

# **DEPARTMENT OF VETERANS AFFAIRS**



## **Congressionally Mandated Report: Access to Care Standards**

**September 2022**

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## **Abbreviations**

ACA	Affordable Care Act (Patient Protection and Affordable Care Act, P.L. 111-148)
ATC	Access to Care
CCN	Community Care Network
CDW	Corporate Data Warehouse
CMS	Centers for Medicare & Medicaid Services
DAV	Disabled American Veterans
DHA	Defense Health Agency
DoD	Department of Defense
EHCPM	Enrollee Health Care Projection Model
FY	Fiscal Year
HHS	Department of Health and Human Services
IHS	Indian Health Service
IPM	Interim Procedures Memorandum
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
MTF	Medical Treatment Facility
ORH	Office of Rural Health
PHE	Public Health Emergency
RCI	Referral Coordination Initiative
TNAA	Third Next Available Appointment
TPA	Third-Party Administrator
USC	United States Code
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs Medical Center
VCCP	Veterans Community Care Program
VHA	Veterans Health Administration
VSSC	VHA Support Service Center Capital Assets

## Executive Summary

The Department of Veterans Affairs (VA) is committed to serving Veterans, their families, caregivers and survivors as they have served our country. The President has called this a sacred obligation with a mission that unites us all.

The population of Veterans that VA serves varies widely and presents health challenges specific to military service and a high percentage of Veterans choosing to live in rural areas, among other factors. This unique population requires VA to be exceptionally proactive and innovative to achieve meaningful health care access and outcomes for each Veteran entrusted in our care. As the population VA serves continues to evolve, we must cultivate a thriving system for current and future generations of Veterans, across both direct and community care.

The John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, P.L. 115-182, (the VA MISSION Act) added 38 U.S.C. 1703B on June 6, 2018. 38 U.S.C. § 1703B requires VA to establish access standards for furnishing hospital care, medical services, or extended care services to covered Veterans under the Veterans Community Care Program (VCCP). As part of this effort to establish access standards, per § 1703B(c), the Veterans Health Administration (VHA) consulted with pertinent Federal entities, entities in the private sector and other nongovernmental entities in establishing access standards. VA designated the appointment wait-time and average drive time access standards shown in Table 1 below through a rulemaking that became effective on June 6, 2019, at 38 C.F.R. § 17.4040. Eligible Veterans who cannot access care within these access standards are able to choose between eligible community providers and care at a VA facility.

**Table 1: Current Designated Access Standards**

Average Drive Time to the Nearest VA Facility		VA Facility Wait-Times	
Primary/Mental Health/Non-institutional Extended Care	Specialty Care	Primary/Mental Health/Non-institutional Extended Care	Specialty Care
30 minutes	60 minutes	20 days	28 days

Section 1703B(e) further requires VA, not later than 3 years after the date on which VA establishes access standards, and not less frequently than once every 3 years thereafter, to conduct a review of the designated access standards and submit to the appropriate committees of Congress a report on the findings and any modifications to

the standards. This report meets this requirement in detailing VA's review of its access standards. VA's review of the access standards included the following components:

- Analyzing Veteran experience with direct and community care;
- Consulting with pertinent Federal entities, entities in the private sector and other nongovernmental entities;
- Researching the current state of telehealth, which became especially important as a result of the COVID-19 pandemic;
- Publishing a request for information in the Federal Register on November 4, 2021 (86 FR 60970);
- Conducting a public meeting on December 1, 2021 (86 FR 63105);
- Conducting stakeholder meetings with VA staff;
- Researching State health care programs; and
- Modeling various scenarios of drive time and wait-time access standards, to include the current standards.

Based on Veteran, VA employee, and public feedback, analyses of internal VA data and trends, and consideration of best practices elsewhere in government and the private sector, VA is proposing no immediate changes to the current designated access standards. However, we are planning to propose incorporating VA telehealth availability into determinations regarding eligibility based on the designated access standards. We will welcome public and Congressional input on this proposal. VA will also actively assess the impact of the designated access standards on Veteran care on an ongoing basis, including as U.S. health care continues to evolve due to multiple public health emergencies, and we will continue to keep Congress apprised of our work.

### **A World-Class Workforce Centered on Veterans**

VHA's approximately 380,000 employees, one-third of whom are Veterans themselves, come to work every day with one goal in mind: to serve Veterans, their families, caregivers and survivors. VHA employees prove daily that they will face any challenge and go to any length—including during the worst pandemic in more than 100 years—to ensure Veterans receive the care and services they have earned and deserve. Despite the strain of the pandemic, VHA employees worked tirelessly to ensure that Veterans received care—deferring time off and retirement out of their own sense of dedication—and this passion is unwavering still today. A recent study in *The Lancet Regional Health* found that our employees succeeded (Feyman, 2022), and VA's strategy likely saved Veteran lives. Today, VA is providing more care, benefits and services to Veterans than ever before.

Hailing from communities across the Nation, the population of Veterans VA serves is unique, with health challenges specific to military service and a high percentage of Veterans choosing to live in rural areas, among other factors. For example, according to

the Health of Those Who Have Served Report 2022 (America's Health Rankings - United Health Foundation, 2022), compared to the general civilian population, Veterans:

- Experience almost twice the rates of increase in mental health challenges, as compared to the general civilian population, with female Veterans self-reporting higher rates of mental health challenges;
- Are more likely to experience physical health challenges, including higher rates of chronic disease and chronic pain, and lower rates of being able-bodied;
- Have higher rates of uptake of preventive clinical services (e.g., colorectal cancer screenings, annual dental visits and flu vaccines); and
- Have higher rates of substance use (e.g., excessive drinking and tobacco use).

The unique health challenges of Veterans require VA to be exceptionally proactive and innovative to achieve meaningful access and outcomes for each Veteran in our care. Furthermore, the population we serve continues to evolve, with record numbers of women Veterans enrolling in VHA health care and VA's work with Congress, Veterans Service Organizations and other stakeholders on military environmental exposures enabling Veterans to seek care more easily for health concerns incurred during military service. VA is committed to cultivating a thriving health care system for current and future generations of Veterans across both direct and community care.

### **Access to Trusted, High-Quality Care**

As VA strives to lead through the global COVID-19 pandemic and beyond, we want Veterans to know that our sacred obligation includes ensuring access to high-quality health care they trust—whether they are in a VA facility, receiving VA care virtually or seeking care in the community. Community care is an essential element of Veteran access to care, and VA is proud of the more than 1.2 million health care providers who serve Veterans in the community and supplement the excellent care provided through VA's direct care system. However, Veteran trust in community care lags behind trust in VA's direct care system, and quality of care is more difficult to measure and monitor given that private sector systems generally do not collect or report the depth of quality data that VA shares for its direct care system. VA desires to provide Veterans with comparative information to inform their health care decisions, but such information from the private sector remains limited at this time.

Peer-reviewed studies provide the best window into comparative quality, and VA direct care has been consistently shown to outperform most private sector hospitals in core measures of inpatient quality of care. VHA also achieves superior levels for important inpatient safety measures (e.g., surgical complications) compared with the private sector. Multiple peer-reviewed scientific studies demonstrate that the quality of health care Veterans receive from VA is as good, if not better, than what is available outside VA direct care—inpatient care, outpatient care, surgery, mental health and emergency care.

A 2018 study published in the Journal of General Internal Medicine found that VA hospitals generally provided better quality care than non-VA hospitals and that VA's outpatient services were of higher quality when compared to non-VA hospitals or non-VA outpatient centers. VA performed better on patient safety, inpatient mortality and inpatient effectiveness than non-VA hospitals and, for outpatient care, VA performed better than non-VA sites in preventive care (cancer screenings) as well as diabetes, cardiovascular disease and depression management (Price, 2018). Another study published in the Journal of Surgical Research in 2020, which compared surgical safety and patient satisfaction indicators at 34 VA medical centers (VAMC) with 319 nearby non-VA hospitals in three disparate regions of the United States, found that VAMCs matched or outperformed neighboring non-VA sites in surgical quality metrics and patient satisfaction ratings in all three regions (Eid, 2020).

Regarding mental health care, a 2019 study published in the journal Medical Care concluded that patients hospitalized in inpatient psychiatric units in community-based general hospitals were twice as likely to experience adverse events or medication errors as Veterans on inpatient mental health units in VHA hospitals (Cullen, 2019).

When it comes to emergency care, an important study published earlier this year showed that Veterans requiring emergency care who were transported to VA hospitals had a substantially lower risk of death within one month than those transported to non-VA hospitals (Chan, 2022), which corresponds to a 20% lower mortality rate among Veterans taken to VA hospitals. The advantage was particularly large for Hispanic and Black patients, older patients and patients who arrived with relatively low mortality risk.

