# MISSION CRITICAL: CARE IN THE COMMUNITY UPDATE

## HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON VETERANS' AFFAIRS

## U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, SEPTEMBER 25, 2019

**Serial No. 116–36**

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

40–992 WASHINGTON : 2022

## COMMITTEE ON VETERANS' AFFAIRS

MARK TAKANO, California, *Chairman*

JULIA BROWNLEY, California
KATHLEEN M. RICE, New York
CONOR LAMB, Pennsylvania, *Vice-Chairman*
MIKE LEVIN, California
MAX ROSE, New York
CHRIS PAPPAS, New Hampshire
ELAINE G. LURIA, Virginia
SUSIE LEE, Nevada
JOE CUNNINGHAM, South Carolina
GILBERT RAY CISNEROS, JR., California
COLLIN C. PETERSON, Minnesota
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands
COLIN Z. ALLRED, Texas
LAUREN UNDERWOOD, Illinois
ANTHONY BRINDISI, New York

DAVID P. ROE, Tennessee, *Ranking Member*
GUS M. BILIRAKIS, Florida
AUMUA AMATA COLEMAN RADEWAGEN, American Samoa
MIKE BOST, Illinois
NEAL P. DUNN, Florida
JACK BERGMAN, Michigan
JIM BANKS, Indiana
ANDY BARR, Kentucky
DANIEL MEUSER, Pennsylvania
STEVE WATKINS, Kansas
CHIP ROY, Texas
W. GREGORY STEUBE, Florida

RAY KELLEY, *Democratic Staff Director*
JON TOWERS, *Republican Staff Director*

## SUBCOMMITTEE ON HEALTH

JULIA BROWNLEY, California, *Chairwoman*

CONOR LAMB, Pennsylvania
MIKE LEVIN, California
ANTHONY BRINDISI, New York
MAX ROSE, New York
GILBERT RAY CISNEROS, JR., California
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands

NEAL P. DUNN, Florida, *Ranking Member*
AUMUA AMATA COLEMAN RADEWAGEN, American Samoa
ANDY BARR, Kentucky
DANIEL MEUSER, Pennsylvania
W. GREGORY STEUBE, Florida

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

# C O N T E N T S

**WEDNESDAY, SEPTEMBER 25, 2019**

# MISSION CRITICAL: CARE IN THE COMMUNITY UPDATE

**WEDNESDAY, SEPTEMBER 25, 2019**

U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 210, House Visitors Center, Hon. Julia Brownley [chairwoman of the subcommittee] presiding.

Present: Representatives Brownley, Rose, Brindisi, Levin, Lamb, Cisneros, and Dunn.

Also present: Representative Roe.

## OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning, everyone, and thank you all for joining us here today for this oversight hearing to receive an update on VA's new Community Care Program, an urgent care benefit required by the MISSION Act.

This new program and benefit have only been up and running for approximately 90 days. As a result, we don't have a lot of concrete data at this point; however, I thought it was important to check in on how things are going, especially as we have new partners in this endeavor.

In 2014, in response to a wait time scandal that rocked the Nation, Congress passed the Veterans Access, Choice and Accountability Act of 2014, commonly referred to as the Choice Act. The implementation of the Choice program was fraught with numerous and widely reported challenges, which ultimately led Congress to completely overhaul VA's community care programs via the MISSION Act. Both the new Veterans Community Care Program and the urgent care benefit launched on June 6th of this year.

While we commend and we truly do commend VA for launching these on time, and we are also impressed with the implemenation of new community care program so far, we must also acknowledge that there are opportunities and areas for improvement. These are areas that have been identified through site visits and listening to the concerns of veterans, VA employees, community providers, veterans service organizations, and other key stakeholders.

Of particular concern is network adequacy. Staff has heard anxieties from multiple stakeholders on this topic. Given my work with the Women Veterans Task Force, I was particularly alarmed to hear of the challenge of enrolling specialty providers for gender-specific services such as high-risk maternity care and fertility

treatments. While I understand that VA and its third party administrators may still be working to bring more providers into networks, a lapse in care in these areas can be incredibly detrimental to these veterans who need ongoing and continuous care.

I have also heard some VA providers are still unclear as to when and how to apply the best medical interest standard. Without appropriate and instructive guidance on when and how to apply this standard, the risk of inconsistent use across the VA health care system increases and is likely to lead to unnecessary inequities in care for our veterans. This is particularly concerning given that of the 710,000 consults where the decision support tool was used to determine veterans' eligibility for care in the community, the overwhelming amount, 534,000 of those were determined eligible based on the best medical interest standard.

Another concern is with the decision support tool itself. The development of this software was rife with well-documented issues, which the full committee discussed earlier this year. This tool is intended to provide VA clinicians and veterans with information to make real-time decisions as to whether veterans are eligible to and whether they should obtain care in the community.

While VA has noted that employees are using this tool approximately 30,000 times per day, issues with this tool continue as it can—as it can time out—sorry, my script is a little messed up here. Anyway, the timeout and the glitchy part of the tool has been—people have talked about that and this is leading many VA providers to forgo its use entirely.

In lieu of this tool, committee staff have heard that some providers have developed a work-around by simply applying the best medical interest standard.

Lastly, while the urgent care benefit has been well received by veterans, there are a few issues with how this benefit is being administered and advertised. There has been confusion over where and how veterans should obtain pharmacy benefits where they have obtained urgent care and a medication has been prescribed. In addition, the online urgent care locator is not always accurate.

During secret shopping trips, committee printed out street addresses to facilities, only to find on arrival that they didn't exist. This directly impacts and delays a veteran's ability to utilize this benefit to obtain urgent and necessary health care.

Furthermore, committee staff found that despite the development of signage to indicate an urgent care facility is in network, its usage is hit or miss, potentially causing further delays in accessing this benefit.

That being said, I hope to have an honest and frank conversation today about how this community care program and benefit has been operating, the challenges VA and its partners currently face, and how we can help in addressing those challenges. We also want to hear from stakeholders like Optum, who is a new partner for VA in providing care to veterans, so we can learn more about how they are standing up their networks in Region 1, 2, and 3, and how the transition from TriWest to Optum has been going.

Lastly, while the new Community Care Network is a much better program than Choice and the implementation of the program appears to be going much more smoothly than the implementation of

the Choice program, we hope to hear from VA and partners like TriWest on how they are using lessons learned from the Choice program to improve provisions of care in the community to veterans through the community care networks and the urgent care network.

I thank you all again for being here and, again, I want to emphasize the fact that we are very pleased about how this is going so far. I have highlighted some of the issues that we have heard from, so that we can address those and learn from them, and move on.

With that, I now recognize Ranking Member Dunn for his opening remarks.

**OPENING STATEMENT OF NEAL P. DUNN, RANKING MEMBER**

Mr. DUNN. Thank you very much, Chairwoman Brownley. It is a pleasure to be here this morning for the first of what I expect will be a series of hearings this Congress on the implementation of the MISSION Act.

The MISSION Act is a landmark piece of legislation, as the chairwoman pointed out. It was signed into law by President Trump last Congress after more than a year of bipartisan, bicameral work in this committee and with the Senate Committee on Veterans Affairs. It impacts and improves virtually every aspect of the Department of Veterans Affairs' health care system, from the alignment of the VA medical facilities to the system of caregiver support, to the flexibilities and authorizations that it makes easier for VA to hire clinical staff and support staff.

The overarching goal of the MISSION Act is to increase access to care in the VA medical centers and clinics, and through the VA's partners in the community, and to empower our veterans to control their own health care decisions.

To that end, today we discuss the consolidated Community Care Program that the MISSION Act created. That program went into effect D-date June 6th, just a little more than 3 months ago, and the rollout of the new government programs of this size and significance are often accompanied by delays and drama. However, the rollout of the MISSION Act Community Care Program has been accompanied by very little fanfare for the last 12 weeks. I hope that is a good thing; I hope the reason for that is it is all good news.

For example, I know that veterans are enjoying the new urgent care benefit the MISSION Care Act provided them without having to travel or wait for an appointment at a VA medical center. However, I have heard some concerns from the providers in my district, and I mean both the doctors and the hospitals. They are telling me that they continue to struggle with getting their bills paid in a timely fashion. They get conflicting messages about whether they are appropriately credentialed as part of the VA's Community Care Network. And, most importantly, they continue to hear concerns about veterans who report waiting a long time to get to community care consults authorizations by the VA, and I hope to get to the bottom of that today.

Three months is not a lot of time, as the chairwoman pointed out, so the data we have is limited at this point. Conclusions that we reach will be preliminary and this committee's ongoing oversight will be needed to make sure that things stay on track, espe-

cially as the VA transitions to new Community Care Network contracts and providers and managers.

I am grateful to be here this morning with Dr. Stone and Dr. Matthews, two senior VA executives who have been leading this effort for the Department. I am also grateful to be joined by our second panel by the VA's new partners, Optum, TriWest, and CVS.

Delivering high-quality care that our Nation's veterans deserve requires a collective effort on behalf of a grateful nation. I appreciate the work that all of you do to create a strong partnership to better serve our veterans.

With that, I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Thank you, Dr. Roe, for joining us here today. As everyone knows, Dr. Roe is the ranking member of the committee as a whole, and if you would like to make any comments before we begin——

Mr. ROE. No.

Ms. BROWNLEY. Well, thank you again for being here.

On today's first panel we have Dr. Richard Stone, Executive in Charge of Veterans' Health Administration (VHA) . He is accompanied by Dr. Kameron Matthews, Deputy Under Secretary for Health and Community Care, and Dr. Jennifer MacDonald, VHA's MISSION Act Lead. We have got all the leaders on this important mission.

Welcome to you all and, Dr. Stone, I now recognize you for 5 minutes.

## STATEMENT OF RICHARD STONE

Dr. STONE. Good morning, Chairwoman Brownley, Ranking Member Dunn, members of the subcommittee, and thank you, Ranking Member Roe, for attending. Thank you all for your dedication to America's veterans.

I appreciate the opportunity to discuss the implementation of the VA MISSION Act, and I am accompanied today, as the chairwoman mentioned, by Dr. Matthews and Dr. MacDonald, two of the key leaders in this implementation. I am very proud of the work that we have done across VA to ensure the MISSION Act is a success for veterans.

When the Veterans Choice Act Program was enacted in 2014, access to care for veterans was a critical concern nationwide. Over the last 5 years, however, the VA has transformed. We have improved how we do all aspects of our business, from scheduling of appointments to referring veterans to specialists, thus resulting in enhanced services for our enrolled veterans.

Today, we are not only providing care to veterans more quickly, we are also serving more veterans inside our system. Over Fiscal Year 2019 to date, VA has completed almost 59 million ambulatory appointments. This is a 1.6 million increase over the same timeframe last year. That represents an increase of 3.1 percent in VA's in-house capacity over this fiscal year. VA is not privatizing and veterans are choosing VA.

We will continue to ensure we meet veterans' needs for care in the years to come. Our priority remains the integration of veterans' care when and where they need it.

On June 6th, we launched the new Veterans Community Care Program under the MISSION Act. This new program makes dramatic improvements in how veterans receive community care and will allow VA to deliver veterans world-class, seamless care aligned to each veteran's individual needs and their preferences.

Launching on June 6th was no small feat, as VA is the largest health care system in the Nation. In response to the sheer size and geographic demands, and dispersion of this system and of this deployment, we established a Joint Operations Center with participation of all of VISNs and all key offices across the Department. The Joint Operations Center structure allowed VA to give our leaders and our employees at all levels the tools for success.

During the lead-up to the launch, as well as on the go-live day of June 6th, the Joint Operations Center shared real-time performance across the Nation, and provided data about the status of implementation and the functioning of the Decision Support Tool with all leaders in order to resolve issues and coordinate actions necessary to ensure success. This coordinated effort is now being sustained.

The Act consolidated a number of disparate authorities to purchase community care into one streamlined and seamless program that includes eligibility, authorization, appointments, care coordination, claims, and the payment of claims, while improving overall communication between veterans, community providers, and VA staff members. These changes will lead to a significantly better experience with community care for the veteran, for the provider, and for VA employees.

In addition, a veteran may now elect to receive community care if the referring VA physician and the veteran decide that care in the community is in the veteran's best medical interest.

Since the June 6th launch, VA has entered more than a million community care consults, and preliminary data shows that best medical interest of the veteran was a factor considered in more than 538,000 of these consults. This demonstrates that VA care teams are committed to put veterans' needs first, and we have actively used the new option for care that the MISSION Act has provided.

VA has also implemented, as required in the MISSION Act, a robust network of urgent care providers. That is a great new benefit for our enrolled veterans who need immediate care. By the end of August 2019, almost 6,000 urgent care centers have now joined VA's Urgent Care Network, which is managed by TriWest. About 90 percent of this country's veterans are now covered by a network urgent care provider and so far more than 16,000 veterans have used their benefit in more than 40,000 visits.

Madam Chairwoman, veterans' care remains our mission. We are committed to rebuilding the trust of America's veterans and will continue to work to improve veterans' access to timely, high-quality care from VA facilities, while at the same time providing veterans with more choice to access care where and when they need it.

The bottom line is that the MISSION Act is a success. Your continued support is essential to providing superior care for veterans and their families.

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

[THE PREPARED STATEMENT OF RICHARD STONE APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Stone. I will now recognize myself for 5 minutes.

I have three questions that I am going to try to get in in this 5 minutes. If we can be succinct in our answers, I would appreciate it.

The first is, which I mentioned in my opening remarks, is this—you know, the transition that we are experiencing through third party administrators and making sure that for any veteran who is in the middle of an episode of care that that transition is smooth, so that that episode of care, there are no interruptions there. I talked about maternity care and fertility treatments, but really it is for any treatment.

My first question is, what are you doing to ensure that veterans are receiving seamless treatment through their episode of care during this transition?

Dr. MATTHEWS. Excellent question. Thank you so much, Congresswoman. This is of utmost importance to us, as well as a clinician myself. This was very much a part of how we crafted the transition plan between the current Patient-Centered Community Care (PC–3) contract, but outgoing as well, as well as Community Care Network (CCN).

Current episodes of care in which veterans are in the community, of course maternity, oncology, but even primary care and the like, those are allowed to continue until the full completion of their episode of care under the Third Party Administrators (TPA) that granted the actual episode of care. There will be no switching in the middle.

What we are managing closely and offering care coordination around is to make sure that those same providers are hopefully available in the new network, that they are willing to contract with Optum as we make that transition in Regions 1, 2, and 3. Unfortunately, we can't necessarily guarantee that they would be open. It is a kind of bilateral contractual decision for them to enter the new network, but we will continue to encourage it and work with them. Optum has been a great partner in this transition.

That, again, no care will be disrupted and we will do everything possible to make sure that those same providers are available in the new network.

Ms. BROWNLEY. Thank you.

The next question is on the Decision Support Tool. At the beginning and the kickoff of this program, we said after the big full committee when we talked about this for a long time, we said—you said that the Decision Support Tool, if it is not up and operating, we would revert back to other legacy systems to be able to accomplish what we need to accomplish.

That doesn't seem to have actually happened in practice, at least the feedback that we have received. Clearly the feedback is that also on this tool, it works some of the time, not all of the time, and we have been reverting to this best medical interest eligibility, you know, criteria.

Do you agree with that assessment and, you know, how are we going to address this so that the preponderance of these visits aren't based on best medical interest?

Dr. STONE. Chairwoman, the Decision Support Tool there was a lot of concern about. Look, this is a department that hasn't had a great track record rolling out new software systems that we developed ourselves. I think the concern was well placed, but using an agile development model and the utilization of the Joint Operations Center that gives complete visibility across the Nation of performance in all areas at all times of the day has allowed not only the implementation of the DST, but also the ability to use the Decision Support Tool and update it.

On October 1st, we will release our 13th update to the Decision Support Tool and, when we release that, we are continuing to respond to the needs of clinicians and the concerns of clinicians. If you remember my previous testimony before you, there was a lot of concern about were we going to slow the system down. As a matter of fact, we are seeing efficiencies with use of the Decision Support Tool.

Now, there have actually been 1.2 million community consults since June 6th, in 1 million the Decision Support Tool has been used. We were seeing about 40,000 usages a day of the Decision Support Tool the first week. I think there was some kicking of the tires of the system and some getting used to opening the page, some of the providers were opening it multiple times; it is now being opened consistently 30,000 times a day.

Even though best medical interest, which is a key—if I was seeing you as a patient, your best medical interest should be at the absolutely top of my list—it has actually been used about 350,000 times as the sole criteria. There has been multiple other usages, including drive time, hardship for the patient, lack of availability of services.

I don't mean to go on too long, I know you want to get one more in.

Ms. BROWNLEY. Well, I agree with you on the best—we want the best for our veterans and that is a good reason to choose community care. I just want to make sure that, you know, the whole system is operating, and I don't want veterans to be under the illusion that all you need to do is say this is what I want and you will receive it. I think we need that balance.

I am not going to have a chance for my last question, but, Dr. Stone, I want you to know that I am going to harp on this issue and you are not going to be able to answer it right now, but it is on wait times.

