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March 25, 2019

Director, Regulations Policy and Management (00REG)
Department of Veterans Affairs
810 Vermont Avenue, NW, Room 1063B
Washington, DC 20420

RE: Access Standards
(RIN 2900–AQ46)

The DAV (Disabled American Veterans) is pleased to respond to the Department of Veterans Affairs (VA) notice of proposed rulemaking on the above-referenced subject as published in the *Federal Register* on February 22, 2019.

DAV is a nonprofit Congressionally chartered veterans service organization (VSO) that provides a lifetime of support for veterans of all generations and their families, helping more than one million veterans in positive, life-changing ways each year. With nearly 1,300 chapters and more than one million members across the country, DAV empowers our nation's heroes and their families by helping secure the resources they need and ensuring our nation keeps the promises made to them.

On June 6, 2018, 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 ("MISSION Act"), Public Law 115–182, was signed into law. Section 101 of the MISSION Act amended Chapter 17 of title 38 United States Code (U.S.C.) to establish a new community care program to replace the Veterans Choice Program. This proposed rule would establish the criteria for determining when covered veterans may elect to receive such care and services through community health care entities or providers, as well as other parameters of this program. Attached are DAV's detailed comments to that proposed rule.

DAV joined with over 30 other veterans service organizations in support of the VA MISSION Act because it is a carefully balanced law designed to evolve veterans health care forward into the 21st century. However, given the many problems with the proposed regulation on access standards discussed in our comments, we suggest that VA revise the current proposed regulation to address critical flaws so that it fully and faithfully meets the VA MISSION Act's intent to expand access, ensure quality and sustain the VA health care system to meet veterans needs today and far into the future. Thank you for considering out comments.

Sincerely,

EDWARD R. REESE, JR.
Executive Director
Washington Headquarters

DAV COMMENTS ON PROPOSED ACCESS STANDARDS

EXECUTIVE SUMMARY

The VA MISSION Act (P.L. 115-182) was developed, debated, approved and enacted into law as the result of a broad, bipartisan consensus among all stakeholders – critically including veterans and the veteran service organizations (VSOs) who represent them. DAV and a coalition of more than 30 other veterans organizations supported this landmark legislation because it has the potential to expand access to and the quality of care provided to enrolled veterans by creating integrated networks of VA and community providers. The MISSION Act affirmed the central role of VA as the primary provider and coordinator of care and our support was predicated on assurances from Congress and VA leadership that the law would be fully and faithfully implemented, in full collaboration with all stakeholders. However, since the White House signing ceremony on June 6, 2018, VA has primarily acted to implement the MISSION Act unilaterally – rather than continuing to work in collaboration with Congress and VSOs.

As a result, the proposed regulation on access standards (RIN 2900-AQ46), if promulgated as currently written, would neither fully nor faithfully implement the law, nor achieve the broadly understood goals and objectives of the MISSION Act. Unless VA's new access and quality standards are realistic, feasible and sustainable, veterans will not realize improved access to care and are likely to end up with lower quality care than currently provided through the VA health care system, which itself could be weakened or endangered in the long term.

The proposed regulation contains a number of significant flaws. Parts of it are inconsistent with the underlying law, internally inconsistent between and within different sections of the proposed regulation and, not supported by sufficient justification or information to sustain critical assumptions behind the specific standards proposed. Further, VA has failed to offer a reasonable explanation or adequate information regarding its ability to operationalize these access standards. Most critically, VA cannot assure that enrolled veterans will receive medical care in the new Veterans Community Care Program (VCCP) networks that is at least as timely, accessible and of a commensurate quality as that provided directly by VA. The detailed comments that follow will address flaws in five critical parts of the proposed regulation: wait time access standards, drive time access standards, specialized care standards, quality standards and applicability of access and quality standards for VCCP network providers.

Therefore, in order to achieve the intended goals of the MISSION Act, VA should consider withdrawing the current proposed rule and swiftly replacing it with a new proposed regulation based on more realistic, feasible and sustainable access and quality standards. Further, in order to regain veterans' trust, we suggest the Secretary certify to veterans that both VA and VCCP network providers will be able to fully meet those standards. Until such time as the Secretary can make these certifications, VA should continue to use the current access standards governing the Veterans Choice Program (VCP) which are at least well known and understood by veterans and VA employees. In addition, VA should make better use of the "best medical interest" eligibility criteria, particularly the "unusual and excessive burden" factors included in the law, to address bias against veterans residing in rural, remote and frontier areas. Before VA implements new and untested access standards, it is vital to heed the Hippocratic Oath that the proposed rule must "first, do no harm" to veterans or the VA health care system so many choose and rely upon.

