soliciting comments concerning the burden related to requirements that escrow accounts, settlement funds, and similar funds be subject to current taxation either as grantor trusts or otherwise.

DATES: Written comments should be received on or before January 13, 2020 to be assured of consideration.

ADDRESSES: Direct all written comments to Philippe Thomas, Internal Revenue Service, Room 6529, 1111 Constitution Avenue NW, Washington, DC 20224. Requests for additional information or copies of the regulations should be directed to R. Joseph Durbala, at Internal Revenue Service, Room 6129, 1111 Constitution Avenue NW, Washington, DC 20224, or through the internet, at *RJoseph.Durbala@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Escrow Funds and Other Similar Funds.

OMB Number: 1545–1631.

Regulation Project Number: TD 9249.

Abstract: This document contains final regulations relating to the taxation and reporting of income earned on qualified settlement funds and certain other escrow accounts, trusts, and funds, and other related rules. The final regulations affect qualified settlement funds, escrow accounts established in connection with sales of property, disputed ownership funds, and the parties to these escrow accounts, trusts, and funds.

Current Actions: There is no change to the burden previously approved by OMB. This form is being submitted for renewal purposes only.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or households, business or other for-profit organizations, not-for-profit institutions and Federal, state, local or tribal governments.

Estimated Number of Respondents: 9,300.

Estimated Time per Respondent: 24 min.

Estimated Total Annual Burden Hours: 3,720.

The following paragraph applies to all the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books or records relating to a collection of information must be retained if their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Desired Focus of Comments: The Internal Revenue Service (IRS) is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including using appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* by permitting electronic submissions of responses.

Comments submitted in response to this notice will be summarized and/or included in the ICR for OMB approval of the extension of the information collection; they will also become a matter of public record.

Approved: December 10, 2019.

R. Joseph Durbala,

IRS Tax Analyst.

[FR Doc. 2019–26914 Filed 12–12–19; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF VETERANS AFFAIRS

Pilot Program for Dental Health Care Access

AGENCY: Department of Veterans Affairs.

ACTION: Notice of Intent and request for comments.

SUMMARY: Upon Congressional approval, VA intends to develop and implement a pilot program designed to increase veteran access to health care and support services at no additional cost to VA or veterans. The initial demonstration project VA proposes under this pilot program is to improve dental health care access for veterans by connecting them with community-based, pro bono or discounted, dental service providers. The objective of this pilot demonstration is to improve overall health by increasing access to dental services for enrolled veterans currently ineligible for dental services through VA. Improving the state of veteran health will be evaluated through assessment of emergency medical care visits. Thus, the anticipated impact of this pilot program is to improve quality of health while decreasing health care related costs associated with the provision of emergency care.

ADDRESSES: Written comments may be submitted through *http://www.regulations.gov;* by mail or hand delivery to the Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1064, Washington, DC 20420; or by fax to 202–273–9026. Comments should indicate that they are submitted in response to ''Notice of Intent and request for comments''. During the comment period, comments may also be viewed online through the Federal Docket Management System at *www.regulations.gov.*

DATES: Comments must be received on or before January 13, 2020.

FOR FURTHER INFORMATION CONTACT: Michael Akinyele, MBA, SES, VA Chief Innovation Officer, VA Innovation Center (VIC) (008E), Office of Enterprise Integration, 810 Vermont Ave. NW, Washington, DC 20420. Email: *innovation@va.gov*; Phone: (202) 461–0462. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

1. Introduction

On June 6, 2018, section 152 of Public Law 115–182, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018 (hereinafter the MISSION Act), amended title 38 of the United States Code (U.S.C.) by adding a new section 1703E, Center for Innovation for Care and Payment (the Center). Section 1703E(f) allows VA to waive requirements in subchapters I, II, and III of chapter 17, title 38, U.S.C., as VA determines necessary for the purposes of carrying out pilot programs under this section. Before waiving any such authority, VA will submit to Congress a report on a request for a waiver that describes the specific authorities to be waived, the standard or standards to be used in lieu of the waived authorities, the reasons for such waiver or waivers, and other matters including metrics, cost estimates (both budgets and savings), and schedules.

VA published a proposed rule (RIN 2900–AQ56) on the Center on July 29, 2019 (84 FR 36507). VA published a final rule implementing its authority on October 25, 2019 (84 FR 57327); this

rule became effective on November 25, 2019.

On December 6, 2019, VA submitted to Congressional leadership its first waiver request. This Notice is published to share this waiver request with the public, to solicit public feedback, and to comply with section 17.450(e)(2) of title 38, Code of Federal Regulations (CFR).

VA seeks to develop and implement a pilot program designed to increase veteran access to health care and support services at no additional cost to VA or veterans. The initial demonstration project VA proposes under this pilot program is to improve dental health care access for veterans by connecting them with community-based, pro bono or discounted, dental service providers. The objective of this pilot demonstration is to improve overall health by increasing access to dental services for enrolled veterans currently ineligible for dental services through VA under 38 U.S.C. 1712. Improving the state of veteran health will be evaluated through assessment of emergency medical care visits. Thus, the anticipated impact of this pilot program is to improve quality of health while decreasing health care related costs associated with the provision of emergency care.

Under 38 U.S.C. 1712, VA has limited authority to furnish outpatient dental care. Generally, veterans must either have a dental issue that is service-connected or qualify based on narrow criteria (*e.g.,* the veteran is a former prisoner of war, the veteran has a service-connected disability rated as total, or treatment is medically necessary in preparation for hospital admission or for a veteran otherwise receiving VA care or services or reasonably necessary to complete dental care that began while the veteran was receiving hospital care). Under this authority, VA provides dental services on an annual basis to approximately only eight percent of veterans who are enrolled in the VA health care system. Poor oral health can have a significant negative effect on overall health. Neglecting oral health can lead to health problems, including oral cancer. Clinical researchers have found possible connections between gum problems and heart disease, bacterial pneumonia, and stroke (Mayo Clinic. (2019). Oral health: A window to your overall health. Retrieved from *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475*). Upon approval of this pilot, VA will work with groups such as the American Dental Association (ADA) and with Federally Qualified Health Centers (FQHC) across the U.S. to offer pro bono and discounted dental services to veterans.

38 U.S.C. 523 authorizes VA to coordinate the provision of VA benefits and services (and information about such benefits and services) with appropriate programs (and information about such programs) conducted by private entities at the State and local level. Under section 523, VA may furnish local veterans with information about the free dental screening and care being offered by local providers and encourage them to make appointments for a screening but may not provide administrative support to local providers who agree to furnish the care.