I don't like the way the VA does wait times when you are going to a VA facility and how that is calculated, I don't think it makes sense to the veteran in terms of how it is calculated, and I want to make sure that we have a reasonable approach to wait times on the community care side. As far as I'm concerned, from the time a veteran calls to the time a veteran receives the appointment, that is wait time, all the other stuff in between I think needs to be eliminated. I think the best way we are going to be able to evaluate that program as we move forward is that we have a common-sense approach to wait times, so that our veterans who we are serving

can respond to us and, if they are happy, we are happy, but that wait time thing I think needs to be clarified.

I will move on. Dr. Dunn, you have 5 minutes.

Mr. DUNN. I would like to associate myself with those remarks about wait times, that certainly is an ongoing area that I hear complaints about back home.

Dr. Stone, in discussion with General Horoho yesterday I learned that the VA is currently working on contract modifications to the CCN contract that supports transplant care in the community, as was directed by law. When will that modification be completed?

Dr. Matthews, sorry. I got the wrong doctor.

Dr. MATTHEWS. No, not at all, sir. We are looking for that to be complete in the coming weeks. Being that Optum is not fully deployed nationwide, we do have some time to actually make sure we work through the excellent network that they are able to provide through their Centers of Excellence and make sure that rates are appropriately negotiated on their part, fitting the requirements of MISSION Act with regard to provider education.

As far as the Optum contracts, we are looking in the coming——

Mr. DUNN. I will be interested to see the modifications in that this is a subject that is dear to my heart. You know, in Florida there are no VA transplant centers. If a veteran in Miami needs a transplant, they are going to drive past 12 or 14 great transplant centers——

Dr. MATTHEWS. Right.

Mr. DUNN.—you know, to get to a transplant center.

Dr. MATTHEWS. I am very excited about the network that Optum will be bringing to the table.

Mr. DUNN. Excellent. The modifications that are being done for Regions 1 through 3 currently, I guess those are the only ones that have been rolled out, those will be included—those modifications will apply to 4 through 6?

Dr. MATTHEWS. Yes——

Mr. DUNN. Okay.

Dr. MATTHEWS.—yes, we will do the same.

Dr. STONE. If I could add just a bit of our information? We have a lot of concern. We are a social safety net for veterans that may not qualify for other transplant groups. There have been 194 veterans that have gone on the transplant list since June 6th; of those, those veterans chose 60 percent of the time to be solely on the VA transplant list. In——

Mr. DUNN. Is that because of coverage or locality? I mean, almost everybody wants to go to the closest one near them, right?

Dr. STONE. Well, not necessarily; 31 percent have asked to go on both lists, both the commercial list and the VA, and about 9 percent have asked to only go on the commercial list. We are watching this closely. We do about a thousand transplants a year and evaluate about 3,000 veterans as potential candidates; because of the presence of co-morbidities, as you well know and are well aware from your professional work in delivering care, you know, this can be a very complex situation. So——

Mr. DUNN. It can be, and it is one of the reasons why I wanted to make sure it works well. We will be following up on the transplant as this rolls out.

Also, Dr. Stone—again, I think Dr. Stone—what if any mechanisms are you putting in place to ease the care? There are certain veterans that live on the edge of these Regions 1 through 6, they might get some of their care in Region 3, some in 4. What provisions are you making for people who live on the edge?

Dr. MATTHEWS. Sure. It is meant to be extremely seamless for the veteran, sir. The contractual obligation of the State lines is purely who is paying the claim. From the veteran's standpoint, when they receive the referral after they have seen their VA provider or even called in, they will have an appointment scheduled with a provider and that's it.

Mr. DUNN. It doesn't matter where, Okay.

Dr. MATTHEWS. It doesn't matter if they live in one region or the other.

Mr. DUNN. That was a concern I had. The other thing, concern is timeliness of reimbursements to our community providers. That is not just doctors, it is hospitals, that I have checked both the providers and the hospitals back in my home time. They are—I am going to be honest with you, they are bitter about the time it takes to get reimbursed by the VA, both the hospitals and the doctors, and I would like to have you elaborate on what you are doing to address that problem.

Dr. STONE. 15 months ago when I returned to the VA, we were processing 175,000 claims a month, we are now processing for payment approaching 2 million claims a month through both our director work, as well as our contract support. We are very proud of the fact that TriWest, as the primary vendor at this point, is processing 98 percent of current claims in less than 30 days——

Mr. DUNN. I have heard this number, I swear I have heard this number, and I can't find those doctors who are being reimbursed in a timely fashion and I talk to a lot of doctors.

Dr. STONE. All right. I will let Kam give some additional clarification of any numbers, but we believe that we have substantially improve this system where——

Mr. DUNN. I would love to have somebody—in the 15 seconds remaining to me, I would like to have somebody come by my office from your office, and I will sit down with spreadsheets of aged accounts on VA bills from a number of providers in my home district and from the hospitals, and, you know, say explain to me how this fits into your 98-percent-on-time payments. I mean, we are talking 180 days, that is what my guys are staying.

Dr. MATTHEWS. Sir, I would be happy to have my staff come meet with you with——

Mr. DUNN. Thank you very much.

I yield back, Chairwoman Brownley.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Mr. Levin, you are now recognized for 5 minutes.

Mr. LEVIN. Thank you, Chair Brownley. I appreciate you holding this hearing to monitor the implementation of VA's new Community Care Program and urgent care benefit.

I want to start by discussing an issue that has been present since implementation of the now defunct Veterans Choice Program and I have heard this from veterans in my district in Southern California. The issue is this: in the past, we have not adequately edu-

cated veterans how to use community care programs. Specifically, as a result, some veterans have sought care from community providers without the necessary authorizations, result in denied claims and unforeseen expenses.

The MISSION Act required VA to develop and administer an education program that teaches veterans about their health care options. It also required VA to evaluate the effectiveness of this education program on an annual basis.

Dr. Stone, what has the data shown so far? For example, are we seeing a decrease in claims for unauthorized care?

Dr. MACDONALD. Congressman, I will take this question. Thank you for this important question and point.

Veteran education and, as we frame it now, really veteran engagement; not just educating, but listening to veterans and having that inform how we do business has been at the core of our entire approach to the MISSION Act.

You are completely right that we had room to grow in this area and that veterans needed more information from us, and they needed to hear it in a way that met their needs from a modality perspective, not just in paper, but meeting the online needs of our younger and newer veterans who may want to see that information in a different format. They also needed it to be in a way that spoke to their experience, not just to the mechanics of the system that serves them. We have changed that for the MISSION Act.

As Dr. Stone was saying earlier, through the Joint Operations Center we pulled colleagues together, our training colleagues, our education colleagues; did outreach with Veteran Service Organizations (VSOs) , did Facebook Live events; sent out emails; sent out My Healthy Vet messages; sent out brochures and books, and put all of these in facilities; and had the most robust and comprehensive education plan that we have had for a rollout of this type.

However, we are not stopping there. We know that there are still people who need this information. Data is showing us, yes, although we are not seeing claims specifically from the MISSION Act, our signals, what we are watching on social media and other places, are showing us satisfaction with the information that has been provided, and we are hearing that from VSOs as well.

We are confident that this has been an initial success, but we are still aiming to grow. We need to put communications in English and in Spanish, as we did for this effort; we need to reach veterans from New York City to Guam; and we need to do that in a way that meets them no matter what era they are, no matter what age they are, no matter what modality they choose.

Thank you for this, and it is something we are very focused on.

Mr. LEVIN. Thank you, I appreciate that.

In addition to educating veterans, we also have to educate VA providers, particularly regarding the eligibility criteria they use to refer veterans to the community.

I understand there is some confusion among clinicians about how to apply the best medical interest criterion. Dr. Stone, what guidance has the Central Office provided on this and other criteria, and have you told providers where to go for follow up questions?

Dr. STONE. Yes, we have. We have actually provided more than 2 million certified training episodes as part of this work through

multiple different training modalities. That was actually executed in the months up to go-live by our Employee Education System (EES), our training group for professional management. We have been able to track literally the participation throughout this. We also have had multiple of those providers come back and do additional training, from MISSION Act 101 to literally all of the criteria that go into referring veterans to the community.

I think probably one of the best pieces of data to come back so far is 48 hours ago the Veterans of Foreign Wars (VFW) released a survey of their 300,000 members, of which about 7,000 responded that they used our care and their relative satisfaction level, it was extraordinarily transformative from previous years, and I know that that has been made available to the committee.

Mr. LEVIN. Thank you. I will try to squeeze in my last questions with the time I have left.

I am concerned by the process for charging copayments for urgent care. Following each visit, the urgent care clinic bills the third party administrator, which is in my district TriWest, then TriWest bills VA and, finally, VA bills the veteran. I understand that as of now, over 3 months since VA launched the urgent care benefit, VA has not received any claims from TriWest. This process is further drawn out if there are issues processing the claim.

Dr. Stone, how long would you estimate this process will take if everything goes smoothly, how long could it take if there are issues with processing?

Dr. MATTHEWS. Thank you for the question, sir. There is an actual correction to that, we have received claims as of—daily now. TriWest actually submits their claims through another clearinghouse sort of group and we have had more than 20,000 claims coming through now. That is why we can actually speak to actual visit numbers.

The copayments are billed by VA, as they have been for other community care services. So those veterans who have been facing copayments in the past would be very familiar with the processes that we use, that we actually bill copayments even after we bill other health insurance that they may have, so that we can even deduct that copayment from the revenue that we receive from the other health insurance. Admittedly, though, the veterans that are newer to copayments under this benefit, we definitely have had broad-spread education through both VSOs as well as an online platform to let them know how these copayments would work, that they would be billed even after VA pays the claim through TriWest to the provider.

Mr. LEVIN. Thank you.

I am out of time, Chair, but I thank you for holding this hearing. I thank our witnesses and I look forward to an ongoing dialog on these issues. Thank you.

Ms. BROWNLEY. Thank you, Mr. Levin.

I now recognize Dr. Roe for 5 minutes.

Mr. ROE. Thank you, thank you, Madam Chairwoman.

Just a couple things to start with. I want to thank the VA. I have been on this committee almost 11 years and this is the smoothest rollout of a massive bill. I think you are to be commended and I want to—Dr. Stone, always the chief always gets the kudos, but I

would like to thank Dr. Matthews and MacDonald. I know they have worked very hard, and your staff has, to make sure that this is as seamless as possible.

Dr. Dunn, I think I agree with you on the payment. I wonder if some of that is not legacy and certainly I think the payments has picked—I have had the same issue in my hometown, but I think that is much better now, I really believe that.

A couple things I want to go over just very quickly with you all and, Dr. Stone, you can take this, if you want to. Do you have any indication at this point in the MISSION Act implementation process as to whether the access standards that the VA has put in place for the new Community Care Program are appropriate, achievable, and working as intended to ensure access for veterans?

Dr. STONE. I would say, yes, they are achievable and have been achieved for the most part. In mental health, a 20-day access standard, 139 of our 141 sites are meeting the 20-day access standard. In primary care, 93 of 141 sites are meeting the primary care access standard of 20 days. Where we are struggling is within various subspecialty and specialty care areas, in frankly the same areas as the rest of the Nation is struggling, and we would be happy to break those numbers out for the record.

Mr. ROE. Thank you for that. The next part of that question, the follow-on is, how do you assure the quality of care in the community, how are you all monitoring that?

Dr. STONE. The quality of care—and I will defer to Dr. Matthews and Dr. MacDonald and some of the work that they have been doing on this—it is very difficult to see. We are the most transparent health care system in the Nation and it is very difficult to see timeliness in the community, it is also difficult to see quality outcomes.

I will defer to Dr. Matthews and then——

Mr. ROE. Before she starts, I mean, our practice has those standards built into it via the Accountable Care Organizations (ACOs) that we have been involved in. Do you have access to—in other words, if my practice saw a VA patient, we know what those quality metrics are with Medicare, are they the same? We could just transfer those right over. We can show you in a heartbeat if the standards are the same.

Dr. STONE. Tremendously variable, including some ACOs that are simply implementation of an electronic record would qualify for participation in the ACO successfully. I will defer to Kam.

Dr. MATTHEWS. Our entire intent—our intent is exactly as you pointed out, sir, to really be in line with industry standards, Medicare being at the front there, in order for us to have some consistency from practice to practice. I have to agree with Dr. Stone, ACO to ACO, there is a lot of differences.

We also would like to make as logistically easy as possible. That perhaps we can get that data through Centers for Medicare and Medicaid Services (CMS), we could get that through other ways that it is already publicly reported as through Hospital Compare, which of course VA already lists a lot of its own quality metrics there as well too. The idea is not to be even more burdensome to our community partners.

Mr. ROE. I agree with that.

One last thing before my time expires. Dr. Stone, the VA medical center in my hometown, which does a wonderful job, I might add, recently made the eye clinic an open-access clinic; in other words, you just walk in. That sounds like a good idea and I am supportive of your efforts to make eye care more accessible, but some veterans in my district are now waiting hours in the eye clinic before they are able to be seen because there are so many other veterans showed up by the time they get there. In some cases, veterans are telling my office, if they are traveling up to 2 hours to get to the clinic and then they are turned away because the clinic is up to capacity.

That is not—I don't think that is how they are supposed to work. Have you heard of this before? If so, what are we going to do about it?

Dr. STONE. We certainly are trying to work our way—and I go back to the chairwoman's opening comments on access to care and how we measure timeliness, I think I share exactly her concern. We have worked hard to move toward an open-access system. An open-access system is not a brown bench system that literally people show up 2 hours before we unlock the front door and then stand in line. That is not what we want.

We are using a model across four different areas, Indianapolis is one where it is running very well, that we hold about 30 percent of appointments open for same-day appointments. As part of the way we have grown too, well over 20 percent of our appointments this year, over 12 million, have been same-day appointments.

Mr. ROE. I would suggest that my local hospital sort of see what they are doing in Indianapolis and open a percent of those.

My time has expired and I am going to have to go to another committee hearing. I would want to say one other thing and I will yield back very quickly. I do think—and the next panel is going to speak on it and I won't be here for that, but I think that the urgent care benefit that was put in there is one of the best things that was put in there. I look at the average cost of $65 to go to an urgent care center, that is a great benefit for veterans; it is convenient for families and people that are busy. I want to commend you all for making that more accessible and I think anything you can do to make that work better would be something I would encourage you to do.

I yield back.

Ms. BROWNLEY. Thank you, Dr. Roe, and thanks for joining us this morning.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Madam Chairwoman. I thank you, Drs. Stone, Matthews, and MacDonald for all being here today to testify.

Dr. Stone, thank you for—well, let's just say, as you are aware, in 2017, VHA developed a staffing tool to help VA medical centers estimate how many community care staff they would need to keep up with the expected workload for processing community care referrals during the Vietnam Choice Program. Now with the MISSION Act there is a whole new set of eligibility criteria; has the VA considered updating the staffing tool based on the new criteria?

Dr. STONE. Yes, we have, and we are in the process of completely transforming how we do human resources and workforce management, and I would be happy to go into that at some length and meet with you about that.

Mr. CISNEROS. All right, that would be good.

How are you certain that the VA medical centers are adequately staffed to handle the current and expected workload, how are we——

Dr. STONE. It is partly wait time and, second, it is the satisfaction of veterans with their accessibility to care. Veterans are choosing to come to us, we have grown by over 80,000 enrolled veterans this year. What is remarkable in that is over 70 percent of newly enrolled veterans are over age 65, so they are Medicare eligible, but yet they are choosing us. That has created some very interesting dynamics and really driven the growth of about 13,000 hiring, so we have grown by about 13,000 over the last year.

Now, there has been a lot made of the fact that we have 43,000 open positions across the entire enterprise. In health care, the average turnover rate each year is about 11 percent, for us it is about 9 percent, between nine and nine and a half percent. So if we are going to stay at 9 percent, better than the commercial marketplace, we will always have about 30,000 to 31,000 openings, plus the growth that we have will run our openings up into the low 40,000; right about where we are.

Now, we have some very difficult areas of the country where we have trouble; recruiting gastroenterology, neurology, neurosurgery, orthopedic surgery are all difficult for us, and that is a fairly complex methodology to repair that, including—and I know you had Mr. Sitterly up here, Hon. Sitterly up here talking recently—we need some relief from the multiple different regulations that we hire under, under Title 38, Title 5, hybrid Title 30, it is very difficult for us to hire effectively.

Mr. CISNEROS. Dr. Stone, you also State in your written testimony that the VA estimates that more than 16,000 veterans have used the urgent care benefit so far and there have been approximately 44,000 urgent care encounters based on the number of times urgent care clinics have called to check veterans' eligibility. This averages out to about 2.75 visits per veteran in just less than 90 days or so since the urgent care benefit went live, which does sound like a lot of urgent care visits in 3 months. Do you think veterans are starting to use urgent care as a replacement for VA primary care?