While these quality achievements are a clear demonstration of VA's long-standing commitment to excellence in providing care through VA facilities, it also means VA must closely monitor Veteran experience and available indicators of quality of care from community providers. Through the Third-Party Administrators (TPA) that manage our Community Care Network (CCN), VA tracks and trends available patient safety and quality data for Veterans receiving care in the community. VA also oversees Clinical Quality Monitoring Plans implemented by the TPAs, which are required to include quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement and peer review. The TPAs' Clinical Quality Monitoring Plans must include a detailed description of the purpose, methods, proposed goals and objectives designed to ensure the highest quality of clinical care for Veterans seeking care in the community. Further, under the contract, TPAs must identify, track, trend and report interventions to resolve any potential or identified quality issues using the most current quality measures, including Serious Reportable Events, Hospital Acquired Conditions as reported to the Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality Patient Safety Indicators.

In an effort to enhance community care quality, VA has also made internal clinical training available, free of charge, to community providers across the country and has

created focused training on traumatic brain injury, post-traumatic stress disorder, military sexual trauma, suicide prevention and military culture. VA also collects and reviews Veteran experience information in the community and analyzes customer experience data and insights in real-time to inform service recovery and performance improvement efforts.

Importantly, the Government Accountability Office, health care literature and VA's proactive assessment of Veteran experience all indicate that fragmentation in the experience of health care is inherently at odds with quality. Veteran feedback shows that Veterans seeking care in the community sometimes experience difficulties retrieving records of the care received from a community provider or struggle to get an external clinician to coordinate with their VA team. Despite VA proactively and securely sending necessary clinical information to a Veteran's community provider, duplicative tests occur, and some Veterans are offered care for which community providers unexpectedly and improperly bill them. Fragmentation of care is known to be a barrier to quality, but importantly, Veteran feedback also shows that this fragmentation is a stressor for Veterans.

Veteran Experience analysis, generated from surveys of VA direct care, community care and telehealth, as well as Veterans Signals (VSignals), demonstrates the following:

- Veterans trust VA to provide equal or better care than in the community;
- Veterans are satisfied with the care they receive in VA;
- Veterans trust telehealth and the modalities of telehealth service delivery VA offers;
- Veterans are satisfied with telehealth as a component of overall care; and
- Veterans find accessing direct care is easier than accessing community care.

## **Health Care Trends**

The VA MISSION Act changed how VA furnishes care through community providers. Three years after the VA MISSION Act's implementation, VA's analysis shows that this landmark law has perpetuated and in some cases accelerated trends that have been observed over the last decade: 1) Veteran reliance—or the amount of health care for which Veterans rely on VA—has been growing, while total enrollment has remained relatively stable over the same time period; 2) VA direct care is growing, but community care is growing at a faster rate; 3) growth is not uniform across the country; and 4) Veterans are experiencing fragmentation of care, with trust scores for community care lagging behind the direct care system. These observations will be evaluated in greater depth over the coming months, and VA will continue to work to understand the effects of COVID-19 on these trends.

VA strives to center everything we do on Veteran experience, access and outcomes. It is extremely important to note that community care growth does not appear to be



predominantly due to Veteran preference, but instead may be influenced by operational factors (e.g., distance to the nearest VA emergency department). VSignals (Veteran experience) data indicates that while Veterans are generally satisfied with both direct care and community care providers, Veterans generally have higher trust in VA's direct care system.

Based on analyses resulting from Corporate Data Warehouse (CDW) and VHA Support Service Center Capital Assets (VSSC) data, from fiscal year (FY) 2014 to FY 2021, the number of community care authorizations increased by 161%, and the number of Veterans authorized to seek community care increased by 86%. Community care appointments now represent more than one-third of all appointments VA provides to Veterans. Last fall, the Congressional Budget Office published a report that examined the effects of VA's changing policies toward community care and "determined that since 2014, Veterans' access to community care has expanded significantly" (Congressional Budget Office, 2021).

Since VA implemented the VA MISSION Act in June 2019, more than 3.4 million Veterans have received care through community providers, including through the use of emergency department and walk-in care options. Moreover, the number of Veterans being authorized to use community care has increased every year since 2014 with a record high number of authorizations made and appointments completed—the latter, more than 33 million—in FY 2021.

To better understand the impact of the growth in community care, VHA conducted an analysis of FY 2021 workload provided in both VHA and community care settings. According to the VA Enrollee Health Care Project Model (EHCPM), while the percentage of care provided through community care would have been slightly lower if the COVID-19 pandemic had not occurred, it is significant to note that VA is rapidly approaching a point where one-half of all care available in both settings is provided through community care. Operational leaders already note concern for the potential of a "spiral effect" in some areas, where workload and talent are shifting externally and thus threaten to harm VA's training, research and emergency preparedness missions.

Even in the absence of resource constraints, if the balance of care provided in the community continues on its current upward trajectory, we anticipate that certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity.

### **Approach to Improving Timeliness of Care**

While VA has generally performed well when coordinating urgently needed care for Veterans, there remain opportunities to improve the timeliness of routine, non-urgent, care in both the direct and community care settings. Making broad assessments about the timeliness of routine care referrals, in general, has several inherent challenges. For

example: a visit to a cardiologist for pre-operative clearance for surgery in someone with an underlying cardiac disorder is not necessarily at the same level of priority as a non-urgent screening colonoscopy in a low-risk patient, but it is difficult to stratify non-urgent visits with full consideration of these nuances.

Nonetheless, VA data have shed further light on opportunities to improve care timeliness for Veterans both in VA's direct care system and in the community. For example: VA's process of scheduling appointments internally is, on average, much faster than VA's process for scheduling appointments in the community. However, Veterans receiving care in VA's direct care system often wait longer between the date that they receive their confirmed, scheduled appointment and the date of their actual appointment. Understanding the unique areas in VA's appointment processes that can be streamlined will help optimize access to care in both the direct and community aspects of the system. For example, a focus on addressing staffing needs, provider availability and clinical productivity would most meaningfully impact overall wait-times in the direct care system. While ensuring community network adequacy continues to be a priority, it is particularly imperative that the process for scheduling appointments in the community be streamlined. VA's Office of Integrated Veteran Care is focused on these precise opportunities in order to effectively improve care timeliness for Veterans, regardless of their care setting.

VA remains committed to achieving greater transparency in the information provided to Veterans and the public. To enhance transparency around care timeliness and more, VA began publishing average wait-times for primary care, mental health and specialty care appointments at each of its VAMCs in 2014. Since that time, VA has received feedback from Veterans, caregivers, Veterans Service Organizations, oversight authorities and Congress that led the Department to initiate efforts to revise the wait-time metrics presented on the Access to Care (ATC) website ([www.accesstocare.va.gov](http://www.accesstocare.va.gov)) to better reflect Veterans' experience when seeking VA health care.

As part of the ATC website redesign, VA conducted focus groups with a diverse group of Veterans by age, service era, race/ethnicity, utilization type (in-person and telehealth), gender and geography. In response to this feedback, as of July 19, 2022, VA made changes to the ATC website to update how the Department presents access information to Veterans. In addition to updating the average wait-time calculations themselves and adding the Third Next Available Appointment (TNAA) metric for sites that have deployed the new Electronic Health Record, website updates also provide Veterans with more relevant information to help inform health care decisions, including the following:

- Veteran experience information;
- Increased detail on timeliness within health care subspecialties; and
- The ability to view more easily relevant VAMC information.

It is important to note that VA does not use average wait-times or TNAA to determine community care eligibility. Wait-time eligibility or community care is always based on the time it takes for an individual Veteran to obtain a specific type of care.

### **Access Standards Analysis**

As noted above, 38 U.S.C. § 1703B(e) requires VA to conduct a review of its access standards and submit a report on the findings and any modifications to the standards to the appropriate committees of Congress at least once every 3 years.

As VA sought Veteran feedback to inform this report and conducted the analysis of Veteran experience, operations and resource utilization that is described in the trends above, the issue of fragmentation of care resulting from implementation of existing regulations and policies was clearly illuminated as an impact to Veteran satisfaction with community care. Veteran feedback makes clear that some Veterans seeking care in the community are driving further or waiting longer for that care than they would if VA provided that care; on top of these delays, Veterans are also experiencing fragmentation of care, duplicative testing and unnecessary and improper billing from community providers. In short, some of these Veterans, once referred to the community, are receiving poorer access to and quality of care. VA believes these results explain, at least in part, lagging community care trust scores.

The following analysis and recommendations describe in detail VA's approach to optimizing access to high-quality care for Veterans. Importantly, this approach preserves Veteran choice while guiding Veterans to the closest, most accessible, highest quality options available. VA believes that when VA and community providers are engaged in friendly, healthy competition to be the best, most accessible, highest quality option, Veterans will benefit. Every policy proposal and decision we make will continue to be centered on Veterans.

