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FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

STATEMENT OF
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DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JULY 11, 2017

Chairman Isakson, Ranking Member Tester, distinguished Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to present our views on the bills under consideration at today's hearing. As you know, DAV is a non-profit veterans service organization comprised of nearly 1.3 million wartime service-disabled veterans. DAV is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

S. 115, the Veterans Transplant Coverage Act

Depending where a veteran resides in relation to a Department of Veterans Affairs (VA) Transplant Center, the Department may only cover transplant procedures for veterans from deceased donors limiting the possibility of finding an organ match from relatives. Additionally, VA national policy indicates VA will only cover the transplant-related round-trip travel and lodging costs for the living donor and a support person. Unless the veteran is the live donor, post-transplant care is not provided by VA.[1]

This bill authorizes VA to provide veterans coverage for live donor transplant operation procedures at any health care facility if the veteran qualifies for the VA Choice Program. The VA would be required to fully fund all care and services before and after the transplant procedure.

DAV has no resolution from our membership to support this draft bill; however, its purpose appears beneficial for veterans in need of this specialized care; therefore, we have no objection to its favorable consideration by this Committee.

S. 426, the Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017

If enacted, this bill would direct VA to carry out a pilot program to provide educational assistance to certain veterans with the goal of employment as VA physician assistants.

[1] VHA Directive 2012-018, Solid Organ and Bone Marrow Transplantation; VHA Handbook 1102.1, National Surgery Office;

Under this bill, the pilot program would target veterans with experience gained in medical or military health care while serving, and who had received a certificate, associate degree, baccalaureate degree, master's degree, or post-baccalaureate training in a science related to health care, and had participated in the delivery of health care services or related medical services.

The bill would require VA to provide educational assistance, including no fewer than 25 scholarships, to participants employed each year of the pilot program. VA would be required to reimburse their costs of obtaining master's degrees in physician assistant studies or similar master's degrees, consistent with VA's existing health professions scholarship program authorized in Chapter 76 of title 38, United States Code. The bill would require VA to make available mentors for participants at each VA facility and would require VA to establish partnerships with other government programs and with a specific number of educational institutions that offer degrees in physician assistant studies. It would also require selectees to agree to an obligated work period.

The bill also would require VA to establish standards to improve the education and hiring of VA physician assistants, and implement a national plan for the retention and recruitment of VA physician assistants.

The bill would establish a series of new, mandatory positions in VA's national Office of Physician Assistant Services in VA Central Office, including a Deputy Director for Education and Career Development, a Deputy Director for Recruitment and Retention, a designated recruiter of physician assistants, and an administrative assistant to support these functions. The bill would outline their major duties.

The bill would re-designate not less than $8 million in funds appropriated prior to the passage of this bill to carry out its purposes. The bill is silent on sources of additional funding that might be needed to meet its mandates.

Finally, the bill would align VA physician assistant pay grades equivalent to the pay grades of VA registered nurses.

DAV does not have a resolution from our membership specific to VA recruitment, training or employment of physician assistants as a single employment category, but we recognize the value of this bill in improving health provider manpower in the VA, and especially in addressing shortages being observed today in VA's primary care provider workforce. On this basis DAV would not object to enactment of this bill.

S. 683, the Keeping Our Commitment to Disabled Veterans Act of 2017

DAV endorses S. 683 and calls for swift enactment of this legislation based on DAV Resolution 142, which calls for enactment of legislation to expand the Department of Veterans Affairs (VA) comprehensive program of long-term supports and services (LTSS), including nursing home care, for service-connected disabled veterans.

This bill would extend an expiring requirement under law that the VA provide nursing care for certain veterans with service-connected disabilities. VA is legislatively mandated by the *Veterans Millennium Health Care and Benefits Act* (Public Law 106-117) to provide continuing nursing home care for enrolled veterans who have a 70 percent or greater service-connected disability, as well as those who need such care for a service-connected disability, or who have a rating of total disability based on individual unemployability.

According to VA, there were around 21,300 veterans nationwide who met the legislative mandate for nursing home care in fiscal year (FY) 2016. VA estimates there will be over 21,800 veterans treated under this legislative mandate in 2017 and this number is projected to increase to over 22,200 in FY 2018 and over 22,600 in FY 2019. Without extension of the current mandate by Congress beyond December 31, 2017, VA would no longer be required to provide this critical LTSS coverage to service-disabled veterans.

Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay nursing home services and in-home and community based services. Currently, World War II and Korean War era enrollees are in the age bands that are the highest users of LTSS. Likewise, Vietnam era veterans will be needing and seeking a greater share of LTSS, with most having aged beyond 75 over the next ten years.