Dr. STONE. That is not what we want. Urgent care is great for an acute sore throat, but it is not good for integrated health care that you see your provider who gets to know you and understands the complexity of just how complex veteran health care is.

We do know, and we have got some great data from TriWest on this, we have got 11 veterans that have already used urgent care ten times in the first 3 months. The vast majority have used it appropriately, the vast—well over 90 percent have used it one or two times and it is a great benefit for them. We need to track this closely and we need to health care manage that veteran or those 11 veterans that have been there ten times already.

Mr. CISNEROS. As part of that management, are veterans aware that there will come a point in these urgent care visits that the VA will start billing them——

Dr. STONE. Yes.

Mr. CISNEROS.—for their copay?

Dr. STONE. Yes, sir.

Mr. CISNEROS. They are made aware of that, they have that information?

Dr. STONE. Yes.

Mr. CISNEROS. Even the ones who went 11—10 times, the 11 veterans who went 10 times?

Dr. STONE. I can tell you that we do a weekly update on this. We made a decision this week to reach out directly to those 11 veterans and discuss with them how we might provide them care more effectively than the urgent care centers.

Dr. MACDONALD. Congressman, to that question, we sent out a quite robust round of messaging on this specific point close to June 6th, but we have reiterated that since then and we continue to, because we know that this will become an issue for some as they cross that third visit threshold, so we will continue that pace.

Mr. CISNEROS. All right. Well, I am out of time, so thank you very much.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

Mr. Brindisi, you are recognized for 5 minutes.

Mr. BRINDISI. Thank you, Madam Chair. Thank you, Dr. Stone, Dr. Matthews, Dr. MacDonald. I want to talk to you about a parochial issue, but one that is very important to constituents that I represent in upState New York. We talked about this a little bit before, the last time you were before the committee, the full committee with Secretary Wilkie back in April, and it involves the Bainbridge Clinic in Chenango County and upstate New York, which is in my district. This is a clinic which has been slated for closure and to be moved to a neighboring county that has a little more population density.

We began a discussion about market area assessments, which you had indicated you were a big fan of, the Secretary was a big fan of, and I indicated to you all that this particular Community Based Outpatient Clinic (CBOC) is not having a market area assessment done until 2020. I want to go through what we talked about back then and then read to you a letter that I received from VHA subsequent to our discussion.

We had an exchange, Dr. Stone, where I asked you, "As I understand it"—this is from your testimony on April 3rd of 2019—my question was, "As I understand it, there is not a market area assessment that is going to take place until at least 2020 in this region, so why move forward with moving the CBOC until you do a market area assessment to determine the needs of the community?"

You responded, "I understand and I am in full agreement with the Secretary on the market area assessments. Please remember, though, that the lease on this facility is not up until 2021, so we would be through a market area assessment before we decided on that move."

I then asked, "Okay. Can I get a commitment from you today that you are not moving the CBOC until at least 2021?"

You responded, "Unless I am substantially misunderstanding the issue."

We then followed up with a letter to VHA and got a response on April 29th, 2019 that contradicts your testimony from just a few weeks earlier where it says that the build-out for the clinic that you are relocating to should be completed and the move would be done in December 2019/January 2020 timeframe, which is a year before the lease ends; it is a move that is also done before a market area assessment has taken place.

I have constituents back home, you know, saying, okay, we are okay until 2021, according to your testimony, then we have a letter saying, no, the move is happening December 2019 or January 2020. Can you answer why the discrepancy between your testimony and subsequent communications from VHA?

Dr. STONE. The lease does end in 2021, it was my understanding that we were not going to vacate that lease in advance. I have found out since then that there is very substantial problems within that building with privacy and they have great difficulty, especially with female veterans and privacy. That doesn't mean that—frankly, I haven't been informed that we were vacating early, but there was substantial discomfort with that area.

I also am aware that the MISSION Act requires that I continue to make business decisions and don't delay business decisions until we go through the entire Asset and Intrastructure Review (AIR) Commission, market area assessments, decisions from the President, and decisions from you in Congress, that we continue to make decisions and move forward.

I would be more than happy to sit with you; in fact, I would like to come up and visit the area. You brought up during that testimony difficulties in public transportation and how difficult it would be. There is a greater density of veterans in the next county. You brought up some very good points, if I remember April, about public transportation, the ability of veterans, what percentage of veterans were taking public transportation.

I think we can reconcile this, but I am not aware that we are vacating that building in December of this year. We will resolve this in the next 24 hours with your staff and my staff will have it, but it is not our intention to change unless I just can't deliver appropriate privacy in that building.

Mr. BRINDISI. Right. I would encourage you to come up, I would love to have you there, because I think you can see firsthand—I have visited the clinic and you can see firsthand. I think some of the challenges that they have encountered there can be rectified within that existing location and I think it would be helpful for you to come up and tell the folks at the Albany VA, please, put the brakes on this a little bit until we have a chance to really see if some of the issues can be worked out. I don't want to have VA stay in a location that is not conducive to serving the needs of the veterans in that community, but I also think that some of the analysis that has been done in the region is flawed and I would like to point that out to you.

Dr. STONE. With the chairman's forbearance for just a few seconds. You introduced the subject by saying this is parochial. All of these decisions, because they affect veterans, are local and we are trying to be as responsive as we can to it.

Mr. BRINDISI. Thank you, Dr. Stone.

Ms. BROWNLEY. Thank you, Mr. Brindisi. Thank you, Dr. Stone, for your quick response to Mr. Brindisi. I understand the issue and CBOCs and locally, and how much that means to each and every veteran who resides there. Thank you very much.

Mr. Rose, you are now recognized for 5 minutes.

Mr. ROSE. Thank you.

Dr. Stone, I want to talk to you a little bit about referrals. I know that you are a believer in integrated care, I know you are a believer in treating the entire person and the value of one health care system treating the patient, moving across the nodes on the continuum of care. I am concerned when someone under our new system, when a veteran gets care from the private sector. Are we finding that they are then referred back to the VA for specialty care, for mental health treatment, if necessary, treating multiple comorbidities potentially, or that they are referred within that hospital or health care system?

Dr. MATTHEWS. Great question, Mr. Rose. Actually, we have a very defined process. The community providers do need to submit requests for services, RFS, back to the VA for authorization of care to determine whether or not the veteran is indeed eligible for community care in the new necessary service, whether or not we are able to provide it within the VA ourselves.

No, the care does not stay out in the community, but——

Mr. ROSE. That is my concern, actually——

Dr. MATTHEWS. Sure.

Mr. ROSE.—is that we can be putting ourselves down the road to a bifurcated care system. Let's entertain the hypothetical, right, that you say, yes, this person does need specialty care or this person does need another form of primary care, at that point does the VA step in and say, we are going to do it, thank you for the referral?

Dr. MATTHEWS. Yes, they can.

Mr. ROSE. Now, at this point, that veteran is caught between two systems. They have got a primary care physician and the VA has taken over another form of specialty care with two Electronic Medical Records (EMRs) . Those EMRs are not shared, right? Two different systems. How do you envision that working?

Dr. MATTHEWS. Sure. I think care coordination is definitely the piece——

Mr. ROSE. Who is in charge of that care coordination?

Dr. MATTHEWS. VA is.

Mr. ROSE. Care coordination is a word that is thrown out a lot, we hear it all the time——

Dr. MATTHEWS. Sure.

Mr. ROSE.—but with two separate EMRs, two separate health care systems, does that mean that the VA has a care coordinator that is tasked with that case every single time that there is two different systems controlling health care?

Dr. MATTHEWS. Yes. The VA will stand as the integrator of care. This is not unlike, honestly, what occurs in the private sector as well. As a primary care doc, I am referring to other hospitals. The Patient Aligned Care (PAC) team, the primary care model is responsible for coordinating that care. The Community Care Office also assists in making sure that there is appropriate communication. We have new IT systems to communicate with those providers as well.

The VA, yes, can pull that care back into VA, but, again, based on the eligibility of the veteran. If the veteran is indeed eligible to receive that new service in the community and chooses to do so, they can continue to receive it in that outside hospital.

Mr. ROSE. Are we operating on then an affiliation-based system almost, that every single private community doctor would work on an affiliation agreement with the VA?

I am trying to get an understanding of what the system is as we go down this road. Is this similar to what Federally Qualified Health Centers (FQHCs) have to go through where they don't operate hospitals, they don't operate often high-level specialty care, and so they are just referring out and then trying to figure out things from there? They will operate on an affiliation agreement. They will only refer to specific hospitals——

Dr. MATTHEWS. Exactly.

Mr. ROSE.—and they will have a system in place?

Dr. MATTHEWS. No. I am very familiar, I used to be a Chief Medical Officer (CMO) at an FQHC, so I am very familiar with what you are talking about—no, it is actually quite different, because of course we are a direct-service system, we of course make the determination along with the veteran of whether or not they would receive that care in VA or not. Our contracted partners in the community are there to supplement services that the VA can't provide.

Mr. ROSE. Are you taking those partners into account, their opinion into account as to whether that patient goes to the VA or goes to where they want to refer them to?

Dr. MATTHEWS. No, because typically the clinical necessity determination of whether that care is actually necessary, that does remain with VA. As any time I refer out to an orthopedic surgeon and I don't necessarily want to take their recommendation as a clinician separate from VA, I would then make sure that I follow up with the veteran.

Mr. ROSE. There is a clear profit motive involved here, you know, that we have many——

Dr. MATTHEWS. I agree.

Mr. ROSE.—it is just the normal way of business that they will want to refer——

Dr. MATTHEWS. Exactly.

Mr. ROSE.—within either their affiliations or their systems.

Dr. MATTHEWS. Which is why VA will maintain oversight of both clinical necessity and assisting the veteran to determine where they would like to receive that care.

Mr. ROSE. Just lastly, so what systems do we have in place in the absence of a shared EMR?

Dr. MATTHEWS. A new system that we have rolled out, it is not fully utilized yet, but our Health Care Referral Manager is an off-

the-shelf system that is cloud-based, like other portals that a lot of private systems use, where the community provider can upload as well as download medical documentation, do direct messaging. So this cloud-based system we are really looking toward——

Mr. ROSE. Have you guys implemented like HIPAA waivers into your workflow?

Dr. MATTHEWS. Yes, of course.

Mr. ROSE. Okay. Then that could also——

Dr. MATTHEWS. Exactly.

Mr. ROSE. Okay.

Dr. MATTHEWS. Actually through our health information exchange that VA has and actually under the MISSION Act, we are actually in an opt-out mode for providers to actually use our Health Information Exchange (HIE), so that they can see the documentation——

Mr. ROSE. Okay.

Dr. MATTHEWS.—from the veterans on an opt-out scale.

Mr. ROSE. All right, great. Thank you, that is very helpful.

Ms. BROWNLEY. Thank you, Mr. Rose.

Mr. Lamb, you are now recognize for 5 minutes.

Mr. LAMB. Thank you to all the witnesses.

I have kind of a similar line of questioning, so we can probably pick up where Mr. Rose left off, but first I just want to clarify something. I have talked to some providers in different parts of Pennsylvania so far and the impression that I got is that the typical case for community care involves a veteran seeing a primary care doc within the VA and then a referral from there, whereas some of the questions that you just heard sort of implied that people were getting primary care in the community. At least within Pennsylvania, I got the impression that primary care in the community was very unusual and that most primary care was happening in the VA still; is that your impression?

Dr. MATTHEWS. That is definitely the case.

Mr. LAMB. Okay.

Dr. STONE. That is our intent——

Mr. LAMB. Right, that seems to make sense.

Dr. STONE.—because of the complexity of veterans' care, that primary care, internal medicine should be the glue that holds the care together in an integrated basis.

Mr. LAMB. Great. That seems like a good emphasis to me and a good control.

My next question I think is related, but it is looking down the road a little bit. We do have, you know, these incredibly different incentives within the VA system and outside of it when it comes to the way patients are treated and the way that fee-for-service medicine works outside the VA is just a different type of practice. I have heard the concern expressed from doctors within the VA that I have talked to about—you know, the way one put it to me is, sometimes the best thing that we can do for one of our patients is to hold off or do the sort of least intrusive or most minimal thing——

Dr. MATTHEWS. Conservative, yes.

Mr. LAMB.—and that decision just doesn't always look the same in the private sector. The concern that was raised to me was, once

these networks are built and the payment is streamlined and the VA becomes known as a reliable payer in the community care context, what safeguards do we have to make sure that private physicians are not just sort of racking up fees and services once a person gets in their hand?

Dr. MATTHEWS. Sure. Excellent question and definitely our concern as well. We are really looking to develop a more robust utilization management sort of set of procedures and even IT systems, so that we can monitor the care that providers are—the services that they are providing and otherwise either educate or even no longer refer to them if indeed we question really their intent behind perhaps not choosing conservative treatment when it is more appropriate, especially from a clinical necessity standpoint.

Again, going back to Mr. Rose's point and my response, all requests for secondary services VA does need to authorize as well too. That, again, with primary care in the community it is a little bit different, but for an orthopedic surgeon, for instance, if they submit authorization to have a procedure done and VA does not agree, we will not authorize. We do have at least that checks-and-balance in place.

We have to balance that, however, with the way the rest of the industry works, of course. Right? That we tend to authorize things in bundles in the private sector and of course we don't want to make it more difficult for our community providers as well. A lot of this is about the communication between the community providers and the VA team.

Dr. MACDONALD. If I may follow——

Mr. LAMB. Yes. Go ahead.

Dr. MACDONALD.—onto this for just a brief moment, Congressman. This is such a critical point.

As we have approached this roll out of the MISSION Act, we have seen really a shift in not only VA thinking, but in our partners' thinking as well. This is a new era of veteran empowerment, if you will. VA has been a leader in making information transparent and putting that in the hands of veterans previously. Now we are helping them make informed choices.

To your question about safeguards, in addition to what Dr. Matthews said, I believe there is twofold additional safeguards.

First of all is veteran experience. If we are the most convenient, the best experienced meeting veterans where they are, not just in a facility, but via Telehealth. If we are meeting them in their living room versus them having to go out down the street and be referred for care in that manner, we are the most convenient option and we also fit into their lives the best. We meet them where they are. That experience will help to safeguard this system and it is something we are aiming directly at.

The second piece is that at Dr. Stone's lead, we look at the data for the system daily and we convene the entire leadership of the Veterans Health Administration weekly. That includes network directors from every single network across the country, and many of their medical center directors as well. We look at this, and we analyze it, and we agonize over it, and we make strategic decisions from it.

Those additional safeguards, in addition to what is mechanically in place, we think would be strategically important going forward.

Mr. LAMB. Okay. Thank you very much. I appreciate what you have done in the last few months. I had a pretty good experience visiting VA hospitals in the initial roll out of this, so I know you are engaged.

I am I think most specifically concerned about chronic pain and stress patients, and whether they will receive the sort of holistic and gradual care before turning to dangerous prescription medicines, especially outside the VA as within it. I don't need you to say anything else on that.

I just want to make sure our eyes are on the ball there and we keep revisiting how that is going.

Thank you. I yield back.

Ms. BROWNLEY. Thank you, Mr. Lamb.

Before we move to the next panel I just, again, want to thank all of you for being here. I feel like before you leave, since we have the A team here, and I really wanted to ask just, you know, two questions really.

First, if you could just summarize briefly for us, you know, the challenges that you see just in the next 3 months. You know, what are the challenges, and how are you seeing progress nationally? You know, we all know if you have seen 1 VA, you have seen 1 VA. I am asking, you know, how are we doing nationally? Do we have strong spots and weak spots and, if we do, if we have the weak spots—and I believe that, you know, there are probably some weak spots in here somewhere if we are going to be honest with each other.

Then how are we working with those locations to bring them, you know, to bring them up to speed?

If you could just be brief. I think those are important questions before we leave to just, to get a snapshot of where we are going.

Dr. STONE. I think there are weak spots in any delivery system. What I worry a lot about is TriWest has been an extraordinary partner and, frankly, a great partner to restore the trust that we lost from previous vendors who failed to pay bills on time. You heard that here as part of this.

I worry a lot about the relationship with a new vendor coming in. I am assured that I have a long-standing relationship with the leadership of that new vendor that is coming in and that Optum has a great track record as does their parent company, a great track record of what they provide.

I worry about that.

I also worry about the fact that, frankly, there is a perversion in the commercial sector of the incentives toward care. We have been very gratified at the fact that we have been able to drop the amount of usage of opioids, dramatic reductions in opioids and benzodiazepines, and provided a safer environment.

Therefore, we must deliver a network that really does provide mental health primary care in a manner that really provides the care integration that veterans deserve.

Our veterans have incredibly complex conditions based on the fact that 70 percent of them have been to combat. The presence of chronic pain, the presence of a history of military sexual trauma

really requires our system to be at the forefront of the delivery of care.

I know I have gone on longer than you wanted, but this is the key issue that you bring up of what the future of this system should be.

I will defer to my colleagues.

Dr. MACDONALD. Madam Chairwoman, if I may? I will be brief.

To your question of where might we have strong spots, where might we have weak spots, we have heard the narrative a couple of times externally, well, now that MISSION Act is over, what are you tackling next. In our view, MISSION Act has just begun.