This waiver seeks to expand VA's authority under section 1712 and would allow VA to more effectively serve veterans. Specifically, VA administrative staff would be authorized to coordinate community-provided care for enrolled veterans who are not eligible for VA provided dental care under 38 U.S.C. 1712 while educating them on the dental care options available in their local community. VA administrative staff would be authorized to work with other entities that would facilitate the connection between veterans and dental providers. The expected impact is that the minimal increase of the full-time employee equivalents (FTEE) to support pilot program implementation, reporting, and analysis will be less than the appreciated cost savings.

2. Effective Date, Duration, and Extension or Expansion of Pilot Program

VA is authorized by 38 U.S.C. 1703E(a)(2) to carry out pilot programs the Secretary determines to be appropriate to develop innovative approaches to testing payment and service delivery models in order to reduce expenditures while preserving or enhancing the quality of care furnished by the Department. VA is also directed by law to test models in implementing pilot programs. See 38 U.S.C 1703E(f)(1), (h)(1). This pilot program is focused on VA collaborations with community entities or providers that connect veterans to pro bono and discounted services. The demonstration model that requires a waiver for implementation is focused on Care Coordination for Dental Benefits (CCDB). This would be the initial demonstration project for the Community Provider Collaborations for Veterans (CPCV) Pilot Program. CCDB would aim to improve access to needed dental care in a cost neutral way. The demonstration model's success would inform whether a different demonstration under CPCV connecting veterans to additional pro bono and discounted services would be beneficial. Upon Congressional approval of this pilot program and the waiver request necessary to implement the demonstration model, VA would begin taking necessary preliminary steps to commence the pilot program and demonstration model. These steps would include development of measurement tools and metrics, outreach to non-VA entities who can participate in the pilot program, and other administrative actions needed to support the pilot program. When VA is ready to commence the pilot program VA would notify the public of the date of the start of the pilot program. The pilot program's period of performance would commence upon the date identified in the notification to the public. The pilot program period of performance would be 5 years.

VA may expand the scope or duration of a pilot program if, based on an analysis of the data developed pursuant to 38 CFR 17.450(g) for the pilot program, VA expects the pilot program to reduce spending without reducing the quality of care or expects to improve the quality of patient care without increasing spending. The pilot is designed to reduce utilization of emergency care by veterans to address dental care and subsequently reduce costs for these services. Expansion may only occur if VA determines that expansion would not deny or limit the coverage or provision of benefits for individuals under chapter 17. Consistent with 38 CFR 17.450(h), expansion of a pilot program may not occur until 60 days after VA has published a document in the **Federal Register** and submitted an interim report to Congress stating its intent to expand a pilot program. Examples of potential program expansions might include, but are not limited to, the geographic location of the pilot and the range of services provided. In general, pilot programs are limited to 5 years of operation. VA may extend the duration of a pilot program by up to an additional 5 years of operation. Any pilot program extended beyond its initial 5-year period must continue to comply with the provisions of this section regarding evaluation and reporting under 38 CFR 17.450(g).

3. Context for Prioritizing This Pilot Program

While VA has a unique mission and framework, the Department is challenged by the same variability in access, escalating health care costs, and need for modernization faced by the

entire U.S. health care system. VA dental care is one facet of the overarching VA health care system that seeks to overcome these barriers via the CPCV Pilot Program.

Problem Statement: Due to defined eligibility for dental care, VA only provides dental benefits to 8 percent of the veterans enrolled in the VA health care system every year. The remaining 92 percent of veterans use private dental insurance, pay out of pocket for dental services, rely on pro bono or discounted dental clinics and services, or forego critical dental services.

Proposed Eligibility: Veterans currently enrolled in VA health care but who are ineligible for VA dental care under 38 U.S.C. 1712.

Proposed Intervention: Provision of administrative support for accessing community-based dental care.

Implementation Steps:

(Step 1) Direct notice of eligibility to veterans.

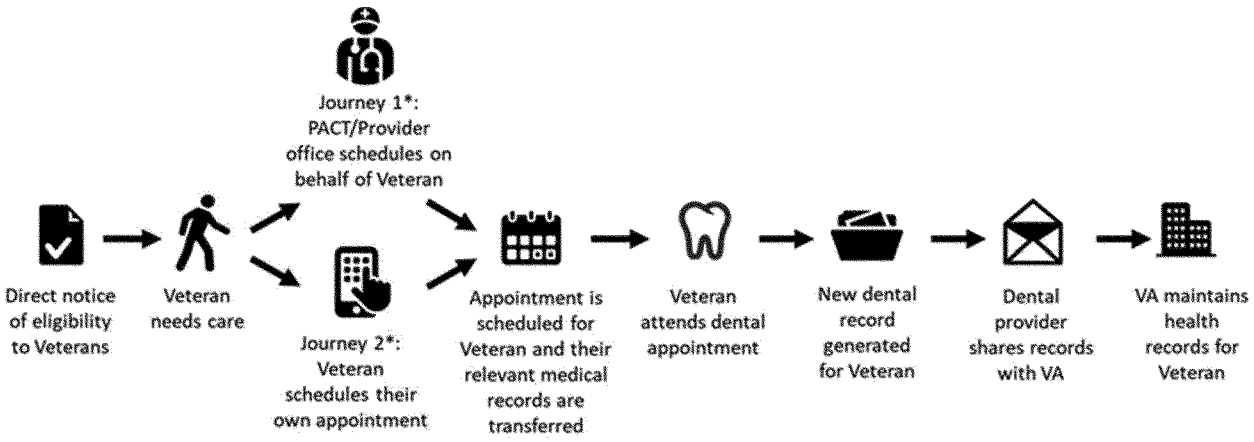
(Step 2) Veteran or Patient-Aligned Care Team (PACT) determines need for oral health care and contacts the CPCV Pilot Program Call Center and/or Portal.

(Step 3) VA staff or CPCV Pilot Program Call Center and/or Patient Portal identify providers based on availability and location, and schedules necessary appointment for the veteran.

(Step 4) Following the dental appointment, dental visit records are provided to the VA primary care provider.

Proposed Sites: The CPCV Pilot Program will be delivered to eligible veterans at selected pilot sites which may include Veterans Integrated Service Networks (VISN) 2, 8, 10, 12, based on the following criteria: Current availability of pro bono and discounted dental service providers; Current demand for dental services; Number of veterans represented; Urban vs. rural population distribution.