SYNOPSIS OF KEY COMMENTS

Wait Time Access Standards

VA's proposed wait time standards are predicated on an assumption that VA will be able to meet the wait time standard for every veteran inside VA facilities, with no veterans becoming eligible for the VCCP networks solely due to wait times. However, this assumption is not reasonably supported by facts or arguments in the proposed regulation, Regulatory Impact Analysis (RIA), or VA's Reports to Congress on Access Standards. In fact, information VA provided in the RIA argues against VA being able to meet these goals in the first year, despite VA's FY 2020 budget including no funding for wait times in the Medical Community Care budget request. Therefore, we suggest VA continue to use the current 30-day Choice wait time standards until the Secretary can certify to veterans the following:

Primary Care Wait Time (20 days):

- If VA continues to assume it will meet the proposed 20-day wait time standard for all veterans in FY 2020 and beyond, VA should first certify to veterans that it has actually met this wait time goal before designating it as an access standard; or
- VA should consider revising the wait time standard so that it is realistically achievable by VA and also by VCCP network providers, who should be required to meet the same wait time and quality standards as VA.

Mental Health Care Wait Time (20 days):

- In addition to the above wait time certifications, the Secretary should also certify to veterans that VCCP mental health providers will meet the same quality standards as VA, including training and certification on evidence-based protocols; and
- No private mental health care professionals should be admitted to practice in VCCP networks until they have satisfied all of these requirements.

Specialty Care Wait Times (28 days):

- For specialty care, similar to primary care, VA should first certify to veterans that it has actually met this wait time goal before designating it as an access standard; or
- VA should consider revising the wait time standard so that it is realistically achievable by VA and also by VCCP network providers, who should be required to meet the same wait time and quality standards as VA.
- In addition, VCCP networks specialty care providers should complete all of VA's training and certification requirements, particularly those on evidence-based protocols.

Drive Time Access Standards

Since the proposed drive time access standards would be a significant change compared to the current Choice distance standards, and since the proposed regulation, RIA and Report to Congress do not support VA's contention it is prepared to properly implement these changes, we suggest that VA consider pilot testing the proposed drive time standards at a small number of facilities or markets for a sufficient time period to:

- Verify of assumptions about how many veterans will be eligible; how many will elect to use the VCCP network; and what the costs are compared to budget estimates.
- Measure the adequacy of VA's systems and processes for eligibility determinations, scheduling, prompt payment and care coordination, including health information sharing.
- Certify to veterans that VA's IT systems capable of fully coordinating care for all anticipated veterans who will use VCP networks before expanding or rolling out the drive

time standards nationally; [NOTE: This would be similar to the provision in the MISSION Act requiring the Secretary to certify that IT systems necessary to support the mandated caregiver program expansion are tested and fully operational.]

- Consider the feasibility and advisability of revising national drive time standards to address local differences between geographic markets and facilities, as well as the reliance on modes of transportation other than individual automobiles.

Specialized VA Medical Services

The proposed regulation raises the question of whether VA should adjust access standards to: *ensure continued utilization of VA care and services that VA has a particular expertise in directly providing, such as VA's specialized care models for veterans with disabilities such as traumatic brain injury, posttraumatic stress disorder, and military sexual trauma."* Although the proposed regulation answers this question in the negative, we disagree and suggest that VA:

- Consider developing and designating different access standards to apply for VA's highly specialized care programs. Specifically this should include those enumerated in the regulation (TBI, PTSD, MST/women veterans health), but we also suggest including other medical services that VA has industry-leading expertise and experience treating with evidence-based treatments.
- Require that all non-VA providers in VCCP networks who will provide care for veterans in any of the above service lines meet the same quality standards as VA providers, including training, continuing education and credentialing requirements.

Quality Standards

Although the MISSION Act clearly required VCCP network providers to report and meet the same quality standards required of VA, the proposed regulations do not enforce compliance. In order to ensure that veterans can make informed decisions about providers in the integrated networks, and to ensure the quality of care from VCCP providers, we suggest the Secretary:

- Certify to veterans that VCCP network providers are meeting the same quality standards as VA providers, including training, continuing education and credentialing requirements;
- Ensure that VA and VCCP providers are reporting, and VA makes readily available to veterans, robust quality information that is important to veteran patients in making decisions about their health care; and
- Certify to veterans that quality comparisons between VA and VCCP network providers for the purpose of remediating VA medical service lines are available at the medical service line level and publicly available to affected veterans to review before extending eligibility for the VCCP network during a remediation.

Ensuring Non-VA Providers Meet VA Standards

In order to meet the clearly stated and well understood intention of the law requiring VCCP network providers to meet the same access and quality standards applied to VA, we suggest the Secretary certify to veterans that:

- A plan is in place to ensure that all VCCP providers meet VA's access and quality standards as a condition of treating veterans within the integrated networks; or
- That it is in best medical interest of veterans to make eligible certain VCCP providers despite the fact they are not able to comply with VA's designated access and quality standards.

DETAILED COMMENTS

WAIT TIME ACCESS STANDARDS

VA proposes to establish new wait time access standards that are more open than those used for eligibility to community care required by the Veterans Choice Program (VCP). Under the proposed rule, the wait time standard would be 20 days for primary and mental health care, and 28 days for specialty care; currently the VCP wait time standard is 30 days.

