CONGRESSIONAL TESTIMONY

STATEMENT FOR THE RECORD

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

VA MISSION ACT: IMPLEMENTING THE VETERANS COMMUNITY CARE PROGRAM

April 10, 2019

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Chairman Isakson, Ranking Member Tester, and Members of the Committee,

On behalf of the over 700,000 federal and D.C. employees represented by the American Federation of Government Employees (AFGE), AFL-CIO, including the over 250,000 frontline employees of the Department of Veterans Affairs (VA) represented by AFGE, we write today to provide our comments on the state of the VA MISSION Act implementation as well as the harm expanded private sector intrusion will have on the VA's ability to deliver high quality, timely care to veterans. We want to take this opportunity to repeat our concerns about the VA MISSION Act, its proposed access standards, expansion of walk-in clinics, and the negative impact this law will have on the VA workforce and the veteran patient population across the country. Without taking substantially more time to analyze the large-scale impact of this law, including the proposed access standards and new walk-in clinic program, the VA MISSION Act will lead to an irreversible dismantling and weakening of VA's exemplary, uniquely veteran-centric health care system.

While there are significant problems with the substance of the new law that must be considered, the first and most obvious problem is the secretive, unacceptable nature of the rule writing process. For example, the proposed access standards were created behind closed doors without any input from Congressional leadership, the veterans service organization (VSO) community, or representatives of the in-house frontline workforce. By writing this proposal without input from stakeholders the VA has made even more controversial an already controversial issue. Problems that are entirely foreseeable could have been mitigated if Congress, VSOs, and the VA workforce had been permitted to participate in the drafting process. That did not happen and, therefore the VA should withdraw the proposed rule and redraft the proposal in a more inclusive manner.

One of the most serious shortcomings of the access standards created by the CHOICE program was the arbitrary 30 day/40-mile rule. Under this program if a veteran's VA had a 30 day wait, or if s/he lived 40 miles or more away from the nearest VA, that veteran was authorized to seek care in the private sector. Under the CHOICE standards, approximately 8 percent of veterans were eligible to go into the private sector.

Unfortunately, the new proposed standards drastically increase the diversion of more VA care into the private sector. Under the proposed rule, if a veteran's nearest VA has a 20-day wait time for primary care (including mental health) or a 28-day wait time for specialty care the patient will be sent to the private sector. We also have strong concerns that if a veteran finds the wait time is too long outside of the VA, that veteran will have to go through an unnecessarily burdensome process to come back inside of the VA. This is not "choice" or "access"; it is a one-way ticket to a fully outsourced VA. Similarly, if a veteran can certify that he or she has an average drivetime of 30-minutes for primary care and one-hour drivetime for specialty care, that also triggers a private sector referral. According to the VA's own Economic Regulatory Impact Analysis the total number of veterans eligible to receive private sector care is estimated to increase from **8 percent to 39 percent** if this proposed rule goes into effect. The Committee must demand that the VA withdraw and re-write this proposed rule.

Equally troubling is that if these new access standards are implemented, they will perpetuate the egregious double standard already inflicted upon VA providers (who have to meet stricter competency standards than private sector providers treating veterans). The private sector will not have to meet the same or even similar access standards. There is no metric in place that will guarantee that a veteran who qualifies for a private sector referral will not be sent out into the "community" to wait 20 days or more for primary care or drive 30 minutes or longer. Without providing an equal playing field the VA is setting itself up to fail and continues the push toward outright privatization.

Another major aspect of this law that is problematic is the expanded access to walk-in clinics for a veteran to receive their care. It's important to look at the Department's past performance with walk-in clinics to articulate our fears with this new proposal. For example, when then-Secretary Shulkin authorized the use of CVS Minute Clinics as a pilot program in 2017 the Department exercised virtually no oversight of the providers. It is premature to allow open access to walk-in clinics without studying the cost associated with these walk-in providers and the quality of care they provide. Since the CVS pilot has at least a year of data for examination, at a minimum, an estimate of how much this program will cost is needed, as well as information compiled on patient outcomes. Yet, unfortunately, no such study has been conducted prior to pushing implementation.

The thought that veterans could use walk-in clinics for mental health services gives AFGE significant pause. We cannot conceive of any appropriate instance when mental health treatment would be suitably provided in a walk-in clinic. The VA is the national leader in integrating primary care and mental health; walk-in clinics will result in inferior, fragmented mental health care by providers with significantly less veteran centric training and accountability. This will most certainly lead to negative health outcomes for veterans. Instead of outsourcing this vital component of veteran care, the VA should be working to build internal mental health capacity.

While it is encouraging to see the Department move toward placing a copayment on walk-in clinics after the third visit in a calendar year, more needs to be done to show this will be a deterrent. Currently there is no insight into how copayments will impact utilization or harm the veteran population. The underlying law also gives the Secretary full discretion to waive copayments. This poses a problem: if the Secretary routinely waives the copayments there will be no disincentive to using these clinics.

Ultimately, none of this would be necessary if the VA would commit to building internal capacity and provide adequate money for staffing and internal resources. In order for the VA to be fully operational it must be fully staffed. In addition to creating a new, permanent private sector care program, the VA MISSION Act also requires the Department to publish data on vacancies and hiring. Since the first set of data was published on August 31, 2018, the number of vacant positions at the VA has steadily increased. As of the most recent reporting the total number of unfilled positions at the VA is nearly 49,000 – with nearly 43,000 of those positions located in VHA. Instead of finding ways to justify sending patients outside of the VA to receive their care, the VA should be laser focused on hiring more fulltime professionals who want to make a career out of serving the veterans.

AFGE insists that the VA stop rushing to implement the MISSION Act and start over, with more provisions in place to ensure the integrity of the program and more oversight of cost and quality. The VA MISSION Act represents a truly massive change to the future of the VA, and its rollout should not be fast tracked, and implementation should not proceed before critical data on market capacity, provider quality and wait times are collected.

Thank you for the opportunity to explain our concerns as it relates to implementing the VA MISSION Act and we look forward to working with the Committee to ensure that the VA workforce is able to grow, thrive, and continue providing world-class care and services to our nation's heroes.