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**STATEMENT OF  
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UNITED STATES SENATE  
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Chairman Moran, Ranking Member Tester and members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for today's hearing examining the Department of Veterans Affairs (VA) status and progress implementing Title I of the VA MISSION Act (Public Law 115-182) which was signed into law on June 6, 2018 and became effective one year later on June 6, 2019. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

The MISSION Act was a comprehensive, bipartisan law designed to improve veterans' access to timely and high-quality health care. The law replaced the Veterans Choice Program with a new community care program with VA as the primary provider and coordinator of health care. It also increased VA's own capacity to deliver health care; developed a long-range plan to modernize and realign VA's health care infrastructure, and expanded VA's comprehensive caregiver assistance program to veterans of all eras.

In January 2019, DAV and our *Independent Budget* (IB) partners (PVA, VFW) released the *Veterans Agenda for the 116th Congress*, which designated a single critical issue: "Fully and Faithfully Implementing the VA MISSION Act." That report included 26 recommendations to ensure that the law would be fulfilled as intended. In January 2020, the IB released a *Special Report on the Status of Implementation of the VA MISSION Act*, which assessed the progress made by VA and Congress towards fulfilling both the letter and the spirit of the law. At that time, the IB concluded that only one of 26 recommendations had been fulfilled; 11 had not been fulfilled; and the status of 14 remained to be determined because it was either too soon or there was insufficient information to properly assess.

## **VETERANS COMMUNITY CARE PROGRAM**

Title I of the MISSION Act established the new Veterans Community Care Program (VCCP), which consolidated seven existing community care authorities, including the Veterans Choice Program. The VCCP established new eligibility criteria for

community care, including new access standards to address both wait times and distance. DAV and other stakeholders envisioned that VCCP would create new integrated veterans care networks (VCNs) comprised of VA and community health care providers in order to provide enrolled veterans with seamless access to timely and high-quality health care. Although the law took effect in June 2019, the VCCP's implementation was slowed by VA's contract negotiations with third party administrators (TPAs) and the TPAs subsequent need to select providers for its new networks and establish rudimentary procedures for billing, collecting and sharing information with VA. Shortly afterward, COVID-19 forced VA and the rest of the health care industry including its new VCCP providers to modify medical care delivery. Like other providers around the globe, VA and TPAs cancelled most non-emergency care during the height of the outbreak. It has since significantly increased telehealth capacity to replace some in-person medical care. To date, many providers are still operating in a more limited capacity than prior to the outbreak and there are many appointments that must be rescheduled. Until the pandemic has ended and normal patient care patterns have resumed, it is hard to determine exactly how well the new VCNs are providing care and meeting veterans expectations and demands.

### **Scheduling and Wait Times**

VA is currently having difficulty scheduling community care appointments in a timely manner. Earlier this year, the VA Office of Inspector General (OIG) reported that veterans seeking care from community providers could face even longer wait times under the MISSION Act than under the prior Choice program. Again, the pandemic has confounded the ability for VA to understand the extent of this problem since VA, like many other health care providers, cancelled non-urgent appointments for several months, creating a significant backlog of scheduling requirements and unmet veteran health care needs.

Last month the Government Accountability Office (GAO) reported that VA did not have any wait-time performance measures or standards for the maximum amount of time for veterans to receive care from VCN providers. Further, GAO noted that in its 2018 report on wait times it had, "...recommended that as VA implemented the VCCP, it should establish an achievable wait-time goal for veterans to receive care. VA agreed with [the GAO] recommendation; however, the VCCP has been operational since June 2019 and this recommendation remains unimplemented," according to GAO.

To improve scheduling problems and provide veterans with a consistent referral experience, VA developed its Referral Coordination Initiative (RCI); however, VA testified in the House last month that the RCI's implementation has been delayed due to COVID-19. Based on conversations with several veterans and VA employees, there is strong anecdotal evidence to suggest that VA's current community care scheduling operations are understaffed and disorganized.

## **Access, Quality and Competency Standards**

While VA must meet specific standards for wait times, drive times and quality metrics, private, non-VA providers in the VCNs do not have to meet the same requirements. DAV and other stakeholders are concerned that this disparity could result in veterans receiving a lower standard of care ultimately impacting health outcomes when receiving VCN care compared to care directly provided by VA.

