



**Paralyzed Veterans
of America**



JOINT STATEMENT OF
THE CO-AUTHORS OF THE INDEPENDENT BUDGET:
DISABLED AMERICAN VETERANS
PARALYZED VETERANS OF AMERICA
VETERANS OF FOREIGN WARS
BEFORE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO
“MISSION CRITICAL: ASSESSING COMMUNITY CARE WAIT TIMES”
SEPTEMBER 30, 2020

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, the co-authors of The Independent Budget (IB)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)—are pleased to present our views examining the timeliness of veterans' access to community care since the Department of Veterans Affairs (VA) implemented the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018, P.L. 115-182).

On June 6, 2019, VA discontinued the Veterans Choice Program and began the new Veterans Community Care Program (VCCP) required by the VA MISSION Act. Though enactment of this law was the culmination of more than four years of debate over the future of the VA health care system, it also marked the beginning of a far more complex and critical phase: implementation.

The MISSION Act was a carefully crafted compromise of many stakeholders. In defining our critical issues for the 116th Congress, the IB co-authors selected only one: Full, faithful, and effective implementation of the MISSION Act. We recognized if VA and Congress did this well, veterans' health care would enter a new era marked by

expanded, timely access to high quality care for all enrolled veterans. However, if implementation deviated from the clear and widespread consensus reached by all key stakeholders, the VA health care system could enter a period of decline with devastating consequences for veterans who rely on VA for their care, and perhaps even threaten the viability of the VA health care system itself.

The law consolidated seven community care programs, including the Veterans Choice Program, into the VCCP, using local integrated networks of community providers, particularly the Department of Defense (DOD) and academic affiliates. The intent of the law was to ensure VA remains the primary provider of care and is responsible for coordinating veteran's care in the community when needed, including scheduling of appointments and follow-up upon completion of the episode of care. VA was required to complete market area assessments prior to June 6, 2019, develop strategic plans to provide care to enrolled veterans in each market, and promulgate all regulations necessary to operate the VCCP.

VA also developed new access standards by regulation to replace current 30-day, 40-mile standards, as well as new quality standards. On July 15, 2020, VA published additional guidance in the Federal Register entitled, "Access Standards Drive Time Calculations," which took effect on August 14, 2020. Service lines in VA facilities that fail to meet quality standards were to undergo remediation, though VA may not designate more than three service lines in a single facility, or a total of 36 across the system. Enrolled veterans are eligible to choose non-VA care providers within integrated networks if they are seeking a medical service that VA does not provide; VA cannot meet its access standards; the service line at the VA facility is in remediation for failure to meet quality standards; or the veteran and his or her clinician agree that it is in the "best medical interest" of the veteran. The law also authorizes veterans to access "walk-in care" a limited number of times each year at community urgent care clinics within the network.

VETERANS COMMUNITY CARE PROGRAM

In February 2020, the VA Office of Inspector General (OIG) reported veterans seeking care from community providers could face even longer wait times under the MISSION Act than they did before the legislation went into effect.¹ Investigators found that problems caused by staffing shortages and unnecessary red tape in the authorization process could worsen with the expected increase in veterans seeking non-VA care. On March 11, 2020, facing significant increases in the number of people stricken with a novel coronavirus (COVID-19), the World Health Organization (WHO) declared COVID-19 a pandemic. The pandemic significantly affected operations in health care organizations all over the world, including the Veterans Health Administration (VHA). Many health care providers closed their doors to non-emergent care needs asking patients to defer routine and preventive care until infection rates decreased. State and quarantine period affected access to care in VHA and through its new network of

¹VAOIG report #20-02794-218 "Appointment Management During the COVID-19 Pandemic." Department of Veterans Affairs.

community providers in the VCCP. As a result, on March 20, VHA sent a memo to its medical system directors stating that "VHA requested a temporary (90-day) pause from the MISSION Act standards," though it still planned to complete referrals for "urgent needs as necessary." Three days later, a VHA document dated March 23, 2020, however, clarified that VHA was not pausing the MISSION Act access standards."²The document further stated that VA "is ensuring the best medical interests of Veterans are met by adhering to the law in a manner that takes into account whether referrals for community care are clinically appropriate during the COVID-19 outbreak." According to VA OIG, VHA was forced to cancel more than 11 million appointments from March to June during the coronavirus pandemic, but did not follow up on more than 3 million of those, potentially putting veterans at risk.

