MISSION CRITICAL: EXAMINING PROVIDER RELATIONS DURING THE TRANSITION TO VA'S NEW COMMUNITY CARE PROGRAM

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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C O N T E N T S

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U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:04 p.m., in room 210, House Visitor Center, Hon. Chris Pappas [chairman of the Subcommittee on Oversight and Investigations] presiding.

Present: Representatives Pappas, Brownley, Rose, Cisneros, Peterson, Lamb, Brindisi, Sablan, Dunn, Bergman, Bost, Barr, Meuser, Steube, and Roe.

OPENING STATEMENT OF CHRIS PAPPAS, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. PAPPAS. Good afternoon. I call this hearing to order. Pursuant to committee rule 4 and House rule XI, clause 2, the chair may postpone further proceedings today, and without objection, the chair is authorized to declare a recess at any time.

Today's joint hearing of the House Veterans' Affairs Subcommittees on Oversight and Investigations and Health will examine community providers' experiences with the ongoing transition from VA's legacy community care programs and contractors to VA's new MISSION Act community care program and its new Community Care Network contractors.

In recent months, community providers have been contacting congressional offices, including my own in New Hampshire, to express serious concerns about significant delays in obtaining payments from VA's contractors. We have heard about administrative burdens associated with resolving outstanding claims, difficulties in being added to the contractors' networks and VA's provider directories, and sudden and dramatic cuts to payment rates for certain types of care, particularly dental and home health care.

In some extreme cases, local healthcare providers have simply stopped seeing veterans altogether because the financial and administrative burdens are too onerous. It is unacceptable that community partners would be forced to stop providing care to veterans because of bureaucratic errors or process problems with transitioning from legacy infrastructure. These issues are happening during the ongoing transition from the third-party adminis-

trators that helped operate the Veterans Choice Program to the new third-party administrators that will help operate VA's new MISSION Act community care program.

With any transition, a certain number of bumps in the road can be expected; however, this is more than just a bump, and we have been traveling this road for a long time and we need to see some significant improvement. Community providers simply cannot afford to continue treating veterans without being reimbursed for those services in a timely fashion, and veterans simply cannot afford to have their care delayed or halted altogether. These frustrations are not new, but the implementation of MISSION Act to date has clearly not alleviated these long-standing challenges with community provider relations.

In my home State of New Hampshire, community providers have now had to work with three different VA contractors in the past 2 years, and many are still awaiting payment for services rendered. In one case, the New Hampshire Hospital Association estimates that 23 of its hospitals are awaiting payment for nearly $137 million in claims for VA community care, the bulk of which was delivered in 2019. Yet another example, Dartmouth-Hitchcock Health System, which is my State's only academic healthcare system, estimates it currently has more than 5,200 claims totaling more than $24 million awaiting payment by VA's contractors TriWest and OptumServe.

Payments are not the only source of providers' frustration with the VA's community care program. As you will hear from one of our witnesses today, Erik Golnick of Veteran First Responder (VFR) Healthcare in Manchester, New Hampshire, community providers are often bounced back and forth between VA's contractors and staff at VA medical centers when trying to figure out why contractors can not locate prior authorizations for veterans that they have treated.

I am also concerned about VA implementing and imposing what appear to be new maximum number of visits for alternative pain management care. The committee has asked VA to explain a letter that some veterans received recently which indicates that veterans may now receive a maximum of 28 visits total per new condition for services like acupuncture, massage therapy, and chiropractic services. To date, the VA has not responded to the committee's request for more information.

At a recent event in my district, I met with a group of veterans who shared with me their experiences with acupuncture. These treatments have significantly alleviated their chronic pain and, in many cases, eliminated their need for narcotics or other pharmacologic treatments. This small business is owned and operated by a dedicated woman named Kathy Twombly. Kathy contacted my office last August to share the hurdle she has had to navigate to provide this life-changing care to her veterans. We worked with Kathy and her medical biller to highlight some of the technical coding issues and confusing authorization forms. The bottom line is that we should not be forcing people like Kathy to struggle with a confusing payment system time after time or to jump through hoops to provide this type of lifesaving care.

Finally, I hope today to hear a little bit more from the VA about its new payment rates for home healthcare. The committee has heard recently from home health providers across the country who were taken by surprise when they began receiving payments under VA's new fee schedule for home health. In some cases, these providers are receiving dramatically lower payments for VA patients than they have in the past, seemingly without any warning. Some health agencies worry that they will have to lay off their staff or stop accepting veteran patients because of these sudden rate cuts. I would like to know more about these changes and what the VA may be doing to revise its fee schedule given the effect it could have on veterans' access to home health care.

Veterans who have fought for this country should not have to face another fight when they return home to get the care that they have earned. Providers who stand ready, willing, and eager to care for our soldiers when their service ends should not face a complicated and inefficient bureaucracy that forces them to lose time, money, and eventually the ability to care for veterans at all. We can do better.

With that, I would like to recognize the ranking member of the Health Subcommittee, Dr. Dunn, for some opening comments.

OPENING STATEMENT OF NEAL P. DUNN, RANKING MEMBER, SUBCOMMITTEE ON HEALTH

Mr. DUNN. Thank you very much, Chair Pappas. It is a pleasure to be here with you, and also Chairwoman Brownley and General Bergman and all of our colleagues on the subcommittees, both of the subcommittees, Health and Oversight. Our joint appearance here is to signal the importance of today's topic.

Almost 2 years ago, in June 2018, the MISSION Act was signed into law creating a consolidated and much improved community care program to serve our Nation's veterans, and 9 months ago, on D-Day 2019, that program went into effect. Since then, the VA has been transitioning to a new Community Care Network, a set of contracts with new community care contractor added to TriWest, OptumServe, in certain regions, including my own.

If we have learned anything in the face of 2014 access and accountability crisis is that the Department of Veteran Affairs cannot serve the veterans alone and in a silo. Strong partnerships with high-quality clinicians in the community are critical to providing the access to care that veterans need. They are also critical to ensuring that the VA healthcare system remains strong and viable as the veteran population shifts and the delivery of care changes.

Moving forward, we want to ensure that the community care networks that the VA is using are robust enough to provide the level of care that veterans are entitled to under the MISSION Act. We must ensure that community care is provided in a timely manner without unnecessary bureaucratic processes that delay needed appointments. We must ensure that community care providers that we are partnering with are providing high-quality, safe, and readily accessible care.

To do this, we must ensure these providers are being appropriately reimbursed for their services, and we want to make sure that those reimbursements are timely and accurate. Those features

have not always characterized the VA's community care programs in the past, which means that the VA, Optum, TriWest, all have a lot to do to ensure the veterans, the providers, the employees, and Congress that the Department is on the right track.

I greatly appreciated the opportunity early this week meeting with Secretary Dr. Matthews, as well as with General Horoho, former surgeon general and Chief Executive Officer (CEO) of OptumServe, and Mr. McIntyre, the CEO of TriWest, earlier this week in preparation for today's hearing. The work that they are doing is not easy, but their sense of dedication in this mission is sincere, and I came away from conversations with them and also with providers, hospitals, and doctors back in my district, a very positive impression of how the MISSION Act is working in our veteran communities.

I look forward to hearing this afternoon about how they are making sure that veterans are well cared for during this transition period and how the community care program that they are building may be high performance, stable, and fully compliant with the law that we all work so hard to craft. I am grateful to all of my colleagues who assisted on that and also to our witnesses for being here today.

With that, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you, Dr. Dunn.

I will now recognize Chairwoman Julia Brownley of the Health Subcommittee for 5 minutes.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN, SUBCOMMITTEE ON HEALTH

Ms. BROWNLEY. Thank you, Chairman Pappas, for agreeing to hold this timely joint hearing on the VA's implementation of its new community care networks and the challenges community providers are facing as they navigate this changing landscape.

Back in September, the Health Subcommittee held an oversight hearing to check in on initial implementation of this new program. At that stage, the MISSION Act community care program had only been operating for about 90 days and Optum was live at just nine sites. Here we are 5 months later, Optum is fully deployed in Region 1 and is continuing its work to stand up Regions 2 and 3 by the end of May. I believe they are now serving about 70 VA medical centers, with more to come.

While your progress is to be commended, arguably, now is an ideal time to reflect on potential lessons learned and how those are being translated into actionable solutions. Arguably, and this is a little bit selfish on my part, as my district is in Region 4, but I am hopeful that veterans and providers in my district will experience the most seamless transition of all yet to come in the new Community Care Network (CCN).

I know that many members of our subcommittees have not been in Congress long and have to remember the initial rollout of the Veterans Choice Program and all the challenges that veterans and community providers experienced during that period. I remember these all too well, and I certainly hope that the VA and its contractors have applied lessons from that experience to the rollout of the CCNs.

In the interest of time, wanting to have the fullest conversation possible from the witnesses, I will yield back the remainder of my time. I do, however, think it is clear from the written testimony submitted for today's hearing that we still have a way to go to improve veterans' access to care and community providers. By no means should we be declaring our mission accomplished. I look forward to our discussion.

I yield back. Thank you, Mr. Chairman.

Mr. PAPPAS. Thank you, Chairwoman Brownley.

I will now recognize Ranking Member Bergman of the Oversight and Investigations Subcommittee for 5 minutes.

OPENING STATEMENT OF JACK BERGMAN, RANKING MEMBER, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. BERGMAN. Thank you, Chairwoman, and thank you Chairwoman Brownley and Chairman Pappas, for holding this very important hearing.

The Veterans' Healthcare Eligibility Reform Act of 1996 greatly expanded eligibility for VA healthcare when it authorized the VA to provide care beyond the traditional service connected and poor to include all other veterans to the extent appropriations were available. Since 1996, the VA has seen an influx of veterans from the recent wars and additional eligibility expansions. As a result, the number of enrollees for VA healthcare has increased nearly 190 percent, from 4.9 million veterans representing 18 percent of veterans in the year 2000, to 9.2 million enrollees representing 48 percent of veterans in 2019.

During this period, the VA has grown its in-house capacity to provide care, while at the same time relying on community care partners to augment VA care as it has for decades. As many of you will recall in response to the Phoenix wait time scandal, Congress established the Choice Program. Since 2014, the VA has consistently allocated approximately 20 percent of the VHA's healthcare funding for community care. The remaining 80 percent is used to fund in-house care.

The Choice Program was, however, inefficient. So during the 115th Congress, then Chairman Roe undertook the daunting task of replacing the Choice Program and consolidating the VA's patchwork of community care authorities into a single program. The result of that work was the VA MISSION Act, which I was proud to support, as well as I know many of the members up here on the dais today were proud to support. On June 6, 2019, the new community care program went live. In the fall, the VA began transitioning to CCN, Community Care Network.

I appreciate the opportunity today to discuss the VA's implementation of the new community care program, because providers and veterans in my district have voiced concerns that the transition between Choice and the CCN contract has not been smooth. For example, in early 2019, providers began transitioning from Health Net as the third-party administrator, or TPA, to TriWest as the bridge contract after the VA elected not to renew Health Net's contract. Around the same time, the VA awarded Optum the Region 2 CCN contract, and providers who wished to continue to serve vet-

erans were, again, asked to transition from TriWest to Optum as Optum built its CCN network.

I understand the VA needed to feel the gap that Health Net left and some frustration was unavoidable. As the transition continues, it will be important to maintain high levels of communication between the network providers and the care providers. When care providers are left uninformed and unconnected to the incoming network, they are more vulnerable to transition and credentialing issues.

Dr. Dunn and I had a really good conversation with Dr. Matthews on Monday, and I respect her for acknowledging the communications deficiencies. I appreciate that Optum is a new VA partner, and it will take time to iron out any wrinkles. If the VA and the third-party administrator partners fail to adequately and clearly communicate with community providers, those providers will elect not to participate in the program, thereby denying veterans the care option. This risk is not unfounded, as many providers declined to participate in Choice when they were unable to get paid in a timely manner.

I look forward to hearing what the VA and its TPA partners have learned about the past communications deficiencies and what is being done to improve communication and provider relationships today and in the future.

Turning to the veterans' perspective, I have heard from veterans in my district that they are waiting 3 to 4 months before being told whether their community care request has been approved. For veterans in my district, many of whom live in remote areas and who face bitter cold and difficult driving conditions during the wintertime, having timely access to quality community care closer to home can mean the difference between receiving care or foregoing care.

Optum is scheduled to deploy to Iron Mountain VA Medical Center on February 19, just a week from today. I recognize that both the VA and Optum have roles in the referral process, so I want to hear what improvements veterans in my districts should expect as it relates to processing community care requests and when they can expect those improvements to materialize.

I thank everyone and our witnesses for being here today, and I look forward to their testimony.

With that, I yield back.

Mr. PAPPAS. Thank you very much, General Bergman.

I would now like to introduce today's witnesses. This afternoon we will hear from Dr. Kameron Matthews, Deputy Under Secretary for Health for Community Care, and Dr. Jennifer MacDonald, chief consultant at the Veterans Health Administration. Next, we will hear from the VA's two community care contractors, and with us today are Mr. Dave McIntyre, president and CEO of TriWest Healthcare Alliance, and Lieutenant General Patricia Horoho, CEO of OptumServe. Finally, we are joined by two witnesses that will offer their perspectives and share community providers' experiences delivering care through VA's community care networks. Mr. William A. Dombi is the president of the National Association for Home Care and Hospice—thank you for joining us—and Erik Golnick and Eric Frieman are co-founders of the Veteran and First

Responder Healthcare, which offers substance abuse and mental health treatment in several cities, including my hometown of Manchester, New Hampshire. Thank you for being with us.

We will begin by recognizing Dr. Matthews for 5 minutes.

STATEMENT OF KAMERON MATTHEWS

Dr. MATTHEWS. Good afternoon. Chairwoman Brownley, Chairman Pappas, Ranking Members Bergman and Dunn, and members of the subcommittees, I appreciate the opportunity to discuss the VA's continuing success in implementing the new community care program via the VA MISSION Act of 2018. I am accompanied today by Dr. Jennifer MacDonald.

This is a time of transformative change at the VA. MISSION Act implementation is succeeding and it has become part of our core business as we prepare to deploy additional benefits to support veterans and their families. On June 6 of 2019, we successfully launched the new Veterans Community Care Program, a cornerstone of the MISSION Act, and have authorized more than 3.85 million episodes of care in the community. Veterans now have enhanced care options, and we are streamlining our processes and technology to make their experience of care even better.

Timeliness of claims payment to community providers remains a top priority. I acknowledge that the growth of community care, including unauthorized emergency care and antiquated payment systems with many limitations, have led to a growing claims payment backlog. We receive more than 1 million claims a month, and while we can process that incoming volume, we need further transformation to attack the backlog that is now more than 2 million aged claims.

This is a backlog that has accumulated since before the Choice Program, and I have been working tirelessly since taking this role to eliminate it. Our goal is to work down the claims' inventory by the end of this fiscal year. A new claim system was implemented late last year, which provides automation of authorized claims. Additional automation will be introduced this spring. We have developed business roles that streamline the manual processing of unauthorized emergency care claims, which comprised the largest portion of our backlog. Additional contract support, along with my staff, now use these roles.

In addition, as more care moves to our Community Care Network, the VA's third-party administrators are able to pay claims on the VA's behalf and are doing so in a timely manner. We are committed to being an excellent partner to the community providers in our network. We have to get this right. However, when we do not get it right, we need to be transparent and fix the issue as soon as possible.

In the beginning of this fiscal year, the VA implemented a new standardized rate structure for home health. This new rate structure ensured a more accurate and standardized reimbursement rate methodology that accounts for variations in services and locality costs. However, after feedback, we agreed that in some locations the change needed to be more gradual over the course of several fiscal years. We worked to mitigate the issues and we have loaded the new fee schedule in VA systems last week.

As we continue to transition to these new networks under the CCN contracts, which I expect to be deployed across the first four regions this fiscal year, we need to ensure that veterans have a seamless experience and that we maximize opportunities for continuity of care. As a primary care physician, I hold this as the ultimate priority and, therefore, we are stepping away from industry standard in order to ensure a veteran-centric approach to this transition. Effective change management is, therefore, critical.

