stakeholders' leadership upon finalization of the deployment dates.

Response by Department of Veterans Affairs to Questions of Senator Patty Murray

Question 1. **What steps is VA taking to ensure care provided in the community is of the same quality as care VA would provide?**

VA Response: CCN has surveillance methods in place to ensure the contractor is meeting the quality assurance measurements in place. Through daily appointment scheduling and comprehensive care reporting, monthly network adequacy performance reports and monthly network adequacy meetings between VA stakeholders and the TPA, VA can ensure that Veterans are receiving proper care when and where they need it.

Question 2. **How quickly are community providers returning records to VA andhow quickly is VA entering it into the veteran's medical record?**

VA Response: The CCN contracts require initial appointment medical documentation, final appointment medical documentation, and inpatient medical documentation submission to VA within 30 days after the date of service or the date of discharge.

Question 3. **How long is it taking veterans in Washington State from the point they ask their doctor to authorize community care to the point they schedule theappointment and the appointment itself?**

VA Response:

Station	Consult Timeliness Metric	Jul-FY19 - Feb FY20
(5V20) (663) Puget Sound, WA HCS	Average Days From Request To Appointment Made	27.6
	Average Days From Request To Appointment	27.7
(5V20) (668) Spokane, WA HCS	Average Days From Request To Appointment Made	24.3
	Average Days From Request To Appointment	36.8
(5V20) (687) Walla Walla, WA HCS	Average Days From Request To Appointment Made	23.5
	Average Days From Request To Appointment	34.6

Question 4. **How long is that process taking for veterans seeking care for behavioral health and mental health services? Is there a backlog for theseservices?**

VA Response:

Total Number of Mental Health Consults	Average Days From File Entry To Appt	Average Days From File Entry To Appt Made
22,760	28.9	28.5

Question 5. **What cybersecurity measures are being taken to ensure veterans'data is secure?**

VA Response: VA implements cybersecurity best practices, leveraging guidance from the National Institute of Standards and Technology (NIST) and comply with FISM and the Risk Management Framework cybersecurity standards for a mature VA cybersecurity posture and continually adopts industry best practices to enhance the protection of veteran data. We take the protection of veteran's health data and patient records very seriously. VA protects the confidentiality, integrity, and availability of all veteran electronic data, including health records, telemedicine, and medical devices using a defense in depth strategy. In our current state we have extensive security protection measures in place as well as robust arsenal of technologies to protect against, detect, and respond to cyber events as they occur.

VA incorporates industry best practices such as encryption of data both at rest and in-transit across our network. Strong multi-factor authentication is required to access VA devices instead of passwords that can be guessed or compromised using a brute-force or dictionary attack. We incorporate cyber protection at our network borders, on our firewalls, and use both intrusion prevention systems and intrusion detection systems. Physical security and guards are used to prevent access to secure locations. We use antivirus and monitor network traffic 24x7x365. We perform training to keep our staff aware of current cyber threats and perform periodic exercises to test our cyber defenses. In addition, we implement cross agency initiatives sponsored by the Chief Information Security Officer council and Federal Privacy Council to incorporate lessons learned from other federal agencies.

VA is continuously reviewing and assessing our practices to ensure we are bringing leading edge solutions to better protect VA systems and Veterans' data. For example, VA is implementing the Continuous Diagnostics and Mitigation (CDM) program administered by the Department of Homeland Security to mitigate threats to Veteran data. CDM allows VA to continuously monitor the assets and users connected to VA's network, network activity, and data accessed. CDM's Identity and Access Management (IAM) tools help VA better manage users on its network, including those with special access to sensitive data. With a better understanding of the universe of assets, users, and network activity, VA can implement the Network Security Management and Data

Protection Management components of CDM to monitor for anomalous activity and effectively mitigate threats to the data on its network.

VA is also poised to respond to any cyber incident against any VA facility implementing the Cerner EHR. Cyber incident response for the electronic health record modernization (EHRM) effort lies with the joint EHRM monitoring group that includes VA, the Department of Defense (DoD), and Cerner. Under a joint monitoring and incident response plan, the group shares cyber threat data and identifies a collective response strategy that aligns with each respective organizational response plan. The entity that leads the execution of this collective response depends on the location of the cyber event. If the incident occurred within VA networks, VA will lead the coordinated response. If discovered within the Defense Health Agency, then the Naval Information Warfare Center would lead; if within Cerner networks, Cerner and Leidos would lead. VA continually monitors its networks and IT environments for anomalous activities. Additionally, we are directing and modifying monitoring efforts to specifically address EHRM architecture and the connections with our EHRM partners

Question 5a. **What cybersecurity measures will be included in the new ElectronicHealth Record System?**

VA Response:

VA is applying cybersecurity controls consistent with the National Institutes of Standards and Technology (NIST) Special Publication 800-53 to the EHRM systems. VA is developing a vulnerability disclosure policy which will enable the receipt of unsolicited vulnerability reports. The policy will simplify the method by which the public can report vulnerabilities to VA. The policy will include the types of testing that is allowed and the systems that are in scope. By September 1, 2022 all VA public facing systems will be in scope for vulnerability disclosure. VA's current plan of action to develop and implement a vulnerability disclosure policy is in line with Department of Homeland Security (DHS) timelines.

VA-CSOC continues to meet with internal OIT partners, OEHRM, and representatives from Cerner and DHA to comprehensively ensure all associated task orders, joint plans, and other supporting procedures include cybersecurity best practices. Most notably, the EHRM Basic Performance Work Statement (PWS) cites specific adherence requirements and is supported by a signed Business Associate Agreement (BAA) between OEHRM and Cerner Corporation.

Question 6. **Has VA conducted nationwide IVF training? If not, when is it scheduled for?**

VA Response: National IVF training was completed on February 11, 2020 at 10:00 AM EST and on February 13, 2020 at 3:00 PM EST. Approximately 740 individuals completed the training.

Question 7. **What efforts is VA making to ensure veterans are aware of IVFservices?**

VA Response: An externally facing VA website discusses IVF and Infertility services for Veterans https://www.va.gov/COMMUNITYCARE/programs/veterans/IVF.asp. The webpage includes two Veteran fact sheets and links to other resources, including the Women Veterans Call Center.

Question 8. **Please describe each step in the process for veterans to access IVF care from the time they request care through completed treatment, including the associated wait times or processing times, and who is the approving authority foreach step.**

VA Response: The local medical center IVF Interdisciplinary team is the approving authority that enters a consult and creates a referral. The VHA team validates that the couple meets the eligibility criteria prior to the referral being sent to the third-party administrator (TPA). Once the referral is forwarded to the TPA, the TPA must abide by contractual processing timelines.

Response by Department of Veterans Affairs to Questions of Senator Bernie Sanders

Question 1. **Last month, VHA determined it had published inaccurate payment rates for home health services. My office, as well as our local home health agencies, was told the new rates would be published before the end of January. As of today, those new rates have not yet been published. Please provide the date on which these new rates will be published, along with an explanation as to what caused the delay. It is my understanding that VA medical centers and VISNs throughout the country are projecting budget shortfalls for Fiscal Year 2020.**
Please provide this committee with projected deficit of each VISN and VAMC for the current fiscal year.

VA Response: The updated GEC rates are currently being loaded into VA payment systems and were available on the VA webpage at the beginning of April 2020. Once complete, we will re-process claims with Dates of Service on or after 10/1/2019 that were paid at a rate less than the revised fee schedule to ensure providers are made whole.

Question 1a. **If a deficit is projected, what are you doing to address theseshortfalls?**

VA Response: VA has sufficient Community Care funding available and is not forecasting a deficit in Fiscal Year 2020. The current Community Care utilization rate indicates that VA has sufficient resources to fund our Veterans needs through the end of the year. However, VA acknowledges that this is a new program and that Veterans may behave differently than our budget projections assumed. To that end, VA will continue to monitor Community Care utilization rates monthly and notify Congressional members should VA see evidence that there could be a shortfall.

Question 1b. **If no deficit is projected, please provide a full list of services byVISN and VAMC that are being reduced, eliminated, or redirected into the Community Care Network.**

VA Response: VA is not planning to reduce or eliminate VA medical center-based healthcare services and redirect them to the community. VA is managing Veteran's healthcare needs and appropriately ensuring they have excellent option in both the community care and direct aspects of our unified system.