To justify these proposed wait time standards, VA states in the regulation (FR page 5643-5644) that these wait standards:

> *"…fall within the range of appointment wait time standards found in other government organizations, State programs, and commercial entities… [and] …are achievable in most VA facilities and are consistent with capabilities identified in the private sector."*

All three of these assertions are unsupported and contradicted by VA's proposed regulation, the accompanying Regulatory Impact Analysis (RIA) and the Report to Congress on Access Standards.

First, VA's comparison to "wait time standards in other government organizations, State program, and commercial entities…" is grossly misleading because VA is using the standards for an entirely different purpose. As VA states on page 7 of its March 2019 Report to Congress on Access Standards:

> *"There are important differences between how or why VA access would work versus how or why access standards are used for other programs… Commercial health care systems and plans, State Medicaid programs, State insurance departments, and other health care organizations use access standards to provide guidance for what constitutes network adequacy."*

In other words, access standards are normally used by regulatory bodies to help determine whether an insurer or health care system has adequate capacity to meet the needs of a target market, not to determine whether any individual enrollee should and could go outside the network at the expense of the insurer or provider. In its RIA (on page 4), VA states that network adequacy is usually defined by regulators as having to be able to meet the standards 80 to 90 percent of the time. However, in VA's Report to Congress, it states that, *"…VA access standards will be used to determine eligibility for community care for each Veteran, 100 percent of the time."*

Thus, when VA asserts that its proposed wait time access standards are near the middle of those it reviewed, it is figuratively comparing apples and oranges. If private health care insurers' networks were required to use their wait time standards in the manner VA proposes – for every enrollee 100 percent of the time – they would have significantly higher out-of-networks costs and would have to make significant changes in their rates, medical benefits package or service areas. As such, VA's comparison lacks probative value to determine if the proposed wait time standard is reasonable.

Second, VA creates a false impression that it will be able to easily meet the wait time standard. At both VA's March 11, 2019 budget briefing to VSOs and again at a meeting conducted by

VA's Office of Community Care (OCC) with VSOs on March 18, 2019, VA officials stated unequivocally that VA requested no additional funding for VA's FY 2020 Medical Community Care budget to pay for community care due solely to wait times because VA facilities would be able to provide access in its facilities within the wait time standard every veteran. But VA's proposed regulation undercuts this assertion on page 5644 of the Federal Register, stating that, "*… proposed wait-time standards are achievable in most VA facilities…"* and then states that *"On average, VA national wait times (as of December 2018) for new appointments (e.g., the first appointment in a new episode of care versus a subsequent appointment in the continuation of an existing episode of care) are approximately 21.6 days for primary care, 11.2 days for mental health care, and 23.2 days for specialty care."*

In its proposed regulation, VA misleadingly conflates, and thereby creates confusion, about, two very different measures that have apparently comparable numerical values: proposed wait time standard and current national average wait times. For example, VA states the "average" wait time for first primary care appointments is 21.6 days. With no other information from VA to define "average," we assume VA refers to the arithmetic mean which would typically require approximately half of all appointment requests to wait more than 21.6 days; whereas VA is proposing to meet 100 percent of all primary care appointment requests in 20 days or less. The assertion that VA's proposed wait time standard for primary care is "achievable in most facilities" is not supported by VA's current average wait times.

Further, VA underestimates how difficult it will be to meet wait time standards for every veteran every time they seek care. As noted above, VA officials indicated that a central component of its plan to reduce wait times is to hire additional primary care and mental health care providers. According to the RIA, VA's estimate of physicians needed is based on "Discussions with primary care and mental health care leadership…," but does not provide any data, assumptions or explanation to justify the estimated staffing increase. Moreover, VA itself goes on to state that the level required, "… may not be achievable in practice due to [non] availability of providers and space limitations." In regard to space limitations, it should be noted that VA's FY 2020 budget request significantly cuts funding for Major Construction, Minor Construction and Non-Recurring Maintenance.

Third, VA's assertion that the proposed wait time standards "…*are consistent with capabilities identified in the private sector…"* is not justified without additional data, information or explanation. VA offers no information about current wait times in the private sector, again appearing to conflate private sector access standards used for network adequacy with actual average wait times. In fact, in VA's Report to Congress on Access Standards, the Executive Summary states that, *"A 2019 study in the Journal of the American Medical Association (MAMA) show that VA wait times are shorter than those in the private sector in primary care and two of three specialty care areas."* The report only provides a sampling in 15 out of 383 metropolitan areas for appointments in primary care, and the three specialty care services—dermatology, cardiology and orthopedics—is but a fraction of all specialty care services VA provides. Because VA offers no evidence that the private sector is capable of meeting the proposed wait time standards, VA's assertion is unsupported.

