Congress of the United States
Washington, DC 20510

March 25, 2019

Michael P. Shores
Director
Office of Regulation Policy and Management
Department of Veterans Affairs
810 Vermont Avenue NW, Room 1063B
Washington, DC 20420

Dear Mr. Shores,

Public Law 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Integrated Outside Networks Act of 2018 (VA MISSION Act), represents a nearly two-year effort to remove the outdated, unnecessary and confusing community care bureaucracy at the Department of Veterans Affairs (VA) by consolidating the Veterans Health Administration's (VHA) seven community care programs into a single, easier-to-use system.

The goal was to rid VHA of the arbitrary one-size-fits-all approach of the then-temporary 30-day/40-mile rules that were developed for the Veterans Choice Program as part of Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014, by leaving the decision on where patients should get care between the veteran-patient and his or her VA provider. Regrettably, the Proposed Rule (PR) does not accomplish Congress' intent and fails the 6.34 million unique veterans who rely on VA health care services.

Hollowing Out of VA Facilities

We are very concerned that this proposal will ultimately degrade VHA for those veterans who prefer and rely on its health care services to lead more meaningful, healthy lives. Since 1811, the federal government has provided health care services to veterans at facilities operated and funded to care for those who have borne the battle, but we fear that this PR will be the first step towards dismantling this system.

The apparent indifference of the Department with regard to the likelihood that these proposed standards could cause too much care to shift to the private sector, crippling the largest integrated health care system in the country for those veterans who rely on its services, is troubling. In a press release announcing VA's proposed access standards, VA stated that these new access standards represent a "win" for veterans and any concern was "false and predictable." Sadly, the analysis accompanying the proposed access standards does little to dissuade those very real concerns. For example, the Regulatory Impact Analysis (RIA) states

that VA will consider the performance of its facilities on wait time access standards when making resource allocation decisions. This is troubling. Will resources be withheld if a facility is not meeting access standards? Will attempts be made to improve timeliness before funding cuts are made? Potentially starving facilities of funds, allowing VA buildings fall into a state of disrepair, and decreasing VA's capacity to deliver care, thereby forcing veterans into the community when VA providers are not available, is de facto privatization.

Further, the RIA specifically states that VA will not prioritize or protect services that VA has particular expertise in providing, yet it makes an exception for nursing home care on the grounds of scarcity of resources and variability of quality in the community. As veterans service organizations (VSOs) and previous VA leaders have noted, the caliber of many areas of VA care— including mental health, polytrauma, spinal cord injury and rehabilitation, prosthetics, Traumatic Brain Injury, and Military Sexual Trauma—does not exist in the community. If facilities are starved of funding, so too will these specialized services suffer to the detriment of the millions of veterans who utilize this military-specific care.

Lack of Congressional and Veterans Service Organization Counsel

VA did not consult with congressional authorizing and appropriating committees when it developed the proposed access standards. Instead, VA engaged in only one-way communication and did not proactively solicit nor accept input from Congress. This presents a stark contrast to the collaborative nature in which the VA MISSION Act was developed. The lack of consultation with Congress shows in the product developed by the Department. Instead of using the proposed regulation as an opportunity to move VHA forward as the law intended, the Department is embracing an approach to VA MISSION Act implementation that mirrors non-collaborative failures of the past. We are disappointed by the Department's approach and view this PR as a squandered opportunity to transform VHA into the premier health care system of the 21st Century.

The most glaring example of the fallout from the Department's lack of consultation with Congress is in its interpretation of the "designated access standard" provision found in section 101 of the law. During last year's VA MISSION Act negotiations, VA leadership agreed that the "designated access standards" would be limited to three to five types of care. This meant that veterans would be eligible for referral to section 101's Veterans Community Care Program only if their wait times, drive times, or driving distances to access specific services at a VA facility exceeded the limits set by VA. Laboratory tests, X-rays, and urgent care were often cited as examples of services or categories of care for which VA would designate access standards. VA specifically argued that the word "designated" would mean that the provision would not cover all types of care, just the types of care that the Secretary "designated" after an assessment of the services VA struggles to provide in a timely manner or make the most sense to allow nearly-automatic access to community care.