Veterans in Regions 1, 2, and 3 who are in the middle of an authorized episode of care under the TriWest network will continue that care until the episode of care ends. With other payers, that care would instead abruptly end. For veterans, if additional care is needed, it will transition under the Optum network after, not during, the originally referred episode of care. This allows the veteran to continue her/his care with the providers with whom they have established a relationship.

We know when we began implementing the MISSION Act, that we had the potential to make an enormous positive impact for America's veterans. Today, we have begun to demonstrate that potential. I am very proud of the future that we are building on behalf of veterans and their families, and sincerely appreciate these committees continued support.

This concludes my statement. My colleague and I are prepared to answer any questions you may have.

[THE PREPARED STATEMENT OF KAMERON MATTHEWS APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Dr. Matthews.

I will now recognize Mr. McIntyre for 5 minutes.

STATEMENT OF DAVID J. MCINTYRE

Mr. MCINTYRE. Good afternoon, Chairman Pappas, Chairwoman Brownley, Ranking Members Dunn and Bergman, and members of the committee. Thanks for the opportunity to appear before you today on Lincoln's birthday to discuss issues related to VA community care. It is an honor for all of those of us associated with TriWest, from our nonprofit health plan owners; to university hospital systems; to nearly 3,500 employees, most of whom are either veterans or veteran family members; and our subcontractors, to be supporting Drs. Matthews, MacDonald, and the entire solid team at the VA as they seek to deliver on Lincoln's words uttered at his second inaugural address: to care for whom shall borne the battle and his widow and his orphan.

Those words equally apply to both males and females, and the commitment of a grateful Nation to be resolved to meet the needs of those who have defended our freedoms are as poignant today as they were when uttered in 1865.

For the past 6 years, we have been called on to construct a community care network the VA could rely on for the care that they needed to place in the community, to process and pay claims, and to deliver customer service support to veterans, providers, and VA staff. On December 7, 2018, to honor World War II veterans, we stepped up to take over the rest of the country for a while at the behest of the VA as they had to let another organization go that was responsible for doing this work.

We will forever be grateful to the nearly 700,000 community providers across the country who answered our call and for whom we have now processed and paid more than 23 million claims for healthcare needed by veterans to an accuracy rate of in excess of 96 percent. Just 11 million of those have occurred just since the start of the MISSION Act, and we look forward to getting to our personal goal which is in the 99 percent range in the near future.

With the exception of a challenge at the end of last year which jammed up nearly 400,000 claims, for which we are nearly finished with the processing and payment, and 10,000 Emergency Room (ER) claims that we in the VA are working through, we have been processing and paying claims within the 10 days that we committed to do in the former Health Net area. For an average of 16 days nationwide, as we said we would do.

The care in which we have been engaged includes everything from making sure that the next veteran generation gets delivered to eye care, to cancer care, to healthcare services unique to female veterans, to primary care and mental health, and to transplants and everything in between. Due to those providers who answered the call, we return less than 2 percent of care requests for no network provider available.

Mr. Chairman, you talked about Dartmouth. We had the opportunity to visit on that yesterday. Out of the 4,137 bills that they provided us, there are only 458 pending, of which only 130 are 30 days old and the oldest is in October. Since June 6, this privileged work now includes new urgent care benefit. As of today, there have been over 190,000 encounters, with more than 90 percent of this Nation's veterans having access to such care within 30 minutes of their home.

We are humbled to have been selected to continue this privileged work in our native territory of the west under the CCN contract for Region 4, and we welcome Optum to this critical work, and we will continue to fulfill our commitment to have overlap in their markets as they stand up strongly at the side of the VA to deliver.

With regard to the coming CCN contract in Region 4, we in the VA are engaged in a full team sport, just as we have been doing for the last 6 years. To ready ourselves for the next leg of the journey in this transformation, we are implementing new tools and processes, assessing what we will leave will be the demand for care and services, and charting the implementation journey, which we expect will deliver for veterans and for the VA and for community providers who we call on to support. That rollout begins with Montana and eastern Colorado on April 7, and will conclude in mid-July with the rest of the region.

There is a lot going on. As some of you have indicated today, it is a challenge. There is a long roadmap and it is extensive embodied in the MISSION Act. It is a privilege to do this work, and we are confident in our ability to deliver.

I would like to close, though, with a story from a veteran who we are all responsible for serving that got conveyed to us last week.

I was in really bad shape physically and mentally, said Thomas. I am pleased to say that I have now gone 12 days without a seizure. I learned a lot. The doctors here have done more to help me with my physical problems than I have received in 20 years. I did

not know there was a treatment for alcohol detox. Since being here, I recognize that I have been in denial about my alcoholism for 48 years. I was in a wheelchair when I came here 30 days ago. Yesterday, I was shooting hoops, and now I have hope.

That is the promise of what you all have birthed and we are privileged to do at the side of the VA. We look forward to doing our part, we look forward to applying the lessons we have learned, and I look forward to responding to any questions that you might have. Thank you very much.

[THE PREPARED STATEMENT OF DAVID J. MCINTYRE APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Mr. McIntyre.

I will now recognize Lieutenant General Horoho for 5 minutes.

STATEMENT OF PATRICIA D. HOROHO

Ms. HOROHO. Chairman Pappas and Chairwoman Brownley, Ranking Members Bergman and Dr. Dunn, and members of the subcommittees, I am Patty Horoho, CEO of OptumServe. On behalf of the more than 325,000 men and women of the UnitedHealth Group, we are honored to be part of this mission, to provide community care networks for Regions 1, 2, and 3.

The veteran is at the center of everything we do. We have a long history of serving our Nation's military and veterans. Our mission is to deliver a high-quality provider network to meet the needs of our veterans, and we are dedicated to fulfilling that mission. I am pleased to report Optum is on track in fulfilling that mission.

Thousands of veterans are utilizing our high-quality, broad Community Care Network. Providers are getting paid promptly. We are providing timely and responsive customer service, and we are continuously building and adapting our network and operations based on data and utilization trends.

Central to our responsibility is delivering a network of high-quality health providers from which VA staff and veterans can choose. To build this network, we began by leveraging the 1.3 million providers and 6,500 healthcare facilities in UnitedHealth network and Optum provider networks, but that was just the beginning.

With the VA, we are identifying an adding preferred providers who have a history for caring for our veterans. Today in Region 1, our network includes more than 178,000 unique providers in health systems across more than 309,000 care sites, and taking a data-driven approach, we continue to evolve the networks across all three regions to meet the needs of our veterans.

On December 10, we completed Region 1. Since then, taking a data-driven approach, we have expanded the network by more than 25 percent, adding 35,000 unique care providers, over 62,000 care sites. Central to the success of the program is the provider experience. This includes paying them promptly, which underscores that Optum is a reliable partner, thus increasing provider confidence and continuing to deliver for our Nation's heroes. As of today, we have processed more than 150,000 claims, and we paid these claims in an average of 11.9 days.

Another critical element is answering questions and resolving issues as they emerge. 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, most importantly, we resolved more than 99 percent of the questions or issues on the first call.

We also want to ensure providers have the information they need to participate in the Community Care Network. Our communications approach uses different channels, including proactive letters, calls, and in-person meetings. After providers join our network, we utilize webinars, in-person trainings, and virtual townhalls to train them on the new network. We provide regular updates, education materials, on-demand videos, and the ability to upload and track their claims all online, and we are restless in our desire to do more. We are committed to identifying new and effective methods in which to communicate with providers.

In conclusion, 7 months into healthcare delivery, veterans are getting care from our network, providers are getting paid promptly, and we continue to adapt and build our networks across all three regions in strong partnership with the VA and TriWest. We are equally committed to continue our open lines of communications and regular engagements with Congress, the veteran community, and our stakeholders. We share your commitment to ensuring this program delivers experience our veterans deserve. Fifty percent of our community care program staff are veterans, and I am a veteran. We understand why getting this right is so important.

Members of the committee, thank you for what you do every day to support our veterans, and thank you for this opportunity to testify.

[THE PREPARED STATEMENT OF PATRICIA D. HOROHO APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you for your testimony.

Mr. Dombi, you are recognized for 5 minutes.

STATEMENT OF WILLIAM A. DOMBI

Mr. DOMBI. Thank you for the opportunity to submit testimony here today.

The Veterans Administration's healthcare benefits for home base care present one of the most robust arrays of supports for care in the home. This shows a strong commitment in the VA to provide significant and unrivaled home base care opportunities. There can be no doubt that the VA is a leader in providing cost-effective, high-quality, and innovative home care services.

While designing a package of home care benefits for veterans is an important step to meeting their healthcare needs, it is equally important that the benefits be implemented in a timely and effective manner. The transition to the new community care program demonstrates the proper implementation planning and execution can make a dramatic difference in delivering on the promise of home care services.

At present, there is room for improvement. However, there is also time to learn from the lessons from the early stages of the transition to establish implementation improvements. In that respect, I will focus on the experiences in home care programs to date.

There, the issues that have surfaced involved, one, confusing communications; two, securing an adequate supply of care pro-

viders; three, care authorizations for payment delays; and five, payment rate cuts. Each of these subjects are addressed in more detail in my written testimony, but I will touch on them briefly.

Communications is a big issue always in healthcare administration. Our members of the association report ongoing difficulties in gaining an understanding of what is changing through community care, who is responsible for the various parts of the transition, and how the care authorization process and provider enrollment process is supposed to work. Today, it is near impossible to find the detailed information needed to determine what is required for an existing VA home care provider to qualify to provide services in community care. For veterans, determining how to access home care benefits is also a major challenge. We recommend that the VA initiate website revisions that provide for improved navigation and content that answer these and other basic questions.

Due to changes connected to the transition to community care, many of the long-standing home care providers are now on the outside looking in, turning away perspective patients on a daily basis while waiting for months to complete a credentialing, contracting, and enrollment process long after the transition has started. Today, many months after the start of the transition, significant numbers of previously qualified home care providers are still waiting to requalify. One company alone reports over 250 locations on hold.

We recommend that the VA consider revising the provider enrollment process to avoid a loss of access to care, improve the options available to veterans, and ensure that patient needs are prioritized over paperwork. The revisions could follow a path traveled by a number of State Medicaid programs. There, the transitions permitted beneficiaries to continue receiving authorized services from their existing provider for 6 months or more. It was a grandfathering of existing home care providers while undertaking any desired credentialing and contracting, and maintaining existing payment rates for some designated period of time. It was heartening to hear that some of that is already now in process.

This manner of programmatic transition secures near seamless experiences for patients and providers alike, without creating any significant difficulties for the benefit program. With respect to care authorizations, it has been a long-standing problem with VA home care. Care authorizations continue in community care problems. Home care providers report ongoing difficulties in getting authorizations processed timely, sometimes waiting 6 months or more to start care. As a result, some home care providers report that they have stopped admission of any new VA patients.

In the absence of care authorization, care cannot start putting the veteran at risk. We respectfully recommend that the VA take immediate steps to expedite home care authorizations. One approach is to rely upon the judgment of the professionals actually providing the care for that veteran and cover care when certified necessary by that attending practitioner.

Payment delays do continue to abound. Our members report delays of multiple months. It has reached a level of concern that a number of providers are discontinuing admissions of VA patients. No business can carry receivables for an extended period of time, and home care companies operate on human capital with payroll

due every week. We recommend that the VA establish a clean claim payment deadline. Failure to meet the deadline should require the payment of interest on the amount owing.

Rate cuts, the chairman mentioned that in his opening statement. When payment finally arrives, it is not always a pleasant surprise. Home care providers report unilateral rate cuts to levels far below the cost of care with no explanation. In many instances, the rate cuts are retroactively applied. Cuts of this nature trigger lost access to care. Rate setting appears to occur behind the curtain, leaving patients and providers often in the dark. We recommend that the VA maintain a transparent rate setting process that is focused on real live care costs and a level of payment needed to ensure uninterrupted access to care. Again, it was heartening to hear from the VA that they have got something of that nature in process.

In conclusion, we greatly appreciate the opportunity to provide the committee with the foregoing information. We stand ready to partner with the VA and its contractors to develop all necessary steps to ensure a viable home care program fully accessible to our Nation's veterans.

Thank you.

[THE PREPARED STATEMENT OF WILLIAM A. DOMBI APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you for your testimony.

I will now recognize Mr. Golnick for 5 minutes.

STATEMENT OF ERIK L. GOLNICK

Mr. GOLNICK. Good afternoon, Chair Pappas, Brownley, Ranking Members Bergman and Dunn, and members of the subcommittees. Thank you for inviting Veteran and First Responder Healthcare to testify today regarding our experience as a community provider working with the VA and with third-party administrators.

As a former naval officer who suffered from post-traumatic stress and substance abuse issues, I am acutely aware of the importance of advancing and improving veterans' access to health, and the hard work that these committees do we sincerely appreciate. VFR Healthcare, along with our sister organization Strive Health, is a veteran-owned and operated organization that was founded to increase the access to and quality of outpatient, substance abuse, and mental health treatment for veterans, first responders, and their families.

In June 2018, we entered into a partnership with the VA to enhance veterans' mental health and treatment to reduce suicide. Since then, we have been working together to advance and improve veterans' mental health and well-being. Through this partnership, we were able to successfully enhance veterans' access to behavioral healthcare. For example, 100 percent of veterans referred to our programs have a scheduled intake within 24 hours.

We are honored to be partnered with the VA and have had the privilege of working and providing behavioral health treatment services to veterans over the last few years. In doing so, we have had the unique experience of working with the VA and providing healthcare services to veterans through several different community care programs and transitions.

As a veteran-run company, we are mission focused on ensuring that veterans and their families get the highest quality care they need in a timely and efficient manner. As such, we assume the administrative burden on behalf of the veterans to make sure that any issues with billing or authorizations are taken by us. Taking on the administrative burden for veterans is especially important in mental health and substance use treatment as these administrative issues can cause stress and anxiety for veterans at a time when their stability and structure in their lives could be life and death.

Now, before discussing our experience and challenges we have had as a provider, I think it is important to mention that we are also in network with over 15 separate commercial health insurance companies and two State Medicaid plans. The challenges we have experienced with the TPAs are not unique and happen quite often with other health plans during periods of transition. It is our hope by illuminating these issues and providing some insight as a community provider, we can assist in making the Community Care Network more efficient and the transition to other regions easier. I will now go through some challenges we have experienced.

First is a clear delineation of rules, responsibilities, and troubleshooting process. On multiple occasions and spanning several different categories, we have run into administrative issues that both the TPAs and the VA were unable to resolve. In these instances, we followed protocol, spoke with TPA employees, who informed us that the local VA was responsible for addressing these issues. We then spoke to the local VA, who then told us that it was the TPAs responsible for resolving these issues.

In all these cases, we ensure that the veteran is still being taken care of. We are not going to let that burden affect them.

Second issue we run into is the ensuring a seamless referral process. We have spent a considerable amount of time with our VA partners and the TPAs to understand the referral processes and potential pressure points. While the new CCN allows VA staff to refer veterans to community providers, in practice, there are several what we would call pressure points where the referral can either be slowed down or almost stuck.

Third is an efficient and accurate uploading into the TPA system. A complete and accurate upload of a community provider to a payer system is critical to ensuring that proper referrals are generated, claims and payments are appropriately paid, and accurate information is provided to veterans and referring providers. Any issues with this upload present dire consequences to the community provider and significantly affects the care currently being provided, as well as the care coordination with the VA.

Fourth, uniform claim submission and reconsideration policies. Claim forms which healthcare providers submit to get paid for services rendered are extraordinarily complex and comprehensive. As such, setting and adhering to uniform claims submission and reconsideration policies is paramount to the claims and payments that we are—that we can—we are able to resubmit and properly adjudicate them.

In conclusion, we appreciate the opportunity to address the subcommittee today to assist the VA and TPAs in their collective mis-

sion to enhance the health and well-being of our Nation's veterans. We believe the Community Care Network is critically important to ensuring veterans can access necessary care in a timely manner. It is imperative that processes, systems, and control are in place so the VA, the TPAs, and community providers can work seamlessly together to enhance access to care for veterans.