Question 2. **Please provide the total number of FTE by VAMC and VISN, month-by-month for each month of FY2020.**

VA Response: Please see attached spreadsheet



Question 3. **What is your current projection for prescription drug spending for fiscal year 2020?**

VA Response: The current projection for prescription drug spending for FY 2020 is included in the 2021 Presidents Budget, page VHA-52 - $7,939,799,000.

Question 3a. **How does this projection compare to the spending on prescriptiondrugs in fiscal year 2019?**

VA Response: The projection comparison to the spending on prescription drug in FY2019 is in the 2021 Presidents Budget page VHA-52 - $7,547,356,000.

Question 3b. **How is this projection reflected in the President's Budget Request for fiscal year 2021?**

VA Response: This projection is reflected in the 2021 Presidents Budget page VHA-52 - $8,465,351,000.

Question 4. **In regions where the CCN contract has been fully implemented, howdoes your current spending on community care compare with your projections?**

VA Response: VHA began rolling out the CCN contracts in June 2019 starting with Region 1, followed by Regions 2 and 3. VHA and the Third-Party Administrators (TPAs) have been rolling out CCN in a phased approach with a transition period built in to allow for care coordination. The CCN contract is fully implemented in Region 1 as of December 10, 2019, Region 2 as of March 17, 2020, and Region 3 as of June 16, 2020 VHA is scheduled to finish rolling out Region 4 by August 25, 2020. While VHA and the TPA complete the roll out of the new CCN contracts, VAMCs will continue to use the PC3 contract prior to and during their specific CCN deployment period. As of July 1, 2020, the current Community Care utilization rate indicates that VA is on plan to meet its annual projection. VA will continue to actively monitor execution rate.

Question 4a. **If VHA does not have sufficient funds appropriated by Congress tocarry out its required work, will you guarantee that you or Secretary Wilkie will come to this committee and request additional funding?**

VA Response: VA will continue to monitor Community Care budget expenditures monthly and will notify Congressional members should VA see evidence that our budget projections no longer apply.

Question 4b. **What is the furthest a veteran has been required to travel for care under the CCN?**

VA Response: Based on CCN contract standards, a highly rural Veteran may travel for specialty care up to 180 minutes, a rural Veteran may travel for specialty care up to 100 minutes, and an urban Veteran may travel up to 45 minutes for specialty care.

Question 5. **What is the current definition of "network adequacy" as agreed to by VA and Optum?**

VA Response: VA defines Network Adequacy as a measurement of both drive time and appointment timeliness relative to a Veteran's rurality and the type of care rendered.

Question 6. **During your testimony, you cited interpersonal connection as a major protective factor in suicide prevention. I agree. Do you agree that being connected with the VA can serve as this much needed interpersonal connection?**

VA Response: Yes, being connected with VA and with our healthcare teams can provide an important resource for interpersonal connection and support through the course of a Veteran's life. Our goal is to engage Veterans in a journey of lifelong health, well-being, and resilience and to support them along the way. Veterans live in broad and diverse communities in which we need to promote ways for them to be well connected.

Question 6a. **Do you think Congress should fund an expansion of non-clinicalprogramming at VA locations, including medical centers, CBOCs, and Vet Centers, that can help foster these connections?**

VA Response: The Department appreciates the question and welcomes further discussion. Should VA identify a specific need for additional funding, we would work to include the request in the Administration's annual request for appropriations.

Question 7. **In order to help a veteran, determine whether to receive care within VA or go to the private sector, VA staff must be able to give veterans informationon wait-times and quality metrics for these private sector providers. To date, Optum has not made this information available to VA medical center staff. When do you expect Optum to provide VA with this information?**

VA Response: VA has developed the VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook (Guidebook). The Guidebook's purpose is to improve information sharing, reporting and feedback to stakeholders for patient safety events (adverse events and close calls) that occur when Veterans are receiving care on behalf of VA in the community. It also provides tools and processes to report, investigate and improve patient safety for Veterans who receive community care. In addition, the Field Guidebook 2.0, Chapter 5 contains guidance for how to receive, document and escalate inquiries received from a Veteran, caregiver or a community provider.

VA has also developed a method to identify High Performing Providers (HPP). VA and the CCN Contractor evaluate individual providers on quality and cost-efficiency measures which results in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor determines scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers result in either a Yes, No or Unknown HPP designation. This information is available to inform a Veteran's decision to schedule with a provider based on HPP designation.

In addition, Optum is required to submit a Clinical Quality Monitoring Plan that articulates the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement and peer review. There are several more deliverables that address any identified quality issues and areas/methods for clinical quality improvement.

VA has provided the current CCN contract required time and distance standards to the field to help them advise Veterans. In CCN Regions 1-3 contract, these are a 30 day wait time and the following for drive times below:

Primary Care	Mental Health	Specialty
Urban: 30 min	Urban: 45 min	Urban: 45 min
Rural: 45 min	Rural: 100 min	Rural: 100 min
Highly rural: 60 min	Highly rural: 180 min	Highly rural: 180 min

Question 7a. **What reasons have you been given for why this has not yet beendone?**

VA Response: Given that VA is not directly connected to the scheduling systems of the more than 880,000 providers in our Community Care Network, neither the Office of Community Care nor the TPAs have access to the actual wait times for CCN providers. Many community providers do not collect or report wait time information. Exact community provider availability is thus determined at the time of scheduling the appointment with community providers. The Office of Community Care is releasing the VA Community Provider Locator in the upcoming month, which will allow all VA staff to easily identify community providers in their community that accept VA patients, based on the type of care being requested and distance from the Veteran's home.

Question 7b. **If the issue is related to IT, what technology solutions need to beimplemented in order to make this information transfer successful?**

VA Response: This issue is not related to IT.

Response by Department of Veterans Affairs to Questions of Senator *Sherrod Brown*

Question 1. **Dr. Stone, please provide a breakdown of VISN 10's current budgetand which facilities might be operating with a projected deficit.**

VA Response: With the recent distribution from the VHA National Reserve and Medical Community Care (MCC), VISN 10 is no longer experiencing a projected deficit. While some VISN 10 sites initially reported a deficit, the Network leadership can redirect funds to resolve any issues.

Question 2. **If there are facilities operating with a projected deficit, what steps isVHA taking to address the deficit?**

VA Response: VA has sufficient Community Care funding available and is not forecasting a deficit in Fiscal Year 2020. The current Community Care utilization rate indicates that VA has sufficient resources to fund our Veterans needs through the end of the year. VA will continue to monitor utilization monthly and notify Congressional members should VA see evidence that our budget projections need adjustment.

Response by Department of Veterans Affairs to Questions of Senator Richard Blumenthal

Question 1. **What is the timeline for VA to provide data on how the CommunityCare network is being implemented in Region 1?**

VA Response: CCN Region 1 is in full health care delivery. The CCN contractual network adequacy was based on prior utilization patterns, Veteran population, and industry standard metrics for network sizing. VA is working with Optum to continually adjust the network based on Veteran utilization rates.

Question 1a. **How many appointments have been completed in the community in Region 1?**

VA Response: Based on available claims data for CCN, Region 1 has completed approximately 750,000 appointments for care between June 6, 2019 and July 24, 2020. VA uses paid claim data as confirmation that appointments have occurred. Providers have 6 months to submit claims under the CCN contract. So, the numbers reported are limited to claims VA has received and paid.

Question 1b. **How much money has VA spent on veterans' appointments in thecommunity?**

VA Response: VA has obligated approximately $13.4 billion as of June 30, 2020 for the total Community Care program which includes the cost of the Family Member Programs.