VA consulted with pertinent Federal entities, including the Department of Defense (DoD), the Department of Health and Human Services (HHS) and CMS, as well as entities in the private sector and other non-governmental entities. This comprehensive review established that there are important differences between VA access standards and the way access standards are used for other programs, and that these key differences should be presented to provide a better foundation for understanding access standards in general.

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. Network adequacy is defined by the National Conference of State Legislatures as a "health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under

the terms of the contract” (National Conference of State Legislatures (NCSL), 2018). Recognizing the importance of network adequacy, Congress passed laws requiring health care organizations serving Medicare beneficiaries (including Medicare Advantage organizations), providing coordinated care plans, network-based private fee-for-service plans and network-based medical savings account plans, to ensure access to essential services as stipulated in 42 C.F.R. §§ 417.414, 417.416, 422.112(a)(1)(i) and 422.114(a)(3)(ii). Accordingly, organizations in these categories must provide their beneficiaries health care services through a contracted network of providers that is consistent with the pattern of care in the network service area (42 C.F.R. § 422.112(a)(10)). Further, as an outcome of the establishment of Health Benefit Exchanges, also termed Health Marketplaces by the Affordable Care Act of 2010 (ACA), existing State and Federal laws are evolving. All “Qualified Health Plans” must include an adequate network of primary care providers, specialists and other ancillary health care providers.

Generally speaking, access standards are used to provide guidance as to what constitutes network adequacy by commercial health care systems and plans, State Medicaid programs, State insurance departments and other health care governmental/non-governmental organizations. Typically, access standards consist of maximum travel time and/or distance and maximum appointment wait-time. Some organizations also consider provider-to-enrollee ratios and/or extended hours of operation as part of their metrics for access. In contrast, VA uses provider-to-enrollee ratios for planning purposes, as a data point in evaluating where we can augment direct care services, and uses access standards, consistent with statute, to determine eligibility for community care.

The use of access standards to determine eligibility of covered participants to use out-of-network providers is not a common practice in Medicare, Medicaid or commercial insurance plans. If a Medicare, Medicaid or commercial health plan meets their overall access standards, a patient is generally not authorized to use out-of-network providers without prior approval or higher patient out-of-pocket payments, even if that individual patient must travel farther or wait longer for in-network care than the designated standard.

In general, Medicare, Medicaid and commercial plan networks must meet the access standards for a large percentage of their beneficiary population. However, VA access standards are used to determine eligibility for community care for each Veteran 100% of the time. This means that if a Medicare, Medicaid or commercial plan and VA have identical access standards, VA standards would provide more opportunity for “out of network” (community care) than the Medicare, Medicaid or commercial plan.

## DoD and TRICARE

In response to the requirements of the National Defense Authorization Act for FY 2017, DoD evaluated and updated its access standards resulting in the Defense Health Agency (DHA) Interim Procedures Memorandum (IPM) 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTF)." While this IPM is currently in the process of being replaced by a DHA Procedural Instruction, it is provided here to demonstrate DoD practice as it relates to access standards.

DHA-IPM 18-001 provided the following direction regarding appointment type and wait-time:

- Routine Primary Care:
  - The patient should be offered an appointment within 7 calendar days.
  - If no appointments are available within 7 days, the MTF will offer to defer the patient to the network.
  
- Specialty Care:
  - The patient should be offered an appointment within 28 calendar days.
  - If no appointments are available within 28 days, the MTF will offer to defer the patient to the network.

DHA-IPM 18-001 also provides the following further access guidance:

- MTFs are to offer extended business hours in areas where the demand exists and/or there is no local network urgent care clinic;
- MTFs may not close more than 3 consecutive days; and
- Deferrals to the network are authorized for travel distance exceeding access to care standards (Defense Health Agency, 2018).

TRICARE Prime, DoD's most comprehensive managed care plan, uses the following travel time and appointment wait-time standards for non-active-duty beneficiaries:

- Routine primary care: 30 minutes and 7 calendar days;
- Well-patient (preventive) care: 28 calendar days; and
- Routine specialty care: 60 minutes and 28 calendar days.

Beneficiaries who wish to enroll in TRICARE Prime and live more than 30 minutes from an MTF, but within 100 miles from a Network Primary Care Manager, may do so but must waive the above-mentioned drive time standards.

There have been no changes to DoD access standards since 2018.

## Indian Health Service

Indian Health Service (IHS) implemented the following access to care standards in 2017 for appointment wait-times for its direct care system:

- Urgent primary care: 48 hours; and
- Routine primary care: 28 calendar days.

There have been no changes to IHS access standards since 2018.

## State Medicaid Programs

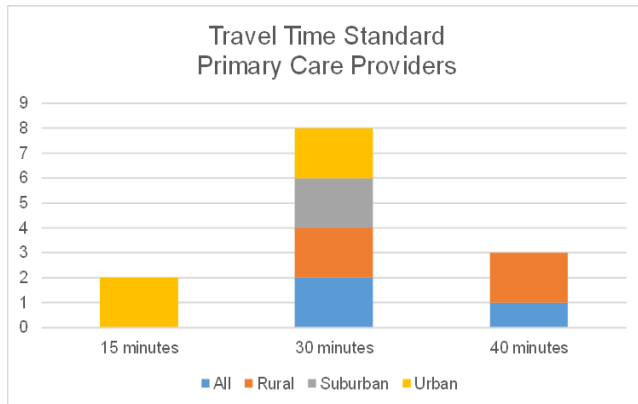
VA researched 14 States, ranging from densely populated States with large urban populations to States with vast rural areas, to assess State Medicaid and private insurance access standards through FY 2021. These States are California, Delaware, Florida, Illinois, Maryland, Nevada, New Hampshire, New Jersey, New Mexico, New York, South Carolina, Texas, Washington and West Virginia. Federal statutes require State Medicaid payments to providers that are consistent with efficiency, economy and quality, and that are deemed adequate to enlist enough providers so appropriate care and services are available to the population in the identified geographic area (§ 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a).

Figures 1-4 on the following page reflect the travel time/distance (one-way, not round trip) standards and Figures 5-7 on page 13 reflect the appointment wait-time standards for selected States with defined access standards (some States do not have defined standards). Some State Medicaid programs establish access standards based on geographical area (i.e., rural, suburban, urban and/or frontier<sup>1</sup>), which are reflected in Figures 1-4. States that do not vary standards by geographical area are designated as “all.” Of note, when travel distance is used as the standard, the miles are a clear standard, which may or may not vary based on urban versus rural geographies depending on the State. When travel time is used as the standard, it may be defined differently State-by-State and may be based on urban versus rural geographies. An average travel time (including variations based on the time of day) will often be used.

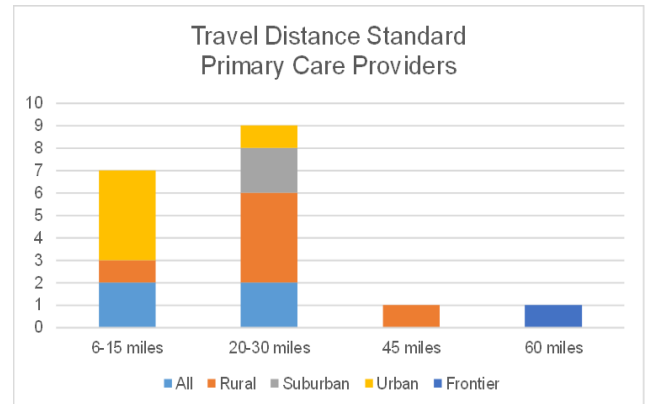
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<sup>1</sup> State definitions of geographic areas vary. Generally rural is identified as any area outside of an urban or suburban area (frontier designates an extremely rural area in New Mexico). Urban areas are generally identified as heavily populated metro areas. Suburban areas surround an urban area and are less populous.