Finally, VA is not properly prepared to ensure care coordination for the potentially large number of additional veterans who may choose or increase reliance on community care as a result of the proposed wait time standards. As noted above, VA's assumption that zero veterans will be eligible for community care based on wait time standards lacks any reasonable justification. It is instructive that VA does not even make the minimum concession that it will not have all of the

newly-hired primary and mental health care providers on the first day of the new fiscal year. In its RIA, VA clearly states that, *"…there is a large degree of uncertainty…"* in its forecasts of increased participation and reliance on the VCCP networks due to the new access estimates, further casting doubt on VA's preparedness to coordinate care to ensure positive health care outcomes for enrolled veterans.

VA further states that *"implementation plans must be clear in order for the forecast to be as accurate as possible."* However, VA has yet to offer information, much less clear or detailed implementation plans, for how it will ensure proper care coordination. For example, VA just recently submitted a reprogramming request to Congress to develop a number of IT systems necessary to make eligibility determinations, schedule appointments in the VCCP networks, share information between VA and network providers, provide robust clinical care coordination and ensure prompt payments requirements are satisfied. However, VA has also acknowledged that scheduling software is at least one year away and fully interoperable electronic health record (EHR) IT systems will require at least a decade, possibly more to be fully implemented.

Moreover, in its Report to Congress on Health Care Standards for Quality, VA indicates its intention that, *"Veterans [using the VCCP networks] as well as family members or caregivers have an ongoing relationship with an individual (case manager) that can keep them informed about each component of the care delivery team."* [page 10] According to this Report, for care provided to veterans in the VCCP networks VA will also ensure, *"…prompt communication of any conditions that might influence outcome and that care coordinator or other clinical expert will be promptly accessible if questions/concerns arise or co-management is needed"* VA will also, *"Ensure Community providers are aware of evidence-based guidelines for ongoing needs of Veterans and can consult with VA clinical experts as needed."* [Appendix B, page 2] However, VA has not offered any specifics in the proposed regulation, RIA or either Report to Congress about how it will meet the staffing requirements or successfully implement critical care coordination plans, much less the total costs for such plans.

In view of the proposed regulation's failure to demonstrate that proposed wait time standards would be realistic, feasible or financially sustainable, VA should continue to use the current 30-day wait time standards under the Choice program until the Secretary can certify that new wait time standards could be implemented in a manner that increases access, maintains quality and strengthens the veterans health care system.

DRIVE TIME ACCESS STANDARDS

VA proposes providing access to the Veterans Community Care Program (VCCP) for primary care and mental health services if a VA health care provider cannot furnish the required care or services within 30 minutes average driving time of the veteran's residence, and access to specialty care if a VA health care provider cannot furnish the required care or services within 60 minutes average driving time of the Veteran's residence.

VA states in the proposed regulation that it "*used the same rationale as TRICARE Prime in proposing its standards related to travel standards, opting to use time versus distance. Distance-based criteria do not recognize the inherent variation of driving speeds in rural versus urban areas. Traffic levels and speed limits allow rural residents to travel farther and faster than urban residents. The switch to average drive-time criteria versus distance provides a more consistent standard of access for urban and rural Veterans."*

In the proposed rule, VA considered the standards in the Veterans Choice Program (VCP), which measures timeliness of and distance to receive care. According to VA, under the existing access standards, veterans, particularly in rural areas, currently must travel farther to receive specialty care because they do not qualify for community care under the VCP distance criterion. For this analysis, VA measured the distance from the patient's home to the service needed, whereas noted above under VCP, VA currently measures the distance from the patient's home to the nearest VA medical facility with a full-time primary care physician.

We disagree with VA's assessment regarding veterans in rural areas traveling farther for specialty care because they do not qualify to use VCP under the distance criteria. The current distance based eligibility standard for the Veterans Choice Program are: The veteran lives 40 miles or more from a VA medical facility that has a full-time primary care physician; The veteran lives 40 miles or less (not residing in Guam, America Samoa, or the Republic of the Philippines) and either travels by air, boat, or ferry to seek care from his or her local facility or incurs a traveling burden of a medical condition, geographic challenge, or an environmental factor, or; The veteran resides 20 miles or more from a VA medical facility located in Alaska, Hawaii, New Hampshire (excluding those who live 20 miles from the White River Junction VAMC), or a U.S. territory, with the exception of Puerto Rico.

Furthermore, a veteran who becomes eligible under the VCP through the "40 miles or more distance" pathway may not have to go through the entire VA community care consult/referral (authorization) process.