S. 833, the Servicemembers and Veterans Empowerment and Support Act of 2017

Section 2 of S. 833, the Servicemembers and Veterans Empowerment and Support Act of 2017, would expand eligibility for VA counseling and treatment for sexual trauma, to include "cyber harassment of a sexual nature" to the definition of MST. It also expands the authority of the Secretary to provide counseling and care to members of the armed forces who suffered MST and are currently on "active duty for training", or "inactive duty training" in addition to service members on active duty.

Section 3 of the measure seeks to relax the standard of proof for MST-related claims by amending Section 1154 of title 38, United States Code (USC) by adding a new section. Specifically, the bill would require that a veteran who claims that a mental health condition began in, or was aggravated by MST during active service the VA shall accept as sufficient proof for service-connection: 1) a diagnosis of the mental health condition by a mental health professional along with satisfactory lay evidence or other evidence of such trauma, 2) and an opinion by the mental health professional that the mental health condition is related to such MST if consistent with the circumstances, conditions, or hardships of service even without an official record of such incurrence or aggravation in service. Furthermore, the bill would require VA to resolve every reasonable doubt in favor of the veteran with the reasons for granting or denying service-connection recorded in full.

Under this bill, a covered mental health condition would be defined as post-traumatic stress disorder (PTSD), anxiety, depression, or other mental health diagnosis described in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that the Secretary determines to be related to MST. MST is

defined as a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred during active military service.

S. 833, codifying existing regulations related to the evaluation of claims for compensation involving MST and requires the Secretary to ensure that non-military sources of evidence that may support the claim are specified and used in adjudication of the claim. Examples of such evidence include: records from law enforcement authorities; rape crisis centers; mental health counseling centers; hospitals and physicians; pregnancy tests and tests for sexually transmitted diseases; statements from family members, roommates or other members of the Armed Forces or veterans and clergy. Evidence of behavioral changes can also be considered in support of a claim for service connection to include, a request for transfer to another duty assignment; deterioration of work performance; substance abuse; episodes of depression; panic attacks or anxiety without an identifiable cause; and unexplained economic or social behavior changes.

The bill requires that VA may not deny a claim of a veteran for compensation for PTSD that is based on an assault, battery, or harassment without first advising the veteran that evidence described above may constitute credible corroborating in their claim and allow the veteran an opportunity to furnish such evidence or advise the Secretary of potential sources of that evidence.

S. 833 also requires the VA to report to Congress not later than March 1, 2018 and once a year afterward to 2027, on claims covered in this section submitted during the previous fiscal year. Reports are required to identify and track claims decision trends across regional offices. Each report shall include: the number of claims submitted; of those claims the number and percentage submitted by sex; the number of claims denied, to include the number and percentage of those denied claims for each sex; the number and percentage of claims that were approved, disaggregated by sex, of claims assigned to each rating percentage. The bill also requires VA include the three most common reasons for denials to include the number of denials that were based on failure of a veteran to report for a medical examination.

Section 4 of the bill directs the VA to ensure that DoD Sexual Assault Response Coordinators advise members of the Armed Forces who report an incident of MST that counseling services are available at VA Vet Centers.

For decades, VA treated claims for service connection for mental health problems resulting from MST in the same way it treated all claimed conditions—the burden was on the claimant to prove the condition was related to their military service. These types of claims, without validation from medical, investigative or police records, were routinely denied.

More than a decade ago, VA relaxed its policy of requiring medical or police reports to show that MST occurred. 38 CFR 3.304 (f)(5) provides for a liberalization of requirements for establishment of service connection due to personal assault, including MST, even when documentation of an "actual stressor" cannot be found, allowing evidence in other records to serve as a "marker" indicating that a stressor may have occurred instead. Nevertheless, since 2002, VA has denied many claims for mental health conditions resulting from MST because

claimants were unable to produce evidence that an assault or harassment occurred. Between 2008 and 2012, VA verified that grant rates for PTSD resulting from MST were 17 to 30 percent below grant rates for PTSD resulting from other causes.

Unfortunately, for various reasons including fear of potential retaliation, personal shame or embarrassment and impact on career, survivors of MST often do not report sexual trauma to medical or law enforcement authorities. Lack of reporting results in a disproportionate burden placed on veterans to produce evidence of MST. Full disclosure of incidents occurring during service tend to be reported years after the fact, making proof of service connection for PTSD and other mental health conditions even harder to establish. Demonstrating a causal relationship between certain injuries and later established disability can be daunting due to lack of records or human factors that obscure or prevent documentation or even basic investigation of such incidents after they occur.

Sexual trauma during military service is ever more recognized as a hazard of service for one percent of men and 20 percent of women who have served. It often later manifests in heavy burdens of mental health conditions for veterans and the need for complex care and specialized treatment required from VHA. An absence of documentation of military sexual trauma in the personnel or military unit records of individuals often prevents or obstructs adjudication of claims for disabilities of this group veterans suffering the devastating after-effects of sexual trauma associated with military service.