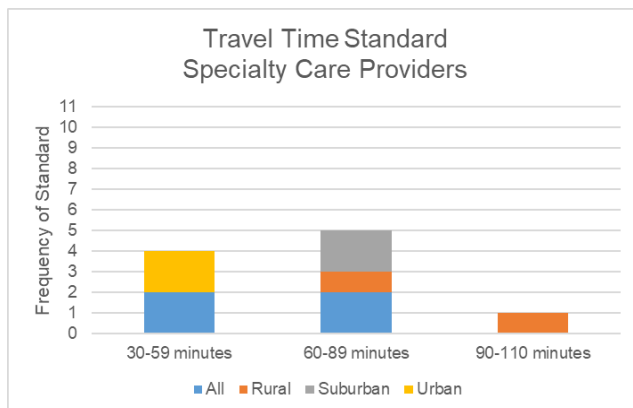
## Figures 1-4: State Medicaid Program Travel Time and Distance Standards<sup>2</sup>



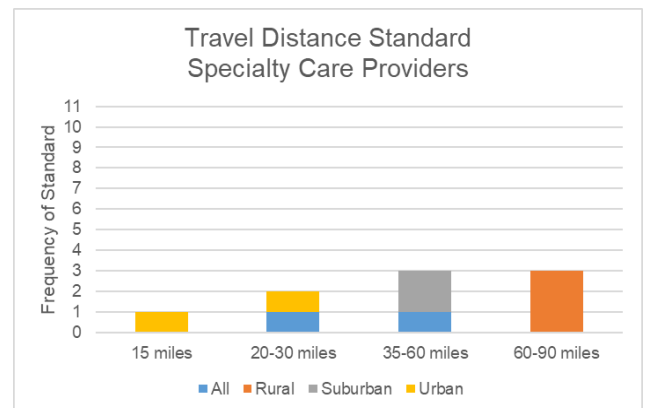
**Figure 1.** Eight of the 14 States analyzed published travel time standards for primary care (ranging from 15 to 40 minutes) with some states breaking out travel time standards by geographic area (urban, suburban and rural).



**Figure 2.** Twelve of the 14 States analyzed published travel distance standards for primary care (ranging from 6 to 60 miles) with some states breaking out travel distance standards by geographic area (urban, suburban, rural and frontier).



**Figure 3.** Eight of the 14 States analyzed published travel time standards for specialty care (ranging from 30 to 110 minutes) with some States breaking out travel time standards by geographic area (urban, suburban and rural).



**Figure 4.** Six of the 14 States analyzed published travel distance standards for specialty care (ranging from 15 to 90 miles) with some States breaking out travel distance standards by geographic area (urban, suburban and rural).

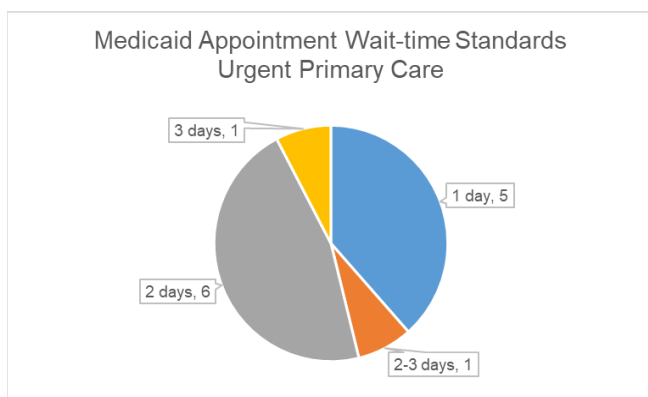
During this review of access standards, there have been minimal changes to State Medicaid Program travel time and distance access standards since VA's 2018 review. Nevada and New Jersey made the following minor updates:

- Nevada
  - Primary Care:
    - 2018 – 25 miles
    - 2021 – 30 minutes or 20 miles
  - Specialty Care:
    - 2018 – No standard

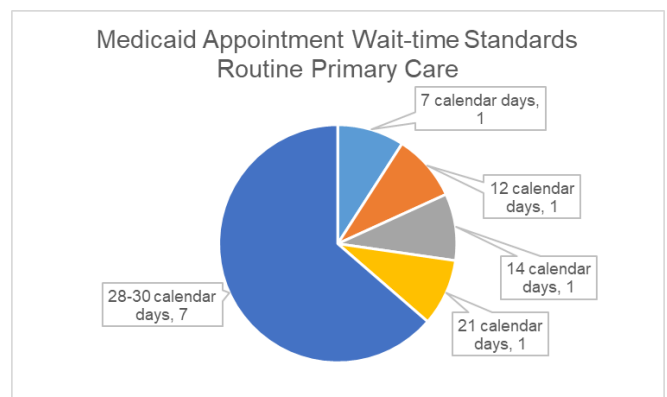
<sup>2</sup> Some States do not require 100% of enrollees to be within identified access standard travel time/distance.

- 2021 – 100 minutes or 75 miles
  - New Jersey
    - Primary Care:
      - 2018 – Urban: 6 miles for 90% of enrollees  
– Rural: 15 miles for 85% of enrollees
      - 2021 – 90% of enrollees within 15 miles or 30 minutes (no references to urban/rural geography)
    - Specialty Care:
      - 2018 – 60 minutes or 45 miles for 90% of enrollees
      - 2021 – 90% of enrollees within 15 miles or 30 minutes (no references to urban/rural geography)

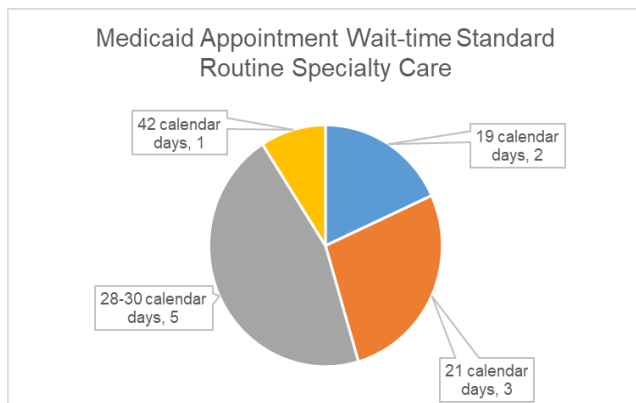
**Figures 5-7: State Medicaid Program Appointment Wait-Time Standards**



**Figure 5.** Thirteen of the 14 States analyzed published appointment wait-time standards for urgent primary care (ranging from 24 to 72 hours).



**Figure 6.** Thirteen of the 14 States analyzed published appointment wait-time standards for routine primary care (ranging from 10 business to 21 calendar days).



**Figure 7.** Eleven of the 14 States analyzed published appointment wait-time standards for specialty care (ranging from 15 business to 42 calendar days).

During this review of access standards, there have been minimal changes to State Medicaid Program appointment wait-time access standards since VA's 2018 review. Illinois made the following updates:

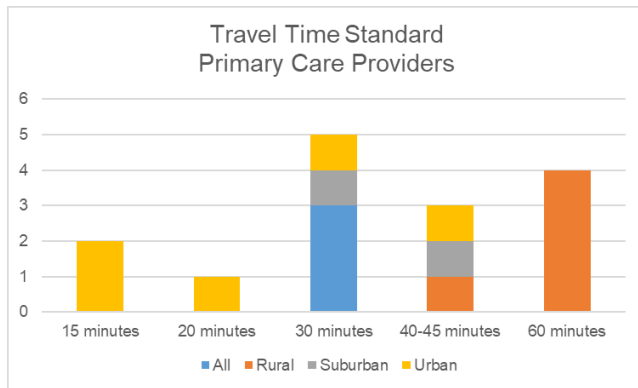


- Illinois
  - Primary Care:
    - 2018 – 35 calendar days
    - 2021 – 3 weeks
  - Specialty Care:
    - 2018 – No standard
    - 2021 – 3 weeks
  - Urgent Care:
    - 2018 – 24 hours
    - 2021 – 1 business day

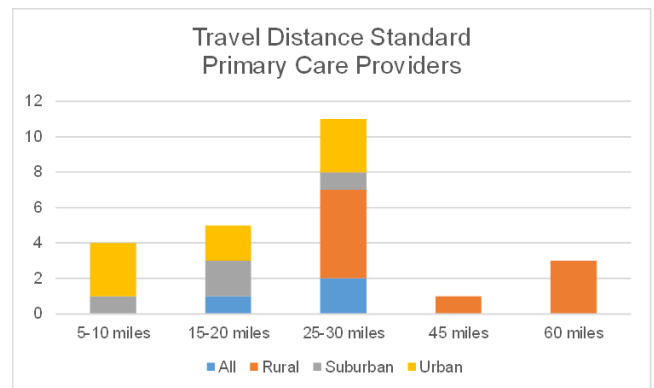
## State Insurance Departments

VA looked at the State insurance standards for the same 14 States noted previously, ranging from densely populated States with large urban populations to States with vast rural areas, to assess across various market types. Figures 8-11 below and on the following page reflect the travel time/distance standards and Figures 12-14 on page 16 reflect appointment wait-time standards for those States assessed which have identified State insurance access standards (some of the States reviewed do not have designated standards). Some State insurance programs establish different access standards based on geographical area (i.e., rural, suburban and/or urban), which is also reflected. States that do not vary standards by geographical area are designated as “all.”