As I said, we are looking at this data every single day at Dr. Stone's direction, and we are now working facility by facility with network directors involved, taking a look at the decision support tool data, the access data, the community care consult data, the internal consult data making sure that not only is the data what we would expect for that population and the geographical needs that might exist there, but that our processes are consistent from end to end.

We are taking a comprehensive look at this and not resting on our laurels because there has been a success on June 6th, but rather pressing ahead and working to enhance this so that it is everything it needs to be and can be sustained from here out.

Ms. BROWNLEY. Thank you all very much. I really do believe you are the A team, and I believe in you and I look forward to another hearing here in the short future again to check in on how we are doing. Of course we all are going to be hearing from our veterans locally and that is—I think we all think that that is a pretty good test in terms of how we are doing.

I do thank you for being here. I thank you for the hard work you have done and accomplished so far, and look forward to continued success.

With that we will move to the next panel. We will give a moment for transition here.

[Pause]

Ms. BROWNLEY. Welcome to the second panel and thank you also for being here today. We have Ms. Sharon Vitti, President of CVS MinuteClinic and Senior Vice President of CVS Health.

Also here today is Mr. David McIntyre, the President and Chief Executive Officer of TriWest Healthcare Alliance.

Lastly, we have Retired Army Lieutenant, General Patty Horoho for her first appearance before the committee who is the Chief Executive Officer of OptumServe.

I thank, again, each of you for joining us today and I know this will be a fruitful discussion.

Ms. Vitti, you are now recognized for 5 minutes.

## STATEMENT OF SHARON VITTI

Ms. VITTI. Good morning. Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee, thank you for the opportunity to testify today and just share CVS Health's role and experience in expanding care for our Nation's veterans.

My name is Sharon Vitti and I serve as President of MinuteClinic and Senior Vice President of CVS Health. I am

pleased to be here today to provide an overview of MinuteClinic's partnership with the U.S. Department of Veterans Affairs. Support for our country's veterans and members of the military is core to CVS Health's mission to help people on their path to better health.

Our support of the MISSION Act is one example of the many ways we stand with veterans, active military and their family. Since 2015, CVS Health has hired almost 15,000 people with military experience and more than 5,000 military spouses.

We provide charitable support to military and veteran focused organizations, including the National Guard, Operation Reinvent, and the USO. We are deeply honored to be recognized by the Military Times which named CVS Health to its 2019 list of best companies for veterans seeking a civilian job.

Providing veterans with convenient access to quality urgent care is a shared goal of the VA and of CVS Health. Our work with the VA began in 2016, with a 1-year pilot funded by the VA health system in Palo Alto, California. This pilot leveraged 14 local MinuteClinic sites to provide access to treatment for minor illness, minor injuries, and skin conditions for local veterans.

Throughout the pilot we developed a system to electronically send information about the veterans visit to the VA through the e-Health Exchange. This allowed us to maintain continuity of care with VA providers and respect the existing patient provider relationship.

Under the pilot, veterans were screened for eligibility when they called the VA triage line. If their condition met the criteria, the veteran was offered the opportunity to be treated at a MinuteClinic. Over 550 visits were conducted over 6 months with an average in-clinic wait time of less than 20 minutes.

Veterans could also fill their prescriptions associated with their MinuteClinic visit at the co-located CVS pharmacy, if desired. The pharmacy followed the VA formulary and applied standard VA co-pays.

Following the success of this pilot, we partnered with the VA's Office of Community Care, the Phoenix VA and TriWest to enable veterans to receive care at 24 MinuteClinic's in the Phoenix area. We later expanded this pilot to additional regions.

The MISSION Act provides the framework needed for the national expansion of this urgent care access for veterans. Veterans can now access urgent care and walk-in medical services under their VA benefits without pre-authorization. Veterans who meet certain eligibility criteria can also receive care at a MinuteClinic. We typically treat acute conditions where prompt care can avoid more serious health issues and keep costs down.

Following the MinuteClinic visit, MinuteClinic is able to make available the full record of medical services electronically to the VA with the veteran's consent.

Our 3,000 nurse practitioners and physician's assistants are trained to welcome and care for veterans in over 1,100 MinuteClinics across 33 states and the District of Columbia. Approximately 8 percent of our providers proudly declare being a veteran or having a military spouse.

Under the MISSION Act we have provided care for more than 5,600 veterans. Combined with the veterans we cared for during

the pilot and under CHOICE, we have provided care for more than 9,500 veterans since our partnership began 3 years ago.

CVS Health deeply values its partnership with the VA and the opportunity to provide care to those who have served. We couldn't be prouder of the program we have created together and appreciate Congress and this committee for recognizing this program and the benefits it offers to veterans.

We look forward to working with TriWest and Optum within the MISSION Act to continue to connect veterans with greater access to quality health care while ensuring they are still linked with their VA care providers.

We appreciate the opportunity to testify and look forward to your questions.

Thank you.

[THE PREPARED STATEMENT OF SHARON VITTI APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Vitti. I know this is your first appearance, too, so thank you again for being here.

Mr. McIntyre, you are now recognized for 5 minutes.

**STATEMENT OF DAVID J. MCINTYRE, JR.**

Mr. MCINTYRE. Thank you, Madam Chairwoman, Ranking Member Dunn, and distinguished members of the subcommittee. It is our privilege to appear before you on behalf of our non-profit owners, team of dedicated subcontractors and nearly 3,500 employees, most of whom are veterans or veteran family members, to discuss the implementation of VA's MISSION Act Community Care programs.

Thank you for your leadership in providing the road map to the next generation of VA, and for your insistence that we all stay focused and leaning forward on effectively executing that which was envisioned in the new law.

Our company, which has been serving the health care needs of those who have served and their families for nearly a quarter of a century, has been proudly supporting VA in its journey of the last 6 years. I will tell you it has been quite a journey.

This chapter of our company's journey has been the privilege of our lives. Serving those who have sacrificed so much on all of our behalf, including this generation's warriors who have leaned forward to defend freedom since September 11, 2001.

I want to thank the amazing team at VA for their dedication, focus, perseverance and endurance in working at the necessary task of beginning to reset the enterprise they inherited so that it might become more effective and deliver better on this Nation's commitment to its heroes. It is an honor as fellow citizens to be a part of your team. We are not here to privatize VA as a company, but rather to support VA in strengthening their ability to make sure that veterans get what they need.

Inspired by those we are collectively privileged to serve, I am pleased to report to this committee that the nationwide network of community providers which we have constructed, including 24,000 OBGYN providers and mammogram screening providers in most communities, has just now delivered as of yesterday almost 1 million appointments since June 6th in support of VA. The network

for urgent care, which has been discussed this morning, has now delivered as of yesterday more than 51,000 encounters in every State and every territory in this great country.

Based on our work so far with VA, Congress and the VSOs, I believe it is fair to say that the words you have articulated this morning are true, and that is this has been a relatively smooth implementation, very smooth compared to Choice and the early crises that we all faced. We were part of that struggled and challenged journey.

I think we would all agree based on the crisis that unfolded in our home town of Phoenix where, among others, we served 3,300 urology patients in 30 days, it was absolutely necessary to get started, even though it was going to be complicated and difficult for all involved.

As you know, one of the things that you and VA sought to do was to consolidate together the community care programs and turn them into one. That is no small feat. That brings new tools. It brings process changes, which take time to implement and refine. Shortcuts or trying to do things too fast are never smart. From our experience, it also brings a requirement for reeducation, modification and refinement, some of which you have heard about under way earlier today.

For our part, our core responsibility was to make sure that there is a network of providers in the community able and ready to serve. They are. We are sending back less than 1 percent of the care that has been requested by VA for no network provider, and that is across the country.

We are paying our bills on time because if you ask people to serve, you have a responsibility to make sure that they get paid on time and accurately. As Dr. Stone articulated accurately, we are paying 98 percent of our bills in less than 30 days.

There is historical Accounts Receivable (AR) and it is our privilege to work with VA to try and resolve that for the great providers who are leaning forward.

We also second built out the urgent care network. We are not quite finished. What has been really fascinating over the last 6 months is to watch the development of new locations all over the country. Wal-Mart announced last week in Georgia that it was standing up a new design. Watch what happens over the next year as they expand that footprint across the country. This is a good thing, not a bad thing. That means that we have to stay very focused on exactly where are these as they stand up so that we can get them under contract.

Our personal commitment is that veterans will not have to drive more than 30 minutes from their house to get to a place that exists. Today, we are at 90 percent of that being factual. Our goal is to make sure that we get to a point where every veteran is able to go at a place that is near their home in order to get what they need.

I want to welcome our new teammate from Optum to the table. I am looking forward personally to having the opportunity to continue to work with General Horoho who I knew as Army Surgeon General. Our company has a responsibility to make sure that we keep things stable. We had the privilege of stabilizing, given the

removal of HealthNet. We have done that as a team, and we intend to keep it stable. We have worked through with VA and Optum the ability to keep that moving as we go forward.

I look forward, ma'am, to being able to hand these great Americans over to you and your places of responsibility so that they shall be served, but that is not going to be a disruption to their continuity of care as we move forward, as was discussed previously.

Thank you for holding this hearing. Thank you for the opportunity to appear. I look forward to engaging with any questions or discussion that you would like to have.

Thank you.

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

Ms. BROWNLEY. Thank you, Mr. McIntyre, and I will say I think you are part of the A team, too. I think you might have been involved in community care longer than some of the people in the VA who are administering it. We thank you for all of your hard work.

With that, Lieutenant General Horoho, you are now recognized for 5 minutes. Welcome to the team.

**STATEMENT OF LIEUTENANT GENERAL PATTY HOROHO**

General HOROHO. Thank you.

Good morning, Chairwoman Brownley, Ranking Member Dunn, members of the subcommittee. I am Patty Horoho, CEO of OptumServe. I am honored to be here today to discuss our role in implementing the VA's community care network. On behalf of the more than 335,000 men and women of Optum and United Health Group, we welcome this opportunity to discuss our partnership with the VA.

We have a long and proud history of serving our Nation's military and veterans. While our work on delivering health care to veterans as part of the community care network officially began 8 weeks ago, I want to highlight recent milestones and describe the road ahead.

I would first like to express our appreciation to the members of this subcommittee, the full committee and Congress for passing the VA MISSION Act into law. We are committed to working with you, the VA and the veterans' community to make your vision a reality.

I would also like to recognize our strategic partners, including Dr. Stone, Dr. MacDonald and Dr. Matthews, and those at the VA who care for our Nation's veterans. We are grateful for their dedication and honored to partner with them.

Our deep partnership with the VA is critical in achieving our shared goal of improving the quality and convenience of care delivered to our Nation's heroes that honors their sacrifice.

Community care provides the opportunity to better connect systems of care in a way that maximizes capabilities across the health system. It can ensure care and information is coordinated, connected and compassionate. I understand firsthand the compassion and the commitment the VA medical staff brings to the exam room every day, and the importance of coordinated care across the health system.

My father served honorably in World War II, Korea and Vietnam, and later developed a number of illnesses, some associated

with Agent Orange exposure. To treat these illnesses he received care both from the VA and from health care providers in our community. One system did not fully treat my father, nor did they work independently of each other. Rather, the partnership between the VA, his health care providers in our community and our family allowed him to live the best life he could while managing his illnesses.

As a veteran, retired soldier, wife of a veteran, daughter of a veteran, and now the proud mother of an Army 2nd Lieutenant Infantry Officer, I am personally committed to the success of VA Community Care. My leadership team at OptumServe, which is comprised of veterans from every branch of service and our community care program office staff where 43 percent are veterans, are equally committed.

We are honored to touch every point in a veteran's journey through the programs that we support. It starts when sons or daughters step up to raise their right hand, to ensuring a reservist is medically ready for deployment, to disability exam when a service member transitions from active duty, and now to the veteran receiving care through the VA Community Care providers.

Central to our responsibility is to deliver a quality and robust network of health care providers and facilities that make up the community care network.

We are leveraging our entire enterprise to build this network, and we are working closely with the VA and local medical centers to contract with quality providers that have a history of working with veterans. We have recruited more than 3,800 providers in Region 1 with more than a third in rural and highly rural areas. When we complete the full development over the next 9 months, we expect to partner with more than 900,000 providers across Regions 1, 2 and 3 representing a comprehensive and deep network across all health services.

We are also making it simpler for a provider to care for a veteran. We are removing administrative burdens and making it easier for them to get paid on time. That is why we have implemented a billing and payment system that is familiar to them. After they care for a veteran, they electronically bill Optum and Optum pays them.

We already do this today, processing 2.8 billion claims every year with 99.5 accuracy representing $178 billion for health systems and health plans across the Nation. We are committed to make this process as familiar and accessible as possible.

Madam Chair, members of the subcommittee, I would like to leave you with 3 thoughts: 1, we have to get this right for our veterans; 2, we have to get this right for our VA and providers; and, 3, we have to get this right for the American people.

Thank you for the opportunity to be here today, and I am honored to be on this panel with Dave McIntyre and Sharon Vitti. I look forward to your questions.

Thank you.

[THE PREPARED STATEMENT OF PATTY HOROHO APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Lieutenant General, and I will now recognize myself for 5 minutes.

I have 2 quick questions right up front that I wanted to ask really probably of Mr. McIntyre since you have been in the trenches here. I want to know, we are hearing that the providers are now getting paid on a timely basis. I want to know how you are getting paid. Are you getting paid on a timely basis?

Mr. MCINTYRE. The VA is doing a remarkable job in turning what has been a very challenged road for all of us. We are getting reimbursed in 18 days by the VA. We have one remaining issue that we are working. We actually have a call on that issue this afternoon, and that is that we have been pushing back a little bit the work to try and put a reconciliation process in place on both sides so that we can handle overpayments and underpayments that go between the two of us. We necessarily pushed that back to stay focused on the providers on the front end——

Ms. BROWNLEY. These are short questions——

Mr. MCINTYRE.—and getting the mechanics——

Ms. BROWNLEY.—Mr. McIntyre. I hear that you are getting paid. The answer is——

Mr. MCINTYRE. Yes, ma'am.

Ms. BROWNLEY.—yes. Okay.

[Laughter.]

Mr. MCINTYRE. We are paying and we are getting paid.

Ms. BROWNLEY. There were a couple of VSOs who submitted written statements for this hearing today.

Mr. MCINTYRE. Yes, ma'am.

Ms. BROWNLEY. One of them pointed out this issue of, or a concern with community providers around the gold standard as they claimed it to be within the VA, meaning that physicians, mental health experts understand the veteran, have been trained in that perspective, and a concern that going to community care professionals veterans aren't going to receive the same type of gold standard. We are talking, you know, this is back to quality care. This is——

Mr. MCINTYRE. Right.

Ms. BROWNLEY.—more about really understanding veterans.

Can you speak to that?

Mr. MCINTYRE. You bet.

Ms. BROWNLEY. Briefly.

Mr. MCINTYRE. Absolutely. There is a requirement that you put in the MISSION Act that has VA and us compelled to make sure that all providers in America understand who veterans are and what things they might want to know to make sure that they meet their unique needs.

Having said all of that, and now having facilitated the delivery of 16 million appointments since the start of our work at the side of VA, in all categories of care what I would say is there are always veterans who should only be served in VA.

Part of the trick for all of us over time, the challenge, is to figure out who are they and how do we make sure they are first in line in VA, not third in line, so that we can make sure that those that are most at risk for things that are unique as a veteran always end up in the VA enterprise.

Ms. BROWNLEY. Thank you. Thank you very much for that.

Lieutenant General, I wanted to just ask you. I enjoyed our conversation briefly on the phone the other day. Tell me what Optum is doing to really reassure some of the skittish community providers who now are being introduced to their third party administrator. What are you doing to make sure that those providers are going to feel comfortable joining the network?

General HOROHO. Yes, ma'am. We have a very robust, strategic outreach. We are leveraging our network of 1.3 million providers across United and we are talking to them to let them know what is different.

What is different is that they will be paid by Optum first when they submit a claim, and then we will submit our claim to the VA. We are talking to them that the reimbursement rate has now increased from 85 percent to 100 percent with Medicare. We are also talking to them about the privilege that each of them would have by being able to treat our Nation's heroes.

We are finding, you can see with our number of 308,000 providers willing to join, we are finding that they are willing to be part of our network and to serve.

Ms. BROWNLEY. Thank you.

This issue that came up with the first panel in terms of episode of care and that not being interrupted, how are you managing that?

General HOROHO. We are in agreement and we are working very closely with TriWest and with the VA. We look at this as a partnership. If a veteran is approved for care in the community, then that continuum of care will continue. If it was with TriWest it will continue with TriWest even if we have taken over in those regions.

Ms. BROWNLEY. Thank you. Thank you very much.

I think with that my time is up and I will yield to Dr. Dunn for 5 minutes.

Dr. DUNN. Thank you, Chairwoman Brownley.

You took a lot of the great questions there I was going to ask. I appreciate you doing that.