Figure 1: Care Coordination for Dental Benefits (CCDB) Journey Map



**Scheduling to be performed via connecting with a call center or online portal*

VA offers comprehensive dental care benefits to certain qualifying veterans under 38 U.S.C. 1712; it also offers limited services to certain qualifying veterans under the same. In addition, veterans enrolled in VA health care may purchase dental insurance at a reduced cost through VADIP under 38 U.S.C. 1712C (U.S. Department of Veterans Affairs. (n.d.). VA Dental Insurance Program. Retrieved from *https://www.va.gov/healthbenefits/VADIP.* (Note: VADIP offers eligible individuals the opportunity to purchase discounted dental insurance coverage that includes diagnostic services, preventive services, endodontic and other restorative services, surgical services and emergency services)). According to an article in the Journal of Oral Microbiology, periodontal treatment may have a beneficial impact on health and wellbeing (Rydén, L., et al. (2016). Periodontitis Increases the Risk of a First Myocardial Infarction: A Report From the PAROKRANK Study. 2016 Feb 9; 133(6): 576–583. 13. doi: 10.1161/CIRCULATIONAHA.115.020324). The Journal cites a 2016 Swedish study where 805 patients, less than 75 years of age with first-time acute myocardial infarction (AMI), were matched against 805 patients without AMI; clinical dental examinations and panoramic x-rays were conducted on all participating patients, and periodontitis (PD) was found to be more common among patients with AMI than the control group (Rydén, L., et al. (2016). Periodontitis Increases the Risk of a First Myocardial Infarction: A Report From the PAROKRANK Study. 2016 Feb 9; 133(6): 576–583. 13. doi: 10.1161/CIRCULATIONAHA.115.020324.) The Mayo Clinic reiterates the range of diseases and conditions that have been linked to oral health including endocarditis, cardiovascular disease, pregnancy and birth complications, and pneumonia (Mayo Clinic. (2019). Oral health: A window to your overall health. Retrieved from *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475*).

4. Statement of Need

In 2018, VA spent approximately $1.1 billion on veteran dental care, averaging approximately $2,185 per veteran (U.S. Department of Veterans Affairs. (n.d.). VA Dental Insurance Program. Retrieved from *https://www.va.gov/healthbenefits/VADIP/.* (Note: VADIP offers eligible individuals the opportunity to purchase discounted dental insurance coverage that includes diagnostic services, preventive services, endodontic and other restorative services, surgical services and emergency services). Currently, VA is operating at near maximum capacity providing dental care for eligible veterans and would require a significant budget increase to provide dental access to all veterans.

While dental care is imperative to overall health and well-being, 92 percent of veterans enrolled in VA health care are not eligible for VA dental care (U.S. Department of Veterans

Affairs. (2019). VA Dental Care. Retrieved from *https://www.va.gov/health-care/about-va-health-benefits/dental-care/*). Dental treatments occurring outside of VA may be fragmented and the data related to these visits is outside of VA's purview, potentially creating uncoordinated care and duplication of services. There were 115,000 veterans enrolled in VADIP as of January 31, 2017. However, it is unclear exactly how many veterans are without access to dental care or services, which could be correlated with poor oral health.

Poor oral health is correlated with potentially avoidable and costly emergency department (ED) visits, causing more than two million visits to the ED each year (Lee, H.H., Lewis C.W., Saltzman B., Starks H. (2012). Visiting the emergency department for dental problems: Trends in utilization, 2001 to 2008. Am. J. Public Health. 2012; 102:e77–e83. doi:10.2105/AJPH.2012.300965). This could be attributed to low oral health awareness, whereby individuals lack understanding around the importance of preventable dental services and the associated health care outcomes (V. Bowyer, et. al. (2011). Oral health awareness in adult patients with diabetes: A questionnaire study. British Dental Journal. [PDF file]. doi: 10.1038/sj.bdj.2011.769). In a study analyzing ED usage in New Jersey, individuals classified as ''high users,'' who had four or more visits during the study period, represented only 4.2 percent of all users but accounted for 21 percent of the visits. The study found that almost all the high users (94.3 percent) had a diagnosis of ''dental disorder not otherwise specified.'' (DeLia, D., Lloyd, K., Feldman, C.A., & Cantor, J.C. (2016). Patterns of emergency department use for dental and oral health care: Implications for dental and medical care coordination. Journal of public health dentistry, 76(1), 1–8. doi: 10.1111/jphd.12103) We believe there is an opportunity for cost savings to be realized through reduction in ED utilization caused by increasing access to dental care.

Amid public calls for modernization, VA is transitioning to a more automated health care system (U.S. Department of Veterans Affairs. (2019). Accelerating VA IT Modernization through DevOps. Retrieved from *https://www.oit.va.gov/reports/year-in-review/2018/stabilizing-and-streamlining/devops*). An online platform connecting veterans to pro bono or discounted dental care services could provide veterans increased access to quality care while possibly reducing costs associated with ED visits linked to oral health. To stay at the forefront of modernization, under this pilot program, VA would explore opportunities to enable and expand veteran access to a network of pro bono and discounted care dental providers. The CPCV Pilot Program aims to improve access to dental services, overall coordination of care, and beneficiary outcomes through an automated system or a call center that would facilitate pro bono or discounted services for veterans or VA employees providing direct administrative support to veterans.

5. Current Approach to Service Delivery and/or Payments

5.1 Dental Care

VA is required to furnish dental care in accordance with 38 U.S.C. 1712, as noted in Sections 1 and 3 above.

5.2. Community Entities and Providers

Historically, community entities and providers have demonstrated a desire and willingness to support veterans through pro bono or discounted services. In the community, veterans have access to legal services, employment and training services, health and social services, supportive housing programs, income support services, and dental care. While various veteran-centered services exist, veterans are not always aware of and/or connected to these programs and services. Given the public's support of veterans and the available pro bono or discounted services for veterans, VA has identified a unique opportunity to engage with community entities and providers to help connect veterans to pro bono or discounted dental care programs and services.

VA tracks dental care provided to veterans directly by VA or by authorized community care providers. However, VA has no mechanism to track dental care provided on a pro bono or discounted basis or dental care received by veterans not eligible for VA dental services. There are currently several non-profit organizations and companies who provide pro bono dental care for veterans. Veterans can receive pro bono or discounted dental care from providers if they meet the requirements of the program.

In September 2019, the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) awarded over $85 million to 298 health centers to expand their oral health service capacity (U.S. Department of Health and Human Services. (2019). HHS Awards over $85 Million to Help Health Centers Expand Access to Oral Health Care. Retrieved from *https://www.hhs.gov/about/news/2019/09/18/hhs-awards-over-85-million-help-health-centers-expand-access-oral-healthcare.html*). These investments could enable HRSA-funded health centers to provide new, or enhance existing, oral health services to communities that include veterans.