However, VA is now planning to designate all clinical services as potentially making a veteran eligible for community care under the "designated access standards," which marks a significant departure from Congressional intent. On this basis alone, we have significant concern about what this decision means for the future of VA health care and urge the Secretary to

reconsider. We suggest that the Secretary reaffirm Congressional intent and limit his designations to three to five types of care initially. Then, if VA is challenged in providing particular types of care in certain areas, it can re-evaluate. In the future, we will insist that legislative deference to the Secretary be limited if there is not a meeting of the minds on this point.

Equally troubling to the lack of counsel sought in Congress, is the Department's failure to engage in meaningful back-and-forth with veterans and VSOs, the users of VA's health care system, when developing this PR. And despite addressing this issue with the Secretary at the December 19, 2018 hearing on implementation of the VA MISSION Act, our understanding is that VA has since made no discernable change in the nature of its communication with VSOs. We are disappointed in VA's continued self-isolation from those groups and stakeholders who are committed to the Agency and the veterans it serves.

Lack of Transparency in How VA Developed the Proposed Regulation

VA officials have not provided adequate information about how they arrived at the 20-day/28-day wait time thresholds or the 30-minute/1-hour drive time thresholds they have proposed. This raises concern that VA is about to establish access standards that are just as arbitrary as those that were previously established for the Veterans Choice Program (i.e., wait times of 30 days and driving distances of 40 miles). We are disappointed that the PR continues on the path of providing less, and not more, information. For example, the RIA notes that the proposed wait-time standards will fall "roughly in the median of appointment wait-time standards found in other government organizations, state programs, and commercial entities," but does not explain if that matters or why it is the appropriate standard for VHA.

Both VA officials and the PR refer in generalities to analyzing access standards from TRICARE, Medicare, Medicaid, and commercial health insurance plans, but the access standards VA has proposed almost perfectly mirror TRICARE Prime access standards. VA officials have provided few specifics about VA's rationale for selecting these standards or explained why, for example, VA decided against establishing different standards for veterans residing in urban, suburban, and rural areas (which is common among Medicaid managed care plans), or adjusting the access standards based on known shortages of community providers in some counties (which is a factor for Medicare Advantage plans).

Further, the PR does not reflect the insights offered by numerous health care industry experts via the summer 2018 public meeting and public comment period. Numerous commercial health plans, major health care systems, provider organizations, a health plan accreditation entity, and public health advocacy organizations offered comments on a path forward for VA community care. Many of these entities urged VA to establish access standards that would be adjusted based on VA's needs and the availability of services in specific markets. On the other hand, Concerned Veterans for America was the only entity that recommended in its public comment that VA adopt access standards similar to those used by TRICARE Prime. Why did VA disregard considerable health care industry and public health advocacy expertise and instead go along with the recommendation of this group? Many of the other organizations that commented made clear that it is important to adjust access standards for population density and

the relative scarcity of community providers. This is what Medicare Advantage does. While the RIA examined one model that was based on Medicare Advantage standards, why didn't VA also run estimates for Medicare Advantage-like models with greater driving distances?

The RIA only presents six alternative access models for comparison, but congressional staff were given verbal descriptions for eight models and told during briefings that 12 or more models were under consideration. Given that the RIA did not include all 12 or more of the models that were contemplated, we lack assurance that VA has selected the best option.

Longer Wait Times and Lower Quality in the Community

There is no guarantee that veterans will be able to access primary care, mental health care, or specialty care in the community sooner than they would otherwise access care at VA facilities. VHA's market assessments are just getting underway. VA does not yet know whether the community has sufficient capacity to provide care to veterans. The fact that the PR fails to address this point is concerning.

A recent study published in the Journal of the American Medical Association found that average wait times for primary care and certain types of specialty care appointments at VA facilities have improved since 2014 and are competitive, if not better, than average wait times in the community. And studies from Dartmouth and RAND have found that VA hospitals outperform private sector hospitals in most markets. Thus, not only is there a risk that veterans could receive less timely health care services in the private sector, there is great risk that veterans could receive care in the community that is of poorer quality than VA-based care.