Question 2. **What steps are being taken to ensure that veterans are aware of howlong the entire process of seeking community care, from referral to completed appointment, is expected to take?**

VA Response: Given that VA is not directly connected to the scheduling systems of the more than 880,000 providers in our Community Care Network, neither the Office of Community Care nor the TPAs have access to the actual wait times for CCN providers. Many community providers do not collect or report wait time information. Exact community provider availability is thus determined at the time of scheduling the appointment with community providers. In order to ensure Veterans are empowered with the best information and options available, and to ensure efficiency of the referral process, VA has launched the Referral Coordination Initiative. Referral Coordination Teams (RCTs) at each medical center will assist Veterans in understanding care options and getting referrals scheduled right away – which may be in VA, via telehealth, or in the community. Three major benefits expected from RCTs include: 1) reduction in the average time it takes to schedule appointments, whether in VA's direct care system or the community; 2) Veteran empowerment and guidance on care options that best

match their needs and care goals; 3) reduction of administrative duty for referring providers, allowing them to spend more time focused on Veteran care.

Question 3. **For a veteran who is receiving care from both VA providers andcommunity providers, who on that veteran's health care team is primarily responsible for integrating care?**

VA Response: The local facility community care office is responsible for following the newly deployed Care Coordination Model to coordinate care between the community provider and the referring VA provider.

Question 3a. **What steps does VA take to ensure that the veteran knows who is responsible for integrating their care, and how to contact them if they encounter problems?**

VA Response: The Veteran receives a copy of the referral packet that has been sent to the community provider, which includes the name of the local community care office to contact if the Veteran needs assistance.

Question 3b. **What steps are being taken to ensure continuity of care for veteransalready receiving care in the community?**

VA Response: If the Veteran is already being seen in the community, no matter which contract they are under, they would continue to be followed utilizing CCM. Community care referrals are captured through the Community Care Referral & Authorization Process. A Standardized Episode of Care (SEOC) is attached with the approved Authorization and provides which services a community provider may administer during the Episode of Care (EOC).

The community provider is given tools to communicate with VA if other services are required beyond the scope of the SEOC under a Request for Services and Community Provider Order process. During the EOC, and at completion of services, medical documentation is returned to VA to determine if care may be continued within VA or if ongoing services are to be continued with the community provider. If the Veteran is followed by a primary care team and was being seen by a specialty community provider, all medical documentation is reviewed by the local office of community care and then reviewed by the PCP to determine the next steps in their treatment. These steps help ensure continuity of care.

Question 4. **What are the reasons for the significant delays in implementing theexpanded Caregiver Support Program?**

VA Response: The MISSION Act predicated expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) on implementation of an information technology (IT) solution. In early 2019 VA made a strategic pivot away from implementation of a home-grown system to a commercial off the shelf (COTS) system.

The development team has worked diligently to configure the COTS product to meet the needs of VA's nationally unique PCAFC program. The final requirements of the IT system are dependent on finalization of the eligibility and stipend requirements proposed in the Caregivers PCAFC regulation. The comment period has closed and VA is currently in the process of drafting the final rule

Question 4a. **What is the current timeline for the new information technology system to be ready to support the expansion of the Caregiver Support Program?**

VA Response: VA plans to complete deployment of the new PCAFC information technology system called Caregiver Record Management Application in late summer/early fall of 2020. VA will perform testing and the Secretary will certify that the IT system is fully implemented before expanding the program, as required under the VA MISSION Act.

Question 5. **When will VA implement the expanded Caregiver Support Program?**

VA Response: VA is working with urgency and diligence to deliver this program with the excellence and nationwide consistency, and we continue to appreciate robust input from Veterans, Veterans Service Organizations, and Congressional stakeholders on the way forward. Expansion is expected to occur in late summer/early fall. The first phase of program expansion will occur once the Secretary has certified that VA's new caregiver information technology system is fully implemented. VA will then begin accepting applications in two phases.

- In the first phase, VA will begin accepting applications of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975.
- The second phase, due, per the MISSION Act, to begin two years after the first phase, will include eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 8, 1975 and September 10, 2001.

Question 6. **Are there any issues with the clinical appeals process under MISSIONAct?**

VA Response: No issues have been reported at this time. Feedback received from the field has been positive.

Question 6a. **How many claims have been processed in the clinical appeals process?**

VA Response: Provided below is the total number of claims that have been processed in the clinical appeals process.

FY 19		FY20	
June	Q4	Q1	Q2 (FYTD)
281	743	563	307

Question 6b. **What is the percentage of claims denied under the clinical appealsprocess?**

VA Response: At present, VA is not able to track the percentage of claims decisions for or against VA in its Patient Advocate Tracking System (PATS). This functionality is being developed for the PATS-Replacement (PATS-R) this calendar year.

Question 7. **What is the anticipated schedule for transferring management of theurgent care program from Optum to Triwest?**

VA Response: On March 18, 2020, VA transferred management of the Region 1 urgent care program from TriWest PC3 to CCN Region 1 Optum. Dates for the remaining transfers have not been finalized.

Question 8. **When Optum assumes control of the urgent care program in Regions1, 2, & 3, what effect will this have on the number of urgent care providers in the network?**

VA Response: The metrics for Urgent Care (UC) network are identical for Optum in Regions 1, 2, & 3, as the current structure for TriWest. The actual providers may differ, but the coverage will remain similar.

Response by Department of Veterans Affairs to Questions of Senator Mazie Hirono

Hiring for new Director of VA Pacific Islands Health Care System (VAPIHCS)

The Director of the VA Pacific Islands Health Care System recently departed her position. As VA continues to implement the MISSION Act and the new Community Care Networks, it is vital that VAPIHCS have stable leadership. VA will quickly appoint someone to this role and urge that person to engage frequently with the community, including in-person engagement with neighbor islands and territories.

Question 1. **What characteristics are you looking for in a candidate for the VAPIHCS Director?**

VA Response: VHA is actively seeking candidates with exceptional healthcare leadership qualities that address the following competencies: mastery of healthcare delivery systems and organizations, healthcare personnel, hospital financial management, strategic planning and marketing, risk management, quality improvement, health care organizational dynamics and governance, patient safety, and competency in developing effective medical staff relationships in support of VA's mission, vision, and strategic plan. This includes the ability to build and maintain established relationships with internal and external stakeholders comprising Veteran populations, Veteran Service Organizations, Congressional members, and news media. The ideal candidate will possess extensive experience in the clinical and administrative management of a healthcare delivery system(s), which may have been acquired leading a nationwide network containing multiple hospitals/sites of care, or a major subdivision of an individual hospital.

The VAPIHCS is uniquely complex as its system of clinics for outpatient and mental health care are geographically dispersed between the main clinic on the island of Oahu, and seven Community Based Outpatient Clinics (CBOCs) on Hawaii (Hilo and Kona), Maui, Kauai, American Samoa, Saipan, and Guam. In addition, VAPIHCS is one of few Joint Venture Facilities partnered with Tripler Army Medical Center. VAPIHCS also has a sharing agreement with Guam Naval Hospital. These partnerships require not only knowledge of VA, but also experience with DoD operations. Candidates must possess or can acquire an understanding of military hospital operations to effectively lead teams capable of integrating DoD operations into VA practices for a blended agency approach to care.

Question 2. **What is the timeline for hiring a new Director?**

VA Response: As of May 14, 2020, VHA has identified a highly qualified applicant that is currently going through the approval process. Once approved, it is anticipated that the selected candidate will report to duty within 30-60 days. In the interim, an extremely

competent Acting Medical Center Director is in place, ensuring continuity of operations until the nomination process is complete.

Question 3. **Does the increase in community care referrals, coupled with a decrease in in-house referrals cause you any concern that VA is not striking theright balance?**

VA Response: When MISSION Act eligibility criteria for community care went in effect on June 6, 2019, eligibility standards broadened, creating more opportunity for Veterans to qualify for community care. As anticipated, there was an increase in authorizations for community care. However, it is still too soon to determine how many of those referrals resulted in completed appointments. We are continuing to watch authorizations for community care versus completed appointments for community care. What VA does know is that the number of internal completed appointments in FY 2019 was more than in FY 2018. Veterans continue to choose VA, and according to a recent VFW survey, more than 90 percent of Veterans surveyed would recommend VA health care to another Veteran.

VA is actively looking at innovative methods to continue to empower Veterans with the healthcare choices that best meet their needs. The Referral Coordination Initiative (RCI) is a key example of our efforts to do so. Referral Coordination Teams are being implemented in every facility across the enterprise to review referrals and provide Veterans with all available care options, including face-to-face, virtual modalities, and community care. This will allow Veterans to make well-informed decisions that match their goals and needs.