### Figures 8-11: State Insurance Travel Time and Distance Standards<sup>3</sup>

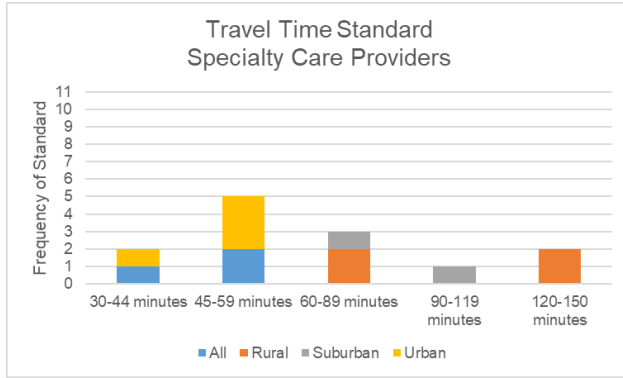


**Figure 8.** Eight of the 14 States analyzed published travel time standards for primary care (ranging from 15 to 60 minutes) with some States breaking out travel time standards by geographic area (urban, suburban and rural).

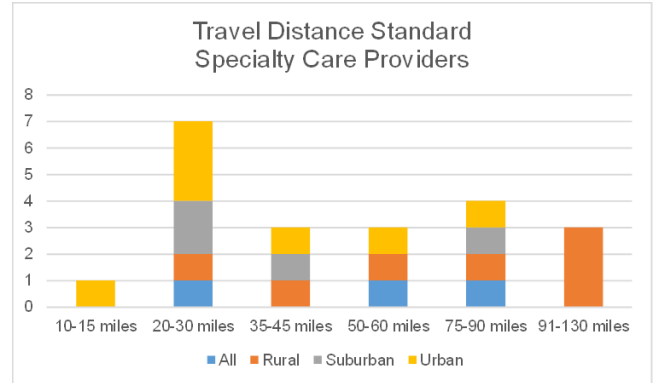


**Figure 9.** Twelve of the 14 States analyzed published travel distance standards for primary care (ranging from 5 to 60 miles) with some States breaking out travel distance standards by geographic area (urban, suburban and rural).

<sup>3</sup> Some States do not require 100% of enrollees to be within identified access standard travel time/distance.



**Figure 10.** Seven of the 14 States analyzed published travel time standards for specialty care (ranging from 30 to 150 minutes) with some States breaking out travel time standards by geographic area (urban, suburban and rural).

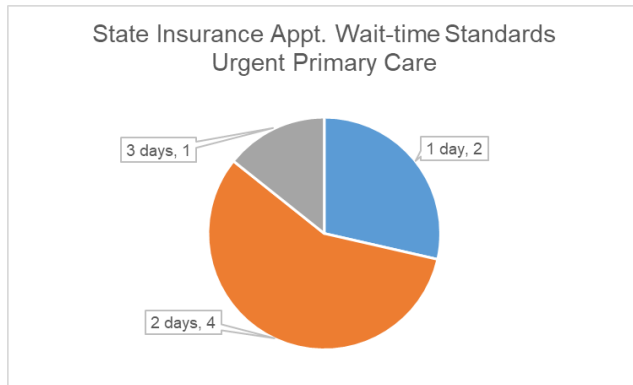


**Figure 11.** Ten of the 14 States analyzed published travel distance standards for specialty care (ranging from 10 to 130 miles) with some States breaking out travel distance standards by geographic area (urban, suburban and rural).

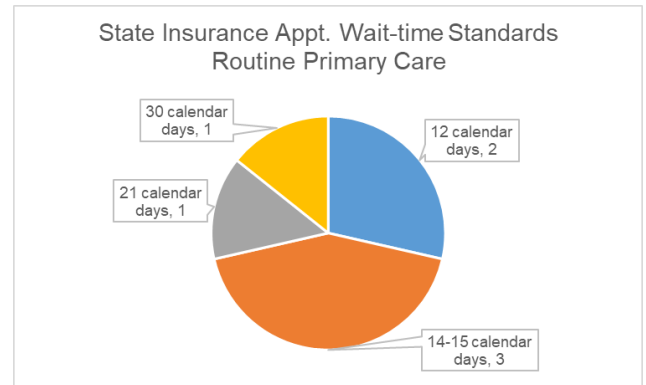
During this review of access standards, there have been minimal changes to State Insurance Department travel time and distance access standards since VA's 2018 review. Nevada made the following minor updates:

- Nevada
  - Primary Care:
    - 2018
      - Metro (core urban population of 50,000 or more population): 15 minutes or 10 miles
      - Micro (centered on an urban area with a population of at least 10,000 but not more than 50,000): 30 minutes or 15 miles
      - Rural (all other areas): 40 minutes or 30 miles
    - 2021
      - Metro: 15 minutes or 10 miles
      - Micro: 30 minutes or 20 miles
      - Rural: 40 minutes or 30 miles

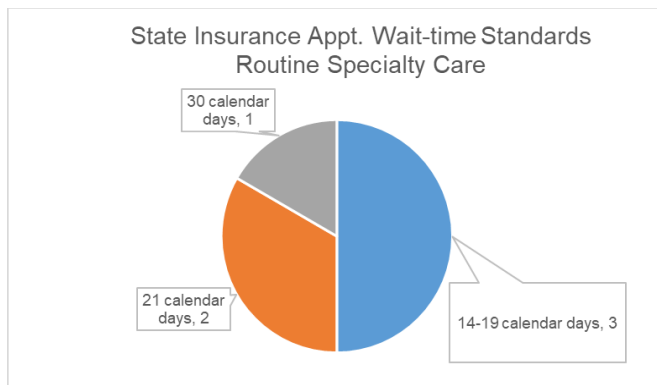
## Figures 12-14: State Insurance Appointment Wait-Time Standards



**Figure 12.** Six of the 14 States analyzed published appointment wait-time standards for specialty care (ranging from 14 to 30 calendar days).



**Figure 13.** Seven of the 14 States analyzed published appointment wait-time standards for routine primary care (ranging from 10 business to 30 calendar days).



**Figure 14.** Seven of the 14 States analyzed published appointment wait-time standards for urgent primary care (ranging from 24 to 72 hours).

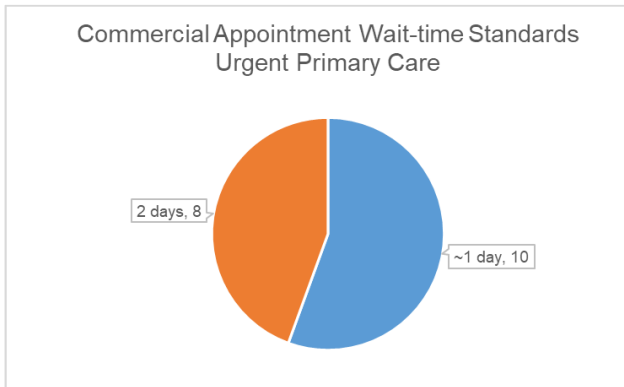
During this review of access standards, there have been no changes to State Insurance Department appointment wait-time access standards since VA's 2018 review.

### Commercial Health Plans

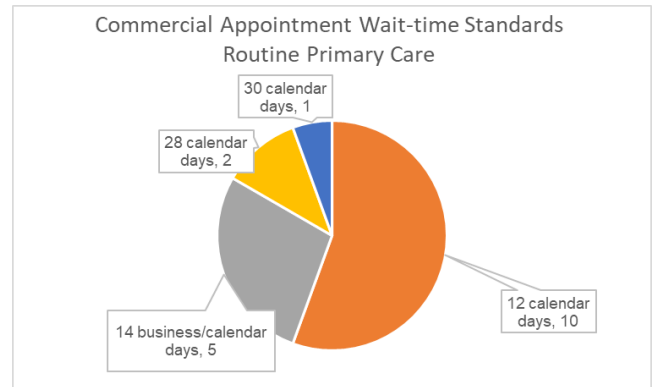
VA considered 18 commercial health care plans/systems with publicly accessible data to assess appointment wait-time access standards. Travel time/distance standards were not available for most of the sampled health care plans/systems and as a result are not reflected here. The organizations used for analysis were: Affinity Medical Group, Blue Cross Blue Shield New Jersey, Blue Cross Blue Shield North Carolina, CareFirst, Emblem Health, Facey Medical Group, Geisinger, HealthNet, Health Plan of San Joaquin, Independence Health Plan, Kaiser Permanente, Lakeside Healthcare, Medica Health, Molina Health, Security Health Plan, Sharp Health Plan, United Healthcare New York and Well Sense Health Plan (further information on each of these plans is available

in the *References* section of this report). Figures 15-17 below reflect the appointment wait-time standards for those commercial health plans assessed that have an identified standard (some plans do not have identified standards for Specialty Care). These standards are generally applied across the entirety of the plan unless regulation of a particular line of business requires another standard.