While community providers like us are bearing the brunt in the short term, they are not unique to the VA or the TPAs, and we believe they are solvable challenges. We are confident that the VA and TPAs will work diligently to resolve these issues. We believe the VA and the TPAs and community providers will work together efficiently as a team to ensure that veterans receive timely and adequate care.

Chairs Pappas and Brownley, Ranking Members Bergman and Dunn, and members of the subcommittees, this concludes my statement. We would be happy to answer any questions any other members of the committee may have.

[THE PREPARED STATEMENT OF ERIK L. GOLNICK APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much for your comments and to all the testimony that we heard from our panel. We will now turn it over to questioning, and I would like to begin by recognizing myself for 5 minutes of questioning.

We just heard from a witness, a community provider, who talked about frustrations that they have seen with the system, bureaucratic issues that result in this kind of palpable frustration that I hear from so many providers in my district. Some of it comes down to a lot of this, which is that, you know, a provider is told to go to the VA and the VA tells the provider to go to the third-party administrator, and it is this circular loop that sometimes they can not get out of.

I am wondering if I could hear a little bit from Dr. Matthews about the support that you offer to providers and how we can get all the parties together to help address some of these concerns and allow people to just get the bill paid and provide the care to veterans that they want to provide.

Dr. MATTHEWS. Sir, thank you so much for that question. I am in complete agreement, not only with our colleague on the panel, but with the intent behind your question. We do need to streamline this process. I like the language that was used, not only about claims, but also referrals and authorizations. There needs to be uniformed processes on how to do this.

What we have adopted and actually have rolled out to all VA facilities is a purchased referral and authorization system, so that there can be communication with our partners in the community, that there can be even messaging, but also sharing of referral and authorization data, of even sharing medical records so that there is a streamlined approach to how communications occur more than anything. A lot of times, there is difficulties in finding the right partner. There is the finger pointing, as you notated as well too. We really are streamlining how those communications occur by just increasing the technology that is available. It is not a phone call, which is just an outdated format.

I think the other piece that I think we are still recovering from through the Choice Program was the need for the TPAs under Choice to authorize the care, so there was often some decision-making on the part of the TPA, which was wholly unsatisfactory for the veteran, for the VA. I think even for the TPA, speaking on their behalf. Under these new contracts, the authorization, the referral information, the scheduling, everything that is veteran focused remains with the local VA. The facility is the one scheduling, the facility is the one authorizing that care, making those decisions. Our third-party administrator partners are there to bill the network and to pay the claims. That is more industry standard, and we hope that our partners in the community have appreciation for that simplification.

We do need to have more consistency, admittedly, amongst our facilities on how they use the new Healthshare Referal Manager (HSRM) system and how they communicate with their providers, and we are providing that sort of training and capability so that it can be streamlined in every way possible.

Mr. PAPPAS. How can we measure that over time? I mean, one of the concerns is, you know, you have cited some process improvements that I think could help the situation, but if we are not getting feedback from folks like Mr. Golnick, how do we know how we are doing? I guess, how do you stay plugged in to the provider community? How do you measure satisfaction, and do you have a tool that you could use for that?

Dr. MATTHEWS. It is a great question and one I was going to answer exactly the wording you used. We would like to have a greater sense of provider satisfaction. We have multiple surveys within the VA of veteran satisfaction, but actually, through our third-party administrators, the network is responsible for collecting provider satisfaction data so, therefore, we can actually take action and improve when these sort of shortcomings are still in place. I look forward to that data. We have not had it in such a comprehensive way previously. Again, one of the benefits of having strong partners here to help us implement that is that it can be uniform across the network, and then we are best suited to then act on it.

Mr. PAPPAS. In the referral and authorization system that you mentioned, is this new? When was that implemented? You know, because I am hearing so much back home about claims not being processed in a timely fashion. You know, is there some kind of a breakdown in this particular system or is it——

Dr. MATTHEWS. No. Multiple systems have actually been rolled out over the fall. The referral system is purely the one where the VA provider enters a referral and authorization and it actually can communicate directly with the community provider, if they so choose to use it. It is a cloud-based format and they can sign in and read about the referral. That was fully deployed over the fall. Not every facility has been using it because it is actually meant to interact with the Community Care Network as opposed to other providers that we have contracts or relationships with. As the facilities have been deploying to CCN, meaning launching to either Optum and soon to be the newer network under TriWest, they will be using HSRM more.

Mr. PAPPAS. Do you know how many providers are using it? Then my time is up.

Dr. MATTHEWS. Unfortunately, I do not, but I can get you that information.

Mr. PAPPAS. I think that would be helpful to know. Thank you for your responses.

I will now recognize Dr. Dunn for 5 minutes.

Mr. DUNN. Thank you very much, Mr. Chairman.

I want to say my couple comments first, Doctor/Secretary Matthews, I was thoroughly impressed with the progress you have made. You hit the community care programs in such a short amount of time. I enjoyed our discussion earlier this week. We both know there are still areas that can be improved, but I am grateful for and reassured by your very obvious detailed grasp of those problems and your proposed solutions and, frankly, your professionalism as well.

General Horoho and Mr. McIntyre, speaking as a community doctor who has cared for veterans in community care programs for decades, and I am a veteran, let me say that the early results of your implementation of your portion of the MISSION Act has been a breath of fresh air. I have spoken with a sampling of my doctors and my hospitals back home about their experiences, specifically since D-Day 2019, and each of them noted dramatic improvements.

I also spoke this morning with the chairman of Duke University Department of Surgery, who happens to be a transplant surgeon. Prior to the MISSION Act, his veterans could not receive an organ transplant anywhere in North Carolina. They were forced to travel to Memphis, Minneapolis, or Pittsburgh repeatedly for these services. He happily reported this morning that these veterans are now being allowed to receive the care right there at home in North Carolina, in his case, at Duke. Further, that the relationship between Duke and the VA hospital, which is directly across the street, is better than ever.

First, Dr. Matthews, I would like you to briefly share with the rest of the subcommittee, share your plans to address those—well, I think you actually did just now, actually, with Chairman Pappas—the addressing the authorizations. I think that is great. There are also some problems, however, in the urgent care area, hospice, there are little hiccups there, home nursing. Briefly, briefly just kind of reassure everybody else as you did me earlier this week.

Dr. MATTHEWS. Excellent question. Thank you so much, Dr. Dunn.

What we have instituted honestly toward the end of the Choice Program, but our more comprehensive with the approach now is a concept of a bundled authorization, not a bundled payment the same way Centers for Medicare and Medicaid Services (CMS) pays for things in bundles, sorry for being repetitive, but that in referring for the care and placing the order for the care, the VA provider is acknowledging a package of care that could be associated with that. If you are referring for a hip surgery, we are authorizing the physical therapy that goes along with it, we are authorizing the follow-up visits, the prescriptions associated with it, the labs, the x-rays.

Mr. DUNN. That was so key. I can not tell you how many times somebody is authorized to see me but not have a CT scan.

Dr. MATTHEWS. Yes. This is just commonplace in really the managed care space. In the VA, we now have these—these are called standardized episodes of care, or SEOCs we also call these. This is critical, and they are being fine-tuned for exactly the services you mentioned, Dr. Dunn——

Mr. DUNN. I know they are. I wanted the other members of the committee to hear that, because we took a deeper dive in it individually.

General Horoho, Mr. McIntyre, your great experience, I will say the credentialing still could use a little massaging there, but I think you are up to it. It looks like the easiest point of the problems that we still had remaining.

I guess what I will do is I will close and I will say, I want to continue our collaboration. I want to continue this conversation and communication back and forth with the committee. We want to give each other feedback, and I will get my feedback from my veterans and my hospitals and doctors back home, but I need to have—we need to have all of us talking to each other about these kind of problems. I think after we have a year's worth of data under our belt, perhaps sometime this fall we could do this again, maybe September, if you would have the data ready by then if you can. I will humbly besiege Chairman Pappas and Chairwoman Brownley and General Bergman all to join me again up here and hear how things are going 1 year in. But so far, I am cautiously optimistic. Thank you very much for your efforts on behalf of our veterans.

I yield back.

Mr. PAPPAS. Thank you. I think that would be timely, you know, given the VA's indication that these 2 million aged claims will be dealt with by the end of the fiscal year. We can see how things are going there.

I will recognize Chairwoman Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Hello, Dr. Matthews, it is good to see you again, after our travels to the Dakotas. It sounded to me in your testimony that you understand now about these rate reductions around home care issues. It was very alarming when I heard Mr. Dombi, is it? Correct?—Mr. Dombi's testimony of these rate reductions and then, you know, charging these providers retroactively a lower rate. It sounds to me as though you recognize that, and maybe you could talk a little bit about how you are going to address it.

Dr. MATTHEWS. Sure. Excellent question and, really, I admit that this was a fumble on our part. The fee schedule is actually updated on an annual basis at the beginning of the fiscal year, but as our colleague Mr. McIntyre acknowledged, the fee schedule got out late. This will be corrected moving forward; however, then in the fee schedule, there were several errors. Those have since been corrected. The new fee schedule has been updated into our claims processing systems and we will be reprocessing all the applicable claims back to the beginning of the Fiscal Year at the improved and updated fee schedule. There is no additional work that the community providers need to do, no resubmitting of claims.

Ms. BROWNLEY. Okay. When you say the rates, there were errors, I want to hear from you specifically that they were reduced improperly.

Dr. MATTHEWS. I actually can not confirm that, ma'am. These were—this was a fee schedule that was created through several subject matter experts who were communicating with the field as well as, I believe, with some community providers. That is how they created the fee schedule. I can not necessarily confirm that they were in error, with the exception that they were most likely reduced a little too quickly from prior rates. They have been adjusted back to something more reasonable and accepting for our partners.

Ms. BROWNLEY. Well, that still remains a concern for me then because, you know, honestly, in the hearings that I have had in my subcommittee, you know, this silver tsunami that is moving through the VA, you know, a large cohort of veterans who are 70 years or older who are going to need, you know, in-home care. This is where veterans want to be is in their homes. They do not want to be in a nursing home. They do not want to be institutionalized. Quite frankly, by serving them in home, it is win-win because it is where they want to be and it is actually cheaper in terms of our resources.

I want to make sure that, you know, the right incentive is there to provide in-home services, you know, throughout the country. If we are going to begin to reduce rates when the cost of care is increasing, it sounds to me that is going to diminish our supply, and that is a concern—that is a concern for me.

I hope when you are looking at the rates, you know, that you are taking a hard look at regional costs and keeping those rates at a level where we can increase the supply, because the demand is going to be greater than the supply and I think we have to move in that direction.

Dr. MATTHEWS. Can I clarify one point on that fee schedule?

Ms. BROWNLEY. Sure.

Dr. MATTHEWS. These are only rates that we are adjusting that do not have applicable Medicare rates. Any other in-home services that have Medicare rates, we follow the CMS fee schedule. This is only when we need to create additional fees that CMS does not cover.

Ms. BROWNLEY. Mr. Dombi, based on what you just heard, can you tell me what you feel the impacts are?

Mr. DOMBI. The impacts to date have been essentially just access to care. I am wondering after hearing what I am hearing, you know, is this a deja vu for being the second child in the family. You know, perhaps it is home care services that was last out of the gate in terms of actions taken, because it seems that we have been bearing the brunt of some of the administrative actions and some of these little snafus that have occurred there.

When I say second child, no, I do not need any psychological counseling. You know, I have weathered that storm and now identify with my grandchildren, who are the second child in their family. You know, home care has been a stepchild, but, you know, we can announce here today we are going to take over the healthcare world, so we will get the respect eventually.

Ms. BROWNLEY. Well, I hope the two of you will converse and talk and work this—and work this out.

I have a very little time left, so one question, Mr. McIntyre, that I wanted to ask you. When you were in my office yesterday, you said mental health usage in the community has increased 400 percent, which was astonishing to me, quite frankly. My question, and very quickly because I have run out of time, is are those veterans who are receiving community care for their mental health needs, are they also getting the wraparound services that they would normally be aware of and accustomed to by receiving their mental healthcare within the VA? I think I have used my time, so maybe you can get back to me on the answer.

Mr. MCINTYRE. Do you want it for the record?

Ms. BROWNLEY. For the record. I yield back.

Mr. MCINTYRE. All right. The one thing that I would say, if I might, is that you all adjusted the access standards for mental health, among a few other things, in the MISSION Act. That is what drove the increase in demand going into the community, because it said to everybody involved in this process, folks need to be seen faster. There is a limit in supply sometimes, and that is why the elasticity of the community exists in these contracts, and that is where the increase in demand came from.

Mr. PAPPAS. Thank you for your comments.

I will now recognize Ranking Member Bergman for 5 minutes.

Mr. BERGMAN. Thank you very much.

You know, as we have the different entities here, in some ways, it is no different up on the dais here than it is for you at the testimony table. We are only going to be successful if we build relationships at all different levels across any potential boundaries.

Mr. Golnick, I would like to just thank you for not leaving anybody behind and being a first responder. You are setting the standard. Others can emulate that.

You know, Dr. Matthews, what are you doing to build relationships with providers?

Dr. MATTHEWS. Great question. We have built, over the past couple of years, actually, a provider engagement team within community care within our office. I admit that it has not necessarily been an audience that has a dedicated area for communication and information prior years where websites were not updated, but really, it is one of our priorities. Without our provider partners, we obviously could not provide these services to veterans. We are really looking to improve communications.

We have more direct consultations available for providers to communicate directly with my staff. We have monthly webinars and trainings where they cannot only learning about our business operations, but also take a lot of the training that VA providers have. We emphasize suicide prevention and a lot of the other veteran-specific conditions, even the ones acknowledged under the MISSION Act. We are really doing as much as possible to hit a broad audience through available resources.

In addition, myself and other leaders in my office, we are definitely communicating with different member associations. I am presenting at multiple different hospital associations, primary care associations, Association of American Medical Colleges (AAMC). We

attend many conferences just to get out the language, the messaging around, really, VA's acknowledgement that——

Mr. BERGMAN. I hate to cut you short because it is a long answer. You are obviously doing a lot of things. Remember, you know, communication is not what is said, it is what is heard.

As you are communicating, I do not want to sound instructional here, but if you can receive feedback at the same time you are trying to communicate to see if your message is being heard in the way you intend.

Also, kind of to piggyback a little bit on the fee schedule piece, Dr. Matthews, this is the type of situation that should be avoidable and negatively impacts the VA reputation because, not only are the veterans concerned, but the providers, as we saw prior to when you do not get paid and you do not know what is going on, that kind of destroys their confidence.

For Dr. Matthews and General Horoho, I would like you to take this one for the record because it is a long answer but, you know, my office has received complaints that for some veterans, it is still taking months to process approvals for community care. With Optum going live in Iron Mountain in my district next week, I am asking your help to manage expectations there. How long should a veteran expect to take from the point of referral by VA to a community provider to the point of seeing the doctor in the community? I mean, should they expect that right away or will it take time to get there. Or if it will take time, how long? I mean, do you have any metrics or goals that maybe you see here you are today and where you are trying to achieve reasonable goals?

Dr. MACDONALD. Sir, we will take this for the record as you asked, but happy to communicate directly with you on this and engage your office, if you would like. We have briefed staff on our new referral coordination initiative which will take care of this. Urgent referrals, VA processes in 2 days and gets that care delivered. It is the routine referrals that you are addressing, and we would be happy to go deeper on that with you.

Mr. BERGMAN. Yes. It is because it is about setting expectations and it is, you know, just getting those—you know, getting the answers.

Mr. McIntyre, I know I have got about a minute left, but would you please elaborate on TriWest's demand capacity assessment process and how it informs TriWest's efforts to build its provider network?

Mr. MCINTYRE. Yes, sir. Thank you for the question. We used a set of tools most recently to lay down the urgent care network for all of your districts across the country. Basically, what we do is we understand and chart out where veterans live, so the actual address of their rooftop. We look at the demand profile from each one of the VA medical centers wrapped around that population. Then from that, we figure out what the supply needs to look like for each of the specialties for which someone needs to see.