These distance-based eligibility standards specifically benefit veterans living in rural areas by offering the veteran the option to seek any type of needed medical care closer to their place of residence from VCP community providers. VA supports this assertion in its final rule posting responding to a public comment that barriers created by the Choice Act disproportionately negatively impact rural veterans. VA states, "In this regard, the 40-mile distance criterion in the Choice Program regulations at § 17.1510(b)(2) is designed to address accessibility issues that affect rural Veterans. Particularly, the 40-mile criterion has been interpreted by VA to consider driving distance and not straight line distance (see 80 FR 22906, April 24, 2015), and to further interpret that this distance must be from a Veteran's residence to a VA medical facility that has at least one full time equivalent primary care physician (see 80 FR 74991, December 1, 2015). Both of these interpretations we believe increase the number of rural veterans eligible for the program, and VA otherwise actively seeks and documents the concerns of rural veterans that participate in the Choice program with its SHEP survey as described above. Therefore, we make no regulatory changes based on this comment.[1]

While it is likely true using the distance from the patient's home to the care or service needed "would assist VA in determining when covered Veterans can be served directly by VA and when covered Veterans can choose community care, thereby helping to ensure adequate health care access for covered Veterans" the same can be said of using the current VCP driving distance standard from the patient's home to the nearest VA medical facility with a full-time primary care physician. In fact, the number of community providers in VCP has grown to nearly 100,000 since this distance-based standard has been implemented to ensure veterans have adequate access to needed primary and specialty care.

[1] https://www.federalregister.gov/documents/2018/05/11/2018-10054/expanded-access-to-non-va-care-through-the-veterans-choice-program

Furthermore, the proposed benefit in this particular instance is overwhelmingly negated as it proposes to replace the current standard that has been in place for nearly five years and is well understood and accepted.[2] Proposing such a replacement acquires other factors that weigh against it to include additional costs in education and training to properly implement the new standard, new costs for development of information technology and subsequent sustainment, and will likely result in confusion and frustration that will invariably ensue among the veteran enrollee population due to the proposed drive time standard that remain ill-defined as we discuss below.

The basis of the drive time eligibility standard that would allow enrolled veterans to elect care in VCCP is the definition of an "average drive time estimate" from the veteran's residence to the care or service needed—if VA cannot schedule an appointment for the covered veteran with a VA health care provider for primary care, mental health care, and non-institutional care within 30 minutes "average driving time" of the veteran's residence, or for specially care within 60 minutes "average driving time" of the veteran's residence.

According to VA, *"The average driving time…would be calculated by using the geographic information system software to calculate the average drive time from the veteran's residence to the applicable VA facility, based on predictive traffic patterns from historical data, as opposed to real-time traffic conditions."*[3] However, VA states it cannot be more specific in naming the system software or describing its methodology because it is proprietary. In light of existing open source/publically available GIS software, this proposed rule does not provide the public sufficient information to determine whether the proposed rule is necessary, the costs and benefits of the proposed rules, and the benefits of other policy alternatives (including maintaining the status quo).

The proposed rule did not provide the specific parameters to define the quickest path; however, it does provide some basic parameters for the calculations such as the "quickest path from the residence to facility and to calculate the driving time and distance between the two locations."[4] However, it does not provide any appreciable information that such calculations considered other modes of transportation, such as veteran enrollees' use of publicly available transportation or paratransit, or time of day, weather, or other conditions that affect a veteran enrollee's drive time to a VA facility.

For example, DAV provides injured and ill veterans with free rides to and from VA medical facilities through the DAV Transportation Network, which is staffed by volunteers who also are veterans and relies on 178 hospital service coordinators at VA medical centers across the country to oversee the DAV Transportation Network. This program provides free transportation to and from VA health care facilities to veterans who otherwise might not be able to obtain needed VA health care services. In 2018, volunteer drivers spent over 1.4 million hours transporting veterans to their VA medical appointments. These volunteers logged nearly 17.7 million miles and provided more than 625,000 rides to veterans to VA health care facilities, saving taxpayers more than $34.6 million. Similarly, VA's own Veterans Transportation Service (VTS) launch in 2010

[2] https://www.federalregister.gov/documents/2015/04/24/2015-09370/driving-distance-eligibility-for-the-veterans-choice-program. VA issues interim final rules modifying how VA measures the distance from a veteran's residence to the nearest VA medical facility. This modification considered the distance the veteran must drive to the nearest VA medical facility from the veteran's residence, rather than the straight-line or geodesic distance to the VA facility.

[3] 84 Federal Register at page 5644

[4] Economic Regulatory Impact Analysis for RIN 2900-AQ46(P), Veterans Community Care Program page 13.

to enhance, coordinate and, in some cases, provide transportation to VA medical centers is especially intended to benefit veterans who are visually impaired, older adults, immobilized due to disease or disability, or who live in rural areas.

The proposed rule appears to acknowledge certain variations from its proposed "computer generated best route" but fails to provide sufficient accurate and precise information that would allow the public to determine how the these other-than-private-transit options are considered in determining drive times and how such other transportation options affect the cost and benefit of this rule. Without clear consideration of these options in drive time, we believe at the minimum the 625,000 rides to veterans to VA health care facilities that were provided by the DAV Transpiration Network in 2018 as well as other the untold number of veterans seeking care at VA using public transit will be negatively impacted.

Finally, VA offers its method of determining average drive times for purposes of estimating the cost impact but admits that it may not be the same as the method VA will use for purposes of determining a covered Veteran's eligibility for the Veterans Community Care Program.[5]

Again, we believe this proposed rule must provide the public accurate and precise information on the method VA will actually use in determining the veterans eligibility for using VCCP. Withholding such information from the public curtails substantive comments and the offering of critical information to aid in the VA's analysis and in the development of these rules.