Enacting this legislation would expand MST counseling and treatment and ease some of the evidentiary requirements for veterans filing claims for service-connection for conditions related to the after-effects of a MST. DAV supports S. 833, the Servicemembers and Veterans Empowerment and Support Act of 2017, in accordance with DAV Resolution No. 027 to improve the process for determining service connection for conditions related to sexual trauma.

S. 946, the Veterans Treatment Court Improvement Act

The bill requires the VA to hire additional Veterans Justice Outreach (VJO) specialists to ensure veterans have greater access to effective and tailored treatment. VA created the VJO program to provide veterans with timely access to VA services and engage justice-involved veterans in specialty treatment courts. The veterans' treatment court model removes veterans from the regular criminal justice process and helps to address symptoms that are unique to veterans, including post-traumatic stress disorder and substance abuse disorder. In a veterans' treatment court, the presiding judge works alongside the veteran and the VJO specialist to establish a structured rehabilitation program that is tailored to the specific needs of that veteran.

The bill would authorize $5.5 million for each fiscal year beginning in FY 2017 through 2027 to hire 50 additional VJO Specialists. Funding priority would be given to VA facilities that work with newly established or exiting but understaffed veterans' treatment courts. VA is required to annually report on the implementation of the bill and its effect on the VJO program. The Government Accountability Office is also required to review and report on the implementation of the bill and the overall effectiveness of the VJO program for justice-involved veterans.

DAV supports S. 946 based on DAV resolution 124 calling for the continued growth of veterans' treatment courts. We recognize the importance of this program and are pleased to inform you that DAV members across the country have volunteered to serve as mentors in veterans' treatment courts.

S. 1153, the Veterans ACCESS Act

DAV supports this legislation that would require the Secretary to make ineligible any non-VA health care provider seeking to provide care to veterans through any of VA's purchased care authorities if the provider had been removed from VA employment or had a VA credential revoked because they endangered the health or safety of patients, or if they had violated any other medical licensure requirements. The legislation would also give the Secretary authority to make ineligible any provider under investigation by a medical licensing board, or who has entered into a settlement agreement for disciplinary action related to their medical practice, if the Secretary deems them a threat to the health, safety or welfare of veterans. In addition, the legislation requires the Secretary to suspend eligibility of any health care provider to provide non-Department health care services to veterans if the health care provider has already been suspended from practicing within VA.

DAV Resolution 238 calls for, "…strengthening, reforming and sustaining a modern, high-quality, accessible and accountable VA health care system; AND … creating integrated networks with high-quality community providers where needed…" S. 1153 would contribute to improving the quality of providers within such integrated networks by helping to preclude certain health care providers when VA is aware they have a documented record of endangering patient health or safety.

S. 1261, the Veterans Emergency Room Relief Act of 2017

Mr. Chairman, DAV supports S. 1261, the Veterans Emergency Room Relief Act of 2017, in accordance with DAV Resolution 240 which calls upon Congress to authorize urgent care as part of VA's basic health benefits package. VA provides a comprehensive health benefits package, yet the availability of urgent care has remained problematic because, in many locations, VA health care services are not offered on weekends, holidays, evenings and nights. The prudent layperson standard VA has used as one of the criteria to establish eligibility for VA reimbursement for emergency care and the rules for contacting VA to ensure veterans are reimbursed for such care are confusing to veterans and inconsistently applied by VA staff responsible for completion of these claims. These factors frequently result in denial of reimbursement for emergency room care and create a significant financial hardship for many disabled veterans.

This bill, authorizing VA to provide reimbursement to veterans who receive urgent care services, fills an important coverage gap for veterans who rely upon VA for care. It also has the potential to create cost savings for VA by allowing veterans to seek care in non-VA urgent care centers which are less costly than hospital emergency rooms. The National Center of Health Statistics found that almost half of emergency room patients (48%) came there because their

primary care doctors were not available. Urgent care fills the gap between the truly emergent care for conditions that may result in the loss of life or limb (which require advanced trauma care treatment), and less complex acute conditions, such as respiratory and skin infections, sprains, back pain or other minor injuries, that require attention and treatment, but would normally be addressed by primary care doctors if they were available. To further strengthen this important measure, we ask the Committee to consider inserting language allowing the VA to enter into agreements in addition to contracts with urgent care providers.

This measure requires the Secretary to establish co-payments for urgent care services for certain veterans. However, veterans who are hospitalized as a result of their urgent care visit and veterans seeking care for a service-connected condition in addition to veterans meeting criteria for hardship exceptions would be exempt from copayments.

DAV supports this legislation to include urgent and emergency care as part of VA's medical benefits package, consistent with DAV Resolution No. 240.