About 5 million of those canceled appointments from March to May, or 68 percent, received some level of follow-up, which the report indicated "generally means the patient was able to complete the appointment virtually by telephone or video, or the appointment has been rescheduled." The VA OIG noted that some of the 5 million, though, include appointments that are still pending but are being actively tracked in VA's scheduling system and "likely still need to be rescheduled for an in-person visit or converted" to a telehealth appointment.

At a briefing by VHA's Office of Community Care on September 22, 2020, veterans service organizations (VSO) were advised that:

The Community Care Network (CCN) has been rolled out to all regions with the exception of Regions 5 and 6 which will respond to needs of veterans in the non-contiguous states of Alaska and Hawaii and other offshore US territories such as American Samoa, U.S. Virgin Islands, Northern Mariana Islands, Guam, and Puerto Rico.

- VA's network includes 49,000 retail pharmacies where enrolled veterans can receive free flu vaccinations;
- The urgent care benefit under new CCN providers went live in Regions 1-3 and 400,000 veterans had received care with plans for Region 4 to begin soon;
- VA is seeing an uptick in rescheduling of canceled CCN appointments but noted longer wait times for appointments as civilian and VA patients are both trying to access care that had been postponed due to the pandemic; and
- VA has established a Referral Coordination Initiative with the goal of standardizing the clinical care coordination process for veterans seeking care in the community so they can make informed decisions about care options.

In preparing for this hearing the IBVSOs reached out to our grass roots network to gain a better understanding about the impact of COVID-19 on veterans' access to care over the past several months. While the feedback we received is not complete, it does represent a snap shot of veterans experiences and the challenges they face.

² Page 17, VA OIG Report 20-02794-218, <https://images.radio.com/connectingvets/VAOIG-20-02794-218.pdf>

VFW recently asked its members to report their experience with the program. Several veterans in Massachusetts, Minnesota, North Carolina, Mississippi, Wisconsin, and Georgia responded with ongoing issues exacerbated by COVID-19. Issues such as veterans receiving bills for care received through VA community care, the provider no longer participating in the program, wait times, and VA's cancellation earlier this year were identified. Continuum of care is vital for both mental and physical well-being. When care is disrupted due to a change in provider, long durations between appointments, or cancellation of the care and then billing issues are added on top of that, veterans can experience unnecessary pain and stress. When a health system, which may be the only other health system in that area beside VA, discontinues their participation in the program, a veteran may need to travel further, wait longer, or go without making a needed appointment.

WAIT TIMES, CLINICAL CARE COORDINATION AND SCHEDULING APPOINTMENTS

VA acknowledges that facilities have not followed up on all appointments that were cancelled during its temporary closure to the public and subsequent closures of community care network providers. We also reached out to a few VA medical centers to solicit feedback from those who are involved in the program. VA sites we communicated with say they are just now starting to contact veterans to reschedule appointments. Based on those discussions, and the volume of referrals that apparently need to be rescheduled, the "bubble" of deferred care is likely to create access problems in both VA and the community as more normal operations resume. Access and timeliness to needed care must be closely monitored over the next several months so veterans with complex medical histories do not have to wait too long for care which in turn, could adversely affect their condition or contribute to poor health outcomes.

As VA reschedules appointments, they should ensure veterans are informed about all care options—including wait times and availability for care in VA, with an affiliate, or CCN provider. The staff at one site we spoke with told us as appointments were being rescheduled, veterans were not told that care was available at VA or that it may be the most timely option. They were scheduled with a CCN provider instead. In addition to making veterans aware of their options for care within the integrated networks, it is essential that veterans are provided evidence-based information about the relative advantages of VA's holistic model of care and benefits in order to make truly informed decisions about their care. Clinical Care coordination by nursing level staff is essential during this period to ensure the veteran's health status has not changed significantly or deteriorated impacting the urgency for an appointment. The guidelines for using "best medical interest" to access community providers when VA has sufficient capacity must be clinically based, but must also consider how the guideline implementation affect VA's ability to manage and sustain a robust health care system to meet the needs of all enrolled veterans. The IBVSOs confirmed that VA sites contacted were trying to stand up referral coordination integration teams to manage rescheduling veterans' appointments for community care providers. The feedback we received highlighted a process that is still being developed with continuous changes and little opportunity for

teams to meet and incorporate feedback from staff to make needed adjustments for streamlining it. There was a strong desire for more training and interface with the community network providers and the lead for community care operations at their facility.