I will note that a number of your providers are physician—the physician providers are veterans as well. You know, as an old Army sub they don't often—they are not going very far outside the circle, I think, to come to the community care programs a lot of the time.

General Horoho, we have heard a few reports from Region 1 that some of the providers are under the impression that they have to join the United provider network in order to join the Optum veterans' network. Is that true? If it is not true——

General HOROHO. You know, part of what we have done is that our contracts have both seals. They have the United seal and the Optum, and it is part of the contract narrative. If they have already been part of Optum, they are still underneath that contract and they don't need to switch over, or if they were a part of United.

It is more of clarifying the language so that they understand that if they are already part of our network, we are contracting them within community care.

Dr. DUNN. Okay. The reimbursement goes to Medicare from whatever it was before?

General HOROHO. The reimbursement, they will, after they visit and they take care of one of our Nation's heroes, they will submit

a claim. That claim will then be paid by us and then the VA will pay Optum.

Dr. DUNN. Excellent. This is for both Mr. McIntyre and General Horoho, if a veteran is referred to one of your networks and they want to see a certain provider, can you ensure that choice? Is that something you can do and, if so, how?

Mr. MCINTYRE. General. Okay.

Today the way it works is we have a panel of providers in each community. It is broad. It is deep in terms of specialties and numbers. The veteran absolutely gets to get involved in choosing which specific provider they would like to see. Our systems are set up that way, and that is the way in which the provider appointing process works.

Dr. DUNN. Good. That is allowed. I just wanted to make sure——

Mr. MCINTYRE. Correct.

Dr. DUNN.—that was. I assume the same is true for Optum?

General HOROHO. The VA can go into our system, see the providers and make that——

Dr. DUNN. Excellent.

General HOROHO.—make that choice for the veterans.

Dr. DUNN. Mr. McIntyre, your testimony had said that all of a sudden June 6th the request for community care outstripped the projections. Yet in the first panel we heard that it was like an uptake of 3 percent or 3.7 percent, something like that. How do I reconcile those 2 bits of information?

Mr. MCINTYRE. The piece I was focused on was the piece that arrives in our domain for which we are responsible for appointing. We do appointing still in the country, which is a human endeavor, for about two-thirds of the country. It would be the work that flowed through our network for which appointing was responsible—yeah well for which we are responsible for appointing.

In the mental health space, our prior experience—prior to June 6th—actually was bested by about 4 times in terms of the demand that came into the community.

Dr. DUNN. Did we enlarge the—I guess we did.

Mr. MCINTYRE. You——

Dr. DUNN. We enlarged the mental health——

Mr. MCINTYRE. You shrunk the access standards, and we were all collectively trying to make sure that people got served in those more narrow access standards.

Dr. DUNN. I just got the 2 different interludes. The impression from the——

Mr. MCINTYRE. Sure.

Dr. DUNN.—2 numbers was different.

Let me also, again, Mr. McIntyre, if I can ask, this is now going right to my region, your Region 3. We are having trouble with credentialing. I have providers who have been credentialed with TriWest. They have been providing VA care. They made the deadlines for getting all their new credentialing in for the PC3 credentials, and then 6 months later they still haven't been credentialed and they are showing up as not certified VA providers even though they have been historically. They continue with you, TriWest, from before and now.

Mr. MCINTYRE. That doesn't make any sense.

Dr. DUNN. I didn't think so either.

Mr. MCINTYRE. I am sure it exists. I would love to sit with your staff or with you and——

Dr. DUNN. Please do. Please do because you can——

Mr. MCINTYRE.—figure out exactly who are they.

Dr. DUNN. Yes. There is——

Mr. MCINTYRE. We will get in touch with them.

Dr. DUNN.—some rather large groups of physicians——

Mr. MCINTYRE. Yes, sir.

Dr. DUNN.—who are feel that they have been—you know, half of them got, you know, a group—so, I mean, I know they know how to do the application. You have a group of 70 physicians——

Mr. MCINTYRE. Yes, sir.

Dr. DUNN.—only half of them made it across the finish line.

Mr. MCINTYRE. We will look forward to that.

Dr. DUNN. I appreciate that. I had one more question. Oh, yes. How long, and for both of you, how long does it take to get an authorization from the time the veteran says, okay, we need an authorization code, Community Care. How long does it take in TriWest and how long does it take in Optum?

Mr. MCINTYRE. I can answer that from the standpoint of what we do with an authorization and when it actually gets to the point of care. We have a couple of day process. When we ingest an authorization it comes from VA. We put it through a process——

Dr. DUNN. What is the timeline? We are down to 3 seconds here.

Mr. MCINTYRE. To go from authorization to full appointment——

Dr. DUNN. Well, no. Actually to get the authorization, to ask for the authorization and get it just in the VA.

Mr. MCINTYRE. 2 days to come through our process.

General.

General HOROHO. With Community Care now the VA makes those scheduling appointments, so we don't have visibility of that.

Dr. DUNN. Oh, so you are not——

General HOROHO. As soon as the——

Dr. DUNN.—there yet?

General HOROHO. As soon as they determine eligibility, though, the VA can go into the system, see our providers, schedule an appointment and then our providers——

Dr. DUNN. Any delays are actually before they get to TriWest or Optum? They are in the VA.

General HOROHO. In new Community Care.

Dr. DUNN. Okay. All right. Thank you.

Thank you. I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn.

I just wanted to follow up on that line of questioning. I am interested from the time of auth—how long it takes for the authorization, not from the authorization to appointment, but from the request of authorization to being authorized.

I will let you mull that over, and I will ask Mr. Lamb 5 minutes.

Mr. LAMB. Thank you, Madam Chairwoman.

I am interested in the answer to that question as well, too, so if you know it and want to answer on my time, that is totally fine.

Mr. MCINTYRE. If you go back about a year and a half to 2 years, the process took 90 days in the VA environment and 90 days in the

TriWest environment to get from end to end. That was completely unacceptable.

The VA spent time on their side of that boundary line. We spent our time on our side of the boundary line. I think it would be a good idea to have us sit down together and map out what that looks like with the various component parts. Why does it look the way it is? Where are we? Get your input on whether we make additional adjustments or whether you are satisfied with where we currently are.

Mr. LAMB. Okay. That is great. I hate to cut you off, but it just sounds like we don't know the answer to the timeline yet. We will get back to it when you have that.

General, I think this is a question for both of you, but, General, Optum is going to be serving Pennsylvania where I am from. Let's say that you have a pain doctor who may have other parts of their practice, too, but let's say that they are a pain management type of doctor in Western Pennsylvania. They are considering joining the Optum network to serve veterans.

What, if any, safeguards are in place to make sure that that doctor is not someone who overprescribes opioids, or casually prescribes them, or has poor prescribing practice, or a record of poor treatment of the people? I mean, I am basically asking what sort of oversight and investigation, if any, is done before this person is allowed entry?

General HOROHO. Thank you for that question. We have—our first priority is leveraging those physicians that are in our network, and we make sure that they are accredited.

Mr. LAMB. Do you mean, that are in your——

General HOROHO. In the United health——

Mr. LAMB.—Optum——

General HOROHO.—network.

Mr. LAMB.—health network already. Okay.

General HOROHO. Priority.

Second are those that have a relationship with the veteran and they want to be part of our network, then we can reach out to them. Anyone that is joining the network gets reviewed through our accreditation process before they are allowed to practice. They have——

Mr. LAMB. Is that—sorry. Is that the same process you would use like if someone wanted to be part of United?

General HOROHO. Yes.

Mr. LAMB. Is it basically the same thing?

General HOROHO. It is one standard. We are also looking at leveraging our choice plus providers which have a higher standard of care and quality. We have all of them that are trained in opioid usage. We also have a providerexpress.com where they can go online and read about opioid training. We make sure that we are monitoring the usage. We also have——

Mr. LAMB. I am sorry. What do you mean monitoring the usage?

General HOROHO. We can look at frequent prescribers. We also can look within community care that they can use complimentary alternative medicine. They can use biofeedback. They can use massage, tai chi. We try to encourage complimentary alternative medicine first. Then also when they are in the community it is a 14 day

prescription. They can't prescribe more than that for that episode of care.

Mr. LAMB. Okay. That is great. Do you actually look at historical metrics of how much that person has prescribed let's say in the last 5 years or the last decade before they are allowed entry to the network?

General HOROHO. We do have within our data analytics to be able to monitor that data and to be able to look at sole source providers as well.

Mr. LAMB. Okay. I guess what I am asking is pretty specific. It is not about——

General HOROHO. Okay. I am sorry.

Mr. LAMB.—monitoring. It is about before the person is allowed entry, is it a requirement that you look at how much they have prescribed in the last 10 years and make a judgment about what that looks like compared to the average?

General HOROHO. I will take that for the record to make sure——

Mr. LAMB. Sure. Yes. That is a——

General HOROHO.—I am giving you accurate information.

Mr. LAMB.—pretty specific question. The reason I am asking you is just because I think where we live in particular, there was a lot of really poor practice for a very long time and not everybody was investigated, not everybody was prosecuted. A lot of those people are still practicing and nothing has ever happened to them. I wouldn't want them to gain admission or access to this group of patients without those questions being asked about how, if at all, they have changed their practice.

If you are able to follow up with us on that about sort of what happens at the beginning to safeguard that, I would really appreciate that.

General HOROHO. Absolutely.

Mr. LAMB. Thank you.

General HOROHO. Thank you.

Mr. LAMB. Madam Chairwoman, I yield back.

Ms. BROWNLEY. Thank you, Mr. Lamb.

There are no other members here, so before I excuse the panel I had 2 questions that I wanted to ask. Ms. Vitti, you haven't been asked a question so I want to make sure that I ask one.

I think from what I am hearing and certainly hearing from Mr. McIntyre that, you know, we are working on getting to 100 percent in terms of coverage. Now that Optum is on board I just want to hear from you, are you engaged with Optum to make sure that—I know you are in 33 states. We have got some more to go here. Are you working with Optum to make sure that those providers are there throughout the country?

Ms. VITTI. Thank you for the question.

We have had a great partnership with TriWest and we have—we are starting to build a great partnership with Optum. For this particular program we have worked with Optum and United on other aspects of our business. We already have a relationship.

I think with both the partnerships we have been able—they have been very gracious and interested in learning about what we have encountered and what we have built in our pilots and incorporating that in the process going forward.

I have been very impressed with both organizations being focused on making it easy and seamless for the patients and the providers. I expect that that will be the ongoing relationship that we have.

Ms. BROWNLEY. Well, terrific. I agree with Dr. Roe and his opening comments when he was here to say that this urgent care piece is such an important addition to services for our veterans within this MISSION Act.

As we are overseeing this whole operation we are going to be looking very closely at the urgent care piece, too, because we don't have any experience with this. This is our first experience and we want to make sure that we get it right. I have great hopes that we will.

Again, I think just in a similar fashion to my questioning along with the first panel, I wanted to just end here by asking Mr. McIntyre, from—you know, from your perspective what do you think are the key sort of lessons learned? You have been in this space longer than anybody else. What would you say are the lessons learned?

Mr. MCINTYRE. I think collaboration is really important. I think looking back and trying to figure out where the challenges have been and applying those lessons as you design what you are doing presently, and then refining going forward as a team and keeping a very open communication and identifying gaps and working those issues. That is literally what has been led by VA through this process, particularly of the last 12 months. And it has been a privilege to be a part of that.

I think from a threat perspective, making sure that we get to a place where we understand what does it take for the life cycle to go from that encounter with the provider in the direct system to the boundary line to move the patient into the community, and then making sure that the pieces come back the other direction. That's really got to be the core fundamental of what we are all doing.

I didn't want to leave people with the impression that we are still at 90 days on each side of that because we are not. There has been a lot of work done and it has been incredible work by people. It is very tight now, but it can probably be tighter. I think it is important to be transparent about what that looks like.

Ms. BROWNLEY. Thank you very much.

I, on that particular piece, too, I look forward to working with you on it. As I said in my beginning comments is that, you know, this wait time issue, this is something that I really do want to resolve because I think, you know, just having a measurement from the time the veteran calls to the time he or she receives the appointment is the basis by which, whether it is within the community care piece or within the VA, is really important. That is the important measurement that we need to move going forward.

Quite frankly I think when we compare ourselves to a private industry, you know, I don't think it is bad if it is taking 30 or 40 days if that is the reality because that is—in reality that is what is happening in the private market.

I just think that that has to be the measurement going forward.

I will just close by saying thank you to all of the witnesses for being here. I thank Dr. Matthews and Dr. MacDonald for staying

through the second part of this. I appreciate that. That is an example of collaboration. I think we have gained some valuable insight into the implementation of the MISSION Act.

It is, I must say it is very nice to chair a committee, to review a program where we are leaving with a sense of hope and that this program is really going to—is working and is going to work. Not to say that we don't have a lot of work to do, but it is very nice to be in a hearing where the outlook is positive.

Again, I thank you all for being here and a very productive meeting. With that I will ask Ranking Member Dr. Dunn if he has any closing comments.

Dr. DUNN. Thank you, Chairwoman Brownley.

I want to echo the note of hope there at the end. I think it is actually a great deal, very rewarding for us to have worked so hard on this MISSION Act in the last session and now to oversee its implementation.

You get the sense that we are keen—here we are just 3 months in and we already have a hearing on oversight. We are keenly interested in knowing that this is working well. We can't get too much input from you, so bring it on. We would love to see this help our veterans. It would be really—it would feel good to stomp out some of the complaints that we get from the veterans on their wait times and access to care and things like that.

I want to welcome General Horoho to the team. She is a former Army Surgeon General. That kind of would have been my boss except that, ooh, I was older than her.

[Laughter.]

Dr. DUNN. I was before your time.

I appreciate the chance to work with all of you and get information from you.

I look forward to working with you, Chairwoman Brownley.

Ms. BROWNLEY. Thank you, Dr. Dunn, and thank you again to all of the witnesses. With that all members will have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection the subcommittee stands adjourned. Thanks again.

[THE PREPARED STATEMENT OF DISABLED AMERICAN VETERANS APPEARS IN THE SUBMISSIONS FOR THE RECORD]

[THE PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA APPEARS IN THE SUBMISSIONS FOR THE RECORD ]

[THE PREPARED STATEMENT OF VETERANS OF FOREIGN WARS OF THE UNITED STATES APPEARS IN THE SUBMISSIONS FOR THE RECORD]

[Whereupon, at 11:51 a.m., the subcommittee was adjourned.]

# A P P E N D I X

# PREPARED STATEMENTS OF WITNESSES

## PREPARED STATEMENT OF RICHARD A. STONE

Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. I appreciate the opportunity to discuss implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. I am accompanied today by Dr. Kameron Matthews, Deputy Under Secretary for Health for Community Care, and Dr. Jennifer MacDonald, Veterans Health Administration (VHA) MISSION Act Lead.

### INTRODUCTION

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

The Choice Program came at a critical time for VA, and it allowed VA to serve over two million Veterans in communities across the country after it was established. VA has also continuously worked to improve Veterans' access to care in VA facilities and has made dramatic improvements since the Choice program was implemented. Improved access to care in VA facilities and continued input from Veterans using VA community care programs enabled VA to identify opportunities to serve Veterans. VA learned that an expanded community care program supplements VA care and better reflects the dynamic realities of health care and the needs of Veterans in their local markets.

We are now using the authority granted by the VA MISSION Act to give Veterans and VA providers more choices in an effort to ensure Veterans have access to the care they need. On June 6, 2019, the new Veterans Community Care Program was implemented in accordance with the VA MISSION Act of 2018. This new program makes dramatic improvements to how Veterans receive community care, allowing VA to deliver world-class, seamless customer service either through a VA facility or a community provider, based on each Veterans' individual needs and preferences.

I am proud of the efforts that VA has taken in the initial launch of the program, and although it is still early to fully quantify, we are seeing demonstrated improvements in how VA delivers Veterans' community care after just 3 months.

### IMPROVEMENTS

VA began implementing the MISSION Act on June 6, through the integration of multiple existing programs into a consolidated community care program. Of note, the Veterans Choice Program ended on June 6, 2019, but some of its elements were adopted into the new program. Under the new Veterans Community Care Program, a covered Veteran is eligible to receive community care if he or she meets any of six enumerated criteria, as opposed to the more restrictive two criteria from the Choice Program mentioned previously. Among the new eligibility criteria under the MISSION Act, a Veteran may elect to receive community care if he or she and his or her referring clinician decide that community care is in his or her best medical interest. That change alone, the ability for VA to allow community care any time it is in the Veterans' best medical interest, is a vital change in VA's community care offerings that allows Veterans and providers more flexibility to meet the Veteran's needs than we have ever had before.

VA heard the concerns of Congress and Veterans about making sure that this important new option of using the best medical interest criterion was implemented in the Veteran-centric way that Congress intended. Since June 6, VA has successfully entered more than a million community care consults, and preliminary data shows that the best medical interest criterion was a factor considered in 538,000 commu-

nity care consults, and it was the sole factor in the eligibility for more than 340,000 of those consults. This demonstrates that VA care teams are committed to put Veterans' needs first under the new program and are leveraging the new options for care that the MISSION Act has provided.