STANDARDS FOR SPECIALIZED CARE

VA declined to designate standards of access for VA's specialized care models including those for traumatic brain injury, posttraumatic stress disorder and military sexual trauma in addition to VA Centers of Excellence such as Polytrauma Rehabilitation Centers, noting in the proposed rule (p. 5645 of the Vol. 84 of the Federal Register) "there are far fewer Centers of Excellence than VA medical centers, and as there would be fewer locations in relation to the total number of veterans nationwide, travel distances for veterans to these Centers of Excellence could in many cases exceed the designated access standards in this rule." Instead, VA notes that "the general specialty care access standards would apply. Moreover, veterans would be made aware if such care was available from VA outside of the designated access standards to be fully informed of their options prior to electing to receive care in the community or in VA."

DAV believes this determination oversimplifies these models of care which are generally based on a "Hub and Spoke" model in which a designated regionalized center provides the most complex and intensive care, but trains and supports additional providers throughout a network to provide ongoing acute and primary care to the populations served closer to their homes. Many of the programs referenced have specific Patient Aligned Care Teams (primary care) associated with them (for example, amputation care, spinal cord injury and women veterans programs). Many are also assigned to coordinators (veterans who have experienced military sexual trauma or those at high risk of suicide, for example) or case managers (veterans with chronic symptoms of traumatic brain injury, spinal cord injury, blindness, or polytrauma) to ensure that veterans receive needed care and supportive services for issues often associated with their conditions.

Like other programs within the VA medical care system, determining standards for specialized care models in isolation from programs that support them also tears at the fabric of the integrated

[5] Economic Regulatory Impact Analysis for RIN 2900-AQ46(P), Veterans Community Care Program page 13.

are models VA has constructed to serve veterans with these needs. For example, mental health programs deploy providers to integrate behavioral medicine into VA's primary care programs. This allows these providers to quickly screen for common conditions such as traumatic brain injury, post-traumatic stress, military sexual trauma and substance use disorders and refer veterans who may need immediate mental health care to appropriate services for further evaluation, diagnosis and treatment. Many VA mental health providers have been trained to provide evidence-based clinical protocols for PTSD, depression and other common mental health issues—private sector providers seldom have access to such training. Polytrauma centers rely upon a variety of medical specialists, mental health providers and social workers in addition to a variety of therapists from physical and occupational, to speech and language, to vocational and recreational therapists and prosthetists to ensure holistic management of patients recovering from severe injuries. Services for women's veterans are unique and VA's specially trained providers have in-depth knowledge about this subpopulation of veterans—such as the increased likelihood of their exposure to military sexual trauma, intimate partner violence, eating disorders and the complications that could affect these veterans' fertility or pregnancies. DAV believes that access to such specialized care may be worth a reasonable wait time or additional drive time especially given the unknown state of such standards at individual community providers.

Using access standards for specialty care to determine eligibility for programs in the community could drastically undermine the patient volumes necessary to ensure the highly specialized programs serving smaller populations (spinal cord injuries, traumatic brain injuries, polytrauma, amputation and some women's programs) remain optimally available for all veterans that depend upon them. In fact, it also runs counter to trends in leading private sector health care organizations including the Mayo Clinic, Cleveland Clinic and Cancer Treatment Centers of America and others who are defining new service line "super-specialists" who provide value-based care to much larger catchment areas and refer patients back to primary care or specialists in their communities after highly specialized interventions (for cardiac surgery, for example) with detailed discharge plans. They combine all the associated specialties within one location to ensure a holistic and synergistic approach to managing patients with complex care issues. They may even pay for travel for a patient and an aid to ensure adequate patient volume to support lower costs and high quality for these highly specialized care centers. These leading edge practices embrace the same type of "bundling" as many of VA's integrated care models (such as those for polytrauma and spinal cord injury).

VA must take a more refined approach to ensuring appropriate access to highly specialized services within VA focusing upon veterans' satisfaction and the quality of care offered within them maintaining ongoing dialogues with veterans' representatives. These are comprehensive models that generally far surpass or differ from anything that exists in the private sector. VA must continue to sustain its referral patterns to assure appropriate patient volumes and maintain their quality and availability.

QUALITY STANDARDS

VA reported "Health Care Standards for Quality (MISSION Act, Section 104) to Congress as required in March 2019. These standards were developed without input from Congressionally chartered veterans service organizations and failed to identify any clear standards it will use to determine whether non-VA providers in its network will be able to meet VA's standards for care.

In fact, the report states: *"Overburdening VA and non-VA providers with new measurement and reporting requirements is a widespread concern. Many providers report quality measures under Medicare quality programs. Forcing them to accelerate their pace of quality measure reporting, beyond what they are doing for Medicare or Tricare, as a pre-condition for seeing Veterans under the provisions of the MISSION Act, will have a significant negative impact on their participation."*

The report also asserts that most providers, including VA, only report data at the organization level (group practice, hospital or facility or health facility) rather than at the level of individual practitioners or specific medical service lines and that quality measures must account for important population differences such as age and comorbidities. It addresses the importance of care coordination in ensuring the care of veterans using more than one system is not fragmented. Finally, it states that quality will become easier to measure in future years as VA implements an interoperable electronic health record.[6] In the interim, the report suggests VA will rely upon "community benchmarks" to determine if care should be rendered within VA or in the community.