We continue to assert that the MISSION Act was unambiguous in its requirement that both access and quality standards must be equally applied to VA and non-VA providers. Section 104 states that VA "...shall ensure health care providers specified under section 1703(c) [i.e. - VCN providers] are able to comply with the applicable access standards established by the Secretary." The law further states that VA, "...shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, **including through non-Department health care providers** [emphasis added] pursuant to section 1703 of this title." However, VA did not include such requirements when promulgating access and quality standards, instead choosing to use contracting processes to establish such standards. Further, VA stated it did not always provide equitable standards in contracts out of concern that private providers might not be willing to adhere to the same clinical standards and training requirements that VA providers must meet. We continue to find this argument specious and call for the law's clear language and intention to be followed. Veterans must be assured that VCNs are held to the same quality and access standards that VA must comply with.

In addition, Section 133 (b)(2) required all non-VA health care providers joining the VCN to meet competency standards and requirements and that they be required to complete training, "...on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise." Although training on military culture and evidence-based treatments is available to community partners, VA interpreted this provision narrowly and did not mandate the training for VCN providers. We continue to call for non-VA providers to be held to all the same standards as VA providers, including completion of training on certain conditions which are prevalent in the veteran population, including post-traumatic stress due to combat and/or military sexual trauma and traumatic brain injury.

## **Strategic Plan to Establish Veterans Care Networks**

Section 106 of the of the MISSION Act required VA to conduct market assessments of both VA and non-VA provider health care capacity, and to use that information to design a "Strategic Plan to Meet Health Care Demand" due to Congress no later than June 6, 2019; VA is required to re-evaluate the market assessments and plan every four years. The strategic plan would determine veterans' needs and preferences for receiving health care in each distinct geographical market, assess both VA and non-VA ability to meet that demand, and develop a plan that best optimizes existing and future resources to deliver that care. Based on this plan, VA would then

determine what health care services it would provide directly and which it would purchase through the VCNs. Regrettably, VA missed this deadline and has yet to provide a timeline to meet this requirement.

In addition, Section 203 of the MISSION Act required a second set of “capacity and commercial market assessments” to inform the Asset and Infrastructure Review (AIR) process, which is just now beginning. Although the law clearly intended these to be two separate and distinct assessments, VA is conducting only one set of market assessments to satisfy both statutory requirements, which it will use to produce its national strategic plan and national realignment strategy for the AIR process. However, Congress intentionally called for two sets of market assessments in order to first guide the development of local VCNs, and then only after these VCNs had been established and provided sufficient time to stabilize would the AIR process begin with its market assessments. This two-pronged approach would more accurately capture data reflecting changes to veterans’ patterns of seeking care under the new eligibility criteria once the VCNs were fully operational and after capacity enhancements in the VA MISSION Act were fully implemented.

The MISSION Act also required VA to conduct market assessments with full transparency and in consultation with VSOs and veterans who use the VA health care system. Yet, since the law was enacted in 2018 through this summer, DAV and other VSOs engaged in very little consultation with VA about the market assessments. We do want to note, however, that VA has recently begun engaging stakeholders in a much more robust and collaborative manner which we appreciate and hope will continue. We also expect VA to engage with local veterans and VSOs to ensure that veterans preferences remain paramount as VA develops its national strategic and realignment plans.

### **Clinical Care Coordination**

One of the foundational principles underlying the MISSION Act was that VA remain the primary provider and coordinator of health care. Care coordination includes scheduling appointments, transferring medical records and ensuring proper payment to providers. VA’s Referral Coordination Initiative and Health Share Referral Manager (HSRM)—a secure, web-based system to generate and submit referrals and authorizations to community providers, are both critical elements in the process.

However, the most critical factor is clinical care coordination. The VA health care system is among the world’s leaders in health care coordination with its Patient-Aligned Care Teams (PACT) model, which use a team of health professionals, led by a VA clinician, working collaboratively with the veteran to meet of his or her health care needs. The PACT provides patient-driven, proactive, personalized, team-based care focused on wellness and disease prevention to improve health care outcomes and veteran satisfaction. Seamless clinical care coordination is the cornerstone of health care quality and the primary reason why health care experts regularly report that VA care is as good as or better than care provided in the private sector care.