6. Proposed Pilot Program

This section describes the details and defines the terms of this pilot program and conditions that would justify pilot program expansion or termination. This demonstration model would be the initial demonstration being developed and tested for the CPCV Pilot Program. This demonstration model seeks to expand coordination and access to dental care for veterans not currently eligible for VA dental care.

The demonstration model aims to enable VA to more effectively serve enrolled veterans not eligible for VA dental care under 38 U.S.C. 1712. In this demonstration model, VA would collaborate with community entities and providers to develop and implement interventions that are cost neutral to VA. The designed interventions would facilitate the referral and scheduling of pro bono and discounted services for veterans who need dental care and services but are not eligible to receive such dental care and services from VA. VA will work closely with OMB to refine the design and scope of the pilot demonstration and provide an update to Congress at a later date.

6.1. Terms and Details of the Pilot Program

This proposal outlines a pathway for veterans who are enrolled in VA health care but do not qualify for coverage through VA to schedule pro bono or discounted dental care using either a call center model or an automated self-service portal that would connect veterans to pro bono or discounted dental services, thus expanding access. The call center or portal would be administered by non-VA entities, but would likely not be administered by the community providers or entities furnishing pro bono or discounted dental services under this program. Additionally, the pilot would connect veterans to HRSA working with Federally Qualified Health Centers (FQHC), Community Health Centers (CHC), free dental clinics, or other parties to provide dental services on a pro bono or discounted basis.

VA staff at selected sites would provide care coordination services between VA, community entities, and providers to support veterans

participating in this demonstration model. Care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services (McDonald, K.M., et al. (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. AHRQ Technical Reviews and Summaries, Vol 9.7. Retrieved from: *https://www.ncbi.nlm.nih.gov/books/NBK44015/*). VA would work with other entities in the community to provide a number to a call center or a web address for a self-service portal to schedule dental services. We anticipate there would be minimal impact on the current duties of VA staff. Any community entities or providers engaged in the development and implementation of this demonstration model should have proven experience with and commitment to serving veterans.

A tiered approach to care could be implemented, where veterans have access to one-time, acute dental care options as well as longer term care options focused on preventative care and long-term dental management; decisions regarding what services will be provided would be subject to the decisions of private entities and providers offering pro bono or discounted dental services to eligible veterans. VA would collaborate with community entities to engage dental providers and non-profit organizations to build a coalition of pro bono or discounted dental care providers willing to share their availability and service offerings with VA and provide their availability in the self-service portal. The portal would allow dental providers to indicate which tier of care they are willing to provide. The call center or online self-service portal would improve access by connecting veterans with conveniently located community entities and providers offering dental services. It is expected that when the call center or self-service portal becomes available, information regarding the self-service portal would be relayed to veterans via a multisource campaign.

The targeted benefits of the demonstration model are: Veterans ineligible for VA dental care experience improved access to dental care services; veterans benefit from enhanced care coordination with community dental providers and improved access to oral health care and benefits; Possibility of improved health outcomes by addressing oral health needs that impact and interact with other physical health and social determinants of health.

6.1.1. Deficits in Care and Affected Populations

The demonstration model would focus on the expansion and coordination of access to dental care benefits for veterans who are not eligible for VA dental care. We estimate that approximately 92 percent of veterans who are enrolled in VA health care do not have access to comprehensive dental care through VA and are thus at an elevated risk for oral health issues and complications.

The Healthy People 2020 Report highlighted limited access to and availability of dental services, and lack of awareness of the need for care, as critical barriers that impact a person's use of preventive dental health interventions. Social determinants that impact oral health include having lower levels of education and income, disabilities, other health conditions such as diabetes, and people from specific racial/ethnic groups (Office of Disease Prevention and Health Promotion. (2019). Oral Health. Retrieved from *https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health*).

The ADA reports that 28 percent of adults between the ages of 35–44 and 18 percent of adults 65 and older have untreated tooth decay (American Dental Association. (2013). Action for Dental Health: Bringing Disease Prevention into Communities. [PDF file]. Retrieved from *https://www.ada.org/~/media/ADA/Public%20Programs/Files/bringing-disease-prevention-to-communities_adh.ashx*). Additionally, the Centers for Disease Control and Prevention (CDC) report that nearly 70 percent of American adults 65 years and older have periodontal disease (Centers for Disease Control and Prevention. (2016). Oral Health Conditions: Periodontal Disease. Retrieved from *https://www.cdc.gov/oralhealth/periodontal-disease.html*).The prevalence of dental health issues reinforces the importance of addressing dental health in a timely fashion. The CDC reports that over 80 percent of adults have had at least one cavity by age 34. There are significant cost impacts arising from poor dental care for patients and VA, both in medical claims (*e.g.,* emergency department visits) and work productivity loss.

6.1.2. Pilot Program Interventions

The core tenets of the demonstration model include developing and enhancing trusted collaborations with community dental providers, prioritizing care and interventions, and individualizing the approach to improving veterans' oral health care needs. This demonstration model enables a standardized and streamlined approach to facilitating veterans' access to pro bono dental care and services. VA intends to pursue a phased approach to developing and implementing interventions for this demonstration model. It is anticipated that the phased development and implementation approach would follow the sequence listed below.

(1) Expanding on VA's experience establishing relationships with community entities to furnish services to VA and veterans at only nominal cost to VA, we intend to collaborate with community entities to establish a call center to schedule and coordinate appointments for veterans with high quality dental service providers participating in this demonstration model.

(2) In addition to utilizing a call center to connect veterans to community providers participating in the CPCV pilot program, VA will also collaborate with community entities to develop and implement a patient portal that allows veterans to directly schedule visits and own their individual data on the platform. An additional feature of the self-service portal would be the control the veteran would have over granting access to dental providers, caregivers, and community support team members of their choice. While the patient portal would not be owned and operated by VA, VA would have access to the veteran data contained on the platform. The platform will ensure that all Privacy Act, Health Insurance Portability and Accountability Act of 1996 (HIPPA), and VA information security standards are satisfied.

We believe a self-service patient portal and/or call center would present an opportunity for VA to enable veteran care coordination with pro bono dental services in a manner that is cost neutral to VA with minimal impact on current VA operations even if this service offering is scaled nationwide through subsequent expansion after determining that the pilot program has been successful. This strategic approach would expand on previously demonstrated interest in collaborations with private entities as demonstrated by the success of VA's recent efforts with organizations such as Walmart, T-Mobile, and Microsoft. A non-VA owned self-service patient portal or call center also would allow VA to enable the development and implementation of a national directory of dentists who are already providing pro bono care in their communities. Additionally, the national directory would create opportunities to

promote further research on the impact of oral health on other health and well-being outcomes.