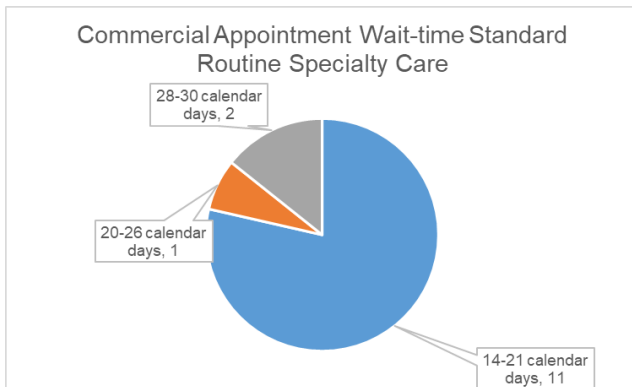
**Figures 15-17: Commercial Appointment Wait-time Standards**



**Figure 15.** Eighteen of the eighteen plans analyzed published appointment wait-time standards for urgent primary care (ranging from 24 to 48 hours).



**Figure 16.** Eighteen of the eighteen plans analyzed published appointment wait-time standards for routine primary care (ranging from 10 to 20 calendar days).



**Figure 17.** Fourteen of the eighteen plans analyzed published appointment wait-time standards for specialty care (ranging from 10 to 30 calendar days).

During this review of access standards, there have been minimal changes to Commercial Health Plan appointment wait-time access standards since VA’s 2018 review. Blue Cross Blue Shield North Carolina and CareFirst made the following updates:

- Blue Cross Blue Shield North Carolina
  - Primary Care:
    - 2018 – 7 calendar days
    - 2021 – 30 calendar days

- Care First
  - Primary Care:
    - 2018 – 10 business days
    - 2021 – 14 business days
  - Urgent Care:
    - 2018 – 48 hours (96 hours for "non-urgent sick")
    - 2021 – 24 hours

## **Public Engagement Regarding Access Standards**

On November 4, 2021, VA published a Notice in the Federal Register (86 FR 60970) requesting public comment on VA's access standards. Specifically, VA requested information regarding access standards, including but not limited to, information regarding health plans on the use of access standards for the design of health plan provider networks; referrals from network providers to out-of-network providers; the appeals process for exemptions from benefit limits to out-of-network providers; and the measurement of performance against Federal or State regulatory standards. Further, VA requested input on Veterans' experience with the access standards designated in 2019. Written comments were collected through December 6, 2021, and a total of 86 comments were submitted.

The following labor organizations provided written comments in response to the Federal Register Notice requesting comment: American Federation of Government Employees and National Nurses Organizing Committee. The following Veterans advocacy organizations also provided written comments: The American Legion, Concerned Veterans for America, Disabled American Veterans (DAV), National Alliance of Women Veterans, Veterans Healthcare Policy Institute (which submitted two separate comments) and Wounded Warrior Project. In addition, two comments were received from members of Congress: Senator Jon Tester (Chairman, Senate Committee on Veterans' Affairs) and Representative Mark Takano (Chairman, House Committee on Veterans' Affairs) provided jointly written comments, and Senator Bernard Sanders submitted a comment. Seventy-five comments were received from the public, including comments from self-identified Veterans and family members. Notable points from written comments included the following:

- Community providers (e.g., CCN contractors) under VCCP must be held to the same access standards as VA;
- VA should continue to be the primary provider of care;
- Access standards should not be made more stringent (result in less eligibility for community care);
- VA should be cautious about comparing VHA health care delivery to the private sector; the way VHA applies and implements these access standards is inherently different from the private sector;

- Veterans deserve to know the real wait-time and drive time (versus an estimate) for a community care appointment;
- Access standard authority should be limited to between three and five types of care (e.g., laboratory tests, x-rays and urgent care), not all clinical services as it is stated now;
  - The VA Secretary should examine the use of future market assessments or similar reviews, which consider the lasting effects of the COVID-19 pandemic, when determining which types of services should be designated for access standards; and
- VA should allow both telehealth and in-person care to satisfy the wait-time standard for VA access to care (i.e., VA should offer direct telehealth prior to referring a Veteran to the community).

VA also conducted a virtual public meeting on December 1, 2021, requesting public comment regarding access standards and requesting input on Veterans' experience with the access standards designated in 2019. At the public meeting, the following organizations provided oral comments: DAV, The Independence Fund, John E. Jacobs American Legion Post 68 and Veterans Healthcare Policy Institute. Notable points discussed at the public meeting included:

- VA should continue to be the primary provider of care for Veterans;
- Most speakers noted access standards should not be made more stringent (result in less eligibility for community care); however, one speaker noted access standards are not stringent enough, allowing Veterans to be eligible based on drive time when VA care is closer;
- Veterans need to be educated on programs available to them, and VA can partner with local Veterans Service Organizations to facilitate this education;
- Community providers should be held to the same access standards as VA;
- Veterans should be provided with real-time comparisons of VA and community care availability;
- VA should be aware of the impact of any changes to access standards and ensure capacity exists in the community should there be an increase in eligibility for community care; and
- Only when VA cannot meet demand (to include using telehealth), should it use community providers.

In addition to the requests for information through the Federal Register Notice and Public Meeting, VA conducted four Listening Sessions to gather feedback from employees to inform its review of VA access standards. The participating groups in these sessions were:

- Clinical Services: National Chiefs of Staff;
- Veterans Integrated Service Network and VHA Program Office Leadership (two meeting attendance options); and
- Nursing Services.

Appointment wait-time, travel time, specialty services, the impact on access due to the COVID-19 pandemic and telehealth were the main topics of discussion. Several themes and concerns were heard from staff, including the following points:

- VA schedulers need near real-time appointment wait-time information for the community to inform whether to refer a Veteran to the community;
- Community providers should be held to the same access standards as VA;
- Veterans are referred to community care despite VA telehealth being available, and then receive telehealth in the community;
- Care teams should be able to offer telehealth first, then offer community care;
- Mental health is a service where telehealth is often being used in the community, and VA could have provided the same care through telehealth; and
- Some Veterans do not seem to prefer telehealth and primarily prefer in-person appointments; the technology for the older Veteran population can be challenging.

## **Telehealth in U.S. Health Care**

By definition, telehealth involves the delivery of remote health care via electronic communication and information technologies. Care via this modality can include a wide variety of health care services and is a tool to diagnose, treat, monitor and counsel patients when in-person care is not preferred, optimal or feasible.

Over the past decade, private insurers and providers have expanded telehealth coverage to furnish affordable expanded access and care for patients. Between 2014 and 2018, private insurance claims for all telehealth services increased by 624% (Agency for Healthcare Research and Quality, 2020). According to an analysis by the Assistant Secretary for Planning and Evaluation from April to October 2021, one in four respondents (23.1%) to the Census Household Pulse Survey reported use of telehealth services (Karimi, 2022). Further, telehealth visits among Medicare fee-for-service beneficiaries increased more than 60-fold from approximately 840,000 in 2019 to approximately 52.7 million and slightly declined in June 2020 before plateauing by the end of 2020 (Samson, 2021). In addition, telehealth increased more than 20-fold, from approximately 6 to over 150 telehealth services per 1,000 Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in April 2020 (Chu, 2021).

In response to the COVID-19 pandemic, the Federal Government, State Medicaid programs and private insurers expanded coverage for telehealth services and utilization of telehealth increased. In the commercial sector, telehealth went from low single digits

(as a percent of visits) to 30% of visits at a high point during the COVID-19 pandemic. Since mid-2020, telehealth has declined somewhat to 10-15% of visits, but is still above pre-pandemic levels. Behavioral health patients were the highest users of telehealth during this time frame and use in this area remains high today.

Further, during the COVID-19 Public Health Emergency (PHE) declaration, the types of health care providers eligible to bill Medicare for telehealth services were expanded, regardless of where in the country or in what setting the patient or provider is located. HHS issued temporary measures in March and April 2020, under the COVID-19 PHE declaration and temporary authority provided by Congress, to make providing and receiving care through telehealth more accessible (Centers for Medicare & Medicaid Services, 2020).

Prior to the COVID-19 pandemic, many States had updated their regulations around telehealth. While there is wide variation in the way States define and regulate telehealth, most State regulations are less restrictive than Medicare's telehealth policy, allowing for reimbursement for a wide range of services with little to no restrictions. There has been a significant increase in reimbursement of health care services with live video being added to the list of eligible services by States and with behavioral health being the most common service added in Medicaid manuals.