We have been using this set of tools since after 9/11 when we built networks for the Guard in States like Idaho. We picked it up in the crisis in Phoenix. Then we used it for urgent care, and we are now—we have just finished the assessments with VA at the

ground level in Region 4, and that is informing how we will set the network for Region 4 going forward.

Mr. BERGMAN. Okay. Thank you.

Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you, Ranking Member Bergman.

I would like to recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman. Thank you to all for being here. Especially thank you, Mr. Golnick, for coming all the way from New Hampshire. Good to see you again.

The veteran's example that you gave in your testimony, it still had not been cleared up after almost a year of nonpayment. Was that an old TriWest claim or was that an Optum claim the entire time? I am sorry if I did not pick that up.

Mr. GOLNICK. That was a TriWest claim.

Mr. LAMB. Okay. We are hoping that with TriWest resolving those old claims in the next year, that that would be resolved along with the rest of them. Is that your expectation now?

Mr. GOLNICK. I am not sure what our expectation is, to be frank. I am hopeful that we will get to a resolution, because in this example, we have the referral in hand that has been authorized, but no one knows from the TPA side or the VA side what to do next in order for the claims to be reimbursed properly.

Mr. LAMB. Okay. I know from talking to you, Mr. Golnick, that you operate in Pennsylvania as well as New Hampshire?

Mr. GOLNICK. That is correct, sir. Yes.

Mr. LAMB. Have you seen similar issues with the TPAs and getting paid on time in Pennsylvania or is there a geographic difference or is it the same?

Mr. FRIEMAN. We have actually seen, in Pennsylvania, it has been a better, more efficient process, and maybe that is, again, learning from lessons that started out in New Hampshire. Really, unfortunately, in New Hampshire is where we have experienced most of our issues.

Mr. LAMB. Okay. Then as far as the provision of care itself, Chairwoman Brownley was asking a little bit about this, the increase in mental health provision in the community. Would you say that there is anything different about the way that you provide mental health or substance abuse treatment to your veteran patients than what they would get in the VA? I mean, I know, obviously, the setting is different, but as far as the actual care and the evidence it is based on and the style.

Mr. GOLNICK. It is all the same evidence-based treatment. We actually partner quite well with the VA, with the local VAs. Our main focus is intensive outpatient treatment, which is the 3 hours, 3 days per week of substance abuse treatment, and we also do outpatient. It depends on what the need of the local VA is. If they need us to do more outpatient treatment, we will do that as well.

Mr. LAMB. I thought that is what you were going to say, and that makes me even more confused as to why it is difficult to reimburse on time, because it is not like you are providing something that the VA would not recognize. It sounds to me like the actual services, interventions, therapies, whatever you want to call them, toward your patients look similar to how they would be inside a VA hospital. Is that fair to say?

Mr. GOLNICK. Yes, absolutely.

Mr. LAMB. What do you think the friction point is as far as making sure that the bundle of services you provide once you get the authorization, what really is the friction point with the payer? Do they not understand what you are doing or——

Mr. FRIEMAN. Unfortunately, behavioral health is not really an understood side of the healthcare industry. For example, we are licensed as a facility, but some insurance companies accidentally consider us a provider group, which we are not. We are a facility. There are two claim forms. We submit via a facility claim form or a professional claim form, and so often, if a policy is not set to begin with, we will get the nod for using either or both. Really what it comes down to is, unfortunately, behavioral health is just progressing and becoming a healthcare industry that insurance companies are paying attention to.

Mr. GOLNICK. I do want to emphasize that on the ground level, the actual clinicians that are setting the referrals up, they understand what we do, and we work very well together. I think once it gets past that level is where we start seeing the issues.

Mr. LAMB. I see. Okay. The last thing I wanted to ask was do you have patients that take advantage of some of the types of services that VA is now offering under the whole health spectrum, so acupuncture, massage, nutrition, meditation, all that kind of stuff?

Mr. GOLNICK. Absolutely. I think one of our main focus is to make sure that when the veteran comes to us for treatment, they understand and are aware of all those treatment options. Again, it goes back to the partnership with the VA. We are trying to make sure that these vets, a lot of them are hesitant to come to the VA, that they understand that there are all sorts of services that they are eligible for.

Mr. LAMB. Do you tend to see veterans use some services at the VA and your services or is it more of a clean break from the VA institution once they come to you?

Mr. GOLNICK. No. Back and forth. We mostly see back and forth.

Mr. LAMB. Okay. I really want to thank you two for what you are doing. I know you do excellent work in my home State, as well as New Hampshire, and please keep it up. We will do everything we can to make it easier on you. Appreciate it.

Mr. GOLNICK. Thank you, sir.

Mr. LAMB. Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you very much.

We are very lucky to having the ranking member of our full committee, Dr. Roe, here with us, and I will recognize him for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman.

If I had a problem getting paid with TriWest, the solution is right down at the end of the table right there. I would be speaking to him before I leave.

Second, we have a guest in the room I just noticed sitting on the back row who did tremendous work on the Choice Program. I remember many nights I spent with Chairman Miller, Jeff Miller, who is in the back, who really teed all of the MISSION Act up with his work as chairman.

Jeff, I want to thank you for all the work you have done for veterans. We would not really, I think, be having this hearing this afternoon had you not done the great work you did on the committee. I think Julia was here and Mr. Sablan. Thank you for that.

Just a couple of questions. We have two generals here. I am going to salute the Army General. The question to you and Mr. McIntyre is, how long on average does it take for a new provider to become credentialed and begin seeing patients as a part of the network? Both of you can answer the question.

Ms. HOROHO. Thank you so much. Also thank you for your service as well.

When we look at those to build the network first, I will kind of bring it in, and so one of the things that we started out doing is we looked at the civilian population, 2 percent of it, to build a very large network, and then now we have brought it down to using referrals, so we are very data driven.

Once we identify providers that need to be in the network, we ensure that they are high-quality providers by credentialing them. The average time for credentialing is around 15 days. It can be a little bit longer because it is very dependent on providers submitting the information so we can do prime source verification, check their education, check the National Practitioner Data Bank. Then once that is done, then they are loaded into our system, and then they are available for the VA to be able to see to make a referral.

Mr. MCINTYRE. We have a consistent process. It is overseen by Utilization Review Accreditation Commission (URAC). We draw from the nonprofit Blue Cross Blue Shield backbone for much of the network that we have access to. If you do a full credentialing process for a hospital, sometimes that can take a long time, and all of the associated practices that are tied with that, but most of the professional stuff fits into the same category of what General Horoho was talking about.

Mr. ROE. One of the things that the whole idea of the MISSION Act was to say, Okay, the VA can not provide everything, the community can not provide everything for everybody, so we want to have a shared goal here, taking the best care of our veterans, and these networks are extremely important in doing that. I guess the next question I have is I am glad to see that Optum, which is our provider where I live, achieved a claims processing rate of under 12 days as of last month. Once Optum is paid, the network provider for care delivered to a veteran, how long does it take Optum to get paid from the VA?

Ms. HOROHO. Thank you for that question. Right now, we are actually getting paid in 5.8 days from the VA.

Mr. ROE. The system, as I hear it, and we are here, and I know everybody up here has heard problems with it. I want to pass along to you all that overall—and that is what we are here, to work out those problems that we have heard here and other places. Overall, I agree with General Bergman; the satisfaction is up. I hear it where I travel. I travel all over the country, various VAs. I know my own VA at home, I have heard that very same thing at Mountain Home VA, so something we are doing is correct.

Dr. Matthews, the next question for you is, does the VA assess veteran satisfaction and trust in the VA's community care programs specifically or just regard to VA healthcare in general?

Dr. MATTHEWS. We actually do both. It is a longer written survey by mail for community care trust only, so we are updating the more electronic surveys to get more real-time data, as we speak.

Mr. ROE. What, if anything, do you think the rising VHA trust scores have to tell us about the rollout of the new community care program?

Dr. MATTHEWS. I would love to take full responsibility for that, but, no, it is obviously wholeheartedly in the fact that we are integrating the care that we provide. As you have recognized, the VA services cannot provide everything to all veterans alone. As we integrate, as we make it more efficient, as we make it more veteran friendly, veteran centric, their trust increases.

Dr. MACDONALD. If I may follow onto that, sir. You have given us the tools in the MISSION Act to truly make our system unified and veteran centric, and I think it is as we use those tools and Dr. Matthews' leadership in the modernization of community care that we are seeing that trust grow in both areas.

I will just note that, in addition to our surveys, what we have been proud to see is that, for instance, in a Veterans of Foreign Wars of the United States (VFW) survey this year, 90 percent of veterans said they would recommend VA to other veterans. That kind of external validation is what we are proudest to see, and we expect that to continue to grow as we continue to modernize.

Mr. ROE. I think it has actually opened up more—the VA is actually seeing more patients within—inside the VA now that the MISSION Act has been—am I correct on that?

Dr. MACDONALD. Yes, sir. 2,100 more a day.

Mr. ROE. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. PAPPAS. Thank you very much, Dr. Roe.

I will now recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

Dr. Matthews, the eligibility criteria that the VA established was set specific drive times and wait times. Those criteria are different from the criteria that has been in the contract for Optum. This, you know, strikes me as it might be a problem on down the future. Can you explain why it was that you used rationale for doing that?

Dr. MATTHEWS. Sure, sir. Thank you so much for that question. The eligibility standards set under MISSION were the VA's promise about access, yes. However, in translating that to a contractual scenario in building a network, we do not want to build waste into a network. In building a network to a set of standards where we are not actually looking at the care or the services that we actually need to purchase, you are possibly contracting with providers, putting them through a credentialing process that is unnecessary because there is not necessarily care that we could refer to them. We will be building the standard based on veteran utilization, looking at the eligibility criteria, looking at how care is needed in each individual catchment area, and both of our partners have committed to that sort of really demand sizing. It is based on demand.

Mr. BOST. Just to follow up, TriWest would be different than Optum, right?

Dr. MATTHEWS. Actually, every catchment area, every market is technically different——

Mr. BOST. Okay.

Dr. MATTHEWS [continuing]. as there is different sets of services that may be needed.

Mr. BOST. Okay. Same, Dr. Matthews, as well. One of the major new aspects of the MISSION Act was to allow for veterans to receive care from urgent care facilities. As part of this, veterans are expected to pay a copay, depending on the number of visits and what priority groups they are in. Does the VA know how many veterans have had to pay copays and which priority groups those veterans are assigned to?

Dr. MATTHEWS. Yes, we do. I apologize, I do not have that entire set of data memorized. I can definitely take that for the record and share that.

Mr. BOST. That would be great. Thank you.

General Horoho, I understand there has been a 10 percent increase in providers in Region 1 since December and that you expect that growth to increase. Is that the level of growth you expect to see in all areas implementation moving forward?

Ms. HOROHO. Thank you, sir, for that question. We are continually looking at the data, and as the referral data shows us where we may need to add different providers with different specialties, we are committed to do that. If you look at just in Region 1, you know, we have added over 20,000 more providers. We have added 44,000 care sites. We are not finished yet, because I really do believe, as this system continues to work well, we will have veterans using it, both the VA and the community care, and we will need to continue to respond and have an agile and robust network.

Mr. BOST. What kind of growth have you seen in Region 2 or TriWest? Same, similar?

Mr. MCINTYRE. On the TriWest side where we will be serving Region 4, we are taking an approach where we have sat down with each of the facilities to map out demand so that we can understand how to tailor the network, and we are constructing against what that will look like. Montana and eastern Colorado go live on April 7. We think because we have been at this for a while, that that approach should put us in pretty good stead, because our responsibility, as Chairwoman Brownley stated, was to make sure that we learned from the things that we have been through because we did precede Optum, and make sure that this is as stable as we can possibly make it. We are tailoring the networks to what we believe the demand is going to look like.

Ms. HOROHO. In Region 2, we have built over, you know, 120-something thousand providers. We are continuing to build in that network as well, and we are using the same data-driven approach.

Mr. BOST. Well, I want to thank you all for being here today. I know there is bugs to work out. There always is. I think we are headed in the right direction, and I look forward to the next hearings we have later on when the chairman sets those up.

With that, I yield back.

Ms. HOROHO. Thank you, sir.

Mr. PAPPAS. Thank you.

I will now recognize Mr. Barr for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman, and thanks for holding this hearing.

Obviously, the rollout of the MISSION Act has been widely watched by veterans across the country, certainly in my congressional district. Thank you to former Chairman Miller for your efforts in kind of laying the groundwork with the Choice Program. I do not think we would be here without—I would echo our current ranking member. We would not be here without those first steps.

As the former chairman knows and as Dr. Roe knows, we did have problems with provider payments under the Choice Act. Confusion over the different authorizations and difficulties with referrals made the MISSION Act's passage a necessity.

To all our panelists here today, thank you for the work that you do to serve our veterans.

Let me start with an anecdote from one of my constituents. I represented a veteran who had difficulty using the Choice Program. He experienced significant delays in obtaining community appointments for cardiology and neurology. The finger-pointing that Mr. Golnick described is precisely the problem with the referral system that my constituent experienced.

He was told by the VA that his case was referred to the TPA, but when he did not hear from anyone, he contacted the TPA, who then told him they did not have his medical records. When he called the VA back, there was some confusion, but ultimately we were able to help him and discover that the delays were due to a failure by his VA primary physicians to submit his consults to the third-party administrator. Meanwhile, precious time had passed, delaying care longer than if we think my constituent had just stuck with the VA and not even attempted to use the Choice Program.

We hope that as we transition to MISSION, that that kind of a scenario would never happen to my constituent or any other veteran.

I will start with Dr. Matthews. How confident are you that as we transition away from Choice and into the post-MISSION Act world, that that scenario that affected the veteran that I represent will never happen again?

Dr. MATTHEWS. If you do not mind, I will actually defer to my colleague. We actually do have an approach to this issue.

Dr. MACDONALD. Yes, sir. If you would be willing to share that veteran's information with us, I would like to make sure that that care has been delivered now and that that veteran has everything he or she needs.

The approach we are taking to this, and as I mentioned earlier, we are delivering urgent referrals within 2 days. We are actually at 1.4, and that number continues to improve. That is better than the private sector, and we are proud of that. Where we have work to do is in routine referrals, and this has been traditionally a fragmented and antiquated process with the technology underlying it that has been also antiquated. What we are bringing ourselves to is in line with industry best practice, which is where we are standing up referral coordination teams, wholesale transforming our process.

When a veteran leaves that primary care visit—you have two primary care clinicians here. When that veteran leaves the primary care visit or sees us via telehealth, immediately there is a team to engage that veteran and make sure they know the next step in their care, that that care is referred, processed, and that care is delivered.

Our goal is to have all of these teams in place in every specialty by July of this year, and our goal is 3 business days or less for the processing.

Mr. BARR. Great. Thank you. We will double check. I think that our veteran's issues were dealt with and he did get the care, but we will circle back to make sure, and I appreciate the offer.

Dr. MACDONALD. Thank you.

Mr. BARR. General Horoho, as Region 2 in my district transitions from TriWest to Optum, ensuring an easy transition for the veterans I represent is a chief priority. As far as providers go, can you describe how you are deciding who to bring into the Optum network if the current UnitedHealth network does not meet access standards?

Ms. HOROHO. Thank you, sir, for that question. The first is to look at the 1.3 million providers that we have across United. We also then look at the data on capabilities that we may need to bring in. We get a preferred provider list from the VA on those preferred providers that either the Veteran Affairs Medical Center (VAMC) is used to using or veterans high-referral rate. They give those to us. We then reach out to those providers. Then we have also had Members of Congress recommend different providers. We look at the big academic universities to bring those in as well.

Mr. BARR. Yes. That is great, because I know the University of Kentucky Health System currently has a great relationship with the Lexington VA. They even share a medical bridge between the buildings. We hope that you would be looking at facilities like these to incorporate in the network.

Ms. HOROHO. Yes, sir. We are.

Mr. BARR. Great. Very good. Also, are you working with TriWest to see what facilities have been seeing high volumes of veterans under their contract?

Ms. HOROHO. Yes, sir. We have weekly meetings with TriWest and with the VA and really look at the referral patterns, lessons learned. We are working very, very closely with our teams.