Finally, a self-service patient portal or call center could encourage increased participation from existing pro bono providers, such as those affiliated with Dentists for Veterans, and the participation of additional dentists who do not currently offer pro bono services to veterans (Dentists for Veterans. (n.d.). About Us. Retrieved from *http://www.dentistsforveterans.org/about-us/.* (Note: Dentists for Veterans is an existing non-profit organization that provides low- to no-cost dental services to veterans and targets low income, physically disabled, and mentally ill veterans in Southern California.). Other groups, for example, include Everyone for Veterans, a private, non-profit organization based in the State of Washington, that connects veterans and their spouses to local community services and dental care (Everyone for Veterans (n.d.). About Us. Retrieved from *https://www.everyonefor veterans.org/about-us.html*), and Dental Lifeline, which has a network of 15,000 volunteer dentists and 3,700 volunteer laboratories that provides care to those who cannot afford dental care and have either a permanent disability, a medically fragile condition, or are over 65 (Dental Lifeline Network. (2019). About Us. Retrieved from *https://dentallifeline.org/about-us/*). Non-profit organizations that provide pro bono or discounted dental care to the general population could also be utilized in the demonstration model.

VA staff could also provide direct administrative support, either using the call center or portal or through other means, to help veterans access these pro bono or discounted dental services.

Where VA refers a veteran to specific providers, which would occur if the call center or portal is not operational, then the Department will provide the veteran with a list of providers which includes a prominent disclaimer that, ''The list is provided for informational purposes. The Department of Veterans Affairs does not endorse any listed provider.''

6.1.3. Pilot Program Costs

VA would collaborate with community entities or providers and dental providers to create multiple avenues for veterans to access pro bono dental care and discounted dental services provided by community providers. Information in this section is considered acquisition sensitive and therefore excluded, however, VA anticipates expending between $5 million and $10 million annually on the execution of the CPCV pilot program. VA would bear the impact evaluation and strategic execution and performance management/oversight of the pilot program.

6.1.4. Pilot Program Implementation

VA anticipates executing this pilot program in metropolitan areas with greater access to pro bono and discounted dental services in the community and in areas with access to FQHCs. Any enrolled veteran ineligible for VA dental benefits in participating areas would be eligible to participate, and any veteran affected by this program would receive direct notice about the program. It is anticipated that veterans would be able to self-identify their need for this program. VA staff working on a veterans' care team would receive information about this demonstration model and could recommend that veterans use the available resources.

VA would provide direct notice to veterans in selected areas regarding the CPCV Pilot Program through hard copy materials and informational advertisements in predetermined VA facilities and on VA's website. VA would also explore opportunities with media organizations to promote the demonstration model and the available resources. Finally, VA would include information on several national VA websites about this pilot program, how to access the portal, and eligibility criteria for qualifying veterans (U.S. Department of Veterans Affairs. (2019). VA Dentistry—Improving Veterans' Oral Health. Retrieved from *https://www.va.gov/dental/*) and VA Innovation Center (VIC) (U.S. Department of Veterans Affairs. (n.d.). VA Innovation Center. Retrieved from *https://www.innovation.va.gov/*).

VA, supporting providers, and participating veterans would have full access to self-reported beneficiary data. Veterans would be enabled and authorized to expand or limit the access to this data. The beneficiary data collected will be subject to the Privacy Act, HIPAA, and VA's information security requirements.

This pilot program would start upon the date identified in VA's notification to the public announcing the commencement of the program. The time between Congressional approval and VA's notification to the public announcing the start of the program would allow VA to engage the community, develop intervention requirements (such as available capacity of certified providers willing to provide services), and execute any necessary agreements with other entities; it would also give VA time to address other administrative requirements for the program. VA would engage dental care entities and providers willing to offer pro bono services or discounted dental care services to veterans and discuss how the pilot would operate while addressing any provider concerns. Initial outreach would focus on dental associations and dental provider organizations that have a history of working with veterans.

6.1.5. Pilot Program Beneficiaries

Enrolled veterans who are not eligible to receive dental care from VA under 38 U.S.C. 1712 would be eligible for the CCDB demonstration model. Initial veteran outreach and education would focus on enrolled veterans in metropolitan areas with access to discounted services and pro bono providers, but if this pilot program proves successful, VA could look for rural areas with available pro bono providers or those offering discounted services as well.

6.1.6. Pilot Program Evaluation

To evaluate the CCDB demonstration model, the performance of the intervention group would be compared to at least one control group.

Intervention group: Veterans that are not currently eligible to receive VA dental services.

Control group: Risk-stratified, randomized, and prospectively matched veteran enrolled in VA health care who are eligible to receive dental benefits in VA; or are ineligible to receive dental benefits in VA and not enrolled in the CCDB demonstration.

Sample performance data includes: Cost savings from reducing ED visits linked to oral health issues; Impact on access and veteran experience; Impact on patient satisfaction and customer experience measures mapped to Office of Management and Budget (OMB) Circular A–11 domains and applicable Consumer Assessment of Healthcare Providers and Systems (CAHPS) Dental Plan survey results (OMB approval would be needed to distribute the CAHPS Dental Plan survey to demonstration participants.) Examples of data sources include: VA claims, encounters, and commercial claims.

Sample evaluation questions: Will experience outcomes for the intervention group exceed the control group? Which of the interventions utilized in this demonstration model will be most effective for veterans to access pro bono dental care? Will VA achieve cost savings as a result of a reduction in the number of ED visits linked to oral health issues?

6.1.7. Potential for Impact on Center for Innovation for Care and Payment Priorities

Section 1703E(a)(3) identifies specific objectives for pilot programs. This demonstration model would focus on improving access to, and quality, timeliness, and patient satisfaction of care and services, and creating cost savings for VA by expanding the availability of dental services through administrative support to veterans currently ineligible for VA dental care. The care would be provided by high-quality providers with oversight provided by HRSA and FQHCs in a timely fashion, and we expect patient satisfaction would improve as a result. Better care should also reduce costs to VA for ED visits linked to oral health issues. The following table contains key measures and desired outcomes that were identified by VA leadership to determine the success of care delivery.

Table 1: Key Factors and Desired Outcomes

Key Factors / Desired outcomes	Access	Quality	Timeliness	Patient Experience	Cost Savings
Addresses deficits in care?	Yes	No	No	Yes	Yes
Geographic considerations?	Yes	No	No	Yes	No
Patient-centeredness focus?	Yes	Yes	Yes	Yes	Yes
Technology-enabled care coordination?	Yes	No	No	Yes	No
Pilot program 5 years or less?	Yes	Yes	Yes	Yes	Yes

6.1.8. Impact on Desired Outcomes

Connecting veterans to pro bono and discounted dental care would enable enrolled veterans that are ineligible for VA dental care to access the services they need at no cost or reduced cost, filling a significant deficit in care. Providing needed dental care to veterans through local community providers would simplify access to care for patients. The self-service automated platform would centralize information related to the availability and specialty of dental care providers in the community willing to provide pro bono or discounted services to veterans. This pilot program would be expected to occur over a period of 5 years to allow adequate time to design and test interventions and aggregate relevant metrics for evaluation.