During the COVID-19 PHE, states significantly expanded Medicaid beneficiary access to telehealth for the delivery of primary care and behavioral health services. The number of states covering telehealth services for physical, occupational and speech therapy, maternity and long-term services/support more than doubled from 2019 to 2020. Further, some States are adopting CMS communication technology-based services codes, including the virtual check-in and remote evaluation of prerecorded information, audio-only service codes and remote physiologic monitoring. Many states expanded coverage for telehealth modalities including telephone only, text-based communication and remote patient monitoring and patients' homes as an originating site (Chu, 2021). All 50 States and the District of Columbia, provide reimbursement for some form of live video in Medicaid fee-for-service and at least 42 states and the District of Columbia provide reimbursement parity for some covered telehealth services to be paid at the same rate as in-person services.

Additionally, twenty-two State Medicaid programs now reimburse for store-and-forward, a type of telehealth whereby health care providers share patient medical information like lab reports, images, videos and other records with a physician, radiologist or specialist at another location. Additionally, 26 State Medicaid programs reimburse for remote patient monitoring. In 2021, Massachusetts made a significant change to its telehealth policy and requires reimbursement for both Medicaid and private payers if the services are covered in-person and are appropriately delivered through telehealth. The Massachusetts law (M.G.L. c. 118E, § 79) included specifying that the rate of payment for telehealth services provided via interactive audio-video technology and audio-only



telephone may be greater than the rate of payment for the same services delivered by other telehealth modalities (see § 79(e)). It also provided payment parity for in-network providers of behavioral health services delivered via interactive audio-video technology or audio-only telephone only (see § 79(g)).

At this time, Medicare Advantage, Medicaid and commercial health plans are not requiring use of telehealth in determining whether they meet access standards. Private health plans are encouraging, but not requiring, members to use telehealth where appropriate. A few health plans are now offering “virtual first” health plans, where a member uses telehealth for most routine primary care services. For DoD, DHA is currently working to expand its telehealth availability across diagnostic groups, specialties and locations across the Military Health System.

## **VA Telehealth**

VA's primary objective during the COVID-19 pandemic continues to be ensuring Veteran health and safety. With the onset of the pandemic, VA rapidly expanded telehealth nationwide, and we have continued to strengthen this and integrate this essential option into care delivery for Veterans. In FY 2021, more than 2.3 million unique Veterans participated in over 11.2 million episodes of telehealth care. The 11.2 million episodes of telehealth care represent a greater than 97% increase in telehealth episodes of care between FY 2020 and FY 2021. This also includes over 1.9 million Veterans who participated in over 9.5 million episodes of video telehealth care in their homes or on a mobile device – representing a greater than 146% increase from FY 2020 to FY 2021. In FY 2021, VA's national asynchronous (store-and-forward) telehealth program provided more than 520,000 visits to more than 430,000 Veterans nationwide, a 41% increase in the number of visits and a 43% increase in the number of Veterans when compared to FY 2020. Additionally, during FY 2021, VA's Remote Patient Monitoring – Home Telehealth program provided more than 752,000 episodes of care to more than 148,000 Veterans nationwide, including 18,575 unique Veterans who received daily monitoring for COVID-19-related symptoms during an estimated 176,424 total sessions.

An important focus of VA telehealth is care for Veterans living in rural areas, and VA's Office of Rural Health (ORH) and Office of Connected Care continue to collaborate to advance access. In 2006, ORH was established, in part, to develop, refine and promulgate policies, best practices, lessons learned and innovative successful programs to improve care and services for Veterans reside in rural areas of the United States. Working through its five Veterans Rural Health Resource Centers (field-based satellite offices that serve as hubs of rural health care research, innovation and dissemination located at host VAMCs in Iowa City, Iowa; Salt Lake City, Utah; White River Junction, Vermont; Gainesville, Florida; and Portland, Oregon), as well as others in academia, State and local governments, private industry and non-profit organizations, ORH strives to break down the barriers separating rural Veterans from quality care.

ORH support programs include Tele Critical Care, TeleMental health hubs, social workers who also work within the Rural Patient Aligned Care Teams, transportation services and rural health training initiatives that include the cross-agency Rural Faculty Development Program, Fellowships for Rural Healthcare Scholars and career development awards for up-and-coming rural providers. ORH also provides seed funding for innovative local projects that address care challenges facing rural Veterans.

### **Financial Impact Analysis and Findings**

To research and estimate the financial impact of any potential changes to the current access standards, several drive time and appointment wait-time access standard scenarios were developed and modeled, as demonstrated in Figure 18 on the next page. This included evaluating the potential impact of implementing a separate highly rural drive standard for Veterans residing in sparsely populated areas. Financial impacts were modeled using VA EHCPM, which is produced in collaboration with actuaries at Milliman USA.

## Principal Findings

**Figure 18: Community Care Access Standards Options and Fiscal Impact<sup>†</sup>**

		Scenario <sup>**</sup>	Access Standard: Drive Time		Access Standard: Wait-Time* Avg. VA (Nov. 21) Primary Care (PC)Mental Health (MH) 21.0/9.0; Specialty Care (SC) 21.0		Projected Total Expenditures Net of Collections (Billions)+++			Projected Increased Total Expenditures (Billions)		
			PC/MH	SC	PC/MH	SC	FY2022	FY2023	FY2024	FY2022	FY2023	FY2024
<b>Current Standards</b>	<b>Implemented June 2019</b>	Current VA Access Standards	30 minutes	60 minutes	20 days	28 days	\$99.4B	\$111.2B	\$116.6B	\$0.00B	\$0.00B	\$0.00B
<b>Other Proposed Standards Applied to VA Population</b>		VA Access Standards with Highly Rural Standard	30 minutes urban/rural***	60 minutes urban/rural***	20 days	28 days	\$99.2B	\$111.1B	\$116.4B	-\$0.10B	-\$0.12B	-\$0.13B
			<b>60 minutes highly rural***</b>	<b>120 minutes highly rural***</b>								
		Reduced SC Drive Time	30 minutes	<b>45 minutes</b>	20 days	28 days	\$100.7B	\$112.7B	\$118.2B	\$1.32B	\$1.53B	\$1.62B
		Reduced SC Drive Time with Highly Rural Standard	30 minutes urban/rural***	<b>45 minutes urban/rural***</b>	20 days	28 days	\$100.5B	\$112.6B	\$118.0B	\$1.19B	\$1.38B	\$1.46B
	<b>60 minutes highly rural***</b>		<b>120 minutes highly rural***</b>									
		<b>Align to State Insurance Departments (PC/MH Wait-Time) and State Medicaid</b>	Increased PC/MH Wait-Time and SC Drive Time	30 minutes	<b>90 minutes</b>	<b>28 days</b>	28 days	\$97.4B	\$109B	\$114.2B	-\$1.96B	-\$2.27B

	<b>Programs (SC Drive Time)</b>	Increased PC/MH Wait-Time and SC Drive Time with Highly Rural Standard	30 minutes urban/rural***	<b>90 minutes urban/rural***</b>	<b>28 days</b>	28 days	\$97.3B	\$108.9B	\$114.1B	-\$2.02B	-\$2.33B	-\$2.47B	
			<b>60 minutes highly rural***</b>	<b>120 minutes highly rural***</b>									
<b>Modified Standards</b>	<b>VA Modified #1</b>	Decreased PC/MH Wait-Time and Medicare Advantage (MA) specific for SC Wait-and Drive Times	30 minutes	<b>MA specific**</b>	<b>14 days</b>	<b>MA specific**</b>	\$101.5B	\$114B	\$119.1B	\$2.11B	\$2.44B	\$2.57B	
		Decreased PC/MH Wait-Time and Medicare Advantage (MA) specific for SC Wait-and Drive Times with Highly Rural Standard****	30 minutes urban/rural***	<b>MA specific**</b>									<b>14 days</b>
			<b>60 minutes highly rural***</b>	<b>MA specific**</b>									
			Increased SC Drive Time	30 minutes	<b>90 minutes</b>	20 days	28 days	\$98B	\$110B	\$115B	-\$1.35B	-\$1.56B	-\$1.65B
		<b>VA Modified #2</b>	Increased SC Drive Time with Highly Rural Standard	30 minutes urban/rural***	<b>90 minutes urban/rural***</b>	20 days	28 days	\$97.9B	\$109.6B	\$114.9B	-\$1.41B	-\$1.62B	-\$1.72B
				<b>60 minutes highly rural***</b>	<b>120 minutes highly rural***</b>								
		<b>VA Modified #3</b>	MA Specific for SC Drive Time	30 minutes	<b>MA specific**</b>	20 days	28 days	\$101.2B	\$113.3B	\$119B	\$1.83B	\$2.12B	\$2.24B

		MA Specific for SC Drive Time with Highly Rural Standard	30 minutes urban/rural***	MA specific**	20 days	28 days	\$101.2B	\$113.3B	\$118.8B	\$1.83B	\$2.11B	\$2.23B	
			60 minutes highly rural***	MA specific**									
	VA Modified #4	Decreased PC/MH and SC Wait-Time		30 minutes	60 minutes	14 days	14 days	\$100.5B	\$112.6B	\$118B	\$1.12B	\$1.38B	\$1.46B
			Decreased PC/MH and SC Wait-Time with Highly Rural Standard	30 minutes urban/rural***	60 minutes urban/rural***								
		60 minutes highly rural***		120 minutes highly rural***									
		VA Modified #5	Increased PC/MH Wait-Time	30 minutes	60 minutes	28 days	28 days	\$98.7B	\$110.5B	\$115.8B	-\$0.61B	-\$0.71B	-\$0.75B
	Increased PC/MH Wait-Time		30 minutes urban/rural***	60 minutes urban/rural***	28 days	28 days	\$98.6B	\$110.4B	\$115.7B	-\$0.72B	-\$0.83B	-\$0.88B	
			60 minutes highly rural***	120 minutes highly rural***									
	Virtual Care Mandate PC/MH only	30 minutes	60 minutes	20 days	28 days	\$1.1 B = Potential maximum community care office visit cost reduction (in FY 2021 applying current drive and wait-time access standards) resulting from a virtual care mandate assuming that all PC/MH visits move to VA direct care.							