VA is one of the first health care organizations to have an enterprise-wide set of measures comparing different aspects of quality at different levels of the organization. While the private sector uses many of the tools VA uses to measure quality, including Hospital Compare, Healthcare Effectiveness Data Information Set (HEDIS), Nursing Home Compare, patient-reported experience data and VA facility quality data (such as Commission on Accreditation of Rehabilitation Facilities, Joint Commission, and other measures), there may be important differences in how VA defines and collects such data. It is also likely to have to adjust quality measurements appropriate for the increased risk, due to age and complexity, of patients it serves.

The private sector is just beginning to look at how it measures and reimburses care according to the "value" of the care received rather than the volume of services offered. The Core Quality Measures Collaborative[7] is assessing services lines such as primary care; cardiology; gastroenterology; HIV and Hepatitis C; obstetrics and gynecology; and orthopedics—this may be the new "wave" of quality measurement and VA is correct when it asserts it must maintain flexibility in measuring quality because it is constantly evolving. But consensus and refinement of measures derived through health care community efforts may be years away. It may take large federal payers such as Medicare and VA to drive the industry to make needed reforms.

In determining its access standards, quality standards are referenced only with regard to determining eligibility for veterans in the proposed rule under § 17.4010(a)(6) depending upon "whether VA medical service lines were identified by VA as underperforming in accordance with timeliness standards when compared with the same VA medical service lines at other VA facilities and based on two or more distinct and appropriate quality measures of VA's standards for quality when compared with non-VA medical service lines."

If veterans sought care from a VA facility with an underperforming service line, VA could authorize them to receive the care from a non-VA partner. VA would be unable to determine,

[6] VA is in year 1 of a 10-year, $16 billion implementation timeline for interoperable medical records.
[7] America's Health Insurance Plans (AHIP) and its member plans' Chief Medical Officers convened leaders from The Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum (NQF), as well as national physician organizations, to form The Core Quality Measures Collaborative in 2014. This collaborative represents 70% of fee-for-service Medicare beneficiaries and health plan enrollees. The Collaborative is working to define health care outcomes that are the most meaningful to patients.

however, whether care from a particular community provider was better or worse than the VA care they would be provided since quality measurement, at this point, is not discrete enough to determine quality at the service line level in VA or elsewhere. Instead it would use "community benchmarks"—averages determined from participating commercial and Medicare providers- to make such determinations. Any one community provider could offer a standard of care that was much lower or higher than VA. In DAV's view, this does not satisfy the Congressional intent of making informed decisions when it determines service lines are "underperforming." Instead of comparing VA to a community partner the determination is only made looking at VA service lines as compared to service lines in other VA facilities. It allows no understanding of quality (or timeliness) for the service from individual community providers. DAV rejects the notion that this process fulfills the law under §1703B(2)(b) calling for access standards that provide both VA and network providers "with relevant comparative information that is clear, useful, and timely so that covered veterans can make informed decisions regarding their health care."

DAV believes that given the evolving state of quality measurement in the non-VA medical community and the underdeveloped state of VA's information technology necessary to schedule, coordinate care, and share patient medical records, Congress should delay implementation of veterans' eligibility for services under the proposed rule § 17.4010(a)(6) until VA's community partners are able to produce truly comparative data to allow the "informed decisions" about health care envisioned by Congress. In the meantime, VA should use its data to identify and remediate underperforming service lines.

ENSURING NON-VA PROVIDERS MEET VA STANDARDS

A central principle of the MISSION Act is that VCCP networks must be capable of delivering timely and quality care that matches or exceeds the standards VA establishes for itself, as clearly spelled out in Section 104 – ACCESS STANDARDS AND STANDARDS FOR QUALITY. The new 38 USC 1703B states that:

> *"The Secretary shall ensure health care providers specified under section 1703(c) [i.e. – VCCP network providers] are able to comply with the applicable access standards established by the Secretary."*

Similarly, new 38 USC 1703C(a)(1) states that:

> *"The Secretary 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 pursuant to section 1703*** *[emphasis added] of this title."*

Furthermore, see reinforcing language at 38 USC 1703(h)(3)(A):

> ***"(h) Contracts To Establish Networks of Health Care Providers.--***
> *(3)(A)* ***The Secretary may terminate a contract*** *with an entity entered into under paragraph (1) at such time and upon such notice to the entity as the Secretary may specify for purposes of this section,* ***if*** *the Secretary notifies the appropriate committees of Congress that, at a minimum-*
> ***(i) the entity--***

(I) failed to comply substantially with the provisions of the contract or with the provisions of this section and the regulations prescribed under this section;
(II) failed to comply with the access standards or the standards for quality established by the Secretary;" *[emphasis added]*

Clearly, the law intends that that non-VA providers in the new VCCP networks be held to the same standards – for both access and quality – as VA is held. After all, it makes no sense to offer a veteran the option to go into the VCCP network for care when VA can't meet an access or quality standard, if the local VCCP network itself is not able to meet that standard. Such a result could lead to delayed care, lower quality care and worse health outcomes for veterans.