6.2 Responsibilities of Key Stakeholders

The key stakeholders and associated responsibilities of related parties involved in the operation of the CCDB demonstration model include:

Table 2: Key Stakeholders, Roles, and Responsibilities

Role	Role Description	Responsibilities
Secretary of Veterans Affairs	Serves as the Executive Sponsor and provides final Department level approval to pilot programs authorized by section 1703E.	• Serves as final approving authority at the Department level.
VA Innovation Center	Leads pilot program development, implementation, and day-to-day oversight. Collaborates with relevant stakeholders across the Department, other public and private sector parties in the development and evaluation of pilot program proposals and reports.	• Operates the Center for Innovation for Care and Payment established by section 1703E. • Provides strategic and tactical oversight to ensure requirements of section 1703E are met in the development and implementation of pilot programs authorized by section 1703E. • Leads stakeholder engagement efforts associated with the development and implementation of pilot programs authorized by section 1703E. • Collaborates with HRSA, FQHCs, and other parties to provide oversight.
VA Program Office	Collaborates with VIC on the development and implementation of pilot programs authorized by section 1703E.	• Serves as a Subject Matter Expert required to provide technical evaluation of pilot program interventions.
Other VA Offices	Department employees actively engaged in the implementation of the pilot program.	• Advocates for broad stakeholder support of the pilot program. • VA OIT establishes mutually beneficial information exchange processes to support the pilot program. • Works with pilot program implementation support and other entities and providers to establish communication needs and approaches required by the pilot program.
Pilot Program Participants	Beneficiaries participating in the pilot program.	• Participates in the pilot program. • Provides qualitative and quantitative data to support pilot program analysis and impact evaluation.
Operating Sites	Facilities participating in the pilot program.	• Supports the efforts of the pilot program as outlined in the pilot program and as requested by Department leadership. • Provides qualitative and quantitative data to support pilot program analysis and impact evaluation.
Pilot Program Implementation Support	Vendors actively engaged in the implementation of the pilot program.	• Performs agreed upon duties and responsibilities in a timely fashion and in a high-quality manner in accordance with the terms and conditions of the pilot program. • Fulfills the contracted statement of work in a timely manner and in accordance with the terms and conditions of the pilot program. • Works with VA to establish communication needs and approaches required by the pilot program.
Pilot Program Development Entities or Provider(s)	Other public and private sector individuals and organizations who establish a formal agreement to collaborate with VA in the joint exploration and development of pilot programs authorized by section 1703E.	• Entities or providers offer resources and expertise to support the design of the pilot program and work with other participants to ensure successful launch and ongoing operations of the demonstration. • Entities or providers perform Veteran outreach, education, and cultural competency to support the pilot program.

6.3. Pilot Program Expansion or Termination

6.3.1.1. Terms

This is a demonstration model of the CPCV Pilot Program. Consistent with 38 CFR 17.450(h), VA may expand the scope or duration of a pilot program if, based on an analysis of the data and analysis developed for the CCDB demonstration model, VA expects this pilot program to (1) reduce spending without reducing the quality of care, (2) improve the quality of patient care without increasing spending, or (3) improve the quality of care while reducing spending. Expansion of the pilot program may occur if the combined results of the impact analysis and evaluation of the demonstration models tested under a pilot program indicate that the desired outcomes of the pilot program were achieved. VA may not expand a pilot program if VA determines that such expansion would deny or limit the coverage or provision of benefits for individuals receiving benefits under chapter 17 of title 38, U.S.C. Expansion of a pilot program may not occur until 60 days after VA has published a document in the **Federal Register** and submitted an interim report to Congress stating its intent to expand a pilot program. Examples of potential program expansions might include, but are not limited to, the geographic location of the pilot and the range of services provided. VA may also extend the duration of a pilot program by up to an additional 5 years of operation, and any pilot program extended beyond its initial 5-

year period must continue to comply with the provisions in section 17.450 regarding evaluation and reporting.

6.3.1.2. Conditions

VA would continuously monitor the performance of this demonstration model. This demonstration model is designed to reduce spending without reducing the quality of care and improve the quality of patient care without increasing spending. The metrics to be measured and compared to the study population include but are not limited to improved veteran satisfaction and reduced ED utilization.

6.3.1.3. Implementation Approaches

The demonstration model would evaluate veteran populations, access requirements, deficits in care assessments, and available provider networks in determining geographic expansion selection.

6.3.2. Pilot Program Termination or Cessation

6.3.2.1. Terms

Pilot termination is defined as ending the pilot program earlier than its authorized period (in this case, 5 years from commencement) upon a determination by the Secretary that the pilot program is not producing quality enhancement or quality preservation, or is not resulting in the reduction of expenditures, and that it is not possible or advisable to modify the pilot program either through submission of a new waiver request or through modification under section 17.450(i). Section 17.450(j) establishes these conditions. If VA determined that the CCDB demonstration model was not producing quality enhancement or quality preservation, or was not resulting in the reduction of expenditures, and that it was not possible or advisable to modify the demonstration model, VA would terminate the demonstration model within 30 days of submitting an interim report to Congress that stated such determination. VA would also publish a document in the **Federal Register** regarding the pilot program's termination.

Cessation of a pilot program is defined as the on-schedule ending of a pilot program, and it may occur if the combined results of the independent impact analysis of the demonstration model tested under a pilot program indicate that the desired outcomes of the pilot program were not achieved or are inconclusive. VA would also publish a document in the **Federal Register** regarding the pilot program's cessation.

6.3.2.2. Implementation Approaches

For the demonstration model, VA would initiate termination with written notification to all beneficiaries, stakeholders, and vendors contractually engaged to support the implementation of this demonstration model. This termination would occur within 30 days of VA submitting an interim report to Congress stating that VA has determined a pilot program is not producing quality enhancement or quality preservation, or is not resulting in the reduction of expenditures, and that it is not possible or advisable to modify the pilot program either through submission of a new waiver request or through modification under section 17.450(i). Notification would be provided to allow for appropriate announcements and initiation of demonstration model termination activities. VA would provide notification 90 days in advance of the cessation of a pilot program.

7. Request for Waivers

To implement the CPCV Pilot Program, we require Congressional approval of a waiver from current restrictions in VA statutes.