S. 1266, the Enhancing Veteran Care Act

S. 1266, the Enhancing Veteran Care Act, would authorize the Secretary of Veterans Affairs to enter into contracts with qualified nonprofit organizations to investigate VA medical centers for the purposes of assessing and reporting any deficiencies identified.

This measure requires the Secretary to delegate the authority to contract for an investigation to the director of the Veterans Integrated Service Network (VISN) in which the medical center is located or the director of the medical center. Before entering into a contract the VISN or medical center director would be required to notify the VA Secretary, the VA Inspector General and the Comptroller General of the United States to ensure there is coordination of any ongoing investigations.

DAV has no resolution from our membership regarding the specific topic of this legislative proposal and takes no formal position on the bill.

S. 1279, the Veterans Health Administration Reform Act of 2017

The Veterans Health Administration Reform Act of 2017 would rewrite VA's existing purchased care authority by establishing a new "Care in the Community" program with streamlined eligibility when VA determines it is in the veteran's clinical best interest, including consideration of timeliness, or when the veteran faces undue access burdens, such as excessive driving distance, or when VA determines it is not economical to directly provide the care. The bill requires VA to reach agreements with the Department of Defense, Indian Health Services and other federally qualified health centers for the provision of care to eligible veterans. It also authorizes provider agreements for VA to engage community health care providers. Administration of the program and coordination of veterans health care would remain within VA.

S. 1279 also seeks to improve timely access to care by authorizing reimbursement for emergency and urgent care services, improving coordination of care for veterans eligible to use Medicare and Medicaid, and making other changes to educate veterans and VA about access options for enrolled veterans.

Although DAV does not have resolutions regarding some of the innovative ideas in the legislation, we support the overall intent of the legislation to strengthen and expand options for veterans to receive care from community providers when VA is unable to directly provide timely, high quality care, as called for in DAV Resolution 238.

S. 1325, the Better Workforce for Veterans Act of 2017

S. 1325, the Better Workforce for Veterans Act of 2017, a comprehensive measure to streamline and strengthen hiring practices at the Department of Veterans Affairs (VA) includes provisions to address chronic workforce shortages by improving recruitment efforts, hiring practices, and training and retention of quality employees.

The bill would allow direct hiring of students and recent graduates into competitive and excepted services and would provide authority for VA to hire former federal employees for certain high demand positions. It would authorize VA to hire senior executives using resume-based hiring techniques and require VA to determine the effectiveness of recruiting and hiring activities as well as the creation of a standardized exit survey for VA employees. We do note that in creating new flexibilities, caution must be taken to ensure that VA still adheres to existing merit review principles including veteran, minority, and disability status of job candidates and new hires.

S. 1325 would require that reductions in force consider performance and the establishment of a process for public-private talent exchange. The bill also requires a report on workforce vacancies within the Veterans Health Administration (VHA); evaluation of pay for medical center directors and VISN directors; and the establishment of a human resources academy within VHA. We note that experts and panels, such as the congressionally established Commission on Care, recommended VA further review and amend its own policies to streamline and reduce redundancies and inefficiencies in its recruitment and hiring processes. We are pleased to see the emphasis on the development of the VA's human capital management talent in this bill and we encourage the Committee to hold VA accountable for reform from within the agency.

DAV Resolution No. 244, in part, calls for modernization of VA's human resources management system to enable VA to compete for, recruit and retain qualified employees needed to provide comprehensive quality health care services to our nation's sick and disabled veterans. While we do not have a resolution from our membership related to all of the specific provisions in this bill, we support the overarching goal of S. 1325, aimed at helping VA to fill important health professional staff vacancies, including key leadership positions within VHA, which is integral and essential for providing veterans timely access to quality care.

Draft Bill, Department of Veterans Affairs Quality Employment Act of 2017

This draft bill, the Department of Veterans Affairs Quality Employment Act of 2017, contains provisions that are aimed at improving the Department of Veterans Affairs' (VA) authority to hire and retain physicians and other employees. The bill would establish an executive management fellowship program, require a process for assessing the performance of political appointees, allow VA to directly hire physicians who have satisfactorily completed residency training in the Veterans Health Administration (VHA); establish mechanisms to improve human resources activities including, recruitment, hiring and retention of quality employees and require that the Government Accountability Office review succession and workforce planning within the Department.

As we noted with regard to S. 1325 above, DAV supports the goal of this bill in accord with DAV Resolution No. 244, which, in part, calls for modernization of VA's human resources management system to enable VA to compete for, recruit and retain qualified employees needed to provide comprehensive quality health care services to our nation's sick and disabled veterans. While we do not have a resolution from our membership related to all of the specific provisions in this bill, we support the overarching goal of this draft bill.