In his testimony, Mr. Atizado mentions the Disabled Veterans of America has heard from veterans that they are being offered access to community care network providers without being fully informed of their options to receive care in the VA.

Question 4. **What standards are in place for informing veterans of their optionsfor care?**

VA Response: As above, Referral Coordination Teams are being implemented in every facility across the enterprise with the aim to empower Veterans with the full range of excellent options available to them – both within VA facilities and in the community. VA care options not only include face to face visits, but also telehealth visits and e-consults. An e-consult is an electronic review and recommendation by a specialty care provider and is used by many high performing health systems around the world. Veterans also have options in many specialty areas to have in-home video appointments which are particularly important for Veterans who have difficulty getting to appointments due to physical limitations or residence in rural areas. VA continues to conduct extensive communication and outreach to Veterans on options under the MISSION Act, including through print materials, MyHealtheVet and email messaging, and continuously updated online information on va.gov.

Question 4a. **When a veteran is eligible for care in the community, is the veteranalso told when they would be able to receive the same care within the VA?**

VA Response: Yes. If the service is offered by VA, staff inform the Veteran of the range of options available, including in-person and telehealth options. As above, Referral Coordination Teams are being implemented in every facility to ensure Veterans this is accomplished in a proactive, consistent manner that provides excellent Veterans experience.

Question 5. **What is VHA doing to ensure veterans are receiving quality care inthe community?**

VA Response: VA has developed the VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook (Guidebook). The Guidebook's purpose is to improve information sharing, reporting, and feedback to stakeholders for patient safety events (adverse events and close calls) that occur when Veterans are receiving care on behalf of VA in the community and provides tools and processes to report, investigate, and improve patient safety for Veterans who receive community care. In addition, the Field Guidebook 2.0, Chapter 5 contains guidance for how to receive, document, and escalate inquiries received from a Veteran, caregiver, or a community provider.

VA has also developed a method to identify High Performing Providers (HPP). VA and the CCN Contractor evaluate individual providers on quality and cost-efficiency measures which results in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor determines scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers result in either a Yes, No, or Unknown HPP designation. This information is available to inform a Veteran's decision to schedule with a provider based on HPP designation.

Question 5a. **How is VHA monitoring quality and timeliness of care?**

VA Response: In addition to the response above, the CCN Network has in place quality assurance measurements for both quality and timeliness of care received by Veterans.

Question 6. **In his testimony, Mr. Atizado mentions the Disabled American Veterans' (DAV) opposition to copayments for urgent care. I understand the desire to use copayments to curb inappropriate visits, but DAV offers an alternative – a national nurse's advice line that veterans who are uncertain if theyare experiencing a medical emergency could call and receive clinical advice on**

the type of care they should receive. TRICARE has something similar. Is this something VA has considered or would consider?

VA Response: Veterans currently utilizing the Department of Veterans Affairs (VA) for clinical care have access to dedicated, telephone-based nurse advice linked directly to each VA medical facility. While there is no single national telephone number, each VA medical facility and associated community-based outpatient clinic provide telephone numbers to a nurse located closest to where the Veteran will access care. These nurses provide urgent and emergent clinical advice and triage. This service is provided at no cost to the Veteran and is available 24 hours a day, seven days a week, and 365 days a year. The Department is expanding this service to include dedicated telephone access and video visits to Licensed Independent Practitioners (LIP) comprising physicians or nurse practitioners, which will provide virtual urgent clinical care to Veterans who telephone VA Medical Center-based nurse advice. Providing urgent care through LIP services provides an additional no-cost option to Veterans for the purposes of achieving clinically meaningful first call resolution.

Question 6a. **Would VA need additional authorities to establish a national nurseadvice line?**

VA Response: No additional authorities are required; the infrastructure currently exists to improve access to care for Veterans through the Veterans Health Administration Clinical Contact Center modernization efforts. By leveraging local and regional clinical contact centers, systematic approaches to nurse telephone advice have been established that allow for access to Licensed Independent Practitioners (LIPs) when needed for diagnosis and treatment for urgent care. Continuing to expand the strategies supporting clinical contact center modernization will promote standardization of care while allowing for local LIP care when diagnosis and treatment of urgent needs is required.

Response by Department of Veterans Affairs to Questions of Senator Joe Manchin

Question 1. **I continually hear from Veterans that there is a lack of services in the Northern Panhandle of WV, especially because there is not a CBOC or outstation.This has recently been exacerbated by the loss of the Ohio Valley Medical Centerin Wheeling, WV which closed in August 2019. The closure of the hospital severely reduced access to care in the region, with only one hospital now servingthe greater Ohio Valley Region. There are roughly 10,000 West Virginia Veterans in Ohio County and surrounding WV counties. Currently, there is in no VA facilityin Wheeling and many Veterans from this important Northern Panhandle area are forced to go to Pittsburgh, PA for care. Does the VA currently classify the Wheeling, WV region as an underserved area for Veterans?**

VA Response: Per VHA Drive Time County Statistics, Wheeling WV has two facility options within 30 min drives for Primary Care and related services at the Belmont CBOC (~14 min and 12 miles) and Washington CBOC (~36 min and 30 miles). Wheeling is beyond the 60 min drive to VA Pittsburgh Healthcare System's (VAPHS) Oakland and Aspinwall campuses for Specialty Care. Therefore, VAPHS, VISN Connected Care, the Wheeling Vet Center, and our CBOC partners are exploring opportunities to better serve the greater Wheeling WV area.

Question 1a. **If not, what steps has the VA taken to update the assessment ofavailable care for Veterans in the Wheeling, WV area since the Ohio Valley Medical Center closed in September 2019?**

VA Response: The Western Market Lead and VISN 4 Connected Care Lead visited the Wheeling Vet Center in January 2020 for a discussion about Veterans living in the Wheeling area. The discussion involved services offered at the Belmont CBOC and Washington CBOCs; review of greater Wheeling Community Care utilization; ideas for improving telehealth coordination with the VA Pittsburgh Healthcare System (VAPHS); learning about the Wheeling Vet Center's square footage addition and telehealth expansion opportunities; and an interest in the Wheeling Vet Center hosting the VAPHS Medical Center Director for a future community Town Hall. Representatives felt the region's most pressing need was more specialty care telehealth and convenient audiology access.

To better serve the area, the new Belmont CBOC was moved to a more convenient location in St. Clairsville, Ohio. This clinic opened inside the Ohio Valley Mall in March 2019. This clinic doubled in square footage to over 16,000sf for Primary Care Patient Aligned Care Teams (PACTs), behavioral health, and specialty exam rooms, as well as new space to provide audiology and hearing aid laboratory services. VA Pittsburgh Healthcare System is also expanding specialty and ancillary care to the Washington

CBOC to include two high-interest services -- chiropractic (two days/week) and Optometry.

Additionally, VISN leadership is closely monitoring post-MISSION Act community care statistics for the region.

Question 1b. **Given the shortage of providers in Wheeling and the drive timedistance to the nearest VA Facility, would the VA consider Wheeling as an optimal site for the construction of a Community Based Outpatient Clinic?**

VA Response: Given the shortage of providers in Wheeling, an alternative to a new clinic may be the chance to strengthen partnerships to more effectively conduct our telehealth activities in the community. The onset of the COVID 19 pandemic is leading VHA expand the virtual modalities we use to ensure Veterans receive their care in the safest, most effective way possible. We have significantly enhanced the use of telephone care, video care – even using more widely available applications such as FaceTime – in addition to our VA Video Connect platform. The acceptance of these modalities, and in fact, the preference for these modalities by some Veterans and providers, is leading us to find ways to use telehealth as a building block for the way that we will deliver a significant portion of care in the future. We will constantly evaluate the need for additional space when we need face to face care, but the more likely scenario may be a shared space where we could effectively conduct telehealth visits for Veterans.