However, in the proposed regulation, VA does not fulfill this well-understood intention of the law, and instead allows VCCP providers to meet lower and nonspecific access and quality requirements. Proposed § 17.4030, Eligible Entities and Providers, as explained by VA:

> *"…would require that the non-VA entity or provider be* ***accessible*** *to an eligible veteran.* ***VA would make determinations regarding accessibility*** *by considering the length of time the veteran would have to wait to receive care or services from the entity or provider; the qualifications of the entity or provider; and the distance between the eligible veteran's residence and the entity or provider. This language would be substantively identical to § 17.1530(c), which requires that non-VA entities or providers in the Veterans Choice Program be accessible to veterans eligible under that Program."[emphasis added]*

Rather than applying the proposed access standards on community providers, VA instead states that in order for a non-VA provider to be eligible to participate in the VCCP network they must be "*accessible*," and then loosely describes the attributes of what "*accessible*" will mean. Further, VA states that it *"would make determinations regarding accessibility"* without any reference to the proposed access standards as the benchmark, despite the statute clearly stating that VA, *"…may terminate a contract with a [VCCP provider that] … failed to comply with the access standards or the standards for quality established by the Secretary."* By indicating that VA will use the standards required under the current Choice program, VA is acknowledging that it will not fulfill the law's requirement to hold VCCP providers to the same access and quality standards required of VA providers. This becomes especially troubling when it comes to provision of VA's foundational services, understood to be core services – including primary, mental health and highly specialized care services – that VA has provides industry-leading care to veterans through evidence based treatments.

To assure VA meets the mandate of the law, VA should revise the proposed regulation so that eligibility for providers to join the VCCP networks requires compliance with the same access and quality standards designated by VA. Before the new access and quality standards can be implemented, the Secretary should be required to certify in a report to Congress that a plan is in place to ensure all VCCP providers comply those standards, or that it is in veterans best medical interests to make eligible certain VCCP providers despite the fact they are not able to comply with VA's designated access and quality standards.

CONCLUSION

The proposed regulation, as currently written, would designate access standards that are not realistic, feasible or sustainable. Because VA's wait time standards would be used differently than other governmental and private wait time standards, they are not comparable for purposes of determining if they are realistic. VA's drive-time standards are also used different than any other system, and in addition raise serious questions about whether VA would be able to implement such untested standards in a single national rollout all at once. VA's failure to include quality standards further raise questions about whether the VCCP networks would be able to sustain the same level of care that VA has proven capable of providing. VA's specialized care services must be protected and sustained because in many cases, there is no comparable non-VA model of care. Finally, it is unreasonable, unrealistic, and unsustainable to exempt VCCP networks and providers from the access and quality standards VA must meet in order to provide veterans with the best health outcomes possible.

The VA MISSION Act was a carefully balanced law designed to evolve veterans health care forward into the 21st century. However, given the many problems with the proposed regulation on access standards discussed above, we suggest that VA revise the current proposed regulation to address critical flaws so that it fully and faithfully meets the intent of the VA MISSION Act to expand access, ensure quality and sustain the VA health care system to meet veterans needs today and far into the future.

Passage of the VA MISSION Act represented a collective agreement to eliminate confusion in eligibility for veterans to receive care in the community, sustain VA as the primary provider and coordinator of veterans health services, and maintain VA as the foundation of a high-performing integrated healthcare network with community providers. To successfully achieve this end, the entirety of VA must be adequately funded to every part of the VA healthcare system continues to meet veterans needs. The RIA itself is predicated on a fully funded and staffed VA to maximize access to internal VA care in order to virtually eliminate any budgetary impact the wait time standards may have. Furthermore, limitations and the reductions in capital infrastructure funding being requested for fiscal years 2020 and 2021 will increase the budgetary impact of the drive time standards beyond that currently contemplated by the proposed rule. In addition, we are concerned with VA's inability to properly estimate costs of community care. For the Veterans Choice Program, Congress had to rush to act twice to provide emergency funding VA did not properly forecast and estimate veterans demand for care. We believe VA should have included in its proposed rules a contingency plan if the demand for care under its proposed designated access standards exceeds available resources.

Ultimately, the VA health care system must continue to evolve to meet the changing needs of veterans in the future. The VA MISSION Act received broad bipartisan support from all stakeholders because it was developed in a truly collaborative process. In order for the proposed regulation to succeed, VA should once again work closely with Congress, VSOs and all veteran stakeholders to address questions and concerns so that the law is fully and faithfully implemented.