Discussion Draft, the Veterans Choice Act of 2017

DAV Resolution 238 calls on the nation to:

> *"…honor the service and sacrifices of our nation's ill and injured veterans by strengthening, reforming and sustaining a modern, high-quality, accessible and accountable VA health care system; AND … in order to provide timely and convenient access to enrolled veterans, the VA health care system must evolve by creating integrated networks with high-quality community providers where needed, including the Department of Defense and academic affiliates, with VA acting as the network coordinator and principal provider to ensure integrated, high-quality, comprehensive and veteran-focused health care.*"

As currently drafted, the Veterans Choice Act of 2017 is not in alignment with the goals contained in DAV Resolution 238. Although there are some provisions within the measure that DAV could support, DAV opposes the draft bill because the overall effect would lead to fragmented and uncoordinated care for millions of enrolled veterans, leading to worse health outcomes. Further, the enormous cost of unfettered choice proposed by the bill, as well as the resultant impact on VA's ability to maintain the critical mass necessary to provide a full continuum of care to enrolled veterans, particularly disabled veterans, would endanger the long term viability of the VA health care system.

The draft bill would require VA to pay for private sector care for every enrolled veteran seeking any health care service from any qualified health care provider without any authorization or even consultation required from any clinical entity responsible for coordinating their care. The congressionally-mandated Commission on Care (Commission) considered and debated similar unfettered choice proposals during the last Congress, but ultimately rejected them because they

concluded such proposals were both clinically unsound for veterans and financially unfeasible for VA or the federal government.

Our main objection to the draft bill is that it would create a separate and operationally-distinct community care network in which VA is simply a payer of care, a concept we strongly disagree with because it would lead to uncoordinated and fragmented care for millions of veterans. The final report by the Commission on Care concluded that, "veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers."[2] Furthermore, VA's primary care (medical home) model with integrated mental health care has proven more likely to prevent and treat conditions unique to or more prevalent among veterans, particularly those with disabilities or chronic conditions. For these reasons, DAV, our partners in the Independent Budget, other VSOs, the Commission on Care and Secretary Shulkin all favor the approach of building integrated networks with a modernized VA health care system acting as the coordinator and primary provider of care, along with other federal and community providers offering high quality health care options for veterans, whenever and wherever necessary.

Although no cost estimates for the draft bill were made available to us, economists working for the Commission did analyze a number of similar proposals that offered varying levels of choice, including unfettered choice, and their projections provide benchmarks. The Commission recommended an option in which enrolled veterans could choose their primary care providers from within an integrated network, but limited their choices for specialty care. The Commission noted that in establishing integrated networks, VA "…must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources…" By contrast, the draft measure does not appear to contemplate any such tradeoffs in terms of network size or veteran choice.

The Commission's economists estimated that the recommended limited choice option would increase VA spending by at least $5 billion in the first full year, though they cautioned that it could be as high as $35 billion without strong management control of the network. The Commission's economists also analyzed an unfettered choice option to allow veterans the ability to choose any VA or non-VA provider—without requiring them to be part of any defined network. The economists estimated such a plan could cost up to $2 trillion more than current projections for VA expenditures over the first ten years. Based on the premise that the draft bill would provide unfettered choice for all enrolled veterans, create an extremely broad – almost universal – network, and lacks any effective coordination mechanisms, it seems likely the costs to implement such a proposal would be significant, somewhere between the estimates for the two Commission options discussed above. In today's fiscal environment, it seems unrealistic such dramatic spending increases would be appropriated or sustained, and even if approved, the cost shift and patient migration to private care would ultimately endanger the viability of the VA health care system.

[2] Commission on Care. (2016). *Commission on Care: Final Report.* Page 28. Accessed July 5, 2017 from https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

It is imperative that any veterans health care reform measure must improve the overall delivery of high-quality care to enrolled veterans, both directly by VA and by community partners. To accomplish this goal, as Secretary Shulkin has repeatedly testified, it is essential to modernize the VA health care system in numerous ways, including, but not limited to addressing: challenges in recruiting, hiring and retaining the best and brightest; deficiencies in capital infrastructure—beginning with VA leases which have not been authorized since 2012; critical gaps in VA's medical care benefits package, particularly access to urgent care in the community; the need to change VA's authority to provide veterans greater access to telemedicine; inadequate clinical grievance and appeals processes available to veterans when there is a difference of opinion between the patient and provider; and budget, appropriations and internal accounting processes that impede fully funding and efficiently utilizing resources provided to VA health care.

These are but some areas identified in the sweeping 4,000-page Independent Assessment Report issued in 2014 and the subsequent Commission on Care report of 2016, both of which recommended taking an integrated systems approach to addressing challenges hindering VA's consistent delivery of timely, high-quality health care to our nation's veterans. These reports and other independent experts agree that care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, however it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. If left unaddressed, problems with staffing, facilities, capital needs, information systems, procurement and health disparities threaten the long-term viability of VA care and the health and well-being of millions of veterans who choose VA to meet their health care needs.