In our opinion, the ultimate success of VA's community care programs and the MISSION Act will be how well VA maintains seamless care coordination for veterans moving back and forth between VA and non-VA providers. The challenge for VA is to replicate the PACT clinical care coordination and between VA and VCN providers.

### **Walk-in and Urgent Care**

Section 105 of the MISSION created a new community care walk-in care benefit to address non-urgent or routine preventative care, such as flu shots. The law provided VA with a discretionary authority to charge copayments, including from service-disabled veterans after their third visit to a VCN urgent care facility in one calendar year. In all other circumstances, VA is prohibited from collecting such copayments from veterans receiving care related to a service-connected disability or from veterans with at least a 50 percent disability rating from VA, regardless of whether such care is received in a VA or VCN facility. Therefore, we continue to call on VA and Congress to remove this copayment requirement for service-disabled veterans.

### **CAREGIVER SUPPORT PROGRAM EXPANSION**

One of the key elements of the MISSION Act was the expansion of VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) to include caregivers of veterans from all eras, expanding on the current eligibility by including those severely injured prior September 11, 2001. The law required VA to implement a new caregiver IT system by October 1, 2018 and certify that the IT system was ready to manage the expanded caregiver program no later than October 1, 2019. Upon certification, the first phase of expansion would begin for those injured on or before May 7, 1975; the second phase would begin two years later for those injured between May 8, 1975 through September 10, 2001.

Despite having 16 months from enactment of the law to the required certification date, VA failed to meet this critical deadline, which ultimately became a full year delay for the first phase of the expansion to October 1, 2020. On that date, VA announced that the new IT system, the Caregiver Records Management Application (CARMA) was certified and fully operational following final user acceptance testing, and that veterans could begin applying online or through the mail. VA also announced that hundreds of new caregiver support program staff and management, including for its Centralized Eligibility and Appeals Teams (CEATs), had been hired and trained to process new applications, conduct reassessments of existing participants and provide clinical appeals.

With implementation of phase one of the caregiver program expansion earlier this month, VA has now fulfilled three additional recommendations; however, most other recommendations pertaining to community care have not changed over the past 8 months, in part due to delays and disruptions caused by the COVID-19 pandemic.

After a decade of waiting for this program to be expanded to family caregivers of veterans from earlier eras, we are pleased that VA is finally moving ahead. We have heard from a number of our members who applied for this benefit on the first day and reported they have already been contacted by VA staff to review their applications and begin the assessment process. We would note, however, that VA had advised DAV and other VSOs that they would announce the certification date in advance in order to allow VSOs sufficient time for us to inform veterans about the application process but unfortunately there was very little advance notice. Applying promptly could be important for many veterans and caregivers since the regulations implementing the law specified that some caregiver benefits, including the stipend, could be granted retroactively back to the date of application.

Moving forward it is imperative that VA be fully transparent and forthcoming by providing timely, comprehensive information about the expansion in order to allow Congress, VSOs and other stakeholders to perform appropriate outreach to veterans and provide oversight of the process.

### **Enact Legislation to Complete Caregiver Phase Two Expansion in 2021**

Because VA was not timely in meeting deadlines to begin the first phase of the caregiver expansion, the anticipated start date for second phase (veterans injured between 1975 and 2001) is now also delayed by a year to October 1, 2022. DAV believes that VA and Congress should move the second phase of the caregiver expansion back to the intended date of October 1, 2021. During a recent VA-VSO call on the status of the CARMA IT system, VA stated that once it was operational for phase one, CARMA would not require any additional functionality or capacity to handle the increased workload from phase two. In fact, other than hiring 700 additional personnel – which can easily be accomplished over the next year – there is no real reason for the two-year wait. Congress clearly intended the second phase to occur by October 2021 and we believe that veterans and their caregivers should not have to wait an extra year to begin receiving this critical benefit.

### **Eligibility Criteria Based on Inability to Perform Activities of Daily Living (ADL)**

The final caregiver regulations promulgated on July 31, 2020, which took effect on October 1, made a number of positive changes to more equitably provide caregiver support to veterans and their family caregivers. In particular, DAV was very pleased that VA's new definition of "serious injury" will expand eligibility to veterans who have serious service-related disabilities from diseases, illnesses and other conditions, not just from wounds and injuries. In addition, VA will no longer require a connection between the need for personal care services and the qualifying serious injury. This change recognizes that assessing the personal care needs of veterans based solely on service-connected conditions can be extremely difficult, particularly when co-morbid conditions frequently contribute to a veteran's functional limitations.