**Footnotes**

+ Assumes changes in VA capacity based on historic trends. The current VA access standards scenario projections are based on the VA EHCPM base year 2020 scenario.

++ Note: For all access standard scenarios modeled with a highly rural access standard, the number of affected Veterans was between 102,677 and 139,755, depending on the scenario.

+++ Projected Total Expenditures Net of Collections reflects the projected cost of all health care services modeled by the EHCPM minus the projected impact of first- and third-party billable revenue collections.

\* Wait-time is calculated from the clinically indicated date, or if no such date exists, from the date the Veteran prefers to be seen.

\*\* The 2020 Medicare Advantage access standards (published by CMS at <https://www.cms.gov/files/document/hsd2020referencefileupdated2020-06-11.xlsx>) are used for the specialty drive time thresholds (these already incorporate geography).

\*\*\* VA used the Rural-Urban Commuting Areas (RUCA) system to define rurality. Developed by the Department of Agriculture and HHS, the RUCA system takes into account population density as well as how closely a community is linked socio-economically to larger urban centers. RUCA is based on how the U.S. Census Bureau counts citizens.

Urban Area: Census tracts with at least 30% of the population residing in an urbanized area as defined by the Census Bureau.

Rural Area: Land areas not defined as urban or highly rural.

Highly Rural Area: Sparsely populated areas – less than 10% of the working population commutes to any community larger than an urbanized cluster, which is typically a town of no more than 2,500 people.

VA's analysis found that across all of the scenarios presented, the two principal drivers of cost associated with travel distance/time and wait-time standards are: 1) distance or average drive time standards for specialty care and 2) average wait-time standards for primary care/mental health.

The analysis also found that implementing a separate highly rural drive time standard had minimal impact on the overall projected total expenditures net of collections for community care. For all scenarios involving a highly rural drive time standard, the estimated savings were not significant (typically less than \$100 million per year).

Further, analysis showed that considering telehealth appointments as available appointments for the purposes of applying VA access standards to determine eligibility for community care would have resulted in a maximum \$1.1 billion community care cost reduction in FY 2021. This assumes that primary care and mental health would be the primary specialties leveraging virtual care.

### **Financial Impact Modeling**

As noted above, VA modeled the estimated financial impact of the various access standards scenarios using the VA EHCPM, which uses the following inputs to generate projections:

- The number of Veterans expected to be enrolled, the priority group of their enrollment, as well as age and geographic location;
- The total health care demand for enrolled Veterans for over 100 health care services;
- The portion of that care enrollees expected to be provided directly by VA versus other providers paid for by VA;
- The expenditures associated with the projected utilization for both direct and community care;
- Future changes in health care practice and technology such as telehealth; and
- The impact of copayments.

VA factored in the following financial impacts when modeling access standard scenarios:

- Impacts of revised travel/wait-time access standards on Veteran enrollment as well as enrollee reliance on VA care;
- Recent average wait-times for VA facilities, which was notably complicated by the impacts of COVID-19 pandemic;
- Geographic location of Veterans and current sites of VA care;
- Ability to meet any proposed revised travel time/distance and/or appointment wait-time access standards both now and over the next several years;
- Current projections for growth in enrollment as well as utilization of ambulatory care; and
- "Grandfathered" Veterans Choice Program eligibility for some current enrollees.

Modeling did not account for potential changes in VA’s operational capacity over time that could result from the standards (i.e., an increase in efficiency in an effort to meet access standards), the growth of VA telehealth or other VA initiatives.

**Access Standards Recommendations**

VA’s current designated access standards, which were established in June 2019, are shown in Table 2 below.

**Table 2: Current Designated Access Standards**

Average Drive Time to the Nearest VA Facility		VA Facility Wait-Times	
Primary/Mental Health/Non-Institutional Extended Care	Specialty Care	Primary/Mental Health/Non-Institutional Extended Care	Specialty Care
30 minutes	60 minutes	20 days	28 days

Notably, *the inability to provide care or services within the designated access standards* is just one of six community care eligibility criteria established by the VA MISSION Act. Additional eligibility criteria established by statute and clarified through regulation include the following:

- The Veteran requires care or services not available at a VA facility;
- The Veteran resides in a U.S. State or territory without a full-service medical facility;
- The Veteran qualifies under the “Grandfather” provision related to distance eligibility for the Veterans Choice Program;
- The Veteran and the Veteran’s referring clinician determine that accessing care or services from a community provider is in the best medical interest of the Veteran, for the purpose of achieving improved clinical outcomes; and
- The care or services would be furnished by a VA medical service line that VA has determined is not providing care or services in a manner compliant with VA’s standards for quality.

Based on Veteran, VA employee, and public feedback, analyses of internal VA data and trends, and consideration of best practices elsewhere in government and the private sector, VA is proposing no immediate changes to the current designated access standards. However, we are planning to propose incorporating VA telehealth availability into determinations regarding eligibility based on the designated access standards. We will welcome public and Congressional input on this proposal. VA will also actively assess the impact of the designated access standards on Veteran care on an ongoing



basis, including as U.S. health care continues to evolve due to multiple public health emergencies, and we will continue to keep Congress apprised of our work.

As noted above, VA also modeled a separate drive time standard for Veterans in highly rural areas. VA is not recommending such a change at this time because it was found to have the potential to reduce eligibility for community care, potentially decreasing access for highly rural Veterans. Further, implementing a separate drive time standard for highly rural Veterans would have limited effect because these Veterans are, or would be, eligible under other criteria. For example, covered Veterans can choose community care for any care or service if they were eligible under the Veterans Choice Program and continue to reside in Alaska, Montana, North Dakota, South Dakota, or Wyoming. Additionally, Veterans who reside in Alaska, Hawaii, New Hampshire and the U.S. territories of Guam, American Samoa, the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands are eligible for community care, because VA does not operate as a full-service medical facility in these areas.

### **Further Exploration**

During this review, VA identified that the following areas could benefit from further exploration, with the aim of enhancing Veterans' access to high-quality, equitable care:

- VA received feedback that CCN contractors should be held to the same access standards as VA facilities. Some of the feedback VA received indicated that CCN contractors' timeliness should include accounting for the time used to process referrals.
- Based on feedback received from VA employees, there is a need for VA schedulers to have improved visibility, in real-time, on where (distance), when (timeliness) and how (modality of care, i.e., virtual or in-person) Veterans will receive community care. At present, some Veterans who choose community care drive further and wait longer than they would if VA provided the care directly; they also face fragmentation of care, as described above. VA intends to pursue real-time, comparative information to provide clarity for Veterans on which options would be fastest, nearest and highest quality.
- Veterans are eligible for community care when the Veteran resides in a State or territory without a "full-service" VA medical facility. The current definition of a full-service facility is one that provides hospital care, emergency medical services and surgical care and having a surgical complexity designation of at least "standard" (38 C.F.R. § 17.4005). U.S. health care is rapidly trending away from inpatient care and toward multi-specialty outpatient and virtual care, and VHA is thus exploring whether to modernize the definition of "full-service" to maximize access and focus on meeting Veterans where they are. VHA does offer high-quality in-person and virtual clinical services in states where VA does not operate a facility that meets the current definition of "full service." As VA works to modernize infrastructure and further expand telehealth, continuing to bring care

closer to Veterans, VA must consider how these strategies intersect with the designated access standards and other community care eligibility criteria.

- VA is committed to health equity, and further analysis is needed to fully understand the impact of access standards on equity in terms of race, ethnicity, gender, age, era of service and other factors.

**Department of Veterans Affairs**  
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