We are very interested to learn more about how these teams are being trained and how they engage with VA's partner organizations TriWest Healthcare Alliance and Optum to work out identified challenges in workflow, scheduling, or systemic problems. The role of the clinical care coordinator is critical to an effective and successful process that includes assessing the referral and urgency of clinical need, communicating all care options with the veteran, oversight of scheduling appointments, and ensuring all the necessary clinical and diagnostic work is completed and shared with the private sector provider.

Some veterans have reported difficulties in VA's exchange of clinical data with community care partners. When this data is not received or provided in a timely manner it can hamper the provision of care, communication with veterans about needed follow up care, and VA's payment for care. While VA has indicated that there has been a secure portal (Health Share Referral Manager) established for the safe exchange of this medical information, it may be that community providers and VA staff in coordinating roles need more training and information about using it. Employee concern over inadequate staffing levels for both nurse care coordinators and scheduling clerks was noted based on the volume of consults that needed to be rescheduled and limited training for schedulers and other team members.

Based on the feedback we received about the implementation of community care services from veterans and VA staff we make the following recommendations.

There is a need to:

- Monitor wait times for both VA and with community providers to ensure that consults are managed in a timely manner and access to care in both VA and the community meets standards for timeliness;
- Ensure adequate staff is assigned and properly trained to manage referrals and coordinate needed clinical information to allow consultations to occur in a timely manner; and
- Develop panels of referral coordinators to meet regularly with third party administrators to address problems and brainstorm solutions in information sharing, scheduling, and billing challenges.

We hope the Subcommittee will continue to monitor the implementation phase of standing up local community care coordination teams and veterans' access to timely community services. While timeliness is important—it is just one part of the equation for ensuring veterans receive the right care at the right time. The quality of care is of equal importance and essential to ensuring good health outcomes.

QUALITY STANDARDS

Section 104 of the MISSION Act requires VA to create standards for quality including for its non-department health care providers. These quality standards must consider existing health quality measures for health care systems to allow enrolled veterans to compare VA and non-VA care and make informed decisions about where to receive certain types of care. The department was also required to develop a survey instrument to assess veterans' satisfaction with VA furnished care and to collect and assess data related to care timeliness, effectiveness, safety, and efficiency.

Quality measurement is in the rudimentary stages of development in the private sector—private practices that are not aligned with large systems of care do not often collect enterprise-level data on preventive care procedures (such as counseling on seat belt use; flu shots; breast health; gynecologic care; colon health; and other routinely performed services and diagnostic work). While VA routinely collects this information, veterans can only use it to assess VA care facilities, not to make an “apples to apples” comparison of VA and available community care partners.

During a September 21, 2020, briefing with VSOs, Dr. Elizabeth Brill, Deputy Director of the Office of Community Care, shared VA's process for assessing the quality of its VCCP partners stressing the stringency of the credentialing process; an internal VA complaint line and a line for complaints to third party administrators, TriWest and Optum; and a peer-review process to ensure that poor performers are removed from the network.³ At the same session, Dr. Mark Upton, Acting Assistant Under Secretary for Health for Community Care, stated that some providers made use of the Survey of Healthcare Experiences of Patients (SHEP) and added that the Veterans Experience Office plans to develop a survey of veterans using community care programs.

The “Independent Budget Critical Issue Report for the 116th Congress”⁴ recommended that competency standards for non-VA community providers should be equivalent to standards expected of VA providers, and non-VA providers must meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture. The IBVSOs feel strongly that non-VA providers who wish to be part of VA's integrated network of care must demonstrate a high level of expertise in veteran and military medicine, significant cultural competency about the veteran and military experience, and a commitment to improving and maintaining their skills and expertise.