The Commission, VA and the VSO community all agree that building an integrated, high performing VA health care network should focus on the most cost-effective, compatible, and highest quality community partners, specifically the Department of Defense (DOD), the Indian Health Service (IHS), and other federal health systems, as well as university hospitals that have existing academic affiliations with VA, followed by the best of private providers. Utilizing these providers first would capitalize on the cultural and military competence inculcated in VA health and offered by federal partners and academic medical centers affiliated with VA. It is important to note that VA's relationship with U.S. medical schools and teaching hospitals has benefitted our nation's ill and injured veterans and serves this nation's medical education system by helping train more than 20,000 individual medical students and more than 40,000 individual medical residents within VA facilities. In fact, the VA health care system represents the largest training site for physicians, and funds approximately 10 percent of national graduate medical education costs annually. Strengthening VA's relationships with academically-affiliated medical centers supports this critical pipeline of clinicians that serves not just veteran patients but the U.S. patient population in general.

To ensure the overall quality of health care provided to enrolled veterans, VA must retain responsibility as the coordinator and principal provider of veterans care. Decisions about veterans' access to community network providers should be based on clinical determinations and veteran preferences. Such shared decision-making would involve veteran patients as active

partners with the clinician in treatment decisions, to clarify acceptable medical options and choose appropriate treatments. While not all patients want to play an active role in choosing a treatment, most want clinicians to inform them and take their preferences into account. The draft bill, however, would result in a system in which veterans who choose to use community care are often left on their own to make critical decisions about health care treatment options, without clinical guidance.

The draft bill also lacks mechanisms to assess the value of care VA purchases from non-Department providers, to review the quality of community care veterans receive, how it impacts veterans' health outcomes, and veterans' satisfaction in the same manner as the care VA directly provides veterans. Without such metrics it is difficult, if not impossible, to ensure the highest levels of quality and safety for veterans. Moreover, because the draft bill lacks strong coordination between VA and community providers, the quality of care could be adversely affected if important clinical information is not promptly and clearly communicated between VA, federal and community providers.

Mr. Chairman, although DAV opposes the draft bill in its current form, we remain committed to working with you and the Committee to develop long-term health care solutions so that ill and injured veterans have increased access to timely, high quality, cost-effective care in a high performing, integrated VA health care network.

Discussion Draft, Improving Veterans Access to Community Care Act of 2017

Pursuant to DAV Resolution 238 calling for strengthening, reforming and sustaining the VA health care system, DAV is pleased support this measure which would improve access to care in the community, while preserving and enhancing the unique benefits and vital services VA provides to DAV members and all eligible veterans. The draft bill includes many of the recommendations put forward by DAV, other VSOs, VA and the Commission on Care, and embodies the shared approach of building integrated networks with a modernized VA health care system acting as the coordinator and primary provider of care, along with other federal and community providers offering high quality health care options for veterans, whenever and wherever necessary.

DAV and our *Independent Budget* (IB) partners have proposed a comprehensive framework to reform VA health care based on the principle that it is the responsibility of the federal government to ensure that disabled veterans have proper access to the full array of benefits, services and supports promised to them by a grateful nation. In order to achieve this goal, our comprehensive framework has four pillars—Restructure, Redesign, Realign, and Reform. We offer our views on specific provisions of this draft bill, the Improving Veterans Access to Community Care Act of 2017, which we believe fit within this framework and recommend it be part of the final legislation this Committee passes to reform VA health care.

> ***I. Restructure*** *our nation's system for delivering health care to veterans, relying not just on a federal VA and a separate private sector, but instead creating local Veterans-Centered Integrated Health Care Networks that optimize the strengths of all health care*

resources to seamlessly integrate community care into the VA system to provide a full continuum of care for veterans.

Veterans-Centered Integrated Health Care Networks

To this end, we believe the health care network contemplated in this draft measure would most likely yield the local Veterans-Centered Integrated Health Care Networks. Like private sector health care plans and larger provider systems that offer health coverage, the proposed section 1730A(c)(4) of this measure will allow VA to create a tiered network that would best meet the expectations of veteran patients at the local level.

This kind of integrated network should provide veterans information they would need to make informed decisions. For example, information about the quality of the community providers in this network will give veterans the ability to discern between those community providers that are more knowledgeable about the veteran experience and unique needs, information about the satisfaction rating from other veterans who have seen that provider, and whether there is a good working relationship with the VA that facilitates care coordination.