In response to Ranking Member Jon Tester's question before the February 26, 2019 joint hearing of the House and Senate Veterans' Affairs Committees, "Does the DAV believe that community providers should be held to the same standards as VA providers?" Randy Reese, Executive Director of the Disabled American Veterans, responded, "We absolutely believe that is the case." We agree. The PR is silent on how VA will assess the access and quality standards of community care providers before determining the appropriateness of sending veterans there for care.

The VA MISSION Act is explicit that community providers must be able to see veterans within the same access standards that VA requires of itself. The Agency is ignoring the law to the detriment of those veterans who rely on the system.

Lack of Education for Veterans on Health Care Options

Notably missing is a full discussion on how VA will incorporate these access standards into the education program required under section 121 of the VA MISSION Act. Here, too, the law was explicit – that the Department develop a robust educational program designed to educate veterans on their health care options, the interaction between other health insurance and VA health care benefits, and how to utilize the access and quality standards established in the law. Beyond a passing mention of a Decision Support Tool, VA did not examine in the PR or the RIA

when and how veterans would receive the required education on health care options available to them.

Further, VA currently lacks the data and technology it would need to show veterans in real time what their estimated wait times and quality of care will be in the community. VA officials have conceded to congressional staff that it will be about two years until VA Medical Centers will have the capability to show veterans at the point of service what their potential wait times will be if they opt for community care. This limits veterans' ability to make informed decisions about where to receive their care. Given that the Department is currently attempting to stand up community care networks nationwide, we are concerned that VA would not require as a condition of participating in the CCN that providers (1) agree to see veterans within the timeframe established in the proposed access standard and (2) give the Agency current data on wait times. Here, too, is another missed opportunity to build the best health care system for veterans.

Care Coordination

VA has not fully explained in the PR how it will coordinate care for the estimated 22 percent of enrolled veterans who will be eligible for community care referrals for primary care under the proposed drive time standards. It is possible that these veterans will never see VA primary care providers (PCPs). Most veterans will still have the benefit of a VA PCP to coordinate their care, whereas drive-time-eligible veterans could elect to receive all of their primary care from a PCP in the community. Unsurprisingly, the PR does not fully explain how VA plans to coordinate their care. This could lead to fragmentation and lower quality of care.

Community providers likely will not deliver the same high-quality, culturally competent care that VA PCPs deliver. For example, community PCPs are less likely to screen veterans for the same conditions and experiences that VA PCPs otherwise would – Military Sexual Trauma, suicide risk, toxic exposures, etc. VA has developed strong clinical practice guidelines and established an electronic health record (EHR) with a clinical reminder system, which PCPs in the community will not be able to use.

Incomplete Estimates of Number of Veterans Affected and Cost

VA has not offered an estimate on the percentage of enrolled veterans who will be eligible for community care based on the proposed wait time standards of 20 days for primary care and mental health and 28 days for specialty care. However, VA expects that the 28-day standard for specialty care will not increase costs because it is close to the current 30-day standard under the Choice Program. Given that VA does not offer number or percentage of veterans projected to be eligible under the proposed wait time standard in the PR or RIA, but deems there is no new cost, it appears that VA is at best "guessing" the impact of the wait-time standards on VA and the budget. As discussed in greater detail below, VA's financial projections, particularly in the area of community care, have historically been significantly off-base.

The Department does not go into great detail evaluating the fact that not all veterans who are offered community referrals will choose to receive their care outside of VA. The PR does not provide any estimates of how many veterans will ultimately choose community care. On this point, we would appreciate more information on how the Department intends to ensure that appropriate funding is provided for care delivered at VA and not solely for community care, given that the estimate provided is for those eligible for community care not those who ultimately choose it.

We are also concerned that veterans who are eligible but not currently enrolled in VA health care will choose to enroll and use the system because they meet the new wait-time or drive-time criteria. A significant number of veterans may be enticed to enroll in VA health care once they are able to access VA community care with lower out-of-pocket costs than they would otherwise pay through their employer-based insurance or other federal program like Medicare. The RIA estimates that there will not be an increase in veterans drawn to enroll in VA health care, a conclusion that is derived from historical Choice Program data. However, the Choice Program was a temporary program, and faced many implementation challenges, especially with its third-party administrators. In contrast, the VA MISSION Act is a permanent program and VA has the benefit of hindsight in terms of working with network administrators. Veterans may be drawn to a more permanent program with accountable network administrators. We are very concerned that the Department might be underestimating the extent to which the new program will draw new enrollees to low- or no-cost VA health care.