Mr. BARR. Great. Thanks so much. Again, I think we are making a lot of progress with the MISSION Act. I appreciate all of your participation and implementation. Thank you.

I yield back.

Ms. HOROHO. Thank you, sir.

Mr. PAPPAS. Thank you.

We will attempt to do a second round of questioning here. We are going to bump up against some votes at a point in time, but we appreciate your patience and hopefully answer a few more questions here before we have to head upstairs to vote.

One question I have. I just wanted to follow up, Mr. McIntyre, on the issue of outstanding claims. You mentioned that late last year, systems were jammed up. There was a backlog of several hundred thousand claims. You have been working through that.

Can you just tell me where that stands, especially as it refers to Region 1? As I hear from providers that say they have legacy claims with TriWest, what we should do to work through those.

Mr. MCINTYRE. You bet. Thank you for the question, Mr. Chairman. Earlier in the hearing, Dr. Matthews talked about the fact that the fee schedule update that we get every year was very late in coming out. The VA has made changes to make sure that that does not happen again, which is a good thing, and she is to be commended for that. We ended up with 400,000 claims getting backed up, because they have to be stopped while the payment updates go into place. As Dr. Matthews said, the file was not even in very good shape when it came across, so it took longer still to get it taken care of.

The day after Thanksgiving, which is when the VA and I started working on this, along with our teams, there were 400,000 claims in a queue that were stopped. We did a prognostication and found that it would probably be the middle of the year before we would be done, and we decided that that was unacceptable between us, and we will finish the burning down of that 400,000 by next week.

We put all the chiropractors, the home health providers, others for which the margins are very narrow, we put them in the front of the list, and those are on the way out the door. Then we are filing the invoices with VA to get reimbursed for the money that we will have paid out of our own pocket.

Mr. PAPPAS. Okay. I want to ask a question for the VA about alternative treatments. I have met with 10 constituents recently in my district that talked about their experiences with acupuncture to treat chronic pain and Post Traumatic Stress Disorder (PTSD), and to a person had all surprised themselves with how this was improving their quality of life, their day to day. It was allowing them to lead a full life without having to take pain medication, so potentially some savings for us within the system too.

I am wondering about some information that we received on caps on the number of authorized visits for certain services, including acupuncture. Do you have any more information about that? We had requested that a while ago. If you do not have it now, can we follow up and get the detail on that? I am concerned about there being new caps in place that will reduce the number of visits that these individuals can receive.

Dr. MATTHEWS. It is a great question and one I can definitely clarify as well as assure that our teams get you the answer in writing. There is a differentiation that we make between—within alternative care. You could have acupuncture or even yoga or massage therapy for the actual treatment of a condition, so it is actually prescribed to take care of pain or some other modality, versus our whole health and wellness packages. Acupuncture, yoga could actually fall into both.

Currently, as I was describing earlier, the standardized episode of care do have limitations on number of visits. However, if for treatment purposes as opposed to whole health you need additional authorization, the requesting provider can get in touch with VA and we will authorize more care. There is not a maximum, there is not a final when it is for treatment of conditions.

For whole health, we do have limitations per year, and that is really just in order to curtail and not necessarily have overutilization, but it is a quite high rate. For instance, for yoga, we approve 30 classes a year. That is more than one a month. That is two a month for wholeness, again, not for treatment of actual conditions. That is really just to make sure that we can circumscribe usage of services. For treatment, again, with an additional referral request, that veteran can continue the services.

Mr. PAPPAS. Okay. I think we might need to get some additional information out to providers to help clarify that issue, so maybe we can work with you on that.

Dr. MATTHEWS. Definitely.

Mr. PAPPAS. I will recognize Dr. Dunn for 5 minutes if he has questions.

Mr. DUNN. Thank you, Mr. Chairman. I am glad we have a second bite at the apple.

I am not sure who is the best person to answer this question, but if a veteran needs or wants, needs or wants, you know, a certain provider who is not a member of the provider network in their area, what happens? Is that honored or is there a way to get there, or no?

Ms. HOROHO. I will go ahead and start with that, and then anybody else can chime in.

We are in regular dialog, and so if there are veterans that have a preference of a provider and they are not in our network, we do assess if they meet the quality standards and work very hard to get that veteran in.

We have also made a commitment, the three of us, that if there is a veteran that is already receiving treatment and we are getting ready to change from one TPA to another, that that veteran gets to continue with that episode of care.

Mr. DUNN. While we have got the general here in line, can you clarify once and for all on the record, is it possible to be a provider to the VA in Optum and not United?

Ms. HOROHO. Yes. Absolutely.

Mr. DUNN. Okay. You can be United and VA?

Ms. HOROHO. Our network draws upon——

Mr. DUNN. I just wanted you to say it publicly.

Ms. HOROHO. Publicly, we welcome anybody that meets the high-quality standards to be able to serve our veterans. Absolutely.

Mr. DUNN. Thank you.

Dr. Matthews, there was some talk about a national nurse line. Is that going to happen?

Dr. MATTHEWS. We have actually some longstanding plans to develop what we call clinical contact centers. It is not in our immediate future just because that is a pretty large, expansive project. Jen, I do not know——

Mr. DUNN. Enough nurses for a whole country?

Dr. MACDONALD. Yes. Thank you. Actually, in the VA Sunshine Network, this has launched, so we do have tele-urgent care. What that means is when a veteran contacts us in that contact center—and we are working to bring this across the country, which will take us a bit of time. What that means is when a veteran contacts us, we can actually spin up a video visit with a single link to that

person's mobile device in their home, in their living room, and get that care met without them even having to move. That is what we are aiming to bring across the country, and so yes. Modeling after Defense Health Agency (DHA), which has an excellent nurse call line, we are aiming to bring these into regional areas and bring in the telehealth capability.

Mr. DUNN. Thank you very much.

Mr. Chairman, I yield back.

Mr. PAPPAS. Chairwoman Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Dr. Matthews, I wanted to go back to our trip to the Dakotas, and I think we both learned a lot on that trip and hearing from Tribal leaders and trying to better understand the unique needs and experience of our Native veterans. Certainly we heard a lot of challenges around coordination of care between the VA and Indian Health Services and the community.

I was just wondering, based on that visit, is there anything that you are planning on working on to help improve that coordination of community care for these veterans?

Dr. MATTHEWS. Thank you, Chairwoman. Glad you asked. Actually, yes. I am actually putting together a proposal to our executive in charge about some different steps. I will definitely share those details with you. I will also be meeting with the Office of Rural Health about the Memorandum of Understanding (MOU), giving them some feedback from our trip, trying to put a lot more teeth into the effort, as well as take into account local MOUs and bridging those communication divides that we even saw that were bridged while we were together in South Dakota. Yes, taking a lot of steps. I do not want to get too ahead of my leadership before I can share them publicly, but I can definitely share as we move forward.

Just of note, I actually do have a listening session with Indian Health Service (IHS) and Tribes tomorrow at the Capitol Hilton. I am also scheduled for a travel consultation in San Francisco later next month. I am very excited about the progress.

Ms. BROWNLEY. Very good. Thank you. Thank you very much. I will look forward to hearing about what you are doing, and hopefully you will keep me abreast of that as well.

Mr. McIntyre, I will go back to asking you the question that I did not have enough time for before. Just again, you know, with a big increase of mental health services within the community, you know, I just want to make sure that those veterans are getting, you know, those wraparound services; things like, you know, homelessness, issues around, you know, housing for veterans, issues around education for veterans, issues around job opportunities for veterans. I am concerned that maybe the physician in the community is not going to be aware of some of those programs, and just wondering if you are making that connection.

Mr. MCINTYRE. When the referral comes to us, it comes from VA, and so our expectation would be that the VA is looking at what are the needs of that individual as that referral comes our direction. Also, what State are those veterans in, right. Are they red on the threat scale or are they green on the threat scale, right, so that we can make sure that things are properly triaged.

My feeling in this space is that we are probably all a little bit ahead of ourselves in terms of how the demand has gone up for care that needs to move into the community in order to be able to meet the standards that are required under MISSION. We on our end as a company have stepped back at a senior leadership level to say do we want to change the model even for how we are doing the appointing support in the mental health space, and we are assessing that at the moment.

We are going to sit down with the VA in our communities and say does the model that we are thinking about going to put us in a better space, because you have really got to have a circular loop that you can tie people back into both within the VA itself but when people move into the community. We will leverage, likely, some of the work that we do supporting the Defense Department services, Marine Corps, and others in the space of threat and tie people together with the VA through that lens.

Ms. BROWNLEY. Very good. Just to General Horoho and Mr. McIntyre, just in terms of training for mental health, how is that deployed?

Ms. HOROHO. Thank you, Chairwoman Brownley. We have got—we use PsychArmor as one of our training modules that are online, very robust of understanding the culture of the veteran, behavioral health, sexual assault, military related sexual assault. Those training modules are all online at the portal where our physicians can access that. We also draw upon—we have over 66,000 behavior health providers that we are tapping into in our network so that we are very robust there.

Then the other area that I think when you talked about behavioral health, there is a close relationship between substance abuse, and so we have Medication Assisted Treatment (MAT) centers, 30 minutes drive with all of our veterans in the area. Trying to link all those together.

Ms. BROWNLEY. Thank you very much.

Mr. MCINTYRE. A similar strategy on our end.

Ms. BROWNLEY. I have to yield back because I am running out of time.

Mr. PAPPAS. Thank you.

I will recognize Mr. Bergman for 5 minutes.

Mr. BERGMAN. It is not going to take 5 minutes.

Mr. Dombi, would you tell me how long on the average it is taking to get the credentials for your providers?

Mr. DOMBI. Providers are reporting to us that it has been taking several months. It is not just credentialing. You start with a contracting approach, then you get into credentialing. Then you get loaded, not in the New Year's Eve sense, but you get put into the system. The word "loaded" came from Optum, so it is taking months to get there.

Mr. BERGMAN. Okay. You know, General Horoho and Mr. McIntyre, does your organization have timeliness goals for credentialing a provider? If so, what is it? Do you have numbers on the actual rate, because we are trying to match up. Are we doing too much of reinventing the wheel when it comes to credentialing? I mean, what has changed? What is the same? What can we carry over? How can we match up but not waste time?

Ms. HOROHO. I will go. I will start.

I will use the example of home health, if I could. When we look at home health, which is extremely important, and there is actually extended care. We have already contracted and loaded and have available over 6,100 providers to provide care in that area. When we talk about—and Bill and I had this conversation outside. There are providers that are still in the system waiting to be loaded into our system and then available. The majority of those are all in Region 3 where we have not gone live, and we will not go live for several months. They will be in the system. One of them, Amedisys, which we have contracted, they will be fully available at the end of March. We are not even going to be live in Region 3 by the end of March.

Some of that long system is more of, as we roll this out in a phased manner, we made sure that we had those that we needed to be available for the areas that we were implementing at that time.

Mr. DOMBI. To Optum's credit, you know, once we got into conversation, you know, resources were committed to bringing these home health agencies and other home care providers in there. I mean, there are thousands of providers out there for services, but we have absolutely seen improvement in the process that has been employed by Optum in that regard.

You know, we kind of set a goal, or at least I did, that we would not hear from any veteran at Christmastime that they could not get access to care. Hopefully, they all did get the access to care because Optum did step up and started bringing things forward. Maybe this was a shakedown cruise.

Mr. BERGMAN. Mr. McIntyre, go ahead, if you had comments. Thank you.

Mr. MCINTYRE. We will be credentialing the network for Region 4 as we go into each one of those areas. We currently have the 700,000-some providers that we are using in a variety of different forms of credentialing, depending on how they show up in the network.

Dr. Dunn and I had a conversation about this yesterday about one particular practice, sir, in your area. There was a visit paid there today. They thought that they had provided us all the files. The files are coming tonight, and we will have that done within the next 5 days.

Mr. BERGMAN. Well, again, thank you, on behalf of Dr. Dunn. We speak for each other from time to time. We never have to think about what we are going to say because we kind of got the Vulcan mind meld going here. You guys have been around a long time.

You know, I guess I will just conclude by saying thanks for what you are already doing. It is always a good idea to try to put yourself in that other entity's shoes, back and forth, to see if you really would like it to be done to you like you are doing to others. I think that is maybe the golden rule. We can go, I believe, a long way to making sure we are sending a signal that we are moving forward as partners with the VA and with all of you providing those services. Thank you.

With that, I yield back.

Mr. PAPPAS. Thank you, General Bergman.

Would any of the members like to offer any closing comments?

Well, seeing none, I want to thank all our witnesses for joining us today. I think it is clear that the only way that veterans can receive timely care in the community is through a very collaborative process among all the players involved, community providers, the VA itself, and the contractors who are hired by the VA.

Community providers have much to offer our veterans but only if they can navigate the complexities of VA's referral authorization and payment processes. I think we heard today that these are a work in progress and more needs to be done.

I want to thank everyone for joining us here today, particularly our community providers, Mr. Dombi, Mr. Golnick, Mr. Frieman, for joining us here. Your voice is so valuable as part of this process. Thank you to the VA contractors and the VA as well for your testimony here today. I think we all have a commitment to working together to make sure that we address some of the issues that were raised in a way that can open doors for our veterans to receive the best care possible.

With that, members will have 5 legislative days to revise and extend their remarks and include any extraneous material.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 3:46 p.m., the subcommittees adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESS

Prepared Statement of Kameron Matthews

Good morning, Chairwoman Brownley, Chairman Pappas, Ranking Member Bergman, Ranking Member Dunn and Members of the Subcommittee. I appreciate the opportunity to discuss Provider Relations During the Transition to VA's new Community Care Program. VA has continued to work with our providers to ensure Veterans receive the best care possible. Community providers are integral to VA's ability to provide Veterans with greater choice of and access to timely, high-quality heath care. VA is continuously striving to enhance relationships with community providers by improving technology systems, deploying new tools to enhance efficiency with electronic file sharing and to address payment timeliness.

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 im-

proving 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.

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 2019, they have provided care to Veterans in more than 160,000 visits.

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. I are prepared to answer any questions you may have.

Prepared Statement of David J. McIntyre

Introduction

Chairwoman Brownley and Chairman Pappas, Ranking Members Dunn and Bergman and Distinguished Members of the Health and Oversight and Investigations Subcommittees, it is a privilege to appear before you today. Thank you for your principled leadership and unwavering commitment to ensuring the Department of Veterans Affairs (VA) provides America's Veterans with timely access to the high-quality care they deserve, both within VA health care facilities and in the community.

Since 2013, those of us associated with TriWest Healthcare Alliance, from our company's non-profit and university health system owners to our nearly 3,500 employees, have proudly served as a committed partner to VA, working every day to ensure VA has a robust network of proven and effective community care providers to meet the unique health care needs of our Nation's Veterans.

In fact, many of our employees are Veterans or Veteran family members committed to serving their fellow Veterans. TriWest has a long history of hiring those who have served this great nation in uniform; we understand that shared military experiences foster trust with fellow Veterans. For us, there is no higher calling than supporting government in giving back to the brave men and women whose selfless sacrifices have made this the greatest nation on Earth.

For example, at our Operations Center in El Paso, Texas, where support is provided for Veterans by processing health care requests, handling inbound and outbound telephone calls with Veterans and health care providers, and scheduling appointments for Veterans in the community with providers in El Paso and across Texas, we have hired many Veterans and Veteran family members to fill these important positions.

I would like to take a moment and highlight an extraordinary Army Veteran and El Paso native who was one of our first employees at the Operations Center. This great Veteran served our country through multiple deployments and is also the mother of an Air Force Veteran. In the Army, she oversaw the medical readiness of 1,200 soldiers. She now uses her leadership, organizational and team building skills to mentor Veterans transitioning into the workplace and to serve her fellow Veterans through our community care efforts. In the wake of last year's senseless

and tragic shooting in El Paso that killed 22 people and injured 24 others, including two cherished TriWest employees, we are so grateful to have dedicated leaders like this Veteran as we embark on our renewed mission of supporting VA under the MISSION Act.

We are proud to have earned the opportunity to continue providing 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 of 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 – Optum Public Sector Solutions, Inc. – for CCN Regions 1, 2 and 3. 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, 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.