This integrated network would create and preserve the kind of community-VA provider partnership that mirrors the care our members value most in the VA health care system. We also support the provision that would prohibit VA from limiting veterans to receiving care or services from an entity in a specific tier.

To that the formation of local Veterans-Centered Integrated Health Care Networks leads to an overall high performing network, our framework places VA as the coordinator and principal provider of care, which is discussed in detail below. The development of VA's current primary care (medical home) model with integrated mental health care has proven more likely to prevent and treat conditions unique to or more prevalent among veterans, particularly those with disabilities or chronic conditions.

II. Redesign *the systems and procedures by which veterans access their health care with the goal of expanding actual, high-quality, timely options; rather than just giving them hollow choices:*

Care Coordination

We strongly urge the Committee to preserve the organizational model required in Section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; title 38, United States Code, 1701 note) in any future consolidation of VA's purchased care authorities. Section 106 effectively created a "wall" that separated the financial and clinical operations of the current Choice program, which better insulated front-line clinicians, such as VA Community Health Nurse Coordinators, social workers, or other VA health care professionals against the fiscal pressures that have been known to sway clinical decisions and delay or deny community care to veterans.

DAV also strongly urges the Committee to discontinue the current arrangement under the Choice program that has effectively removed a critical part of the care coordination responsibility away from VA front-line clinicians. VA Community Health Nurse Coordinators are the veteran's case manager and coordinators of care who work with the veteran's health care team to provide for the veteran patient's medical, nursing, emotional, social and rehabilitative needs as close to and/or in the veteran's home.

While VA Community Health Nurse Coordinators are now better able to exercise their clinical authority due to the Section 106 reorganization, they are frustrated having lost their ability under the current Choice program to act as a liaison between community providers and VA and as an advocate for their veteran patients—who themselves have unsuccessfully tried to exercise their Choice option and asked for assistance from their VA nurse coordinator—to get the care they need in the community.

We strongly support the proposed section 1730A(a)(2) in this bill that requires VA coordinate veterans care especially if that care is provided in the community and paid for by the Department.

Community Care Eligibility

For veteran patients, waiting for a health service begins when the veteran and the appropriate clinician agree to a service, and when the veteran is ready and available to receive it. We believe it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor—without bureaucrats, regulations or legislation getting in the way. We urge the Committee to consider that as the new local Veterans-Centered Integrated Health Care Networks are fully phased in, decisions about providing veterans access to community network providers should be based on clinical determinations and veteran preferences, rather than arbitrary time or distance standards that exist in the current Choice program.

While this measure proposes a standardize eligibility criteria for veterans to receive clinically necessary care in the community, we stand ready to work with the Committee to ensure veterans, and especially service-connected veterans are not any more encumbered in receiving care in a reformed VA health care system. For example, if clinical access to a primary care provider is to be used, we recommend language employing a full-time primary care "provider" rather than "physician."[3] This would ensure uniformity with the private sector practice of using non-physician providers in primary care settings. We also support the provision making eligible to receive care in the community those veterans enrolled in Project ARCH so they do not experience a disruption in the care they have been receiving when the authority for the program is consolidated.

DAV is supportive of VA's approach in determining when veterans should be given the option to receive care in the community through shared decision-making leveraging the relationship between a veteran and their doctor, and using business intelligence about clinical performance and quality of care. This new focus will strike a better balance in using community

[3] Proposed section 1730A(b)(1)(B)(ii)

care to fill gaps in service than unfettered choice. This approach is more likely to be sustainable, a hallmark of good governance, as well as garner higher patient satisfaction.

Veterans Care Agreements

Section 201 of this draft measure would authorize the establishment of "Veterans Care Agreements," and would prescribe the types of providers eligible for participation. We support the establishment of such agreements, but we are concerned that VA would be required to first exhaust other acquisition strategies before being allowed to pursue such agreements. In addition, different terms are used for paragraph (4) in both bills. We appreciate the use of the term "provider" be used rather than "health care provider" for consistency and ease of implementation of this section by the Department. We agree with VA's assessment regarding the need for this authority to be enacted into law without further delay and applaud the inclusion of this provision.

Emergency and Urgent Care

DAV recommends this measure includes provisions to make urgent care part of VA's medical benefits package and to better integrate emergency and urgent care with the overall health care delivery system. DAV believes a health care benefit package is incomplete without provision for both urgent and emergency care. We note S. 1261, the Veterans Emergency Room Relief Act of 2017, is on today's agenda and refer to our comments on that bill as it pertains to these critical health care services.

Emergency Care Defined

Carrying out the multiple and complex authorities[4] for VA to pay or reimburse emergency care under title 38 are a source of continuous complaints and can drive ill and injured veterans and their families to financial ruin.