Question 2. **With the VA increasing its use and frequency of Telehealth appointments, what specific steps are you taking to ensure Veterans who live in areas without high speed broadband have the same opportunity to use Telehealthfrom home as other Veterans?**

VA Response: The VHA Office of Rural Health (ORH) actively collaborates with clinical program offices to extend a wide variety of clinical care services into the homes and communities of Veterans who reside in rural and highly rural areas. To accomplish this, the VA is equipped to access cellular service, fiber networks, and community wireless networks utilizing existing equipment, including clinical based telehealth equipment, VA-issued tablets, cellular phones, and tabletop home monitoring devices to support Veteran access to services where they reside. VA has partnered with the Microsoft Airband initiative which uses new technology to establish connectivity in rural areas to benefit interested Veterans and offers educational programs to teach technology skills to Veterans in these areas. In addition, VA has created a new Digital Divide consult to identify Veterans who are eligible for discounted broadband and a device through the FCC's Lifeline Program.

Yet, there are areas of the country where gaps still exist. VA is addressing these using community partnerships with organizations as Veterans Service Organizations, Walmart, and others who currently host sites wherein rural Veterans can receive VA

Telehealth care in their local area. Telehealth Services is implementing the ATLAS (Accessing Telehealth through Local Area Stations) program as part of VA's Anywhere to Anywhere telehealth initiative, which sets out to better serve Veterans who receive care through VA – no matter where they are. VA recently teamed with Philips, VFW, and the American Legion to establish ATLAS sites at VFW and American Legion locations. The ATLAS site in Eureka, MT saw its first patient in January 2020 at the local VFW post. In addition, ATLAS sites at five select Walmart locations have been established for a 12-month pilot in 2020. Through ATLAS, Veterans' can more easily access VA health care by telehealth. This new option reduces obstacles to care, such as long travel times to appointments and poor internet connectivity at home.

Additionally, ORH, in collaboration with program offices, fund the following: Clinical Resource Hubs, In-Home Telerehabilitation, Gerofit Geriatric Exercise Program, Genomic Counseling, Web Based Therapy Programs, Cardiac Rehabilitation, Eye Care Services, Dermatology, and a host of other programs, all delivered via telehealth—either in home or in clinic. Notably, Clinical Resource Hub teams deliver care both in-person in rural areas and via telehealth. VA is also continuing to expand our telehealth partnerships with community partners.

Question 2a. **How are you mapping out the areas where Telehealth is not feasiblefor Veterans due to broadband issues?**

VA Response: Microsoft created an interactive map using broadband data from the Federal Communications Commission that displays broadband quality by county and drive time to VA facilities. The Telehealth Services staff members use this tool to identify Veterans living in access and broadband challenged areas. The Office of Rural Health's GeoSpatial Outcomes Division (GSOD) has compiled information on broadband Internet service by accessing publicly available datasets from Broadband.gov, which is operated by the Federal Communications Commission (FCC). These FCC datasets report the service providers, upload, and download speeds across the United States at the U.S. Census Block level. GSOD utilized those data to map out the geographic areas with adequate broadband coverage. Merging those geographic areas with a master U.S. Census Block geographic file, the GSOD determined which Census Blocks were not covered by an area of broadband internet service and not considered feasible for telehealth technology.

In addition, the White House established the Rural Broadband Interagency Working Group in 2017 to address broadband access in rural America by consolidating all federal efforts in this area for easy access by rural broadband providers. The results of this workgroup's efforts can be found on the US Department of Commerce, National Telecommunications and Information Agency's (NTIA) web site. The work of this group continues, and it is currently engaged in a new comprehensive rural broadband mapping effort led by NTIA. The results of their work should be available in FY 2020 and VA will use those results to direct our efforts to find new community partners that may be interested in hosting VA telehealth.

Question 3. **With an increasing number of Veterans getting referred to care outside of the VA and decreasing number getting referred in-house how can yoube certain that this care in the community is as good or better than care at WV VAMCs?**

VA Response: VA has developed the VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook (Guidebook). The Guidebook's purpose is to improve information sharing, reporting, and feedback to stakeholders for patient safety events (adverse events and close calls) that occur when Veterans are receiving care on behalf of VA in the community and provides tools and processes to report, investigate, and improve patient safety for Veterans who receive community care. In addition, the Field Guidebook 2.0, Chapter 5 contains guidance for how to receive, document, and escalate inquiries received from a Veteran, caregiver, or a community provider.

VA has also developed a method to identify High Performing Providers (HPP). VA and the CCN Contractor evaluate individual providers on quality and cost-efficiency measures which results in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor determines scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers result in either a Yes, No, or Unknown HPP designation. This information is available to inform a Veteran's decision to schedule with a provider based on HPP designation.

Question 3a. **How is the Veteran being informed about the quality of care whenthey are choosing between outside and in-house referrals? I've been hearing reports in WV that the Decision Support Tool does nothing to actually help theVeteran make any decisions in this process**

VA Response: The HPP designation, as described above, is visible in the provider locator tool in the Provider Profile Management System (PPMS). Instructions are available for facility community care staff to discuss HPP designation with Veterans as they are choosing a provider. The va.gov locator also displays the HPP designation for Veterans to review when searching for providers in the outside network.

Question 4. **With the Drive Time Standards the Mission Act was supposed to make it easier for Veterans to get care close to where they live. However, I getVeterans call our office all the time telling me that they have to drive hours to Ohio or beyond. Is that because the networks haven't been actually built out enough to satisfy demand?**

VA Response: Specific to Ohio and some surrounding areas, there were initial issues with cross-border coverage between the go-live dates with Regions 1 & 2. These issues included some Veterans who resided in a state where CCN was not yet implemented, but the VAMC they belonged to fell into another state where CCN was in place. VA

eliminated most concerns as such states phased into CCN. However, VA and our contractors continue to rigorously review network adequacy.

Question 5. **I assisted a 100% service-connected Veteran recently who was referred to the Cleveland Clinic because of his complicated cancer diagnosis. Hewas unable to obtain VA coverage to go to the Cleveland Clinic because Optum does not have a contract with Cleveland Clinic. How is it that contracts like thesefell off from TriWest and why wasn't this worked out ahead of time?**

VA Response: VA would appreciate knowing that this Veteran has full access to the care he needs. Please share any available information with us, as approved by the Veteran.

The CCN contract does not require Optum to contract with every provider in TriWest's network, and VA is not able to intervene in the business relationship between non-governmental entities. However, Optum is charged in building a complete network of providers to the quality, distance and timeliness standards of the contract, including for oncology services.

Response by Department of Veterans Affairs to Questions of Senator Kyrsten Sinema

Question 1. **In your testimony, you mentioned that it can take roughly one month to schedule an appointment for the veteran. You also outlined that VA's goal is toreduce that to 3 days. I am equally concerned about this delay. My constituents have outlined a process by which the clinician refers the patient, those orders arethen reviewed, possibly altered through a voucher review process, and then the orders move to the community care office to authorize and schedule the appointment. Does this accurately represent the VA internal process from referralto scheduling a community care appointment?**

VA Response: Once a clinical decision is made between a Veteran and care team that care is needed, a referral is placed. The Referral Coordination Team will then determine the range of clinical options available and offer those to the Veteran. When the Veteran is eligible for community care and elects to receive their care in the community, care is authorized and scheduled. The Referral Coordination Initiative aims to ensure referrals are processed within 3 business days.

Question 1a. **Please outline in detail the steps to securing an appointment, the average time it takes for each step to be completed, and what recommendationsyou have to further streamline and improve the process.**

VA Response: Please see the response to Question 1. Three major benefits expected from the implementation of Referral Coordination Teams include: 1) reduction in the average time it takes to schedule appointments, whether in VA's direct care system or the community; 2) Veteran empowerment and guidance on care options that best match their needs and care goals; 3) reduction of administrative duty for referring providers, allowing them to spend more time focused on Veteran care.

Question 1b. **What do you need to implement these improvements?**

VA Response: VHA Senior Leadership has provided strong endorsement of the Referral Coordination Initiative and provided the resources required for implementation.

As part of this implementation, Office of Community Care is asking the RCTs (Referral Coordination Teams) to capture the Veterans Community care scheduling preferences, confirm clinical appropriateness for the referrals and implement texting capabilities to assist with notifying and managing community care appointments with the Veteran.