One example of the partnership and effective "team based" effort needed to serve the needs of our Nation's Veterans was conveyed to me by an Army Veteran from the Phoenix area. Like so many, he epitomizes the greatness of our country and the men and women who wear the uniform. He is a two-time cancer survivor and credits his recovery to the joint care he received from the Department of Veterans Affairs and in the community. VA health care providers and community care providers are partnering and collaborating together to save lives. This Phoenix Veteran now generously gives of his time and volunteers at a local VA clinic to help serve his fellow brothers and sisters. The 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.

Thank you for your bipartisan determination to focus us all on the right objectives to help VA honor its sacred mission and transform its services to improve care for Veterans today, tomorrow and well into the future. It is work worthy of nothing but our very best, and we consider ourselves very fortunate to be a part of the dedicated team all working together in support of our Nation's heroes!

America's Veterans have earned the very best care possible and that includes a robust VA system of care as well as community care options when necessary. Our role at TriWest is to strengthen and support the overall VA system of care and ensure that Veterans are always at the center of everything we do. It is a solemn responsibility that we take very seriously.

History of Service to Veterans and Service Members

To better understand where we are going and how we can continue to improve VA community care services for Veterans, we must understand where we have been, what has worked and what must be improved. I would like to share with you some background on TriWest's history of service to America's military and Veteran communities, and some lessons learned along the way.

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 experience prepared us to effectively serve alongside VA as a full partner during a time of great challenge. In our book, there is no greater privilege than to be doing our part as grateful citizens to serve those who have so honorably served in defense of our Nation at home and abroad.

Supporting VA 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 three PC3 regions encompassing all or parts of 28 states and the Pacific. Several months later, the Veterans Access, Choice and Accountability Act (VACAA), which included the Veterans Choice Program, was enacted in response to a wait list crisis that first was discovered in our hometown of Phoenix, Arizona in April 2014. Congress gave VA 90 days to stand up the program, and VA asked TriWest 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.

During the five-years the PC3 and Choice programs were operational, VA, Congress and TriWest worked to refine these community care options. Ultimately, more than 90 program improvements and contract modifications were made – both to enhance the PC3 and Choice programs to better serve the needs of Veterans and to

arm VA with additional tools to support its eligible Veteran population. These improvements ranged from the addition of primary care services to PC3, to expanding the mental health and women's health provider bases, and to conducting collaborative and comprehensive demand capacity assessments at the local VAMC level to determine optimal community care provider sizing and configuration.

In the fall of 2018, VA extended TriWest's initial PC3 contract and asked us if we would agree to 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. We agreed to do so. We began expansion efforts on December 7, 2018, and completed the expansion in spring 2019. Upon completion, we provided 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 several areas as the CCN contracts are implemented. It has been an honor to serve constituents from all of your districts and states and to help stabilize the enterprise across all states as we all awaited the conversion to CCN in Regions 1, 2 and 3.

Progress Improving VA Community Care Services

From the beginning of our work in support of VA in 2013, TriWest has worked diligently to focus first on understanding and then responding to VA's specific needs at all levels – the local VA Medical Center (VAMC), the 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 690,000 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 – currently less than 2 percent, in fact. TriWest's tailored network has delivered more than 24 million total appointments since the start of this privileged work supporting VA community care.

At its apex, with TriWest serving nationwide, we received more than 400,000 requests for Veteran care in the community per month, are handling approximately 700,000 calls per month, and to date, we have processed and paid over 25 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 in outstanding payments 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 partnering together 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 we will singularly focus on supporting the enterprise and its service to Veterans in that area of the country.

VA Stakeholder Collaboration—Listening & Learning

As we shared with the Health Subcommittee last September, TriWest has proactively engaged with Veteran Service Organizations and other key stakeholders since 2013 to gain a better understanding of how we are doing and where improvements need to occur. Examples of this engagement over the past year 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 – January 2020).
- 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:
  - o Paralyzed Veterans Wheelchair Games
  - o VFW, DAV, American Legion and VVA national conventions
  - o National Association of State Directors of Veterans Affairs national convention
  - o National Veterans Summer Sports Clinic
  - o 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:

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

We will continue these proactive communications and education efforts as we transition to CCN.

MISSION Act Launch

Thanks in large part to the principled and diligent work of the House and Senate Veterans Affairs Committees in crafting the VA MISSION Act in 2018, VA has been armed with the authorities to reset the enterprise and, among other things, move the community care benefit to one that is more streamlined. Shortly after expanding 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 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, 2019, over 2.7 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 the addition of an 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 are currently 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 TriWest and VA with a brand-new benefit, especially given this population presents differently than any other... given that there is no insurance "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 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 several 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 new and existing processes, achieve informed decisions and implement lasting solutions.

Under CCN, there are several VA community care process changes, as well as the inclusion of several 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 worked closely with the leadership of each VISN and VAMC to assess 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 unique 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 VAMC in driving down the backlog of nearly 15,000 Veterans waiting in line for care. This tool allowed us to assess the demand and determine the needed number of providers and appropriate level of staffing to assist the Phoenix VA in successfully eliminating the initial backlog by the end of August 2014.

Beginning in 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 together to assess demand and then map the supply of providers that would be needed in each community to supplement VA care. We met one on one with each VAMC 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 finalize implementation schedule details but are looking to April 7, 2020, when we will begin to operate under the CCN contract in Montana and Eastern Colorado, to be followed by VA converting the rest of the Region 4 geographic area to the CCN platform by July 14, 2020. We and VA are in the midst of implementing the new tools, systems and processes to make the next generation of our privileged work together a success; we have compared demand information so that we might effectively tailor the provider network for CCN to meet community care needs of the Veterans who reside in Region 4; and, we are underway with setting the network for the start of health care under CCN.

Prior to the start of health care delivery, TriWest will demonstrate to VA several key capabilities:

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

Following the start of health care delivery in Montana and Denver on April 7, 2020, TriWest will continue to work with VA to identify and implement lessons learned and refine processes, as needed, before continuing deployments across the region. In addition to our CCN Region 4 transition 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 together 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:

- Timely Appointment Scheduling: The volume of care requests has been significant, 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 notice, it creates complication.
- Claims Processing: Provider network development becomes complicated 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:

  o 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 2020 schedule arrived unusually late which necessitated that we backed up payment on 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 addressed, and we expect to return to achieving performance standards within the next few weeks.

  o Emergency Room Claims: In an effort to effectively address VA claims payment challenges, TriWest agreed to process and pay emergency room claims for VA. VA notified providers across the country to send emergency room claims to TriWest. However, in order to process these claims, we must first receive authorization from VA. The relatively short notice in this process change has created some confusion and has resulted in less timely receipt of the authoriza-

tions. Hence, we are currently holding emergency room claims for which we have 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 given providers would have to otherwise refile the claims.

o Urgent care facilities: In processing and paying claims for this new benefit, we have determined that claims will process easier by using 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 completed 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 eliminate 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

Chairwoman Brownley and Chairman Pappas, Ranking Members Dunn and Bergman and Distinguished Members of the Health and Oversight and Investigations Subcommittees, 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 are our heroes. They have risked their lives to protect American values and society, so when their lives are at risk here at home, it is our moral obligation to serve and protect them. They have had our back as a country, so now we should have theirs.

It is TriWest's great honor 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, but those of us associated with TriWest and in VA all are very focused, and I am very proud of the work we are doing together and our accomplishments thus far. Working at the side and in support of the leadership of VA and the staff at all levels has been and remains a privilege. They are a group of very dedicated citizens working tirelessly and as solid partners to execute what you have envisioned as the future of VA, embodied in the MISSION Act. And, I am confident that the trajectory we are on will continue to improve this program in CCN 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 enhance it and to supplement VA care** in the community, **when and where VA determines 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 DoD and VA, we have developed crucial experience in helping these systems implement and mature their programs to provide timely and convenient access to quality health care services. We are committed to providing Congress our full support as we continue our work alongside VA, helping Veterans to access high quality care in the community. For us, this is sacred work. Our mission is to find and serve those in need, ensuring they have access to the right services and health care providers while also supporting community care providers fully as they serve the needs of our Nation's heroes.

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

Thank you.

Prepared Statement of Patricia D. Horoho

Introduction

Chairman Pappas, Chairwoman Brownley, Ranking Members Bergman, and Dr. Dunn, members of the Subcommittees, I am Patty Horoho, Chief Executive Officer of OptumServe, and I am honored to be here today to provide an update on our operations in connection to 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, Veterans and their families, providers, and each of you 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.

In short, Optum is on track with our phased implementation plan:

- Thousands of Veterans are actively utilizing our high quality and broad Community Care Network;
- Providers are promptly getting paid for the care they deliver to Veterans;
- Our customer service channels are quickly answering questions from VA Staff and community providers; and
- Using data and utilization patterns, we are continuously building and adapting our network and operations to meet the needs of Veterans and the VA.

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

I was pleased to join Chairwoman Brownley, Dr. Dunn, and Members of the House Veterans Affairs Subcommittee on Health last fall to update them on our progress in serving our Nation's heroes through the Community Care Network. We appreciate the opportunities we have had to spend time with many Members of Congress and their staffs as part of our implementation of this important effort, and to introduce or reintroduce them to our organization.

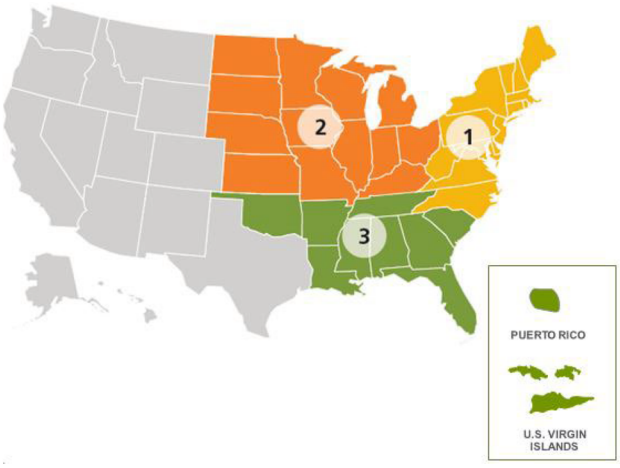
OptumServe is the Federal health services business of UnitedHealth Group. We bring together the unique capabilities of the entire Company with broad and deep experience in health care services, technology, data analytics, and consulting. We partner with the U.S. Departments of Veterans Affairs, Defense,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

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 percent of our Community Care program office staff are Veterans.

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 buildupon 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 for promptly processing claims from providers who care for Veterans as part of the VA Community Care Network. This function is critical to ensuring we sustain the 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, explanation of benefits (EOBs), 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 team has a team leader, a nurse, a business analyst, and one Veteran Experience Officer (VEO) assigned to each Veteran Integrated Service Network (VISN) within the region. 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.

Early on, we recognized the need to incorporate the voice of the Veteran to ensure we were well-positioned to meet their needs.

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, and how the process could work better for Veterans, VA staff, and community providers.

As part of this effort, 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.

We have used these 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 to 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 teams 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 VISNs 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.

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

With this, I would highlight a few specific areas 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.

Our approach to building the Community Care Network is twofold: We begin by leveraging the 1.3 million providers in the national UnitedHealthcare and Optum networks. And, we also recruit 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, which is a new requirement under the Community Care Network. For the first time in VA Community Care, all providers in the Community Care Network are now 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.

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

In Region 1 where we have recently completed the transition, Optum has built a network that includes 178,000 health systems and providers[2] across 309,000 care sites.[3]

We recognize that network management is a dynamic process and networks evolve over time – as they routinely do in health care markets outside of those served by Government. When we complete a transition, our work continues. We continuously refine and build the network to meet the needs of the VA and Veterans. We add providers based on utilization, 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 to the network. Since December 10th, when our deployment was complete, our network has grown by an additional 25 percent. This represents 35,000 additional unique health systems and providers over 62,000 sites of care now available to the VA in just Region 1.[4]

Our networks will continue to evolve and adapt to meet the needs of Veterans. This will continue in every area in which we are privileged to serve Veterans.

- **Ensuring Prompt Payments for Providers**

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 and vital to building trust between providers and our organization.

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 February 4th, Optum has processed more than 150,000 claims, and has paid claims in an average of 11.9 days with 99.93 percent of clean claims being paid within 30 days.[5]

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. As a restless organization, we continuously evaluate how we do business. We take in feedback from all our stakeholders and strive to optimize our processes and to communicate more.

And when questions 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 through when they are a confirmed network provider. Key touchpoints, among others, include:

- 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 the opportunity to participate in the Community Care Network and action necessary;
- Calls, letters, and 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;
- Just prior to the go-live date in a particular area, Optum contacts providers again and provides information on where and how to submit a claim; and

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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 2/4/2020.

[4] Data extracted on 2/4/2020.

[5] Across all regions where Optum is live.

- Regular updates, educational material and on-demand videos are also available on our provider portal at www.vacommunitycare.com.

And, if a provider has a concern that needs to be addressed, our goal is to resolve that issue as quickly as possible through our customer service channels.

We are restless in our desire to do more. We are committed to identify new and effective methods to communicate with providers.

- **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 February 4th, we have received more than 35,000 calls to our customer service center, with an average speed to answer of 3.6 seconds and 99 percent of calls are answered within 30 seconds. And, our customer service staff has resolved more than 99 percent 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 Subcommittees 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 these Subcommittees, 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, for 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.

Prepared Statement of William A. Dombi

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of home health, hospice, and home care providers across the Nation, including home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types—from small rural agencies to large national companies—and include government-based providers, nonprofit voluntary agencies, privately owned companies and public corporations. The provision of high-quality, life-enhancing care to vulnerable individuals and education and support to their loved ones is central to our collective purpose. We welcome the opportunity to submit testimony for the record for a hearing before the House Committee on Veteran's Affairs, Subcommittees on Health and Oversight and Investigations on "MISSION Critical: Examining Provider Relations During the Transition to VA's New Community Care Program," and to provide our views on key issues related to The operation of the VA's home care benefit programs.

Home Care Benefits in VA Health Care

The Veteran's Administration health care benefits for home-based care present one of the most robust arrays of supports for care in the home of any government health care program, far exceeding Medicare supports and rivaling even the best Medicaid program for home and community-based care. The benefits include skilled home health care, homemaker& home health aide care, hospice care, respite care, palliative care, home-based primary care, remote monitoring care, Veteran-Directed

care, and adult day health care. https://www.va.gov/GERIATRICS/pages/Home__and__Community__Based__Services.asp.

While the exact number of veteran's receiving such services is not readily known, we estimate that it is nearly 1 million veterans of all ages. As such, the array of benefits shows a strong commitment in the VA to provide significant and unrivaled home-based care opportunities for this Nation's veterans. There can be no doubt that the VA is a leader in providing cost effective, high quality, and innovative health care services in the home.

While designing a package of home care benefits for veteran's is an important step to meeting their health care needs, it is equally important that the benefits be implemented in a timely and effective manner. The transition to the new Community Care program demonstrates that proper implementation planning and execution can make a dramatic difference in delivering on the promise of home care services. At present, there is a great deal of room for improvement in the VA's transition to Community Care. We do emphasize that the VA and its contractor, Optum, are working hard to bring about full implementation of the home care benefits as part of Community Care. Unfortunately, the outcome continues to fall short of what our veteran's deserve. However, there is time to learn lessons from the early stages of the Community Care transition to establish implementation modifications and improvements as the transition continues to unfold.

In that respect, we can only speak to experiences in home care programs. We sincerely hope that home care is an anomaly in the implementation of Community Care. Still, in terms of the home care programs, the implementation issues cover several important aspects of health care access and delivery. The issues that have surface involve:

1. Confusing communications
2. Securing an adequate supply of care providers
3. Care authorization
4. Payment delays
5. Payment rate cuts

Each of these subject areas are addressed in more detail below.

Communications

NAHC members report ongoing difficulties in gaining an understanding of what is changing through Community Care, who is responsible for the various parts of the transition to Community Care, and how the care authorization process and provider enrollment process is supposed to work.