Independently, DAV, PVA, and VFW testified on mental health and suicide prevention legislation before the House Veterans' Affairs Committee on September 10, 2020. All three organizations supported H.R. 7504, the VA Clinical TEAM Culture Act of 2020, which would require mental health providers participating in VA's CCN to meet the same clinical standards and requirements as those applicable to VA mental health providers.

³VSO Briefing from Department of Veterans Affairs, Office of Community Care, Sept. 21, 2020.

⁴ [Page 8, "IB Critical Issue Update for the 116th Congress; Special Report on the Status of Implementation of the VA MISSION Act"](#)

This legislation would require that community care providers engage in training on military culture and a number of other courses, including screening and management of suicidal ideation, military sexual trauma, post-traumatic stress disorder, and traumatic brain injury, conditions that affect a broad cross-section of the veteran population. While the Clinical TEAM Culture Act has not yet been considered by this chamber, we hope it will be before the end of the 116th Congress.

INFORMATION TECHNOLOGY MODERNIZATION

Another issue that is integral to modernization of the VA health care system—and especially important to streamlining and truly integrating a community care network into VA's system of care—is the implementation of a new electronic health record (EHR) and scheduling system.

As the Subcommittee is aware, VA is now in the midst of a complex upgrade of its EHR system that will improve the sharing of health data between VA, DOD, and community providers. One of the first milestones for the modernization project is implementation of Cerner's enterprise scheduling system in all VHA facilities.⁵ After delays due to the COVID-19 pandemic, VA revised its previous schedule to convert facilities to its new EHR capabilities with updated timelines for deployment.

On August 7, 2020, VA announced VA's Office of Electronic Health Record Modernization (OEHRM) has reengaged with the VA Central Ohio Healthcare System in Columbus to launch a new patient-scheduling system in August and resumed activities at Mann-Grandstaff VA Medical Center (VAMC) in Spokane, Washington, working toward an October implementation of the department's new EHR.⁶ We are hopeful that the scheduling protocol being developed standardizes data collection on preferences for location of care received and other critical information to simplify and streamline the administrative process for the veteran and VA.

ERRONEOUS BILLING OF VETERANS WHEN CARE IS AUTHORIZED BY VA

Lastly, we would like to bring to your attention concerns veterans have shared with us regarding VA community providers inappropriately billing veterans for care authorized by VA. When the community network provider erroneously submits a bill to a veteran and the veteran reaches out to VA for assistance, they are being referred to multiple VA personnel to address their concerns. Recently, a PVA member and PVA's Director of Field Services described this experience as a "chaotic maze" of referrals to Community Care Staff in Louisville, Kentucky; Denver, Colorado; Jackson, Mississippi; and even the National Payment Center in Austin, Texas.

⁵ Department of Veterans Affairs. FY 2021 Budget Submission to Congress: Vol. II: Medical Programs and Information Technology Programs. P. 504.

⁶ VA August 7, 2020 Press Release announcing its revised Electronic Health Record Implementation <https://www.ehrm.va.gov/news/article/read/va-responds-to-covid-19-with-schedule-revisions-to-electronic-health-record-implementation>

To give you an idea of the scope of the problem, a section of VFW's recent "Our Care" survey asked about VA coordinated community care, and over a third of respondents reported receiving a bill. Billing errors and how to prevent and correct billing errors ranked number three when veterans were asked about their community care experience and how VA can improve the community care program.

PVA has alerted VA Central Office to these issues through outreach to the former Deputy Under Secretary for Health for Community Care and VHA Executive in Charge Dr. Richard Stone. When veterans get bombarded with bills, overdue notices, and threats of collection activity for bills which VA is responsible, they not only get frustrated and concerned, but anxious, and worried about their credit records and possible lawsuits. This is not acceptable, and we urge VHA to redouble its efforts to ensure CCN providers are informed and understand that veterans are not to be billed for VA approved care through its CCN.

Thank you for the opportunity to submit our views on this timely and very important matter. To gain a better understand on how well VHA's Office of Community Care program is performing, the IB recommends Congress request the Government Accounting Office conduct a thorough assessment of VHA's Community Care program specifically looking into the process for establishing referrals for community care consults, appointment scheduling, and how VA is engaging veterans prior to referring them to a community network provider.