Question 2. **What data is VA collecting to identify the bottlenecks in the process from clinician referral into the Community Care Network to appointment secured,and how is that data driving improved efficiencies in the process?**

VA Response: VA tracks the average time it takes to schedule an appointment from referrals – referrals to appointments within VA and appointments to the community. We measure this from the date the referral is entered into the scheduling system to the date the appointment is scheduled. Monitoring and improving this piece of the scheduling process has the greatest potential to reduce the overall time a Veteran has to wait to see a provider, and this is the premise of the Referral Coordination Initiative. VA intends to empower Veterans with the full range of their options and ensure referrals are processed within 3 business days.

Question 2a. **My understanding of the Referral Coordination Team is that it will allow for more immediate scheduling of a community care appointment having ateam on site at VA to do this. Please outline what ways the RCTs will or will not impact the process by which VA reviews and authorizes the referral.**

VA Response: VHA is implementing Referral Coordination Teams (RCTs) at each facility that will be responsible for identifying community care eligibility and having a meaningful discussion with Veterans about care modalities both within the VHA and in the community to help Veterans make an informed decision. This provides VHA with an opportunity to streamline the referral and consult management for both internal request and community care referrals by ensuring timely care delivery and helping Veterans make more informed decisions about where to receive their health care.

Question 2b. **If it will not, how will this improve the timeline for veterans toreceive care in the community?**

VA Response: As stated above, Referral Coordination Teams will streamline the process by understanding Veteran preferences up front and expediting referral processing, both for direct care and in the community.

Question 2c. **What delays do you expect will continue as a result of inefficienciesin the authorization process?**

VA Response: VA is confident the improvements we are making in the process will enable us to process referrals within 3 business days.

Question 3. **A large goal of the Community Care Network is to ensure that veterans who want or need more timely access to medical care are getting it through the network. How is VA defining and tracking the veteran wait time fromthe time of referral to completion of a community care appointment?**

VA Response: VHA is measuring referral timeliness from the point of requested care (referral entry) to time the care is scheduled, to the time the care is provided. With the implementation of the HealthShare Referral Manager (HSRM), a system that allows facility community care offices to track and manage referrals to community providers, VHA will have the capability to monitor the time for each step in the referral process.

Question 4. **There has long been an issue with the challenges of sharing medical records with community care partners. Based on constituent feedback, this challenge persists with the Community Care Network. Veterans and their caregivers are frustrated when they find that the coordination between VA and the community provider is leading to added work on their part. How is VA monitoring, identifying, and improving communication between VA clinicians andits community providers to take the burden off of the veteran/caregiver team right now?**

VA Response: The VHA Care Coordination Model (CCM) was released in September 2019 and provides Veterans with personalized and well-coordinated care system-wide to help smooth transitions of care between facility community care offices and community providers. Once a consult is received in the facility community care office, the Veteran's needs assessment is completed to determine the appropriate level of care coordination. A Veteran's care coordination needs depend on both psychosocial and clinical factors. The screening/triage (S/T) tool uses a combination of automated and user-input information regarding clinical factors, psychosocial factors, and Veteran's care assessment need score (CAN score) to assess with a Veteran's care coordination need is basic, moderate, complex/chronic, or urgent. These four levels are intended to provide a level of context and standardization for VA staff that will be coordinating care. Each level demonstrates increasing complexity and, therefore, a greater need for various care coordination services.

Once the Veteran's needs are identified, the team in collaboration with providers and internal VA care team members (if appropriate) would develop and implement a care coordination plan personalized to the Veteran's needs. Each referral that goes to a community provider has a Referral Documentation (REFDOC) packet of information related to the Veteran's demographics, consult information, pertinent progress notes, medication lists, lab work, and imaging results. The Veteran will receive a letter stating they have been approved for Community Care under Community Care Network (CCN) or PC3, the referral validity period and the authorized service. After a Veteran is seen by the community provider, that provider is required to return medical records to the referring VAMC to be entered into the medical record and made available for the referring VA provider to review and act upon as needed. As more sites launch CCN and the HealthShare Referral Manager (HSRM), VA expects that these sites will adopt the CCM.

Question 4a. **What administrative entity is reviewing patient records to ensurethat the medical record is complete in advance of the patient seeing the community care provider?**

VA Response: Each referral that is sent to the community has a referral documentation (REFDOC) packet of information that is pertinent to the appointment. The REFDOC packet of information can be compiled by either the

administrative or clinical staff members working in the facility office of community care. The REFDOC packet is electronically generated in a PDF file that contains information needed to facilitate the appointment in the community. The packet includes the following information: Patient Demographics, Referral Type, Authorizations, Consults, Problem List, Appointments, Medications, Non-VA Medication, Allergies and Orders.

Question 4b. **How do you anticipate CERNER EHR roll out will or will not help toalleviate these challenges in the long-term?**

VA Response: Care coordinators work is not anticipated to substantively change as a result of EHR Modernization. Facility community care offices will continue to compile patient records in preparation for an appointment. However, EHRM may allow this action to happen faster, and enhancements to health information exchange will promote easier care coordination.

Response by TriWest to Questions of Senator Jerry Moran

Mr. David J. McIntyre, President and CEO, TriWest Health Alliance

Question 1. **Please provide your company's views on whether the VA is paying TPAs for submitted invoices efficiently, timely, and accurately.**

Question 1a. **Can you identify any improvements your company would suggest to facilitate more efficient, timely, and accurate payment of invoices by VA?**

TriWest Response: As the Committee is aware, TriWest has been privileged to serve at the side of the Department of Veterans Affairs (VA) since the outset of the Patient-Centered Community Care (PC3) program. Accordingly, TriWest addresses this question based on its lengthy experience with both VA's legacy payment systems as well as under the Plexis Claims Management (PCM) through which VA is currently processing the vast majority of TriWest's claims.

VA's Legacy Payment Systems

From the outset of TriWest's work on PC3, including the 2014 expansion of the program to include the Veterans Choice Program, VA's legacy payment systems have caused significant issues for the TPAs' ability to perform their contracts.

First, VA's lack of rules for claims payment has resulted in frustration on the part of both the TPAs and the providers, who cannot understand why their claims are rejected or underpaid by VA. The TPAs have no desire to make an incorrect payment to providers or to receive an incorrect payment from VA, but the risk of doing so is much greater when the VA relies on unpublished rules or inconsistent decisions to reject or reduce a health care payment without explanation. This is an area where VA's practices differ from those of similar health care claims processing systems, such as Medicare and TRICARE, which provide substantial guidance and business rules. In part because of the lack of such rules, there are still many thousands of health care claims under the PC3 program that remain unresolved by VA – unpaid, unexplained and effectively in limbo – and VA has not provided a path toward resolution.

Second, VA has declined for several years to respond to TriWest's many requests for basic claims accounting data, including confirmation of payments issued, that are needed to reconcile accounts. As a result, claims and payments under our contract have remained unreconciled for more than six years. To that end, it bears noting that although VA's contracts do not require reconciliation until the close-out of the contract, rather than interim reconciliations that are required by other similar contracts (including TRICARE), TriWest nonetheless believes that the implementation of regular reconciliation mechanisms and requirements would benefit both VA and the TPAs. TriWest has proposed to VA that the parties agree to contract modifications to provide for such reconciliation.

Third, the issues caused by the lack of accounting data have been compounded by the VA's prescribed process for handling adjusted claims (claims that require modification following original submission). Since the outset of the PC3 program, VA has required the TPA to submit adjusted claims in the full amount of the adjusted claim, rather than simply billing VA for the net difference between the amount that was originally claimed by the provider and the new amount

claimed. VA had explained that the government would avoid overpaying these claims because VA's practice was to issue a Bill of Collection (BOC) to recoup the full amount of the original claim. For example, if the TPA originally submitted a provider's claim for $1,000, but later the provider then increased the claim to $1,200, VA requires the TPA to submit an adjusted claim to VA in the full amount of $1,200, rather than simply billing VA for the net amount due of $200, and VA will then pay the TPA the full amount of the adjusted claims – $1,200 – rather than just paying the net amount due. However, despite assurances from VA at the outset of the PC3 contract, VA has only issued a small number of BOCs to collect the initial payments, and many payments were made by VA in bulk without any indication of which claims were being paid, underpaid, or rejected. The result has been that large amounts of overpayments have remained unreconciled for years despite TriWest's repeated requests for accounting data needed to match and confirm VA's payments to the TPA's invoices.