However, there are also new eligibility requirements that we are concerned will unfairly prevent deserving veterans with great caregiver needs from entering the program. Specifically, the new regulations state that in order to determine if a veteran is in need of caregiver services, VA must determine that the veteran is unable to perform an activity of daily living (ADL), which includes dressing, bathing, grooming, adjusting prosthetics, toileting, feeding, walking and transferring. The regulation further states that “Inability to perform an activity of daily living (ADL) means a veteran or servicemember requires personal care services **each time** [emphasis added] he or she completes...” that ADL. DAV and a number of other stakeholders opposed this requirement as an unreasonable and arbitrary standard.

For example, severely disabled veterans with musculoskeletal and/or neurological conditions that limit muscle endurance may have sufficient muscle strength at certain times of the day to complete a specific ADL without assistance, but due to having to repeat the ADL throughout the course of the day would eventually require assistance. In this example the veteran would be found ineligible under the established standard. There are also situations where a veteran’s condition makes it difficult to move certain muscles after periods of inactivity, including sleeping, and require assistance with transferring and ambulating, but after that assistance, they may be able to perform those same ADLs without assistance later in the day. There are also severe disabilities that relapse and remit, or wax and wane, without regularity, thereby leaving the veteran in need of personal care services. Congress must carefully monitor how consistently and accurately VA makes these determinations about requiring assistance “each time” and consider revising the law to allow eligibility for veterans who require assistance with ADLs “most of the time” or “consistently.”

### **Caregiver Clinical Appeals’ Processing, Notification and Tracking**

As mentioned above, VA has established Centralized Eligibility and Appeals Teams (CEATs) in each VISN to process new applications for caregiver benefits, conduct reassessments under the new rules for existing program participants, and consider appeals of their decisions. A primary purpose of establishing the CEATs was to provide more consistent and standardized decisions for caregiver program applicants. If a veteran or caregiver does not agree with the decision of the CEAT in their VISN, they may seek a clinical appeal that should be filed through their local VA patient advocate. The clinical appeal will be considered by the CEAT located in an alternate VISN, and that VISN’s Chief Medical Officer will make the decision based on the recommendations of that CEAT. If the veteran or caregiver is still not satisfied with the outcome of their first clinical appeal, they may file for a second clinical appeal, which would be reviewed by a second alternate CEAT in another VISN with the decision made by that VISN’s CMO.

In order to help determine how well this new caregiver appeals process is working, VA should be required to provide monthly reports on the number of such appeals, the disposition of these appeals, and the reasons for affirming or overturning eligibility determinations. We also have concerns about the notification and tracking

processes for such appeals. VA should be required to provide a standardized notification letter with eligibility decisions. For those who are denied, the notification should offer sufficient information to empower the veteran or caregiver to determine if and how to appeal that denial. Such notification must include a clear statement of the applicable laws and regulations; the factors and evidence considered; a clear explanation of the reasons and bases for the decision; an explanation of any additional evidence required to overturn denial; and a clear explanation of the process for filing a clinical appeal of the decision. The notification should be modeled after the decision notification provided to veteran claimants under 38 USC 5104(b).

According to VA, caregiver eligibility appeals will be entered into its Patient Advocate Tracking System (PATS), along with documentation of the appeal in the veteran's electronic health record. VA must ensure that the PATS system is sufficiently robust to handle the expected workload of appeals and that it is accessible to veterans and their representatives to track their appeals. VA must also ensure it seamlessly integrates with both the CARMA system and new EHR system.

Mr. Chairman, the success of the VA MISSION Act will depend heavily on the ability of VA and Congress to ensure the law is implemented as intended by all of the stakeholders involved in the law's creation. We continue to call on VA to improve its transparency as well as expand its consultation and collaboration with VSOs. Over the past eight months, the COVID-19 pandemic has significantly impaired VA's ability to implement some elements of the MISSION Act. VA and Congress must recognize those impacts as well as the changes in health care delivery that will be needed in the future. We must all allow VA sufficient time to analyze these lessons and when appropriate incorporate them into the ongoing implementation process of the VA MISSION Act.

In closing, we thank the Committee for inviting DAV to share our views on this issue and submit testimony for today's hearing.