Drive time has also been a factor in about 347,000 of community care consults since the MISSION launch. With respect to the other criteria, about 86,000 consults have factored in a Veteran being grandfathered under the Choice Program, 5,000 factored in that the service was unavailable at the desired VA location, and 2,000 factored in medical hardship. These early data show that the greater flexibility under this program have been valuable to Veterans and providers.

VA is establishing a new Community Care Network (CCN) of contracted community providers for the Veterans Community Care Program that will be administered through third party administrators (TPA). CCN is VA's new approach to doing business with community providers that we developed from lessons learned under the Choice Program and other past community care authorities. CCN is improving the Veteran Community Care program by de-centralizing our contracts with community care providers. CCN consists of six regional contracts that each provide a credentialed network of community providers within that region to provide care to Veterans. Consistent with the lessons learned under prior programs, VA has enhanced its business practices under these contracts with the TPAs to ensure that the they pay VA's valued clinical partners in the community in a timely manner. VA has also launched new state-of-the-art commercial software to ensure that our payments to the TPAs are timely. Once CCN is fully implemented, VA will directly coordinate with Veterans to schedule community care appointments and support care coordination—and some Veterans will even be able to schedule their own appointments. CCN deployment in Region 1 started in Philadelphia at the end of June 2019 with dental services and was expanded to all services at the end of July in both Philadelphia and White River Junction, Vermont. It will be deployed to remaining sites in Region 1 in the fall of 2019, and there are currently more than 52,000 active providers in the network.

VA is modernizing its information technology (IT) systems for the Veterans Community Care Program to replace a patchwork of old technology and manual processes that previously slowed down the administration and delivery of community care. The new IT systems streamline all aspects of community care—eligibility, authorizations, appointments, care coordination, claims, payments—while improving overall communication between Veterans, community providers, and VA staff members. Even before the MISSION Act passed, VHA was working closely with VA's Office of Information and Technology (OIT) to begin planning for expected IT requirements and systems that would either be impacted by the new law or created entirely because of the law. Since passage of the MISSION Act, VHA and OIT have worked together to ensure that staff in VA facilities had the necessary tools and technological capabilities to implement the MISSION Act starting on June 6, 2019.

Deployment of many tools that supported implementation of the MISSION Act started before June 6, 2019. For example, a tool known as the Provider Profile Management System (PPMS) was deployed nationally in Fiscal Year (FY) 2018 and provides VA staff and Veterans with a directory of VA providers, Department of Defense (DoD) providers, and community providers who are part of VA's network. This year, VA has deployed a new referral and authorization system, Health Share Referral Manager (HSRM), that streamlines information sharing between VA and community providers and expanded its deployment of Electronic Claims Adjudication Management System (eCAMS), a tool that modernizes VA's claims processing systems and improves both timeliness and accuracy of payments to community providers. All of these tools are helping VA implement a modernized approach to providing community care under the MISSION Act.

VA developed one entirely new IT tool to help implement the new Veterans Community Care under the MISSION Act, the Decision Support Tool (DST). DST helps VA identify and document Veterans' eligibility for community care, as well as the basis for their eligibility. The tool interfaces with other systems including PPMS, the enrollment system, and the scheduling system, to identify Veterans who are eligible for community care. This tool deployed in production on June 6, 2019. However, having learned from past implementations, and hearing the concerns of Congress, Veterans, and VA staff about ensuring that the staff had adequate training and preparation for the software launch, users were provided training and a "sandbox" in May 2019 so that they could become familiar with the tool prior to production use. This training and sandbox testing prepared VA for a successful launch of the tool on June 6.

Overall, early data shows that Veterans are using the Veterans Community Care Program under the MISSION Act only slightly more than they were using commu-

nity care before the June 6 launch. VA will receive more data from providers in the coming months to better understand trends in Veterans' choices and preferences with the new program. I am proud that inside our health care system, VA has completed over 53 million appointments Nation-wide as of mid-August of this fiscal year, which is more than 1.6 million higher than the same timeframe in Fiscal Year 2018, or an increase of 3.1 percent. While VA continues to provide greater choice in the community, we also remain committed to ensuring that Veterans have exceptional access to care inside our facilities.

URGENT CARE

As part of the VA MISSION Act of 2018, VA now offers an urgent care benefit that provides eligible Veterans with greater choice about meeting their health care needs and improved access to timely, high-quality care. Veterans can use this option for minor injuries and illnesses, such as colds, sore throats, and minor skin infections. Veterans are eligible for the urgent care benefit if they are enrolled in VA health care and have received care through VA (from either a VA or community provider) within 24 months prior to seeking urgent care. Although it is too early for us to examine definitive data, we estimate that more than 16,000 Veterans have used this benefit and there have been a total of 44,000 urgent care encounters, based on eligibility checks by providers.

The contracted network currently includes almost 6,000 urgent care providers Nation-wide, and TriWest Health Care Alliance, one of VA's TPAs, continues to recruit more providers into the network each day. Eligible Veterans can receive urgent care under this benefit without prior authorization from VA, when seeing a provider that is part of the network. VA offers the urgent care benefit to Veterans in addition to the opportunity to receive prompt care from a VA provider—Veterans can get same-day services for primary care and mental health needs in-house at all VA facilities.

The urgent care benefit covers treatment of non-emergent symptoms such as flu-like symptoms (coughs and colds), wheezing, sprains, sore throats, painful urination, bumps and bruises, ear pain, and mild skin irritations, which are typically addressed by urgent care facilities and walk-in retail health clinics. The urgent care benefit also covers diagnostic services like X-rays, some lab testing, and some medications. The availability of services depends on the array of services that the contracted providers offer, so the specific services available to Veterans in a given area may be limited by the capabilities of the participating providers. VA urges Veterans to avoid using urgent care to manage chronic conditions or longer-term care needs through this benefit.

CHALLENGES VA HAS OVERCOME

One of the challenges in implementing the new Veterans Community Care Program, both before the initial June 6 launch and as our programs continue to develop, is ensuring that all stakeholders received appropriate communication regarding the transition to the new program—especially Veterans. VA as an organization reached out directly to Veterans using multiple means of communication, including direct mailing, email, secure messaging through VA's health portal, Community Veterans Engagement Boards, and social media. By mail alone, VA contacted about 9 million Veterans with educational materials about the new program. To overcome the challenges of educating the public about changes under the MISSION Act, VA has partnered in new ways with Veterans Service Organizations and other external partners, working with them to help amplify VA's messages and provide outreach, training, and materials for distribution to Veterans. VA also engaged community providers prior to the new program launch through monthly provider newsletter updates, briefings and outreach through professional associations.

Internally, each VA facility has designated a MISSION Champion to serve as the local lead for implementation. This MISSION Champion's role includes engaging staff, providing VA Central Office with direct feedback, and distributing key materials (including a robust field implementation guide), as well as guiding training and operational rehearsals. VA set ambitious training goals for all Veteran-facing staff and I am proud to say that our dedicated staff far exceeded our goals, both in terms of the number of people who tooktraining, and how quickly they completed it. On June 6, VHA leaders deployed to more than 30 sites to be shoulder to shoulder with field leaders across the launch. VA continues to refine and reinforce messaging and work with partners, including Veterans Service Organizations, to ensure that Veterans, VA employees, and community providers have all the information they need for continued success.

VA is a large entity with specialists that work in many separate parts of the organization. The MISSION Act required and still requires many significant changes to

VA's operations. To address the challenges of implementing the MISSION Act and bring together these experts, a Joint Operations Center (JOC) was established, with participation from all Veteran Intergrated Services Networks (VISNs) and all key offices across the Department. This command center is focused on frontline needs to develop a common operating picture for the enterprise—bringing about unprecedented cross-functional collaboration and rapid progress. During the lead-up to the launch, as well as on the go-live day of June 6, the JOC shared real-time data with the experts needed resolve issues and escalated and coordinated actions necessary for operational success.

As an example of the power of the JOC, as discussed above, Congress had raised some concerns about VA's ability to launch the DST software by June 6. VA's launch of the DST was successful, but it also was not without technical glitches in some areas. The fact that the software was ready for launch and that VA was able to recover from those glitches is a key victory of the JOC approach. This was due to JOC-facilitated communication between VHA and OIT that enabled direct field feedback during development and in early testing that led not only to a solid product by June 6, but also enabled VA to develop and train people across the organization on how to give Veterans what they needed even in the event of a software failure. Given the success of the JOC for the June 6 launch, VHA leadership continues to convene the JOC on a weekly basis—refining implementation and preparing for the launch of other key MISSION Act components. In the future, the JOC will similarly be utilized for the progress and launch of other key VHA initiatives.

Another challenge that VA continues to address is building a network of urgent care providers that is accessible to the Veteran population. VA is dependent on the urgent care provider community in joining the contracted network. TriWest Health Care Alliance, one of VA's TPAs, is continually working to expand the network; however, they are reliant on providers being both present in the communities and interested to work with TriWest to serve Veterans. In some parts of the country, such as rural areas, there are limited urgent care or walk-in clinic providers. VA continues to work with TriWest to identify areas that need urgent care provider coverage to focus their outreach. As of the end of August 2019, almost 6,000 urgent care centers had joined the TriWest network.

CONCLUSION

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

---

PREPARED STATEMENT OF SHARON VITTI

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, thank you for the opportunity to testify today and to share CVS Health's role and experience in expanding access to care for our Nation's veterans.

My name is Sharon Vitti, and I serve as President of CVS MinuteClinic and as Senior Vice President at CVS Health. In this role, I lead all aspects of MinuteClinic care delivery, business operations, and strategic development.

CVS Health is the Nation's premier health innovation company helping people on their path to better health. Whether in one of our pharmacies or through our health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. Our innovative health care model increases access to quality care, delivers better health outcomes, and lowers overall health care costs.

Our support of the MISSION Act is one example of the many ways we stand with veterans, active military and their families. We have several Workforce Initiatives programs dedicated to recruiting, training, and retaining veterans to build a pipeline of workforce talent. Since 2015, CVS Health has hired almost 15,000 people with military experience and more than 5,000 military spouses.

In addition, we provide charitable support to military and veteran-focused organizations, including the National Guard, Operation Reinvent, and the USO. And, colleagues can connect through the CVS Health Colleague Resource Group BRAVE, which is comprised of nearly 1,400 members with a passion to serve those who have served our country.

We were recently recognized for our efforts to support veterans and military members. In May, Military Times named CVS Health to its 2019 list of best companies for veterans seeking a civilian job.

With that as background, I am pleased to be here today to provide an overview of MinuteClinic's partnership with the U.S. Department of Veterans Affairs (VA). Support for our country's veterans and members of the military is central to the work we do at CVS Health, whether through our workforce programs or our efforts to connect this population with easily accessible, high-quality care.

## SHARED VISION FOR EXPANDING ACCESS

Addressing the growing need to provide veterans with convenient access to quality urgent care in their communities is a shared vision for the VA and CVS Health. The program in place today originated in 2016 with a pilot funded by the VA Health System in Palo Alto, California. Palo Alto utilized discretionary funds for a 1-year program that leveraged 14 local MinuteClinic sites to provide access to treatment for minor illnesses, minor injuries, and skin conditions. The initial months of the pilot were devoted to the development of criteria, information sharing protocols, and training materials, including defining the list of eligible services and creating educational materials to assist VA nurses with triage.

A critical first step was to ensure the capability was in place to quickly convey information about the veterans' visit to the VA electronically so we could maintain continuity of care for the veterans we provided care for and keep VA providers informed of the veterans' health status. As a result of our work together with the VA in Palo Alto, we established the connectivity that today makes it possible for us to provide information about a veteran's visit directly to the VA through the e-Health Exchange.

In addition to establishing standards and protocols, we focused on ensuring a positive experience for the veterans we serve by working closely with both the VA and our own CVS Health colleagues with prior military service to create a welcoming environment and to ensure our services are viewed as an extension of their coordinated care with the VA.

We began to see veterans in our clinics during the second half of the pilot.

Veterans were screened for eligibility when they called the VA triage line and, if their condition met the criteria, the veteran was offered the opportunity to be treated at a MinuteClinic. Over 550 visits were conducted during this roughly 6-month operational phase with an average in-clinic wait time of less than 20 minutes.

Under the pilot, veterans who desired to do so could also fill prescriptions from their MinuteClinic visit at the co-located CVS Pharmacy. The pharmacy followed the VA formulary and applied standard VA co-pays.

## EXPANSION UNDER THE CHOICE PROGRAM

The Palo Alto pilot generated considerable interest from other VA service areas, including the VA Health System in Phoenix, Arizona. In April 2017, we partnered with the VA's Office of Community Care, the Phoenix VA, and TriWest, the third-party CHOICE administrator for the region, to enable veterans to receive care at 24 MinuteClinics in the Phoenix area.

Operating under the CHOICE Program helped us identify and create new protocols for billing and pharmacy access, which were crucial to future program expansion. As an example, pharmacy services were not included in the CHOICE program. To maintain the same seamless veteran experience as created in the Palo Alto pilot, the VA's emergency prescription fill authority was approved to allow veterans to receive their initial first-fill of prescriptions written in conjunction with their MinuteClinic visit at the pharmacy of their choice.

Our partnership with the Phoenix VA further demonstrated that MinuteClinic filled a need for veterans and offered another convenient access point for care within the broader community care network. Once proven in Phoenix, the program resumed operation in Palo Alto and expanded to additional regions, including Santa Clarita, California and Corpus Christi, Texas.

## ENACTMENT OF THE VA MISSION ACT

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or VA MISSION Act, (P.L. 115–182) provided the framework needed for the national expansion of urgent care access for veterans. Under the MISSION Act, veterans can now access urgent care and walk-in medical services under their VA benefits without pre-authorization. Veterans who meet certain eligibility criteria can receive care at any MinuteClinic location. Following the visit, MinuteClinic is able to make the

full record of medical services provided available to the VA with the patient's consent.

We provided comments to the VA throughout the regulatory process and worked closely with the VA to provide location data and technical assistance to ensure a successful launch on June 6, 2019. Since the "go-live" date, we have provided care for more than 5,600 veterans in all 33 states and the District of Columbia in which we operate MinuteClinics. Combined with the veterans we cared for during the pilot and under CHOICE, we have provided care for more than 9,500 veterans since our partnership with the VA began 3 years ago.

Our experience suggests there is a high level of knowledge among veterans about MinuteClinics and the types of conditions we treat. We typically treat for acute conditions where prompt treatment can avoid more serious health issues and additional costs. The top conditions for which veterans visit a MinuteClinic are cough, sore throat, sinus infection, rash, and ear ache. Veterans also have demonstrated a good understanding of the structure of the new benefit as well as the intent that urgent care augments, not replaces, their relationship with VA providers.

## CONCLUSION

CVS Health deeply values its partnership with the VA and the opportunity to provide care for those who have served. Starting with a shared vision, we are proud of the program we have created and appreciate the opportunities we have had to work with the VA Office of Community Care, the Palo Alto and Phoenix VA Health Systems, TriWest and now Optum to meet the needs of veterans.

We also appreciate Congress and this Committee for recognizing this program and the benefits it offers veterans when drafting the VA MISSION Act. Our participation in the MISSION Act provides deserving veterans across the country greater access to quality health care when and where they need it, while ensuring they are still linked with their VA care providers. We are proud to be able to support Congress and the VA in bringing this meaningful and impactful program forward to help improve the health of our Nation's veterans.

## PREPARED STATEMENT OF DAVID J. MCINTYRE, JR.

**Written Testimony**

**Mr. David J. McIntyre, Jr.**

**President and CEO of TriWest Healthcare Alliance**

**Hearing of the House Committee on Veterans Affairs, Subcommittee on Health**

**September 25, 2019**

***Introduction***

Chairwoman Brownley, Ranking Member Dunn and Distinguished Members of the Subcommittee, it is a privilege to appear before you today as part of VA's Team working to ensure that Veterans are afforded access to high quality care to conveniently meet their health care needs, whether that be in the direct care system or in the community under the VA MISSION Act. For all of us associated with TriWest Healthcare Alliance, from our company's non-profit health plan and university health care system owners to our nearly 3,500 employees, most of whom are Veterans or Veteran family members, it is an honor to appear before you and to have been engaged in this critical work for the last six years in support of the Department of Veterans Affairs (VA) so that it might effectively execute the government's commitment to this nation's heroes.

Thank you for your leadership and complete engagement in making sure that we all are focused on the right objectives and are sufficiently stretching ourselves to accomplish that which needs to be done with intensity so that an enterprise that was struggling a few years ago to meet the country's commitments to those who have put it all on the line for our freedoms might effectively re-set itself for the benefit of this generation's Veterans and the next. It is work worthy of nothing but our very best, and we consider ourselves very fortunate to be a part of the team seeking to deliver that which is envisioned. That team of which we are fortunate to be a part is led by VA and involves providers from both VA and the community… all working together in support of our collective heroes!