Fourth, as noted in prior OIG reports and VA testimony, VA's legacy claims processing systems have caused a constant state of backlog in the processing of claims because VA has relied on a predominantly manual approach to claims processing, which is performed in many different locations. As a result, decisions made on health care claims have been subject to inconsistency and delays. See, e.g., VA-OIG Report 17-05228-279 at p. iii and 13 (https://www.va.gov/oig/pubs/VAOIG-17-05228-279.pdf) (finding VA payments made within 30 days for 15% of provider claims in 2015, 45% in 2016, and 76% in 2017); GAO Report 16-253 (May 2016) at 14 (https://www.gao.gov/assets/680/677051.pdf) (describing VA's manual claims processing system).

These well-documented problems with timeliness and accuracy of VA payment have spilled over into the laps of the TPAs and interfered with efficient performance of TPA contracts. Moreover, delays in VA's payment processing also have forced the TPAs to provide free financing to the government ("float") for the advance payments TPAs are required to make to providers while the TPA is either waiting for VA to decide whether to pay a claim or trying to obtain clarification or guidance from VA regarding the reasons that VA has rejected a claim. Because the TPAs had not agreed to offer free "float" to the government, this unstated demand has required the acquisition of additional capital and has imposed an unfair burden and risks on the TPAs. While interest costs are certainly a consideration, the larger cost is related to the innumerable efforts required to attempt to collect payment from VA.

Plexis Claims Management (PCM) and Work Under CCN

At present, VA processes the vast majority of claims using the PCM system, which was implemented in early 2019. PCM corrected significant problems with payment errors and delays under the VA's legacy payment systems that we experienced in the initial five (5) years of our contract, but despite these improvements, some challenges remain. For example, in our experience, the substantial claims volume flowing through PCM and lack of sufficient dedicated VA staff continue to cause delays in the payment of health care claims under the PC3 program.

When we start to process health care claims in the coming months under the new Community Care Network (CCN) program, we are hopeful that the VA's new reimbursement system will further improve the timeliness and accuracy of VA payments under the contract. We are currently working with VA to identify disconnects between contract requirements and actual practice as described by VA's experts in the new payment system.

Our biggest challenge with the existing PCM system is the disconnect between our contract requirements and VA's practice of rejecting invoices and making "short payments" to the TPA

based on "codes" that VA applies. Specifically, VA does not provide guidance to the TPA regarding certain "codes" that will be payable and others that will not be payable, and we have been unable to obtain guidance from VA to resolve these claims. Despite our submission of numerous requests, issue summaries and follow ups with VA, many thousands of health care claims remain in limbo. While we expect that VA's new prescribed payment methodology for the CCN program will avoid these problems, there is no identified path toward resolution of the many PC3 health claims that remain unpaid.

The other significant challenge with the PCM system is VA's lack of consistency in adjusting claim payments. VA's announced practice is to issue a Bill of Collection (BOC) to adjust and recover the value of claims that were initially overpaid, as well as claims where the value has been lowered through the provider's own adjustment (which the TPA passes along to VA for correction). Although VA announced that it would use the BOC process for making such adjustments, VA has not used this process consistently. This inconsistency creates confusion and has made it impossible for TPAs to reconcile invoices and payments in a timely manner. Added to this confusion, as discussed above, VA has declined for several years to respond to TriWest's many requests for basic claims accounting data, including confirmation of payments issued, that are needed to reconcile accounts, nor does TriWest's current contract encompass a regular reconciliation (as other similar healthcare programs require). As noted above, TriWest would welcome the implementation of regular reconciliation mechanisms and requirements, and believes that would benefit both VA and the TPAs.

Finally, with regard to timeliness, under TriWest's current contract for PC3, about 63% of claims are paid within the current contract standard of 18 days (and 87% in 30 days).

Question 2. **Please provide your company's views on whether the VA and TPAs are ready to establish and utilize a dedicated fund for paying for health care services delivered to Veterans under the Community Care Program as contemplated and authorized in the MISSION Act.**

Question 2a. **Can you also identify any steps that VA and TPAs should be taking beforeestablishing and utilizing the dedicated fund?**

TriWest Response: We believe there are at least two fundamental controls that must be implemented before any such move occurs.

First, the financial risk of paying provider claims needs to shift from the TPAs to VA. As noted above, the TPAs are currently expected to pay providers from their own funds and then be reimbursed by VA after the fact — in essence, acting as a bank for VA. When VA falls behind in paying claims, the TPAs are forced to float the VA millions of dollars a day (and, historically, hundreds of millions in total). To avoid that result, TriWest would propose a new process whereby TPAs submit claims to VA for initial editing, VA "accepts" the claim and communicates that acceptance to the TPA, and the TPA at that point releases payment to the provider. In this scenario, the payment will be drawn on a Treasury account rather than the TPAs' own funds.

Second, there are a number of banking controls that would need to be adopted; however, most of these would be quite similar to those already in use under the TRICARE program, and therefore TriWest believes that implementation could be straightforward.

Finally, it is worth noting that while these additional controls are critical to implementation of a dedicated fund in our view, additional enhancements may be required for processing certain unique categories of claims, such as pharmacy claims. Also, these changes would not adequately address certain disconnects between existing contract requirements and how VA edits or adjudicates a claim once it enters the system, such as the adjusted claims and BOC issues discussed above.

Response by TriWest to Questions of Senator Mazie Hirono

Urgent care benefit

In your testimony, you stated that TriWest is now at a point where 90 percent of eligible veterans are within a 30 minute drive of an urgent care facility and your goal is to get to 100 percent. I applaud that goal. However, right now, TriWest has not been able to secure contracts with the two urgent care providers on Maui.

Question 1. **What is your plan to provide urgent care coverage on the island of Maui, particularly if those two providers choose to not participate in the Community Care Network?**

TriWest Response: In Maui, we have contacted all urgent care providers that operate on the island. Currently, one of those urgent care providers – located in the town of Hana – has agreed to participate in our network. As you know, though, Hana is about a two-hour drive from the cities of Kahului and Wailuku, where most Veterans live. Three other urgent care locations we identified do not meet the requirements to participate – two are not Medicare participating providers and one has very limited accessibility. The remaining locations have declined participation. One of the larger practices, which has three locations, is unwilling to participate unless allowed to charge an urgent care fee. However, this fee is not listed in any VA Standardized Episode of Care (SEOC) or on the expanded code list for urgent care. We continue to follow up with providers who previously declined participation and would welcome any assistance in encouraging these providers to support the urgent care needs of our nation's Veterans.

TriWest issues with VA

In your testimony you cite several issues TriWest feels need to be addressed by VA including higher call volume than initially estimated by VA; processing challenges with emergency room and urgent care claims; and the delayed release of VA's fee schedule.

Question 2. **Are these issues impacting patient care, and if so, how?**

TriWest Response: Higher than anticipated call volumes generally do not affect patient care, but rather, results in longer hold times for callers. This clearly creates a less-than optimal experience for the caller, whether that be a provider, a Veteran or a VA representative. TriWest has consistently focused on delivering the best customer experience possible, which is why we have worked with VA to obtain better volume estimates on which to base our staffing levels.

With regard to emergency room claims, the biggest impact is on the provider of those services. Delays in receiving authorizations from VA mean we are unable to pay the claims for emergency room services as timely as we, and more importantly, the providers desire. Lengthy delays in

paying provider claims creates provider frustration and at times may result in providers refusing to participate in serving Veterans under the VA community care program. To minimize provider claims payment challenges, TriWest works hard to pay providers accurately and timely. Unfortunately, delays in emergency room authorizations and the delay in the annual fee update impact our ability to deliver timely payment. VA is actively working to address these challenges to ensure a timely resolution and ultimately, no impact to Veterans' ability to access needed community care services.