7.1. Statutory Requirements

7.1.1. Specific Authorities To Be Waived

Specifically, Congress must waive the limitations in 38 U.S.C. 1712 concerning the population of veterans eligible for VA dental care and services to permit VA to offer administrative support to enrolled veterans otherwise ineligible for this care.

7.1.2. Standard(s) To Be Used in Lieu of Waived Authorities

Congressional approval of this waiver would allow VA to operate the pilot program as though 38 U.S.C. 1712 were revised as described below:

(a) By redesignating subsections (d) and (e) as subsections (e) and (f), respectively;

(b) by inserting after subsection (c) the following new subsection (d):

''(d)(1) Through collaboration with community entities and providers approved by the Secretary, the Secretary may provide administrative support for the provision of dental care to enrolled veterans for care that they are not eligible to receive from the Department.

''(2) Notwithstanding any other provision of law, the Secretary shall incur no liability (including under section 1151 of this title) for any disability, injury, or death resulting from care furnished by a non-Department entity or provider pursuant to this subsection.''

7.1.3. Reason(s) for Waivers

As previously explained, VA has limited statutory authority to furnish dental care. This waiver would authorize VA to provide administrative support for the provision of needed outpatient dental care in the community to enrolled veterans who are not eligible to receive that dental care from VA under 38 U.S.C. 1712. This waiver would authorize VA staff, in the scope of their normal duties, to work with community entities or providers approved by the Secretary to refer veterans to dental care resources that are provided pro bono or at a discount. This waiver would also expressly exempt VA from any liability that may arise from tortious conduct by a community provider. A veteran's sole remedy in such a situation would be recovery against the provider of services.

This waiver would expand VA's authority under section 1712 and would allow VA to more effectively serve veterans ineligible for VA dental benefits. Specifically, VA administrative staff would be authorized to educate veterans who are not eligible for VA dental care on the dental care options available to them from the community. VHA administrative staff would be authorized to connect veterans to resources that can schedule veterans for dental care.

7.1.4. Metrics To Be Used To Determine the Impact of Waivers

Metrics used to assess the pilot would include utilization of care and services related to oral care, ED utilization, ED outcomes, and patient satisfaction. These would be used to assess the effect of the waiver upon the quality, timeliness, or patient satisfaction of care and services furnished through the pilot program.

Table 3: Sample Metrics and Sources

Outcome Category	Metric	Desired Performance	Source(s)
Cost Savings	Spend on care and services related to oral care	Decrease	VA, key stakeholders
Quality	ED utilization Veteran satisfaction	Decrease Increase	VA, key stakeholders

Assumptions

Funds spent on care and services related to oral health and ED utilization would include both data on community care utilization and VA internal data.

Quality would be measured through monitoring of ED utilization for oral health. Veteran experience would be measured by sources such as customer experience measures mapped to OMB Circular No. A–11 domains and applicable CAHPS survey results. Consistent with 38 CFR 17.450(g), evaluation of this pilot will include a survey of participants or beneficiaries to determine their satisfaction with the pilot program. VA will make the evaluation results available to the public on the VA Innovation Center website. All collections of information will be conducted in accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

7.1.5. Anticipated Cost Savings

Anticipated benefits for the CCDB demonstration model are improved patient care and satisfaction, as well as reduced expenditures associated with ED visits linked to oral health issues. Improving ED utilization is a quality metric because by eliminating time spent on dental services that could have been treated in a clinic, ED Physicians can devote their time to higher priority patients.

VA anticipates that reduced expenditures associated with ED visits linked to oral health issues would reduce costs for other related Federal programs, but we anticipate that VA would be unable to measure the impacts to other related Federal programs.

This waiver would have minimal to no net cost impact to VA, as VA would not be paying for the pro bono or discounted dental services and would not be liable for any tortious conduct by community providers. This provision would have no impact on VA clinicians (medical doctors and nurse practitioners), as they routinely provide general oral assessment for enrolled veterans eligible for dental benefits as part of their examination. VA also anticipates this would have no impact on clinic medical support assistants that might recommend the scheduling portal or otherwise provide administrative support.

Improved access to care should lead to better dental health outcomes and reduced unnecessary utilization of care and services associated with poor oral health that could lead to cost savings. Improved access to dental health services could lead to a reduction in ED utilization for dental health care needs. Drivers of these cost savings would include improved access to care, increased use of preventative oral care, and improved care coordination.

VA does not have a reliable actuarial basis to identify the estimated cost savings. Further analysis would be required to determine potential savings over current expenditures for participating veterans. Development of a comprehensive financial impact model could be pursued once the details of this demonstration model are finalized. Factors that would influence the financial predictions include: Overall acuity and health risk factors of the demonstration population; Participation strategies and speed of uptake (pilot elements); Specific services offered by pro bono care providers, location of service, etc.; Comorbidities associated with oral health care; Operational plans for VHA pilot program sites and Office of Information and Technology.

The detailed budgetary impact and anticipated cost savings analysis associated with these cost factors will be provided at a later date.

Based on information from ADA from private providers, there are significantly lower costs for common preventive services compared to common restorative services, as represented below (American Dental Association. (2013). Action for Dental Health: Bringing Disease Prevention to Communities. Retrieved from *https://www.ada.org/~/media/ADA/Public%20Programs/Files/bringing-disease-prevention-to-communities_adh.ashx*).

Table 4: Preventive Service Compared to Restorative Service

Cost of Common Preventive Service	
Topical fluoride (adult)	$32.59
Periodic exam	$44.10
Cleaning (adult)	$82.08
Sealant application (per tooth)	$44.12
Cost of Common Restorative Service	
Amalgam filling, two-surface	$146.61
Resin-based filling, rear tooth	$197.09
Root canal on molar	$918.88
Porcelain crown	$1,026.30

7.1.6. Schedule of Interim Reports

VA would submit interim reports to the Committees on Veterans' Affairs of the House of Representatives and the Senate no later than once every 6 months from the date of the commencement of the pilot program. These interim reports would describe the results of the pilot program so far and the feasibility and advisability of continuing the pilot program.

7.1.7. Schedule for Cessation of Pilot Program and Submission of Final Report

Absent any extension of the pilot program pursuant to 38 CFR 17.450(h), VA would end the pilot program 5 years after the date on which it commences. VA would submit a final report on the pilot program describing the results of the pilot program and the feasibility and advisability of making the pilot program permanent no later than 6 months after the end date of the pilot program.

7.1.8. Estimated Budget of Demonstration Model

VA would not be paying for the pro bono dental services so there would be no costs related to care. However, the direct costs to VA of operating the CCDB demonstration model would depend on participation, duration, and other factors.