In addition, in the RIA, VA assumes that enrollees eligible for the new program under the Choice Program's 40-mile criterion (the "grandfathered 40-milers") will further increase their reliance on VA. VA also envisions these individuals maintaining their eligibility for community care under the "best medical interest" provision. This is concerning and clearly not what Congress anticipated. In the VA MISSION Act, Congress capped the time that these grandfathered 40-milers would be eligible for the new Veterans Community Care Program. Had we intended for these individuals to maintain their eligibility, we would not have limited the time they would be grandfathered into the new Program.

VA's Poor Track Record on Estimating Community Care Costs

VA has a poor track record of estimating past community care costs. Since 2017, Congress has stepped in three times to provide additional funding so that the Department would not exhaust its Choice Program funding. That funding totaled $9.4 billion and was in addition to the $10 billion initially appropriated for the Choice Program in 2014. In at least two of the instances where Congress was forced to act and provide emergency funding, veterans were needlessly stressed and inconvenienced while VA sorted out its funding issues and sent ineffective direction to the field on what should happen if Choice Program funds were exhausted. Congress had to act to provide additional Choice Program dollars because VA ineffectively planned for what would happen when this temporary program's funds ran out. This lack of fiscal responsibility on the Department's part was and is alarming. We have no reason to believe that VA's past forecasting woes will improve, and therefore are applying increased scrutiny to the estimates VA included in the RIA and to the President's budget proposal for Fiscal Year 2020. On page 7 of the RIA, it appears there is a discrepancy between the 5-year cost estimate for the

proposed access standards shown in the last row of Table 2 ($19.9 billion) and the 5-year cost estimate mentioned in the text below the table ($17.2 billion). A third 5-year cost estimate ($16.99 billion) was presented by VA's actuaries at a March 12, 2019 briefing for congressional staff, which differs from yet another estimate VA officials presented to staff on February 8, 2019 ($18.7 billion). Given that there are inconsistencies in the 5-year cost estimates presented in the RIA itself, that VA officials presented two additional estimates in staff briefings, and that VA has seemingly excluded wait-time eligible veterans from its cost estimates, we are understandably apprehensive about whether the Administration's Fiscal Year 2020 budget proposal of $2.9 billion will be sufficient to implement these proposed access standards.

Given the concerns outlined in this comment, we would urge the Agency to re-evaluate the number and type of access standards the Secretary is designating under the VA MISSION Act. We also strongly recommend that VA review its estimates of the budgetary impact of these standards. Finally, we believe that the Department should remain the primary coordinator of care for all veterans, instead of setting up a system where it's possible that a subset of veterans will never see a VA PCP.

We appreciate your thoughtful review of our comment on the Proposed Regulation for the Veterans Community Care Program.

Sincerely,

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United States Senator

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Member of Congress

Patty Murray
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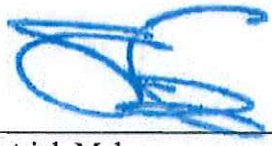

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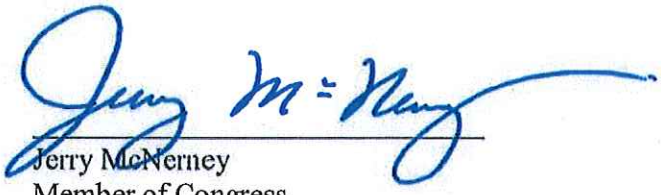

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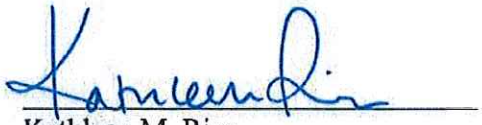

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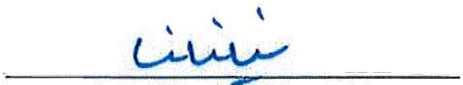

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