Response by TriWest to Questions of Senator Kyrsten Sinema

Question 1. **Given TriWest's experience overseeing community care contracts with VAand understanding that TriWest and VA are partners in this effort, what challenges are you seeing with the implementation of the Community Care Network and how can Congress and VA address these challenges?**

TriWest Response: TriWest has had the privilege of partnering with VA in community care efforts since the start of VA Patient-Centered Community Care (PC3) in 2013. Over the span of this partnership, we have collectively identified opportunities for improvement and, at times, sought assistance from Congress to address shortfalls requiring legislative fixes.

Currently, our organization is focused on both the transition out of our support of VA in the new Community Care Network (CCN) Regions 1, 2 and 3, as well as transitioning in CCN in Region 4. We also are planning for the transition of urgent care network services to Optum in its new CCN Regions – beginning with Region 1 in mid-March – and will continue to administer existing authorizations, claims and other related items for PC3 services across the country for up to a year from now, even after we complete the transition to Optum.

Our experience serving the military and Veterans' communities has shown us that there always are areas for refinement and innovation. Current areas of additional focus we are working in collaboration with VA include:

1) **Emergency Room Claims** – In an effort to effectively address VA claims payment challenges, TriWest agreed to process and pay emergency room claims for VA. For us to pay these claims, however, we must first receive authorization from VA to do so. Unfortunately, there have been some challenges and delays with receiving these authorizations. Currently, we are working with VA to resolve these challenges quickly. In the meantime, we are holding the ER claims for which we have no VA authorization to pay while VA addresses the issues and works on a timely resolution. Holding these ER claims seemed preferable to most stakeholders all versus denying claims and creating even more challenge and delay for the provider community given providers would have to otherwise refile the claims.
2) **Program Stability** – The transition from PC3 to CCN will take some time to get right because CCN includes a number of VA community care process changes, as well as the inclusion of a number of services and benefits that were not a part of PC3 or Choice. These changes require VA and TriWest to re-engineer a number of existing solutions and systems, as well as requiring VA and TriWest staff to do things differently in many cases. Transitions and change always have the potential to create stress and uncertainty. As a result, VA and TriWest are working very closely and transparently on CCN implementation to minimize confusion and prevent instability. A key component to minimizing confusion and instability is clear communication. We are working closely with VA and with Optum to communicate transition timelines and key details consistently to stakeholders, especially Veterans and community providers.

An improvement we recommend Congress consider, in consultation with VA, is the creation of a Federal account within the Treasury Department from which VA community care claims would be paid. Currently, the Third Party Administrators (TPAs) are expected to pay providers from their own funds and then be reimbursed by VA after the fact — in essence, acting as a bank for VA. When VA falls behind in reimbursing the TPAs for claims paid to community providers, the TPAs are forced to float the VA millions of dollars a day (and, historically, hundreds of millions in total). To avoid that result, TriWest would propose a new process whereby TPAs submit claims to VA for initial editing, VA "accepts" the claim and communicates that acceptance to the TPA, and the TPA at that point releases payment to the provider. In this scenario, the payment will be drawn on a Treasury account rather than the TPAs' own funds.

Question 2. **TriWest expects to begin healthcare delivery for Region 4 on April 7, 2020 with Montana and Denver rolling out first, and expanding from there to fully implement by July 14, 2020. What are the steps you need to take between now and July to meet thisgoal and what concerns do you have about meeting the timeline?**

TriWest Response: TriWest has had the privilege of serving both Montana and Eastern Colorado over the past 15 months as part of the national expansion of our support of VA PC3 services. We look forward to beginning CCN Region 4 implementation in these two areas and continue to work collaboratively with VA to accomplish this task. As shared during the hearing, TriWest and VA have met with the leadership of each VISN and VAMC in these areas, as well as the remaining areas of CCN Region 4, to assess the Veterans' community care needs in their respective markets to ensure that we will have a network optimally tailored to support them. Through our years of working in collaboration with VA, we know it is essential to customize the network of community care providers according to the demand and referral patterns of each VA facility. That approach enables the network to effectively supplement VA's internal capacity, providing VA, and ultimately Veterans, access to the right care at the right time from the right provider.

We also are working to complete a number of required and enhanced technologies to support VA, Veterans and community providers. While the timetables to complete these and other program requirements and initiatives are quick in coming, we are on track and confident we will be ready to go when directed by VA. As mentioned in my written statement which was submitted for the record, we need to demonstrate a number of key capabilities to VA prior to the start of healthcare delivery:

- Appropriate toll-free lines have been established
- A caller can call in to the lines and be routed to the correct call center representative
- Electronic messaging is available
- Website capabilities are available and functioning
- Support for English and Spanish speaking and hearing/vision impaired callers is available both telephonically and online
- Warm Transfer capabilities are available

We already have begun the testing phase with VA, as it pertains to Montana and Eastern Colorado. After we go live in Montana and Eastern Colorado, we and VA plan to assess the success of implementing CCN in these two areas, refine our processes as needed, then move forward smartly with the rest of Region 4 until we achieve full health care delivery.

Question 3. **The VSO community and other stakeholders have expressed concerns thatclinicians in the VA Community Care Network are not being held to the same high standard of care to which VA clinicians are being held. How are you addressing this concern as you build the network to ensure that providers provide an equally high standard of care?**

TriWest Response: We largely draw upon the networks of our Blue Cross Blue Shield and two university medical system owners for our VA community care network. Tracking and compelling network provider quality is inherent in their practices, as well as at TriWest. TriWest has always made it clear – both to our network subcontractors and to the health care clinicians and facilities who seek to join us in this mission of caring for our nation's Veterans – that we (and VA) seeks to direct Veterans to quality health care clinicians in the community, when their local VA facility does not have the services available.

Under CCN, all health care professionals must be fully credentialed to participate in the CCN network. TriWest has a comprehensive credentialing program that complies with applicable laws, regulations and contractual obligations, including URAC standards. TriWest is proud of the fact that it has earned Credentials Verification Organization (CVO) accreditation from URAC. This accreditation recognizes TriWest's practice of identifying qualified health care practitioners for inclusion in its network. TriWest currently holds accreditations for Health Utilization Management, Case Management, and Health Network. URAC is the independent leader in promoting healthcare quality through accreditation, certification and measurement. By achieving this status, TriWest has demonstrated a comprehensive commitment to quality care, improved processes and better patient outcomes.

Question 4. **A large goal of the Community Care Network is to ensure that veterans who want or need more timely access to medical care are getting it through the network. Howis TriWest defining and tracking the veteran wait time to help ensure that this goal is being met?**

TriWest Response: We take our responsibility of providing timely access to community care seriously and track our performance very closely. TriWest has always tracked the number of days from when we receive a request for community care (referral) for a Veteran from VA to when we obtain the Veteran's preferences and secure an appointment for him/her. We also track the number of days from receipt of the request until the actual community care appointment. We report this information on a monthly basis to VA.

In addition, we track it internally on a daily basis and review it formally twice a month at a performance review attended by all TriWest executives at the vice president and above level.

Question 5. **There has long been an issue with the challenges of sharing medical records with community care partners. Based on constituent feedback, this challenge persists withthe Community Care Network. Veterans and their caregivers are frustrated when they find that the coordination between VA and the community provider is leading to added work on their part. What is TriWest hearing from its provider network regarding challenges in medical record sharing, communication, and coordination with VA?**

TriWest Response: The challenge of sharing medical records has been an issue between VA and health care clinicians and facilities, in both directions, dating back to our initial VA contract. This is not an indictment of either party, as both seek to receive documentation (either pre or post-care) to properly treat Veterans. This process has improved on both sides as a result of a number of factors: realignment of VA documentation requirements with specialty/industry best practices; inclusion of VA Standardized Episodes of Care (SEOCs), enabling VA to provide approval for a range of pre-approved services and information based on the primary need for the Veteran; and an increased understanding of the medical record needs of both community providers and VA.

With VA now responsible for coordinating medical record sharing between its facilities and community providers, VA is implementing new systems and processes to better facilitate the transferring and coordination of key medical documents. We hope that as VA rolls out these new approaches during the implementation of CCN, the challenges of disseminating appropriate Veteran medical information will decline. Since we have yet to implement CCN and these new approaches in Region 4, we are unable to share the reaction of our network providers to them. VA is best positioned to describe these enhancements and community provider adoption of them to date.

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