While we have yet to arrive at the point at which we can declare we are in maintenance mode, and it will still be some time given the pieces yet necessitating our collective and individual focus, I would submit that much is moving in the right direction and the potential of what will ultimately exist for all Veterans under the MISSION Act is starting to be present. To make my point, I would like to highlight the experiences of two Veterans with whom we recently engaged.

A few weeks ago, one of my staff met a Veteran from Kansas while meeting with Legionnaires at the American Legion National Convention in Indianapolis – a group I was honored to personally address. This Veteran has suffered from severe back pain as a result of a service related injury and had been dependent on opioid pain medications for over a decade. He had tried a number of different options to lessen his dependency on these medications, but it wasn't until an encounter with an acupuncturist while on a vacation that he found success in addressing the pain. The Veteran returned to his VA Medical Center and asked about receiving acupuncture through VA and was told that he could be referred out

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

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

I want to be clear up front, we are not here to privatize VA! In fact, our role at TriWest is not to replace VA, but rather to ensure that VA and Veterans are always at the core. Our responsibility is to help strengthen VA by providing it with effective elasticity to ensure that Veteran's health care needs can be met on a convenient and timely basis.

***History of Service to Veterans and Servicemembers***

To best understand the nature of our work and the lessons learned regarding community care, I would like to share with you some background on TriWest's history of service to America's military and Veterans communities.

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

***Supporting VA Community Care Needs Since 2013***

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

In April 2014, just a few short months after we had started that work, the wait list crisis was discovered in our hometown of Phoenix. Congress recognized that the problem was national in scope and further reform was needed to meet Veteran health care needs. This led to enactment of the Veterans Access, Choice and Accountability Act (VACAA), which included the Veterans Choice Program. Congress gave VA 90 days to stand up the program, and VA asked us to assist them in doing so. We worked diligently with VA to implement the Choice Program, and then with VA and Congress to refine it.

Over the past 5+ years, over 90 program improvements and contract modifications have been made – to refine the Choice program so that it would better serve the needs of Veterans and arm VA with the tools it needed. Among the improvements:

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

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

Last fall, after VA elected to not extend the contract of the third-party administrator that was serving the other half of the country, VA extended TriWest's contract and asked us if we would agree to stretch ourselves and expand our services to support it for a while in all 50 states, Puerto Rico, the U.S. Virgin Islands, Guam, and the Northern Mariana Islands until the next generation of VA community care – the Community Care Network (CCN) – could be implemented in 2019. Beginning on December 7, 2018, TriWest expanded services using a phased approach to implementation. We completed the expansion this past spring – at the end of March 2019 – and now offer VA 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 is also performing appointment scheduling and providing customer service support in the majority of our original service area, as well as on an as-needed basis across the expansion areas.

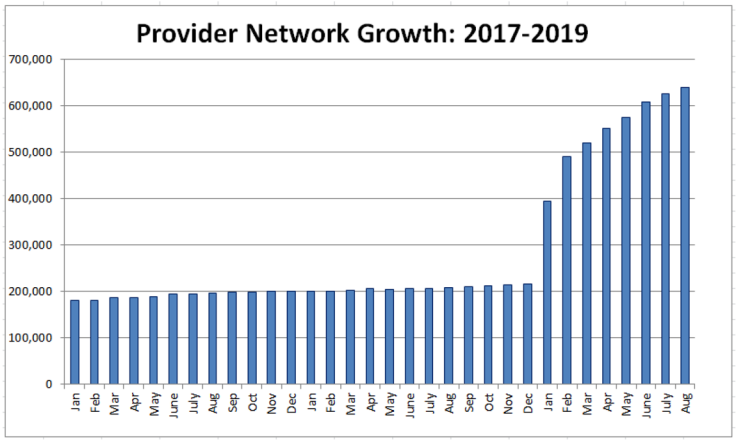
And, we are now beginning to be joined in this privileged work by Optum, which now is starting to stand up the CCN contracts it won. Soon, we expect to be implementing the CCN Region 4 (West Region) contract that we were honored to have been awarded a few weeks ago.

***Access***

The most important component of VA community care is ensuring ready access to community providers when needed to supplement VA. To develop a customized network sized for VA and its specific needs, we initiated a process with the team from 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," which, beginning the summer of 2016, was conducted with nearly every VAMC within our service area. We met one on one with each medical center to assess how many providers of each specialty would be needed in addition to the supply of providers working at the VAMC to meet the needs of Veterans in each geographic area. This included not only a projection of the demand that was already known to exist but also that which was anticipated to materialize. We then took the output of this data-driven process and started to tailor the network on a market-by-market basis to meet demand.

We first leveraged these tools, used by us in customizing a network to support the Idaho Guard and their families at the start of this generation's wars, for a process over Memorial Day weekend of 2014 in preparation for assisting the Phoenix VA in working off the backlog of nearly 15,000 Veterans waiting in line for care. Those tools allowed us to assess the demand and determine the needed providers and level of staffing to assist the Phoenix VA in successfully eliminating the initial backlog by the end of August 2014.

Armed with the Demand Capacity Assessment Tools, we and the VAMCs in our geographic areas of responsibility worked to assess demand and then mapped the supply of providers that would be needed in each community to supplement VA care. This targeted approach has resulted in the tailored construction of a network that now grown from 150,000 providers in early 2016, to 180,000 in early 2017, to 200,000 in 2018, and 400,000 in early 2019. Today, there are 639,000 unique providers leaning forward across the country in the network we constructed to support VA.




***Stakeholder Communications and Collaboration***

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

- Attendance at over 45 VA Town Halls, with active involvement/outreach to Veterans in attendance.
- Participation in more than 30 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 – September 2019).
- Conducting 7 teleconference briefings on expansion efforts with Congressional staff – district/state and DC staff – across 11 VISNs, attended by approximately 350-400 staffers.

- Conducting 7 teleconference briefings on expansion efforts with local and state Veteran Service Organizations, County Veteran Service Officers and Veteran non-profit representatives across 11 VISNs, attended by approximately 300-350 Veteran representatives.
- Participation in numerous Veteran Stand Downs designed to ensure homeless and low-income Veterans are aware of, and educated on, community care benefits.
- Supporting and attending 9 national VSO conventions and VA events between January and September 2019, connecting with thousands of Veterans and providing education and issue support.
    - Paralyzed Veterans Wheelchair Games
    - VFW, DAV, American Legion and VVA national conventions
    - National Association of State Directors of Veterans Affairs national convention
    - National Veterans Summer Sports Clinic
    - National Disabled Veterans Winter Sports Clinic

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

- Conducted 273 provider education webinars with a total of 3,400 attendees (April 2019 – Sept. 17, 2019).
- Sent 595,416 faxes related to provider education or provider relations (January 2019 – Sept. 17, 2019).
- Sent nine monthly Provider Pulse e-newsletters to an average of 48,973 recipients, resulting in an average open rate of 26% (January 2019 – September 2019).

***Results to Date***

From the beginning of our work in support of VA in 2013, TriWest has worked diligently to approach the work by first understanding and then responding to the specific needs, at all levels – at the local VA medical center, Veterans Integrated Service Network (VISN) and VA central office (VACO). Today, TriWest's provider network – tailored through use of VA demand and capacity assessments – is comprised of over 639,000 individual providers who represent more than 1.2 million access points. This robust network helps ensure that minimal authorizations are returned for not having a network provider available. In fact, in August, only .14 percent of authorizations were returned for no network available – well below the industry standard. TriWest has helped schedule over 1.9 million unique Veterans for care since the start of our work with VA, and our tailored network has delivered over 6.2 million initial Veteran appointments and 10 million follow up appointments.

With our expansion across the country, TriWest now receives between 16,000-20,000 requests for initial care each day, resulting in more than 400,000 requests for Veteran care in the community per month. Most recently, in August, TriWest received a total of 419,000 requests for care. In addition, TriWest handles approximately 1.1 million calls per month, and to date, we have processed and paid over 19 million health care claims to community care providers. We are 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.

With regard to IVF services, TriWest has developed a very personalized and customized approach to supporting Veteran couples authorized to receive these services. Because most IVF providers are not accustomed to contracting with and billing third parties, we worked closely with VA on addressing IVF provider issues and processes. And, in recognition of the fact that IVF is an extremely personal service, we work closely with VA-authorized couples to contract with the providers they prefer to use. The results of this highly-coordinated approach are solid. To date, we are privileged to have supported around 320 IVF cases, with 46 IVF pregnancies discharged to OB care.

***MISSION Act Implementation***

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

Thanks to the extensive collaboration on VA MISSION Act implementation, this much-needed reform of consolidating all of VA's separate 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. Under the law, VA developed new access standards for community care that require the Veteran to be seen within 18 days (Primary Care and Behavioral Health) and 26 days (Specialty Care) from the time of authorization for care. Since June 6, over 980,000 appointments have been scheduled with the providers in our community care network. This demand has outstripped projections, which has challenged a bit our ability to meet all of the timeframes. However, a few weeks ago we were able to assess what we now know to be the trend-line and are making tweaks to our tools and expanding personnel levels in an effort to be fully compliant with the new standards, in spite of increased demand, by the end of next month.

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

Since the MISSION Act went into effect on June 6, 2019, TriWest has developed and is growing a national network of urgent care providers, with additional providers joining the network every week. 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 are proactively sending 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 already is delivering access to timely care. Key statistics that demonstrate this fact as of September 17, 2019, include:

- Over 6,000 urgent care and retail locations currently are in our network.
- There have now been nearly 50,000 urgent care visits.
- The Provider Locator Tool has been used more than 404,000 times.
- We have received over 553,000 MISSION Act IVR calls.
- There have been more than 15,000 calls to the Urgent Care support line.

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 will continue to build and refine the network 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 it is willing to be available to meet the needs of those heroes who call their community home. For our part, we will make sure the processes are simple to execute and that provider bills are processed and paid quickly and accurately.

**Challenges**
While the community care aspects of the MISSION Act are off to a promising start, there certainly are adjustments and refinements to be made as the program matures. Some early challenges include:

- Limited availability of urgent care/retail clinics in rural areas, where there are few to no national retail chains present. This requires finding and contracting with smaller, local urgent care facilities if they exist in the market. This challenge is not unique to this program, but one that exists in the commercial marketplace also.

- Limitations in the regulations that restrict the types of urgent care/retail clinic locations which can participate most readily. The regulations allow for specific types of urgent care facilities such as chain retail clinics and free-standing urgent care facilities. The construction of this rule has made it necessary for VA to develop a waiver process to allow other, more localized options to participate.
- The volume of care requests being received has greatly exceeded VA projections – by about 20 percent overall. This higher than anticipated volume has resulted in some Veterans seeking community care to experience appointing delays.
- Thanks to congressional engagement, we determined that the urgent care provider locator tool, custom-build for this effort, has some limitations in certain geographic areas, such as mountainous and waterway areas. The anomaly in the tool results in inaccurate drive times for those specific areas.
- Some providers have been reluctant to join the expansion network due to prior and outstanding claims issues, and some urgent care providers have been reluctant to join, based on previous (prior to MISSION Act) claims challenges.

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.
- Revisions to the urgent care locator tool to address the anomaly related to inaccurate drive times for mountainous and waterway areas.
- TriWest senior leadership engagement and outreach with key VA preferred providers to assist in closing remaining network gaps.

***Conclusion***

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

It is the honor of our lives to be engaged in this privileged work on behalf of a grateful nation. The partnership between VA and TriWest has progressed and matured substantially over the past 6 years. It

is a dynamic relationship in which we both continue to refine and strengthen operational processes and communication. The work is complex and challenging, and there always seems to be more work to be done. We are all very focused, and I am very proud of the work we are doing together and all that we have accomplished thus far. And, I am confident that the trajectory on which we all are on will continue to improve this program and provide the high-quality community care Veterans have earned and deserve.

No health care system in the country has more expertise than VA in addressing the health care needs of Veterans. The work ahead should not be to reduce or replace the VA system, but to learn from it and to supplement that VA care in the community, when and where necessary.

After all, ensuring our nation's Veterans have access to the full range of timely, high-quality health care services they need must be our collective mission. Meeting our Veterans' ever-growing demand for care is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible that affords our Veterans an opportunity to live a healthy, full life.

Through our nearly quarter of a century operation in support of the two systems that exist to serve those who serve, we have developed substantial experience in helping these systems implement and mature their programs to provide timely and convenient access to quality health care services. Just as we have done since 1996, we are committed to providing Congress our full support and cooperation as we continue our work alongside VA on the shared privileged mission of protecting the lives of our nation's heroes. Helping Veterans access high quality care in the community is the most sacred work in health care. For us, it is service first and then business. Our mission is to find and serve those in need, ensuring they have access to the right services with the right provider and supporting providers fully as they serve the needs of their hero.

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 PATTY HOROHO

**Written Testimony of**
**Lt. Gen. Patricia D. Horoho, USA, Retired**
**Chief Executive Officer, OptumServe**

**Before the United States House of Representatives**
**Committee on Veterans Affairs, Subcommittee on Health**

**September 25, 2019**

**Introduction**

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, I am Patty Horoho, Chief Executive Officer of OptumServe and I am honored to be here today to discuss our role in the implementation of the U.S. Department of Veterans Affairs (VA) Community Care Network.

On behalf of the more than 335,000 men and women of Optum and UnitedHealth Group who work every day to help people live healthier lives and to make the health system work better for everyone, thank you for the opportunity to discuss our partnership with the VA to ensure that our nation's Veterans have timely access to the best care available.

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

Leading our efforts to care for our nation's Veterans is the privilege of a lifetime. As a Veteran, retired Soldier, Army Surgeon General, 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 Officer, I am committed to the success of the VA Community Care program and OptumServe's role in ensuring access to care for our nation's Veterans.

My leadership team at OptumServe, which is comprised of Veterans from every branch of service, and our Community Care program office staff, where 43% are Veterans, is equally committed. Our commitment is demonstrated not only by meeting our contractual requirements, but also through the deep partnership we have fostered with the VA to not only build strong relationships with our client, but to gain a deep and broad understanding of them, their systems and processes, providers and the Veterans we are honored to serve.

At the outset, we recognized the need to incorporate the voice of the Veteran in our efforts to ensure we were well-positioned to meet their needs. Well before we were awarded this contract, we conducted one-on-one interviews with Veterans, as well as a national survey of Veterans with a large sample size. This enabled us to gain a foundational understanding of the experience and mindset of Veterans, and how Veteran status impacts health and health-seeking behaviors.

We have spent considerable time with our VA partners and within Optum to better understand the processes and potential abrasion points. Through a process called journey mapping, we are gaining insights into the process of getting care, how the process could work better for Veterans, VA staff and community providers. We then use those insights to prioritize and take action. This work is critical to our combined success because we are looking at the whole system through the eyes of the Veteran. We also performed journey mapping for health care providers to develop similar insights.

We have learned a great deal through this process and better understand how every component of the program works together. This is critically important because the experience a Veteran has while seeking and receiving care is just as important as the quality of care they receive. From the very first contact, the experience of care has to be positive, both for our Veterans and for providers.

**Partnering with the Federal Government and Private Sector**

While I have served as CEO of Optum's federal health services business since 2017, both Optum and UnitedHealth Group have long histories of partnering with the federal government to help them accomplish their missions to serve and meet the health care needs of the American people. This includes serving individuals in our armed forces, their families, and Veterans.

Today, we are honored to support programs that touch virtually every point in a Veteran's journey. It starts from when a son or daughter steps up to raise their right hand, to ensuring a reservist is medically ready for deployment, to a disability exam when a service member transitions from active duty, and, now, to the Veteran receiving care through the VA from a community provider.

And we do this by:

- Ensuring service members are medically ready for deployment through our network of providers on behalf of the U.S. Military Entrance Processing Command;
- Supporting the VA and the Department of Defense's effort to update clinical care guidelines;
- Operating the Military Health System's nurse advice line, which provides timely access to health care services for more than 9 million active duty service members and their families worldwide;

- Administering health assessments, dental, audiology, vision, radiology, laboratory, immunization and physical exam services to U.S. service members on behalf of the Reserve Health Readiness Program;
- Performing hundreds of thousands of medical disability examinations on behalf of the Veterans Benefits Administration;
- Partnering with the Veterans Health Administration to provide a telephone lifestyle coaching program to help Veterans strive for a healthy weight, eat wisely, be physically active, manage stress and limit alcohol; and
- Standing up the VA Community Care Network in three community care regions that encompass 36 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Overall, our enterprise is focused on working across the health care system to deliver the Quadruple Aim – improved outcomes, lower costs, and enhanced consumer and provider experiences.

More broadly, Optum works with health care providers and facilities across the country, serving a broad cross section of the health care system – and the people who depend on it – to deliver better experiences and quality outcomes. You can find us in 4 out of 5 hospitals, serving 4 out of 5 *Fortune* 100 companies, and providing health care services to 128 million individuals who need and deserve the best care.