Today, a starting point in communications is the website of the government agency. To the extent that comprehensive information about the Community Care transition is available on the VA website, it is very difficult to uncover. For professional providers of care, a crucial linkage for patients, the website navigation is very confusing and appears to offer information only through laborious searches that depend on knowing the right key words. Once a party gets past the scanty description of the home-based care benefit package, it is near impossible to find the detailed information need to determine what is needed for an existing VA home care provider to qualify to provide services in Community Care. For veterans, it is seemingly impossible to determine how to access home care benefits in the new program model.

NAHC recommends that the VA undertake a wholesale evaluation of its website and to initiate revisions that provide for improved navigation and content that answers these and other basic questions that exist in any heath care program.

Access to Providers of Home Care Services

Across the country there are an estimated 30,000 providers of home care and hospice services. Of those, over 11,000 are home health agencies and over 4500 hospices participating in Medicare. The remainder provide Medicaid and private pay nursing and personal care services. Many of these providers had accepted VA patients into their care. However, due to changes connected to the transition to Community Care, many of these longstanding providers of care to veterans are now on the outside looking in, turning away prospective patients on a daily basis while waiting for months to complete a credentialing, contracting, and enrollment process long after the transition to a new contractor in Community Care has started its administration of the home care benefits.

The difficulties experienced by home care providers is well explained by Sheila Rush in a recent email to NAHC. Ms. Rush is the owner of a home care company, Nurses Care, Inc., operating in Ohio.

Our agency, Nurses Care, Inc, receives referrals for home care for veterans from the VA, ordinarily several in 1 week, sometimes several in 1 day. We care for the vets in the Dayton/Cincinnati region. As of Dec 10, 2019, the VA office from where our referrals normally come told us that we are not on the provider list, so they cannot give us referrals unless it is for a vet that we have previously cared for through VCA or Triwest. We contacted Optum on Dec 10 to find out why they do not have us as a Provider.

A little background: Prior to this, I was sent a Contract to sign on June 21, 2019, via email from Coletta Lloyd, VA Network Contractor, United Healthcare in St Louis, with instructions to sign and mail to this address: United Healthcare, 780 Shiloh Rd, MS–1.700, Plano, TX 75074, so that we could continue to be a Provider for the VA. I signed the contract and mailed the same day. I also emailed Ms Lloyd a copy of that signed Contract.

When informed by our VA office that we could no longer receive referrals as of Dec 10, I contacted the Optum phone number (888) 901–7407 to find out why we are not in the system. I was told they would escalate our complaint, and they would call me back within 5 days. They gave me a Case Id #. I called Coletta Lloyd who then called Optum and forwarded my signed Contract to the Optum office on Dec 10, so I know they have had our signed Contract since Dec 10.

They told her our case was being escalated. We have never received a call back. I now have called Optum **ten** times over the past month, only to be informed the exact same thing every time, our case was being escalated and they would call back within 5 days.

Today I called the VA customer service center and explained to her our situation. She called Optum with me on the line and asked for a supervisor. We again explained our situation, and were told, "We have a Contract signed by you on Dec 16 that we received on Dec 10. We are just waiting for it to be downloaded into the system." I informed the girl that I signed the Contract on June 21, and asked how she could have received a Contract on Dec 10 that was signed on Dec 16. I asked her to forward it to me. She stated that she was only reading notes in my file. They promised to call back by noon tomorrow, Jan 9. So, the same run-around again.

We received 107 VA referrals in 2019. What is going to happen to these vets in 2020? The VA Dayton loves working with Nurses Care, because we cover a large area and get out to see the patient the day of or the day after the referral. We spoke with them again today, and they have been instructed that, as of Jan 10, they can no longer give us **any** referrals unless we are in the Optum system as a Provider, not even patients that we have had in the past. I don't understand why we can't continue to see the vets under Triwest. Is there anyone who can help us?

Update 2/6/20—The Dayton VA contacted us to let us know that Nurses Care is showing up in the Optum system! The Dayton VA has been sending us referrals under Triwest, which they had the approval to do until Feb 8. The last few weeks we have received a few Triwest, VCA, and now Optum referrals. Our next issue is trying to make sure that we get paid as promised.

The good news is that Nurses Care, Inc. is finally an approved home care provider. It took many months of confusion to work it all through. That is not an appropriate experience for a longstanding VA home care provider. A different outcome is affecting another home care provider.

"We are a small independent home care agency with a census of 85. 64 percent of our clients as veterans. When the transition to Triwest occurred, we were required to credential with them rapidly but not required to have a contract. This transition happened in late February 2019. We heard about the upcoming transition to Optum and have been reaching out to them to ensure our clients will continue to be cared for. As of this date, we have not received any official word from Optum when this transition will take place. The local VA office continues to provide authorizations for Triwest , however Triwest is slow to pay resulting in RAPS being autocanceled and claims being rejected. It has been a living nightmare! Currently Triwest owes us close to $300,000 for services rendered. Multiple attempts to collect have fallen on deaf ears or pass the buck scenario happens. The local VA doesn't appear to have any clue what is happening as well. We are the only home care agency that will provide care to our local vet-

erans but will soon be forced to discontinue doing so." **Greg Leivishka (Dove Home Health Professionals**

NAHC is also aware of significant problems on the credentialing and enrollment loading phases involving multiple home health providers that operate throughout the country. Despite significant time and resources put into resolving the issue, nearly 250 of those locations are still outside the Optum system. Many of these locations are some of the highest quality home health agencies in the country according to the Medicare Home Health Compare website presented by the Centers for Medicare and Medicaid Services (CMS).

As the transition to a new VA contractor occurs across the country, NAHC recommends that the VA consider revising the provider enrollment process to avoid a loss of access to care, improve the options available to the veterans, and ensure that patients' needs are prioritized over paperwork. The revisions could follow a path travelled by a number of State Medicaid programs when those programs transitioned from a "fee for service" program to Managed Long Term Services and Supports. There, the transitions permitted: 1.) beneficiaries to continue receiving authorized services from their existing provider for 6 months or more; 2.) grandfathering in existing home care providers on a provisional basis while undertaking any desired credentialing and contracting; and 3.) maintaining pre-existing payment rates for a designated period of time. This manner of programmatic transition secured near seamless experiences for patients and providers alike without creating any significant difficulties for the State or its contractors.

Care authorization

A longstanding problem with VA home care, care authorization, continues in Community Care. With this issue, it appears that the causation lies with the VA rather than its contractors. Here are some of the reports we have recently received:

- "we are having much difficulty getting VA physicians on a timely routine of signing our orders prior to billing."
- "At this time we are having an issue with getting our Auths form the VA in Newington CT in a timely manner, we are still waiting on auth from 10/1/2019 and we need them in order to bill its now 1/8/2020."
- "Another issue with VA is receiving authorizations for Community Care Services such as homemaker and HHA services. We receive the referral and begin services but it may take 6 months or more before we receive the authorization. We must have the Authorization number before we can bill so we have to wait for 6 months or more before we can bill."
- "I am a director in Nebraska and we are having a very difficult time with getting a straight answer regarding who are to put in as a payer...all our auths are coming in a VA Care in the Community, but they have stated that VA is now a PPS payer and that they should have been with Triwest...we were never told that and they are saying that Optum is not ready until at least March to begin paying...my billing company hasn't received a straight answer from anybody at the VA regarding who should be put in as a payer...please advise...thank you!"
- "We are having similar challenges with the Rodebush VA in Indianapolis, IN. Claims that are directly being paid thru the VA Hospital are just very slow to pay and deny for erroneous reasons such as incorrect bill type. We then have to fax our dispute and it appears they only have one person processing all home health claims and researching errors. Therefore the timeliness of payment resolution is poor.

  In addition, authorizations are a challenge especially for clients that need additional authorization. Receiving the necessary paperwork is always behind therefore we have to see the client prior to receiving the authorization.

  Referrals with authorization / claims going to contracted party, TriWest and/or Optum , is also a challenge because even if the referral/initial auth states TriWest or Optum, many times they are not even aware of the client. So we have to assume the VA is not notifying them. We start service on the client but do not have the ability to get reimbursed. Many times, necessary information required by the third parties such as referral numbers are not being given to us on the forms either.

  I am in discussion on all of these issues with Rodebush VA but at this time these are still current issues."
- "The owner at this time has stopped taking any New VA patients until they VA can get our auths to us faster."

In the absence of care authorization, care cannot start. In the absence of a start of care, the veteran is at risk of an acute exacerbation of his/her condition that may necessitate much higher cost care than home care. In some circumstances, the absence of a care authorization can jeopardize the life of the veteran. NAHC respectfully recommends that the VA take immediate steps to expedite home care authorizations. Alternatively, the VA can rely upon the judgment of those professionals caring for the veteran and cover care a certified necessary by the attending practitioner.

Payment Delays

For those patients and providers fortunate enough to secure home care authorizations, the trials and tribulations are just beginning. Payment delays abound. Here are a few recent comments from NAHC members:

- "We are just starting to get pd now 97 days out"
- "A lot of the claims starting May 19 has not been paid due to VA internal workings."
- "We ... have been providing services to the VA since 2009.

  Over the last few years, our payments have become slower and slower with more and more denials. In the last year or so, there was a major change in the VA and they moved the billing staff from Orlando to Tampa, and now we cannot even reach anybody there anymore.
  Despite all this we continue to serve the veterans because we don't want to see them suffer more than they are already.
  It has come to the point where we are owed more than $250,000 by the VA, which as you can imagine is putting a major financial strain on our operations, and we are afraid that we will either need to close down or cease serving these veterans if these issues do not get resolved shortly."
- [We] "made the very difficult decision to discharge 18 of our VA patients after endless talks with UHC, the VA and OPTUM. We were unable to come to an agreement or get an answer in regards to payment. We had never switched to TriWest – the VA agreed to keep paying us directly so we did not lose money there. We did see patients into the time were supposed to bill Optum. I am not sure that we have received anything from them yet. We were all heartbroken for the patients who were picked up by an agency that many were not happy with."

No business can carry receivables for an extended period of time. Home Care companies in particular do not have the capital to manage unpaid bills for services as they are not "brick and mortar" institutions. Instead, they operate on human capital with payroll due every week. NAHC recommends that the VA establish a clean claim payment deadline. Failure to meet the deadline should require the payment of interest on the amount owing equivalent to the interest level Federal debtors pay under the Federal Claims Collection Act.

Rate Cuts

Once a provider completes the myriad of pathways to provider enrollment, its challenge turns to care authorization. From there, the adventure shifts to payment delays. When payment finally arrives, it is not a pleasant surprise. Here are recent experiences:

- TV News Story in Vermont and New Hampshire – Rates cut in half. That led to discharge notices being sent to veterans the providers were caring for. https://www.wcax.com/content/news/Last-minute-deal-saves-home-care-services-for-veterans-in-Vt-NH–566788631.html
- "I received a call from VA stating that there was an oversight on the rates that were released by the central office. I was told yesterday that they have updated the rates and will be released to us shortly. The new rates for S5130 are $27.12/hour, however, no change in G0156 at this time. This updated rate agreement is for all community care providers is my understanding."
- "After our Board Meeting last Thursday, I came back to the Office and checked the VA Optum rates and none of them covers our costs. So I contacted the VA, VA Optum, Joanie Ernst, Chuck Grassley and Abby Finkenour. I let them know that no Home Health Agency will be able to treat veterans who have the unbundled VA Optum and we will have to discharge all of them.

  I got a response from both the VA and VA Optum and they said they need to set up a meeting with each other to discuss this . . . not sure when this will happen.

I also got a response today from Joanie Ernst and Abby Finkenauer's Office and I gave them specifics. Here is an example:

o VA Optum pays 6.88 per unit for a bath aide. Our Aides typically spend 30 minutes for a bath; therefore VA Optum would pay us 13.76 per visit. We pay our Home Health Aides $18/visit.

o VA Optum pays 29.92 per unit for Physical Therapy. Our PT's typically spend 30 minutes for treatment; therefore VA Optum would pay us 59.84 per visit. We pay our contract therapy company $92/visit."

One message puts it all together well. It comes from Diana Taylor of Freedom Home Health Care in Iowa.

We need help from NAHC. We received this information last week that our rates are being drastically cut and also in 15 min increments. And get this it went retroactively to November 1, 2019 claims. This hit my company hard, there is talk of a proposed increase but we need some advocacy to keep rates the same til they get something figured out. I will need to begin lay offs the end of this week. This is way worse than any PDGM issue for us, this was a surprise.

Below is a copy of a letter I sent out to Legislators.

Allow me to introduce myself, I am Diana Taylor owner of Freedom Home Health Care. In the event you are not aware the Home Based Community Care program has not been able to meet the needs of its Veterans in the Des Moines Metro and surrounding area. For the past 10 years, Freedom Home Health Care has been a contracted provider of nursing, home health aide, homemaker, and respite. In fact, the VA Home Based Community Care does not even employ persons to provide Home Health Aide, Homemaker, or Respite. We are the VA's most utilized sub contracted home care service. In fact, I have been proud to say that 60 percent of the clients we serve are Veterans. We have proudly stood by the VA through the transition of VA Choice, then TriWest, and now Optum. Not one Veteran has gone unserved or underserved during this transition despite the fact that this billing mess means I have not been paid on claims for services I provided in August, September, October, November, and December. The VA has been as far as $200,000 in debt at one time to Freedom Home Health Care as we patiently wait for the VA to sift through the mess of this transition.

I was given notice yesterday, that our rates have dropped drastically without any warning. Services are paid for in 15 minute units. Our particular agency was paid, $11.61 per unit and now the new RETROACTIVE rate is $6.88. Yes retroactive. Waiting to be paid on claims is a huge hindrance for my company. But I just found out for all services that I provided since Nov.1, 2019 I have had drastic unforeseen cuts from my contracted rate.

As a provider, I am required to be Medicare Certified, and to hold that certification the Federal Government requires that I give Patient Rights. One of the rights is letting them know verbally and in writing the charge for services prior to providing a service and prior to a change. Hence, I believe as a provider of a government contract I should be afforded at least the same right. I understand that other home health care agency in other parts of the State have already given notice to their clients that effective Feb. 1, 2020 they will be discharged from their services due to the new rates. I do not want to do that to our Veterans, I want to hold out to see if the pending/proposed rates go through. I do not want to let our Veterans down because they certainly have not let my country down.

However, I want there to be understanding of the effects of this reimbursement change. So consider the following:

A Veteran is incontinent of urine, and in order to shower and get dressed they need a home health aide. It takes 30–45 minutes to give a bath but for the sake of this example, we stay a full hour. Our new surprise rate is $27.52 per hour.

a) Average wage of a HHA is $17/hr

b) McDonalds website advertises $10/hr

c) Minimum wage $7.25

******Key Concepts: Cost for that 1 hour bath visit

1) $17 for direct wage

2) Add 30 percent to cover employment tax FICA, FUTA, SUTA, and Work Comp = $5.10

3) Average mileage between clients 10miles paid to staff at (lower than allowable IRS) 48 cents per mile = $4.80

SO FAR This visit costs me $ 26.90 and I haven't even figured in the cost of administration, billing, and providing health and liability insurance.

I AM PAYING YOU TO TAKE CARE OF A VETERAN.

This table represents the new "surprise rate" versus the proposed. I am asking you to consider this as an emergent need and provide immediate support to at a minimum restore previous rates till you consider the Pending.

I truly cannot sustain this business relationship with the VA without immediate intervention.

	SN	HHA/RESPITE	HMKR	PT	OT	ST
CURRENT/*NEW*	$28.47	$6.88	$4.13	$29.92	$29.80	$28.88
PROPOSED/*PENDING*	$36.09	$15.29	$9.17	$34.50	$34.50	$34.50

Rate cuts of this nature have the natural and foreseeable effect of lost access to care. NAHC has been informed that it is the VA that sets payment rates, not the contractor. We have also been informed that rates are based on Medicare rates where such exists for the type of service involved. The reality of rate setting is that it appears to occur "behind the curtain," leaving patients and providers often in the dark. NAHC recommends that the VA (and its contractors where applicable) maintain a transparent rate setting process that is focused on real life care costs and the level of payment needed to ensure uninterrupted access to care.