According to VA, "in FY 2014, approximately 30 percent of the 2.9 million emergency treatment claims filed with VA were denied, amounting to $2.6 billion in billed charges that reverted to Veterans and their [Other Health Insurance]. Many of these denials are the result of inconsistent application of the "prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care."

One of the by-products of Emergency Medical Treatment and Labor Act (EMTALA) was the prudent layperson standard in response to a critical payer issue of the day—payment denials for the lack of prior authorization. To address the inconsistent application of the prudent layperson standard, DAV recommended the "emergency condition" be defined using EMTALA, with a minor amendment to include behavioral conditions, so that the definition of an emergency condition for VA purposes would be:

> "A medical [or behavioral] condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate

[4] 38 U.S.C. §§ 1703, 1725 and 1728

> medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. With respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child."

Claims Processing and VA as Primary Payer

In addition, VA's processing of claims has been a significant weakness to the Department's community care programs resulting in costlier care, inappropriate billing of veterans and strained partnerships with community providers. Government Accountability Office reports throughout the years have consistently highlighted disturbing limitations in the Department's claims processing system as having unnecessary manual operations rather than automatically applying relevant information and criteria to determine whether claims are eligible for payment and notifying veterans and community providers about the results of the determination, payment, and appeal procedures.

Many veterans worry about claims that are not paid promptly or are left unpaid, and they are left in a difficult position of trying to get claims paid or be put into collections. These delays or denials create an environment where community providers are hesitant to partner with VA for fear they will not be paid for services provided. Hospitals and community providers have also expressed concern that prompt payment laws do not apply to care that is provided to veterans if they do not have a contract with VA.

Having heard complaints from veterans regarding section 101(e) of the current Choice program, which places on them greater financial burden and emotional stress while trying to recover from injuries and illnesses. Congress passed Public Law 115-26 reverting back the responsibility of the government as first-payer and prompt payer for care and services. We appreciate this measure reaffirming this policy.

Thus, DAV supports the required claims processing in Section 102 of this draft measure, which would apply the prompt payment act to all services under the new Veterans Community Care Program and would allow VA to continue accepting paper claims. Ostensibly, the quicker processing of electronic claims could act as an incentive for community providers to submit claims electronically. This section would mandate the establishment of an electronic interface to enable private providers to submit electronic claims as required by the section. We appreciate the provision in this draft measure requiring an eligible provider to submit claims to VA within 180 days of furnishing care or services. These factors are critical elements in high performing Veterans-Centered Integrated Health Care Networks particularly with community providers who do not have the resources to dedicate solely to electronic claims processing.

First and Third-Party Collections

We urge this committee to include language statutorily requiring VA to offset a veteran's copayment debt with monies VA receives from billing the veteran's health insurance plan.

Under current law, service-connected veterans are required to pay their share of costs created as a result of medical treatment rendered as inpatient, outpatient, extended care, or medication for a nonservice-connected disability or condition. VA is also authorized by law to recover the reasonable cost of medical care furnished to a veteran for the treatment of a nonservice-connected disability or condition when the veteran or VA is eligible to receive payment for such treatment from a third-party.

While the law allows VA to recover reasonable costs, the Department has had a long-standing practice of applying all third-party payments first to the corresponding co-payment to extinguish the veteran's share of costs before the government's. The veteran is billed for the portion of the co-payment not covered by the insurance reimbursement and the portion of the co-payment.

Recently however, VHA issued a memo (VHA Notice 2017-40) rescinding this long-standing practice. It is unconscionable that VA is placing its interest before that of service-connected veterans by requiring them to pay copayments in addition to collecting reimbursements from their health plan without offsetting the veteran's copayment debt.

III. Realign *the provision and allocation of VA's resources so that they fully meet our national and sacred obligation to make whole those who have served.*

Section 203 is in line with our recommendation to maintain the financial and clinical reorganization under Section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; title 38, United States Code, 1701 note). We believe it is beneficial to require, rather than make discretionary, the transfer of funds and payment of services to the Chief Business Office of the VHA. This would help ensure transparency and accountability to a single entity when conducting oversight. Moreover, we believe Section 204 is beneficial in addressing known issues with VA purchasing care in the community and allowing the Department to better manage its resources.

In conclusion Mr. Chairman, DAV supports this draft measure, the Improving Veterans Access to Community Care Act of 2017, which contains many provisions and aligns with the overall approach proposed by DAV, the IB, other VSOs, the Commission on Care and VA. Further, it embodies the goals of DAV Resolution 238, which calls for strengthening, reforming and sustaining a modern, high-quality, accessible and accountable VA health care system, while expanding access to care by creating integrated networks, with VA acting as the coordinator and principal provider of care, and community partners providing access whenever and wherever necessary.

This concludes my testimony, Mr. Chairman. I would be pleased to respond to any questions from you or the Committee Members concerning our views on these bills.