Assumptions

VA would incur only nominal costs associated with monitoring the results of the program. Section 1703E(g)(2)(A) states the Secretary may not expend more than $50 million in any fiscal year from amounts provided in advance in appropriations acts for the Veterans Health Administration and for information technology systems. In section 17.450(d), VA clarified this authority to state that it will obligate no more than $50 million in any fiscal year for the conduct of the pilot programs (including all administrative and overhead costs, such as measurement, evaluation, and expenses to implement the pilot programs themselves) operated under this authority; VA also will not actively operate more than 10 pilot programs at the same time.

7.2. Regulatory Requirements

7.2.1. Geographic Location

This pilot would serve enrolled veterans who are not eligible for dental care from VA in metropolitan areas with greater access to pro bono and discounted dental services in the community. Metropolitan areas generally have more dental providers, and more dental providers who are willing to provide pro bono or discounted services, than other areas. The veteran population in metropolitan areas is also more densely located, allowing more veterans to be served by these providers. It is believed that operating this pilot program in metropolitan areas would address deficits in care related to oral health by expanding access to quality dental care at no cost or at a discounted cost. In Section 3, we identified VISN 2, 8, 10, and 12 as possible areas in which the pilot program would be operated.

7.2.2. Any Applicable Provision of Existing Regulations Implementing Any Laws To Be Waived

No existing regulations would need to be waived to execute this pilot program.

7.2.3. Notice of Eligibility

An initial outreach communication plan would focus on introducing this demonstration model and building program awareness. VA would take reasonable actions to provide direct notice to veterans eligible to participate in this demonstration model and would provide general notice to other individuals who are also eligible to participate. Direct notice would include hard copy materials and informational advertisements in VA health care facilities selected for this model. VA would also explore opportunities with media organizations to promote the demonstration model and the available resources. Finally, VA would include information on several national VA websites about this pilot program, how to access the portal, and information about how eligible veterans could participate. VA would engage dental care entities and providers willing to offer pro bono or discounted services to veterans and discuss how the pilot would operate while addressing any provider concerns. Initial outreach would focus on dental associations and dental provider organizations that have a history of working with veterans. During the initial period, strategic monthly outreach campaigns would be identified and presented for approval. Each communication outreach plan would include outreach goals, target groups, release dates, and campaign distribution details.

7.2.4. Definitions

VA's regulations at 38 CFR 17.450(b) provide general definitions of terms in the statute and VA's regulations, but also permit further definition through the pilot program proposal. VA offers no further definition of terms in its regulations, but it has previously identified the metrics it would use to determine whether the program is successful.

7.2.4.1. Patient Satisfaction of Care and Services

Patient satisfaction of care and services refers to patients' rating of their experiences of care and services. Patient satisfaction of care and services would not be further defined for this pilot program.

7.2.4.2. Payment Models

Payment models refer to the types of payment, reimbursement, or incentives that VA deems appropriate for advancing the health and well-being of beneficiaries. Payment models would not be further defined for this pilot program.

7.2.4.3. Quality Enhancement

Quality enhancement refers to improvement or improvements in such factors as quality, beneficiary-level outcomes, and functional status as documented through improvements in measurement data from a reliable and valid source. Quality enhancement would not be further defined for this pilot program.

7.2.4.4. Quality Preservation

Quality preservation refers to the maintenance of such factors as oral health, beneficiary-level outcomes, and functional status as documented through maintenance of measurement data from an evidence-based source. Quality preservation would not be further defined for this pilot program.

7.2.4.5. Reduction in Expenditure

Reduction in expenditure refers to, but is not limited to, cost stabilization, cost avoidance, or decreases in long- or short-term spending. Reduction in expenditure would not be further defined for this pilot program.

7.2.5. Measures

Measures to assess whether VA is achieving its goals would include the following: Reducing costs of ED utilization related to oral health; and improving veteran satisfaction.

7.2.6. Schedule of the Release of Evaluation Results in the Proposal

In addition to interim and final status reports, an evaluation would be completed at the end of the demonstration model and the pilot program to determine if the tested models and interventions were more effective than the status quo. Interim reports would be submitted every 6 months, and a final report would be submitted within 6 months of the completion of the pilot program.

8. Additional Considerations

8.1. Sustainable Value Creation and Capture

Veterans participating in the CCDB demonstration model would gain coordinated access to high quality pro bono or discounted dental services, enabling them to receive preventative and restorative dental care. Value creation may occur after the successful implementation of the CCDB demonstration model by: Addressing deficits in care resulting from underutilization of preventative care, geographic barriers, and poor clinical outcomes for the veterans participating in the demonstration model; Addressing availability of pro bono or discounted community dental care services for veterans ineligible for dental care under 38 U.S.C. 1712; Enhancing access to dental care and improved satisfaction with the availability of dental services; Improving the coordination of care and benefits for veterans to increase their access to dental care benefits, thereby improving overall health outcomes.

8.1.1. Impacted Stakeholders

VA anticipates that the CCDB demonstration model would create cost savings related to overall veterans health, increased access to care, and improved health outcomes through the delivery of pro bono or discounted dental services and care coordination. Due to the current statutory eligibility criteria for VA's dental program, the impact to VA dental care expenditures would be limited. However, we expect that this demonstration model would result in reduced overall VA health care expenditures due to the relationship between improved oral health and comorbid disease states. Pro bono dental providers and those offering discounts would benefit from a well-coordinated scheduling process that allowed them to list their availability on a platform where veterans could schedule appointments directly.

8.1.2. Maximizing Pilot Program Impact

The impact of the pilot program could be enhanced by developing a culture of cooperation. Further, this pilot program would: (1) Increase the availability of dental health benefits to veterans, and (2) Improve the coordination, execution, and efficiency of dental health care delivery.

Existing non-profit organizations and pro bono providers or those offering discounted services should be encouraged to recruit their peers to expand the care coordination platform. There is potential for this demonstration model to expand to include coordination of other needed services for veterans over time.

8.2. Pilot Program Modifications

Consistent with section 17.450(i), the Secretary may modify elements of this pilot program in a manner that is consistent with the parameters of the Congressional approval of the waiver described above. Such modifications would not require a new submission to Congress for approval.

8.3. Record Keeping

VA would maintain all pilot program records and relevant analysis in accordance with applicable record control schedules.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Pamela Powers, Chief of Staff, Department of Veterans Affairs, approved this document on December 10, 2019, for publication.

Jeffrey M. Martin,

Assistant Director, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

[FR Doc. 2019–26901 Filed 12–12–19; 8:45 am]

BILLING CODE 8320–01–P