Conclusion

We greatly appreciate the opportunity to provide the Committee with the foregoing information. We stand ready to partner with the VA and its contractors to develop all necessary steps to ensure a viable home care program fully accessible to our Nation's veterans.

Prepared Statement of Erik L. Golnick

Introduction

Good afternoon Chairs Pappas and Brownley, Ranking Members Bergman and Dunn, and Members of the Subcommittees. Thank you for inviting VFR (Veteran and First Responder) Healthcare to testify today regarding our experience as a community provider working with the Veterans Health Administration (VHA) and its third-party administrators (TPA), OptumServe and TriWest Healthcare Alliance. As a former Naval Officer who suffered from Post-Traumatic Stress after my separation from the Navy, I am acutely aware of the importance of advancing and improving Veterans' access to health care and I thank you for the hard work these Committees do to ensure care for our brothers and sisters.

VFR Healthcare, along with our sister organization Strive Health, is a Veteran-owned and operated organization that was founded to increase the access to, and quality of, outpatient substance abuse and mental health treatment for Veterans, First Responders, and their families. Our clinical and medical leadership team, all of whom are Veterans, developed trauma-informed clinical programming designed to address the specific issues and unique needs, preferences, and values of Veterans, first responders, and their families.

Our network of Centers for Recovery and Community Health utilize this population-specific clinical programming and provide a wide range of trauma-informed, evidence-based treatment programs and services for individuals and families suffering from substance use and mental health disorders. In addition to providing behavioral health services, we are dedicated to promoting community collaboration to increase all Veterans' access to mental health as well as other health resources.

In June 2018 we entered into a partnership with the U.S. Department of Veterans Affairs to enhance Veterans' access to substance abuse and mental health services to reduce suicide. Since then, we have been working together to advance and im-

prove Veterans' mental health and well-being and expand and promote community collaboration to increase all Veterans' access to mental health and substance abuse resources. Through this partnership we have been able to successfully enhance Veterans' access to behavioral health care, which is evidenced by the fact that 100 percent of Veterans referred to any of our treatment programs could have scheduled an intake within 24 hours.

We are honored to be partnered with VA and have had the privilege of providing behavioral health treatment services to Veterans over the last few years. In doing so, we have had the unique experience of working with VA and providing health care services to Veterans through several different community care programs, TPAs, and transitions.

Challenges with Community Care

As a Veteran-run Community Care provider, we are mission focused on ensuring that Veterans and their families are getting the highest quality care that they need in a timely and efficient manner. As such, we assume the administrative burden on behalf of the Veterans we serve and deal with any issues with referrals, authorizations, and billing. Taking on the administrative burden for Veterans is especially important in mental health and substance use treatment as these administrative issues can cause stress and anxiety for the Veteran at a time when stability and structure in their lives is the difference between life and death.

Now, before discussing our experience and challenges we have faced as a community provider working with the TPAs I believe it's important to note that VFR Healthcare is contracted with over 15 separate commercial health insurance plans as well as two State Medicaid plans. The challenges we have experienced with the TPAs are not unique and unfortunately happen quite often with other health plans during a period of transition. It is our hope that illuminating these issues and providing some insight as a community provider, we can assist in making the Community Care Network more efficient as well as the transition to other regions easier.

Challenges

First: Clear Delineation of Roles, Responsibilities, and Trouble-Shooting Processes

I will provide an example that clearly highlights this challenge. In this instance, we received a complete and accurately authorized treatment referral from a VA Medical Center. The authorization covered the provision of intensive mental health treatment services for a Veteran-beneficiary, which were not immediately available through VA or through its other contracted providers of care.

We began providing care upon receipt of the authorized referral from VA, granting access to the specific modalities and services, which were critical for the treatment and well-being of the Veteran. After a few weeks we began receiving denial of claims from the TPA, stating there was no authorization on file. We followed protocol and spoke with a TPA employee who said that: (i) no authorization existed in the system for this Veteran; and (ii) even though we had a copy of the authorization in-hand, we would have to contact the community VAMC to resolve the issue.

We subsequently spoke to the local VAMC official, who stated that all proper steps were followed, and this was an issue on the TPA side. We then contacted the TPA a subsequent time, to no avail. This continued for two additional rounds of escalations from both the TPA and VA, each unable to apparently resolve this impasse. All the while we continued provision of care – the Veteran and their well-being must come first in our view. It has been almost a year since this issue began and we are no closer to resolving this matter.

Second: Ensuring a Seamless Referral Process

We have spent considerable time with our VA partners and with the TPAs to better understand the referral processes and potential pressure points. While the new CCN allows VA staff to refer Veterans directly to community providers, in practice there are several pressure points where a referral can be slowed down or "stuck."

Third: Efficient and Accurate Uploading to the TPA System

A complete and accurate upload of a community provider to a payer system is critical to ensuring that proper referrals are generated, claims and payments are appropriately paid, and accurate information is provided to Veterans and referring providers through the VA. Any issues with this upload present dire consequences to the community provider and significantly affects the care currently being provided as well as the care coordination with VA.

Fourth: Uniform Claim Submission and Reconsideration Policies

Claim forms, which healthcare providers submit to get paid for services rendered, are extraordinarily complex and comprehensive. As such, setting and adhering to

uniform claim submission and reconsideration policies is paramount to ensuring that claims and payments are appropriately paid and erroneously denied claims can be resubmitted and properly adjudicated in a timely manner.

Conclusions

We appreciate the opportunity to address the Subcommittees today to assist VA and the TPAs with their collective mission to enhance the health and well-being of our Nation's Veterans. We believe the Community Care Network is critically important to ensuring Veterans can access the necessary care in a timely manner. As such, it is imperative that processes, systems, and controls are in place so VA, the TPAs, and community providers can work seamlessly together to enhance the access to care for Veterans.

While community providers like us are bearing the brunt of these challenges in the near-term, they are not unique to VA or the TPAs and we believe they are solvable challenges. We are confident that VA and the TPAs will work diligently to resolve these issues and on a go-forward basis VA, the TPAs, and community providers will work together as a more efficient team to ensure that Veterans receive timely and adequate care.

Chairs Pappas and Brownley, Ranking Members Bergman and Dunn, and Members of the Subcommittees, this concludes my statement. We would be happy to answer any questions you or other members of the Subcommittees may have.

STATEMENTS FOR THE RECORD

Prepared Statement of Health Net Federal Services, LLC

Kathleen E. Redd is the President and Chief Executive Officer of Health Net Federal Services, LLC (HNFS), a wholly owned subsidiary of Centene Corporation, a national leader in publicly financed health care, including Medicare, Medicaid, and state-sponsored health care programs. In this capacity, Ms. Redd is responsible for the strategic direction and management of both HNFS and MHN Government Services, a subsidiary specializing in behavioral health care services in support of Federal programs. Ms Redd became President and CEO in June, 2018.

An industry leader in developing large-scale, federally managed health care programs, HNFS is a health care solutions company that has provided high-quality, cost-effective managed health care programs and behavioral health services to public sector employees and beneficiaries for over 31 years.

We appreciate the Committee's focus on provider relations for the Department of Veterans Affairs' (VA) contracts.

At a time of crisis, HNFS stepped in to assist the VA in securing critically needed medical care for our Nation's heroes as a supplement to in-house VA patient care. In 2013, HNFS proudly began managing the Patient-Centered Community Care (PCCC) Program in Regions 1, 2 and 4. Our work expanded to the Veterans Choice Program (VCP) in these regions in 2014. As the need for urgent medical care was acute, VCP began only 90 days after the Veterans Access, Choice and Accountability Act was approved. Nearly one million veterans received expedited care through HNFS' administration of this contract with over 1.7 million referrals processed. HNFS' contracted duties with VA to manage care under PCCC and VCP were transitioned back to VA on Oct. 1, 2018.

Thousands of community providers across our VA-contracted regions (37 states and the District of Columbia, Puerto Rico and the U.S. Virgin Islands) answered the call to action and quickly responded to provide our veterans the care they needed and deserved. We are thankful to our provider network for their patriotism and the value they provided. It is critically important that we ensure our providers are paid for the services they rendered under the PCCC and Choice contract, in accordance with the terms and conditions the VA established. Since early 2018, we have worked with our providers and the VA and have increased our focus on reconciling provider accounts and helping them seek reimbursement either through HNFS or VA.

Over the period of performance on the PCCC and Choice contract, HNFS has processed approximately 9.5 million claims. Our provider payments total approximately $2.7 billion. We will continue to support the effort to reimburse providers into the summer of 2020, ensuring appropriate payments are made to all of our providers who helped in this time of need. We are pleased to report that we are nearing completion of reconciling all of the claims we are responsible for from our PCCC and Choice contract. We anticipate all remaining claims to be processed and completed by the end of July.

At the VA's request, and in good faith, we extended the original timely filing claims submission deadline of March 26, 2019 to Dec. 31, 2019. As a result, with no action required by providers, we reprocessed approximately 35,000 claims previously denied for timely filing. Additionally, we accepted new PCCC/VCP claims for services performed through Sept. 30, 2018, for care authorized by HNFS. (A new claim is one that had not previously been received and processed by HNFS.)

As of Jan. 31, 2020, our claims inventory is less than 20,000 (14,000 new claims, 6,000 disputed claims) with expected provider payments of approximately $4 million. Much of the remaining claims inventory is complex and will require additional research to ensure appropriate payment and proper stewardship of Government funding.

We are on schedule to complete our new claims inventory of 14,000 by the end of February and our provider claims inventory of 6,000 by the end of July. Our claims reconciliation efforts include reprocessing, adjusting for additional payment and recouping overpayments, as appropriate.

HNFS' team of claims experts has deployed a significant number of personnel to work both telephonically and onsite with many provider groups to resolve claims resubmission and payments in an effort to make the process easier for providers.

As we approach the end of our work on the contract, we are committed to continue working with the VA and providers to pay any and all eligible claims to fulfill our contractual obligations and our commitment to our Nation's heroes. Additionally, HNFS has assisted the VA in identifying providers seeking assistance around continued confusion on where to submit claims that are associated with the current MISSION Act program contractor or the VA directly.

As this committee knows, the Veterans Choice Program underwent many changes and faced many challenges: for veterans navigating care, for the VA, for providers as well as the administrators. We hope many lessons can be learned from this valuable program and that veterans will continue to receive the care they deserve, whether directly through the VA or in their own communities.

We remain committed to supporting our Nation's military service members and veterans, and are happy to be a resource to the VA and the committee as you move forward with the Community Care Program.

About Health Net Federal Services

Health Net Federal Services has a long history of providing cost-effective, quality managed health care programs for government agencies, including the U.S. Departments of Defense and Veterans Affairs. For over 31 years, HNFS has partnered with the Department of Defense to provide health care services to the men and women who serve, and their family members. Health Net Federal Services was one of the first companies in the U.S. to develop comprehensive managed care programs for military families. In addition, HNFS provides quality behavioral health services for active duty service members, veterans and their families. Visit www.hnfs.com for more information.

About Centene

Centene Corporation, a Fortune 100 company, is a diversified, multi-national health care enterprise that provides a portfolio of services to government sponsored health care programs, focusing on under-insured and uninsured individuals. Many receive benefits provided under Medicaid, including the State Children's Health Insurance Program (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care and Long Term Care (LTC), in addition to other state-sponsored/hybrid programs with the U.S. Departments of Defense and Veterans Affairs. Centene operates local health care plans and offers a range of health insurance solutions. It also contracts with other health care and commercial organizations to provide specialty services including behavioral health management, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services.

About Kathleen E. Redd

Ms. Redd has over 30 years of experience in corporate financial management. Prior to joining Health Net Federal Services, LLC., Ms. Redd was the Vice President and Chief Financial Officer of Aerojet Rocketdyne Holdings, Inc., a New York Stock Exchange listed aerospace and defense contractor.

In April 2019, Ms. Redd was named as an honoree for the Sacramento Business Journal's "Women Who Mean Business" Award. In 2012, she was one of the Sacramento Business Journal's "Leaders of the Year" and in 2010, was named the Sacramento Business Journal's "CFO of the Year" in the large company category. Kathy is a certified public accountant and a graduate of California State University, San Jose.

Headquartered in Rancho Cordova, California, Ms. Redd leads an employee base of over 2,000 across 44 U.S. states, two territories and 17 countries across the globe who provide health care services to more than 2.9 million eligible military beneficiaries through the Department of Defense's (DoD) as well as our work with the U.S. Department of Veterans Affairs (VA).

Prepared Statement of Home Care, Hospice & Palliative Care Alliance of New Hampshire

Congressman Pappas and Members of the Sub-Committee:

Thank you for seeking public input regarding the transition to the Veterans Administrations' new Community Care Program. I am writing on behalf of the Granite State Home Health and Hospice Association, which represents home care, hospice

and palliative care providers and the people they serve. Association members range from traditional non-profit visiting nurse agencies **(VNAs)** to privately owned small businesses. These members are committed to providing compassionate medical care and personal care services that enable veterans to remain independent in their homes.

Over the last several months, home care agencies have reported many problems related to the provision of care to veterans. In December, the Association conducted a survey of our members regarding VA clients. Sixteen agencies caring for approximately 350 veterans a year responded. These agencies generally serve patients from the Manchester, NH and White River Junction, VT VA Medical Centers. The reported problems vary among referring sites, suggesting a VA third party administrator system that lacks uniform standards and appears to be in disarray to providers on the front line of care. Here are some trends:

Backlog of Provider Payments

- All agencies reported payments in arrears for VA clients. The total payment backlog was over $550,000. While this may not seem like much to Congress, it can significantly impact cash-flow for many small agencies and affects their ability to participate in the VA system.
- One agency reported a backlog of over $100,000 in payments.
- The backlog was highest for TriWest and relatively even between the VA and Optum.
- Claims are paid randomly. One agency reported that August claims were paid for one client, but June claims were still outstanding.

Problems Obtaining Referrals/Prior Authorizations

- The prior authorization process between the VA and its TPAs appears dysfunctional.
- Agencies receive referrals from the VA, but have difficulty obtaining authorizations from Optum. Agencies provide care yet wait months for authorizations, which delays billing.
- Those agencies that have received authorizations report that documents do not sync with referrals. Some authorizations are for 60-day episode periods, while the VA referrals are for a specific number of visits. It's unclear to agencies what they are required to track.

Rate cuts

- On October 1, provider payment rates for VA home care services paid for by Optum were decreased significantly with no advance notice.
- Rates for veterans referred by the White River Junction VT VA Medical Center dropped between 60 percent and 40 percent depending on the service.
- Rates for veterans referred by the Manchester, NH VA Medical Center dropped between 41 percent and 6 percent depending on the service.
- The rates for homemakers, who assist veterans with cooking, cleaning, laundry and groceries are now at $4.24 per 15 minutes for Manchester patients and $4.23 for Vermont patients. These rates will not cover wages, insurance, taxes, supervision and mileage for these employees.
- For some agencies, the rate cuts will reduce their annual reimbursement for VA services by 50 percent.
- Some agencies plan to leave the VA provider network because of the rate cuts

Lack of Resg—onsiveness from the VA and TPAs

- Home health agencies report that communications between the VA, TriWest and Optum and its providers in the Community Care program is appalling.
- Agencies have difficulty reaching anyone who will speak to them, never mind resolve problems. One agency has been attempting to obtain an authorization for a referred client for over two years.
- It is not unusual to spend 4 to S hours on hold. Voice mail messages are seldom returned.
- Agencies have heard from some VA case managers that the recent rate cuts will be reversed. Unfortunately, the lack of official communications, either from the VA or Optum, creates an atmosphere of uncertainty.

New Hampshire's home health and hospice agencies are proud to serve our country's veterans. Many hospice programs have implemented the "We Honor Veterans"

program for those service men and women approaching end of life. However, the administrative burden and financial losses associated with the Community Care Program will lead to a serious decline in access to care for veterans in New Hampshire. When a home care agency leaves the provider network, it is unlikely that another agency will accept VA clients.

I ask the Committee to urge the VA to work with its TPAs and provider network to resolve prior authorization delays, develop a reasonable fee structure, and restore trust with home health and hospice providers.