Optum also leverages diverse capabilities to meet our clients' and patients' needs:

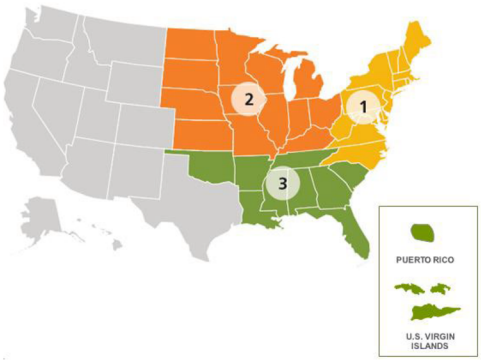
- We currently process more than 2.8 billion claims a year with 99.5% accuracy, representing approximately $174 billion in claims paid.
- We invest approximately $3.5 billion annually in technology and innovation;
- We manage one of the largest behavioral health networks in the United States, with more than 200,000 clinicians; and
- With our partners at UnitedHealthcare, we work with a vast nationwide network of medical, behavioral, specialty and other providers and health care facilities that includes 1.3 million physicians and other health care professionals and approximately 6,250 hospitals and other facilities.

**VA Community Care Network**

Through the Community Care Network, VA medical staff authorize and schedule care with a community care provider if the Veteran so chooses. In addition, VA staff manage customer service for Veterans who are receiving care from a community provider. The network of community care providers and provider billing are managed by third-party administrators (TPAs) in each region. With the VA Community Care Network, Veterans will have better access to, and greater choice in, their health care, whether at a VA facility or through a community provider. At all times, VA staff and Veterans are the decision makers when it comes to the course of care, whether it be in a VA Medical Center (VAMC), care in the community, or a combination thereof.

**Optum's Role as the VA Community Care Third-Party Administrator**

Optum was proud to be named as the TPA for the VA Community Care Network for Regions 1, 2 and 3 on December 28, 2018, which include 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.
- **Claims processing.** Optum processes claims from providers who see Veterans as part of the VA Community Care Network.
- **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. Calls or questions from Veterans are handled by VA staff.
- **A portal for providers, VA staff and Veterans.** Optum operates an online portal where users can find additional resources including claims and referral information. Individuals can access the portal at www.vacommunitycare.com.
- **Community Care Experience Team.** This Optum team provides on-the-ground support and resources to VA Medical Centers and staff.

We appreciate that Congress and the VA have envisioned a program that provides a phased approach in implementation in order to ensure a successful transition for VA staff, contractors, providers, and most importantly, our nation's Veterans. We understand that health care is local and this phased approach enables us to work closely with the VA, VA Medical Centers, TriWest, CVS Caremark and others to deploy

our network and capabilities, and ensures success based on readiness of particular sites, while accounting for relevant local factors.

This is similar to what those of us who have served on the battlefield call a "Left Seat, Right Seat" transition where the redeploying unit overlaps for a time with the incoming unit in order to share lessons learned from the battlefield, minimizing gaps during the transition.

Optum is on track with our phased deployment plan and is currently providing the Community Care Network and billing operations in the Philadelphia area and in White River Junction, Vermont, which have been fully operational since July 29, 2019. Last week, we deployed seven additional VAMC sites in Connecticut, Delaware, Massachusetts, Pennsylvania and Rhode Island. This cadence will increase over the weeks and months to come to include additional regions in coordination with the VA and local Medical Centers.

At every stage of deployment, 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 manage issues, ensure consistent and frequent communication with the VAMC sites, and provide continued education and feedback to ensure the system tools and network are performing as intended and to make necessary adjustments.

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;
- 45 days prior to a go-live date, we have initial planning meetings with VAMC leadership;
- 14 days from the go-live date, our advance parties increase the intensity of training and communications;
- In the week leading up to deployment, we create a joint command center and provide site-level support teams consisting of both Optum and local VA staff, and have three stand-up meetings a day to review the status; and
- On the day a VA Medical Center goes live, our command center monitors progress in real time and works with local support teams to ensure a smooth transition.

**Network Strategy**

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

provider network team leverages our enterprise to build a robust Community Care Network that meets the health care needs of the Veteran population. These include:

**Health Care Services Network:**
- UnitedHealthcare (UHC): Medical network
- Optum: Physical therapy, occupational therapy, speech therapy, chiropractic, acupuncture, skilled nursing facilities
- Optum Behavioral Health: Psychiatry, behavioral facilities, other behavioral health practitioners
- UnitedHealthcare Vision: Routine eye examination and refractions

**Pharmacy:**
- CVS: All CVS Caremark and partner pharmacies

**Complementary & Integrative Health Services**:
- Optum Behavioral Health: Hypnotherapy, biofeedback, relaxation techniques, Native American healing services
- Optum: Tai Chi, massage therapy

**Dental:**
- Logistics Health Incorporated: General and specialty dental services

We are also working closely with our VA partners, TriWest and others to identify those community providers who have a history of working closely with VA Medical Centers and Veterans in order to give these providers an opportunity to continue to care for Veterans in their community by joining our new network. Eight weeks into providing health care to Veterans under this contract, we have already recruited more than 308,000 providers in Region 1. Because we recognize that network management is a dynamic process and networks evolve over time, we will continue to actively monitor the needs of the VA and Veterans and make adjustments based on our experiences and feedback on the ground.

By leveraging the broad and deep resources across our enterprise, we will support the 6.2 million Veterans the VA has estimated who may need a community care health care provider across the three regions we serve. When we complete the deployment over the next nine months, we expect to partner with more than 900,000 providers to serve Veterans in the areas of medical, surgical, dental, complementary and integrative health and pharmacy services.

As of September 19, 2019, we are pleased to report the following progress and milestones in our deployment of the VA Community Care program:

- 4,460 referrals for care have been made by the VA
  - 4,288 referrals for medical services;
  - 172 referrals for dental services.
  - Top three referral categories are:
    - Physical therapy
    - Skilled nursing
    - Orthopedics
- 248 claims have been paid
  - 60% within 10 days and 100% within 30 days.

We appreciate the opportunity to address the Subcommittee today to outline Optum's role in assisting the VA with their mission to provide world-class health care to our nation's Veterans. I would like to leave you with three thoughts. First, we understand that it is a privilege to care for those that served and the families who support them. Second, we are committed to fully leveraging the capabilities across Optum and UnitedHealth Group to meet the unique needs of the VA and Veterans. And, third, to accomplish this, we will need to execute our responsibilities in very close partnership and collaboration with the VA, providers and other partners.

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

# Additional Submissions for the Record

# SUBMISSIONS FOR THE RECORD

## PREPARED STATEMENT OF ADRIAN M. ATIZADO

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee:

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

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

### VA URGENT CARE BENEFIT

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

We are pleased Congress included DAV's recommendation to provide veterans an urgent care benefit under section 105 of P.L. 115–182, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018.

The urgent care benefit is intended to offer eligible veterans convenient care for certain, limited, non-emergent health care needs from qualifying non-VA entities or providers. Eligible veterans include any enrolled veteran who has received care under chapter 17 of title 38 U.S.C. within the 24-month period preceding the furnishing of care under this section where such care includes: care provided in a VA facility; care authorized by VA performed by a non-VA provider; emergency room care authorized by VA performed by a non-VA provider; care furnished by a State Veterans Home; or urgent care under this proposed section. Qualifying non-VA urgent care providers include any non-VA entity that has entered into a contract, agreement, or other arrangement with VA to provide urgent care.[1]

We applaud TriWest Health Care Alliance's (TriWest) initial effort and continuing hard work to build a network to what is currently about 6,000 urgent care providers nationwide. According to TriWest, they are nearing their maximum achievable goal of 92 percent of veterans to have access to an urgent care or retail clinic, if one exists, within a 30-minute drive. Moreover, TriWest developed a new online training course and simple to use quick reference guide for network urgent care providers to understand the processes and procedures on the VA urgent care benefit. We are pleased to report DAV members who have used this benefit have expressed positive comments about their experience from their eligibility determination at the point of service and satisfaction with the care they received. In addition, we have not received any reports to date of inappropriate billing of veterans using the VA urgent care benefit.

However, we remain disappointed in VA's decision to charge urgent care copayments to service-connected veterans, who are generally not required to pay copayments under other VA health care programs. In DAV's view, service-connected disabled veterans have already paid through their service and sacrifice and should not

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

have additional copayment or cost-sharing requirements imposed by the Federal Government.

While we appreciate VA's desire to incentivize appropriate health behavior, we strongly urge VA to provide positive rather than punitive incentives. Rather than charge veterans who have become ill or injured due to military service in order to limit their use of this urgent care benefit, VA should take a more veteran-centric approach to controlling costs by establishing a national nurse advice line to curtail overreliance on costly emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line.

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

Finally, VA should assess its telehealth program to determine the feasibility of providing virtual urgent care services, particularly for certain veteran patient populations such as chronic care patients. Such a platform combined with a mobile app would allow veterans to connect with VA and schedule a visit online or in person. Also, providing this type of care would allow for easier integration with VA's electronic health record and could help incorporate elements of remote patient monitoring.

VA VETERAN COMMUNITY CARE PROGRAM

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

To implement section 101, VA intends to award Community Care Network (CCN) contracts to provide eligible veterans non-VA care across six regional boundaries aligned to State lines, including Alaska and the Pacific Territories. On December 28, 2018, OptumServe Federal Health Services (Optum) was awarded contracts with a base period ending September 30 of the Fiscal Year in which the award is made and seven 1-year options for regions 1, 2, and 3, covering Veteran Service Integrated Networks 1, 2, 4–10, 12, 15, 16, 19 and 23. Subsequently however, protests were filed for regions 2 and 3 VA's work with Optum had to stop while CCN work for region 1 continued. It has been less than 5 months since the Government Accountability Office (GAO) denied these protest for OptumServe to continue work to deliver on these contracts.

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

In advance of awarding CCN contracts and implementing CCN networks across all six regions, VA's contract with Triwest to expand its network of Patient Centered Community Care and Veteran Choice Program providers across all CCN regions was used as a "bridge contract" to ensure veterans continue to have access to care during the transition to the new Veterans Community Care Program. We understand the current option year for this bridge contract expired September 20, 2019 with one final option year available through September 30, 2020. It is imperative Optum develop and deploy its network of providers that is at least equal or better that the one it is replacing by the final option year. Our concern regarding region 4 will heighten if the Government Accountability Office decision that is anticipated to be

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

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

issued by the end of November 2019 sustains the protest with the TriWest bridge contract set to expire 10 months later.

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

In our experience, the QASP determines how VA will focus on the level of performance required by the PWS, which at times differ from the method used by the contractor to achieve a level of performance. This is where we generally see weaknesses in the validity and reliability of the data and gaps in the surveillance process itself that may hinder identification of trending issues ill and injured veterans may experience with CCN and formulation of appropriate corrective actions.

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

While CCN is still being developed, it may be helpful for the Subcommittee to review VA's Community Care Patient Survey that was initiated in March 2016 to assess veteran experiences with VA Community Care, including care through the Choice Program. This survey includes questions regarding veteran experiences with the process of obtaining non-VA care (eligibility, referral, making the first appointment, billing and out-of-pocket payments), provider communication with the veteran, and very basic provider-patient coordination of care. There is a 3-to 6-month lag to associate the referral to a non-VA provider and the survey for that non-VA visit, analyze the data and generate the report. This delay should be accounted for if the survey is used as a sort of proxy to describe the State of CCN implementation in light of Optum network's deployment schedule.

We remain concerned about the lack of guidance to veterans and VA medical centers regarding the required care coordination with and competency standards for non-VA health care providers as required under sections 101 and 133 of the VA MISSION Act of 2018. For example, VA mental health providers caring for veterans with PTSD have to meet strict qualification standards. In addition to graduating from discipline accredited graduate and training programs, the mental health provider must undertake training in suicide prevention and military culture. Certain mental health providers must complete advanced training to provide evidence-based psychotherapy, which includes an 3 day in-person workshop followed by at least 6 months of ongoing training and weekly followup from an expert who maintains progress notes or audio recording reviews of the provider trainee's clinical sessions. This gold standard training model has been developed and used in VA based on numerous studies measuring clinical performance and showing sustained quality of care in comparison to mental health providers that participate in one-time training workshops whose practice reverts back to pre-training quality. Ignoring these standards shortchanges veterans and taxpayers of high-quality and high-value care, and fragments what otherwise should be an integrated high-performing health care network.

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

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

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

need. Any reduction of these hours would make VA less veteran centric and appear more concerned about themselves than the veterans they are meant to serve.

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

---

PREPARED STATEMENT OF THE PARALYZED VETERANS OF AMERICA

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to share our views on the Department of Veterans Affair's (VA's) rollout of the new Veterans Community Care Program (VCCP) and Urgent Care benefit.

Poet Thomas Carlyle once said, "Silence is golden" and for the most part, that has been our experience since VA implemented the VCCP. Aside from anecdotal reports of problems, the launch appears to have unfolded relatively problem-free. In preparation for this hearing, we surveyed our National Service Officers (NSOs) and asked the following questions:

1. Do veterans believe the VCCP has improved access to VA health care?
2. Is VA honoring veterans' requests to be referred to an authorized network community health provider?
3. Has the rollout of the VCCP had any impact on Bowel and Bladder contracts?
4. Have you received any comments, positive or negative, from veterans about the VCCP?
5. Have you received any comments, positive or negative, from veterans about the new Urgent Care benefit?

Sixty of our NSOs responded to the our survey. The overwhelming majority of responses received for questions 1, 2, 4, and 5 were "no" or "none." The consistency among their responses seems to suggest that it may be too soon to determine how well the VCCP is meeting the needs of veterans.

However, a number of respondants did identify a concern with VA's Bowel and Bladder (B&B) program. Veterans with spinal cord injuries or disorders (SCI/D) often experience gastrointestinal problems, including neurogenic bowel, peptic ulcer disease, impaction, diarrhea, and incontinence. Many of these complications may result in hospitalization and some can be life-threatening. Complaints related to gastrointestinal dysfunction are quite common following an SCI/D and they always negativly impact the veteran's quality of life. Therefore, VA established the B&B program to assist SCI/D patients with bowel and bladder care, which can be provided by an authorized health care provider or a family member trained and certified by a VA SCI Center.

With the implementation of Veteran Care Agreements (VCA) required by the VA MISSION Act (Public Law 115–182), VA medical centers sent letters to caregivers and family members authorized by VA to provide B&B care to veterans. It tells them that they are now required to get a National Provider Identifier (NPI) in order to continue to receive reimbursement for B&B care provided. They are being directed to obtain the NPI and submit a signed VCA to VA not later than September 30, 2019. A copy of one of these letters is provided with our statement for your review.

An NPI is a unique ten-digit identification number required by the Health Insurance Portability and Accountability Act (HIPAA) for covered health care providers in the United States. Covered providers, health plans, and health care clearinghouses (public or private entities that process or facilitate the processing of health information) must use an NPI in administrative and financial transactions adopted under HIPAA. Unfortunately, caregivers and family members were only recently notified of the need to obtain an NPI; thus, there may not be enough time to get the information in by the deadline. Understandably, we are very concerned that those who provide these critical services to PVA members will not be paid and have raised our concerns to VA.

Aside from the information we have received from our NSOs, little information has been provided by VA since they launched the VCCP and the Urgent Care benefit. VA has kept us informed about the awarding of contracts for the six community care regions and the status of contractors' efforts in those regions. However, we have received little information about how either the VCCP or the Urgent Care benefit is working from VA's perspective.

Again, PVA thanks you for the opportunity to provide this update on how well the VCCP is working. We would be happy to take any questions you have for the record.

INFORMATION REQUIRED BY RULE XI 2(G) OF THE HOUSE OF REPRESENTATIVES

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

FISCAL YEAR 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—$193,247.

FISCAL YEAR 2018

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—$181,000.

FISCAL YEAR 2017

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—$275,000.

DISCLOSURE OF FOREIGN PAYMENTS

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

---

PREPARED STATEMENT OF RYAN M. GALLUCCI

Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our feedback on the Department of Veterans' Affairs (VA) implementation of the MISSION Act of 2018.

Since 2015, the VFW has regularly surveyed its members on their health care options, experiences, and preferences to best understand not only the VA health care landscape, but also how veterans make their health care decisions. As a result, the VFW has published a series of reports entitled "Our Care," which present a snapshot of veterans' care.

With the implementation of the MISSION Act on June 6, 2019, the VFW decided it was time to once again commission a survey of our members, once again asking about their health care decision-making to evaluate whether improvements to the veterans' health care system are working and what further improvements may be necessary.

This year's survey not only reiterated questions on care experiences from our past "Our Care" surveys, but the also included logic-based questions on innovations unique to the MISSION Act, like community care consolidation and the new urgent care benefit.

In lieu of a statement, the VFW submits the "Our Care 2019" report for the record on how the VFW believes the MISSION Act has affected veterans' health care decision-making. The report can be found online at the VFW's VA Health Care Watch web page: www.vfw.org/VAWatch

The VFW would be happy to answer any questions the subcommittee may have on this report, our methodology, and our findings.